

Meeting: Trust Board Meeting in Public

Date: Wednesday, 27 July 2022

Time: 09:30 – 12:00

Venue: Via MS Teams

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

General Business

	3.	Patient Story	Discussion	Chief Nurse	Paper
10.00	4.	Minutes of the last meeting held on: <ul style="list-style-type: none"> 25 May 2022 	Approval	Chair	Paper
	5.	Actions and Matters Arising	Approval	Chair	Paper
	6.	Chief Executive's Report	Assurance	Chief Executive Officer	Paper
	7.	Place and System Briefing <ul style="list-style-type: none"> Levelling Up Buckinghamshire 	Assurance Approval	Chief Executive Officer	Paper

Board Sub-Committee Chair's Reports

10.25	8.	Finance and Business Performance Committee Chair's Report	Assurance	Committee Chair	Paper
	9.	Charitable Funds Committee Chair's Report <ul style="list-style-type: none"> Terms of Reference 	Assurance	Committee Chair	Paper Paper
	10.	Quality and Clinical Governance Committee Chair Report	Assurance	Committee Chair	Paper
	11.	Strategic Workforce Committee Chair Report	Assurance	Committee Chair	Paper
	12.	Audit Committee Chair's Report <ul style="list-style-type: none"> Terms of Reference 	Assurance	Committee Chair	Paper Paper

Performance

10.40	13.	Integrated Performance Report (IPR)	Assurance	Chief Operating Officer	Late Paper
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QUESTIONS FROM THE PUBLIC

10.55		COMFORT BREAK – 10 minutes			
11.05	14.	Operating Plan Update	Assurance	Director of Finance	Paper

Finance

11.15	15. Monthly Finance Report	Assurance	Director of Finance	Paper
	16. Charitable Funds Policy	Approval	Director of Finance	Paper

Quality

11.25	17. Quality Account	Approval	Chief Nurse	Paper
	18. Mortality Report	Assurance	Chief Medical Officer	Paper

People

11.35	19. Medical Appraisal and Revalidation Annual Report	Approval	Chief Medical Officer	Paper
	20. Freedom to Speak Up Guardian Annual Report	Assurance	Chief People Officer	Paper

Risk and Governance

11.45	21. Corporate Risk Register	Assurance	Chief Nurse	Paper
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Information

11.50	22. Infection Prevention Control Report (<i>changes to IPC policies only not report that goes to quality committee</i>)	Information	Chief Nurse	Paper
	23. Health and Safety Annual Report	Information	Chief Commercial Officer	Paper
	24. Private Board Summary Report	Information	Trust Board Business Manager	Paper
	25. Modern Slavery Act Annual Statement	Information	Chief People Officer	Paper
	26. Risks identified through Board discussion	Discussion	Trust Board Business Manager	Verbal

ANY OTHER BUSINESS

QUESTIONS FROM THE PUBLIC

Date of Next Meeting:
28 September 2022, 9:30am

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

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

TRUST BOARD MEETINGS

MEETING PROTOCOL

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

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

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

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

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

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

David Highton
Trust Chair

THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

Selflessness

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

Integrity

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

Objectivity

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

Accountability

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

Openness

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

Honesty

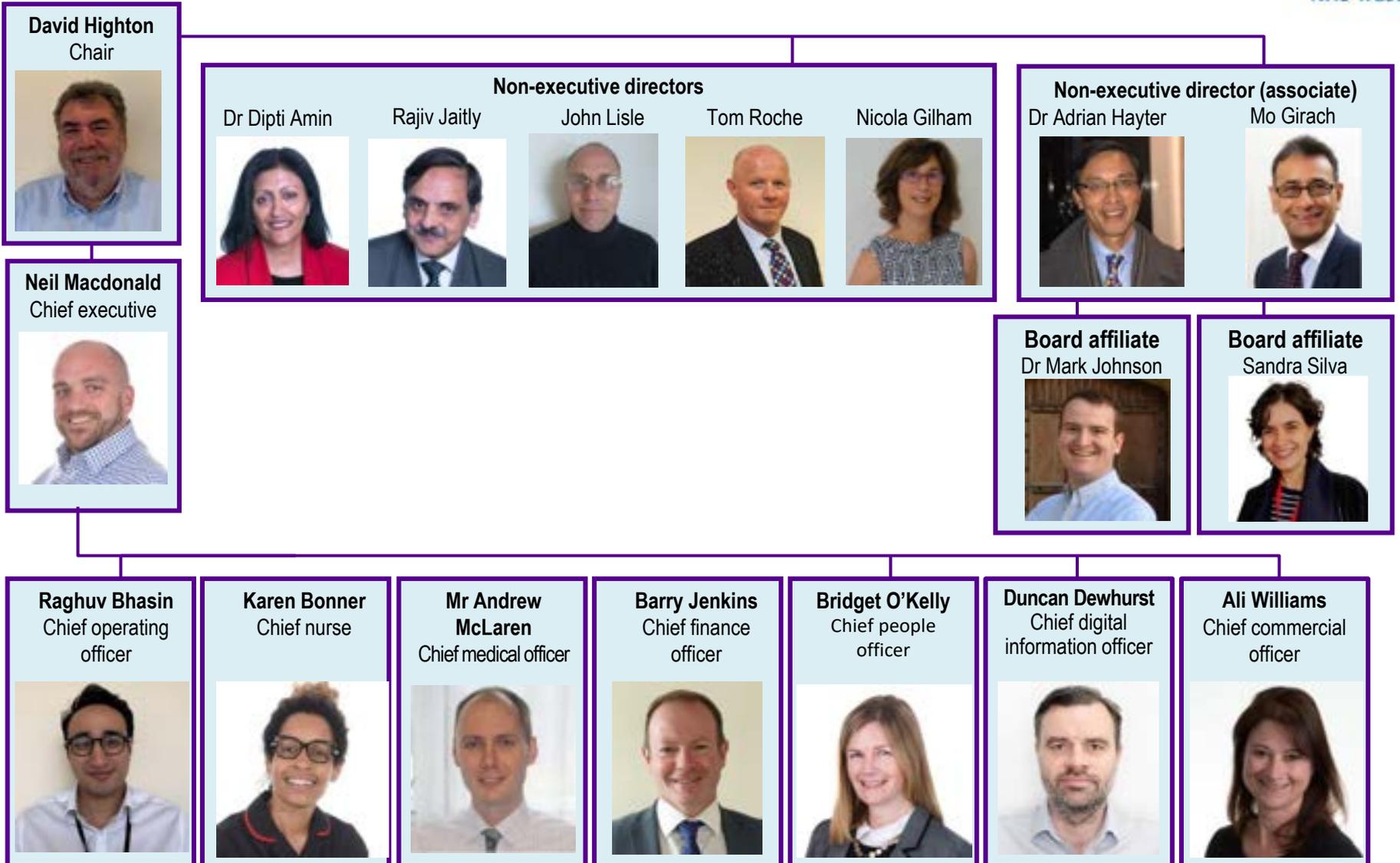
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

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

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

Board of directors



Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Patient Story
Board Lead	Karen Bonner, Chief Nurse
Type name of Author	Heather Brown Interim Head of Patient Experience and Involvement
Attachments	Maya's Story – Youtube clip
Purpose	Discussion
Previously considered	QCGC 20.07.2022

Executive Summary

This paper summarises the patient feedback given by a 17-year-old paediatric patient who was admitted to Ward 3 at Stoke Mandeville Hospital in 2022.

When a young teenage girl was admitted to Ward 3 at SMH with an eating disorder, she gave us feedback that staff lacked confidence to engage and support her.

BHT colleagues listened carefully to Maya's experience and worked in partnership with our Child and Adolescent Mental Health Service (CAMHS) to make improvements. Other families experiencing all types of mental health crisis were equally generous with their feedback, and further contributed to changes to the way we care for children and young people – including the innovative use of therapy dogs. When Maya was next admitted, it was a whole new and much more positive experience.

Given the significant rise in admission of young people with mental health problems over the past 2 years, these changes - informed by patient experience - have had far-reaching impact.

Maya's story: <https://youtu.be/E1CAClydkqs>

The Quality & Clinical Governance Committee discussed the patient story on 20 July congratulating the work of the team, recognised regionally, particularly in view of the national rise in mental health issues in children and young people, specifically eating disorders. The positive leadership of the team was recognised, acknowledging that mental health training was no longer compulsory within basic nursing training.

Decision	The Board is requested to reflect and learn from the patient feedback provided.		
Relevant Strategic Priority			
Outstanding Care <input checked="" type="checkbox"/>	Healthy Communities <input type="checkbox"/>	Great Place to Work <input checked="" type="checkbox"/>	Net Zero <input type="checkbox"/>
Implications / Impact			
Patient Safety	Impact on quality and safety standards and patient experience		
Risk: link to Board Assurance Framework (BAF)/Risk Register	None		
Financial	Financial impact of clinical variation, avoidable harm and length of stay and complaints.		

Compliance CQC Standards	Person centred care, safety, safeguarding, complaints, Duty of Candour compliance
Partnership: consultation / communication	Working with key stakeholders in quality, safety and experience including the paediatric wards.
Equality	Potential for inequality due to known health inequalities across the county. The current Covid-19 pandemic has been found to disproportionately impact on specific patient groups e.g. men, over 50s and BAME. Risk of discrimination of patients from diverse backgrounds and poorer socio-economic communities.
Quality Impact Assessment [QIA] completion required?	No. All policies impacting on activity referred to in this report have undertaken Equality Impact Assessments including: Duty of Candour and Being Open and Incident reporting including the Management of Serious Incidents

1 Introduction/Position

Listening to the personal stories of others, especially those about emotional issues like health, can help us learn and make an impact on how we behave.

Reading/listening to their stories helps us understand the experience of being a patient/relative. They also show how staff can play a critical role in optimising the power of the story in the patient's journey towards physical and psychological healing.

2 Problem

Patient feedback identifying that staff seemed to lack confidence in engaging/communicating with Maya (the patient) due to her mental health. Maya felt that staff lacked the time to communicate with her or include her in conversations about her care.

3 Possibilities

Learning from colleagues within ward 3 on the changes/improvements made to ensure patients experience and feedback is positive.

4 Proposal, conclusions recommendations and next steps.

Telling the story of one patient's experience of care can memorably illustrate improvements or problems in a care pathway. Statistics and data have an important place in monitoring and understanding services and facilitating improvement, but the right story can also have the power to motivate and change minds.

5 Action required from the Board/Committee

The Board is requested to:

- a) Reflect on the feedback provided by the patient and their family
- b) Note the improvement implemented in response of the patient feedback

APPENDICES

Appendix 1: Maya's Story - <https://youtu.be/E1CAClydkqs>

Meeting: Trust Board Meeting in Public

Date: Wednesday, 25 May 2022

Time: 09.30 – 12.00

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

MINUTES

Voting Members:

Mr D Highton (DH)	Trust Chair
Mr N Macdonald (NM)	Chief Executive Officer
Mr Raghuv Bhasin (RB)	Chief Operating Officer
Ms K Bonner (KB)	Chief Nurse / Director of Infection Prevention Control
Mrs N Gilham (NG)	Non-Executive Director
Mr R Jaitly (RJ)	Non-Executive Director
Mr B Jenkins (BJ)	Chief Finance Officer
Mr J Lisle (JL)	Non-Executive Director
Mr A McLaren (AM)	Chief Medical Officer
Mr T Roche (TR)	Non-Executive Director

Non-Voting Members:

Mr M Girach (MG)	Associate Non-Executive Director
Dr A Hayter (AH)	Associate Non-Executive Director
Dr M Johnson (MJ)	Board Affiliate
Mrs B O'Kelly (BOK)	Chief People Officer
Mr I Roddis (IR)	Interim Chief Digital Information Officer
Ms S Silva (SS)	Board Affiliate

In attendance:

Mrs E Jones (EJ)	Senior Board Administrator (minutes)
Ms R Kennedy (RK)	Matron Amersham Hospital (for agenda item 3)
Mr W Preston (WP)	Deputy Chief Commercial Officer

01/05/22 Chair's Welcome, introductions and apologies

The Chair welcomed everyone to the meeting

Apologies for absence had been received from Jo James, Trust Board Business Manager, Dipti Amin, Non-Executive Director and Ali Williams, Chief Commercial Officer, Wayne Preston, Deputy Commercial Officer was representing her.

02/05/22 Declarations of Interest

Nicola Gilham noted she had recently been appointed to the Board of North West London ICS / ICB as Independent Non-Executive Director.

There were no additional declarations of interest declared.

03/05/22 Staff Story

BOK introduced Rose Kennedy, Matron at Amersham Hospital who was attending to share the story of Mark, who had joined the Trust as an HCA after completing a six-week Positive

Steps course with Bucks University. Mark had an IT background, had never worked in healthcare before and had been unemployed for 18 months before undertaking the course. Mark had proved to be an excellent and caring member of staff demonstrating calmness and confidence and had recently been promoted within the Trust as an HCA with therapy skills and was also a mentor for HCAs to help support and develop their careers.

NG applauded the opportunity the Trust was taking looking at individuality and transferable skills and KB thanked RK recognising her leadership skills and noted it was hoped to use the scheme across the Trust.

SS commented on the great programme especially the combination of an HCA with an interest in therapies and queried the plans for increasing participants in the programme. BOK responded noting the programme was a real success and would be continued and expanded.

TR queried how the Trust could identify and reach out to potential candidates for this scheme. RK recognised the volunteers currently coming onto wards which was an opening for accessing the Positive Steps course. BOK explained there were multiple channels of recruitment including ways in which people can come into the Trust and offer support.

DH thanked Rose and Mark for sharing their story.

The patient story was **NOTED** by the Board.

04/05/22 Minutes of the last meeting

The minutes of the last meeting on 30 March 2022 were **APPROVED** as an accurate record.

05/05/22 Actions and matters arising

The Board **NOTED** the action log.

06/05/22 Chief Executives Report

NM highlighted the impact of COVID-19 on children and the Trust's responsibility to contribute to the recovery of the effect of this. The high-profile consequences were on elective waiting lists and accessing GPs. The Trust's community services for children were focusing on health outcomes and developmental pathways for very young children following lockdowns. The local Special Educational Needs and Disability (SEND) inspection results showed there was more work to do with partners, and the Trust would make this a high priority in making our community healthier. KB would lead this work which would be reported back to the Trust Board Meeting in Public.

NG commented on the action included to recruit into specialties which would support this work and queried if there were clear and robust plans for this recruitment. NM noted the national shortage of health visitors, community paediatricians and community speech and language therapists which was a challenge however work was underway to provide information and advice in other ways such as pharmacists and webinars.

AH queried how community waiting lists were being tackled such as speech and language therapy and audiology. NM and RB noted work was underway to manage the waits in the same manner as the other waiting lists (risk based) and to have complete visibility and overview including follow up lists. NM stressed the importance of all patients waiting for care were communicated with.

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

07/05/22 Place and System Briefing

NM highlighted the mutual aid and key system working to reduce the long waiters list and the development of a provider collaborative which would bring better value for the taxpayers by understanding the benefits of scale.

NM highlighted the national information around planning and noted the Trust did not yet have a compliant financial plan however the plan would be resubmitted in June recognising the System had a financial gap. It was expected there would be support for inflationary pressures. The Trust was part of supporting the System to a compliant plan and it was noted this had been discussed in full at the Finance and Business Performance Committee the previous day.

RJ queried how specialities and expertise would be shared across the system and how this would work for both patients and the Trust's recovery work. TR questioned the benefits of this for both colleagues and residents of Buckinghamshire.

NM responded noting the sharing of expertise and focus on specialities would ease pressure on orthopaedics, ophthalmology and ENT by sharing capacity, clinical leadership and opportunities to share learning. Theatre performance, both safety and productivity, would also be tracked at a system level. The integrated space provided a huge opportunity to share learning and benchmarking. NM noted the benefit for the patient would be to provide the best in class, quality of care, a reduction in waiting times and improving access.

DH noted the creation of the Integrated Care Board was part of the plan to achieve an integrated and collaborative approach rather than a competitive approach.

The Board **NOTED** the report.

08/05/22

Finance and Business Performance (F&BP) Committee Chair's Report

NG updated the Board on the meetings of F&BP held on 26 April and 24 May 2022. Assurance had been provided from scrutiny of the Integrated Performance Report (IPR) noting the improvements in cancer performance, theatres being booked to full capacity and reducing cancellations. The Committee had recognised the importance of pay spend and asked for triangulation of safe staffing, vacancy rates and temporary staffing use and actual spend versus budgeted pay spend. Significant milestones were in place for the Urgent and Emergency Care improvement plan and the monthly finance report and the operational plan had been discussed.

The Board were **ASSURED** by the report.

09/05/22

Organ & Tissue Donation Committee Chair's Report

In the absence of DA, NM recognised the important work of the team led by the specialist nurses and critical care team and flagged the importance of organ donation.

The Board **NOTED** the report.

10/05/22

Quality and Clinical Governance Committee (Q&CG) Chair Report

In the absence of DA, KB updated the Board on the meetings of the Q&CG Committee on 20 April and 18 May 2022. The Committee had discussed the new quality strategy including commissioning quality and innovation standards. The Committee were assured by the infection prevention control report, cancer report, litigation report, mortality report and GIRFT (Getting it Right First Time) report, corporate risk register and Ockenden report. Partial assurance had been received on the emergency recovery and waiting times.

The Board were **ASSURED** by the report.

11/05/22

Strategic Workforce Committee (SWC) Chair Report

TR updated the Board of the meeting of SWC held on 9 May 2022. Assurance had been provided on progress with nursing recruitment which included international recruitment and work ongoing for the Trust to 'grow its own'. The Committee were assured through the IPR on community recruitment and more detail was requested on managing long term sickness and keeping staff supported. The Committee discussed

retention noting the Trust was part of the People Promise Exemplar Programme. The Committee received assurance from the divisional risk registers.

NM queried the scrutiny and oversight of the People Promise Exemplar Programme, BOK informed the Board this would be monitored through the SWC and would come to Board on an annual basis for oversight.

The Board were **ASSURED** by the report.

12/05/22 Audit Committee Chair's Report

RJ updated the Board on the work of the Audit Committee focussing on the Annual Report and Accounts, Governance Statement, Self-Certification and Audit. All the actions except one on the Board Assurance Framework were showing as complete. Concern had been expressed on the responsiveness of internal audit actions, due diligence around contracts and single tender waivers and actions had been set by the Committee to mitigate these.

The Board were **ASSURED** by the report.

13/05/22 Integrated Performance Report (IPR)

RB noted the improvements during April despite significant sickness absence due to COVID-19, including cancer performance and in the urgent community response standard which provided care for patients in their own homes to prevent admission. There had been a continued reduction in 12 hour waits in the emergency department which reflected the urgent and emergency care improvement programme. There had been a lower than expected hospital mortality ratio which was positive and a reduction in temporary staffing usage.

The report reflected the challenges in the high number of medically optimised for discharge patients and challenges for capacity in April which had since been addressed but remained an area of focussed work for the Trust working with partners in local authorities and in commissioning. There had been a challenge in responsiveness to complaints due to significant numbers of leavers and sickness within the team, however the Executive team had discussed and agreed a programme of recovery and improvement. KB assured the Board all those waiting for a response to a complaint had been contacted. Work was ongoing to improve the Trust vacancy rate although this was not wholly reflected due to increases in establishments to support delivery of the Trust Operating Plan.

DH noted the Q&CG committee would be having a deep dive into discharges before 17.00 which had remained flat at 50% recognising new workstreams were being initiated within Urgent and Emergency Care and across the organisation. RB noted decisions were being made too late which caused challenges especially for colleagues working at night. Board rounds were being introduced on wards to standardise the approach and promote earlier patient reviews as part of a ward-based improvement programme to move discharges earlier in the day and enable patient flow to be managed more safely.

AH commented on the improvement in 62-day cancer waits and queried how the trajectory to bring waits down would be managed. RB noted this was managed closely and additional resource was being brought in for progress tracking recognising the increase in demand and capacity was being bolstered for the summer and through learning from other organisations.

NG asked for assurance on proactive management of children's community waiting lists which had significantly increased. RB explained data for the children's community waiting list was currently being validated. All community paediatric patients were triaged, and clinical harm reviews were undertaken. Additional capacity was being provided to support these patients and urgent patients were prioritised. KB provided assurance by noting community waiting lists for children and associated actions would be overseen by the Q&CG Committee.

BOK commented on the nurse vacancy rate noting an additional 150 nurses were in post compared to the previous year. There would be further investment in the nursing workforce with international and UK graduates as well as apprenticeship pathways which would reduce the vacancy rate later in the year. The Board were assured safety was constantly monitored.

The sickness absence peak due to COVID-19 was continuing to reduce with ongoing referrals into occupational health and wellbeing team for mental health issues which was reducing mental health related sickness absence. There has been further absences due to musculoskeletal issues and a further two physiotherapists had joined the team to support this.

Statutory training had reduced in month, this was due to the addition of Level 3 Safeguarding being added further to national guidance.

JL noted there had been an increase in falls although numbers were within the control limits and queried if there was an underlying trend. KB noted the slight increase due to patient complexity and a requirement for one to one supervision. The increase in falls had not meant an increase in harm. Work was ongoing to decrease the number of falls however the numbers were indicative of the type of patients being seen in the hospitals.

NM queried how the Board could be assured colleagues were safe to work recognising the non-compliance with statutory and mandatory safeguarding training. KB noted extra training was in place and quality and safety huddles were held every morning across the acute and community services. There was good knowledge across all colleagues of where to go for support with safeguarding queries and this was being monitored by Q&CG

The Board **NOTED** the report.

QUESTIONS FROM THE PUBLIC

There were no questions from the public.

14/05/22 Monthly Finance Report

BJ informed the Board of the good progress being made with the annual accounts and the month 1 report was reporting against a penultimate plan of £29m deficit. The month was on plan with some variance and additional work to do with divisions particularly integrated medicine. It was noted COVID-19 sickness was impacting on pay expenditure. Significant work was ongoing to identify income to improve the position in the deficit plan looking at stretch opportunities around temporary staffing and recovery activity which would be finalised by 20 June 2022. BJ noted the regulator had been very supportive.

TR noted the report had been discussed in detail at F&BP however he expressed concern after Month 1 the plan was slightly behind and requested assurance the plan was achievable. BJ noted he had met with divisional leadership teams who had committed to deliver on activity, quality and finance. The importance of credible income sources were noted. The stretch would be around temporary staffing and it was important any movements in the plan were credible. Additional money was flowing into BOB and it was important to get the appropriate benefit from this income.

DH noted an additional Board meeting was required to sign off the plan by 20 June 2022 prior to submission.

The Board **NOTED** the report.

15/05/22 General Practice Vocational Training Scheme Purchase Order approval

BOK requested the Board approve the purchase order limit of up to £2.6m for the purposes of raising the annual General Practice Vocational Training Scheme (GPVTS).

AH stressed the importance of paying GP trainees on time.

The Board **APPROVED** the Purchase Order.

16/05/22 Safe (Safest) Staffing including maternity

KB informed the Board the safe (safest) staffing was overseen by daily safety huddles including at weekends. The annual nursing establishment review and budget setting had taken place and a robust process was being followed.

RJ and TR queried controls around temporary staffing. KB explained the Trust would always need temporary staffing due to a lack of nurses. BOK noted the numbers would reduce in the autumn when the recruitment of international and UK graduates as well as apprentices took place. In addition, the work on retention through the People Promise Programme would improve retention. BOK highlighted the work at system level and with colleagues in Frimley and Surrey. There were weekly meetings and complete oversight of unit costs of agencies which were tracked through SWC and F&BP plus reviews of those areas which were more dependent on temporary staffing. The focus at system level was on interdependencies and agreeing an agency rate card so the workforce was not imbalanced. There were opportunities at system level to agree an hourly rate to make savings. There would be key performance indicators (KPIs) against the number of shifts and the spend. RJ noted it was important to have an overview of rising temporary costs and to have assurance on controls and the need for temporary staffing. BOK recognised the importance of controlling temporary staffing noting the numbers in month 1 were down on the same month the previous year. BOK assured the Board the Executive Directors were focussed on this area.

RJ expressed concern most colleagues had not completed safeguarding training. KB noted safeguarding level 3 was an extra module and the Trust was working hard to ensure colleagues completed their additional training noting the safeguarding team were providing extra resilience where needed.

RJ queried why there was no quality impact assessment on the front page. KB would address this.

The Board were **ASSURED** by the report.

17/05/22 Ockenden Final Report

KB informed the Board the Trust was 100% compliant with the immediate actions in the report including weekend and evening face to face consultant ward rounds which had been implemented. The audit had been signed off by the Executive Team and submitted to NHSE/I.

JL noted the good progress and queried if there had been a review of patient feedback with regards to the culture and listening dimension. KB noted the Trust worked with the Maternity Voices' Partnership where listening and hearing from mothers was very important.

NM asked for assurance the areas in the report aside from ward rounds had been tested and were robust. KB noted all actions had oversight by the South East Region Maternity Services and the plans were tested with ongoing rigour and supported. KB noted learning would be embedded throughout the Trust, not just in maternity.

The Board were **ASSURED** by the report.

18/05/22 Annual Governance Statement

The Board **APPROVED** the Annual Governance Statement.

19/05/22 Self-Certification

The Board **APPROVED** the self-certification report.

20/05/22 Corporate Risk Register

KB updated the Board on the corporate risks for the Trust noting the ongoing work to keep the document updated and used as a live working document. Four new risks had been approved by the Executive Management Committee to be added to the register and five removed. The reason for the removals was a combination of redefining risks, lowering of scores and merging risks.

DH commented on the risk associated with midwives and queried how long the recruitment would take to be able this to be removed from the register. KB noted continuity of care was ongoing and the number of midwives had been increased to be compliant with Ockenden actions noting overseas recruitment would support this. BOK noted it would be autumn before a reduction was seen when graduates and overseas recruitment would enable the vacancy rate to be reduced.

The Board **NOTED** the report.

21/05/22 Board Assurance Framework (BAF)

NM noted the BAF had been reviewed by Audit Committee and would be updated following the Board workshop on risk and structured around the Corporate Objectives linked to the 2025 strategy.

The Board were **ASSURED** by the report.

22/05/22 Infection Prevention Control (IPC) Report

KB noted restrictions around COVID-19 were beginning to be relaxed and guidelines for 'living with COVID-19' had been received for the Trust to consider how best to continue to deliver safe care during the next phase of the pandemic.

The Trust was cautious not to overcrowd clinical areas and there was tightened governance in place for this. A weekly IPC review group had been set up to review the operational plan to deliver the guidelines including having a robust plan for oversight of lateral testing which had been raised to the national team. KB noted it was now easier for patients coming into the hospital and progressing through the waiting lists and it was important to ensure the public were fully aware of the changes.

DH commented on the change of laboratory testing to lateral flows, KB noted this was a national issue as the Trust were not able to access the results of patients' lateral flow tests prior to coming into hospital.

DH noted the closing of the financial gap nationally suggested that Trusts who had not fully implemented the national guidance would have to identify the cost of not complying. DH believed it was important to retain a level of discretion particularly over social distancing where necessary. KB concurred with DH noting the Trust was particularly cautious around cancer and immunosuppressed patients.

There would continue to be a monthly update from IPC.

The Board **NOTED** the report.

23/05/22 Private Board Summary Report

The Board **NOTED** the report.

24/05/22 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

25/05/22

Any other Business

- RJ noted the usefulness of the acronym buster and requested it was updated.
Action: Acronym buster to be updated – EJ

26/05/22

Risks identified through Board discussion

The following risks were identified:

- Capacity in community paediatrics
- Complaint responsiveness
- Non-compliance with safeguarding training
- Temporary Staffing pay spend

Date of next Meeting: Public and Private Trust Board Meeting: 27 July at 09.30

Public Board Action Matrix

Action ID	Agenda Item	Summary	Target Date	Variable Target Date	Exec Lead	Status	Update
1280	Ockenden - One Year On	Priority given to listening themes in complaints for review across the Trust	27/07/2022	n/a	Chief Nurse	Propose close	The Patient Experience Group review the themes of all complaints and PALS contact and enquires including listening and present a quarterly report to the Quality and Clinical Governance Committee. A monthly theme of complaints by division is also provided by the Patient Experience team to the Divisional Heads of Nursing.
1281	Serious Incidents	Update on sharing learning with midwifery schools	27/07/2022	n/a	Chief Nurse	Propose close	Learning shared with students through academic half days and learning boards
1277	Operating Plan 2022-23	Performance metrics to be included within the plan to track progress	27/07/2022	n/a	Chief Finance Officer	Propose close	Key Operating Plan metrics included within the IPR with improvement trajectories under development. Metrics not part of the IPR will be reported to Transformation Board as part of the Operating Plan Portfolio Updates. Complete dataset available from September 2022. Transformation Board retains overall oversight of delivery of the Operating Plan.
1304	AOB	Update acronym buster	27/07/2022	n/a	Senior Board Administrator	Propose close	Included within meeting papers
1279	Minutes of the Last Meeting	Confirm Trust Mental Health Lead	27/07/2022	n/a	Chief Nurse	Propose close	Executive Lead - Chief Nurse, supported operationally by the Deputy Chief Nurse
1208	Compliance with Legislation	Improved Board oversight of Health & Safety Reporting	27/07/2022 26/10/2022	n/a	Chief Commercial Officer	In Progress (deferred)	RAG rated dashboard in development, organised by area of H&S compliance. Proposing twice yearly presentation to Board. Committee oversight of H&S to be included within Committee framework
1276	Community Hubs Proposal	Detail on dementia pathway to be brought back to Board (in the context of Community Hubs Proposal). To include financial/workforce resource issues.	26/10/2022	n/a	Chief Nurse	In Progress	

TRUST BOARD MEETING IN PUBLIC
27 JULY 2022
CHIEF EXECUTIVE'S REPORT

Introduction

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

Like the national picture of NHS services, our Trust has been experiencing significant pressure in recent weeks. We have seen an increase in the numbers of colleagues testing positive for COVID-19 and either isolating and working from home or needing to take sick leave. This has added to the challenge of ensuring safe staffing levels across our sites. On top of this, the extraordinary temperatures we have seen in recent days have meant the Trust has operated under our Heatwave plan with additional support for hydration, air conditioning and fans where appropriate in terms of infection, prevention and control, and working from home to minimise unnecessary travel where possible.

These pressures come at a time when colleagues are continuing to recover, mentally and physically, from the past two years of working through a global pandemic, and I would like to take this opportunity to extend my gratitude to Trust colleagues as well as those in our partner organisations, for their continued dedication to delivering services for our patients and service users, and each other.

CQC inspection report

The Care Quality Commission (CQC) performed an unannounced inspection of our medical and surgical services in February 2022, followed by a well-led inspection in March. The CQC have now published their report of the Trust based on their findings during the days that they visited us as well as requested information that we submitted.

I am very pleased that the CQC have maintained our overall rating of 'Good', as well as 'Outstanding' for the 'Caring' domain. This is a remarkable achievement given the events of the past two years and the context at the time of the inspection, notably the high demand for our services in winter and following the peak of the COVID-19 Omicron variant, as well as associated staff absences. I personally feel privileged to work alongside colleagues who have been able to maintain a caring and compassionate attitude in their dedication to our patients and service users at such an incredibly difficult time.

The CQC identified several areas for improvement, some driven by known challenges in our estate, and reduced our rating for the 'Safe' domain to 'Requires Improvement'. We acknowledge that coming out of such a tumultuous time, we have work to do to ensure the fundamentals of safe patient care are routinely in place and there is lots of work underway by many towards this.

The CQC improved the Trust rating in the 'Well-led' domain, which is now 'Good'. This domain reflects the leadership and governance systems in place across the organisation and I am very pleased that the inspectors were able to see we have made progress in these elements since our last inspection in 2019. Of particular note, the report sites: "the Trust has an open culture where patients, their families and in general staff could raise concerns without fear". Establishing a speaking up culture in NHS Trusts has been a significant focus over the past several years since Sir Robert Francis' Freedom to Speak Up review in 2015 so, while every organisation will always have more it can do, I am pleased that this was something the inspectors noticed about BHT.

Performance and recovery

Significant focus remains on seeing patients as quickly and safely as possible.

In terms of urgent care, we continue to have challenges in seeing some patients in our Emergency Department (ED) within the timeframes that we aspire to and have recorded 71.9% performance against a target of 95% for the percentage of patients spending 4 hours or less in ED in June. Ambulance handover times have been the subject of national news recently and for June we are

reporting 27.3% against a target of 65% of handovers taking 15 minutes, and 78.6% against a target of 95% of handovers taking 30 minutes or less. Work continues in earnest with partners to improve the flow of patients through the hospital, focusing on facilitating discharge of patients who are medically fit to leave hospital.

For those patients waiting for planned care, a lot of hard work continues across all specialties, including a focus on those who have been waiting the longest. I would like to reiterate my thanks to members of the public for their patience while waiting for their appointments or treatment.

We are paying particular attention to the performance of our cancer services. While we are meeting our target of seeing 95% of patients referred for cancer testing within two weeks, due to the large numbers of patients waiting to be seen following the pandemic, we know there are many patients waiting at the next stage in their cancer pathway, whom we would typically expect to see within a maximum of 62 days. As of Friday 15 July, 342 patients had been waiting for longer than 62 days. We recognise this does not provide the experience we want to offer our patients, at what can be a particularly anxious time, and are working hard to improve this through enhancing our administrative processes so that patients receive communication as quickly as possible; expediting surgery where we can; and working with colleagues in neighbouring Trusts to help our patients see an oncologist. We expect to be able to report an improvement within the next couple of months and are aiming for the number of patients waiting longer than 62 days to be reduced to fewer than 200 patients by the end of September.

In the community, we are currently performing above the 80% target for patients with urgent referrals seen within two hours by our community teams (the Urgent Community Response services); however, our total waiting list for community services has been growing over the past few months and we have more to do to meet the demand for our services.

I would like to draw attention to the latest project to be rolled out in our digital programme - we have just launched Intellispace Critical Care & Anaesthesia (ICCA) in our intensive care units at both Stoke Mandeville and Wycombe Hospitals. ICCA is a digital application which enables charting, prescribing and clinical noting and is integrated with existing systems for patient monitoring. It will replace the current non-digital records used in the units. My thanks to our teams for their continued hard work enabling this.

Learning

In May we recorded seven instances of *clostridioides difficile* infection and four in June. We reported zero instances of MRSA bacteraemia infection in May and June. In May we recorded 423 births and 375 in June; in the same months we recorded 78 and 89 deaths, respectively. We did not report any never events in May, however, I am disappointed to confirm that on 1 July we reported an incident that had occurred a few days prior in June, had met the criteria of a never event. A guide wire was found to have been retained during a chest drain. This has been discussed with the patient involved and the guide wire removed, and colleagues involved are being supported. A full investigation is now taking place.

We continue to learn from what we have done right as well as where our patient care may not have met the high standards that we aspire to. In May we recorded 37 formal complaints and 39 in June; in total we received 164 excellence reports in these two months.

The following is an example of the personal and compassionate care we aspire to deliver at all times:

“XXX supported the admission and treatment of a very challenging paediatric patient. The surgical team which the child was admitted under were unsure whether this child would be able to attend and proceed with their treatments because of the level of her anxiety. XXX was able to build a relationship of trust with the child and enabled [the child] to remain calm throughout her admission. An excellent example of patient-led, compassionate care.”

We are currently experiencing challenges in responding to enquiries via our Patient Advice and Liaison Service (PALS) and formal complaints. This is due to staff resourcing issues which are being rectified but, in the meantime, I know that those currently using these services may not have experienced the

high standard that we continually strive to deliver, and I would like to apologise for this. Our teams are doing their utmost to communicate and respond within the expected timeframes, and we greatly appreciate the public's patience at this time.

People and Partners

Under the Health and Care Act 2022, from 1 July two core parts of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) became statutory bodies: an Integrated Care Board (ICB) which amongst others takes on the functions of the Clinical Commissioning Groups (dissolved on 30 June) within the area; and an Integrated Care Partnership (ICP) which has responsibility for delivering a health and wellbeing strategy for the system together with local authorities and other key partners.

I would like to welcome Philippa Baker as ICB Place Director. Philippa has a wealth of experience in the public sector, most recently overseeing delivery of the Health and Care Act 2022 through Parliament. We look forward to working closely with Philippa and the rest of the Integrated Care Board, further details of which can be read here: <https://www.bucksoxonberksw.icb.nhs.uk/what-is-the-icb/our-board-leadership/>.

I would also like to take this opportunity to congratulate Dan Leveson, Deputy Director of Strategy, for his appointment as ICB Place Director for Oxfordshire. Dan has worked for our organisation since 2018 and has been instrumental in developing our corporate and clinical strategy, as well as engaging with our communities on many initiatives during this time. This promotion is a tremendous achievement for Dan and I have no doubt he will lead great things for the health and wellbeing of our neighbouring county.

In June we celebrated our annual staff awards – One Team, One Goal – with several categories including but not limited to: Quality Improvement & Innovation, Lifetime Achievement, People's Award for Personal and Compassionate Care, Volunteer of the Year, and Rising Star. It is always a highlight of the year taking time to celebrate our colleagues and especially reading their nominations. As an NHS Trust we are lucky to work with dedicated people who have a huge variety of skills and expertise in many different specialties, several of whom are leaders in their fields, and it is wonderful to have the chance to recognise when individuals and teams go above and beyond.

We were also able to celebrate 30 years of Scannappeal, a charity that fundraises for equipment for several different fields. Since being established in 1987 they have raised a total of £16m and funded equipment in every major department in our hospitals. I would like to take this opportunity, on behalf of the Board, to thank the charity and especially all of the volunteers, both past and present, for the incredible support they have given, and continue to give, to our organisation and our patients and service users.

Proud to be BHT

In the height of the COVID-19 pandemic, Olympic Lodge was set up in a joint initiative together with colleagues in social care from Buckinghamshire Council. This was a pilot of an integrated discharge hub with the aim of providing a setting for patients who are medically fit to be discharged from hospital but who require ongoing care. I have appended to this report a poster (Appendix 3) outlining the project and its successes in more detail. I look forward to using the evaluation of this pilot to inform future initiatives in partnership with Buckinghamshire Council.

The Thames Valley Trauma Network recently conducted a peer review of the performance of our trauma units. The review made several recommendations but did not raise any immediate risks or concerns. They highlighted "many areas of good practice" and were "impressed by the proactive and often innovative solutions that have been implemented and the level of care by the teams involved at the trauma unit". My congratulations to all the clinical, operational and support teams involved in the service.

The Trust has been awarded the Ministry of Defence Employer Recognition Scheme Silver Award by the Reserve Forces' & Cadets' Association for the South East. Four years ago we started our journey in formally recognising our support for veterans of the armed forces under the Armed Forces Covenant and I am grateful for the huge amount of work by many colleagues to ensure our services

meet the needs of these members of our local population. Work now continues in our ambition to achieve the Gold Award.

Huge congratulations to Mr Edward Arbe Barnes, one of our junior doctors, who has won the F1/F2 Research Award in the prestigious 2022 Dr Falk-Pharma/Guts UK Charity national awards for his investigation in the biology of tumours in pancreatic cancer titled: 'Single Cell RNA Sequencing of Pancreatic Ductal Adenocarcinoma (PDAC) Epithelial Cells'. Lots of colleagues lead and participate in research in different areas across the Trust and it is always brilliant to see individual projects receiving such significant awards.

In June we held several celebrations. At the start of the month we joined the nation in decorating our wards and offices in honour of Her Majesty the Queen's Platinum Jubilee. Many colleagues went to huge efforts to create extraordinary displays and celebrate as a team in their breaks. My thanks to those who showed particular dedication to our patients and fellow colleagues by working over the weekend and bank holidays.

We also celebrated our amazing volunteers during Volunteers' Week. We currently have over 320 active volunteers providing invaluable support to patients and colleagues in many different parts of the organisation, from ward support and meal-time companions to gardeners.

June was also Pride month and this year marks 50 years since the events that led to the establishment of LGBTQ+ rights. I was honoured to raise our new Pride Progress flag outside the main entrance of Stoke Mandeville Hospital and join the celebrations with colleagues. We have more to do to ensure everyone feels they can bring their whole selves to work, but I hope that our open and visible support to this community helps towards our ambition to be an inclusive organisation and a Great Place to Work.

Lastly, I would like to thank the RAF Halton recruits who recently volunteered in the gardens at our Brookside Clinic. Their hard work has helped hugely to progress the development of a new garden for use by colleagues and users of our Community Head Injury Service. We are extremely grateful for their support.

Neil Macdonald
Chief Executive

Appendix 1 – Trust CARE Value awards

Appendix 2 – Executive Management Committee and Transformation Board

Appendix 3 – Olympic Lodge poster

Appendix 1 – Trust CARE values awards

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

April 2022

Category	Name	Role	Nomination	Nominated by
Collaborate	Dr James Maggs	Gastroenterology Consultant	We had an elderly patient recently discharged from a ward requiring an urgent colonoscopy. We managed to book him an appointment, but the patient and his wife were unable to collect the bowel prep from the pharmacy at Wycombe as they were unable to drive and their daughter who could have done this had Covid. In order to avoid a delay in the patient's treatment Dr Maggs kindly offered to collect the prescription from pharmacy and deliver it to the patient himself as he passed their house on his way home. The patient was able to attend his appointment as planned and I would like to acknowledge this act of kindness by Dr Maggs for going above and beyond to ensure the patient was able to have his procedure within the appropriate time frame.	Staff
Aspire	Sarah Shipley	Sister ICU	Sarah has been a pillar of support for several staff members, inspiring them to improve their patient care, which has subsequently improved patient experience of this. An example of this is garden visits for ICU patients; although this was standard practice pre-pandemic, Sarah has been the influence behind members of the team getting patients outside for family visits etc, improving their mental wellbeing. She is a fantastic leader and teacher and an inspirational nurse, and I believe that my practice has improved in my time working with her.	Staff
Respect	Maureen Malanaphy	Sister Ward 6	Maureen is an exceptional ward sister who always has time for her staff. If any member of staff has an issue either work related or personal, she is always willing to listen and help where she can. She often goes above and beyond her role when caring for her staff, emotionally and practically and is always available to assist her staff in enabling them to be able to provide safe care for their patients. An example is a member of staff whose Mum died suddenly. Maureen stepped up and provided care and support to him throughout this traumatic time. This same member of staff developed cancer during this period and Maureen continues to support him practically and emotionally. Maureen is the glue that holds the ward 6 team together and without her support and protection the team would not feel valued, supported and appreciated. Maureen has intervened when plans to move staff to other wards would result in the remaining staff being unable to provide safe care to their patients demonstrating that the safety and welfare of her staff and patients is her priority.	Staff
Enable	Rachel Osnowska-Evans	Senior Admin Marlow ACHT, Marlow Health Clinic	Rachel works as a senior admin for Marlow ACHT. Rachel is always willing to help not only her team but other localities in ACHT. When Thame ACHT had no admin in post, Rachel arranged a rota for herself and the other 2 admin in Marlow ACHT to rotate to Thame ACHT to ensure there was admin cover until there was new staff in post. Recently there has been sickness in Southern ACHT and	Staff

			Rachel has travelled to Southern so there is admin support and she was given no notice to do this. Rachel is always so happy to support the bigger team.	
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May 2022

Category	Name	Role	Nomination	Nominated by
Collaborate	Waterside Ward Team Amersham	Various	My father, who is 87 and has Parkinson's Disease, after 6 weeks under medical care at another Trust, was admitted to Waterside Ward for his rehabilitation after being seriously ill. Throughout his stay the care, empathy, encouragement and compassion given to my father was outstanding. The whole team was incredibly welcoming and friendly from the clinical teams right the way through to the support services such as cleaning and catering and he was put an ease from the beginning. The change in him over the four weeks he was on the ward was marked. From the nurses who cared and encouraged him to the physios, occupational therapists and speak and language teams who helped rehabilitate him. The support and reassurance from other teams was also outstanding with a special mention to the Doctors, the Parkinson's nurse and the activities team, who all combined to help enormously on his journey. He has now been discharged and has a quality of life that we did not feel was likely a few weeks previously. Thank you all.	Relative
Aspire	Sarah Davies	Health Visitor	Sarah attended a New Birth Visit for a baby who had been diagnosed with a congenital abnormality. During the visit, the Baby unexpectedly suffered a critical event. Sarah remained calm and in control of the situation, applied pressure to the site of the bleed, called an ambulance and kept parents calm and reassured while waiting for an ambulance. The baby was taken to hospital where baby received further, lifesaving treatment. I am proud to be Sarah's colleague and while I hope I never find myself in this situation (it is not expected in our role), I can only aspire to be as calm and competent as Sarah demonstrated that day.	Staff
Respect	Mark Henderson	Health care assistant Ward 2 Stoke Mandeville	We cannot praise Mark enough, his care, patience, genuinely kind attitude to the patients, of whom some were extremely trying and difficult but made no difference he retained his calm manner and was just amazing. You should be very proud of this young man; he is a great ambassador for Stoke Mandeville.	Relative
Enable	The Wycombe Endoscopy Nursing and Decontamination team	Various	The Wycombe Endoscopy Team managed to relocate the entire unit from the 1st to the 5th floor of the tower block at WGH over the course of a weekend and only 2 working days. This is a complex unit with multiple large machines as well as IT systems and several patient areas which needed to be moved, set up and tested. The nursing and decontamination team worked incredibly hard together to physically move every piece of equipment and to overcome many unanticipated challenges to produce a fully functional unit. This was up and running full lists the following day with a smooth	Staff

			patient pathway in a calm, safe and professional setting. Everyone involved should be congratulated on this remarkable achievement.	
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Appendix 2 – Executive Management Committee and Transformation Board

Executive Management Committee 17 May to 12 July 2022

The Executive Management Committee meets three times a month and covers a range of subjects including progress against our strategic aims, performance monitoring, oversight of risk and significant financial decisions. The meeting is chaired by the Chief Executive Officer and attended by Executive Directors. The following provides an overview of some of the key areas considered by the committee since 17 May 2022.

Quality and Performance

Infection prevention and control report
Integrated performance report
Care Quality Commission (CQC) insight report
Ockenden report
Maternity safety report
Midwifery staffing report
Serious Incidents report
Safe staffing report
Urgent and emergency care improvement programme
Nursing, midwifery and allied health professionals strategy
Quality Account
Equality and Quality Impact Assessment
Draft Paediatric Special Educational Needs or Disability action plan

People

CARE awards
Temporary staffing joint programme
Publishing facility time
Medical appraisal and revalidation annual report
Freedom to Speak Up Guardian annual report
Statutory and mandatory training plan
Appraisals plan
People Promise retention exemplar programme
Messenger review

Money

Contracts update
Monthly finance report
Integrated Care System financial plan

Strategy, Digital, Estates & Commercial

Information governance strategy
Record management strategy
Information governance and data security & protection toolkit
Cyber resilience

Governance

Internal Audit
Corporate Risk Register
Compliance with legislation
External reviews
Lapsed policies and policies due to lapse report
The following policies were approved:

- BHT Pol 147 Charitable Funds Investment Policy
- BHT Pol 129 Media Policy
- BHT Pol 059 IT Computer Usage Policy
- BHT Pol 208 IT Mobile Device Security Policy
- BHT Pol 244 Mental Capacity Act and Deprivation of Liberty Standards Policy
- BHT Pol 093 Safeguarding Adult Policy
- BHT Pol 156 Information Governance Policy for the Use & Release of Person Identifiable Data
- BHT Pol 079 Risk Management Policy
- BHT Pol 033 Display Screen Equipment Policy

Transformation Board

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

Quality Improvement projects on a page
Quality Improvement leadership development
Virtual wards
Deep dive: temporary staffing
Operating Plan monthly update
Portfolio updates:

- Urgent and emergency care
- Planned care
- Integrated communities
- Diagnostics
- National Spinal Injuries Centre and rehabilitation
- Digital and technology
- Great place to work
- Property
- Quality plan

Thanks to you...

"Thank you all so much to all of the staff at Stoke Mandeville, you are all amazing"

"I feel more independent"

"They are lovely. Very nice. Very helpful. They are on your doorstep, you know... I've got this remote and if you want anything, you press that button and they are here quickly as flash!"

"The two weeks I stayed here helped me find my feet. I hope Olympic Lodge continues long-term"

"I came here malnourished, so they ensured I had hot lunches and dinners, they understood my situation, they were great"

Olympic Lodge has provided the opportunity to pilot a new approach for Buckinghamshire, an integrated discharge hub, with the long-term intention that the model will eventually replace Buckinghamshire Healthcare CCCT. By consolidating a limited workforce onto one site, Olympic Lodge provides a more concentrated level of care meaning a greater number of patients can go home more quickly and with reduced care packages.

- staffed by co-located nursing and social care staff – council healthcare assistants worked alongside NHS nurses
- provides additional acute hospital capacity for our sickest patients through winter 21/22
- improves hospital flow
- delivers additional capacity for reablement that is not dependent on private providers

19 
days to set up 22 bed facility

100+ 
members of staff involved in setting up, running and closing the Olympic Lodge

In the 18 weeks*
it was open:

167 admissions 

11 days average length of stay 

11 weeks max length of stay 

**Extended by 9 weeks due to success*

65% of service users care needs did not change during admission

41% of service users mobility improved during admission

74% of service users function improved

Evaluation

Key themes from a robust evaluation* was that Olympic Lodge was able to offer:

- real person-centred care
- caring relationships with healthcare practitioners
- patient awareness of package of care
- promotion patient independence
- genuine coordinated care

**Evaluation undertaken by Bedfordshire University*

Bucks Health Care Trust, Buckinghamshire Council and Serco have together created a facility that not only adds value and benefit to Buckinghamshire residents, but that provides a blueprint for future intermediate care.

This integrated intermediate care facility, played a vital part in ensuring 'flow' in our local health and care system during the extreme challenges of this winter.

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Place and System Briefing	
Board Lead	Neil Macdonald, Chief Executive	
Type name of Author	Chloe Powell, CEO Business Manager	
Attachments	Place and System Briefing July 2022 Letter re BOB ICB BOB ICS Elective Care Board Monthly Provider Update June 2022	
Purpose	Information	
Previously considered	None	

Executive Summary

This paper aims to brief the Trust Board on important updates at Place and System level over the past month, including key discussions at meetings attended by the CEO.

Meetings included in the report are as follows:

- BOB ICS System Leaders Group meeting – 06 July 2022
- Buckinghamshire Integrated Care Partnership Executive System Leaders meeting 12 July 2022

The System Leaders Group (SLG) meeting is a monthly meeting attended by partners across BOB ICS, Oxford County Council, South Central Ambulance Service, Oxford Health NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust, Oxford Academic Health Science Network, Oxford University Hospitals NHS Foundation Trust, Royal Berkshire NHS Foundation Trust, West Berkshire Council, Buckinghamshire Council and Buckinghamshire Healthcare NHS Trust.

The Buckinghamshire Integrated Care Partnership Executive System Leaders meeting includes members of Buckinghamshire Council, Buckinghamshire Healthcare NHS Trust, and BOB ICS.

The following are appended to the report:

- Letter from Dr Javed Khan and Dr James Kent, BOB ICS – This letter confirms the BOB Integrated Care Board becoming a legal entity on 01 July 2022
- BOB ICS Elective Care Board Monthly Provider Update June 2022 – This provides the June update on ICS elective recovery.

Decision	Trust Board is requested to note the paper
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Relevant Strategic Priority

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

Patient Safety	Patient safety is considered as part of the core objectives of the Trust, BOB ICS and the ICP.
Risk: link to Board Assurance Framework (BAF)/Risk Register	CEO participation in place and system meetings and subsequent briefing to Trust Board mitigates the risk of potential loss of system leadership due to changes in the Integrated Care System and in Buckinghamshire in line with the ICS Design

	Framework publication. This directly links to risk 4.2 on the BAF.
Financial	This briefing on key discussions across system and place will reduce duplication of work and create an optimum environment for regionally aligned delivery of cost-effective patient care. Financial updates and details of expenditure and funding are also included in the briefing.
Compliance NHS Regulation Good Governance	The paper will support the Board to review the effectiveness of the system of internal control and accountability across system and place.
Partnership: consultation / communication	This paper is a briefing about place and system meetings that occurred over the past month for effective collaboration and working in partnership across system and place.
Equality	Close working and collaboration across the Trust, ICS and ICP will help to reduce health inequalities across the local population.
Quality Impact Assessment [QIA] completion required?	Not required.

Place and System Briefing

Trust Board in Public
July 2022

SYSTEM

Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) System Leaders Group (SLG) Wednesday 06 July 2022

Item	Notes	Impact
<p>ICS Chief Executive Designate and Directors Update</p> <p>James Kent, Executive Lead, BOB ICS</p>	<p>Update on key system priorities from past month in line with system priorities.</p> <p>The Integrated Care Board (ICB) became a statutory organisation on 1 July 2022 (see Appendix 1, letter from ICS). Appointments have been made for Partner Members of the ICB and the ICB Executive team. The September meeting of the ICB will be the first full board meeting.</p> <p>BOB ICS submitted a balanced financial plan to NHSE/I on 20 June 2022, on the basis it would identify £22m of cost reductions. Improvements in the process have been identified which will be taken forward for planning the 2023/24 process.</p> <p>The ICS has submitted draft bids of £12.3m into the demand and capacity fund and applied to participate in the national discharge frontrunner programme.</p> <p>Continued focus on patients waiting more than 78 weeks for planned care (see Appendix 2, Elective Care Board monthly update).</p> <p>Five-year diagnostics strategy has been drafted and includes an ambition to bring elements of the Elective Recovery Programme closer with diagnostics priorities e.g. by building sustainable clinical models and pathway transformation.</p> <p>Quarter one funding has been released to the ICS following approval of the Thames Valley Cancer Alliance delivery plan.</p> <p>Temporary staffing programme continues progress in implementing a collaborative agency rate cap card for nursing, allied health professionals, and administration and clerical colleagues. Additional projects for medical and bank staff also planned.</p>	<p>Opportunity over the coming months to develop strong working relationships with new members of the ICB.</p> <p>BHT will have its share of the £22m of cost reductions to identify within this financial year. Identified improvements will support next year's process.</p> <p>The Trust should anticipate positive impacts under its Great Place to Work priority, as well as financial improvements, as a result of the temporary staffing programme.</p>

<p>SLG and future plans</p> <p>James Kent, Executive Lead, BOB ICS</p>	<p>Discussion about the value currently provided by the current shape of SLG and whether a different membership and/or format could bring improvement in terms of value and efficiency.</p>	<p>The future format of these CEO-level meetings will ensure input into System decision-making and an appropriate level of oversight.</p>
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PLACE

Buckinghamshire Integrated Care Partnership (ICP) Executive System Leaders Tuesday 12 July 2022

Item	Notes	Impact
<p>Discharge to assess</p> <p>Jo Baschnonga, Programme Director Care Integration, BHT and Buckinghamshire Council</p>	<p>There is a significant focus for BHT in partnership with Buckinghamshire Council to improve the challenges currently faced with discharging patients who are medically fit to do so from inpatient stays in hospital, recognising that staying in hospital longer than necessary is suboptimal for the patients involved, and causes issues of patient flow through the hospital and pressure on the emergency services as a result.</p> <p>The group, which includes Executive-level representatives from BHT and Buckinghamshire Council, held a detailed discussion regarding plans to implement improvements in the discharge to assess model for the remainder of this financial year.</p>	<p>An improvement in discharge will positively impact the patients involved, meaning they can leave hospital when medically fit to do so and continue to receive care in an appropriate setting.</p> <p>There will be knock-on positive impacts of improving the flow of patients through the hospital including the experience of those requiring urgent and emergency care.</p>

1st July 2022

David Highton
Chair
Buckinghamshire Healthcare NHS Foundation Trust
Stoke Mandeville Hospital
Aylesbury
Buckinghamshire HP21 8AL

Neil MacDonald
Chief Executive

Dear David and Neil

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) is now legally established on 1st July, following the first formal meeting of the Board this morning.

This is a milestone in the reorganisation of the NHS created by the Health and Care Act 2022. This Act aims to remove barriers to joined up working and create fully integrated care systems across England so that people can get the care and support they need, joined up across local councils, the NHS, and other partners.

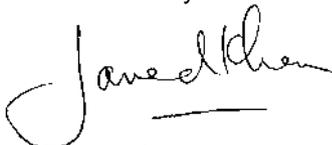
The Integrated Care Board (ICB) is now the formal NHS body responsible for planning, commissioning, and coordinating NHS services across our area. The ICB takes over from the three now-dissolved clinical commissioning groups (CCGs). The members of the ICB Board can be found [here](#).

We have an opportunity to use the formation of the ICB to make a major step change in how we work together. We believe the switch from competition to collaboration will enable a different, more productive and more innovative ways of working that will benefit the population we serve.

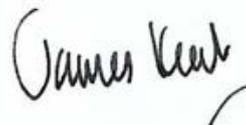
There is a lot to work on as you both know – but we are really looking forward to working with you to deliver even better health outcomes for our people.

Regards,

Yours sincerely



Dr Javed Khan
Chair
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board



Dr James Kent
Chief Executive

Monthly Provider Update Report June 2022

Monthly BOB ICS ERP Update

This slide is in place to allow the ECB to track monthly achievements, escalate any risks/issues, record any risks and note actions for future meetings.

Headline Achievements

- Continued focus on reducing 104 and 78 waits – with the system eliminating all 104s in line with trajectory, remaining 104s are at OUH with significant complex / P6s only
- Gynaecology have developed a plan on a page to support pathway improvements across 3 areas
- NHSE and wider GIRFT/ Model Hospital data being utilised to identify areas of variation and opportunities for improvements – presentations to Urology and Gynae in June.
- Lead provider data model progressing – hosting of Theatres dashboard to become live first, with Outpatients following after
- All specialty groups implemented an intervention tracker to quantify benefits of Short and Long term actions – to be used to monitor progress
- Pilots across Peri-Op and Referral management remain live and plans to expand in early autumn

Provider actions

- Work with ICS colleagues surrounding planning for OP New and transformative ways of working initiatives
- Specialties to have visibility of GIRFT data and understand opportunities for improvement

Risks/Concerns

- Mutual aid providers returning patients due to emergent issues impacting on their capacity
- Cancellation of activity/restrictions placed on elective capacity due to staff sickness/other capacity constraints
- Precise arrangements for Elective Recovery Funding in 2022/23 still unknown and there is a risk that this may cause delays to commissioning capacity generating initiatives

Forward look of priority actions

- Developing a Medium Term Strategy to consider wider pillars of elective recovery (e.g. workforce and digital agenda)
- Capital Bid business cases to be completed by Trusts within the next month

Elective Recovery Flash Report

Programme Trajectory:

Summary: The confirmed >104 cohort as of 12/06 (NHSE report) was a total of 26 patients, shown in table 1 below. RBFT have shown reductions across >104 and >52 metrics as well as 3 week trend of more clock stops than starts (reduction in total waitlist). BHT have seen a reduction in patients across all long wait areas but with a small net increase in waitlist. The overall system has seen growth in the waitlist, driven by OUH waitlist increases. OUH have seen a net increase in long waits (>52). Whilst we await final activity volumes for June to measure against plan, the NHSE report indicates VWA trend is increasing with all Trusts achieving above 100% in the first week of June which is above the SE Regional trend (estimated).

Overview of Long Waits

> 104 Update	22/05/2022	05/06/2022	12/06/2022
BHT	1	-	1
OUH	26	23	25
RBFT	-	-	-
BOB System	27	23	26

>104 Risk cohort (30/06/22)	15/05/2022	29/05/2022	12/06/2022	4 week variance
	>97 weeks	>99 weeks	>101 weeks	
BHT	14	4	1	-13
OUH	46	36	31	-15
RBFT	-	-	-	0
BOB System	60	40	32	-28

>78 Trajectory	15/05/2022	12/06/2022	4 week variance
BHT	713	552	-161
OUH	195	202	7
RBFT	56	50	-6
BOB System	964	804	-160

>52 Trajectory	15/05/2022	12/06/2022	4 week variance
BHT	4,371	4,250	-121
OUH	1,182	1,303	121
RBFT	3,011	2,176	-835
BOB System	8,564	7,729	-835

Overall Waitlist size

	29/05/2022	05/06/2022	12/06/2022	3 week trend
BHT	34,904	35,142	35,109	205
OUH	60,969	61,110	64,896	3,927
RBFT	52,713	49,974	49,712	-3,001
BOB System	148,586	146,226	149,717	1,131

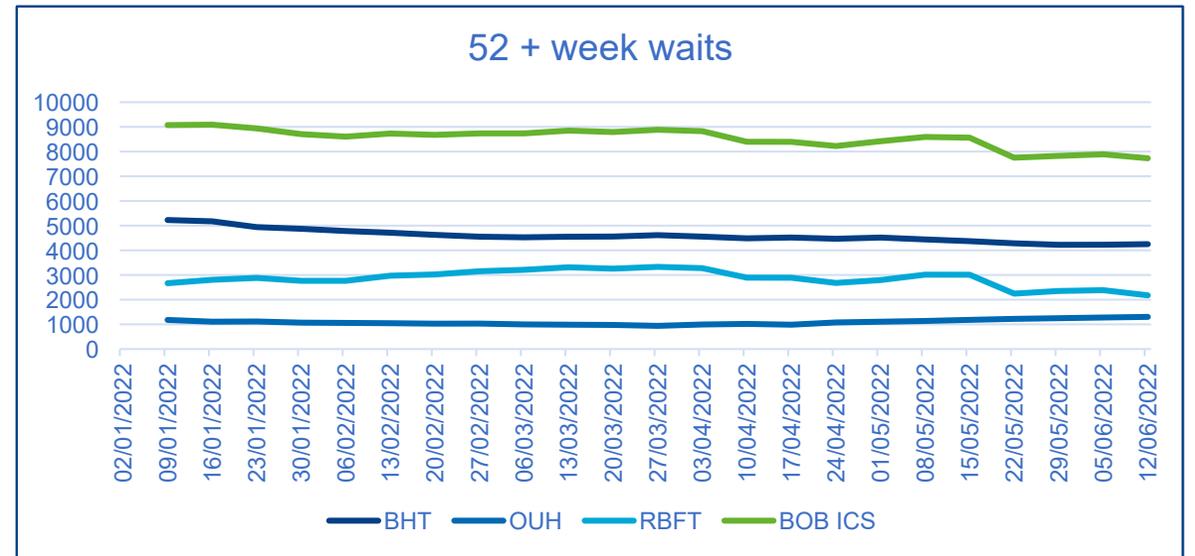
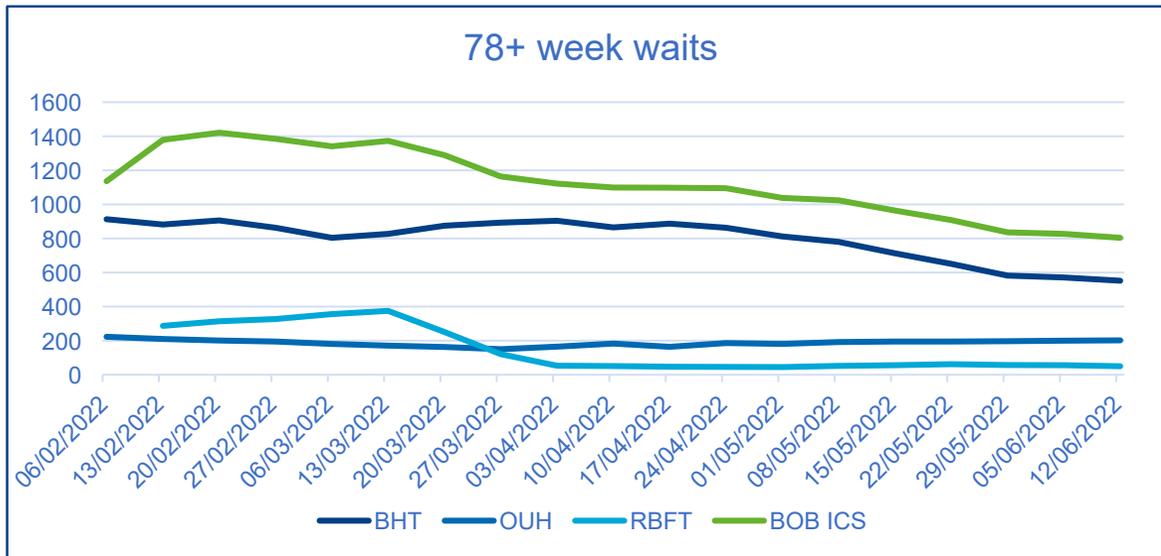
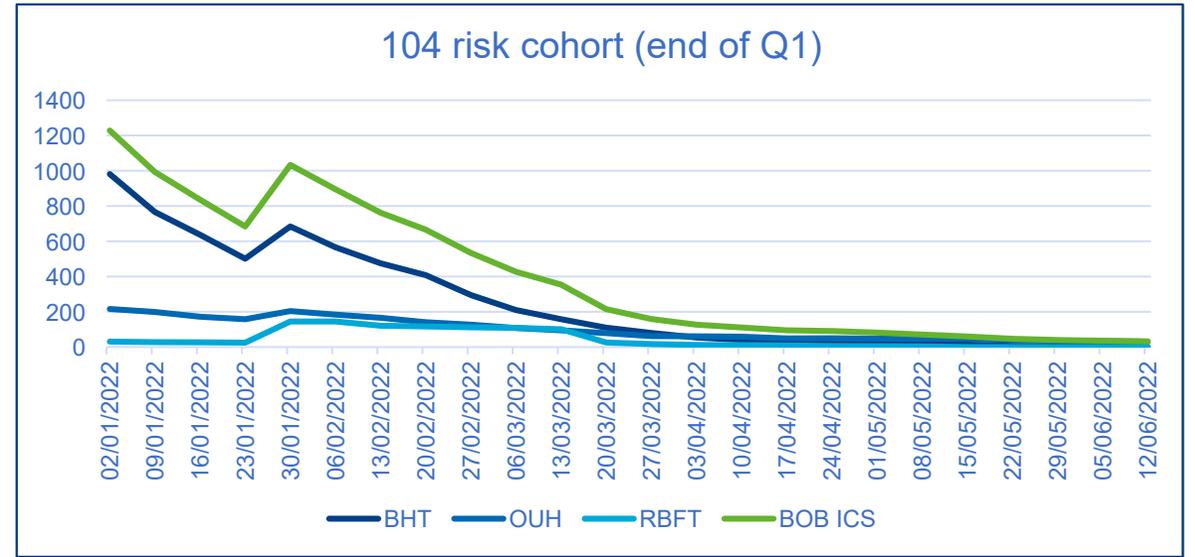
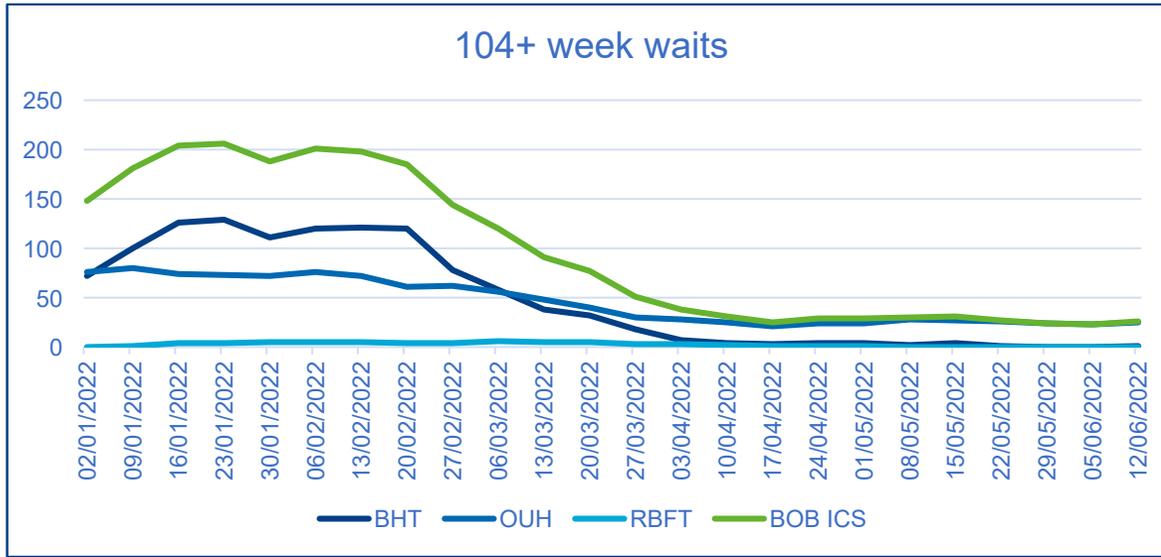
RTT Pathway Overview

SUS – month to date	Total Completed Clock Stops			Number of Clock Starts			Net Additions to Waiting List in month (Clock Starts minus Stops)		
	22/23 plan	22/23 actual	% plan	22/23 plan	22/23 actual	% plan	22/23 plan	22/23 actual	Variance
Apr-22	37,012	26,894	87.4%	38,016	33,226	87.4%	1,004	6,332	5,328
May-22	39,291	20,737	72.0%	39,556	28,480	72.0%	265	7,743	7,478
June-22	38,936	2,787	57.0% (MTD)	38,294	4,366	57.0% (MTD)	-642	1,579	2,221 (MTD)

VWA Trend SUS Value (est)	10-Apr-22	17-Apr-22	24-Apr-22	01-May-22	08-May-22	15-May-22	22-May-22	29-May-22	05-Jun-22
South East	94.1%	93.7%	93.2%	94.5%	95.4%	96.8%	96.9%	98.3%	98.6%
BOB ICS	94.0%	94.7%	94.1%	95.5%	95.0%	97.7%	99.1%	101.7%	101.3%
BHT	99.8%	101.1%	102.0%	100.8%	98.0%	99.3%	97.0%	99.8%	100.4%
OUH	93.8%	94.5%	94.4%	97.5%	98.2%	101.6%	104.2%	105.1%	105.1%
RBFT	98.0%	97.4%	95.4%	95.3%	94.3%	96.9%	98.5%	104.1%	102.5%

ERF Trend SUS Value (est)	10-Apr-22	17-Apr-22	24-Apr-22	01-May-22	08-May-22	15-May-22	22-May-22	29-May-22	05-Jun-22
South East	90.8%	90.6%	90.6%	91.4%	92.2%	93.3%	93.3%	94.3%	95.1%
BOB ICS	91.4%	91.8%	91.9%	92.5%	92.3%	94.2%	94.9%	96.7%	96.7%
BHT	98.0%	99.2%	99.7%	98.3%	95.7%	96.0%	94.2%	95.7%	97.3%
OUH	90.4%	90.8%	91.3%	93.5%	94.4%	97.2%	98.8%	99.6%	99.5%
RBFT	96.1%	95.4%	94.6%	93.9%	93.4%	95.5%	96.3%	100.7%	99.8%

Elective Recovery Flash Report: Long wait trends



Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Buckinghamshire Levelling Up Framework: Opportunity Bucks – Succeeding for All		
Board Lead	Neil Macdonald, Chief Executive		
Type name of Author	Buckinghamshire Council		
Attachments	Buckinghamshire Levelling Up Framework: Opportunity Bucks – Succeeding for All		
Purpose	Approval		
Previously considered	Levelling Up Programme Board (external)		

Executive Summary

“Outcomes for people living in Buckinghamshire are some of the best in the country. However, there are also parts of the county where residents experience significant hardship.

Buckinghamshire Council, in discussion with partners, has been exploring the potential for a local approach to ‘levelling up’ within Buckinghamshire designed to address disparities of outcomes experienced by particular communities within the county and promote community wellbeing and increased productivity. The proposed framework attached is designed to set the context for this approach, establish a shared ambition and a programme of work to tackle the underlying issues.”
Executive Summary in report to Levelling Up Programme Board

The report outlines five themes: education and skills; jobs and career opportunities; quality of public realm; standard of living; and health and wellbeing. The programme will impact residents of Buckinghamshire who may be patients of our Trust, as well as colleagues who live in the county.

Decision	The Board / Committee is requested to agree to the proposals for a Buckinghamshire Levelling Up Framework and support the programme ‘Opportunity Bucks – Succeeding for All’
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Relevant Strategic Priority

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

Patient Safety	Addressing disparities in outcomes and promoting health and wellbeing should have positive impacts on patient safety
Risk: link to Board Assurance Framework (BAF)/Risk Register	Links to Board Assurance Framework area 4: <i>We do not recover services adequately, fail to meet public / regulator expectations, and do not play a leading role in the health, economic and social recovery of Buckinghamshire</i>
Financial	Improving the health and wellbeing and reducing disparities in the county should lead to fewer urgent and emergency attendances
Compliance Select an item. Select CQC standard from list.	This report forms the initial response to the Levelling Up in the United Kingdom White Paper published in February 2022
Partnership: consultation / communication	Levelling up programme is led by Buckinghamshire Council and will involve close partnership working
Equality	The levelling up programme seeks to address disparities experienced by certain communities
Quality Impact Assessment [QIA] completion required?	Not at this stage

OPPORTUNITY BUCKS – SUCCEEDING FOR ALL

A local response to Levelling Up



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1. Introduction
2. Summary
3. The Buckinghamshire Context
4. Our Ambition and priorities
5. Our Approach
6. Taking Action
7. Overseeing Delivery

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1. INTRODUCTION

Buckinghamshire is a beautiful place to live and work, famous for its natural environment and its quality of life.

As the 'entrepreneurial heart of Britain' we are home to both global brands and large numbers of small and medium sized businesses which underpin our strong economy. We have robust and effective partnerships which bring together public service bodies, business leadership and the voluntary and community sector, and together we are ambitious for our communities and our residents.

Whilst the majority of our communities are thriving in the county, we know that in some areas of Buckinghamshire, people are experiencing significant hardship. As partners, we want to come together with these communities, draw upon our collective resources, and work together to enhance opportunities and promote community wellbeing.



LEVELLING UP

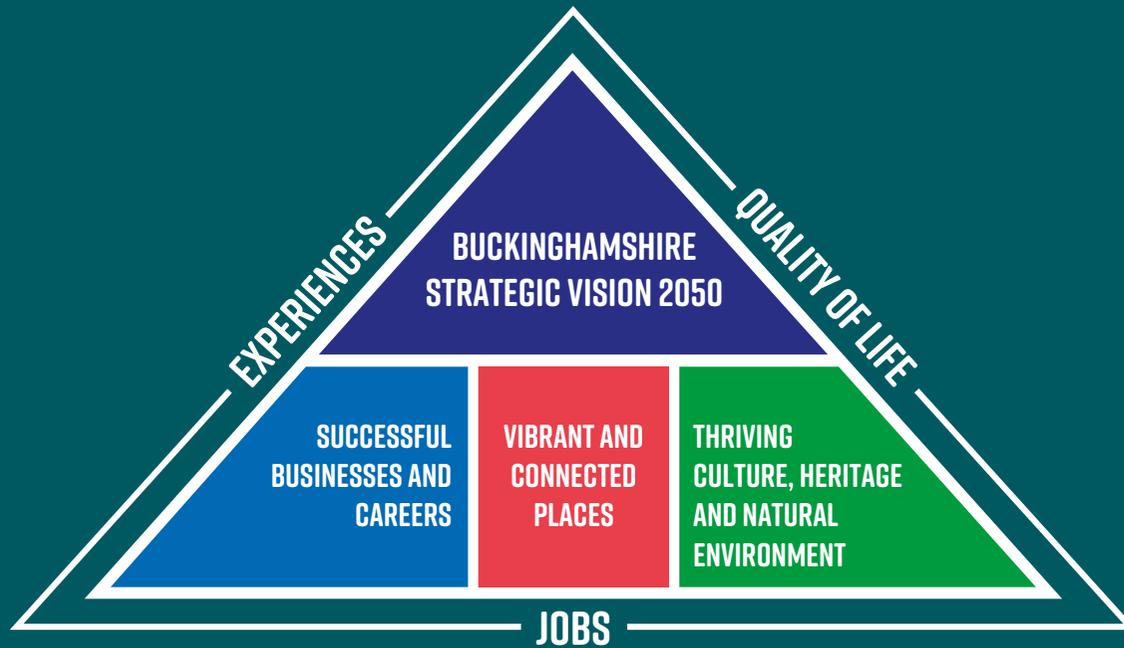
The Government has placed 'Levelling up' at the heart of its agenda to recover after the pandemic. The Levelling Up White Paper published in February 2022 sets out 12 national missions designed to spread opportunity across the whole UK and improve everyday life and life chances for people in underperforming places. These missions are grouped into four themes:

- a) Boost productivity, pay, jobs and living standards by growing the private sector, especially in those places where they are lagging – with a focus on living standards, research and development, transport infrastructure and digital connectivity
- b) Spread opportunities and improve public services, especially in those places where they are weakest – with a focus on education, skills, health and wellbeing
- c) Restore a sense of community, local pride and belonging, especially in those places where they have been lost – with a focus on pride in place, housing, and crime
- d) Local Leadership -with a focus on devolution deals from national to local government.

“It is about improving living standards and growing the private sector, particularly where it is weak. It is about increasing and spreading opportunity, because while talent is evenly distributed, opportunity is not. It is about improving health, education and policing, particularly where they are not good enough. It is also about strengthening community and local leadership, restoring pride in place, and improving quality of life in ways that are not just about the economy”

(Boris Johnson, May 2021)

SUCCEEDING AS A PLACE, SUCCEEDING AS A COUNTRY



The Buckinghamshire Growth Board has set out a shared strategic vision for Buckinghamshire for 2050.

The vision is underpinned by three interlinked strategic ambitions that will guide a thriving, resilient, successful, connected, healthier and inclusive Buckinghamshire.

Building on the Levelling Up missions, Opportunity Bucks – Succeeding for All is aimed at spreading opportunities and promoting pride in place in Buckinghamshire. It is a partner document to the Buckinghamshire proposition “Succeeding as a Place, Succeeding as a Country” which focuses on our ambition for economic recovery and a devolution deal.

Changes will not happen overnight and we know that this is a long term commitment.

This Framework provides a clear statement of intent by Buckinghamshire partners, together with a structure for taking action and providing accountability.

2. SUMMARY

Buckinghamshire is widely known as an affluent county with great outcomes. However, we know that this overall picture masks some significant variations in outcomes, with some areas experiencing significant hardship.

'Opportunity Bucks' provides a framework for bringing partners together to focus our collective resources on tackling those local priorities that will make a difference to the outcomes of residents.

It will focus on five themes:

- **Education and Skills**
- **Jobs and career opportunities**
- **Quality of our Public Realm**
- **Standard of living**
- **Health and Wellbeing**

Initially, the programme will be targeted at 10 wards focused in 3 areas – parts of Aylesbury, High Wycombe and Chesham. Local action plans will be developed through engagement with the communities, led by the Community Boards.

The Buckinghamshire Growth Board will provide clear accountability for the programme.



3. THE BUCKINGHAMSHIRE CONTEXT



AN AFFLUENT COUNTY WITH GREAT OUTCOMES

Buckinghamshire is an affluent county and residents enjoy some of the best outcomes in the UK. We have a strong £15.5bn (GDP £17.4bn) economy with the 44th highest GDP per head in the country (39th in England, 12th if referring to LEP areas). There are 249,000 jobs , 31,470 businesses and 547,060 residents.

The County enjoys low unemployment and higher than average incomes. We have high skills levels, with over 45% of residents having a degree or equivalent qualification or higher, compared to 40% nationally. Earnings are high with median resident wages 15% higher than nationally. At April 2022, 2.8% of the working age population in Buckinghamshire were claiming unemployment benefits, compared with 4.1% nationally. Life expectancy for both men and women is higher than the England average.

As of April 2022, 90.4% of pupils attended a school rated good or outstanding. 97.8% of early years registered providers were rated good or outstanding. Attainment levels for secondary school pupils are above both statistical neighbour and national average.



SIGNIFICANT VARIATIONS IN OUTCOMES FOR PEOPLE AND PLACES

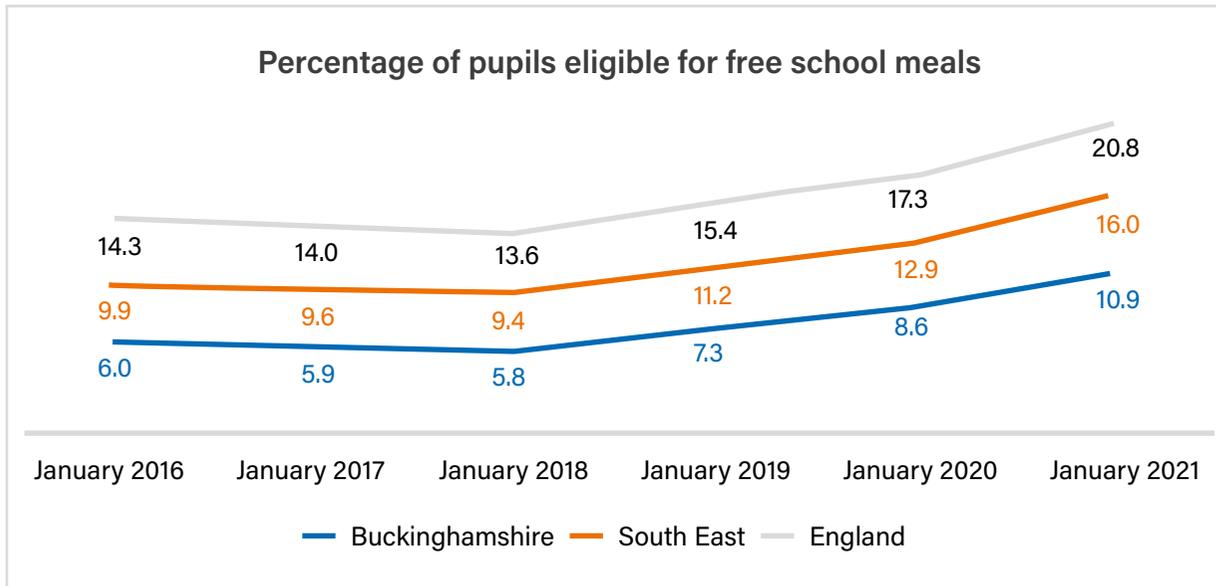
However, we know that this overall picture masks significant variations in outcomes across the county, with some areas experiencing significant hardship.

Health inequalities has long been identified as a key public health challenge to tackle in the UK. The lower an individual's socioeconomic position, as defined by where they live, their job, qualifications, income and wealth, the more likely they are to experience poor health. The effects of the Covid-19 pandemic have mirrored, and in some cases exacerbated, existing inequalities, impacting particularly on those who are most vulnerable and putting a spotlight on underlying health and economic challenges within our communities.

Life expectancy in Buckinghamshire averages 85 years for a woman and 82 years for a man. However, there is a difference of 8 years for a woman and 6 years for a man depending on where you live. Life expectancy in North West Aylesbury is 80 years for a woman and 78 years for a man. This contrasts with 88 years for a woman in Ridgeway East and 84 years for a man. The Emergency hospital admissions in Aylesbury and High Wycombe are all well above the average for the county.

Acorn data identifies 16% of Bucks residents as 'financially stretched'. In January 2021, 9,495 Buckinghamshire pupils were eligible for free school meals, 10.9% of all pupils. This is an increase of 2,046 pupils since January 2020, when 7,449 (8.6%) pupils were eligible for free school meals.





Again, there are considerable disparities across the county. As at April 2022, 19.4% of the working population in Booker, Cressex and Castlefield claim universal credit, compared with 5.4% in Gerrards Cross (8.9% for Buckinghamshire). 27% of residents over the age of 16 in Booker, Cressex and Castlefield have no qualifications, compared with 10% in Gerrards Cross (17% for Buckinghamshire).

Experiencing hardship in an area of relative affluence brings particular challenges. Buckinghamshire has higher than average house prices and rents. The average house price in November 2021 in Buckinghamshire was £549k. This figure disguises considerable variation, with the least expensive average house price at £240k in Aylesbury South-West and the most expensive at £1.3m in Gerrards Cross. 73% of housing in Buckinghamshire is owner-occupied, this falls to 55% in Ryemead and Micklefield and 56% in Booker, Cressex and Castlefield and Aylesbury South-West.

The lack of affordable housing is a key driver of homelessness. There is a growing gap between local housing allowance rates and private sector rents. Based on September 2021 ONS data, even the cheapest single room in Buckinghamshire in the private sector rental market (£559 per month) is unaffordable for anyone on benefits, including working households on low incomes. Ending of a private tenancy, or family/friends no longer willing to accommodate are key reasons for approaching the homelessness service.

The landscape is becoming even more challenging for those who are struggling with the rising cost of living and fuel crisis. In 2020, 12.6% of households in Booker, Cressex and Castlefield experienced fuel poverty and we expect that this has figure will have grown since that date. The impact of COVID is likely to be particularly acute in these communities. Cases of chronic disease that wasn't being managed during peak waves are likely to lead to rises in ill health, and children's development and education is likely to be hardest hit in these areas.

The six food banks in Buckinghamshire have experienced significant increases in demand.

Together, they have distributed:

- **35,477 parcels in 2021**
- **26,386 parcels in 2020**
- **13,503 parcels in 2019**

The top 5 reasons for people being referred to the food bank (June to August 2021 source ONECAN) are:

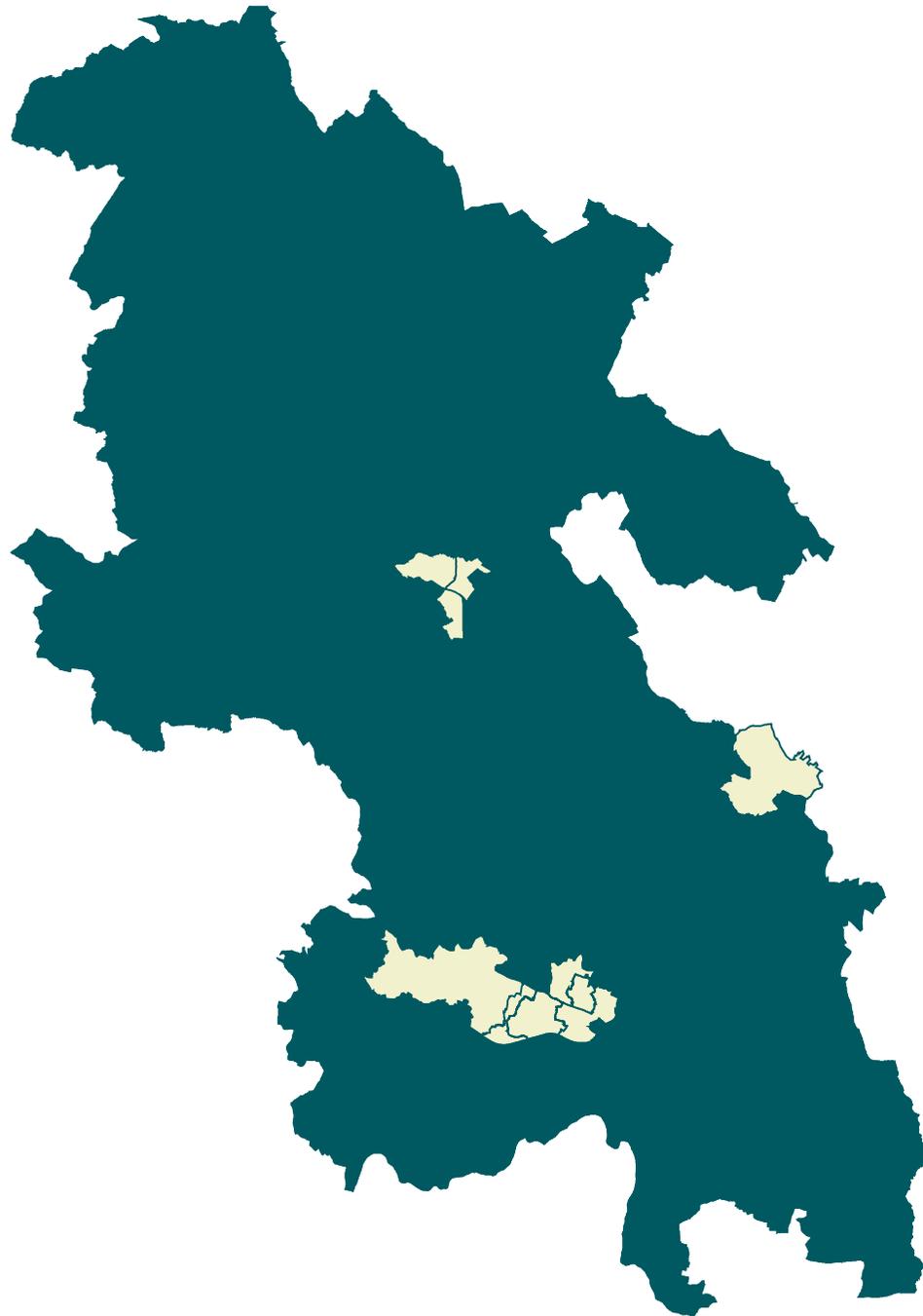
- **Debt (19%)**
- **Housing/homeless (14%)**
- **Benefits related issues (13%)**
- **Sickness and ill health (12%)**
- **Work-related changes such as reduced hours or loss of work (9%)**

Areas suffering high levels of deprivation suffer disproportionately from crime. Total crime offences across Buckinghamshire is:

- **69.7 per 1,000 residents as of February 2022.**
- **Abbey ward, the rate is 199 per 1,000 residents.**
- **Ridgeway East, the rate is 26 per 1,000 residents.**

Levels of crime impact significantly on the wellbeing of the population and satisfaction with their neighbourhood.





Together, the mix of factors result in poorer outcomes for the individuals, pressure on public services and constraints on the growth potential of the county.

The 10 wards experiencing multiple indicators of inequality are:

- **High Wycombe**
 - Booker, Cressex & Castlefield
 - Totteridge & Bowerdean
 - Ryemead & Micklefield
 - Abbey
 - Terriers & Amersham Hill
 - West Wycombe
- **Aylesbury**
 - Aylesbury South West
 - Aylesbury North-West
 - Aylesbury North
- **Chesham**

These wards have the highest needs in the county and experience the poorest outcomes.

EMPLOYMENT

The number of claimants in Buckinghamshire is almost double that of pre-pandemic levels despite an unprecedented increase in the number of vacancies seen across the county. The high percentage of people unemployed in deprived wards in Wycombe contrasts with the high number of vacancies, Wycombe reported the highest number of job posts in Jan-Mar 2022. In December 2021 the roles with the most postings were admin, nursing, customer service and social care roles and further analysis is required to understand if the skills held by residents in these areas match with the job opportunities available.

These wards have high proportions of people from Ethnic Minority groups compared to the rest of the county, as well as a high proportion of people with no qualifications, lower levels of people with degrees or higher qualifications, high numbers of children receiving free school meals and high rates of children living in areas of deprivation.



4. OUR AMBITION AND PRIORITIES



AMBITION

Reduce Inequality whilst improving outcomes for all

Together, our public, private and voluntary sector services have played a vital role in responding to the pandemic in Buckinghamshire. Throughout this period, we have delivered at speed, working in partnership together locally to support communities.

As we turn our attention to tackling the significant challenges ahead, **we are ambitious for Buckinghamshire.**

We have an innovative recovery and growth proposition that will accelerate economic growth and prosperity for the county. Our plans will build on our distinctive and internationally recognised economic assets to deliver quality jobs, a strong talent pipeline, and quality, low carbon and connected communities for people to live and work. Through investing in regeneration schemes in our town centres, we want to create vibrant town centres that meet the needs of residents and businesses.

But we also want to ensure that nobody gets left behind. We want to reduce inequality within our communities, whilst improving outcomes for all our residents.



Everyone in Buckinghamshire should have the opportunity of achieving:

- A good quality job, that pay enough money to support a decent quality of life
- Good standard of attainment and skills
- Learning and career progression
- Good mental and physical wellbeing and independent living
- Decent, warm home and good quality food
- Involvement in shaping their community, with strong social connections
- Feeling safe where they live
- Pride in where they live.

We want to ensure that all Buckinghamshire residents have the opportunity to succeed in life, to play their part in and share in the success of the county. But this is not the position today and we know that things will get worse if we don't come together as partners and take action.

Our ambitions of developing the local economy and reducing inequalities are intrinsically linked. By breaking the cycle of disadvantage, we will improve health outcomes and grow our economy.

The purpose of this framework is to establish a shared vision for what levelling up means in Buckinghamshire and to translate it into specific initiatives and strategies locally which will improve living standards and opportunity across the county.



OUR PRIORITIES

We will focus on five key themes:

EDUCATION AND SKILLS

- Helping the under 5s catch up post Covid-19
- Joined up, placed-based skills and careers system that offers young people and adults access to quality education and training opportunities in Buckinghamshire;

JOB AND CAREER OPPORTUNITIES

- Good quality positions that pay a decent salary and provide progression opportunities, combined with active support for residents to secure employment;

QUALITY OF PUBLIC REALM

- Public realm improvements which will promote a sense of wellbeing in our communities;

STANDARD OF LIVING

- Assistance to help residents find sustainable solutions to difficulties with decent housing, warmth, food and debt;

HEALTH AND WELLBEING

- Engaging communities in mental and physical health initiatives, and supporting businesses with a healthy workforce and reduced absenteeism.

In tackling these priorities, we will initially focus our action on those wards where residents experience a combination of inequalities:

- **High Wycombe**
 - Booker, Cressex & Castlefield
 - Totteridge & Bowerdean
 - Ryemead & Micklefield
 - Abbey
 - Terriers & Amersham Hill
 - West Wycombe
- **Aylesbury**
 - Aylesbury South West
 - Aylesbury North-West
 - Aylesbury North
- **Chesham**

Where possible, we will draw on the initiatives and learning being developed through the Levelling Up White Paper.

5. OUR APPROACH



PLACE BASED PARTNERSHIP

Buckinghamshire is an aligned county, with a shared geography between the Council, the Local Enterprise Partnership, the Healthcare NHS Trust and Buckinghamshire Business First. Our universities, further education providers and voluntary and community sector are also closely tied in, giving us a unique ability to unite key organisations to delivery coherently for the benefit of all. This strong collaborative model means that we are able to take effective action to tackle inequalities on a place basis.

RECOGNISING LOCAL IDENTITY

Our commitment to localism is also a key strength that we can draw on. We recognise that our communities are distinct places, with their own local sense of identity, and their own definitions of success. Local residents need to be at the core of what we do. In developing levelling up plans, we will work with residents at a local level to ensure that action builds on local strengths and responds to the needs, ambitions and experiences of the specific individual communities. Our Community Boards will play a critical role in this.

INNOVATION

As partners, we already have a range of services and initiatives in place in the identified communities. Many of these will be focused on responding to the result of inequality, rather than tackling the root causes. We need to take account of these but also be prepared to try new ideas that can build sustainable change. We will develop pilots that we can learn from, evaluate and, where appropriate, scale up. We will also learn from the initiatives developed nationally, as set out in the Levelling Up White Paper.

EVIDENCE BASED

We want to ensure we have a firm evidence base for developing our approach. We have a wealth of statistical information which will support us but we also want to expand our insight into the barriers experienced by the identified communities and the approaches that are most effective. We will invest in qualitative research and insight to inform our strategy. We will also use and develop this evidence base to monitor the impact of any interventions that are delivered.

6. TAKING ACTION



39 HIGH STREET
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Working with the identified communities, we will identify key local priorities and develop an action plan for each of the identified communities which tackles each of the five themes. In Year 1, this could include:

EDUCATION AND SKILLS

- Develop localised skills plans for the identified communities, matched to the needs of local employers;
- Develop a local version of the National Youth Guarantee concept tailored to the needs of our identified communities.

JOB AND CAREER OPPORTUNITIES

- Expand the number of apprenticeships taken up by residents in the identified communities, in partnership with local businesses
- As public services, identify entry level job opportunities and paid internships that can be targeted at the identified communities, working with DWP restart providers
- Develop 'work readiness' programmes for residents in the identified communities who have limited work experience

QUALITY OF OUR PUBLIC REALM

- Develop and deliver a Regeneration plan for each of the three town centres
- Produce a delivery plan for public realm improvements in each of the identified communities

STANDARD OF LIVING

- Through our 'financial insecurity' partnership, roll out a scheme that provides advice and support on debt prevention and helping people out of debt in the identified wards
- Working with the Buckinghamshire Food Partnership, implement the recommendations of the 2020 Sustain report
- Review our approach to 'affordable warmth' and develop an action plan for 2022+

HEALTH AND WELLBEING

- Undertake public health projects targeted at the particular needs of the identified communities (including cardiovascular health)

By strengthening coordination across partners and collaboration with local communities, we will seek to maximise the benefit of the existing multi-agency resources already targeted at these communities. Where appropriate, we will build business cases for investment in specific projects and bid for external funding to support our objectives.

7. OVERSEEING DELIVERY



Governance

The Buckinghamshire Growth Board will be responsible for the governance of the strategy, underpinned by a partnership steering group which will oversee the detailed development and delivery of our approach. This will include a lead champion for each of the five themes.

The Community Boards in Aylesbury, High Wycombe and Chesham will play a key role in overseeing the development and delivery of the local action plans.

Monitoring and Evaluating Impact

Levelling up is not going to happen overnight. This strategy requires long term and sustained commitment and it would not be appropriate to set targets at this stage. To assess progress, performance will be tracked against key metrics in the identified communities in order to understand the direction of travel, including measures that evidence:

- Healthy life expectancy
- Unemployment rates
- Early Years and Primary education attainment
- GCSE performance
- Completion of skills training
- Number of children eligible for free school meals
- Crime and anti-social behaviour
- Quality of the environment
- Number of people living with multiple morbidities
- People's satisfaction with their neighbourhood and community connectedness (measured through an annual survey and focus groups)

Views and feedback will also be gathered from communities and partners to evaluate impact.

Progress will be reported to the Buckinghamshire Growth Board and the Council's Cabinet on a regular basis.

OPPORTUNITY BUCKS – SUCCEEDING FOR ALL

A local response to Levelling Up

Report from Chair of Finance and Business Performance Committee

Date of Committee 28 June 2022

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the F&BP meeting 24 May 2022	Minutes approved	None	Refer to Audit Committee for noting	n/a
Monthly Integrated Performance Review (IPR)	Monthly reporting on Trust performance metrics and actions/progress with actions to address negative variance. Reporting defined by NHS System Oversight Framework, BHT Strategic Priorities and the 2022/23 Operating Plan	Assured	Consider a set of rules on the provision of narratives to focus on risk and actions, develop forward view of deep dives and consistently provide productivity measures	n/a	Take assurance from ongoing development of report

<p>Monthly Finance Report</p>	<p>Update on financial position at M02 including YTD headline position, capital, balance sheet and cash flow analysis</p>	<p>Assured – noting risks related to divisional performance and budgets but with strong divisional ownership</p>	<p>Write to BOB interim CFO and regulatory finance colleagues to ensure awareness of Trust position related to cash and capital</p> <p>Deep dives with divisional attendance where performance is off trajectory</p> <p>Adjustment of report to align pay and non-pay reporting format</p>	<p>n/a</p>	<p>Take assurance from the M02 report</p>
<p>Costing Update and National Cost Collection</p>	<p>Detailed assurance for Board ahead of approval of the National Cost Collection</p>	<p>Assured – noted to be robust and rigorous.</p>	<p>Ongoing work with Community teams to achieve compliance and focus on acute WAU benchmarking</p> <p>Data collection to be submitted</p>	<p>n/a</p>	<p>n/a</p>
<p>Transformation and Efficiency Update</p>	<p>Revised monthly reporting on the Trust Efficiency Plan</p>	<p>Assured – progress welcomed on productivity measures</p>	<p>Further work planned to define true productivity measures across all areas</p>	<p>n/a</p>	<p>n/a</p>

Diagnostics Deep Dive	Deep dive into (non-endoscopy) diagnostics considering the programme level strategy, diagnostic operating plan, key risks and the national context	Assured – noting development of the local pathology network	Separate endoscopy deep dive planned	n/a	n/a
HEE Funding and Returns Update	Summary of funding received from Health Education England during 2021/22 with details of related expenditure	Assured	None	Final submission to be considered by Strategic Workforce Committee (SWC)	n/a
Data Security and Protection Toolkit (DSPT)	Summary of progress against the DSPT standards and building cyber resilience with detail of required actions	Partially assured – noting increased resource within senior IT team and quarterly updates to EMC, FBPC and Board	Greater assurance on the effectiveness of self-assessment processes Fully detailed project plan to September 2022 Committee	As per planned reporting schedule	Unmitigated risk related to cyber resilience and DSPT compliance with potential for NIS notice
Back Scanning of Paper Records	Business case for back scanning and off-site storage of medical records within the Alexandra House storage unit	Approved – noting this was within the capital plan, facilitated the removal of notes from Alexandra Hose and was supportive of the long-term paperless ambition	None	n/a	Recommended for approval

National Spinal Injuries Centre (NSIC) – Delayed Discharges	Detail regarding delayed transfers of care from the NSIC including details on capacity, income and the NHSEI peer review transformation project	Assured	Update in 3 months to review trajectory and transformation work	n/a	n/a
Operational Management Excellence Programme	Overview of the Trust development programme for operational colleagues including aims and priorities and programme deliverables	Assured – development of programme welcomed by the Committee	n/a	Overview of Messenger Review by SWC	n/a
Business Case Tracking	Overview of business cases approved by Trust Board since April 2021 with plans for review of progress and tracker development	Assured	Further work to fully complete tracker ahead of next formal update to Committee	n/a	n/a

Emerging Risks noted:

- Forward cash trajectory and need to alert regulators.
- Unmitigated risk related to cyber resilience and DSPT compliance and associated potential cost of rectifying.
- Timescale for removal of medical records following the end of lease.
- Specific operational and financial performance risks; to be addressed through deep dive programme.
- Risk to overall financial position from adherence to agreed budgets by divisions.

Report from Chair of Charitable Funds Committee

Date of Committee 19 May 2022

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<p>Minutes of the previous meeting(s)</p>	<p>Minutes from the meeting on 3 March 2022.</p> <p><i>During this section, BJ informed the Committee about Nelson Garcia-Narvaez resignation.</i></p> <p><i>NG formally thanked NG-N for his passion, diligence and professionalism in his role at Charitable Funds.</i></p>	<p>Approved</p>	<p>None</p>	<p>n/a</p>	<p>n/a</p>
<p>Charitable Funds Activities</p>	<p>Summary of financial, operational and governance developments since the previous meeting in March 2022</p>	<p>Assured</p>	<p>None</p>	<p>n/a</p>	<p>n/a</p>

<p>Fundraising & Business Strategy</p>	<p>Update on the: - Development of the Children's Unit Appeal - Legacy Campaign Status</p> <p>Financial report; Fundraising Strategy</p>	<p>Noted</p>	<p>None</p>	<p>n/a</p>	<p>n/a</p>
<p>Fundraising Policy</p>	<p>Final Fundraising Policy</p>	<p>Approved</p>	<p>None</p>	<p>Submitted and Approved by TPSG and EMC</p>	<p>To be endorsed after EMC approval</p>
<p>Appeal Committee Terms of Reference</p>	<p>Final Draft Appeal Committee ToR for review and comments</p>	<p>Approved</p>	<p>None</p>	<p>To be circulated to the Divisional Directors and Medical Leads together with the invitation to register their participation in this committee.</p>	<p>n/a</p>

<p>Financial Statements & Investment Reports</p>	<p>Portfolio Investment Report from Cazenove detailing a summary of investments, an analysis of performance review and analysis and the position/outlook</p> <p>Portfolio Valuation Report as at 30 April 2022</p> <p>Charitable Fund Committee Financial Reports from 1 April 2021 to 31 March 2022</p>	<p>Assured – Noted the improvement in the Portfolio Value.</p> <p>Noted the disclosure from Cazenove related to a probable reduction in the investment income for 2022/2023. Requested to be logged on the Risk Register.</p> <p>Noted the portfolio assets are in line with the policy established by the board and the Committee.</p>	<p>None</p>	<p>n/a</p>	<p>n/a</p>
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Bids for Approval	Energy requirement in children with spinal cord injury	The Bid was withdrawn. Additional work required by the Research Department.	None	n/a	n/a
	Consultant in Public Health Medicine	Bid was not approved by the CFC but requested a revision of the role which could be resubmitted in the future as long as the Committee's concerns are addressed.	None	n/a	n/a
	Funding for Staff Network Support and & Activities	Bid was not approved by the CFC but requested revised bids after spending the £9,500 approved in the prior year, the ROI on the spend and the request for further funds as a result; and showing how a new role would benefit patients.	None	n/a	n/a
Reserve Policy	FRS 102 requires an annual statement on the Charity's policy on reserves; 2021 level of reserve for approval and proposed disclosure in the Annual Trustees Report	Approved	None	n/a	n/a

<p>Charity Risk Assessment</p>	<p>Risk management re-assessment and Risk Register as of 31 March 2022</p>	<p>Noted</p> <p>APPROVED the revised Risk Assessment Register, noting it was a retrospective view.</p> <p>To review and update the risk register and governance thereof.</p>	<p>None</p>	<p>n/a</p>	<p>n/a</p>
<p>Investment Policy – Annual Update</p>	<p>Update in process approval</p>	<p>Noted</p> <p>Policy approved by TPSG and EMC. Will be presented in the Public Board Meeting in July for endorsement.</p>	<p>None</p>	<p>n/a</p>	<p>To be endorsed in July Public Board meeting</p>
<p>Charitable Funds Terms of Reference</p>	<p>Update in process approval</p>	<p>Noted</p>	<p>None</p>	<p>n/a</p>	<p>To be endorsed in July Public Board meeting</p>
<p>Recruitment process for the Honorary Independent Member for the interest of the medical/clinical activities</p>	<p>Due to the resignation of NT, the CFC requested to start with the recruitment of this position.</p>	<p>Noted</p>	<p>None</p>	<p>n/a</p>	<p>n/a</p>

<p>Items for Update, Reflections and Other Business</p>	<p>BJ noted that despite both bids being rejected there are plenty of positives from the Committee and these should also be celebrated.</p> <p>NG suggested that bids and projects that are approved through the finance team could be clearly summarised in future meetings.</p>	<p>Noted</p>	<p>None</p>	<p>n/a</p>	<p>n/a</p>
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Emerging Risks:

- Expected reduction in Investment Income but being mitigating by the Investment Management and Monitor by the Charitable Funds Team.

Buckinghamshire Healthcare NHS Trust

Charitable Funds Committee Terms of Reference (ToR)

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Charitable Funds Committee

Terms of Reference

1. Background

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

2. Purpose

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

3. Constitution

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

4. Membership

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

4.2 The CFC comprises:

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

4.3 The CFC's structure is:

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

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

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

5. Quorum

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

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

6. Meetings

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

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

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

7. Authority

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

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

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

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

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

8. Duties

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

8.1 Governance and Policies

8.1.1 Ensure the Charity complies with current legislation.

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

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

8.2 Finance and Controls

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

Up to, and including £5,000	Fund Holders
£5,001 up to, and including £50,000	Director of Finance and Chief Executive
£50,001 up to, and including £100,000	Charitable Funds Committee
Over £100,001	Trust Board

- 8.2.4 Review individual fund balances within the overall Charity on a regular basis.
- 8.2.5 Review a regular report of all expenditure from charitable funds.
- 8.2.6 Agree expenditure plans from individual fund holders in accordance with funds objectives.
- 8.2.7 Implement appropriate policies and procedures to ensure that accounting systems are robust, donations received are acknowledged and that all expenditure is reasonable and in accordance with donors wishes.
- 8.2.8 Agree guidance and procedures for fundraising and expenditure.
- 8.2.9 Ensure that all fundraising and expenditure is clinically and ethically appropriate.

8.3 Investment

- 8.3.1 Determine the charitable fund's investment policy, including the selection of appropriate investment advisers and banking service provider.
- 8.3.2 Review the performance of the Charity's investments.

8.4 Other

- 8.4.1 Encourage where appropriate a culture of fundraising and raise the profile of the Charity within the Trust and local population.
- 8.4.2 Develop and approve promotional material of the Charity on behalf of the Trustees to ensure that material used will promote the charitable funds purposes and not place the Charity's reputation at risk.

9. Reporting

- 9.1 The minutes of all meetings shall be formally recorded and a summary report regarding the Committee's activities should be submitted, together with recommendations where appropriate, to the Board of Directors.
- 9.2 The Charity's Annual Report shall include a section describing the work of the Committee in discharging its responsibilities.

10. Review

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

11. Support

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

12. Monitoring Compliance and Effectiveness

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

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

13. Document Control

Version	Date	Author	Comments
1.0	1 st December 2013	E. Hollman	Draft for Committee Chair

2.0	30 th January 2014	Nelson Garcia-Narvaez E. Holman	Approved by CFC and the Board
3.0	29 th May 2016	Nelson Garcia-Narvaez	Approved at EMC 22/07/16
4.0	12 th January 2017	Nelson Garcia-Narvaez	Approved at CFC 12 th January 2017 Approved at Trust Board 31 st May 2017
5.0	28 th February 2018	Nelson Garcia-Narvaez	Approved at CFC 28 February 2018 Approved at Trust Board 28 March 2018
8.0	23 rd November 2018	Nelson Garcia-Narvaez	Approved at CFC 28 November 2018 Approved at Trust Board 31 July 2019
9.0	28 th May 2020	Nelson Garcia-Narvaez	Approved at CFC 28 May 2020 Approved at Trust Board
10.0	27 th May 2021	Nelson Garcia-Narvaez	Approved at CFC 27 May 2021 Approved at Trust Board 28 July 2021
11.0	3 rd March 2022	Nelson Garcia-Narvaez	Approved at CFC 19 th May 2022 Approved at Trust Board TBC

Report from Chair of Quality and Clinical Governance Committee (Q&CG)

Date of Committee 14 June 2022

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the Q&CG meeting on 18 May 2022	Minutes approved	None	Refer to Audit Committee for noting	n/a
Integrated Performance Report	Item not discussed; work ongoing to support availability of quality metrics by week 3.				
Community Paediatrics Medication Harms Review	Overview of plan for paediatric medication reviews for children with ASD/ADHD	Partially assured – noting ongoing plans aligned with recruitment and a clinical risk-based approach to prioritisation	Further work required on contingency plans and specific detail on all workstreams with trajectories and progress to date	n/a – for further review by Q&CGC in July 2022	To note the ongoing challenges in Community Paediatrics related to difficulties in recruitment and associated capacity challenges

Serious Incident (SI) Report	SI update and update on Never Events and timeline for report submission. Report includes full detail of Maternity SIs	Assured	None	n/a	To take assurance from the report and work ongoing to improve processes
Complaints Recovery Plan	Overview of current position related to complaints response times with improvement actions and associated trajectory	Assured – noting progress with recruitment to complaints team and trajectory for improvement in response times	None	Weekly update to EMC noted	n/a
Infection and Prevention Control (IPC) Monthly Report	Monthly update on staffing, outbreaks, national COVID-19 guidance, IPC key performance indicators and hand hygiene, PPE and cleaning and mandatory training compliance	Assured – noting oversight of outbreaks and changes in COVID restrictions via EMC. Uptick in infection rates mirrored regionally	None	n/a	n/a

Midwifery Staffing Six Monthly Oversight Report	Summary of midwifery staffing and safety issues in line with recommendations from the maternity incentive scheme	Partially Assured – noting recruitment efforts to reduce delays in inductions and the provision of clear and robust escalation processes but concerns regarding national shortage of midwives and impact on training sessions	None	n/a	n/a
Integrated Safeguarding Quality Report	Update on safeguarding performance for Q4 including progress against specific agendas and associated risks	Partially assured – noting ongoing risk related to statutory level 3 safeguarding training. Mitigations, recovery plan and trajectory in place	None	n/a	n/a
NEWS Escalation Audit	Summary of results from the second NEWS audit and suggested resultant actions	Partially Assured – in light of audit findings but noting recommendations to be actioned	None	n/a	n/a
Quality and Patient Safety Chairs Report	Summary of meeting on 26 May 2022	Noted	None	n/a	n/a

Mortality Reduction Group Minutes/ Report	Minutes of the meeting on 10 May 2022 Dr Foster mortality summary for February 2021-January 2022	Noted	None	n/a	n/a
Publication of SEND letter and draft action plan	Overview of findings from the Buckinghamshire SEND inspection from March 2022	Noted	Action plan under development; to be seen by the Committee prior to submission	n/a	n/a

Emerging Risks noted:

- Inability to take assurance on the actions related to Community Paediatrics, insufficient clinical resource and potential for harm to CYP. Focus required on what can be done to reduce the risk of potential harm out with recruitment efforts.
- Compliance with safeguarding mandatory training (as part of a wider issue with statutory/mandatory training compliance).
- National shortage of midwives.

Report from Chair of Quality and Clinical Governance Committee (Q&CG)

Date of Committee 11 July 2022

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the Strategic Workforce Committee meeting on 9 May 2022	Approved	None	Refer to Audit Committee for review and assurance	n/a
Chief People Officer Report	Update on key people developments since the previous Committee meeting (May 2022)	Assured	n/a	n/a	n/a
Fire, Security and Health & Safety Annual Reports	2021/22 reports for: <ul style="list-style-type: none"> - Fire - Security - H&S 	Assured - subject to further work required	<p>'Tightening up' of words on each report. Include actions, owners and timescales on priorities</p> <p>H&S Report: to include relevant data from 2021 staff survey results</p>	n/a	Recommended to Board

Integrated Performance Report (IPR)	<p>Monthly reporting on Trust performance metrics and progress with actions aligned to the Strategic Priorities and the NHS System Oversight Framework</p> <p>May data discussed with a focus on people metrics</p>	<p>Assured – noting continued work on recruitment and retention</p>	<p>Paper on temporary staff to be presented at next Finance & Business Performance Committee</p>	<p>n/a</p>	<p>To take assurance from ongoing work related to the recruitment and retention</p>
Freedom To Speak Up Guardian (FTSUG) Annual Report	<p>Annual report for 2021/22 summarising FTSU activity and reporting progress against the objective to build a positive speaking up culture across the Trust including next steps</p>	<p>Assured</p>	<p>Include actions, owners and timescales on priorities</p>	<p>n/a</p>	<p>Recommended to Board</p>

Guardian of Safe Working Hours Annual Report	Annual report for 2021/22 summarising progress against the objective to promote a reporting culture amongst junior doctors. Includes detail on exception reporting and breaches The report also highlighted that a new IT system was being used to support the August junior doctor rotation. The GSWH and Medical HR team were keeping in close touch with the junior doctors.	Assured	On future reports redesign the format to include the solution directly after the situation	n/a	Recommended to Board
Medical Appraisal and Revalidation Report	Summary of 2021/22 activity and overview of Trust compliance with required processes	Assured	Confirmation required in September's Committee that the outstanding appraisals have been completed	n/a	Recommended to Board
Education Report	Overview of key educational activities delivered across the Trust, managed and delivered by the education department	Assured	n/a	n/a	n/a

Corporate Risk Register (CRR); People Risks	Review of risks from the CRR related to People including mitigations in place	Assured	For future reports highlight any changes to the previous report	n/a	n/a
Feedback from Committee Self-Assessment	Summary of responses from the Committee self-assessment survey including initial recommendations for consideration	Assured	Draft action plan in place, to be discussed at next SWC Committee reflections: ensuring the committee has representation from the Chief Medical Officer's team; ensuring that Allied Health Professionals are effectively represented in the future	n/a	n/a
People Board	Minutes from the meeting on 9 June 2022	Noted	n/a	n/a	n/a
Nursing, Midwifery and AHP Strategy	Draft strategy for nursing, midwifery and allied health professional colleagues setting out five key commitments over the next three years	Provided for information	n/a	n/a	n/a

'Great Place to Work' – Transformation Programme Update	Overview of progress including that related to recruitment, retention, occupational health and wellbeing, organisational development and education and rostering	Noted	n/a	n/a	n/a
Messenger Review	Details of Messenger Review published June 2022, assessment of current Trust position and identification of gaps with suggested next steps	Noted	n/a	n/a	n/a
People Promise Exemplar Programme	Provision of driver diagrams setting out action plans for three key programme aims	Noted	n/a	n/a	n/a

Emerging Risks noted:

- Potential impact on staff turnover as a result of changes to pensions.

Report from Chair of Audit Committee

Date of Committee 7 July 2022

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Minutes of the previous meeting	Minutes from the Audit Committee meeting on 6 May and 20 June 2022	Approved	None	n/a	n/a
Corporate Risk Register	Reviewed/Discussed the CRR Committee asked for escalation to board on Discharge to Access and review of Fluoroscopy business case by F&BP	Assured	Yes – as per minutes	F&BP	n/a
Risk Management Policy	Noted the work done on this – however policy needs further work and therefore it was not approved	Assured – positive work noted by the Committee although Committee has deferred approval	Yes	Not approved – to return to the Committee once additional work has been completed	
External Audit	Discussed progress on VfM report	Assured	To be completed ahead of September deadline	n/a	n/a
Internal Audit	Medical Assets – partial assurance	Assured – but Medical Assets also referred to		Referred to Quality on Medical assets	Note

	Progress update – several reviews underway Annual Report – formally noted	Quality Committee for review			
LCFS	Update	Assured	High number of referrals to be considered further	n/a	To take assurance from work ongoing
STW	Review of report	Assured	n/a	Exec Committee to review ahead of Committee with actions to prevent avoidable and retrospective STWs	n/a
Internal Audit; Progress Report	Update on progress including presentation of one new report: - Financial Management (RA)*	Assured – noting the importance of budget setting training	As per action plans in place	n/a	n/a
Losses and Special Payments	Report noted write off of high cost drugs	Noted – further benchmarking to be done	None	n/a	n/a
Minutes of Finance &	Noted	Noted	None	n/a	n/a

Business Performance Committee					
Minutes of Quality & Clinical Governance Committee	Noted	Noted	None	n/a	n/a
Minutes of Strategic Workforce Committee	Noted	Noted	None	n/a	n/a

*RA – Reasonable Assurance; PA – Partial Assurance; MA – Minimal Assurance

Emerging Risks Identified:

The following matters would be escalated to the Board:

- Discharge to Access (on the CRR)
- Risk level for capital to be reviewed
- BJ to update the Committee on what has happened in the sexual health commissioned out of contract service.
- Policy in relation to risk comes back once completed
- Delay in paediatrics unit
- Process for commissioning and renewal of contracts and due diligence
- Patient safety on medical assets and referral to Quality Committee for further assurance.
- Further details required on the delay around HVLV.
- (Referral to Quality & Clinical Governance Committee of report on Medical Assets)

-

Audit Committee Terms of Reference

1. Purpose

The overall purpose of the Committee is to assist the Board in the performance of their duties including:

- Review 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;
- Monitor the integrity of the financial statements of the Trust;
- Monitor the independent auditors' qualifications, independence and performance;
- Monitor the performance of the Trust's Internal Audit function and Local Counter Fraud provision;
- Make recommendations to the Board on the appointment of external and internal auditors; and
- Monitor compliance by the Trust with legal and regulatory requirements.

2. Constitution

The Board resolves to establish a standing Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. These terms of reference shall apply for as long as the Trust is an NHS Trust and can only be amended by the Board of Directors.

3. Membership

3.1 The Committee shall be appointed by the Board from amongst the non-executive and associate non-executive directors of the Trust and shall include up to four independent non-executive directors who are financially literate and have the personal and professional characteristics necessary to be effective.

3.2 A term of membership shall be for two years and renewable for three further two year terms subject to the approval of the Board of Directors.

3.3 One of the members will be appointed Chair of the Committee by the Board and will not be a Chair of any other standing Committee of the Board.

3.4 The Chair of the Trust shall not be a member of the Committee.

3.5 The following shall attend the Committee at each meeting but as attendees rather than members:

- Director of Finance
- Trust Board Business Manager
- Committee Secretary
- Clinical representative
- Local Counter Fraud Specialist (LCFS).
- Representative from External Audit

- Representative from Internal Audit
- Others may be invited to attend according to the agenda

The Chief Executive has an open invitation to the meeting but is only required to attend when presenting the Annual Governance Statement.

4. Quorum

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

Where a Committee meeting is not quorate under paragraph 4.1 within one half hour from the time appointed for the meeting; or becomes inquorate during the course of the meeting, the Committee members present may determine to adjourn the meeting to such time, place and date as may be determined by the members present.

5. Meetings

5.1 The Committee shall meet at least four times per year and at such other times as the Chair of the Committee shall require. Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chair of the Committee.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date shall be forwarded to each member of the Committee no later than ten days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees, as appropriate five days ahead of the date of the meeting. The Committee shall follow an annual work plan reviewed by the members in advance of each financial year.

5.3 The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

5.4 In addition to the formal meetings the Committee members will be provided with at least one session for training and development each year.

6. Authority

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

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

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

The Committee is authorised by the Board to obtain external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and

expertise if it considers this necessary. This shall be authorised by the Chair of the Committee and shall be within any budgetary constraints imposed by the Board of Directors.

The Audit Committee has the authority to require any member of staff to attend its meetings.

7. Duties

The Audit Committee shall be responsible for the following duties:

7.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement and Quality Accounts), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives and assurance over quality of data in relation to performance reporting. This shall be through a review of the work of other relevant Committees which provide relevant assurances to support the Audit Committee's own scope of work;
- Risk Management Strategy, Standing Orders, Standing Financial Instructions and Limits of Delegation policy;
- The Committee shall be notified of, and review, any decision to suspend Standing Orders;
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by National Institute for Health Protection; and
- The policies and procedures for staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee shall report issues in relation to audit, risk or internal control to the Board of Directors after each of its meetings in addition to an annual report focused on the effectiveness of the Committee in exercising these duties.

7.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides

appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Considering and making recommendations for the provision of the internal audit service, the audit fee and any questions of resignation and dismissal;
- Review and approval of the internal audit plan and the detailed programme of internal audit work, ensuring that this is consistent with the audit needs of the Trust as identified by the Assurance Framework;
- Consideration of the major findings of internal audit, together with management's response;
- Monitoring and seeking assurance against the implementation of actions to address all recommendations arising from Internal Audit reports through the use of an overall audit and assurance outstanding recommendation tracker to be reported to each meeting;
- Facilitating co-ordination between the internal and external auditors to optimise audit resources and avoid duplication;
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust through ongoing monitoring against core Internal Audit KPIs; and
- Annual review of the effectiveness of internal audit.

7.3 Local Counter Fraud Service

The Committee shall review the work plan and periodic reviews of the local counter fraud service and consider actions necessary to combat fraud and corruption. This will be achieved by:

- consider the appointment of the Local Counter Fraud Specialists (LCFS), the LCFS' scope and any question of resignation and dismissal;
- consider and approve the counter fraud strategy and the annual workplan, ensuring that this is consistent with the needs of the Trust;
- The policies and procedures for all work related to fraud and corruption as set out in Service Condition 24.2 of the commissioning contract and as required by NHS Counter Fraud Authority in line with Government Functional Standard GovS 013: Counter Fraud; and
- review LCFS reports, consider the major findings of fraud investigations, and management's response, and ensure co-ordination between the LCFS, internal and external auditors.

7.4 External Audit

The Committee shall ensure a cost-efficient service, review the work and findings of the appointed external auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor;
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan, and ensure coordination, as appropriate, with other external auditors in the local health economy;

- Discussion with the External Auditor of their local evaluation of audit risks, their assessment of the Trust and the associated impact on the audit fee;
- Review of all External Audit reports together with the management responses;
- Agreement of the annual audit letter before submission to the Board and agreement to any work falling outside the annual audit plan; and
- The Committee will develop a policy, and monitor its implementation, on the engagement of the external auditor to supply any non-audit services to ensure the external auditor retains a high degree of independence from the Trust.

7.5 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust.

Internally this will include the assurances provided through the Quality and Clinical Governance Committee, the Finance and Business Performance Committee and the Strategic Workforce Committee. The Committee shall review the processes used by other Board Committees to gain assurance. In particular the Committee will wish to satisfy itself on the assurance that the Quality and Clinical Governance Committee gain from the clinical audit function.

The Committee will monitor that the Board Assurance Framework records the level of assurance given by external reviews carried out by regulators such as the Care Quality Commission, the NHS Resolution, Royal Colleges and other similar professional bodies. The Committee will receive assurance through the Quality and Clinical Governance Committee that there is a process for monitoring external reviews and that any external reviews that have taken place have been considered at the appropriate Board Committee.

The Committee will also monitor the use of Single Tender Waivers (STW) and losses and special payments.

7.6 Management

The Committee shall request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.7 Financial Reporting

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures within the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies and practices;
- Unadjusted misstatements in the financial statements;
- Significant judgements in the preparation of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall monitor compliance with the Trust's Standing Orders, including through notification and review of any decision to suspend them.

8. Reporting

The minutes of all meetings shall be formally recorded and a summary submitted, together with recommendations where appropriate, to the Board of Directors.

The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

9. Review

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

10. Support

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

- The Agreement of the agenda with Chair and attendees and collation of papers. Papers will be distributed five working days before the meeting in electronic copy.
- Advice to the committee on pertinent areas is provided.
- That Minutes are taken and a record of matters arising and issues to be carried forward is made.

Document Control

Version	Date	Author	Comments
1.0	1 Dec 2013	E Hollman	Revised Draft for Committee Chair
1.1	17 March 2014	B Courtney	Revised draft following Audit Committee
1.2	26 March 2014	B Courtney	Board approved.
1.3	27 August 2015	N.McKechnie	Periodic review for Committee
1.4	22 December 2016	E Hollman	Periodic review for Committee
1.5	24 January 2018	E Hollman	Periodic review for Committee
1.6	4 January 2019	E Hollman	Periodic review for Committee
1.7	24 January 2022	J James	Periodic review for Committee

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Integrated Performance Report – For Review		
Board Lead	Raghuv Bhasin, Chief Operating Officer		
Type name of Author	Wendy Joyce, Director of Performance		
Attachments	Trust IPR June 2022		
Purpose	Information		
Previously considered	Transformation Board Finance and Business Performance Committee		

Executive Summary

This document provides a draft Integrated Performance Report for review. Metrics have been aligned to the Trust's three core strategic objectives and report on key areas. Focus is on key areas:

- Performance highlights and challenges against national targets and standards
- Risks and actions to address negative variances
- Quality and workplace standards

Decision	The Board is requested to consider performance and risk impact
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Relevant Strategic Priority

Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒
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Implications / Impact

Patient Safety	Quality and Safety Metrics core part of the IPR
Risk: link to Board Assurance Framework (BAF)/Risk Register	1. Failure to consistently provide outstanding quality care that is compassionate, cost effective & safe, 3. Inability to lead an organisation with the capacity and capability to deliver our best in everything we do, 4. We do not recover services adequately, fail to meet public / regulator expectations, and do not play a leading role in the health, economic and social recovery of Buckinghamshire
Financial	Financial reporting outlined in the outstanding care section of the report
Compliance Select an item. Select CQC standard from list.	Well Led - Operational planning is a statutory requirement of NHS Trusts.

Partnership: consultation / communication	
Equality	Reducing health inequalities is a core part of our strategy and a core part of the planning requirements for the NHS. Health inequalities metrics included in the health Communities part of the IPR.
Quality Impact Assessment [QIA] completion required?	Not required

Integrated Performance & Quality Report

June 2022

CQC rating (July 2022) - GOOD

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK



Integrated Performance & Quality Report

Introduction & Contents

The Buckinghamshire Healthcare Trust Integrated Performance and Quality Report is aimed at providing a monthly update on the performance of the Trust based on the latest performance information available and reporting on actions being taken to address any performance issues with progress to date.

The contents of the report are defined by the NHS System Oversight Framework for 2021/22, the Trust's three strategic objectives and the Trust Improvement

Outstanding Care

Provide outstanding cost effective care

Operational Standards

- Urgent Emergency Care Recovery
- ED Performance
- Ambulance Handovers
- Emergency Admissions

Elective Recovery

- Waiting List
- Activity
- Outpatients
- Cancer
- Diagnostics

Quality and Safety

- Incidents
- Infection Control
- Complaints
- Friends & Family Test
- Patient Safety
- Maternity

Finance

Healthy Communities

Taking a lead role in our community

Community Activity

- Community Contacts
- Caseload

Community Hospitals

- Admissions
- Length of stay
- Discharges
- Discharge Destinations

Community Productivity

- Urgent 2 Hour Response
- New Birth Visits Within 14 Days
- Waiting List

A Great Place to Work

Ensuring our people are listened to, safe and supported

People

- Vacancies
- Occupational Health
- Sickness
- Training

Report changes this month

Metrics that have been added to or removed from the report since last month

Added

Removed

Changed

Inset chart for Waiting List by weeks wait changed to look at 78 weeks and over (previously 90 weeks and over).

Community waiters chart includes an additional 10 community services and now represents **all** community services.

Integrated Performance & Quality Report

Executive Summary

June saw significant operational challenges for the Trust particularly relating to the Urgent and Emergency Care pathway for both paediatrics and adults and cancer performance. The Trust showed it was more resilient to the pressures than at previous periods in the recent past but there was a decline in some key performance metrics.

It is also important to note that in June the Trust achieved 0 104-week waiters for the first time since April 2021 which is a significant achievement given the reduction needed.

The key highlights from an operational performance and healthy communities perspective include:

- The Trust continued to see high level of ED attendances that, when combined with high levels of medically optimised discharge patients, caused challenges in patient flow resulting in an increase in the proportion of patients waiting for 12 hours in ED and a decline in ambulance handover delay performance. Performance levels were maintained at a relatively steady level showing early signs of the impact of the longer UTC opening hours.
- The Trust achieved the 2 week wait cancer waiting time standard in May 2022 for the first time since October 2021. Performance improvement on 62-day cancer plateaued over June – there is a concerted focus on returning to the performance improvement through July and August.
- Whilst health visitor appointments within 14 days performance continued to decline in May unvalidated June data shows a significant improvement.

With regards Quality and Safety key areas to draw out include:

- Number of unstageable pressure ulcer cases reported remains below the monthly average in the last three months. Thematic review of PU resulting to moderate harm and above since April 2022 is ongoing.
- Treatment escalation plan (TEP) compliance is at 84% showing common cause variation. Cross site initiative and improvement project to assist patient at End of Life (EOL) instigated by the Critical Care Outreach Team and Palliative Medicine since the 4th July 2022.
- Continued improvement in 25 days response since March 2022 but still below the set target of 85%. Complaints team fully recruited and additional temporary staff in post to support compliance recovery and backlog. Complaints weekly meeting instigated by the Heads of Nursing within the divisions.

Areas of focus for A Great Place to Work include:

- Continued positive performance in sickness levels related to mental health
- Support for our staff with the cost of living which is a major focus for the Trust working with ICS partners.

Accompanying the IPR this month are the first of a series of deep dives – on medically optimised for discharge patients and temporary staffing respectively - into key areas of operational plan delivery. Two deep dives a month will be presented to Board Committees going forwards as part of additional assurance for the Board and public around operational plan delivery.

Consequently, we have reduced the narrative for the other metrics focusing on those areas that meet one of the three criteria below:

- Outside the 'negative' control limit – e.g. the control limit that signifies challenged performance – in one month
- Metric within the upper and lower control limits, but three or more months data worse or better than actual target
- Metric within upper and lower control limits for six or more months and there is no target

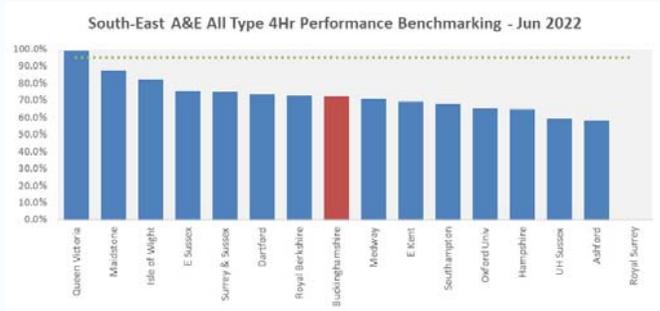
Integrated Performance & Quality Report

Overall Performance Summary

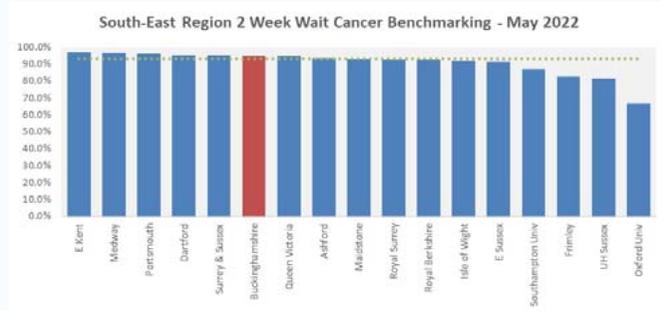
June 2022		Assurance		
		Pass 	Hit and Miss 	Fail 
Variance	Special Cause - Improvement 	Open pathway 78 week breaches	VTE Assessments Community urgent 2 hour response Early Warning Score compliance Sickness - mental health	Open pathway 52 week breaches Diagnostic activity levels Diagnostic compliance Endoscopic patients waiting > 6 weeks Non-endoscopic breaches Nursing and Midwifery vacancy rate
	Common Cause 	Overall size of the waiting list Theatre utilisation Outpatient appointment disruption Medication incidents as SIs Hospital Standardised Mortality Ratio (HSMR) Extended perinatal mortality Stillbirths per 1,000 cases Stillbirths total cases Pre term births <37+0 weeks	ED activity 21 day LOS - Acute Zero LOS admissions Discharges by 5pm Admitted clock stops Cancelled elective operations Cancer wait times - 2 Week Waits Cancer treatment levels - 31 day treatments Incidents that are low/no harm Medication incidents Number of Falls Pressure Ulcers SIs confirmed Never events MRSA bacteraemia infections C Difficile infections Treatment escalation plan compliance Non critical care cardiac arrests Complaints received 21 day LOS - Community Community average Length Of Stay Health Visitor appointments - 14 days Sickness - musculoskeletal Occupatient health - management referrals response time FTSUG outreach	ED 4 Hour performance 12 Hour waits in ED Seen by senior decision maker within 60 minutes Ambulance handovers within 15min, 30min & 60min Non admitted clock stops Elective activity Outpatient DNA rate Outpatient letters to GPs within 14 days Cancer wait times - 104 days Cancer screening Complaints response rate Friends & Family test - positive responses Trust vacancy rate Average time to replace vacancies Sickness Referrals into OH and Wellbeing - stress Data security awareness training Corporate Induction
	Special Cause - Concern 		Faster diagnostic standard (28 days) Friends and Family test - response rate Community waiting list size Employee relations cases closed	Medically optimised for discharge patients Medically optimised for discharge bed days Open pathway performance Outpatient activity delivered remotely Cancer Performance - 62 day pathway Complaints outstanding at 90 days Turnover rate Statutory training

Integrated Performance & Quality Report

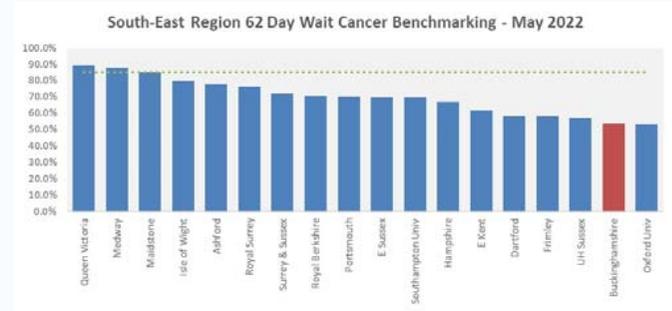
Benchmarking Summary for South-East Region



8th out of 16 (May 2022 was 6th)



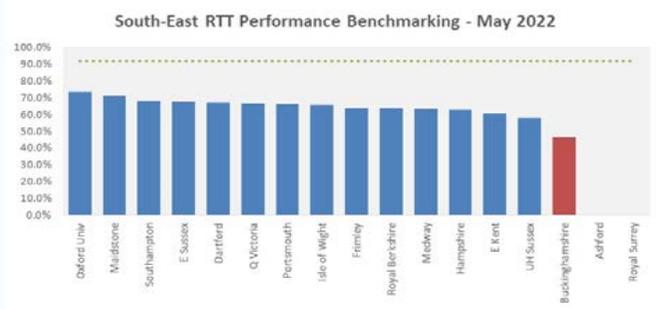
6th out of 17 (Apr 2022 was 7th)



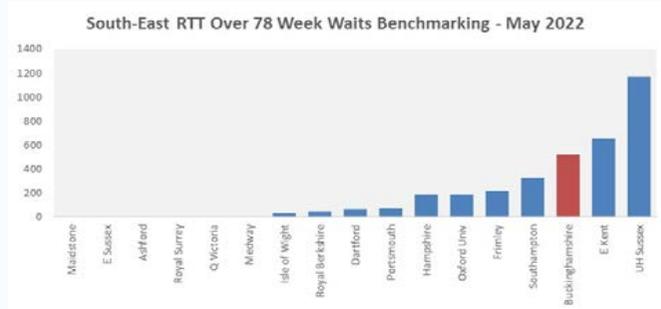
17th out of 18 (Apr 2022 was 9th)

Note: Frimley Health & Portsmouth Hospitals do not report 4 Hour performance as they are part of the Clinical Services Review

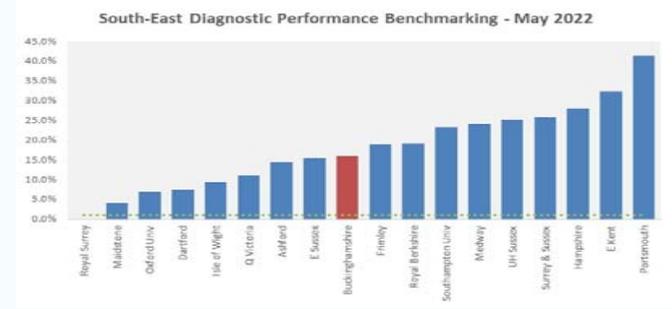
Note: Hampshire does not report 2 week waits performance as they are part of the Clinical Services Review



15th out of 17 (Apr 2022 was 17th)



15th out of 17 (Apr 2022 was 16th)



9th out of 18 (Apr 2022 was 7th)

Source: NHS England - <https://www.england.nhs.uk/statistics/statistical-work-areas/>

Outstanding Care

Operational Standards - Urgent & Emergency Care

Emergency Department and Ambulance handovers

Performance remained relatively static in June despite significant challenges with flow placing pressure on the Emergency Department. These flow challenges – largely driven by a planned reduction of beds in the wider system at the end of May and in early June and a unexpected spike in respiratory virus amongst Paediatric patients – also saw an increase in the % of patients waiting 12 hours in ED and an increase in the number of ambulance handovers. This position mirrors the wider NHS.

The Trust continues to implement its Urgent and Emergency Care Improvement Plan to improve patient flow. Key initiatives implemented in June include:

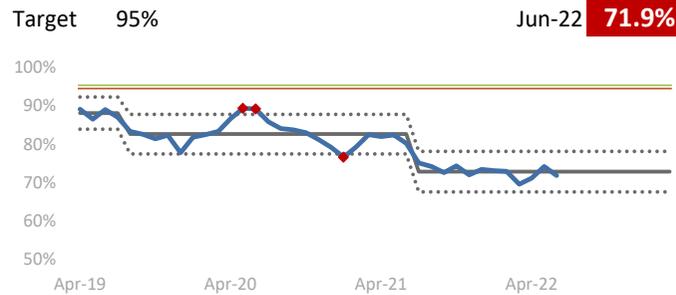
- SDEC ‘pulling’ patients from ED in the morning with further steps to be taken to standardise and refine this process;
- Appointment of a Divisional Chair for Integrated Medicine to start on 6 October. The appointee is an ED clinician and will be crucial to improving patient flow across Medicine
- Training of new discharge co-ordinators to support earlier and better discharge planning. Four colleagues appointed with a further eight to be appointed ahead of winter.

The Trust has also submitted its bid for funds to support reducing bed occupancy over winter and is expecting to have confirmation of these funds by the end of July. Further elements of the Urgent and Emergency Care Improvement Plan are being implemented across July and the rest of the summer to add further resilience to ED performance and importantly reduce those waiting for the longest periods in ED.

A deep dive on UEC Improvement including winter planning will be provided to the Board in September alongside performance trajectories for the rest of the year.

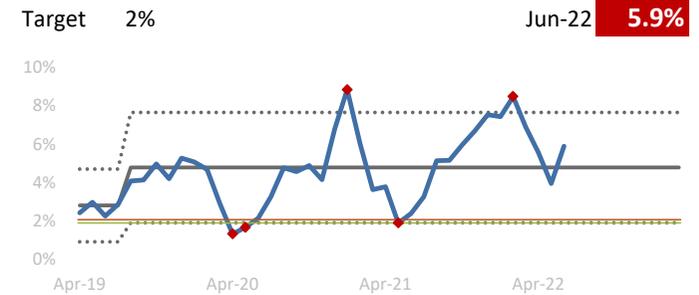
ED 4 hour performance

The percentage of patients spending 4 hours or less in ED from arrival to departure over all types of in month departures from



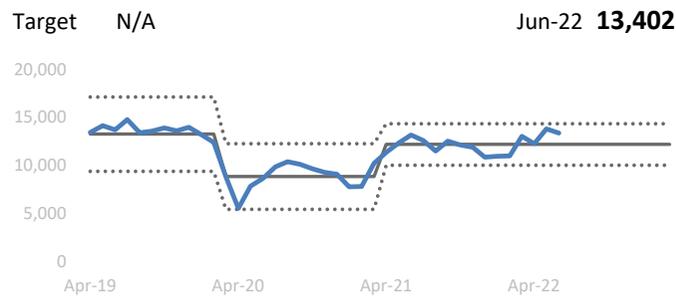
12 hour waits in ED

Percentage of patients spending more than 12 hours in Stoke ED from arrival to departure (over all types departures in the month).



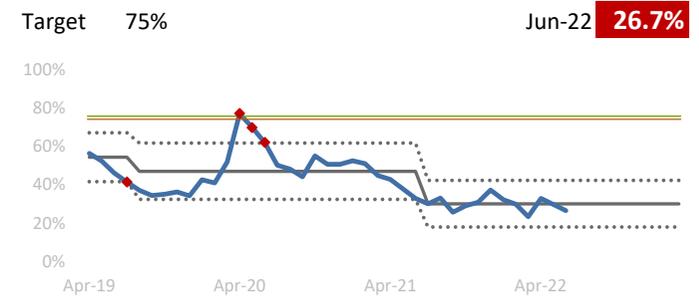
ED attendances

The number of patients attending ED (all types) during the month.



Senior decision-maker seen within 60 minutes

The percentage of Stoke Mandeville ED attendances who were seen by a senior decision-maker within 60 minutes of arrival.



★ Oversight metric — Target

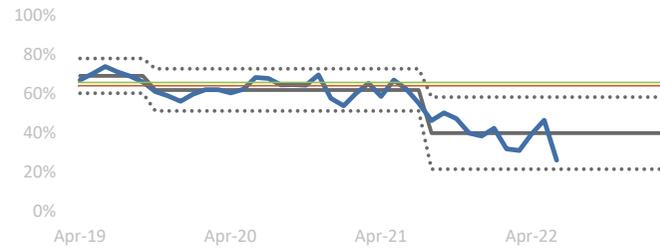
Outstanding Care

Operational Standards - Urgent & Emergency Care

★ Ambulance handovers within 15 mins

The percentage of ambulance handovers during the month taking 15 minutes or less, over all handovers in the month.

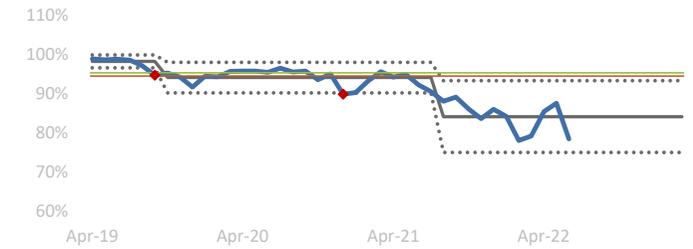
Target 65% Jun-22 **26.4%**



★ Ambulance handovers within 30 mins

The percentage of ambulance handovers during the month taking 30 minutes or less, over all handovers in the month.

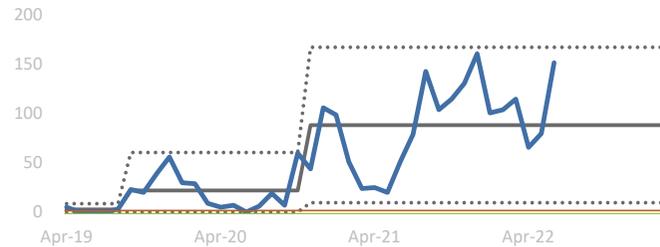
Target 95% Jun-22 **78.6%**



★ Ambulance handovers over 60 mins

The number of ambulance handovers in the month taking longer than 60 minutes.

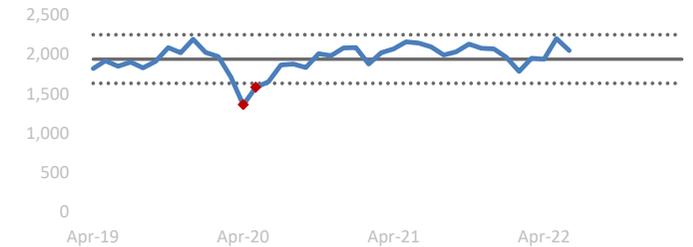
Target 0 Jun-22 **152**



Ambulance arrivals

The number of ambulance arrivals at Stoke Mandeville ED in the month.

Target N/A Jun-22 **2,054**



★ Oversight metric ———— Target

Outstanding Care

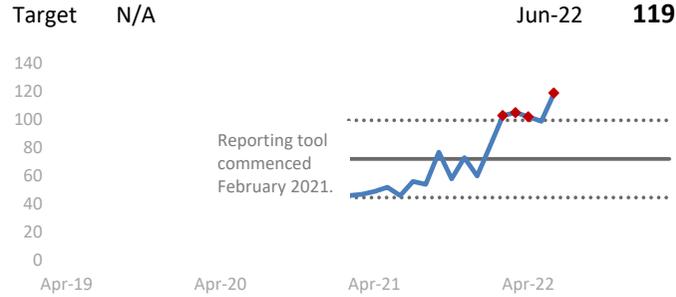
Operational Standards - Urgent & Emergency Care

Medically optimised for discharge

A deep dive into MOFD patients accompanies this report.

Medically optimised for discharge

The number of patients in hospital who are medically optimised for discharge. Snapshot taken at month end.



MOFD Bed days lost

The number of bed days lost during the month for patients who were medically optimised for discharge but not discharged.



★ Oversight metric

— Target

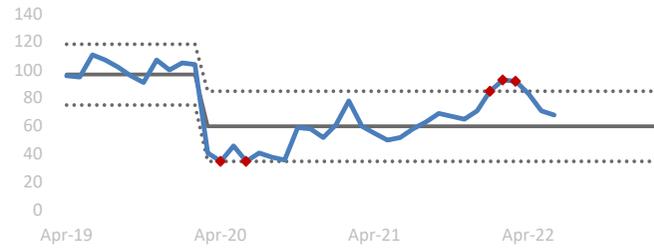
Outstanding Care

Operational Standards - Urgent & Emergency Care

21 day LOS - Acute

Count of patients in an acute bed at the end of the month who have a total length of stay of more than 21 days.

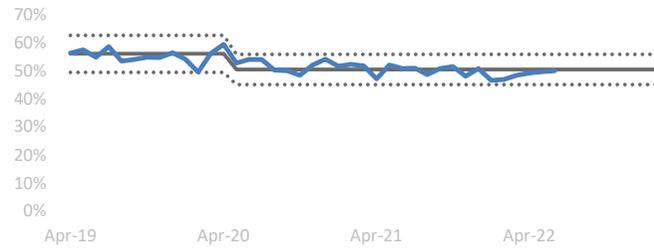
Target N/A Jun-22 **68**



★ Discharges by 5pm

Proportion of inpatients discharged between 5am - 5pm of all discharges. Excludes maternities, deceased and patients not

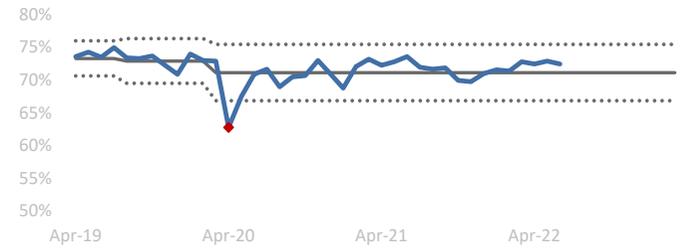
Target N/A Jun-22 **50.0%**



★ Zero LOS admissions

The percentage of emergency admissions spending less than 24 hours in hospital (out of all emergency admissions in month).

Target N/A Jun-22 **72.5%**



★ Oversight metric Target

Outstanding Care

Operational Standards - Elective Recovery

Open pathway performance

Compliance with the national target of treating 92% of patients within 18 weeks remains poor.

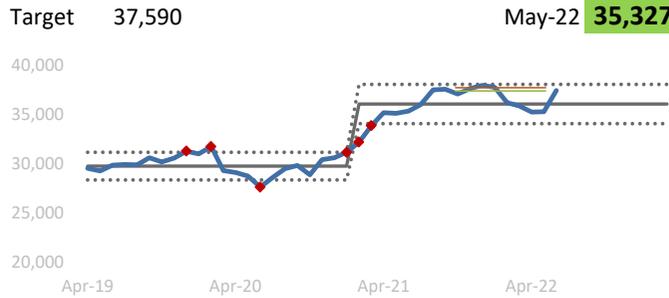
The Trust is reducing the number of patients waiting 78 weeks and above and will then focus on those waiting over 52 weeks. This work will continue through 22/23 and 23/24.

This will contribute to the reduction of the total number of patients waiting over 18 weeks but improvement of compliance is part of long term recovery. All cancer and urgent patients are treated early in their pathway and within 18 weeks and this will continue.

Compliance is expected to slowly improve but the Trust is committed to ensuring patients are treated in the correct order to achieve improvement of overall waiting times to ensure all patients receive appropriate care as soon as possible before focussing on reducing to 18 weeks wait. Current actions will gradually improve compliance and an improvement trajectory is to be agreed to monitor improvement, with a proposed minimum of 2% improvement each month in 22/23 and increasing compliance through 23/24.

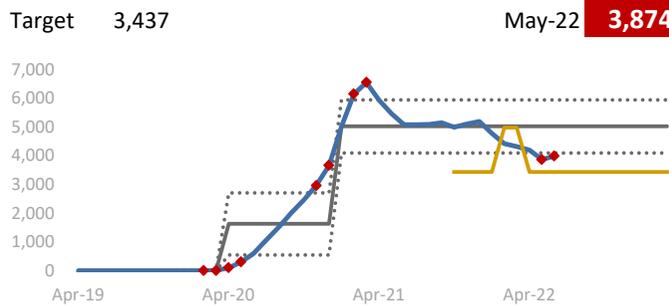
★ Overall size of the waiting list

The number of incomplete RTT pathways (patients waiting to start treatment) at the end of the reporting period.



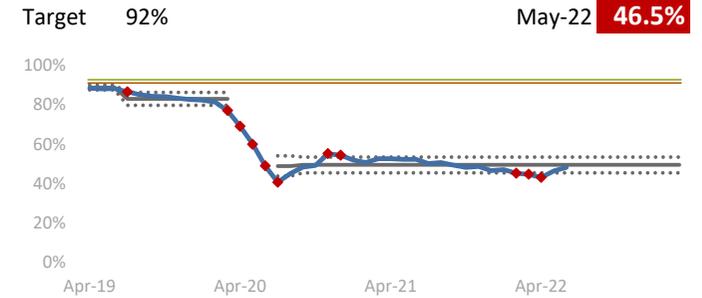
★ Open pathway 52 week breaches

Number of patients waiting over 52 weeks on an incomplete RTT pathway at the end of the month.



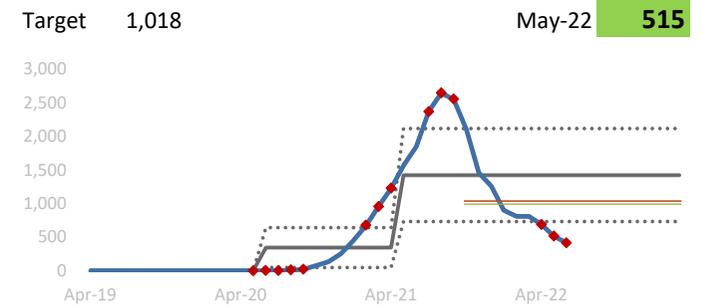
Open pathway performance

Percentage of patients waiting less than 18 weeks on an incomplete RTT pathway at the end of the month.



Open pathway 78 week breaches

Number of patients waiting over 78 weeks on an incomplete RTT pathway at the end of the month.

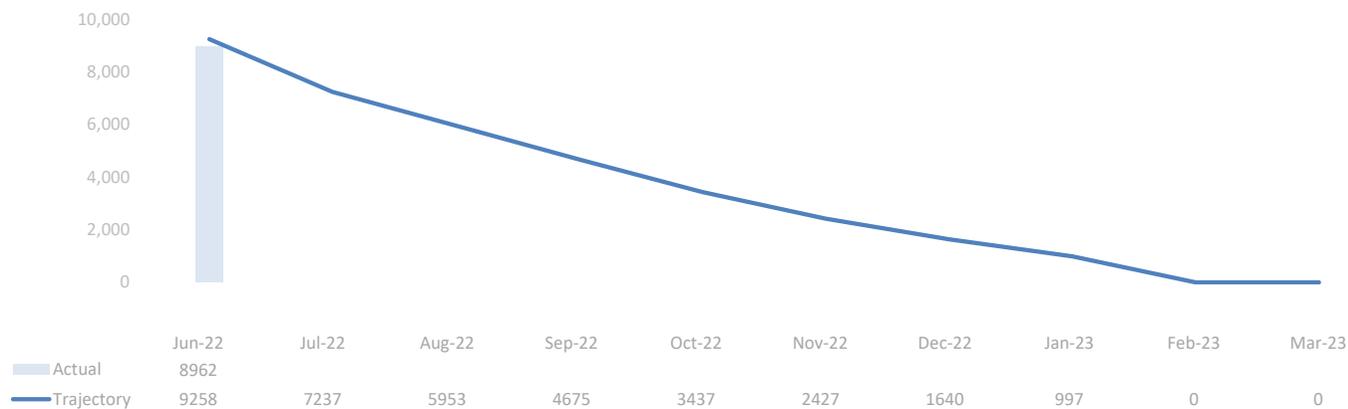


★ Oversight metric ———— Target

Outstanding Care

Operational Standards - Elective Recovery

Open pathways - 78 week waits reduction trajectory



★ Oversight metric — Target

Outstanding Care

Operational Standards - Elective Recovery

P2 patients

Patients are prioritised with a P category at the point the clinician decides to admit the patient for treatment. As our waiting list reduces and patients are seen earlier, we expect this decision to be made earlier and P2 by weeks wait to reduce.

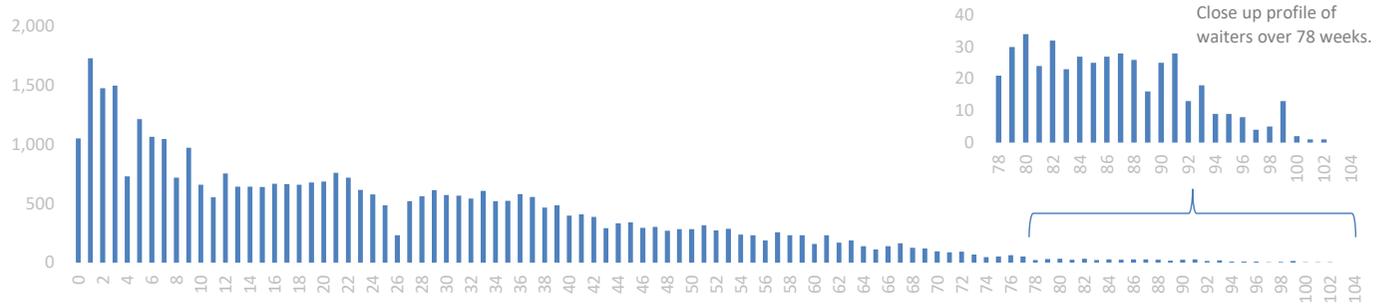
We have made significant progress in reducing the longest waiting P2 patients with weekly meetings now reviewing those at 23 weeks plus compared to 38 weeks plus at the same point in April. We aim for no P2 patients >12 weeks undated by the end of October 22. Work over Q2 with more theatre capacity coming on-line will determine this target.

The Surgical Division has launched the Clinical harm review process across all specialties, and these should start being completed as the month progresses. Reporting mechanisms are still being developed.

The graph shows a smaller number waiting longer and this will continue to improve in coming months.

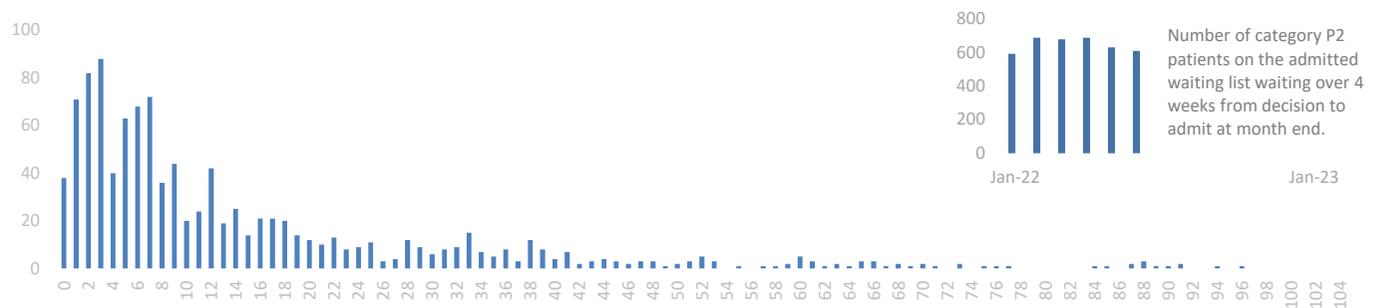
Open pathways by weeks wait

The number of incomplete RTT pathways (patients waiting to start treatment) at the end of the month (Jun-22) by weeks waited from clock start date.



P2 patients by weeks wait

Number of category P2 patients waiting by wait band (from clock start date) at the end of the month. (Jun-22)



★ Oversight metric — Target

Outstanding Care

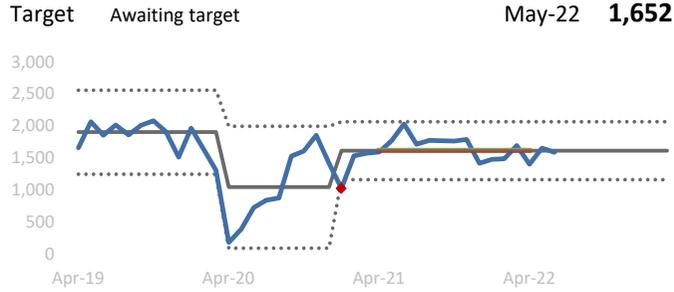
Operational Standards - Elective Recovery

Clock stops

BHT aim to improve on 2019/20 treatment rates and targets will be agreed and included for next month.

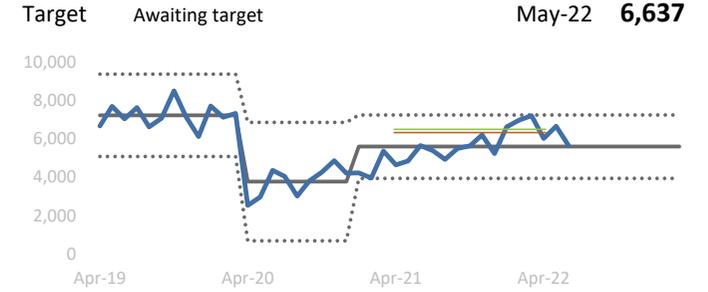
Admitted clock stops

Number of patients with an RTT admitted clock stop during the month.



Non Admitted clock stops

Number of patients with an RTT non-admitted clock stop during the month.



Admitted patients booked

Percentage of admitted waiting list patients at month end who have a future TCI date booked. Excludes future cancellations.



Non admitted patients booked

Percentage of non-admitted waiting list patients at month end who have a future appointment date booked (not cancelled).



★ Oversight metric — Target

Outstanding Care

Operational Standards - Elective Recovery

Elective Activity

Activity levels remain consistent, however Theatres are finalising workforce plans and estates challenges are being supported by the Divisional leadership team, which will enable the opening of 2 additional theatres 5 days a week and boost the volume of elective activity.

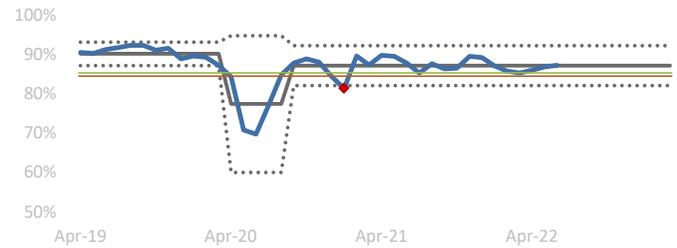
Theatre 2 SMH main is also coming back online to support emergency service. Theatre 1 at WGH still remains out of service and has challenging estates issues which teams are working to resolve.



Theatre utilisation

Total run time of theatre lists as a percentage of total planned time.

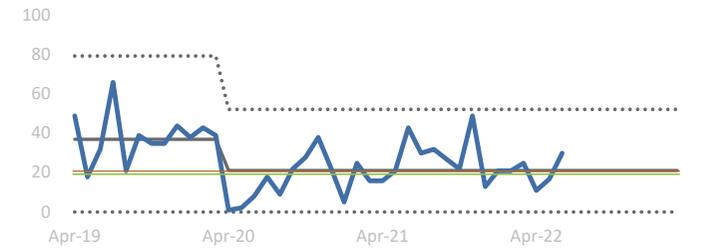
Target 85% Jun-22 **87.4%**



Cancelled elective operations

Number patients cancelled due to elective, non-clinical, hospital initiated cancellations on the day of procedure.

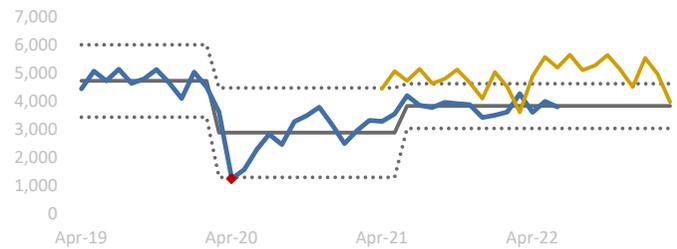
Target 20 Jun-22 **30**



★ Elective Activity

The number of elective inpatient and day case admissions during the month.

Target 5,203 Jun-22 **3,804**



★ Oversight metric — Target

Outstanding Care

Operational Standards - Elective Recovery



Outpatient DNA rate

BHT continue to utilise a text messaging service to remind patients of their appointments and as part of transformation we will be implementing two-way texting in August to improve communication and aid reducing DNAs.

Outpatient letters to GP within 14 days

Staffing levels continue to affect the timeliness of communication to GPs following appointments across all Divisions.

An assessment of demand and productivity against staffing levels will take place in August, with a plan to improve compliance with 14 days to be agreed and implemented for 1st September. This is expected to bring an improvement of 5% per month and will be monitored through Divisional meetings.

Outpatient Activity delivered remotely

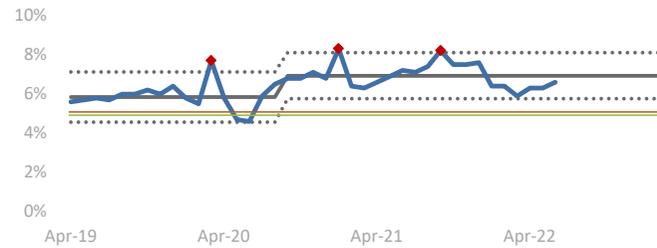
Specialities are seeing an increase in patients who need to be seen face to face, such as surgical and paediatric patients. However work has commenced to promote the accessibility of virtual consultations, focussing on medical and non-surgical areas.

Templates are due to be republished to include more virtual appointments to achieve 25% of all outpatient appointments by October 22.

Outpatient DNA rate

Percentage of patients who did not attend outpatients over all outpatient attendances and DNAs during the month.

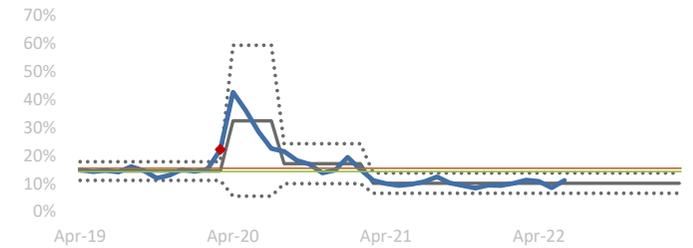
Target 5% Jun-22 **6.6%**



Outpatient appointment disruption

Percentage of hospital cancellations over all OP attendances, hospital cancellations and DNAs during the month.

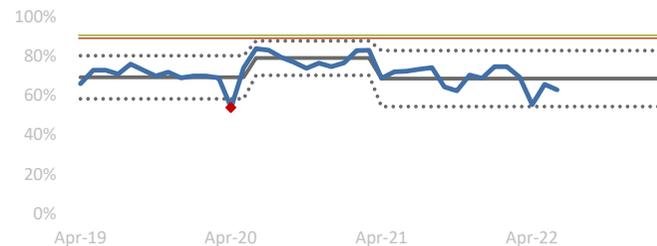
Target 15% Jun-22 **11.3%**



Outpatient letters to GPs within 14 days

The percentage of GPs that received an outpatient letter within 14 working days of patient's outpatient attendance.

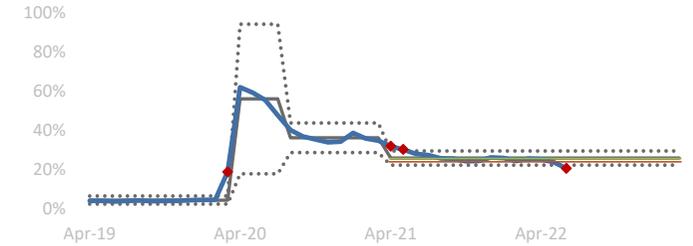
Target 90% Jun-22 **62.9%**



Outpatient activity delivered remotely

Percentage of all outpatient activity delivered remotely via telephone or video consultation.

Target 25% Jun-22 **20.8%**



★ Oversight metric — Target

Outstanding Care

Operational Standards - Elective Recovery



Cancer Wait times - 62 day pathway

A focussed project team have agreed steps to improve 62 day compliance aiming for short and medium term actions initially as seen against trajectory.

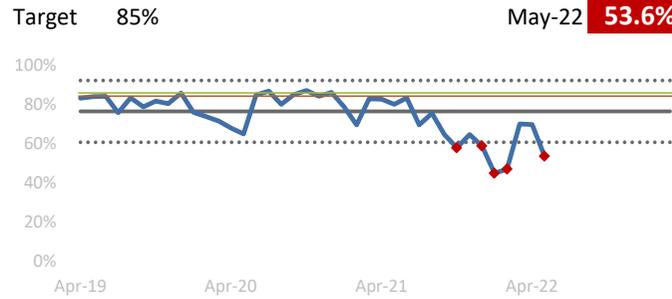
Intervention	Intervention notes	Expected impact (Backlog flow impact per day)	Start date
Backlog validation blitz	Short term focused work and overtime for validation team	30	11/07/2022
Ongoing focused validation	Extended focus of validation team additional resource based on targeting cohorts. Includes 3 x weekly meeting	12	15/07/2022
Improved PTL recording	Improved practice in cancer team to not add to reported figures patients who are not appropriate e.g. BCCs, tertiary centres	6	01/08/2022
Division led focused actions and prioritisation	Prioritising cancer long waiters for available capacity and using 2 x weekly action lists to support local ownership	2	14/07/2022 (Impact one month in areas)
Improved patient communication	Ensuring new long waiters are not added to the backlog where pathways can be closed quicker by communicating results quickly	3	30/08/2022 (impact delayed by month due to holiday impact)
Skin centre online	Amersham specialist skin centre increases capacity for Skin cancer minor ops	2	19/09/2022

Cancer Wait times - 104 days

Backlog reduction trajectory in place. Validation of pathways continue to ensure data is as clean and accurate as possible.

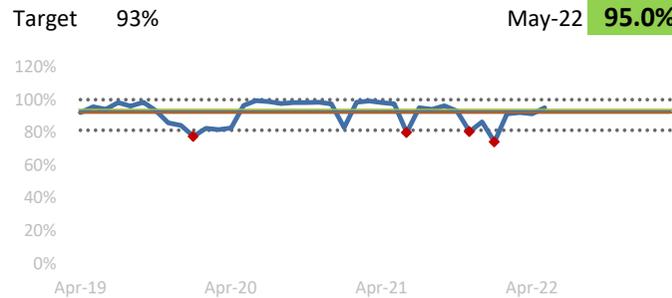
Cancer Performance - 62 day pathway

The percentage of patients treated in month within 62 days over all patients treated in month. For 62 day pathway patients.



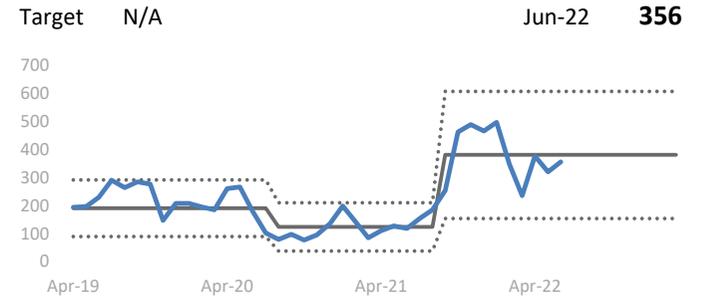
Cancer Wait Times - 2WW

Percentage of urgent referrals for suspected cancer to first outpatient attendances within 2 weeks.



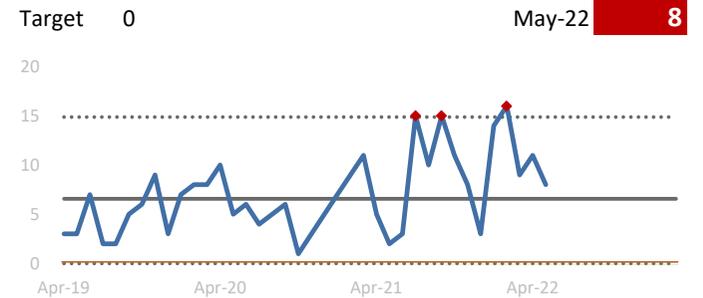
★ Cancer Wait Times - 62 day waiters

The number of cancer open pathways waiting > 62 days after an urgent suspected cancer referral at month end.



Cancer Wait Times - 104 days

The number of cancer patients waiting 104 days or more from referral to first treatment at month end.



★ Oversight metric — Target

Outstanding Care

Operational Standards - Elective Recovery

Cancer treatment levels – 31 day treatments

The majority of the breaches are plastics due to capacity. Recruitment of 2 plastic surgeons are in progress. Revised 2ww form for dermatology/plastics to be rolled out by the end of July that will streamline pathways to plastics and will reduce waiting times. The skin cancer centre is planned to be in operation by Sept 2022 will improve waiting times for skin.

Faster diagnostic standard (28 days)

Sub-optimal performance is mainly due to delays in first diagnostic tests and delay in completion of correspondence. There are daily tracking in place to improve on the 28 day FD standard.

Cancer screening

Actions have been taken to implement improved data capture on the NHS Cancer Screening Programme for suspected cancer starting first treatment. This will feed through to performance data expected in September 22.

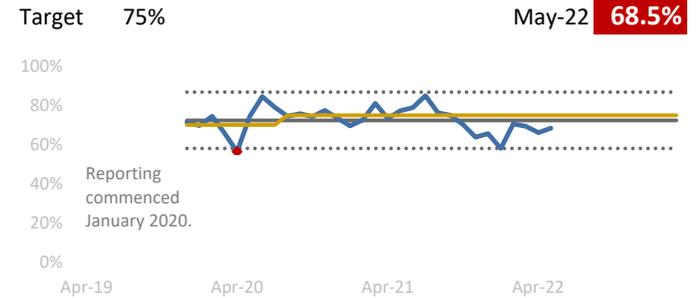
★ Cancer treatment levels - 31 day treatments

Number of patients receiving first definitive treatment, following a diagnosis, within the month, for all cancers.



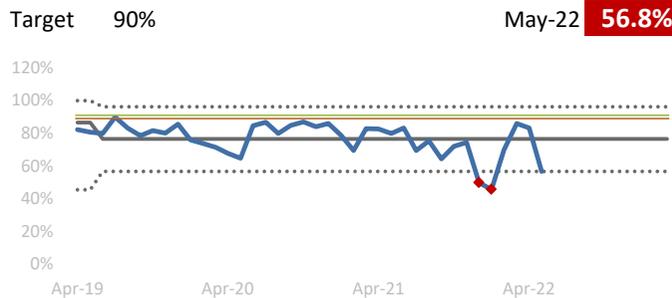
★ Faster diagnostic standard (28 days)

Percentage of patients receiving a diagnosis/ruling out for cancer or a decision to treat within 28 days following referral.



Cancer screening

Percentage of the NHS Cancer Screening Programmes' urgent referrals for suspected cancer starting first treatment <62 days.



★ Oversight metric ——— Target

Outstanding Care

Operational Standards - Elective Recovery

Diagnostics activity

MRI activity has reduced as the mobile MRI scanner at WGH has been removed as part of a transfer process from mobile to new scanner. Unfortunately the new scanner is delayed due to ongoing estates issues and therefore activity will not be fully restored until the new SMH scanner is online, likely date is October 2022.

Ultrasound services are sporadic while building work in Radiology at SMH is completed which will provide new Interventional Radiology rooms.

This does affect non-endoscopic capacity and breaches will be managed as part of a recovery plan, agreed once the issues have been resolved.

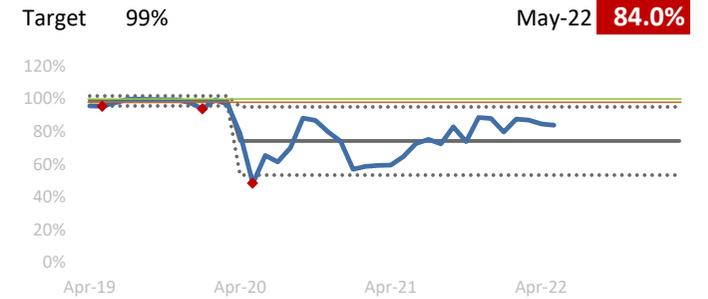
★ Diagnostic activity levels

The number of diagnostic tests or procedures carried out in the period. Based on DM01 definitions.



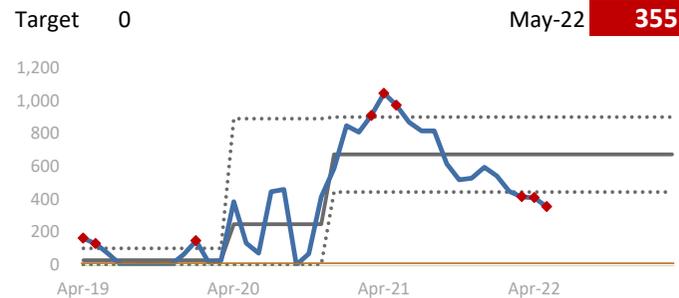
Diagnostic compliance

The number of patients waiting more than 6 weeks at month end for Imaging or Physiological Measurement tests.



Endoscopic patients waiting > 6 weeks

The number of patients waiting more than 6 weeks at month end for an Endoscopic procedure.



Non-endoscopic DM01 breaches

The number of patients waiting more than 6 weeks at month end for Imaging or Physiological Measurement tests.



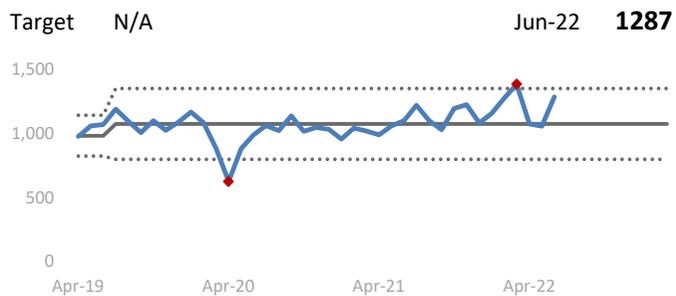
★ Oversight metric ——— Target

Outstanding Care

Operational Standards - Quality & Safety

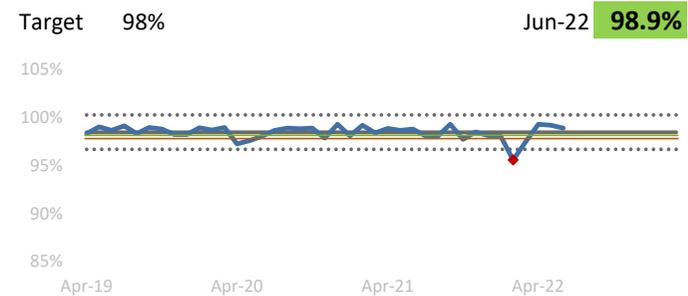
★ Incidents reported

Total number of incidents reported on DATIX during the month.



Incidents that are low/no harm

Percentage of incidents classed as low or no harm in the month - over all incidents reported.



★ Oversight metric     Target

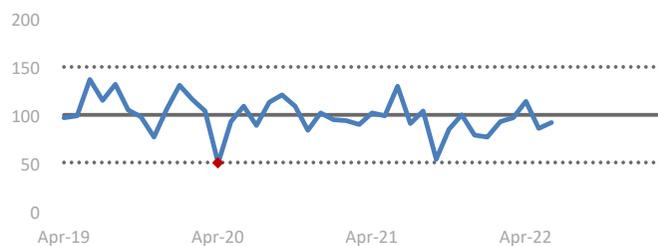
Outstanding Care

Operational Standards - Quality & Safety

Medication incidents

Total number of medication incidents reported on DATIX during the month.

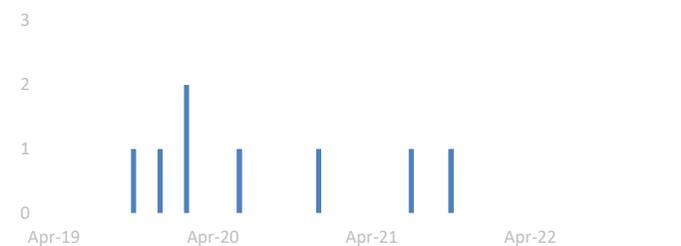
Target N/A Jun-22 **94**



Medication incidents as SIs

Total number of medication incidents reported on DATIX that have been declared as Serious Incidents during the month.

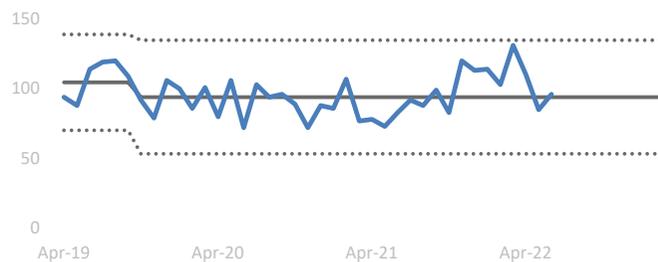
Target 0 Jun-22 **0**



Number of falls

Total number of patient falls reported on DATIX.

Target N/A Jun-22 **96**



★ Oversight metric — Target

Outstanding Care

Operational Standards - Quality & Safety

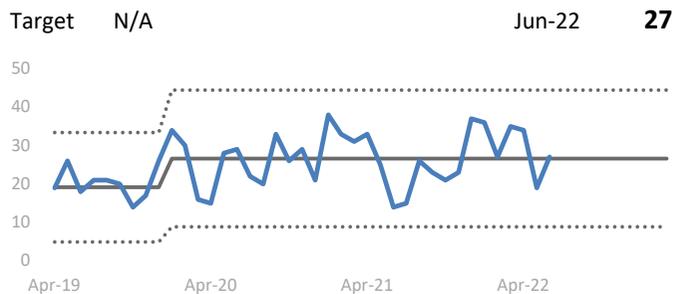
Pressure ulcers

Unstageable PU remains below the monthly average of number of cases reported.

Thematic review of PU resulting to moderate harm and above since April 2022 is ongoing. Themes and corresponding quality improvement plan will be monitored by the Harm Free Care Group and the Quality and Patient Safety Group.

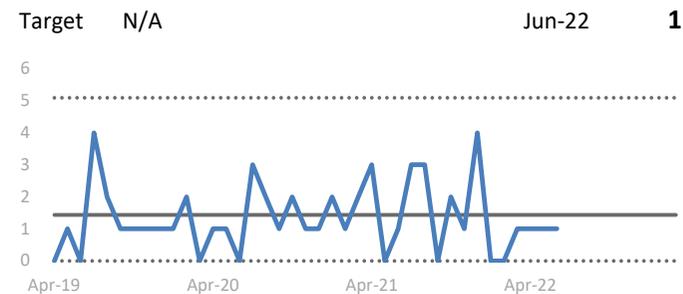
Pressure ulcers - category 2

Number of acquired category 2 pressure ulcers.



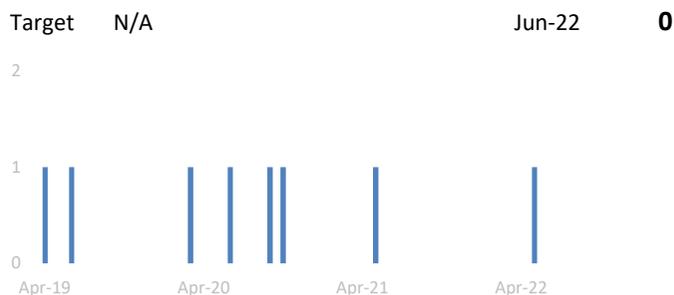
Pressure ulcers - category 3

Number of acquired category 3 pressure ulcers.



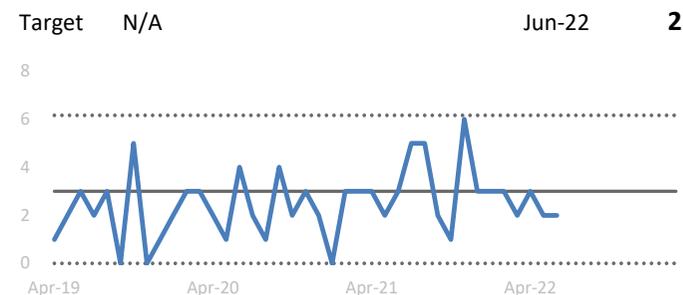
Pressure ulcers - category 4

Number of acquired category 4 pressure ulcers.



Pressure ulcers - unstageable

Number of acquired unstageable pressure ulcers.



★ Oversight metric Target

Outstanding Care

Operational Standards - Quality & Safety

SI's confirmed

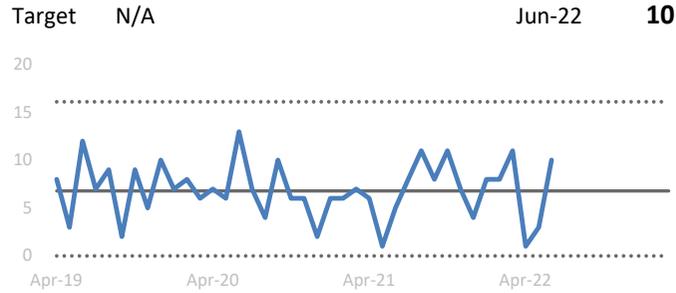
The Serious Incident Executive and Divisional Management panel continue to meet weekly. Theming of pressure ulcers, inpatient falls and VTE incidents since April 2022 in progress.

HSMR

HSMR = 91.4 banded as statistically 'lower than expected' (March 2022).

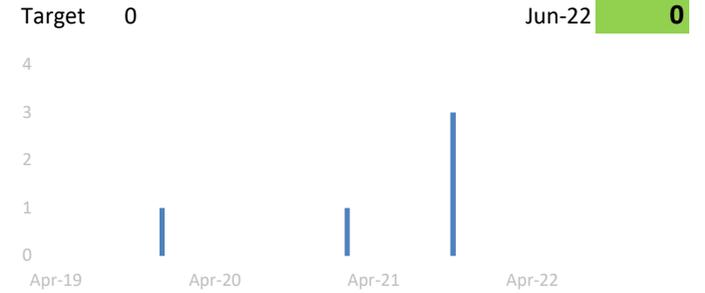
SI's confirmed

The total number of Serious Incidents confirmed during the month.



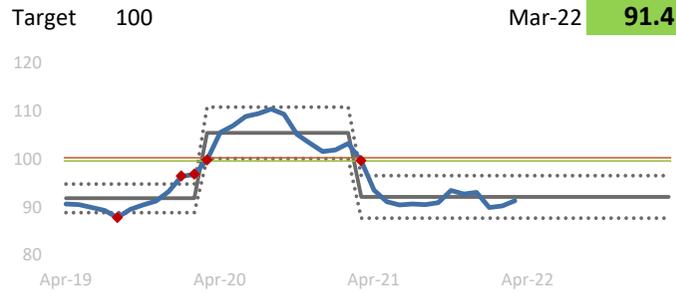
SI's declared as never events

The total number of Serious Incidents declared as Never Events during the month.



HSMR

Hospital Standardised Mortality Ratio (rolling 12 months).



★ Oversight metric Target

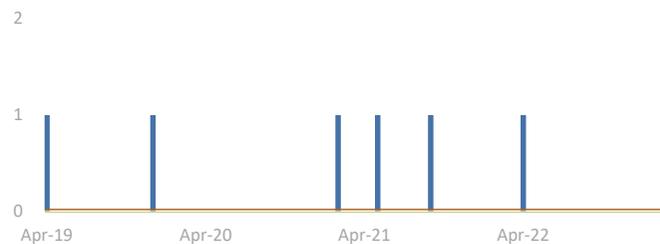
Outstanding Care

Operational Standards - Quality & Safety

★ MRSA bacteraemia

Number of hospital acquired MRSA bacteraemia infections during the month.

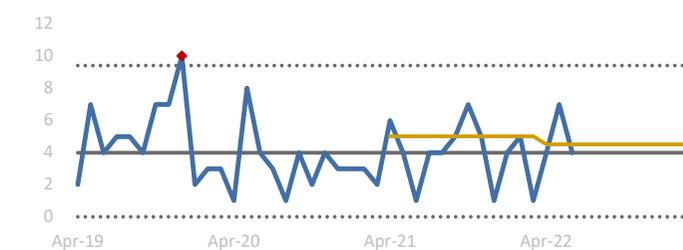
Target 0 Jun-22 **0**



★ Clostridioides difficile

Number of hospital acquired Clostridioides difficile infections during the month.

Target 4.5 Jun-22 **4**



★ Oversight metric Target

Outstanding Care

Operational Standards - Quality & Safety

VTE

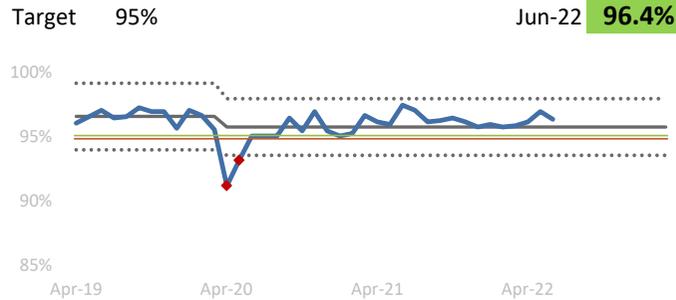
VTE assessment continues to be compliant against the target of 95%.

Treatment Escalation plan

Treatment escalation plan (TEP) compliance is at 84% showing common cause variation. Cross site initiative and improvement project instigated by the Critical Care Outreach Team and Palliative Medicine commenced on 4th July 2022.

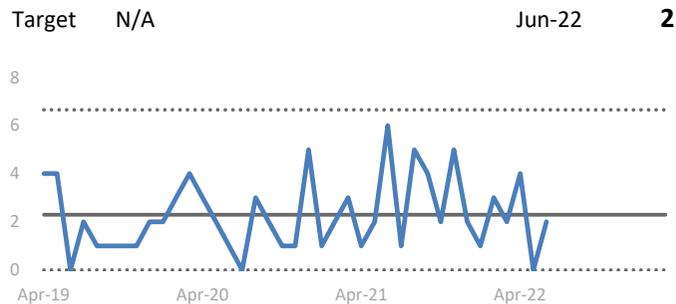
★ VTE assessment

The percentage of patients aged 16 and over, admitted within the month, assessed for risk of VTE on admission.



Non-critical care inpatient cardiac arrests

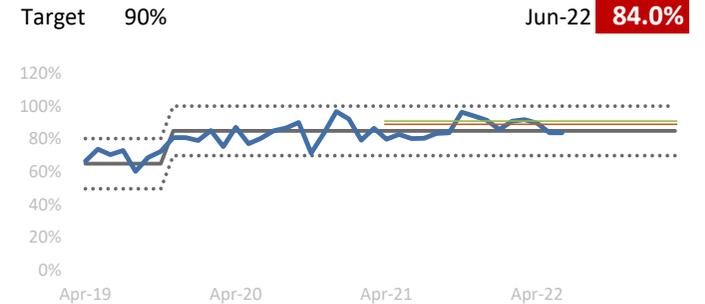
Total number of 2222 cardiac arrest calls in month. For inpatients in non-critical care areas.



★ Oversight metric Target

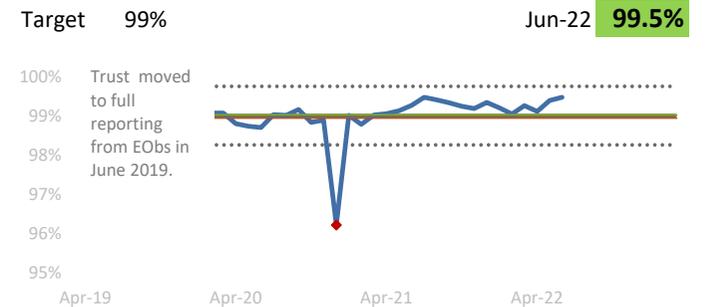
Treatment escalation plan compliance

Treatment Escalation Plan completion rate based on documentation audit conducted via Tendable app.



Early warning score

Percentage compliance with early warning score (EWS) completion.



Outstanding Care

Operational Standards - Quality & Safety

Complaints

Continue improvement in 25 days response since March 2022 but still below the set target of 85%.

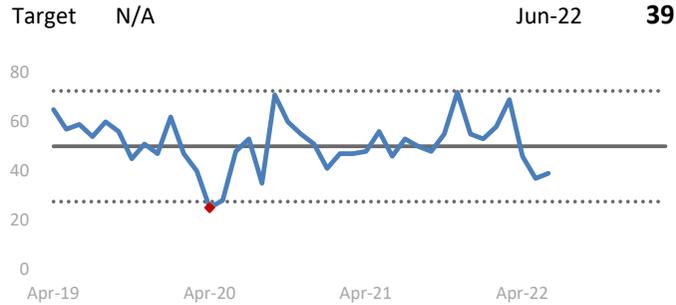
Complaints team fully recruited in substantive post and additional temporary staff in post to support compliance recovery and backlog.

Executive Management Committee continued to receive weekly updates on performance and recovery plan trajectory.



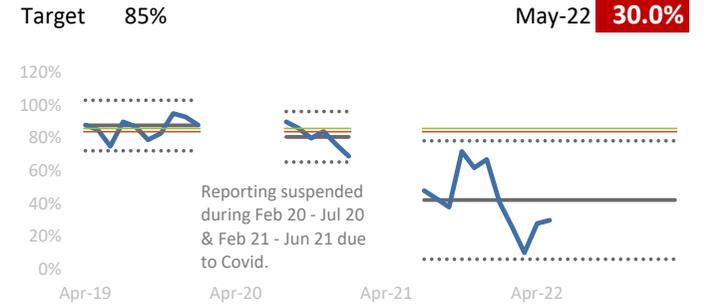
Complaints received

Number of complaints received during the month.



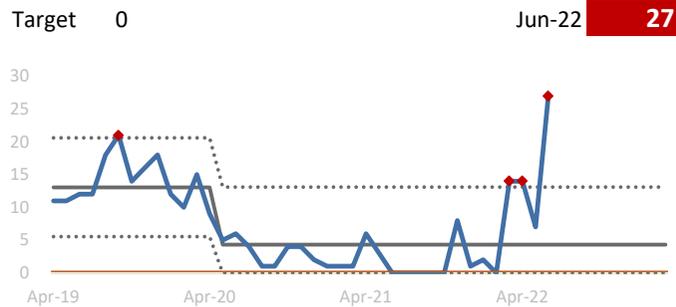
Complaint response rate

Percentage of complaints responded to within 25 days of receipt.



Complaints outstanding at 90 days

Number of complaints still open after 90 days.



★ Oversight metric — Target

Outstanding Care

Operational Standards - Quality & Safety

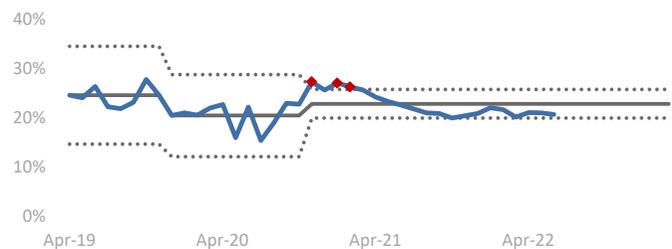
Friends and family Test

Patient Experience Group attended by patient partners continued to meet monthly. Plan to roll out Trust ward accreditation programme which include participation of patient partners in September 2022.

Friends and family test - response rate

The proportion of eligible patients responding to FFT for inpatients, maternity, A&E, OP and community combined.

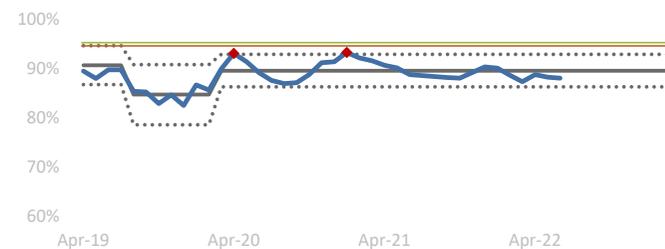
Target Awaiting target Jun-22 **20.7%**



Friends and family test - positive responses

The proportion of positive responses (of all responses) to FFT for inpatients, maternity, A&E, OP and community combined.

Target 95% Jun-22 **88.1%**



★ Oversight metric ——— Target

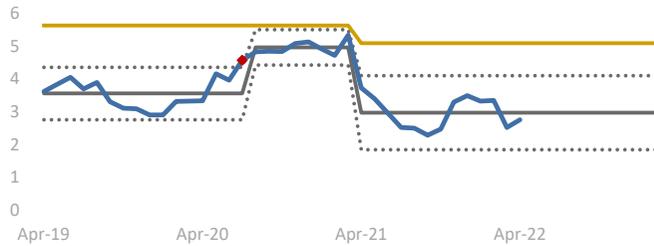
Outstanding Care

Operational Standards - Quality & Safety

Extended perinatal mortality

Extended perinatal mortality per 1,000 cases (rolling year).

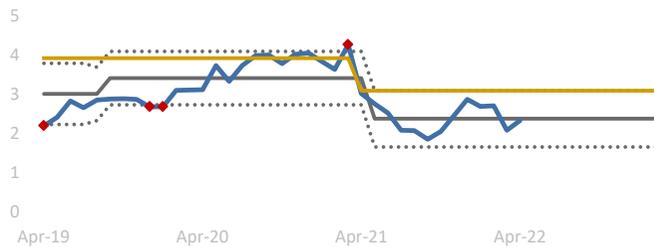
Target 5.10 Apr-22 **2.8**



Stillbirths - per 1,000 cases

Stillborn at 24 weeks or later per 1,000 cases (rolling year).

Target 3.1 Apr-22 **2.3**



Stillbirths - total cases

Number of cases of stillbirths at 24 weeks or later.

Target 2 Apr-22 **1**



★ Oversight metric — Target

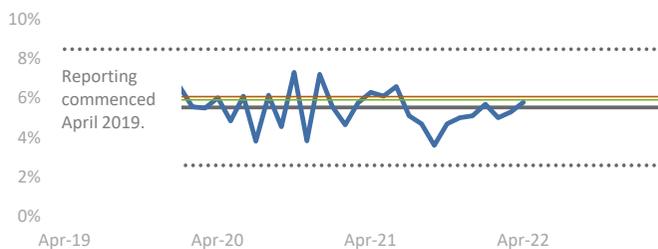
Outstanding Care

Operational Standards - Quality & Safety

Pre term births <37+0 weeks

Percentage of pre term births at < 37+0 weeks - over all births during the month.

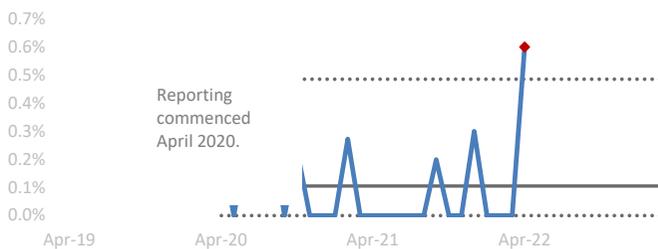
Target 6% Apr-22 **5.8%**



Pre term births 16 - 23+6 weeks

Percentage of pre term births between 16 and 23+6 weeks - over all births during the month.

Target N/A Apr-22 **0.6%**



Pre term births 24 - 36+6 weeks

Percentage of pre term births between 24 and 36+6 weeks - over all births during the month.

Target N/A Apr-22 **5.2%**



★ Oversight metric — — — Target

Ethnicity comparison compared to Buckinghamshire Population by waiting list

The last couple of years has highlighted the clinical benefit of having ethnicity on file for when dealing with patients ongoing health needs. Although some people prefer to not state their ethnicity.

Ethnicity - June 2022	Buckinghamshire	Admitted	Admitted Variance	Non-Admitted	Non-Admitted Variance
A - White British	56.91%	70.31%	13.40%	56.49%	-0.42%
B - White Irish	0.71%	0.89%	0.18%	0.71%	-0.01%
C - Any other white background	9.17%	4.25%	-4.92%	4.02%	-5.16%
D - Mixed White and Black Caribbean	0.56%	0.47%	-0.08%	0.56%	0.01%
E - Mixed White and Black African	0.26%	0.32%	0.06%	0.16%	-0.11%
F - Mixed White and Asian	0.55%	0.39%	-0.16%	0.35%	-0.20%
G - Any other mixed background	0.95%	0.44%	-0.52%	0.57%	-0.39%
H - Indian or British Indian	3.32%	1.32%	-2.00%	1.25%	-2.07%
J - Pakistani or British Pakistani	4.57%	3.83%	-0.75%	4.17%	-0.41%
K - Bangladeshi or British Bangladeshi	0.24%	0.19%	-0.06%	0.22%	-0.02%
L - Asian - other	1.67%	1.70%	0.03%	1.64%	-0.03%
M - Black Caribbean or Black British Caribbean	0.66%	1.21%	0.56%	0.88%	0.22%
N - Black African or Black British African	0.85%	0.57%	-0.27%	0.59%	-0.26%
P - Any other black background	0.35%	0.32%	-0.03%	0.41%	0.07%
R - Chinese	0.40%	0.30%	-0.10%	0.18%	-0.23%
S - Any other ethnic group	2.11%	1.18%	-0.93%	1.02%	-1.10%
Z - Not Stated	7.02%	3.46%	-3.56%	6.45%	-0.57%
Not Known	9.68%	8.84%	-0.84%	20.34%	10.67%
Sub-Total	100.00%	100.00%		100.00%	

IMD comparison compared to Buckinghamshire Population by waiting list

The Indices of Multiple Deprivation (IMD) gathers a number of postcodes together in small fixed geographic areas and measures the relative deprivation therein - decile (10 make up 100%) 1 being the most deprived and 10 the least deprived. Buckinghamshire County has zero in decile 1.

Index of Multiple Deprivation Decile - June 2022	Buckinghamshire	Admitted	Admitted Variance	Non-Admitted	Non-Admitted Variance
1	0.00%	0.19%	0.19%	0.10%	0.10%
2	0.31%	0.56%	0.24%	0.50%	0.19%
3	2.51%	3.85%	1.34%	3.31%	0.80%
4	5.02%	6.66%	1.65%	6.10%	1.09%
5	5.96%	7.10%	1.15%	6.48%	0.52%
6	9.09%	8.38%	-0.71%	8.31%	-0.78%
7	9.40%	10.36%	0.95%	10.18%	0.77%
8	18.18%	16.09%	-2.09%	16.15%	-2.03%
9	14.73%	14.25%	-0.48%	14.72%	-0.01%
10	34.80%	32.52%	-2.27%	34.08%	-0.72%
Not Known	0.00%	0.03%	0.03%	0.07%	0.07%
Sub-Total	100.00%	100.00%		100.00%	

Note: The IMD was published in 2019 and so some newer postcodes or those outside of UK form the 'Not known' Decile

Healthy Communities

Community Activity

Community Contacts

No significant changes to report in activity in June. The community teams remain busy and provide high quality patient – centred care. They continue to foster partnership working, improving clinical pathways across systems.

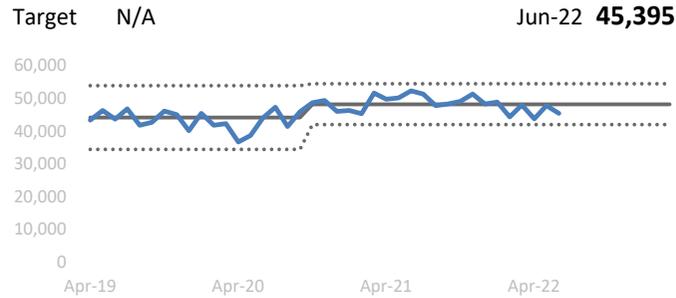
The change in Face to Face and Non-Face to Face is as expected as all teams resume their pre-pandemic activity, with virtual appointments continuing to be booked where clinically appropriate.



Buckinghamshire Healthcare
NHS Trust

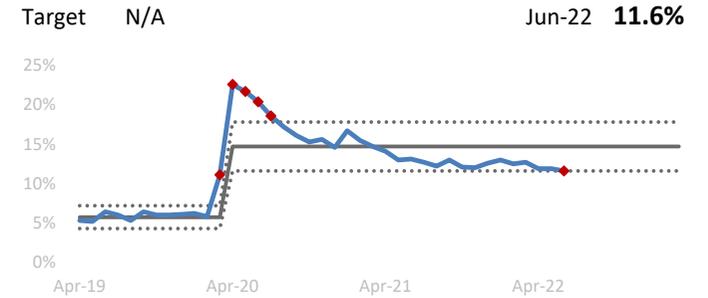
Community contacts

Total number of attended community contacts in the month.



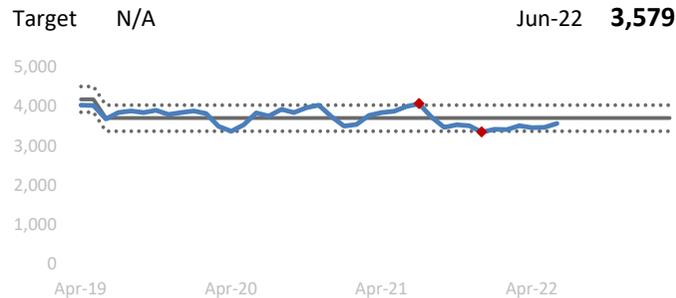
Community telephone contacts

Percentage of attended community contacts conducted by telephone - over all attended contacts in the month.



Community District Nursing caseload

The number of patients on the community district nursing caseload at month end.



Community RRIC caseload

The number of patients on the community Rapid Response and Intermediate Care (RRIC) service caseload at month end.



★ Oversight metric — Target

Healthy Communities

Community Hospital Admissions

Community hospitals are Buckingham Community Hospital, Waterside Ward and Chartridge Ward (excludes Bucks Neuro Rehab Unit as this is a Tier 2 rehabilitation ward).

LOS – community hospitals

21-day average Length of Stay is 20 days in June – a further reduction from May (23.5 days). This is attributed to improved discharge processes and the twice weekly MDT Deep Dives with Adult Social Care and Service Finding.

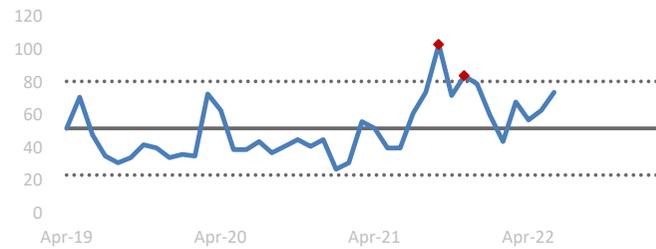
Bed capacity on Chartridge and Waterside was increased in June by five beds to help support system flow.



Community hospital admissions

Total number of patients admitted to a community hospital.

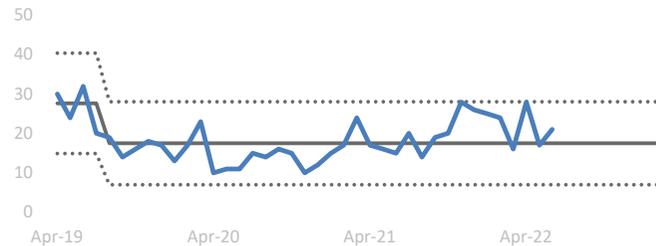
Target N/A Jun-22 **74**



21 day LOS - community hospitals

Count of patients in a community bed at the end of the month who have a total length of stay of more than 21 days.

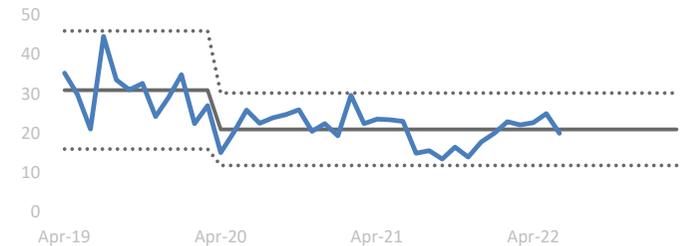
Target N/A Jun-22 **21**



Average LOS - community hospitals

Mean length of stay in a community bed for patients discharged from a community hospital during the month.

Target N/A Jun-22 **20.0**



★ Oversight metric — Target

Healthy Communities

Community Hospital Discharges

Community hospitals are Buckingham Community Hospital, Waterside Ward and Chartridge Ward (excludes Bucks Neuro Rehab Unit as this is a Tier 2 rehabilitation ward).

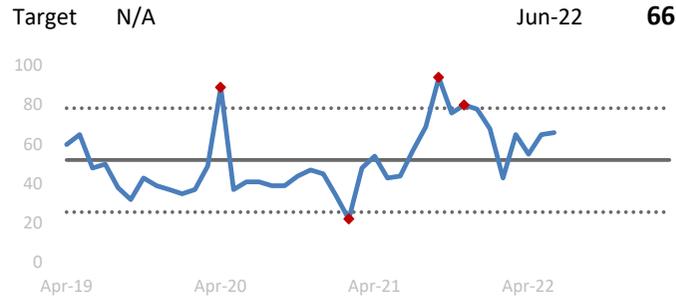
Community hospital discharges

The reduction in discharges to residential/care homes this month is partly attributed to a system agreed reduction in D2A beds. However, discharge levels to care homes are almost back in line with pre- pandemic numbers but requires careful monitoring to see if the trend is sustained.



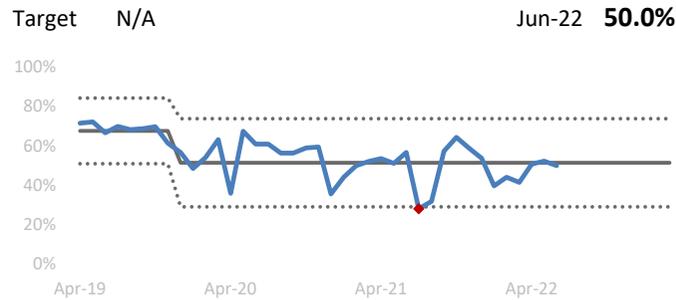
Community hospital discharges

Total number of patients discharged from a community hospital.



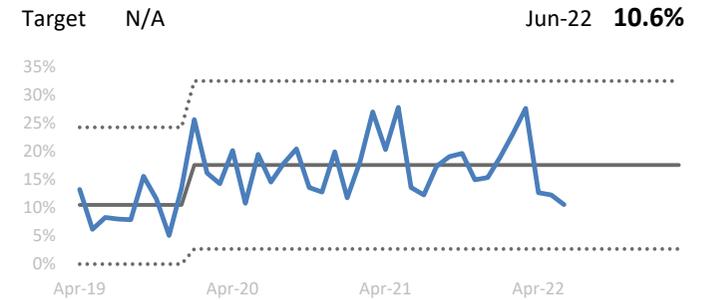
Discharges home

The percentage of patients discharged home from a community hospital - over all discharges in the month.



Discharges to residential/care home

The percentage of community hospital discharges to a residential/care home - over all discharges in month.



★ Oversight metric — Target

Healthy Communities

Community Productivity



Urgent 2 hour response

Throughout the last three months, the Urgent Community Response (UCR) service has continued to over perform against the target of 80%.

For the first time, national ICS benchmarking is available for the two-hour UCR standard, taken from April '22 data.

Community waiting list

This month an additional 10 community services are now being included. Historic data has been revised and show an accurate reflection of waits for **all** community services provided by the organisation.

Ongoing implementation of local actions have achieved improvements within most community services. All open referrals are systematically reviewed and categorised around complex pathways and data validation. This has narrowed down an estimated 7000 open referrals in the system that potentially may not require an appointment. The longest waits remain within CYP and Podiatry services – with urgent and statutory referrals being prioritised.

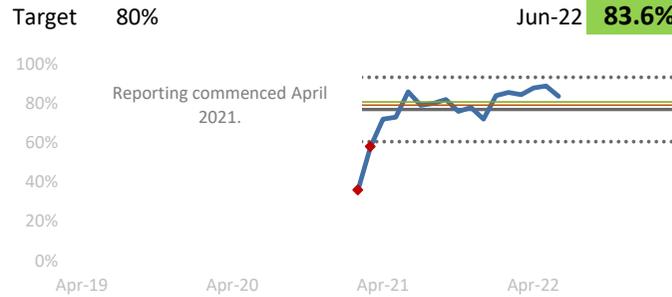
A Deep Dive into community waits is planned for early August with the COO and the informatics team. This is to understand what additional organisational support can be provided to help with the reporting, management and tracking of community waits across the relevant Divisions.

Health Visitor appointments - 14 days

New Birth Visit (NBV) compliance data for quarter 1 22/23 is 82% for babies seen between day 10 and 14 and 97% overall. (awaiting validation) Meeting held with commissioners on 11th July to update on NBV deep dive action plan. The remaining 3% will be either babies in NICU, transfer out of area or parents declining the Health Visiting service. The deep dive and ongoing monitoring have confirmed that the BHT escalation processes are effective and that children/families with higher need are prioritised and seen within

Urgent 2 hour response

Percentage of urgent referrals (2 hour) from community services or 111 that are seen within 2 hours.



Urgent 2 hour response benchmarking

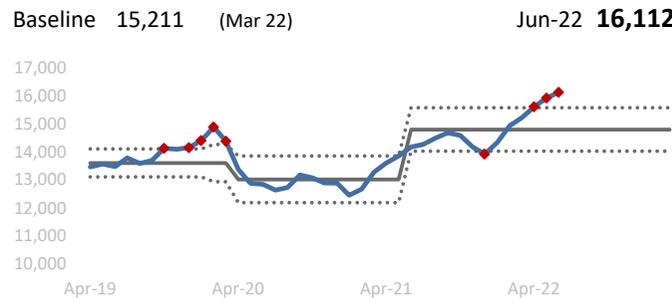
Region	ICS	Percentage
NATIONAL	Region	78%
EAST OF ENGLAND	Region	78%
LONDON	Region	82%
MIDLANDS	Region	76%
NORTH EAST AND YORKSHIRE	Region	83%
NORTH WEST	Region	81%
SOUTH EAST	Region	71%
SOUTH WEST	Region	75%
KENT AND MEDWAY	ICS	59%
FRIMLEY HEALTH AND CARE ICS	ICS	71%
HAMPSHIRE AND THE ISLE OF WIGHT	ICS	79%
BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST	ICS	85%
SURREY HEARTLANDS HEALTH AND CARE PARTNERSHIP	ICS	76%
SUSSEX AND EAST SURREY HEALTH AND CARE PARTNER ICS	ICS	75%

System	Count of 2-hour UCR referrals in scope of the 2-hour standard	% of 2-hour UCR referrals that achieved the 2-hour standard	Average UCR referrals per 100,000 population*
KENT AND MEDWAY	1,210	59%	35
FRIMLEY HEALTH AND CARE ICS	120	71%	1.8
HAMPSHIRE AND THE ISLE OF WIGHT	310	79%	2.0
BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST	890	85%	5.4
SURREY HEARTLANDS HEALTH AND CARE PARTNERSHIP	205	76%	2.2
SUSSEX AND EAST SURREY HEALTH AND CARE PARTNERSHIP	20	75%	1
South East	2,799	73%	3.8

*UP registered population - April 21 and over (estimated)

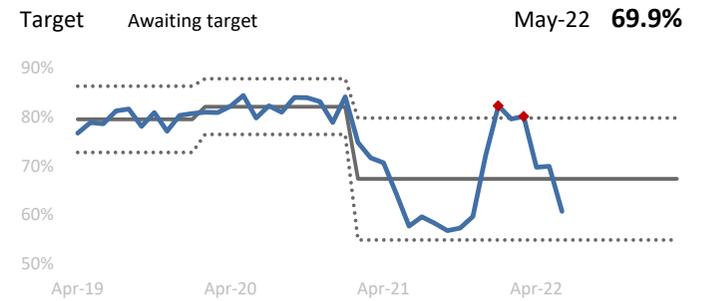
Community waiting list size

The number of patients with a referral to a community service waiting for a first community contact at month end.



Health Visitor appointments - 14 days

Percentage of new baby reviews carried out within 14 days of birth - over all births in the month.



★ Oversight metric — Target

A Great Place to Work

Ensuring our people are listened to, safe and supported

Nursing and Midwifery Recruitment

The vacancy rate fell by 0.1% in June to 10.1%. Our first cohort of internationally trained nurses arrived at the end of June and are currently undertaking their OSCE (Objective Structured Clinical Examination) training. From now until December at least one cohort of 15 arrive each month, which will start to have a positive impact on our vacancy rate from September once their OSCE training has been completed.

Turnover

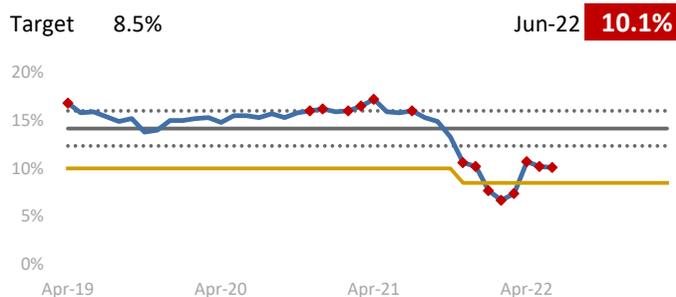
Turnover is at 14.6% (a 0.3% decrease from May).

70 colleagues left the Trust in June, of whom 27 were nurses. Of the 70, 16 retired (of whom 3 retired and returned). Of these retirees, 8 were nurses and 2 returned to work at the Trust.

As part of the National People Promise Exemplar Programme, we submitted our final programme plan, which details our organisational aims. This will form the basis of our retention people promise programme for delivery during f/y 2022-23. In the meantime, we have increased our centralised support to the leaver process to ensure that individuals are aware of all opportunities to stay at BHT. Work is also underway to improve the retire and returnee process, which is being informed by colleagues' experiences.

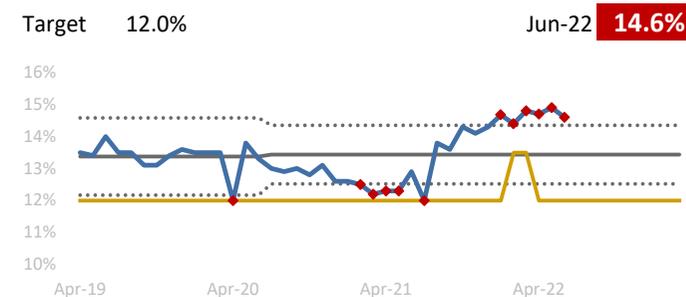
Nursing and midwifery vacancy rate

% number of vacant N&M FTE positions in Trust vs number of N&M FTE positions (occupied and vacant) in the Trust.



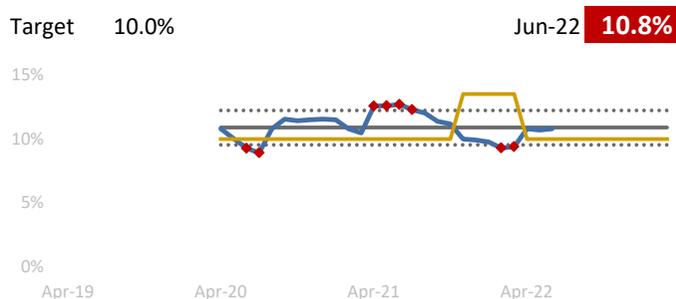
Turnover rate

% number of FTE staff that have left the employment of the Trust compared to the total FTE staff employed by the Trust.



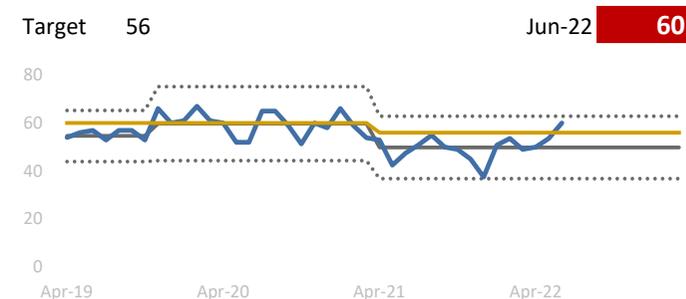
Trust overall vacancy rate

% number of all vacant FTE positions in Trust vs number of all FTE positions (occupied and vacant) in the Trust.



Average time to replace vacancies

Total average elapsed days to replace vacancies with staff starting in those roles.



★ Oversight metric ——— Target

A Great Place to Work

Ensuring our people are listened to, safe and supported

Sickness

During June, COVID-19 sickness absence increased, mirroring infection rates seen in the community. In line with overall sickness absence in the Trust.

Teams in the People Directorate are proactively supporting the prevention of sickness absence. Actions are also in place to support long-term and multiple short-term sickness absence management from all causes.

We continue to focus on stress and mental health, through increasing out-reach support Trust-wide. We are partnering with teams to offer manager support, targeted drop-in sessions and group restorative supervision sessions. In-house health checks were launched in May and will continue throughout the year.

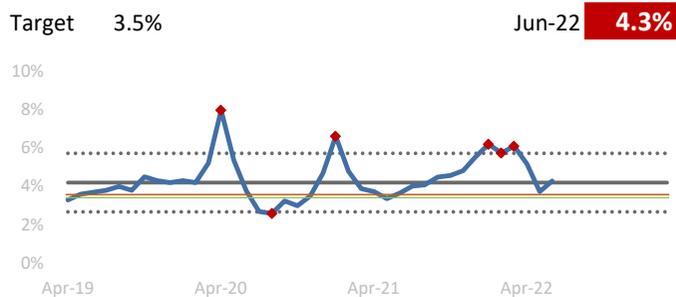
A second Physiotherapist joined the OH team in May to undertake more proactive prevention work, especially for home workers and to support a new reasonable adjustments process.

Vaccinations - COVID-19 booster and seasonal flu

In June we received notification that there will be an autumn booster for COVID-19 for cohorts 1-9, which includes health and social care staff. We also work in collaboration with the Trust vaccine team to continue the 'evergreen' opportunity to have a COVID-19 vaccine for new starters and any other colleague that now wishes to take up this offer.

Sickness

% total working hours lost because of sickness absences compared to the total working hours undertaken by the Trust.



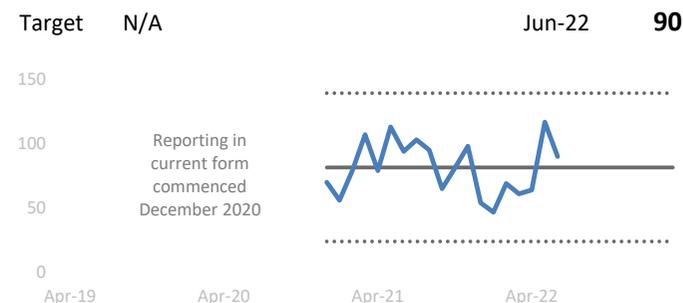
Sickness - mental health

% total working hours lost because of sickness absences due to mental health illnesses compared to the total working hours.



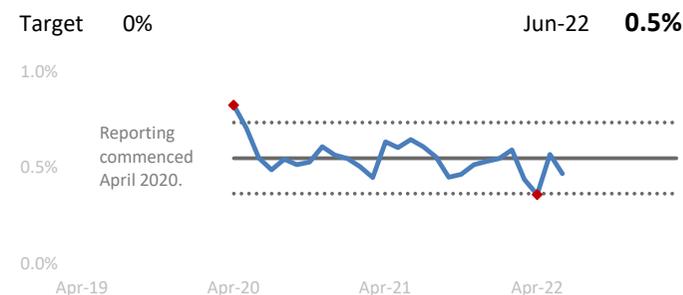
Referrals into OH and Wellbeing - stress

Referrals into Occupational Health and Wellbeing for stress per month.



Sickness - musculoskeletal

% total working hours lost because of sickness absences due to MSK illnesses compared to the trust total working hours.



★ Oversight metric — Target

A Great Place to Work

Ensuring our people are listened to, safe and supported

Occupational Health (OH) and Wellbeing

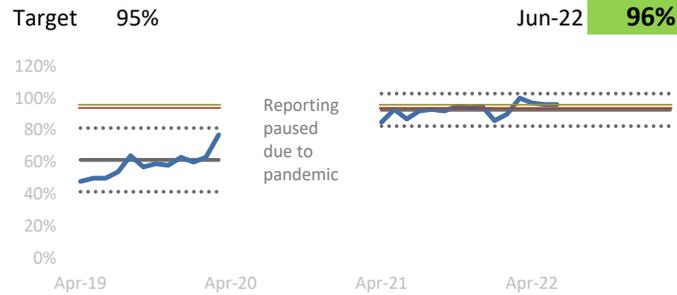
The OH&WB hub at Stoke Mandeville is now open and providing a multi-disciplinary service with easy central access, supported by outreach activities.

Employee relations

Decrease in cases closed from 8.97 to 7.99 (per 1000 employees), with 4 cases closed in June across medical and non-medical cases-loads. The increase in sickness absence levels across the Trust has impacted the management of this casework. We expect to see an improvement as absence rates improve.

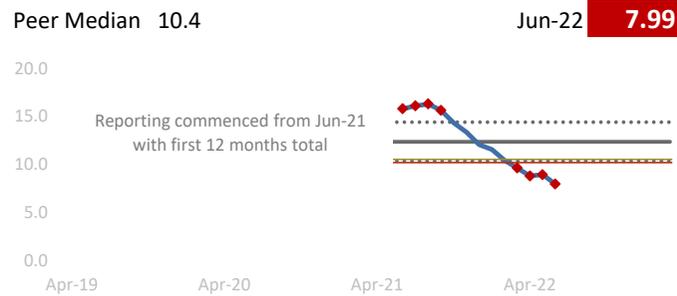
Occupational Health Management referrals

Occupational Health Management Referrals – first appointment offered within 10 working days of receipt.



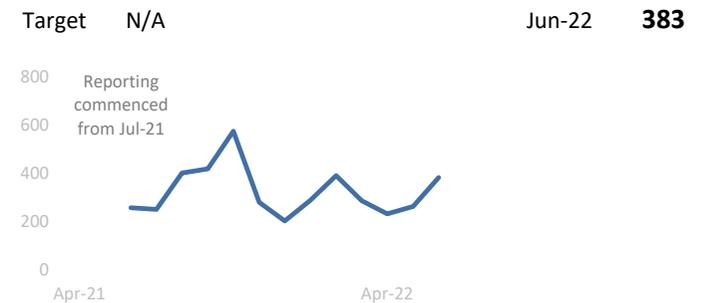
Employee Relations Cases Closed

The number of Employee relation cases closed per 1000 staff rolling total of previous 12 months



FTSUG outreach contacts

Freedom To Speak Up Guardian Outreach contacts within month.



★ Oversight metric Target

A Great Place to Work

Ensuring our people are listened to, safe and supported

Data Security awareness training

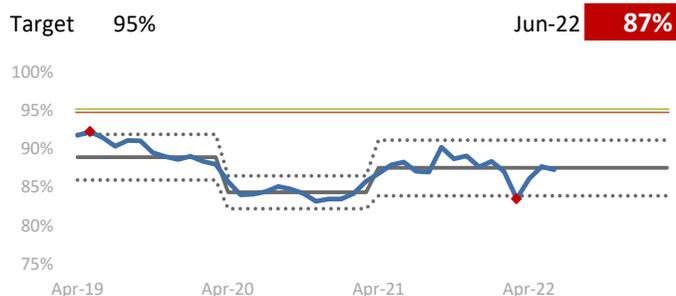
The training compliance has reduced by 1% to 87% in June. This remains below the DSP Toolkit requirement of 95% compliance. The IG team continue to write to all non-compliant staff at the beginning of each month and escalate to the line manager for continued non-compliance. Regular reminder bulletins are released via comms, both IG and Education and Learning newsletters. In addition, training compliance is linked to pay progression through the appraisal process. Compliance is monitored through the Divisional Performance meetings.

Statutory training

Compliance with mandatory and Statutory Training (MaST) is currently 87%. Key elements are safeguarding and basic life support - additional training capacity has been secured for both. We expect to reach our target of 90% by end of Q2.

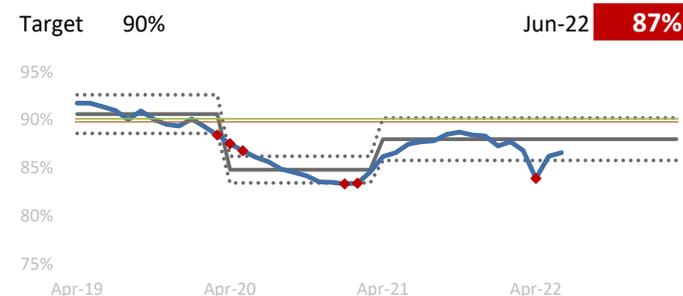
Data security awareness training

The percentage of eligible staff members being up to date with data security awareness training. Snapshot at month end.



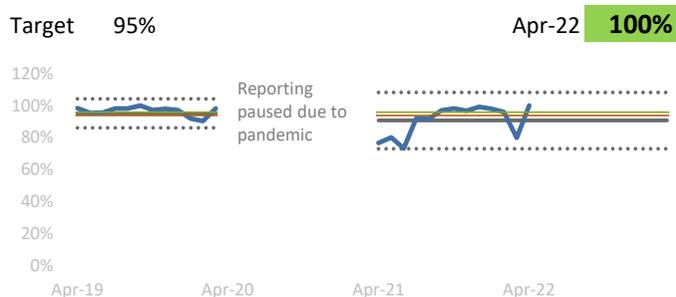
Statutory training

The percentage of eligible staff members being up to date with statutory training. Snapshot at month end.



Corporate induction

Percentage of staff attending corporate induction within 3 months of joining the trust.



★ Oversight metric Target

Integrated Performance & Quality Report

SPC Charts

Metrics are represented by Statistical Process Control (SPC) charts, with target and latest month's performance highlighted.

These SPC charts are based on over four years' worth of data to show pre, during and post Covid (where back data is available).

SPC charts are used to monitor whether there is any real change in the reported results.

The two limit lines (grey dotted lines) around the central average (grey solid line) show the range of expected variation in reported results based on what has been observed before. New results that fall within that range should not be taken as representing anything different from the norm. i.e. nothing has changed.

However, there are certain patterns of new results which it is unlikely will have occurred randomly if nothing has changed on the ground. For example a run of several points on one side of the average or a significant change in the level of variability between one point and the next.

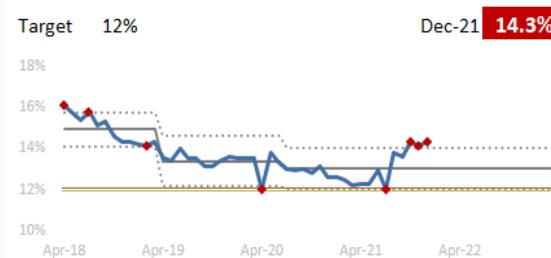
In these charts, where it looks like there has been some kind of change in the variability or average result in the reported data, the limits and the central line have been adjusted to indicate when it appears - statistically - that the change happened. This should be a prompt for users of the chart to look for factors which may have effected the change in the reported data. These may have been changes in the way things were done or external factors e.g. bad weather causing more accidents and therefore an increase in demand/change in case mix.

Likewise, if there is no change in overall average result or variability this suggests that actions taken to improve performance have not had the desired effect.

Either way, users of the charts should take care not to directly attribute causal factors to changes in the charts without further investigation.

Target lines are also plotted on the charts. This allows users of the charts to see whether targets can be expected to be achieved consistently, whether achievement in the current month is due to common cause or special cause variation or whether the target cannot be achieved unless there is a change in the process.

e.g. target line is just under the lower limit line for this indicator showing that it will not be achieved consistently without a change to the process.



Many of the target lines are shown in red and green to indicate which side of the line should be aimed for.

For example, in this case,  points lying above the target line would be rated as red; points below would be rated as green.

Where it has not been possible to display the target line like this due to variations in the target, it has been denoted as follows .

Key to Variation and Assurance icons

Variation

Special cause of improving nature due to (H)igher or (L)ower values.

This indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. (L)ow special cause concern indicates that variation is upward in a metric where performance is ideally above a threshold. e.g. ED or RTT performance. (H)igh special cause concern is where the variance is downward in a metric where performance is ideally below a threshold. e.g. Pressure ulcers or falls.

Common cause - no significant change.

Special cause of concerning nature due to (H)igher or (L)ower values.

This indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. (L)ow special cause concern indicates that variation is downward in a metric where performance is ideally above a threshold. e.g. ED or RTT performance. (H)igh special cause concern is where the variance is upward in a metric where performance is ideally below a threshold. e.g. Pressure ulcers or falls.

Assurance

'Pass' - variation indicates consistently (P)assing the target.

'Hit and Miss' - variation indicates inconsistently passing and failing the target.

'Fail' - variation indicates consistently (F)ailing the target.

		Assurance		
		Pass 	Hit and Miss 	Fail
Variance	Special Cause - Improvement 	Special cause of an improving nature due to (H)igher or (L)ower values. Variation indicates consistently passing the target.	Special cause of an improving nature due to (H)igher or (L)ower values. Variation indicates inconsistently hitting or missing the target.	Special cause of an improving nature due to (H)igher or (L)ower values. Variation indicates consistently failing the target.
	Common Cause 	Common cause - no significant change. Variation indicates consistently passing the target.	Common cause - no significant change. Variation indicates inconsistently hitting or missing the target.	Common cause - no significant change. Variation indicates consistently failing the target.
	Special Cause - Concern 	Special cause of a concerning nature due to (H)igher or (L)ower values. Variation indicates consistently passing the target.	Special cause of a concerning nature due to (H)igher or (L)ower values. Variation indicates inconsistently hitting or missing the target.	Special cause of a concerning nature due to (H)igher or (L)ower values. Variation indicates consistently failing the target.

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	BHT Operating Plan Quarter 1 Update		
Board Lead	Barry Jenkins, Chief Finance Officer		
Type name of Author	Debbie Hawkins, Head of QI & Transformation		
Attachments	Trust Board Q1 Operating Plan Update		
Purpose	Assurance		
Previously considered	Transformation Board 19.07.2022		

Executive Summary

The BHT 2022/23 Operating Plan was approved by Trust Board in April 2022. This sets out the priorities for the year taking into account national requirements and the BHT 2025 Strategy.

This report provides an update on the delivery of the Quarter 1 (Q1) *milestones* set out in the Trust's 2022/23 Operating Plan.

Updates on *performance improvements* in the Operating Plan are reported through the Integrated Performance Report (IPR).

Overall assurance on the delivery of the Operating Plan is through the Executive-level Transformation Board, which meets monthly.

Decision

The Board is requested to note the update on the delivery of the Quarter 1 Operating Plan milestones.

Relevant Strategic Priority

Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒
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Implications / Impact

Patient Safety	Patient safety implications are addressed as part of the delivery of specific milestones.
Risk: link to Board Assurance Framework (BAF)/Risk Register	<ul style="list-style-type: none"> 1.1 Inadequate staff resource to deliver outstanding quality care (insufficient levels of qualified, experienced staff and training opportunities) 1.2 Digital immaturity 1.3 Estates infrastructure not fit for purpose (outdated, limits clinical care provision)¹ 1.5 Underlying organisational financial deficit 1.6 Gaps in learning from incidents and best practice 1.7 Inequalities in access to care 2.3 Variation in the productivity of clinical service lines 3.1 Inability to deliver the Trust's strategic case for change

	<p>3.2 Inability to innovate and work with partners to deliver new models of elective care</p> <p>3.3 Failure to reform our urgent care pathway and meet future urgent care health needs of the population</p> <p>3.5 Not realising the Trust's potential as an Anchor Institution</p> <p>3.6 Not using integrated care records and data to manage whole population health and inequalities</p> <p>3.8 Adverse contribution to climate change</p> <p>4.3 Variations in organisational culture and behaviours</p> <p>4.5 Governance not always being both easy to navigate and enabling of change, whilst providing robust, forward-looking assurance of risk</p> <p>4.7 Lack of consistent attainment of key operational and performance standards</p> <p>4.10 Not being an organisation where innovation and new ideas can always thrive and be easily adapted</p>
Financial	The financial implications linked to delivery of specific milestones are addressed through normal Trust processes.
Compliance <small>Select an item.</small> Good Governance	This report provide assurance against the delivery of key milestones.
Partnership: consultation / communication	The delivery of specific milestones is done in conjunction with relevant partners, with appropriate consultation as required.
Equality	Equality considerations are addressed as part of the delivery of specific milestones.
Quality Impact Assessment [QIA] completion required?	N/A for this report. QIAs are completed as required linked to specific milestones.

BHT Operating Plan Delivery

Quarter 1 Update to Trust Board

27/07/2022

2022-23 Operating Plan



Overview

BHT's Operating Plan sets out the Trusts priorities for 2022/23, taking into account national requirements and our BHT 2025 Strategy. This provides a shared focus for the organisation to concentrate our efforts.

The Operating Plan is organised around 10 Portfolios. Each has an Executive Lead and SRO, underpinned by programme governance (*note governance for three portfolios is still being fully established - Healthy Communities, Rehabilitation Centre of Excellence, Planned Care Endoscopy*).

Delivery of the Operating Plan, and any issues/risks, are actively managed through relevant programme governance, with overall assurance through the Executive-level Transformation Board.

This report provides an update on the delivery of the Quarter 1 (Q1) *milestones* set out in the Trust's 2022/23 Operating Plan.

Updates on *performance improvements* in the Operating Plan are reported through the Integrated Performance Report (IPR).

Of the 48 milestones to end Q1 (*see detail in Appendix*)

- 12 are complete (Blue)
- 1 is Green (on track) (*'Improving Patient Safety - 98% low and no harm incidents reported and maintained'*- requires sustaining through 22/23)
- 27 are Amber – meaning the milestone is expected to be delivered, however the original date has been delayed. In some instances this is a result of a change in national/regional priorities, a dependency on external funding, or external supplier dependency; for other milestones dates have been amended in response to internal complexities, or to deliver with the available resource.
- 8 are Red – meaning there is either a material delay in the original date, or a material issue/risk to the delivery of the milestone.

Note two Q1 milestones have been closed:

- **UEC:** *Sustainable solution for planned medical day case* - milestone not part of UEC programme.
- **Diagnostics:** *PathLAKE consortium develop AI for cellular pathology, start image acquisition* - milestone not relevant to BHT.

Successes – priority milestones delivered in Q1

- **UEC Urgent Treatment Centre (UTC) pathway** moved from 8am to 10 pm 7 days a week from 1st June, with bookings remaining steady and utilisation of slots over 80%. Medical take also now live in SDEC (Same Day Emergency Care).
- **UEC ‘Optimising Board Rounds’** (incls. Criteria-to-Reside and SAFER) - first cycle implemented, with rollout dates up to end of March for remaining three cycles. This is an important part of the UEC Improvement Programme and will have a significant impact on flow by standardising discharge decision-making and practice. Note the dates for the remaining 3 cycles are later than originally planned to accommodate within the available resource.
- **Integrated Communities Respiratory Virtual Ward** launched on the 6th June, with the first oxygen weaning patient successfully accepted and discharged.
- **Integrated Communities System Integration** - BHT, Bucks Council and BOB ICS Integration statement published which aims to implement a new integrated discharge model.
- **Integrated Communities Urgent Community Response (UCR)** consistently achieving > 80% for 2-hour responses.
- **Diagnostics Community Diagnostic Centre (CDC)** activity performance is above plan. Notable success in the phlebotomy service now offering appointments 7 days per week at Amersham.
- **Quality Plan:** DATIX Risk and Incident management system upgrade to version 14 went live on the 1st April 2022.
- **Great Place to Work** - New dedicated on-site health and wellbeing hub at SMH for all colleagues operational.
- **Hospital Redevelopment Programme** Business Case approved by Trust Board.

- **Planned Care Endoscopy** – the recovery plan is delayed from the original date of Apr, with a new date Oct-22. The recovery plan has been written, however this is dependent on funding which is currently being explored with NHSEI. The original plan for Endoscopy vanguard is paused due to unaffordability.
- **Planned Care Theatres Skin Cancer Centre at Amersham** – the original date of Jun has currently been revised to Sept-22, however this is potentially at risk due to issues with securing theatres staff. This is key component of plans to increase theatre capacity to deliver activity trajectories. Other milestones linked to increased theatre capacity are also behind plan due to theatre compliance issues, although there has been recent progress with New Wing Theatre 2 (SMH) and DSU 1 and 2 theatres now fully compliant.
- **Estates Hospital Redevelopment Programme** – while there has been positive progress with the sign-off of the Outline Business Case by Trust Board, future milestones are currently at risk with the programme currently paused due to lack of funding for next stage.

Quarter 2 (Q2) Priority Milestones

- **UEC:** A number of enhancements relating to **SDEC** are due to be implemented in Q2, including direct referrals to SDEC from 999, direct booking into SDEC from 111, Consultant Connect Go-Live, and Frailty/Adult SDEC integration. Further improvements are also expected through the **BHT UEC Improvement Plan**, including completion of the second cycle of 'Optimising board rounds'.
- **Planned Care Theatres Capacity** – linked to the previous slide, the expectation is that additional theatre capacity will come on line during Q2 through the re-opening of non-compliant theatres, and the Skin Cancer Centre at Amersham if staffing issues can be resolved.
- **Planned Care Endoscopy** – the business case setting out long-term capacity requirements is due to be presented to Trust Board in Q2.
- **Diagnostics:** Key milestones due for completion in Q2 include: CDC Phase II Outline Business Case (OBC) approval at Trust Board; installation of the Fluoroscopy unit (although there is still some risk associated with the timescales); and installation of the new NHSEI funded MRI scanner at SMH.
- **Great Place to Work:** leadership Behaviours Framework is due for finalisation and rollout.
- **Digital & Technology:** Milestones due in Q2 include rollout of Patient Flow; automation of booking of e-referrals through Robotic Process Automation (RPA); and 100% of consent and pre-op delivered digitally.

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	2022/23 Month 3 Finance Report
Board Lead	Barry Jenkins, Chief Financial Officer
Type name of Author	Aneel Pattni, Deputy Chief Financial Officer
Attachments	Month 3 Finance Committee Report
Purpose	Assurance
Previously considered	EMC 12 th July 2022; Transformation Board 19 th July 2022; Finance and Business Performance Committee 26 th July 2022

Executive Summary

- 2022/23 I&E month 3 year to date (YTD) headline position of £5.6m deficit, being £0.1m behind the YTD plan** agreed by Board in June 2022. The Trust Board agreed to an improved revised Plan of £17.6m deficit in line with the resubmissions to BOB ICS and NHSE/I in June 2022. Analysis of this revised Plan has now been incorporated into this report.
- Divisional forecasts have been prepared showing a total of £16m of mitigations to be developed across the clinical divisions.** The divisional forecasts are based on current run rates and confirmed efficiency savings for 2022/23. There will now be a process of detailed review and challenge by the CFO and COO through the July 2022 Divisional Review meetings. Focus will be on reducing this mitigations figure during July 2022, backed by agreed financial recovery trajectories in each division, in particular, reducing spend on temporary pay and introducing grip and control measures with each division. Further details are provided in page 7 of the report.
- Balance Sheet, Capital and Cash Flow** is in the main in line with expectations. The capital programme remains extremely tight pending confirmation of additional capital resourcing. Based on current forecast projections, the Trust will not need cash support in 2022-23 however this will be continually and actively monitored throughout the year.

Through discussions at the Executive Manage Committee and Transformation Board, the importance of both further work within divisions and the continued focus on temporary staffing were noted in mitigating further risk to the financial plan.

The report was considered by the Finance and Business Performance Committee on Tuesday 26 July 2022. A verbal update of the discussion will be provided to the Board.

Decision	The Board is requested to be assured by the paper.
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Relevant Strategic Priority

Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒
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Implications / Impact

Patient Safety	Any impacts on patient safety are identified and addressed as part of the Trust and divisional integrated performance review process
Risk: link to Board Assurance Framework (BAF)/Risk Register	BAF 4.1a Failure to deliver the annual financial plan
Financial	See Executive Summary in paper
Compliance NHS Regulation Good Governance	Monthly reporting is provided to the committee to provide assurance. The financial position is reported to NHSE/I on

	a monthly basis as part of the regulatory oversight process
Partnership: consultation / communication	This report is shared with partners across the ICP, ICS and regulators, as required.
Equality	Any material equality impacts of expenditure are identified and addressed as part of the budget setting process
Quality Impact Assessment [QIA] completion required?	Impact assessments of budget setting and planning were undertaken during the Operating Planning round for 2022/23. See CIP Productivity and Transformation report for further information.

Finance Report Month 3 - 30th June, 2022

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK

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Page 9	Balance Sheet
Page 10	Cash Position
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Page 12	Glossary and Definitions

Financial performance

Table 1 - Income and expenditure summary

(£m)	In Mth Plan	In Mth Actuals	In Mth Variance	YTD Mth Plan	YTD Actuals	YTD Variance	Annual Plan
Contract Income	43.4	42.9	(0.5)	126.3	126.3	(0.0)	505.3
Other income	4.2	5.0	0.9	9.9	12.0	2.1	35.5
Total income	47.6	47.9	0.3	136.2	138.3	2.1	540.8
Pay	(27.8)	(28.7)	(1.0)	(83.1)	(85.6)	(2.5)	(329.4)
Non-pay	(16.7)	(17.1)	(0.4)	(48.8)	(48.9)	(0.1)	(190.1)
Total operating expenditure	(44.5)	(45.8)	(1.3)	(132.0)	(134.6)	(2.6)	(519.5)
EBITDA	3.1	2.1	(1.0)	4.2	3.7	(0.5)	21.4
Non Operating Expenditure	(2.9)	(2.8)	0.1	(9.8)	(9.3)	0.4	(39.0)
Retained Surplus / (Deficit)	0.2	(0.7)	(0.9)	(5.5)	(5.6)	(0.1)	(17.6)

Executive Summary

- The Trust reports a £5.6m deficit position YTD which is £0.1m adverse to plan.

- The Board approved financial plan was resubmitted in June for 2022-23 and now totals a £17.6m deficit plan. This plan includes an efficiency target totalling £24.7m and includes investments totalling £14.5m. Budgets have been prepared in line with this Board approved plan and the Trust's Budget setting and business planning guidance paper.

- Each division has prepared and reviewed a divisional forecast at month 3 based on current run rates and confirmed efficiency savings. There will now be a process of detailed review and challenge by the CFO and COO through the July 2022 Divisional Review meetings. The overall current forecast position shows that £16m and £4m of mitigations will need to be developed in Clinical and Corporate areas respectively. Further details are provided in page 7 of this report.

- A revised contract income position has now been agreed with Specialist Commissioning resulting in a £4m income increase. This position is reflected in the month 3 year to date position. Contract income is in line with plan YTD.

- The Clinical Divisional Budget Plan for the year totals £380m. YTD the clinical divisions report a £2.9m adverse variance to this plan which is primarily driven by additional spend within the Integrated Medicine Division. Further details of the key drivers of this overspend are detailed in page 7 of this report.

- YTD pay costs total £85.6m, £2.5m adverse to plan. Key drivers of this adverse position include medical staffing spend, temporary staffing usage and wards working to operational establishments that continue to be above approved budgeted levels. Further details and actions being taken are provided on page 5.

- YTD non-pay costs total £48.9m, £0.1m adverse to plan. Clinical supply costs are favourable to plan YTD and offset overspends within PBR drugs issues. Further details are provided on page 6.

Key Highlights: Income

NHS Income and Activity

- The contract income position totals £126.3m YTD, which is on plan. The variances are all within BOB ICB and will come into line with the change from CCG to ICB in M4.
- Elective recovery funding (ERF) received by the Trust as part of our contract baseline values, are subject to repayment (income clawback) where the weighted activity levels in 2022/23 fall below the 104% and 110% targets of 19/20 levels. If the rules set out in national planning guidance were to be strictly applied to month 3 YTD then this would create additional financial risk of up to £3.1m. No provision for repayment of ERF has been made at month 3, in line with discussions with other providers in the ICS and NHSE/I.
- The Statistical Process Control Chart (Graph 1) for Contract Income shows income is above the mean average throughout the 2020-21 and 2021-22 financial years. The February 2021 position includes £2.6m additional monies received from NHSE/I relating to funding support for lost income during the Covid-19 pandemic and the March 2021 position includes further income received to cover income lost during the Covid-19 pandemic totalling £2.8m. The increase in contract income in September 2021 relates to the back-dated medical and agenda for change pay award income and the additional BOB ICS ERF allocation. The March 2022 includes an additional £2m received from Bucks CCG. The increase in income in month 3 reflects agreed changes to income for the June 2022 Final Plan submission..

Table 2 - Breakdown of Contract Income

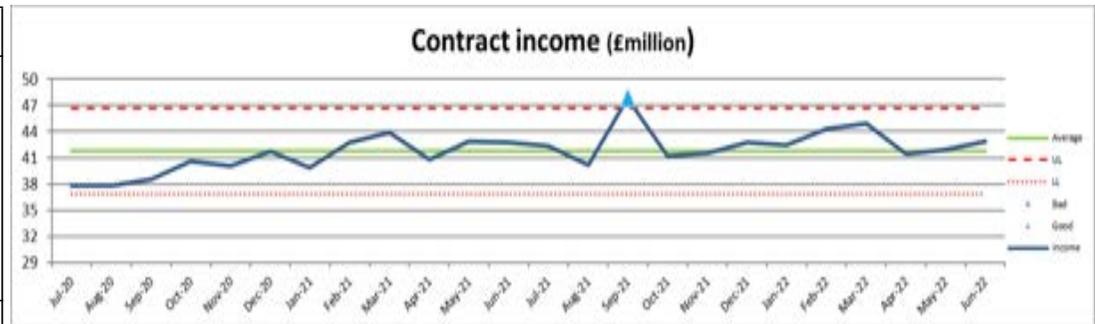
Commissioner (£m)	Annual Budget Total 2022-23	YTD Budget	YTD Actuals	YTD Variance
Bucks CCG	305.7	76.4	82.6	-6.2
Other NHS	38.0	9.5	9.7	-0.2
Specialist Commissioners	76.2	19.1	18.8	0.2
Other Income	3.9	1.0	0.9	0.0
Bucks Council	14.0	3.5	3.5	0.0
Top up	33.3	8.3	0.0	8.3
Covid funding	14.6	3.6	2.8	0.9
Growth & SDF	7.2	1.8	4.9	-3.1
ERF	12.5	3.1	3.1	0.0
TIF	0.0	0.0	0.0	0.0
Total	505.3	126.3	126.3	0.0

Other Income

Table 3 - Breakdown of other income

Category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Research	1.2	0.3	0.5	0.2
Education And Training	11.3	2.8	3.5	0.7
Non-NHS PPS & Overseas Visitors	3.5	0.9	0.6	(0.3)
Injury cost recovery scheme	1.2	0.3	0.3	0.0
Donated Asset Income	1.0	0.3	0.5	0.2
Other Income	17.4	5.4	6.6	1.3
Total	35.5	9.9	12.0	2.1

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



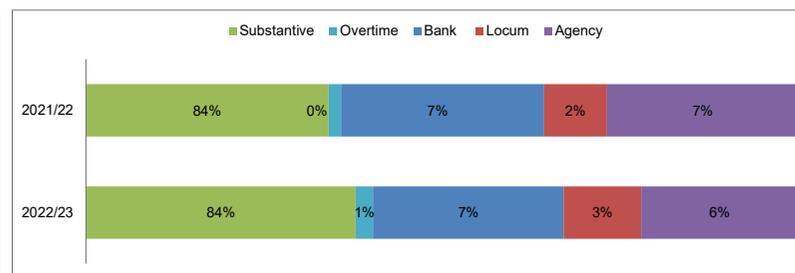
- Other Income (Table 3) is £2.1m favourable to plan YTD.
- Private Patient and Overseas work is £0.3m adverse to plan YTD.
- Donated Asset Income reports a £0.2m favourable variance. This variance however is removed when calculating the bottom line financial position as the full impact of donated asset income and depreciation is removed when calculating the final position.
- Education and Training income is £0.7m favourable to plan YTD. Work is underway to establish robust income and expenditure trajectory for the 22-23 financial year with the aim to reflect these in the budgeted plan.
- Other income is £1.3m favourable to plan. This is mainly due to non-recurrent and project income from local authorities and not a trend that will continue.

Key Highlights: Expenditure (Pay & Workforce)

Table 4 - YTD pay position

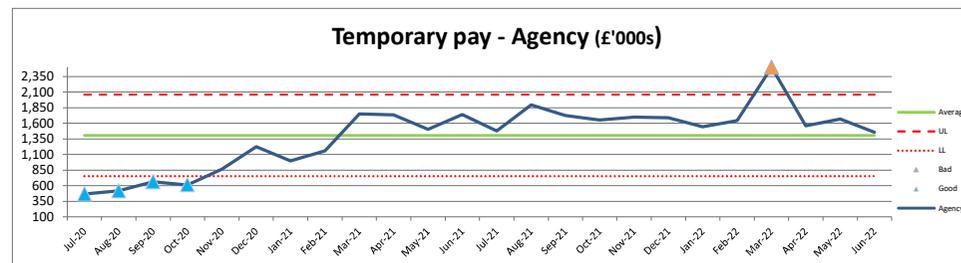
Pay category (£m)	YTD Budget	YTD Spend *	YTD Variance	% of Total Pay Bill	Last Year YTD Spend	Last Year % of Total Pay Bill
Substantive	82.4	72.3	10.1	84%	66.9	84%
Overtime	0.0	0.5	(0.5)	1%	0.4	0%
Bank	0.6	5.7	(5.1)	7%	5.7	7%
Locum	0.2	2.3	(2.2)	3%	1.8	2%
Agency	0	4.7	(4.7)	6%	5.4	7%
Total	83.1	85.6	(2.5)	100%	80.1	100%

Graph 2 - YTD pay position



- Pay expenditure totals £85.6m YTD, £2.5m adverse to plan. Key pressure areas in pay include Integrated Medicine, where high covid-19 sickness levels have driven high temporary staffing usage in Emergency and Acute Medicine. Further details are provided on p divisional narrative.
- The YTD pay position includes an £2.6m estimated provision for pay awards expected to be confirmed later in the year. This provision is also included in the plan so does not drive an adverse variance to plan YTD.
- The 2021-22 pay position included a year end provision relating to annual leave to be taken in the 2022-23 financial year totalling £5.8m. £1.2m of this has been released in the position YTD with the remainder to be released as we move through the financial year as st leave. The budget plan also assumes this will be released so does not drive an adverse variance against plan.
- Temporary staffing expenditure (Bank, Agency & locum) totals £12.8m for the year, £4.2m in month. A large proportion of this is offset by underspends against substantive budgets, £10.1m underspent YTD (See table 4 above). Agency expenditure totals £1.4m for the n YTD. Key usage areas include Emergency Medicine, IT, Radiology, Medicine for Older People and Acute Medical wards. Several urgent actions are being taken to reduce temporary pay spend to 2019/20 levels by Q4. This work is being led through joint work by Finance clinical divisions, initially Integrated Medicine and Surgery divisions. The full benefit of this work is not currently reflected in divisional forecasts on page 7, pending development and agreement of recovery trajectories. The nursing acuity review has been finalised and agreed nurse at the time of writing - this will help to align operational nursing ward establishments with approved budgets.
- 2020-21 year end provisions for the working time directive payments and ongoing flowers legal case payments continue to be held in the balance sheet position as at month 3 and will be released to match spend as and when this comes through.
- The Pay Statistical Process Control Charts are detailed below (Graph 4). Key highlights include the increase in total pay costs in February 2021 and 2022, relating to provisions for the Flowers legal case, unsocial hours claims and payment of consultant CEA awards. The total pay costs in March 2021 and 2022 includes payment of the bank winter incentive payments and year end pay related provisions as noted above. The drop in pay costs in April 2022 reflect the one of adjustments made to the position in month 12 and the release of annual leave accrual. The increase in agency costs from January 2021 onwards relates to management of the latest wave of the Covid -19 pandemic in addition to high usage in the areas noted above. The increase in agency costs in March 2022 relates to H2 investment cos

Graph 3 - Pay Statistical Process Control (SPC) Charts



Key Highlights: Expenditure (Non Pay)

Table 5 - YTD non-pay position

Non-Pay category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Drugs	50.2	12.6	12.9	(0.4)
Clinical supplies	40.7	10.0	9.3	0.7
Other non-pay	99.2	26.3	26.7	(0.4)
Total Expenditure	190.1	48.8	48.9	(0.1)

• Non-pay expenditure totals £48.9m for the year, £0.1m adverse to plan.

• Key drivers of the YTD favourable position include clinical supplies, £0.6m favourable within Surgery & Critical care, primarily relating to Theatre consumables.

• Drugs expenditure totals £12.9m YTD, which is £0.4m adverse to plan. This mainly relates to Integrated medicine and is split across PBR and non PBR drugs, and across a number of SDUs.

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

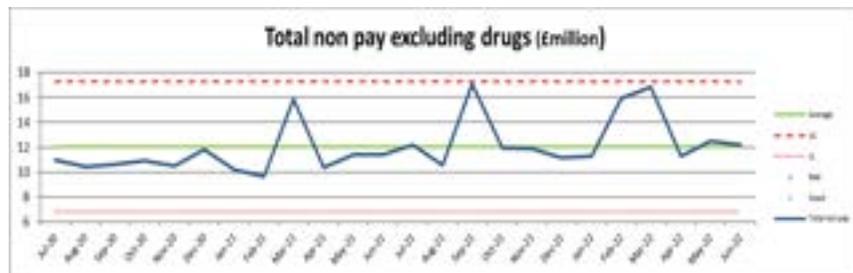
- Total non pay expenditure is below the mean average from June 2020 to February 2021 primarily due to reduced elective activity levels during the covid-19 pandemic. February 2021 costs have also reduced due to February being a short month which sees a reduction in working days and therefore associated costs including the PFI contracts. March 2021 costs are above the mean average as activity levels begin to increase again. The August 2021 non pay position includes a £1.0m VAT reclaim and the September 2021 cost increase relates to ERF non pay expenditure. The increase in non pay expenditure in February 2022 relates to expenditure incurred for IT cyber and windows 10 licences and site works including roof repairs and demolition works. The increase in March 2022 costs relates to further IT expenditure items and site works in property services along with the reassessment of capital / revenue expenditure hitting the non pay expenditure position.

- March 2021 and March 2022 costs includes the impact of non recurrent year end balance sheet adjustments.

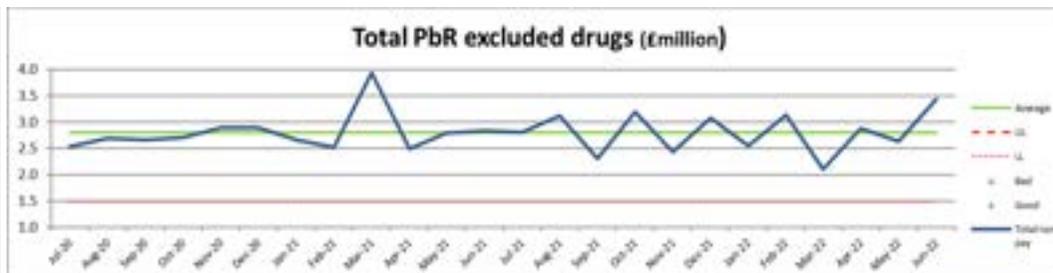
Table 6 - YTD drugs position

Drug Categories (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
PBR Drugs	11.3	2.8	3.5	(0.7)
PBR excluded Drugs	37.0	9.3	8.9	0.3
Other Drug Items	1.9	0.5	0.5	(0.0)
Total expenditure	50.2	12.6	12.9	(0.4)

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



Graph 5 - Non Pay Statistical Process Control (SPC) Charts



Divisional Position

Breakdown of financial position by division

Table 7 - Divisional income and expenditure

Division / (£m)	YTD Budget	YTD Actuals	YTD Variance against Plan	Annual Plan	Forecast Outturn	Variance Plan to Forecast	Position Signed Off by Divisions*	Current Month Run Rate		
								M01	M02	M03
Integrated Medicine	(23.4)	(26.2)	(2.8)	(91.2)	(102.7)	(11.5)	Yes	(8.8)	(8.6)	(8.8)
Integrated Elderly Care	(11.2)	(10.9)	0.3	(44.6)	(44.7)	(0.0)	Yes	(3.8)	(3.5)	(3.7)
Surgery And Critical Care	(27.4)	(27.8)	(0.4)	(110.1)	(114.2)	(4.1)	Yes	(8.9)	(9.5)	(9.4)
Women and Children	(11.8)	(11.8)	(0.0)	(47.8)	(49.0)	(1.2)	Yes	(3.9)	(3.8)	(4.1)
Specialist Services	(21.4)	(21.4)	0.1	(86.1)	(86.1)	0.0	Yes	(7.4)	(7.0)	(6.9)
Mitigations to be developed	0.0	0.0	0.0	0.0	16.8	16.8				
Total Clinical Divisions	(95.2)	(98.1)	(2.9)	(379.8)	(379.8)	(0.0)		(32.8)	(32.4)	(32.9)
Chief Executive	(1.0)	(0.8)	0.2	(3.8)	(3.8)	0.0	Yes	(0.3)	(0.2)	(0.2)
Chief Operating Officer	(0.9)	(1.4)	(0.5)	(3.5)	(4.0)	(0.5)	Yes	(0.5)	(0.5)	(0.4)
Corporate Services	2.8	(0.2)	(3.0)	0.8	(3.5)	(4.4)	N/A	0.1	(0.7)	0.3
Commercial Director Mgmt	(0.0)	0.1	0.1	(0.0)	0.0	0.0	Yes	0.0	0.0	0.0
Finance Dept.	(1.9)	(1.7)	0.2	(7.0)	(6.8)	0.2	Yes	(0.6)	(0.6)	(0.5)
Information Technology	(4.0)	(3.8)	0.2	(16.2)	(16.0)	0.1	Yes	(1.3)	(1.2)	(1.3)
Property Services	(14.9)	(15.7)	(0.7)	(57.1)	(57.5)	(0.4)	Yes	(5.2)	(5.4)	(5.1)
Human Resources	0.0	0.6	0.6	(0.1)	0.1	0.2	Yes	0.1	0.6	(0.0)
Medical Director	(0.1)	0.0	0.1	(0.4)	(0.5)	(0.0)	Yes	(0.0)	0.0	0.0
Nursing Director	(4.4)	(4.5)	(0.1)	(17.7)	(17.8)	(0.1)	Yes	(1.5)	(1.5)	(1.5)
PDC And Depreciation	(7.1)	(6.4)	0.7	(28.4)	(27.5)	0.9	N/A	(2.5)	(1.7)	(2.2)
H2 Investments	0.0	0.0	0.0	0.0	0.0	0.0	N/A	(0.2)	0.2	0.0
Mitigations to be developed	0.0	0.0	0.0	0.0	4.0	4.0				
Total Corporate	(31.6)	(33.7)	(2.1)	(133.4)	(133.4)	0.0		(11.6)	(11.1)	(10.9)
Contract Income	126.3	126.3	0.0	505.3	505.3	(0.0)		41.4	41.9	42.9
Provisions	(5.0)	0.0	5.0	(9.7)	(9.7)	0.0		0.0	0.0	0.0
Donated Asset Reporting Adj	0.0	(0.1)	(0.1)	0.0	0.0	0.0		0.1	(0.4)	0.1
Retained Surplus / (Deficit)	(5.5)	(5.6)	(0.1)	(17.6)	(17.6)	(0.0)		(2.9)	(2.0)	(0.7)

Key reasons for YTD divisional variances are as follows:

Integrated Medicine (£2.8m overspend YTD)

Overspends on Medical wards due to acuity and absence cover. Medical Consultant vacancies and gaps in rota being covered by agency and locum at a premium. SMH UTC pathway additional costs are unfunded, although an invoice for additional income has been raised for Q1. The CCG is disputing the invoice. Recovery Remedy insourcing costs for Dermatology and Gastro. Drugs are spending above budgeted and prior year levels.

Integrated Elderly Care (£0.3m underspend YTD)

MFOP Wards & Mudas overspending due to activity, and awaiting Acuity Review completion. Medical Staffing overspending due to additional activity, agency, and locum usage. Offset by vacancies within Therapies and the Locality Teams, and business cases awaiting funding approval.

Surgery & Critical Care (£0.4m overspend YTD)

Adverse position driven by Medical staffing overspend due to waiting list initiative (WLI) activity and locum/agency premium, and unfunded Independent Sector spend. Offset by favourable variances against Nursing and Clinical Supplies in ICU & Theatres.

Women & Children (£0.01m overspend YTD)

Overspends within Medical Staff across the Division due to rota gaps, maternity leave and restricted duties cover for oncalls along with increased activity in Paediatrics. Unidentified CIP target is offset with overachievement of existing pay schemes.

Specialist Services (£0.1m underspend YTD)

Favourable position driven by change in income recognition for CDC based on YTD activity performance. Work still required on the delivery of unidentified Pay CIP targets and Radiology Pay is still a pressure from unfunded Insourcing and Prof & Tech Agency usage covering the MRI mobile rental and vacancies.

Property Services (£0.7m overspend YTD)

Adverse position driven by phasing of the CIP plan to date and slippage in achievement of schemes, significant unplanned overspend on maintenance, currently offset by phasing underspend in relation to energy.

Information Technology (£0.2m underspend YTD)

Significant underspend on pay, offset by consultancy and additional non pay expenditure, Significant vacancies within BI & performance.

Chief Operating Officer (£0.5m overspend YTD)

Pay costs of senior bank and agency staffing (ceasing in Q2). Consultancy costs earlier in the year. Recovery plan to be developed.

Corporate Services (£3.0m overspend YTD)

Corporate services are where central provisions are held for items including the impact of bad debt and balance sheet adjustments. In addition, corporate services holds the remaining unallocated annual CIP target totalling £4.6m which will be allocated out to in divisions and individual budget lines once schemes are identified. The overspend in corporate services is offset overall with the underspend against provisions totalling £5.0m YTD.

Balance Sheet

Statement of financial position

Table 8 - Balance Sheet summary

Statement of financial position / (£m)	Planned Position	YTD Position	Variance to Plan	Change from Prior Month
Non-current assets	349.3	348.4	0.8	5.7
Cash and cash equivalents	35.1	31.7	3.4	(3.9)
Trade and other current assets	37.5	36.1	1.4	0.4
Total Assets	421.8	416.2	5.6	2.2
Current Borrowing	(3.9)	(3.7)	(0.2)	0.4
Other Current liabilities	(83.9)	(77.9)	(6.0)	(3.8)
Non Current Borrowing	(43.9)	(41.2)	(2.7)	0.0
Other Non-current liabilities	(1.0)	(1.5)	0.4	0.0
Total Liabilities	(132.7)	(124.3)	(8.4)	(3.4)
TOTAL NET ASSETS	289.1	292.0	(2.8)	(1.2)
PDC and Revaluation reserve	410.0	410.0	(0.0)	2.5
Income and Expenditure Reserve	(120.8)	(118.0)	(2.8)	(3.7)
TOTAL EQUITY	289.1	292.0	(2.8)	(1.2)

- Non Current assets have increased by £5.7m from the prior month. This is due to a catch up in capital spend particularly around the Paediatric development. The balance is behind plan due to an underspend on depreciation.
- The closing cash balance is £3.4m lower than plan due to the repayment of creditors at a quicker than planned rate. This is reflected in the current liability plan variance £6m. The cash balance has decreased by £3.9m from the prior month. Cash will continue to decrease throughout the year as the impact of a deficit plan materialise and 2021-22 commitments are paid.
- Non Current / Current Borrowing is lower than plan pending capitalisation of right of use assets and the associated liability under IFRS 16.
- Remaining changes in the statement of financial position are consistent with the reported £5.5m deficit prior to technical adjustments.

Accounts Receivable

Table 9 - Accounts Receivable

Month 3

(£m)	Current	30-60 days	60-90 days	90-120 days	>120 days	Total
NHS	1.0	0.3	0.2	0.7	1.3	3.5
Non-NHS	1.2	0.3	0.1	0.1	1.8	3.6
Total	2.3	0.6	0.3	0.8	3.2	7.1
% of total	32%	8%	4%	11%	45%	100%

Month 2

(£m)	Current	30-60 days	60-90 days	90-120 days	>120 days	Total
NHS	0.5	0.2	0.8	0.5	0.9	2.8
Non-NHS	1.9	0.2	0.5	0.3	1.6	4.4
Total	2.3	0.3	1.3	0.8	2.5	7.3
% of total	32%	4%	18%	11%	34%	100%

- Debtors have decreased by £0.2m from £7.3m in month 2 to £7.1m in month 3.
- The decrease in debtors is due to a decrease in University of Buckingham debt of £0.2m.
- Overdue has decreased by £0.2m from £4.9m in month 2 to £4.7m in month 3. (However the > 120 days category includes longstanding outstanding debtors).

• Top 5 outstanding debts at month 3 are:

- 1 - Oxford University Hospitals NHS FT £1.08m
- 2 - Oxford Health NHS Foundation Trust £0.65m
- 3 - Buckinghamshire Council £0.5m
- 4 - Mandeville Medicines (Chapter) Ltd £0.2m
- 5 - Imperial College Healthcare NHS Trust £0.2m

Balance Sheet

Accounts Payable

Table 10 - Accounts Payable

Creditors

(£m)	Current	30-60 days	60-90 days	90-120 days	>120 days	Total
NHS	0.9	-0.1	0.0	0.1	0.1	1.0
Non-NHS	5.2	0.0	0.1	2.1	0.0	7.4
% of total	72%	0%	1%	26%	1%	100%

The creditors table reflects creditors which have been fully processed on the ledger and are awaiting payment. These are being paid as quickly as possible to maintain cash flow to our suppliers. The creditors table is a debit balance as all invoices approved for payment have been paid leaving only credit notes due to the organisation.

Invoice Register

	Total Value (£m)	Total Count	0-30 days		31-60 days		61-180 days		6 months to 1 year		1 year to 2 years		More than 2 years	
NHS	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty
Month 7	5.8	1,129	1.8	107	0.4	42	1.7	173	1.0	235	0.6	485	0.2	87
Month 8	3.1	770	0.7	75	0.5	67	0.5	136	0.6	173	0.4	213	0.3	106
Month 9	5.4	748	3.3	98	0.3	47	0.6	133	0.5	145	0.3	218	0.3	107
Month 10	2.7	683	0.6	48	0.2	41	0.6	129	0.5	145	0.4	212	0.3	108
Month 11	2.9	553	0.9	63	0.4	35	0.6	102	0.6	113	0.2	160	0.2	80
Month 12	2.1	315	0.6	64	0.2	26	0.5	49	0.5	64	0.2	74	0.2	38
Month 1	4.0	335	2.6	70	0.5	48	0.3	56	0.2	63	0.3	62	0.2	36
Month 2	4.5	387	2.6	91	0.6	44	0.7	88	0.2	61	0.3	65	0.2	38
Month 3	3.4	328	1.2	68	0.7	39	0.9	88	0.1	35	0.3	64	0.2	34

Non NHS	Total Value (£m)	Total Count	0-30 days		31-60 days		61-180 days		6 months to 1 year		1 year to 2 years		More than 2 years	
	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty
Month 7	5.9	3,292	2.6	804	0.7	355	1.2	825	0.7	551	0.5	531	0.1	226
Month 8	5.3	3,109	1.8	757	1.0	356	1.0	648	0.8	531	0.5	551	0.1	266
Month 9	7.4	3,561	3.1	907	1.5	489	1.4	743	0.7	556	0.5	581	0.1	285
Month 10	5.7	3,250	1.4	556	1.5	446	1.4	821	0.7	567	0.5	558	0.2	302
Month 11	6.5	2,714	3.4	720	0.7	247	1.1	643	0.5	401	0.6	401	0.2	302
Month 12	10.2	2,493	6.6	673	1.8	364	0.7	480	0.3	317	0.6	328	0.2	331
Month 1	6.8	2,386	3.7	642	1.2	361	1.1	512	0.4	316	0.3	295	0.2	260
Month 2	6.5	2,407	2.2	520	1.8	391	1.7	580	0.4	334	0.3	297	0.1	285
Month 3	6.4	2,598	1.7	546	1.7	388	2.1	699	0.5	365	0.3	307	0.2	293
Total M3	9.8	2,926	2.9	614	2.4	427	3.0	787	0.6	400	0.6	371	0.3	327

The Invoice Register at Month 3, which details invoices awaiting processing as they cannot be matched to an order or receipt, totals £9.8m. In Value terms this is £1.2m less than previous month. In the period, the number of invoices held on the register increased by 132 (from 2794 in month 2 to 2926 in month 3). The value of invoices with a invoice date longer than 30 days increased by £0.7M and the count increased by 129. In month 2, those invoices less than 30 days old made up 40% (value) and 20% (count), in month 3 this has decreased to 30% (value) and 20% (count).

Top 5 reasons for invoices being held on the register:

- 1 - Invoice cannot be matched to an order as the order number is not quoted on the invoice.
- 2 - Goods/services not being receipted despite order being in place .
- 3 - Invoice is under query, usually due to price differences.
- 4 - Awaiting credits from the supplier .
- 5 - No purchase order and awaiting authorisation .

Better Payment Practice Code

Table 11 - Better Payment Practice Code

	Count Total	Count Pass	% Pass	Total (£m)	Pass (£m)	% Pass
NHS	221	121	55%	5,442	4,558	84%
Non-NHS	5,373	3,153	59%	20,675	14,061	68%
Total	5,594	3,274	59%	26,117	18,620	71%

Adherence to the BPPC (which requires 95% of suppliers to be paid within 30 days of invoice date) remains an area of challenge for the organisation due to the volume of invoices trapped on the register as detailed above.

The Committee to note that all processing of Pharmacy invoices which impact the BPPC are processed outside of finance.

Cash Position

Cash

Table 13 - Cash summary position

£'000	Actual Apr-22	Actual May-22	Actual Jun-22	Forecast Jul-22	Forecast Aug-22	Forecast Sep-22	Forecast Oct-22	Forecast Nov-22	Forecast Dec-22	Forecast Jan-23	Forecast Feb-23	Forecast Mar-23	22/23
INCOME													
Clinical Income	40,875	42,070	43,021	42,480	42,480	42,478	42,480	42,479	42,478	42,480	42,480	42,479	508,275
Clinical Income top up / Covid / Growth			1,802	0	0	500	0	0	500	0	0	500	3,302
Education and Training	229	3,175	0	0	2,400	0	0	0	2,400	0	0	2,400	10,604
Other Income	2,355	1,916	1,018	600	600	600	600	600	600	600	600	600	10,689
HMRC vat reclaim	2,144	3,693	0	2,900	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	21,537
PDC capital	0	0	0	0	0	0	0	0	0	4,303	0	3,359	7,662
Other Receipts	630	2,759	781	900	900	900	900	900	900	900	900	900	12,269
TOTAL RECEIPTS	46,232	53,612	46,622	46,880	47,980	46,078	45,580	45,579	48,478	49,883	45,580	51,838	574,338
PAYMENTS													
Pay Costs	(30,048)	(27,913)	(28,563)	(28,500)	(28,500)	(28,500)	(28,500)	(28,500)	(28,500)	(28,500)	(28,500)	(28,500)	(343,025)
Creditors	(17,421)	(15,773)	(14,239)	(14,000)	(14,000)	(14,000)	(14,000)	(14,000)	(14,000)	(14,000)	(14,000)	(14,000)	(173,433)
Creditors - Capital Spend	(9,274)	(2,785)	(1,901)	(1,500)	(1,500)	(1,500)	(1,500)	(1,500)	(2,500)	(2,500)	(2,500)	(5,000)	(33,960)
NHSLA	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	0	0	(13,240)
PDC Dividends	0	0	0	0	0	(2,414)	0	0	0	0	0	(3,726)	(6,140)
PFI CHARGE	(5,097)	(4,426)	(4,451)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(54,024)
TOTAL PAYMENTS	(63,164)	(52,221)	(50,478)	(49,774)	(49,774)	(52,188)	(49,774)	(49,774)	(50,774)	(50,774)	(49,450)	(55,676)	(623,821)
NET CASH FLOW IN PERIOD	(16,932)	1,391	(3,856)	(2,894)	(1,794)	(6,110)	(4,194)	(4,195)	(2,296)	(891)	(3,870)	(3,838)	(49,483)
OPENING CASH BALANCE	51,046	34,114	35,505	31,649	28,754	26,960	20,850	16,655	12,460	10,163	9,272	5,401	51,046
CLOSING CASH BALANCE	34,114	35,505	31,649	28,754	26,960	20,850	16,655	12,460	10,163	9,272	5,401	1,563	1,563

- Clinical Income receipts forecast has been aligned to the Income and expenditure assumptions as per the operating plan.
- Total Receipts in month 3 decreased from £53.6m to £46.6m mostly due to Education and Training received of £3.2m in M2.
- PDC Capital receipts include £4.3m to support the ICS agreed capital programme of £20m. In addition it is anticipated that there will be PDC receipts for the community diagnostic centre and ophthalmology.
- Pay costs have been forecast based on trend. The income and expenditure plan assumes efficiencies which have not been factored in for the purposes of the cash flow forecast. This is a prudent application to ensure there is sufficient cash available to meet financial commitments if efficiencies do not deliver.
- Capital Creditors and Other Creditors have been forecast lower than the first 3 months. This is due to the repayment of year-end creditors in the first quarter which are higher than other quarters.
- The PDC dividend payment in month 6 will be reduced by the year end closing receivable of £1.3m. Dividends in year will be collected on the basis of the operating plan calculations.
- Based on current forecast projections and the information available at present, the Trust will not need cash support in 2022-23 however this will be continually monitored throughout the year.

Capital Position

Table 14: Capital Overview: M03 2022-23

Capital Expenditure	£m	Annual Plan	FY Fcast	Variance	YTD Plan	YTD Actual	Variance	Prior Month YTD Actual
Medical Equipment		3.2	5.0	(1.8)	0.2	0.0	0.2	0.0
Property Services		10.6	14.0	(3.4)	7.8	7.8	0.0	1.9
Information Technology		8.4	8.4	0.0	1.3	1.8	(0.5)	0.4
General		1.6	1.6	0.0	0.4	0.2	0.2	0.1
Total Capital Expenditure		23.8	29.0	(5.2)	9.8	9.8	0.0	2.5
Funded By Trust		20.0	20.0	0.0	9.4	9.6	(0.2)	2.4
PFI Lifecycle		1.6	1.6	0.0	0.4	0.2	0.2	0.1
Donated		2.2	2.2	0.0	0.0	0.0	0.0	0.0
Total Capital		23.8	23.8	0.0	9.8	9.8	0.0	2.5

Table 15: Capital Detail: M03 2022-23

	£'000	Capital Resource	Adjust	Revised Capital Resource
BOB/ICS Allocation		20,000		20,000
PFI Lifecycle		1,640		1,640
Donated			2,200	2,200
Total 2021/22		21,640	2,200	23,840

Table 16: Capital Expenditure Plan

Capital Expenditure Plan	BOB/ICS	Lifecycle	PDC Plan	ERF	Donated	NHSx	TIF	Salix	2022/23 Total	YTD Expend	FY Expected Expend	FY Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Medical Equipment	1,000				2,200				3,200	14	5,014	(1,814)
Property Services	10,622								10,622	7,812	14,011	(3,389)
Information Technology	8,378								8,378	1,763	8,449	(71)
General		1,640							1,640	196	1,640	0
	20,000	1,640	-	-	2,200	-	-	-	23,840	9,785	29,114	(5,274)

- Capital spend of £5.2m from the prior month taking total spend on the capital programme to £9.8m. The catch up is due mostly to accrued spend on the Paediatric development.
- The forecast overspend of £5.2m represents a risk to the capital programme which will need to be managed and mitigated to remain within the approved Capital Resource Limit (CRL). This is a statutory duty so no overspend can be reported against this.
- The programme is being monitored against the allocation agree with the ICS of £20 together with £1.64m of PFI lifecycle. Business cases around ophthalmology and the Community Diagnostic Centre are underdevelopment.

Glossary and Definitions

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

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Charitable Funds Investment Policy - BHT Pol 147 - V8.5		
Board Lead	Finance Director		
Type name of Author	Nelson Garcia-Narvaez		
Attachments	Policy		
Purpose	Approval		
Previously considered	Charitable Funds Committee (CFC), TPSG and EMC		

Executive Summary

The Charitable Funds Investment Policy (BHT Pol 147) was thoroughly scrutinised and amended in 2021 by the Charitable Funds Committee and endorsed by the Board. Therefore, this policy only required in this revision an update to reflect the instructions given to Cazenove that were already approved by the Committee and the Board, in relation to operating the portfolio under a total return approach.

This updated policy was submitted and approved by the CFC, TPSG and EMC.

Decision The Board is requested to formally approve this policy.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	It is expected that any support from the Charity to enhance the services that are provided by the Trust may have an effect and contribute with patient safety.
Risk: link to Board Assurance Framework (BAF)/Risk Register	The Trustees must ensure that the resources of the charity are managed appropriately and deployed to the best advantage of the patients.
Financial	Enhancement in services will support a financially sustainable health and care system.
Compliance Select an item. Select CQC standard from list.	Good Governance by complying with Trustees Act 2000, Charity Commission Guidance, current legislation and ensure the correct management of the Charity's funds.
Partnership: consultation / communication	N/A
Equality	This report has no effect on patients, staff or people with any protected characteristics; the only impact is to allow the Trust to operate more efficiently. EQIA completed – no impact
Quality Impact Assessment [QIA] completion required?	Not Required

1 Introduction/Position

This Charitable Funds Investment Policy (BHT Pol 147) was presented and approved in the Charitable Funds Committee, reviewed by the Trust-Wide Policy Sub-Group (TPSG) and approved by the Executive Management Committee (EMC).

This Policy was thoroughly scrutinised and amended in 2021 by the Charitable Funds Committee and endorsed by the EMC and the Board.

Since then, there are no external regulations or guidance modifications that should be considered. Therefore, the policy was not required to be examined thoroughly.

The only modifications introduced in this policy, which were agreed with Cazenove by the CFC, are as follows:

Section 7.1 Investments Objective (Page 5) section d) will state:

(d) A distribution of approximately £200,000 p.a. from the portfolio, which is currently equivalent to a yield of about 2.31% p.a.

Additionally, the following paragraph has been inserted in the same section:

The portfolio is currently operating under a total return approach, where spending is taken from both income and capital.

2 Action required from the Board/Committee

2.1 The Board is requested to:

- a) To **Note** the changes and **Endorse** the policy.

APPENDICES

Appendix 1: Charitable Funds Investment Policy (BHT Pol 147)

Once printed off this is an uncontrolled document. Please check the intranet for the most up to date version.

July 2020 Version 8.5

CHARITABLE FUNDS INVESTMENT POLICY

Summary of Changes:

This version has been significantly revised to take into account the Trust's requirements on the writing of Policies

Version:	8.5
Approved by:	Charitable Funds Committee
Date approved:	May 2020
Ratified by:	Trust Board
Date ratified:	27th January 2021
Consultation:	Charitable Funds Committee
Name of originator/author	Revision: Nelson Garcia-Narvaez / Charities Head of Finance Original Policy: Nelson Garcia-Narvaez / Charities Head of Finance
Lead Director	Barry Jenkins – Director of Finance
Name of responsible committee/individual	Charitable Funds Committee / Charitable Funds Head of Finance
Document Reference	BHT POL 147
Date Issued:	- March 2022
Review date:	- March 2023
Target Audience:	Directors, Non-Executive Directors and Fund managers
Equality Impact Assessment:	May 2020

Document History

Version	Issue	Reason for change	Authorising body	Date
1	0	New Document-Issued		
2	0	Update		
3	0	Formal Review		Nov 2008
4	0	Formal Review		July 2010
5	0	September 2012	Charitable Funds Committee 08.08.12 Trust Board 29.09.12	Sept 2012
6	0	Formal Review – Sept 2014	Charitable Funds Committee Trust Management Committee Trust Board	29.07.14 Sept 14
7	0	Formal Review – July 2016	Charitable Funds Committee Executive Management Committee	25/05/16 22/07/16
8	0	Formal Review – August 2016	Charitable Funds Committee Executive Management Committee	25 th August 2016
8.1	0	Update	Charitable Funds Committee Executive Management Committee Board	May 2017
8.2	0	Update	Charitable Funds Committee	28/02/2018
8.3	0	Update	Charitable Funds Committee Board	05/02/2019 31/07/19
8.4	0	Update	Charitable Funds Committee Board	28/05/2020 27/01/21
8.5	0	Update	Charitable Funds Committee Executive Management Committee Board	03/03/2022 TBC

Associated Documents

BHT Ref	Title	Location/Link
n/a	Investing charity funds: regulatory perspective	https://www.gov.uk/government/publications/investing-charitable-funds https://www.gov.uk/government/publications/charities-

		and-investment-matters-a-guide-for-trustees-cc14
n/a	Trustee Act 2000	http://www.legislation.gov.uk/ukpga/2000/29/contents
n/a	Charity Act 2011	https://www.legislation.gov.uk/ukpga/2011/25/contents
n/a	Charity Act 2016	www.legislation.gov.uk/ukpga/2016/4/contents/enacted
n/a	SORP 2015 and 2019 – FRS 102	https://www.gov.uk/government/publications/charities-sorp-2005
n/a	Regulations 2008	www.legislation.gov.uk/uksi/2008/629/contents/made

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Charitable Funds Investment Policy Document

1. Introduction

This policy governs the investment strategy of the Trust's charitable funds.

Under the Trustee Act 2000 it is a legal requirement that, if the investment function is delegated to an investment manager, the Trustees have a written investment policy which is kept formally under review.

The Health Services Act 1977 gives NHS bodies the authority to hold charitable funds. The Trust's charitable funds are derived from donations, legacies and investment returns. The charity's objectives are to utilise the charitable funds for the benefit of the National Health Service rather than to accumulate funds with which to achieve investment returns.

For some time, new gifts of a charitable nature have been encouraged to be made to a general fund, which can be used for any general charitable purposes of the Trust. However there are some funds which have specific 'restricted' purposes. These general and restricted funds are held under one 'umbrella' charity for Buckinghamshire Healthcare NHS Trust. Although there is a distinction between the funds for administrative purposes, from an investment perspective the assets of all underlying funds are pooled and then managed as a single coherent whole.

Charitable fund trustees are under a duty to ensure that the funds are appropriately utilised and this means that the funds should not remain unused for a long period of time, particularly when there are no future plans for spending. However, in relation to the Trust's charitable funds, as with most NHS charitable funds, resources are only expended slowly. After allocating funds that are likely to be required to fund identified expenditure ('short term monies') the balance will be invested in an investment portfolio designed to be long term in nature ('long term monies').

This policy should be read in conjunction with the Management of Charitable Funds Policy (**BHT Pol 063**) to cover complementary information regarding the way in which the Trust's charitable funds are managed and utilised.

2. Scope and Purpose

This policy applies to the investment of all funds of the Buckinghamshire Healthcare NHS Trust Charitable Fund.

The purpose of this policy is to facilitate effective management of funds, whether these are invested or held as liquid assets, to achieve the objectives of the Charity in the immediate and longer term in conjunction with identification and understanding of the risks to the Charity.

3. References and Definitions

The main Charities Commission website provides further details on the responsibilities of Charities and Trustees for investment policies and can be found at www.charity-commission.gov.uk/Charity_requirements_guidance/Charity_governance/Managing_resources. Only elements of the guidance that is relevant to this Charity have been produced here.

Legal requirements covered within this Policy are outlined in the Charities Act 2011 as amended by Charity Act 2016 and the Trustee Act 2000.

Definitions:

The Charity: the Buckinghamshire Healthcare NHS Trust Charitable Fund, registered charity number 1053113, a separate legal entity from Buckinghamshire Healthcare NHS Trust NHS Trust.

Trustee: Charity Trustees are responsible for the general control and management of the administration of the charity. The Charity has a corporate trustee – the Board of Buckinghamshire Healthcare NHS Trust.

Investment Manager: an individual or corporate body appointed by the Charity's Trustees to advise and make investment decisions on behalf of the charity.

Charitable Funds Committee: a sub-committee of the Board whose responsibility it is to oversee the management of Charitable Funds.

Common Investment Fund: an arrangement whereby the money invested by a number of charities is pooled and invested in a range of investments in accordance with the published policy of the scheme.

The size of each share is determined by the number of 'units' each contributor owns and investment returns (or losses) are allocated in the same proportion.

'Umbrella' Charity: a charity registered under a single name and number under which several funds are held and administered. These funds may have separate purposes and objectives and the balance will be managed by different fund holders. Income and expenditure is allocated to these fund balances individually, whereas investment returns will be allocated in proportion to the fund balances held.

Volatility of returns: there is a link between the rate of return that can be expected on an investment and the risk inherent in that type of investment. This is separate from the systematic or market rate of return, where a whole class of investments will be affected by an upturn or downturn in the market caused by macro-economic trends. The more risky an investment is seen to be the higher the return that would be expected to be achieved. However there is also a potential for large losses on this type of investment, where safer investments would have much lower rates of returns. This link between levels of risk and the rate of returns is known as the volatility of returns.

4. Roles and Responsibilities

4.1 The Board

The Board as corporate Trustee of the Charity has the overall responsibility for setting the investment policy for the Charity through setting an overarching set of objectives that need to be taken into account when deciding on specific investment allocations. It is responsible for appointing the investment manager. It has delegated responsibility for monitoring and making amendments to the portfolio of investments to meet the overarching objectives to the Charitable Funds Committee.

4.2 Charitable Funds Committee

The Committee has the responsibility to monitor performance of the portfolio of investments through the receipt and review of reports from the investment manager. The investment manager will attend each quarterly Charitable Funds Committee in order to give the members the opportunity to raise questions about the performance of the investments and the appropriateness of moving investments into other areas. The Committee will update the Board with regard to significant changes or issues with performance of the investments.

4.3 Investment Manager

The investment managers appointed will be responsible for investing the available funds as far as possible to fulfil the investment objectives laid out below. They will provide quarterly reports to the Charitable Funds Committee. They will take into account any concerns raised by the Committee in the allocation or performance of the funds. They will take into account the Trustees stance on ethical investment.

4.4 Trust finance staff

The Trust, through its finance staff, carries out financial administration of the Charity. It is the responsibility of the appropriate finance staff to ensure that the invitations to attend the Committees are sent to the investment manager and that investment information provided is passed onto the Committee members. It is their responsibility to ensure that the Charity keeps accurate records of its investments, properly accounts for investment returns and movements in the value of investments.

5. Consultation and dissemination

This Policy has been formulated by taking into account the guidance issued by the Charities Commission as well as the previously documented objectives of the Trustees in achieving investment returns. It was presented to the Charitable Funds Committee on TBA for their comments before they ratified it.

The Policy will be published on the Trust's intranet within the Finance Policies section.

6. Monitoring compliance with the Policy

The Trustees wish to monitor the performance of the investments carefully and will seek quarterly valuations and reviews of performance. Whilst the precise mechanics will depend on the independent professional advice given to the Trustees, it is proposed that performance should be measured against one of the industry standard measures such as the WM Charity Survey.

The Charitable Funds Committee will provide information in its Annual Report to the Board on its actions in managing the investments. If the Committee identifies that there are shortfalls in the performance of its investments, and that these shortfalls are not being remedied by the investment manager, the Committee will report this to the Board together with its proposals on remedying the situation. This may include a change of investment manager.

The Committee will, in turn, monitor compliance with this Policy by the investment managers and finance staff.

7. Investment Strategy

7.1 Investment Objectives

As stated above, it is not the Trustee's primary aim to accumulate funds and the investment strategy set out below is written with this in mind. Accordingly, a portion of the total funds will be held back as short term monies or working capital (assets which are capable of being released to generate cash quickly, or cash) with the rest constituting the investible portfolio (long-term monies), which is the subject of this policy paper, being invested.

The Trustees objectives are:

- To maintain the value of the capital in real terms over the medium term (3-5 years).
- To realise capital gains (i.e. returns on the investments achieved) only if there is a bona fide charitable purpose for them.
- To receive dividends and interest from the investments as income to the charity and utilise it as such.
- To reinvest capital gains where no immediate charitable purpose exists.
- To take normal charitable expenditure from ongoing donations and interest from investments that is surplus to administrative expenditure.
- To fund unusual major capital projects on a case-by-case basis from one-off reductions in investment capital.

That part of the portfolio which must, as a minimum, be kept in liquid funds should be sufficient to cover three months of anticipated charitable expenditure. However, the investment advisers have discretion to increase the liquid element of the portfolio if market conditions should so dictate.

Subject to the recommendations of our independent adviser, the funds will be invested on a discretionary basis by the purchase of pooled funds, ordinarily Common Investment Funds [CIFs] or others where they are not available.

The investment principles of the Trustees are to ensure: -

- (a) A balance between income (interest or dividends) and capital growth whilst adopting an appropriate medium to long-term risk profile, accepting that this will **impose a degree of volatility in performance (*A)**
- (b) The maintenance of the 'real' value of the capital within the portfolio after allowing for the effects of inflation but before any strategic change in historic expenditure levels.
- (c) That they are prepared to realise capital gains if achieved and if there is a bona fide charitable purpose for them.
- (d) A distribution of approximately £200,000 p.a. from the portfolio, which is currently equivalent to a yield of about 2.31% p.a.
- (e) That the administrative burden on the Trustees is kept to an acceptable minimum.
- (f) That they receive independent professional advice on the set up and monitoring of the performance of the investments.

The portfolio is currently operating under a total return approach, where spending is taken from both income and capital.

7.2 Risk Profile and asset allocation

The Trustees are bound by the rules for Charities on investments and have adopted a strategy, which avoids speculation and high risk, while accepting **a reasonable degree of volatility of returns (*B)**. They will spread the investments over a number of different investment classes such as UK Equities, overseas Equities, Bonds, Property and cash and have considered and agreed a limited amount of exposure to non-traditional assets like hedge funds and absolute return funds, subject to clear restrictions.

The trustee will define a range for each asset class as set out in annex 1. Within that range the Charitable Funds Committee will agree with the Investment Manager the actual allocation to each class. Movements outside of the range will be explicitly approved by the trustee.

7.3 Ethical Considerations

The Trustees have considered whether to impose any ethical restriction on the investment of the Trust's assets by their investment managers and are mindful that their primary duty is to seek the best returns within the limits of the overall investment policy.

The Trustees have decided to avoid direct investment in certain types of stocks and to this end they will specifically avoid direct investment in stock adverse to health (e.g. Tobacco). They will also seek to minimise investments in areas where conflicts of interest could be seen to occur, such as with pharmaceutical companies.

The Trustees accept that the investment in common investment funds (and similar products) may give the charity indirect exposure to such stocks. Any indirect exposure is monitored biannually and will not exceed 5% of the total portfolio value.

The Ethical Screening Analysis is benchmarked using the revenue screens selected by the Church of England's Ethical Investment Advisory Group (EIAG) screened at 100%.

Should the indirect exposure through funds reach a total of 4%, based on the restricted list published by the Church of England's Ethical Investment Advisory Group (EIAG), each individual investment will be assessed with regard to its adverse exposure and this may lead to a reduction or complete sale.

7.4 Investment Powers

The appointed fund managers or funds will be given discretionary powers and empowered to buy and sell securities on behalf of the trustees, subject to the overall investment policy as set out in this document. All such transactions must be reported to the Trustees in the next quarterly review.

7.5 Review of Policy

The Charities Committee will review this policy annually and the Trustees will approve any proposed changes.

A* This is defined as movements in performance of 5%

B* This is defined as movements in performance of not more than 10%

8. Related Policies

The following related policies & guidance are available on the Trust Intranet and external websites

	Document
(a)	Standing Orders / Standing Financial Instructions (BHT Pol 089)
(b)	Limits of Delegation Policy (BHT Pol 061)
(c)	Code of Conduct (BHT Pol 019)
(d)	Standards of Business Conduct (Corporate Policies)
(e)	Charitable Funds Committee Terms of Reference
(f)	Management of Charitable Funds (BHT Pol 063)

Annex 1

Currently Approved Range of Asset Allocations

In line with the current professional advice to the Charitable Funds Committee, the agreed ranges for each asset allocations are as follows: -

	Asset Type	Agreed %
1	UK Equities	42.5% – 82.5%
2	Global/Overseas Equities	
3	Fixed Interest	0 % – 30%
4	Alternatives	5% – 25%
5	Property	0% – 20%
6	Cash	0% – 10%

These approved ranges of asset allocation are approved by the trustee (Trust board) and can only be amended by the Board. Within each range the Charitable Funds Committee can agree specific asset allocations upon advice from the Investment Manager.

The Committee takes the view in order to cover eventualities regarding a variation in the asset allocations agreed with the investment manager to accept a margin of fluctuation of 2% of the % stated in each category, where there is a proven benefit to the charity.

In any case this variation should be corrected in a period no longer than 6 months without formally changing the investment policy. The decision to vary must be reconsidered and the case represented at each meeting of the committee."

The Committee requires that any fluctuation to the agreed asset allocations is reported as soon as the information is disclosed by the Investment Management.

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Trust Quality Account 2021/22
Board Lead	Karen Bonner, Chief Nurse
Type name of Author	Mitchell Fernandez, Deputy Chief Nurse
Attachments	BHT Quality Account 2021/22
Purpose	Information
Previously considered	Quality and Clinical Governance Committee – 18 May 2022 Quality and Patient Safety Group – 26 May 2022 Executive Management Committee – 31 May 2022 Trust Board Meeting in Private – 29 June 2022

Executive Summary

NHS healthcare providers are required to publish a Quality Account (QA) each year. This is based on the quality accounts regulations published by the Department of Health and Social Care.

The QA is an annual account to the public about the quality of services that we provide and deliver, and our plans for improvement. The QA is designed to assure our local population, our patients and our commissioners that we provide high quality clinical care to our patients.

The publication of this document is one of the ways in which we can share our evidence on the quality of care we provide to our patients. It also allows us to focus on the plan we have made to support continuous quality improvement throughout 2022/23. The QA includes an assessment of our performance in 2021/22 and our quality priorities for 2022/23.

As the same with previous year, the QA for this year reflects the incredible hard work and resilience of our people in helping us to achieve our goals. The emotional and physical toll the pandemic has taken on our colleagues should not be underestimated. Improving staff experience and wellbeing will continue to be one of the Trust quality priorities for 2022/23.

Whilst the QA has been produced in accordance with national reporting protocols, ordinarily we would have seen greater collaboration through stakeholder groups and feedback forums. However, this has not been possible due to restrictions imposed by the pandemic.

In 2022/23, we will focus our quality priorities on the following three themes:

1. Patient safety
2. Better patient experience and outcomes
3. Improving the experience and wellbeing of our colleagues

In order to measure the Trust achievements against these, a set of indicators are included in this year's QA to measure our success. The indicators proposed are aligned with the Trust Operating Plan for 2022/23. Delivery of the quality priorities will be monitored quarterly by the Quality and Patient Safety Group and reported to the Quality and Clinical Governance Committee.

Stakeholders' comments on the Trust Quality Account 2021/22 are included as appendices.

The content of the Quality Account report follows the NHSE guidance <https://www.nhs.uk/using-the-nhs/about-the-nhs/quality-accounts/about-quality-accounts/>

The Quality Account 2021/22 has been published on Trust external website following approval on 29th June 2022 by the Trust Board meeting in private.

<http://www.buckshealthcare.nhs.uk/documents/u-quality-account-2021-2022/>

On 29th June 2022, an email was sent to england.quality-accounts@nhs.net and QualityAccounts@dhsc.gov.uk for notification of publication of the Trust Quality Account 2021/22 in line with the national requirements.

Decision	The Committee is requested to note the Quality Account 2021/22 publication on the Trust external website in line with national requirements		
Relevant Strategic Priority			
Outstanding Care <input checked="" type="checkbox"/>	Healthy Communities <input checked="" type="checkbox"/>	Great Place to Work <input checked="" type="checkbox"/>	Net Zero <input type="checkbox"/>
Implications / Impact			
Patient Safety	The Quality Account includes a summary of patient safety incidents and actions to increase patient safety.		
Risk: link to Board Assurance Framework (BAF)/Risk Register	The paper outlines the quality of patient care delivered.		
Financial	No impact		
Compliance <small>Select an item.</small> Good Governance	The paper includes aspects of quality of care and our response to patient feedback to improve our services.		
Partnership: consultation / communication	The paper was shared with our Clinical Commissioning Group, local Healthwatch and social care colleagues to provide a statement in the appendix before publication.		
Equality	The quality of the care which we deliver requires us to deliver models of care which addresses Health Inequalities in our community. The work Quality Account celebrates the way we deliver care.		
Quality Impact Assessment [QIA] completion required?	No		

1 Introduction/Position

- 1.1 NHS Healthcare providers are required to publish a Quality Account (QA) each year. These are based on the quality accounts regulations published by the Department of Health and Social Care.
- 1.2 The QA is an annual account to the public about the quality of services that we provide and deliver, and our plans for improvement. The QA includes an assessment of our performance last year and our priorities for coming year.
- 1.3 The Quality Account is an important way for the Trust to report on quality and show improvements in the services we deliver to our local communities and stakeholders.
- 1.4 In the last two years of COVID-19 virus global pandemic, Buckinghamshire Healthcare NHS Trust main goal remains which is: to protect the most vulnerable, keeping its patients and colleagues safe.
- 1.5 As with previous year, the Quality Account for this year reflects the incredible hard work and resilience of our people in helping us to achieve this goal. It includes feedback from our stakeholders on how well they think we performed.
- 1.6 The publication of this document is one of the ways in which we can share our evidence on the quality of care we provide to our patients. It also allows us to focus on the plan we make to support continuous quality improvement throughout 2022/23.

2 Problem

- 2.1 During the first year of the pandemic, our primary objective was to keep our patients and our colleagues safe, ensuring that we could continue to provide care to those that needed it most. Whilst this remains one of our top priorities, as COVID is still prevalent in the community, we have been dealing with the fall-out from the pandemic.
- 2.2 The emotional and physical toll the pandemic has taken on our colleagues should not be underestimated. During 2021/22 staff absence remained high as the virulent Omicron variant meant that many colleagues either had the virus or were self-isolating to protect the vulnerable and control the spread of COVID-19. Improving staff experiences and wellbeing will continue to be one of the Trust quality priorities for 2022/23.

3 Proposal, conclusions recommendations and next steps

- 3.1 The Trust Quality Account 2021/22 has been published on the Trust external website on the 30th June 2022 in line with national requirements.
- 3.2 In 2022/23, we will focus our quality priorities on the following three themes:
 - A. Patient safety
 - B. Better patient experience and outcomes
 - C. Improving the experience and wellbeing of our colleagues
- 3.3 Stakeholder comments on the Trust Quality Account 2021/22 are included as appendices.

- 3.4 In order to measure Trust achievements on quality priorities we have proposed for 2022/23, a set of indicators are included in this year's Quality Account to measure our success. The indicators proposed are aligned with the Trust operating plan for 2022/23.
- 3.5 Delivery of the quality priorities will be monitored quarterly by the Quality and Patient Safety Group and reported to the Quality and Clinical Governance Committee.

4 Action required from the Board/Committee

- 4.1 The Committee is requested to note the Quality Account 2021/22 publication on the Trust external website in line with national requirements.

APPENDICES

Appendix 1: BHT Quality Account 2021/22

OUTSTANDING CARE

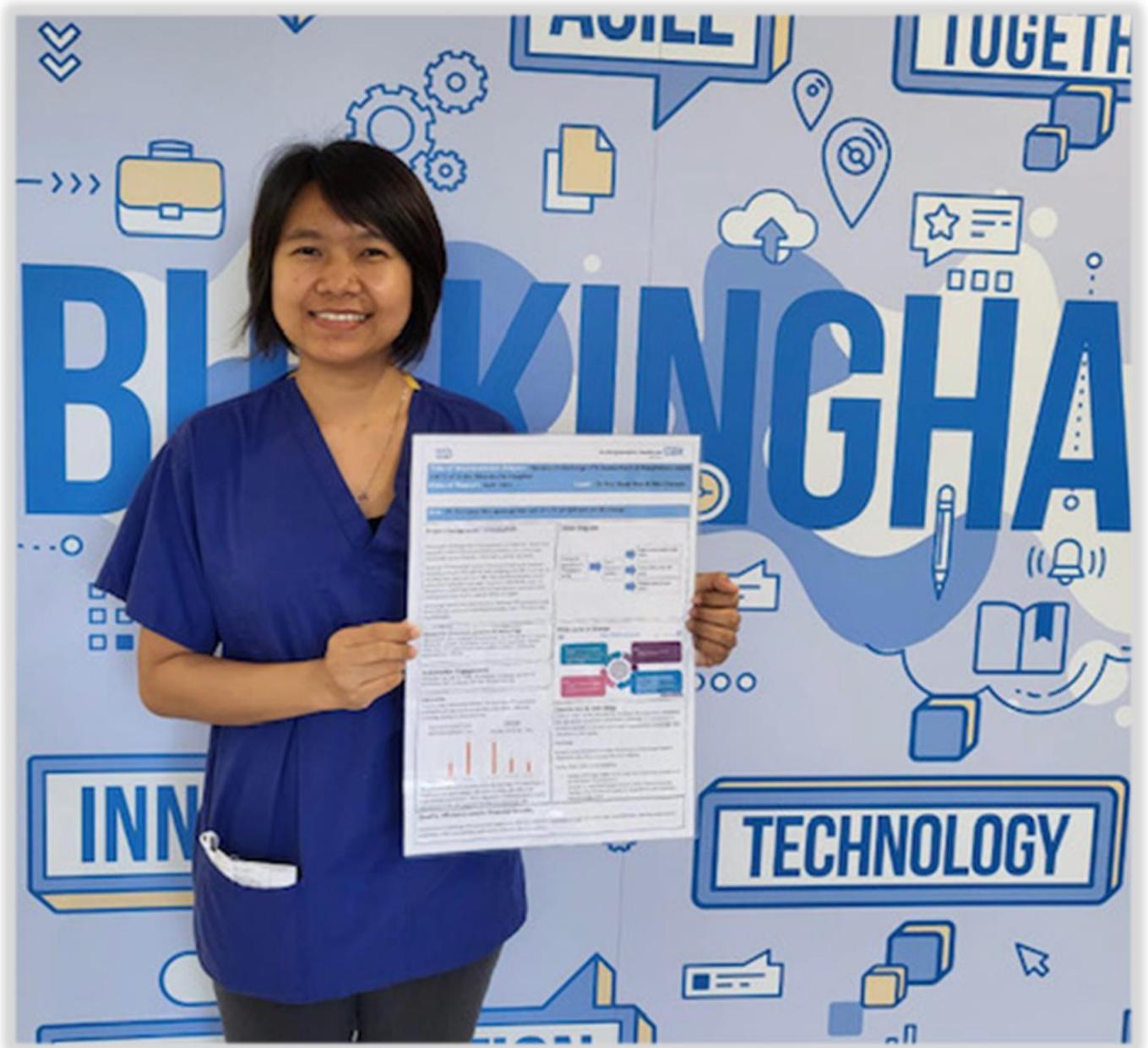
HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK



Buckinghamshire Healthcare
NHS Trust

Quality Account 2021/22



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Part 1: Quality Summary

Introduction

The Quality Account is an annual account to the public about the quality of services that we provide and deliver, and our plans for improvement. This report is designed to assure our local population, our patients and our commissioners that we provide high quality clinical care to our patients. The Quality Account includes an assessment of our performance last year and our priorities for the coming year. This document includes indicators to measure our performance against the priorities we have set for 2022/23.

Over the last two years, during the COVID-19 virus global pandemic, the Trust's main goal has been **to protect the most vulnerable, keeping its patients and colleagues safe.** This year's Quality Account reflects the continued hard work and resilience of our people in helping us to achieve this goal.

The publication of this document is one of the ways in which we can share how we measure the quality of care we are providing to our patients. It includes feedback from our stakeholders on how well they think we have performed.

The Quality Account has been reviewed by the Quality and Clinical Governance Sub-Board Committee and the Trust Board.

Your Feedback

If you have any comments or suggestions on this Quality Account, we welcome your feedback. Please contact Ms Karen Bonner, Chief Nurse, by email at: bht.pals@nhs.net.

Statement on Quality from the Chief Executive

In last year's Quality Account, I described 2020/21 as a year like no other. Little could I have imagined that 2021/22 would, in many ways, be even more challenging.

During the first year of the pandemic, our primary objective was to keep our patients and our colleagues safe, ensuring that we could continue to provide care to those that needed it most. This remained paramount throughout last year as COVID-19 continued to be prevalent in the community.

The emotional and physical toll the pandemic has taken on our colleagues should not be underestimated. During 2021/22 staff absence remained high as the virulent Omicron variant meant that many colleagues either had the virus or were self-isolating to protect the vulnerable and control the spread.

In line with national guidance, non-urgent elective procedures were suspended at the height of the pandemic. All services were re-started during 2021/22 and we have been trying our best to see the many patients now waiting.

Thanks to the dedication of our colleagues, we have significantly reduced the longest waits. At the heart of this has been working more closely with patients to create individual plans for their care. Pre-operative assessments have been combined with outpatient appointments to create a one-stop shop approach, reducing the time and number of visits before operations. Where possible, operations were moved from inpatient stays to day cases meaning that patients did not have to stay overnight in hospital and more operations could be carried out. Working in partnership with other local NHS trusts and private hospitals we have been able to offer more choice of locations for treatment and increase capacity for operations.

We have continued to look after the most vulnerable in the community and, together with our partners in health and social care, we are supporting families in Buckinghamshire to provide the right healthcare support in the right setting at the right time. Another year of the pandemic has had a profound impact on our children and young people that will continue to be felt across all our services for many years to come.

Meeting the changing needs of the population, especially those living in deprived areas, will require significant transformation of how we and our partners provide care. There is high demand for care and people have increasingly complex needs. In Buckinghamshire alone we are expecting significant population growth.

One of the key pillars of our new vision is to provide outstanding care. To achieve this will involve developing new ways of working, creating new partnerships as well as requiring investment in new facilities, equipment, technologies and innovation. The priorities we set were focused on the following three themes:

- Providing outstanding, best value care;
- Taking a leading role in our community; and
- Ensuring our workforce is listened to, safe and supported

You can read more about the progress we have made against these in this year's Quality Account.

We would like to thank the public for their continued patience as we work tirelessly to see people as quickly as possible, which we will do based on clinical need. We have been overwhelmed by the continued generosity shown to us by local businesses and members of the public.

Last, but by no means, least, I would like to thank my colleagues, our partners and our volunteers. I am extremely proud of the way they have continued to respond to the most difficult of situations.

Signature:  Date: 29 June 2022

Neil Macdonald
Chief Executive
Buckinghamshire Healthcare NHS Trust

Trust Profile

Buckinghamshire Healthcare NHS Trust is a major provider of integrated hospital and community services for people living in Buckinghamshire and surrounding counties. Our 6,000 colleagues provide 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, for our patients. Our highly trained doctors, nurses, midwives, health visitors, therapists, healthcare scientists and other support colleagues deliver our services from a network of facilities including a range of community settings:

- health centres
- schools
- patients' own homes
- community hospitals
- community hubs

Our main hospital sites are:

Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL

Wycombe Hospital, Queen Alexandra Road, High Wycombe, HP11 2TT

Our main community facilities are:

- Amersham Hospital, Whielden Street, Amersham HP7 0JD
- Buckingham Hospital, High Street, Buckingham MK18 1NU
- Chalfont & Gerrards Cross Hospital, Hampden Road, Chalfont St Peter SL9 9SX
- Marlow Community Hub, Victoria Road, Marlow SL8 5SX
- Thame Community Hub, East Street, Thame OX9 3JT
- Florence Nightingale Hospice, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL
- Community Neurorehabilitation Service, Rayners Hedge, Croft Road, Aylesbury, HP21 7RD
- Brookside Clinic, Station Way, Aylesbury, HP20 2SR

Our Trust Headquarters is based at:

Stoke Mandeville Hospital.

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

Part 2: Review of Our Achievements

The priorities we set in 2021/22 were focused on the following three themes:

- Provide outstanding, best value care;
- Taking a leading role in our community; and
- Ensuring our workforce is listened to, safe and supported.

The aim of the Quality Account is to review performance against our priorities and to outline focus areas for 2022/23. This section of the document will outline the Trust's achievements against our priorities last year and demonstrate the improvements we have delivered.

Our Approach to Quality Improvement

The Trust has a three-year Quality Improvement (QI) strategy to embed quality improvement across the organisation. Our improvement methodology is underpinned by the national 'Model for Improvement' and Quality, Service Improvement and Redesign (QSIR). We also use other methodologies including Lean and Appreciative Inquiry and we have a targeted programme to build QI capabilities across the Trust at all levels.

Taking a structured approach to improvement facilitates our ability to support change at both an individual, team and organisational level. Using robust methodology not only provides a deeper understanding of what the problem is, but also helps to understand the problem from multiple perspectives.

A central team (QI & Transformation) is in place to lead the implementation of the QI strategy and support colleagues to deliver a safe, quality patient care and efficient healthcare service.

A QI approach has been taken to improve the top three safety issues and put in place an improvement plan for falls, pressure ulcers and medicines management. As a result, there has been a reduction in falls, with moderate harm falls having reduced from 20 (2020/21) to 16 (2021/22) and Serious Incidents declared from 13 in 2020/21 to two in 2021/22. There has been a reduction in the number of category 2 pressure ulcer (PU) cases reported and PU cases declared as Serious Incidents with two in 2021/22 compared to 13 in 2020/21.

The QI & Transformation team is currently working with the nursing team and others on a programme of reducing variation in practice across the wards, including optimising board rounds and implementing electronic whiteboards to improve patient flow.

During 2021 bespoke virtual QI training was developed and by March 2022, 1,038 colleagues had watched our 'Introduction to Quality Improvement' video. A total of 384 colleagues were trained on QI theory and methodology.

Two cohorts of QSIR programmes were delivered with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System Faculty.

During 2021/22, 60 'Projects on a Page' were completed showcasing QI projects, Appreciative Inquiry reflections and improvement work following audit. Close collaboration

with the Clinical Effectiveness Team has been developed and the teams deliver joint monthly drop-in sessions for doctors in training. 'Projects on a Page' were showcased along with engagement activities for colleagues during World Quality Week, with the theme of sustainability.

By March 2022 there were 121 registered users on LifeQI (a platform to support and share improvement projects) and 62 registered improvement projects. Work is ongoing with the Patient Experience Team to increase service user involvement in QI work.

Examples of QI stories can be viewed in the following video;

<https://youtu.be/FzfwZpKqnnA>



Our community rapid response and intermediate care team has received some excellent patient feedback.

NHS
Buckinghamshire Healthcare NHS Trust

“We're so proud of our QI work which improved patient safety by reducing pressure ulcers on our ward by 70%. Such a rewarding result!”

KELLY, HEALTHCARE ASSISTANT

WORLD LEADER IN QUALITY WEEK 2021 Quality Improvement QI@BT

@BHTQI #WQW21 REDUCING PRESSURE ULCERS

NHS
Buckinghamshire Healthcare NHS Trust

“Using ‘Plan-do-study-act’ with feedback and engagement from colleagues, we've made sustained change managing post-partum haemorrhage.”

JAYNE, LEAD MIDWIFE AND MARIA, CONSULTANT

WORLD LEADER IN QUALITY WEEK 2021 Quality Improvement QI@BT

@BHTQI #WQW21 MEASURING MATERNAL BLEEDING



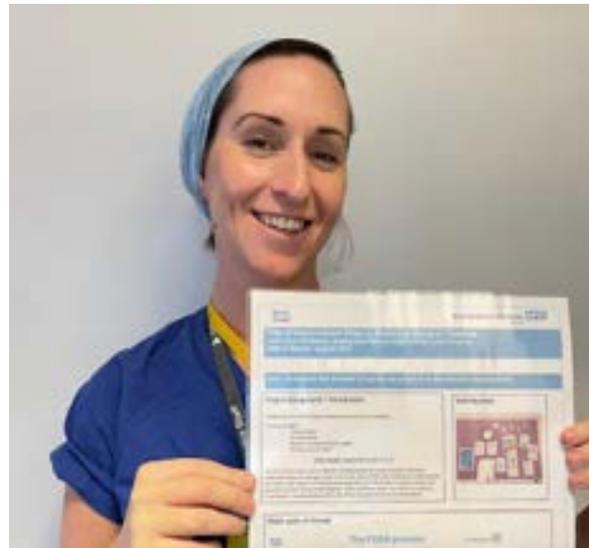
NHS
Buckinghamshire Healthcare NHS Trust

“Using qFIT homebased testing for bowel cancer is more comfortable for patients, reliable and more cost effective. Definitely a win-win.”

ARNOLD, CONSULTANT SURGEON

WORLD LEADER IN QUALITY WEEK 2021 Quality Improvement QI@BT

@BHTQI #WQW21 HOMEBASED CANCER TESTING



Provide outstanding, best value care

Overview of patient safety incidents and safety alerts

This section sets out the Trust's work and progress during 2021/22 in relation to reporting, management and learning from safety alerts, and patient safety incidents including Serious Incidents (SIs) which includes Never Events, detailing trends across types of incidents, categories and severity of harm.

Our starting point is how well we meet our obligations to patients and/or families for Duty of Candour (DoC) compliance in terms of deadlines but also assurance on the fundamentals of conversations with patients and/or families in order to ensure consistency and quality.

Patient safety reporting data for 2021/22 – both patient safety incidents and the much smaller number of incidents which meet the criteria of Serious Incidents – are provided. Not all Serious Incidents result in severe harm or death, but they may be significant in that they have implications for learning within the local healthcare system, as they have the potential to lead to severe harm or death.

A strong reporting culture is encouraged across the organisation to support continuous improvement through learning and improvement activity, thus enhancing patient safety and patient experience. Incident reports are uploaded to the National Reporting and Learning System (NRLS).

The NRLS is one vehicle by which national patient safety alerts are identified, enabling collective understanding across the healthcare community about risks in the systems such as medication, a product in use, or a clinical intervention which may then need to be responded to as a national patient safety alert.

An overview of data on the Trust's performance for reporting patient safety incidents and sharing them with the NRLS is provided.

High quality investigations are conducted, and reports written, mindful of the principles of a just culture which support consistent, constructive and fair evaluation of the actions taken by colleagues involved in a patient safety incident. Collaborative work Trust-wide has given the just culture ethos visibility, and has set the tone and approach within incident and serious incident reporting to ensure that weaknesses in care and identified risks are considered through a system lens rather than being considered the result of solely one individual's actions.

Duty of Candour

The Duty of Candour is integral to providing high quality healthcare through the adoption of the principles of being open, transparent and candid with a patient and/or family and acknowledging that an incident or event has not gone well. It is a statutory, regulatory and legal requirement. Through investigating an incident or event, colleagues are able to look closely at the circumstances and learn how we could do things differently, or reference what happens when a similar event goes well, in order to provide a better service in the

future. Where an incident is identified as of moderate or greater harm, the Trust must disclose this information to the patient and/or their family within 10 working days. As such incidents are uploaded to NRLS. The Care Quality Commission can access the detail through their access to NRLS.

172 of the 192 reported incidents meeting the criteria for Duty of Candour in 2021/22 achieved the 10-working day deadline for compliance. The delay in the remaining 20 cases was mostly due to staff absence.

Incident reporting

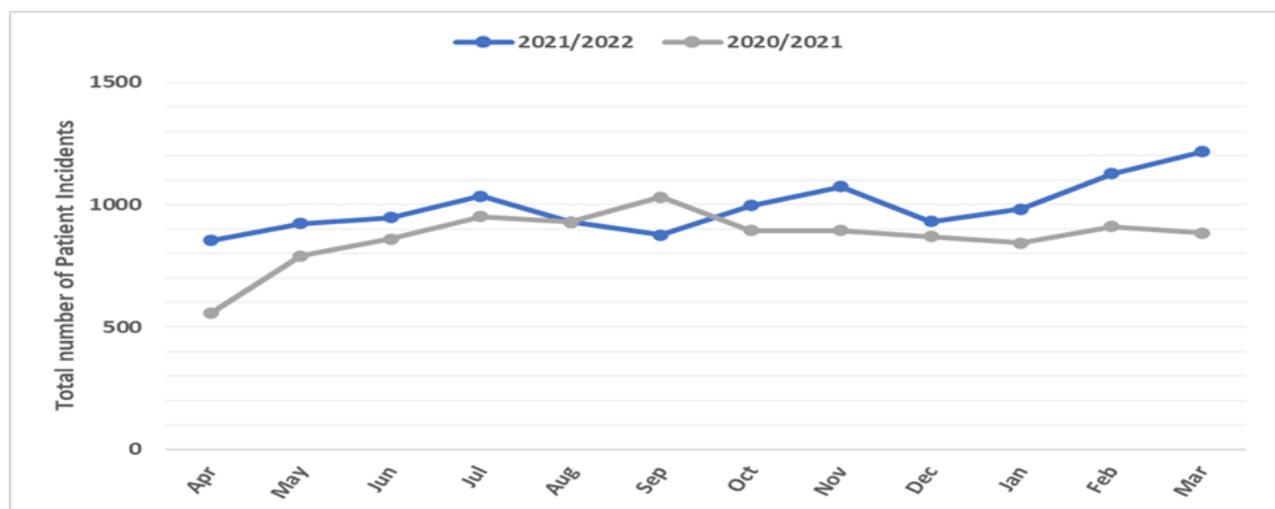
During 2021/22, as in previous years, the Trust's electronic incident report system (DATIX) had limited functionality.

In April 2022, the DATIX system was upgraded. In addition to reporting incidents, complaints and claims, the new systems will also enable us to more effectively track audit and risk management.

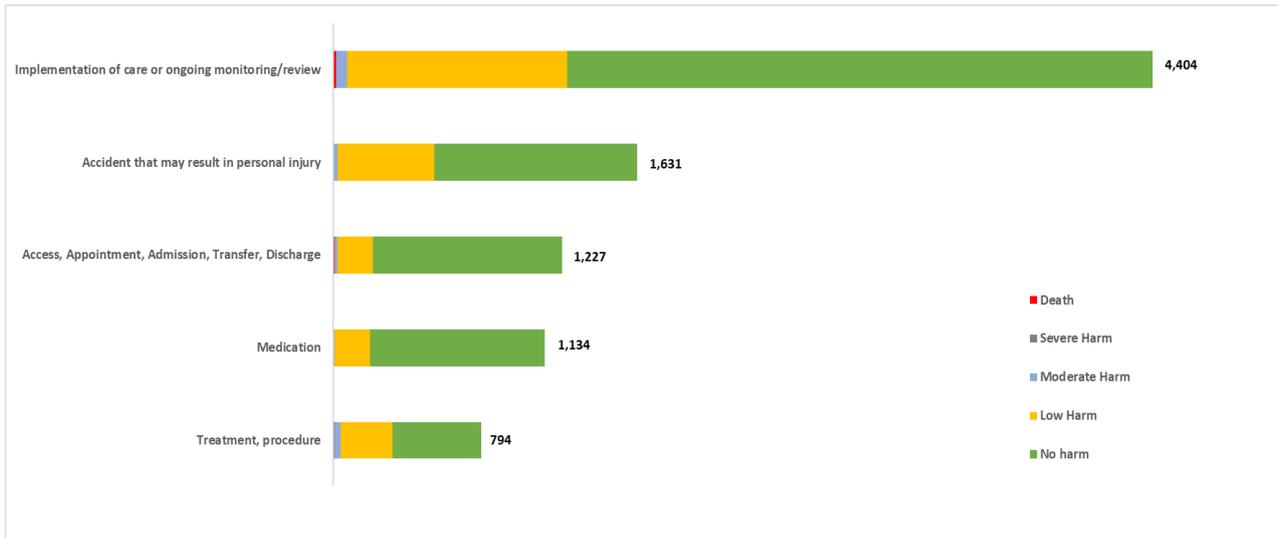
Trends in reporting patient safety incidents

A total of 11,899 incidents were reported on DATIX during 2021/22. This is a slight increase in comparison to previous year total of 10,414 incidents, attributable to levels of activity returning to pre-pandemic levels. High reporting of incidents is an indicator of a mature patient safety culture and incident reporting is valued within the Trust as a way of identifying risks and learning.

Monthly patient safety reporting 2021/22 compared to 2020/21



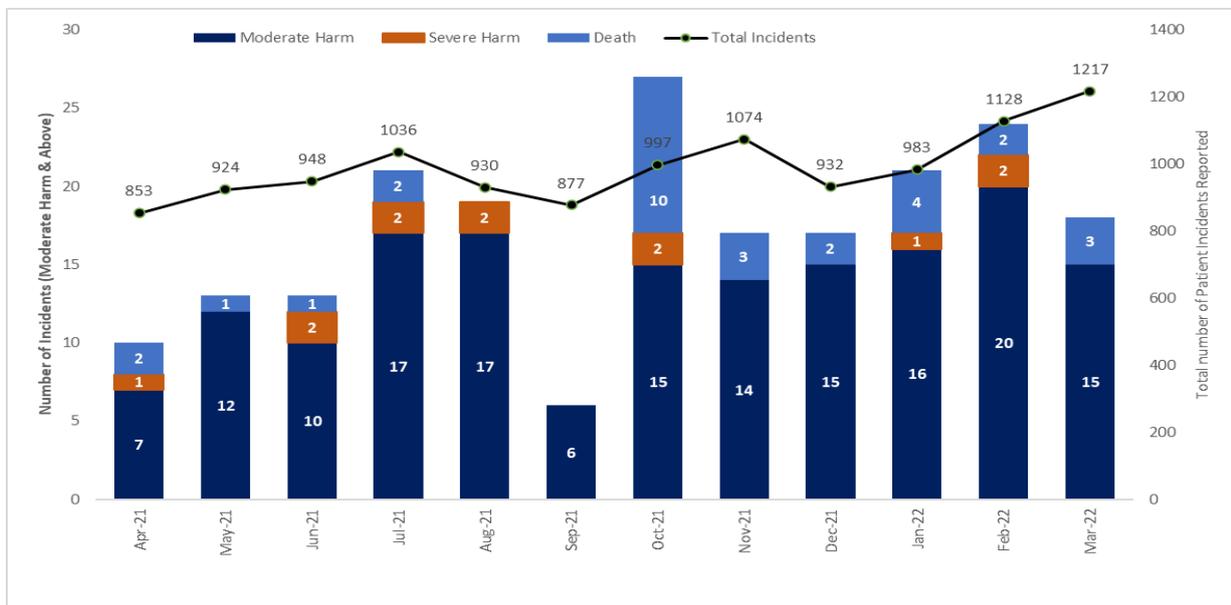
Top five themes in patient safety related incidents in 2021/22



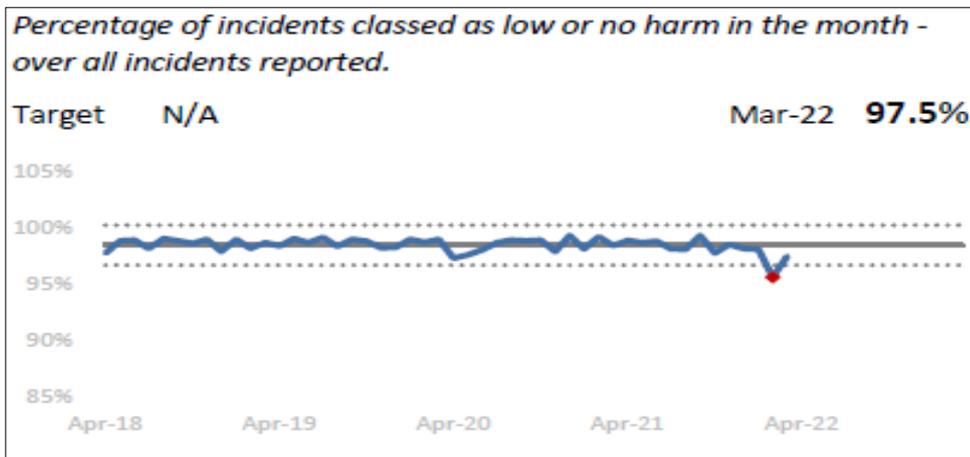
Incident reporting by severity

The chart below illustrates the number of patient safety incidents reported by level of harm/severity, shown against the trend in overall incident reporting. Out of 11,899 incidents reported on DATIX in 2021/22, 98% were either low harm or no harm incidents. All incidents are reviewed and investigated within the divisions and those of moderate and greater harm considered for closer scrutiny as potential Serious Incidents.

Monthly patient safety incidents 2021/22 by severity



Incidents that are low/no harm



The Statistical Process Control (SPC) chart above is based on four year's data. The two limit lines (grey dotted lines) around the central average (grey solid line) show the range of expected variation in reported results based on what has been observed before.

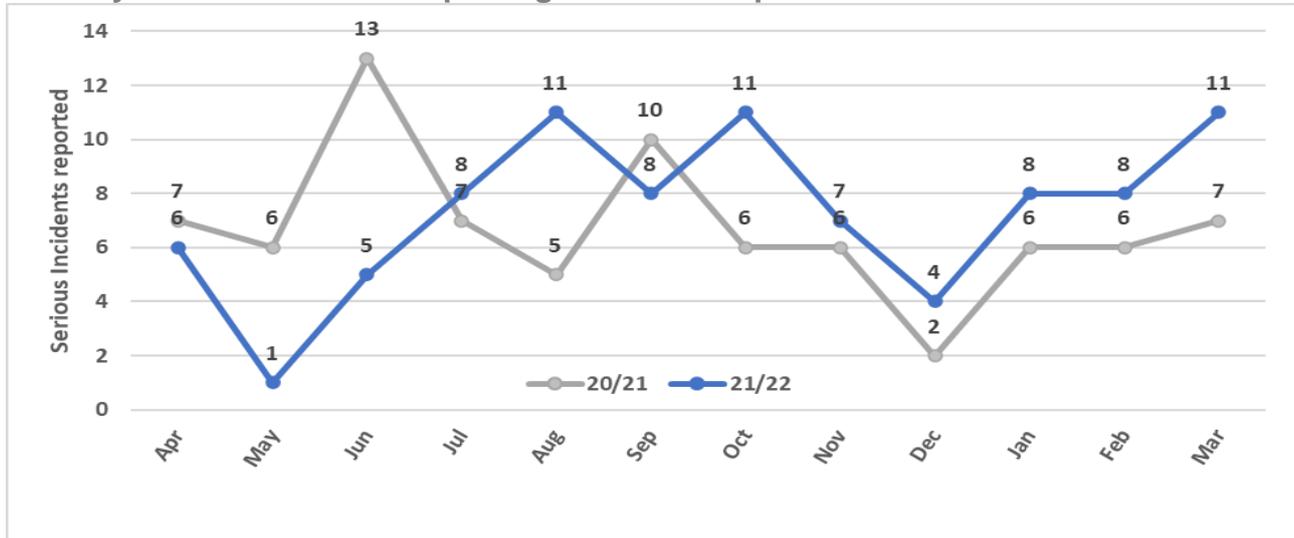
Serious Incidents

During 2021/22, the Trust confirmed 88 incidents met the NHS England Serious Incident criteria and were logged on the national database – the Strategic Executive Information System – compared to 81 in 2020/21.

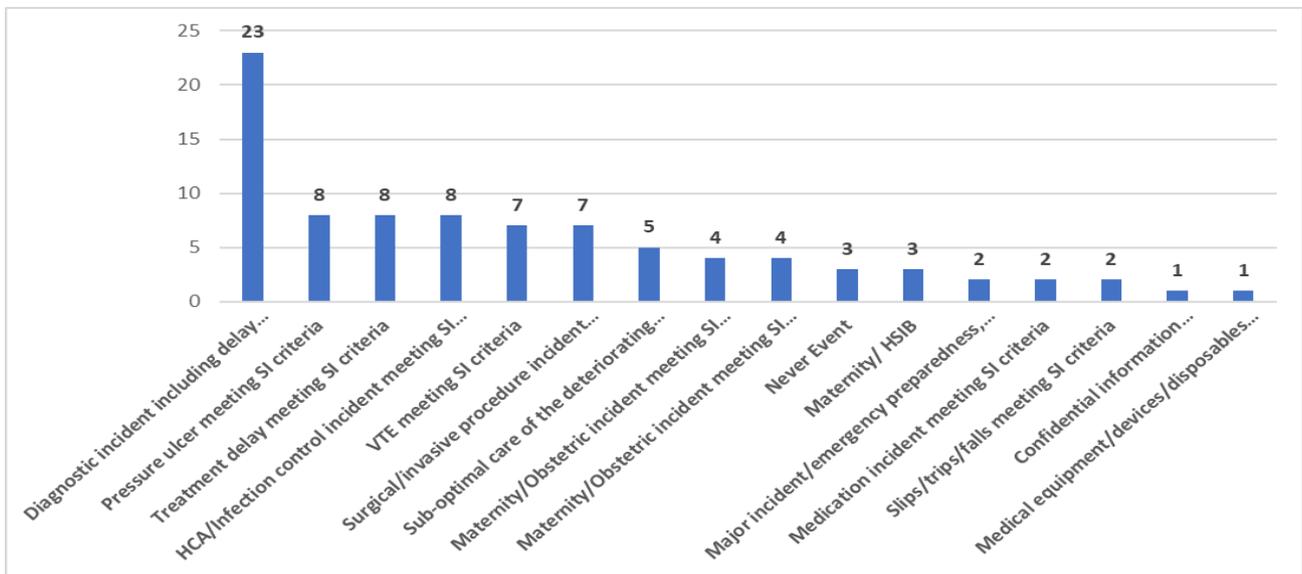
This highlights an expected slightly upward trend as the Trust moved into the recovery position of the pandemic and was able to increase appointments and procedures, and resume provision of a wider range of services. The Trust is committed to reducing incidents of greater harm and significance. At the same time, it is committed to maintaining high reporting of near misses and no harm and low harm incidents as these provide early warning signals for areas we need to focus for improvement before greater harm occurs.

At the start of 2022/23, The Trust introduced a revised approach to the management and review of Serious Incidents, with oversight at a weekly Executive-led Serious Incident Executive and Divisional Management Panel.

Monthly serious incidents reporting 2021/22 compared to 2020/21



The table below highlights the categories of serious incidents by volume, reported in 2021/22.



Diagnostic incidents are the highest volume category – a category which covers any type of diagnosis, but also includes delays in diagnosis – some of which will be attributable to backlogs due to the pandemic.

Learning from Never Events

There are few Never Events. These are rarely attributable to one practitioner and often found to involve a set of circumstances for which each individual aspect – perhaps inconsequential on its own – collectively then creates an environment in which a Never Event can occur. The Healthcare Safety Investigation Branch (HSIB), National Learning Report (January 2021) ‘Never Events: analysis of HSIB’s national investigations’ concluded that ‘...for many Never Events, including all those investigated for this report, there are no strong and systemic barriers.

During 2021/22 the Trust reported three Never Events as listed below, compared to three in 2020/21 and a target of zero. Robust Serious Incident investigation reports and action plans are always undertaken for all Never Events, approved by an Executive Director.

The three Never Events were each reported as Serious Incidents in October 2021 – with two of the incidents occurring in October and one in August (the issue had not been immediately recognised as meeting Never Event criteria, until the investigation was underway). Listed below are the three Never Events reported and key actions taken:

1: Unintentional connection of patient to air instead of oxygen

Key actions:

Temporary cap for all air inlets replaced with permanent cap, except in paediatrics, in collaboration with estates team.

All wards have received portable nebulisers negating the need for piped air. Estates maintained the record of machine asset numbers where devices have been deployed.

2: Retained foreign object post procedure

Key actions:

Reduce disruption or distraction during swab counts. Swab counting procedure reviewed in theatres and monitor implementation of ‘Time Out’ for scrub team.

Every theatre has a Trust standardised dry wipe swab count board and positioned to be visible to Scrub practitioner and ‘Circulating Team’.

Swab and Instrument Count policy reviewed, and implementation monitored.

3: Wrong implant/prosthesis (ophthalmic lens)

Key actions:

World Health Organisation (WHO) Cataract Surgical Safety Checklist reviewed, and compliance monitored through an audit programme

Dissemination of learning from incidents and Serious Incidents

There are a range of forums – formal and informal - through which learning from incidents is shared, including Academic Half Days, Chief Nurse learning forum and bite size training sessions. A 'Big 4 Safety Messages' poster is issued fortnightly which highlights identified safety issues, identified through audits or incidents.

Each week the Chief Nurse and Chief Medical Officer share key safety messages from subject matter experts (often linked with national health awareness days and always with patient experience a focus) in the Trust- wide daily newsletter and on the Trust's intranet. Topics in 2021/22 have included World Aids Day, Venous Thromboembolism (VTE), safe support of patients with Parkinson's Disease, Stop the Pressure (pressure ulcer prevention) and the importance of nutrition and hydration to patient safety.

WHO World Patient Safety Day

World Health Organisation (WHO) World Patient Safety Day was celebrated on 17 September 2021 with a week of events which focused on the WHO designated theme of safe maternal and new-born care with a call to 'Act now for safe and respectful childbirth.'

The week was used as an opportunity to highlight patient safety activity and initiatives such as safety huddles.



Care of the Deteriorating Patient

The Trust has made many improvements over the previous year in care of the deteriorating patient. Deteriorating patients are those patients who may become acutely unwell during their hospital stay. Early intervention and timely management are key to best outcomes.

The Trust has introduced a 24/7 Critical Care Outreach Team (CCOT) which comprises of nurses and practitioners with acute and critical care experience to care for acutely unwell patients across our hospitals. The service is activated via the National Early Warning Score (NEWS) – an illness severity score advocated for use in all acute trusts. These practitioners have an extended skill set to deliver care at the bedside with a view to avert further deterioration or, where not possible, facilitate timely admission to our Intensive Care Unit. In April 2022, this service was extended to our Wycombe Hospital site.

In February 2021, we launched an Emergency Department Deteriorating Patient Group. This has led to a NEWS escalation pathway for deteriorating patients as well as the introduction of electronic observations (Eobs) providing surveillance of patients' observations across the organisation. This system called Careflow Vitals is used by clinicians to access real-time data in terms of monitoring vital signs. The Critical Care Outreach Team also accesses this system to provide a response to deteriorating patients.

Training and education are key to improving care and empowering ward teams in caring for deteriorating patients. The CCOT now have an Outreach Practice Development Nurse who has led training in the care of acutely unwell patients across ward areas. The CCOT also has a dedicated physiotherapist who provides focused rehabilitation for long term intensive care patients until they are discharged from hospital. Improvements to this patient pathway have been commended by the regional Oxford Intensive Care Society

Further service improvement has led to the opening of an enhanced maternal care facility within obstetrics. This is a two-bedded facility for mothers who require further support and intervention either pre- or post-labour, supported by the CCOT. This is the first facility of its kind in the region and ensures that mothers can remain with their babies.

Sepsis

Sepsis can be a primary cause of deterioration. As sepsis is a time-critical treatment, all adult patients arriving at the Emergency Department are screened for the condition – sepsis suspicion intravenous antibiotics (IVAB) are recommended within one hour of diagnosis. The Trust's Eobs system also has an electronic sepsis screen. When patients reach a score of five on NEWS, a sepsis screen is triggered. If high risk sepsis is identified this triggers an electronic time clock over one hour for delivery of appropriate treatment which includes administration of IVAB.

The time of sepsis suspicion to time of antibiotics is audited quarterly and the Trust achieved its set target of 90% compliance.

As an organisation we learn and adapt to improve care for our patients. One such example is "Remember Ben", a case presentation of a Serious Investigation which has led to Trust-wide change and is used as part of our educational strategy for sepsis. A presentation and video were created with the kind permission of Ben's mum.

Pressure Ulcers

The most common sites for pressure ulcers (PU) to occur are the sacral area (buttocks) and heels. This is consistent with nationally reported figures.

During 2021/22, the Trust reported 56 category 3 and 4 PU – an increase compared to the 46 cases reported in 2020/21.

31 of these were in the community and 25 in hospitals. Six of these were declared as a Serious Incident compared to 16 in 2020/21.

There has been a reduction in the number of category 2 PU with 315 cases in 2021/22 and 325 in 2020/21. A PU reduction QI project was carried across the Trust which includes a driver diagram and implementation plan.

Category 3 and 4 PU 2021/22

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Serious incidents
2018/19	4	1	1	1	2	0	3	2	2	2	5	5	28	9
2019/20	2	3	4	6	5	1	6	0	2	5	4	5	43	10
2020/21	3	2	5	6	3	6	5	4	2	4	2	5	47	16
2021/22	6	4	4	8	8	2	3	7	6	3	3	2	56	6

Category 2 PU 2021/22

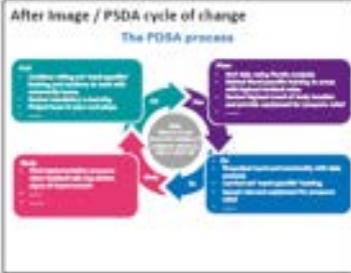
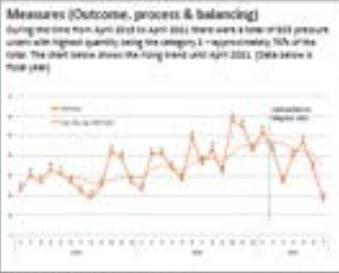
	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
2018/19	29	21	16	19	19	18	11	16	27	13	18	13	220
2019/20	19	26	18	21	21	20	14	17	26	34	30	16	262
2020/21	15	28	29	22	20	33	26	29	21	38	33	31	325
2021/22	33	25	14	15	26	23	21	23	37	36	27	35	315

Title: Pressure Ulcer Reduction
Date: December 2021 **Lead: Julie Sturges**

Aim: To reduce the incidents of category 2 pressure ulcers

Project background / Introduction
 Throughout the trust there has been pressure ulcer prevention projects that have been completed, but this information is not widely shared and not widely accepted. There are posters and training that have been issued, however engagement appears limited in terms of keeping the techniques to prevent pressure ulcers from developing. Additionally, when an inpatient pressure ulcer has developed, the team report the issue, they have seen to the PUs team to advise. There is only a small focus usually seen for all of Bucks. QI theory has not really been used much, however there is activity in some wards, for instance Chesham has completed work on pressure ulcers with great success. As of October 2020 pressure ulcer incidents had peaked at an average of 10 over 20 months – see chart below for further details.
 This is Project on a page is part of an ongoing Quality Improvement Project which is aiming to significantly reduce the incidents within the Trust.

- Driver Diagram (Change Ideas)**
1. Meet with the 10 highest incident wards & 7 community teams with individual reports on universal demographics - **Complete**
 2. Team & PUs to formulate individual improvement plans for wards and community - **Complete**
 3. Create individual/local improvement plan specific to ward - **Complete**
 4. Create overarching community improvement plan - **Complete**
 5. Audit of compliance & trial of alternative risk assessment tool of "Purple P" - **Complete**
 6. Formulate paper to propose change to "Purple P" to Quality & patient safety committee - **Complete**
 7. New designation system distributed to all areas - **Complete**
 8. Meet to hear feedback from PUs accident practitioners - **Ongoing**
 9. Identify suitability by PUs to all areas on their data reports - **Ongoing**
 10. Update patient information system on prevention of pressure ulcers - **Awaiting CIP review (2022)**
 11. Update mandatory pressure ulcer screening protocol - **Not started**
 12. Trial to introduce clothing adjustment - **Not started**
 13. Provide DR (DRUG) on admission to ward & on transfer between areas - **Complete**
 14. Formulate new monthly report to focus on themes and learning for quality and patient safety committee - **Complete**
 15. Two incidents to be discussed at monthly pressure ulcer meeting to disseminate learning - **Not started**



Stakeholder Engagement
 The PUs team worked with QI on identifying a pilot of below (included in the Driver diagram above) and then they worked with the wards (and community teams) that had the highest incident rates of pressure ulcers to engage staff at all levels.

Outcome / benefit

Outcomes	Benefits
• Fewer incidents of pressure ulcers	• Better patient outcome
• Improved and updated training	• Reduced need for medical surgery
• Reduced length of stay	• Better staff awareness
• Better sharing of information	• Reduced cost of inappropriate care

Conclusion & next steps
 Traditionally the pressure ulcer reduction effort was a bottom approach, whereas using the QI approach, this has resulted in a targeted, practical plan. As can be seen from the date analysis of the project, the team identified the areas with the highest incidents and worked with those teams initially. Moving forward the team will continue to work with those same teams but include further teams to ensure that the improvement effort continues throughout the rest of the trust. Additionally, there are several change ideas that will be initiated in 2022, which will continue to better the pressure ulcer reduction plan.

Title of Improvement Project: Falls Reduction 2021 Update
Date of Report: Dec-21 **Lead: Angela Brooke**

Aim: To reduce inpatient falls

Project background / Introduction
 This is an update report from the Trust-wide Falls Working group, this quarter the group has focused on:

- developing BHT inpatient falls mandatory training, advertising and monitoring compliance
- investigate the best Falls alarm product and incorporate existing details and best practice into Falls Policy
- Produce and share PUs about the 5 key areas for improvement based on the Falls Safe Audit

Falls Plan - 5 Objectives - [https://www.bhcths.uk/Document/2021/01/2021%20Falls%20Plan%205%20Objectives%20-%2020210124.pdf](#)

- Invite Division Clinical Governance leads to Trust-wide Falls meeting for next round analysis of DATSI learning from 20
- Develop local Falls improvement plans



Improvement

Month	Incidents
Jan 2020	17/104
Feb 2020	15/104
Mar 2020	13/104
Apr 2020	12/104
May 2020	11/104
Jun 2020	10/104
Jul 2020	9/104
Aug 2020	8/104
Sep 2020	7/104
Oct 2020	6/104
Nov 2020	5/104
Dec 2020	4/104
Jan 2021	3/104
Feb 2021	2/104
Mar 2021	1/104
Apr 2021	0/104

Outcome
 During the last quarter new documentation was produced staff training was completed, in the last 24 months there has been only 1 serious incident related to an inpatient fall, prior to this in the space of 9 months 12 20 were declared leading to falls.
 The number of falls was trending down but during November there was an increase in falls from PUs in one Division area in particular one ward. A specific, targeted and supported action plan has been developed.

Conclusion & next steps
 Next Steps:

- Embed completion of Falls practice audit
- Encourage progress with local improvement plans despite to clinical area as embedding support from Clinical Governance Leads
- Develop Trust-wide patient Falls leaflet
- Develop more detailed reporting in new DATSI

Quality, Efficiency and/or Financial Benefits: The cost of falls to health & social care is estimated at £2.3 billion (NICE 2005). Increasing hospital stay by an average of 4 days, affecting economies and reducing quality of life particularly in older people (75% occur in patients over 65).

Falls

Inpatient falls are one of indicators of the quality and experience of patient care. Despite progress identifying causal factors, falls remain nationally a significant healthcare problem, with an average of 250,000 in-patient falls per year (NHS Improvement, 2017) and a rate of 6.6 per 1,000 occupied bed days (OBD) in an acute setting (Royal College of Physicians).

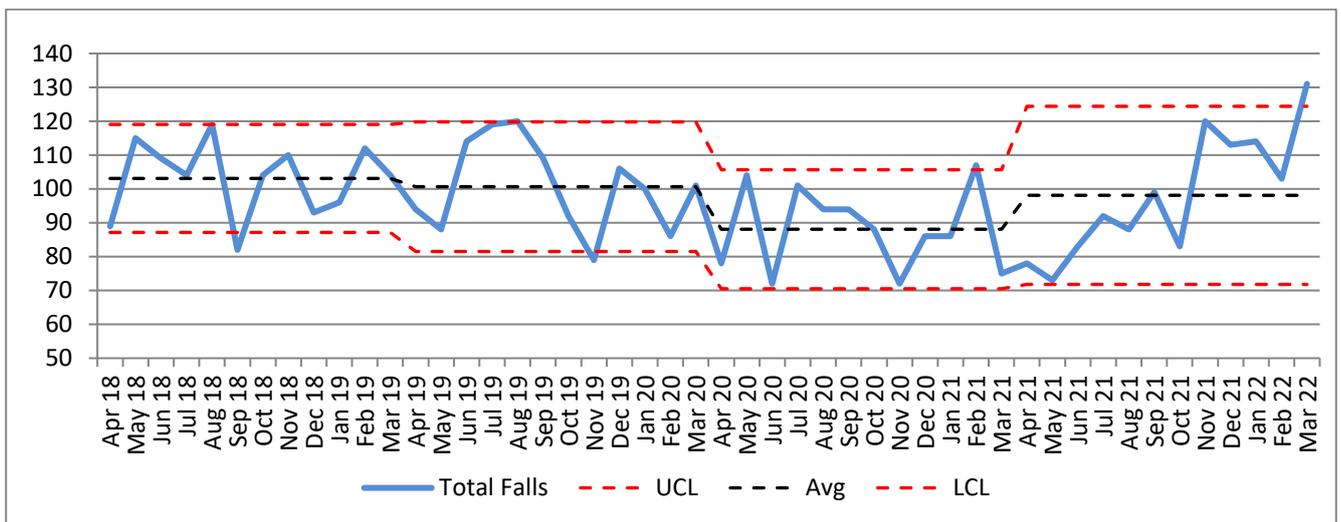
The Trust's inpatient average falls rate of 5.0 per 1,000 OBD in 2021/22 remains below the national average.

A new Trust falls documentation was produced in 2021/22, supported by additional training for colleagues. In 2021/22 there were two Serious Incidents related to an inpatient fall which is lower in comparison to 2020/21 when there were 13 Serious Incidents reported relating to falls.

Patient falls declared as Serious Incidents (SIs) 2021/22:

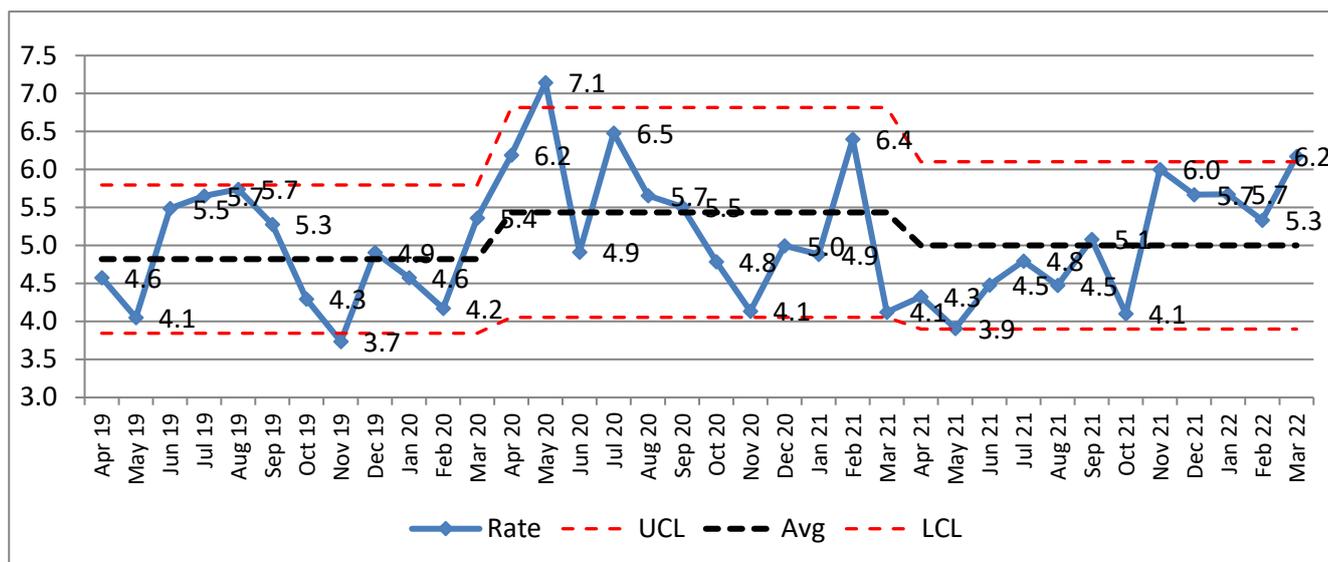
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2017/18	1	1	1	0	3	0	0	0	0	2	1	0	9
2018/19	2	1	0	1	0	0	0	3	1	1	2	1	12
2019/20	2	0	2	2	2	1	1	0	2	0	0	2	14
2020/21	3	2	5	0	1	2	0	0	0	0	0	0	13
2021/22	0	1	0	0	0	0	0	0	0	0	1	0	2

Inpatient falls 2021/22



Time series graph above shows performance over time with three reference lines; average (Avg), Upper Control Limit (UCL) and Lower Control Limit (LCL). The two limit lines (red dotted lines) around the central average (grey dotted line) show the range of expected variation in reported results based on what has been observed before.

Inpatient falls per 1,000 occupied bed days 2021/22



Emergency Department

Our Emergency Department (ED) has been under intense pressure. There has been an increase in attendances with 146,022 in 2021/22 compared to 105,786 in 2020/21 although numbers are still below pre-pandemic levels with 159,066 attendances in 2019/20. Waiting times have deteriorated with 75.2% of people being seen within the 4-hour target compared to 83.4% in 2020/21.

Many people are now attending ED that have previously delayed attendance, either through fear of catching COVID-19 or not wanting to burden the NHS. As a result, many of them are more acutely unwell and their length of stay is longer than the average pre-pandemic. In addition, at any one time we have circa 80 patients who are well enough to go home but cannot be discharged without an additional package of care being in place. We are working closely with other health and social care providers in the county to address this issue.

Urgent and Emergency Care

We have been working hard to improve the patient experience for people who come to our Emergency Department as we know that current waiting times are not acceptable. The aim is to help our patients to be seen in the right place, by the right people first time.

At the beginning of 2022, we changed the way we assess people when they arrive at our Emergency Department to ensure that they are seen as quickly as possible by the right service, bringing together our GP service, Minor Illness, Minor Injuries, a new Urgent Treatment Centre and the Emergency Department in one place at Stoke Mandeville Hospital. We have also introduced new models of care with an additional 10 advance care practitioners and 13 physician associates appointed.

We are actively encouraging patients who are not in a life-threatening situation to contact NHS 111 (either by phone or on-line) so that their clinical needs can be assessed and they can be directed to the right place whether that is their own GP, local pharmacy, the Urgent Treatment Centre or the Emergency Department. We have increased the number of appointment slots available in our Emergency Department so that people can arrive at their allotted time and reduce waiting times.

We have been working closely with our ambulance provider, South Central Ambulance Service, to help direct patients to the right place or to help them in their own home setting.

Urgent Community Response

Urgent Community Response (UCR) is part of the Ageing Well Programme which aims to provide fast support to people in their usual place of residence (either their own home or a care home) as an alternative to being taken to or admitted to hospital. In Buckinghamshire, UCR is delivered by the Trust's Rapid Response and Intermediate Care service (RRIC) along with the district nursing and respiratory services. RRIC also works closely with other health and social care partners to deliver person-centred care to improve patient outcomes and help older people to maintain an independent life for as long as possible.

The Buckinghamshire, Oxfordshire and Berkshire West ICS was one of the first seven areas in the England to introduce UCR as part of the Ageing Well Programme. Referrers include Emergency Departments, NHS 111, South Central Ambulance Service (SCAS), GPs, health and social care professionals and care homes.

RRIC is made up of physiotherapists, occupational therapists, health care assistant practitioners and assistants. During 2021/22, we recruited nurses and paramedics to improve response times and the breadth of care the team can provide.

A two-hour response is typically required when a person is at risk of admission (or re-admission) to hospital due to a 'crisis'. Where a person is not in a 'crisis' situation, but needs to be seen as soon as possible, we aim to see them within two days to prevent further deterioration and keep them safe at home.

By the end of the year, the Trust exceeded its targets of seeing 80% of 'crisis' cases within two hours and 80% of non-crisis patients within two days.



During 2021/22, 5,388 patients were referred for an urgent community response – 3,037 of these were for a two-hour response.

During 2022/23 we aim to increase the number of referrals, particularly from SCAS, NHS 111, Emergency Departments and GPs, to reduce the number of people taken to or admitted to hospital. One of the ways we hope to achieve this is by closer collaborative working with SCAS. In February 2022, we started a pilot to award honorary contracts for SCAS specialist practitioners to join the Trust’s RRIC team. Following the success this pilot, we are planning to increase the number of SCAS specialist practitioners working as part of the team.

Children’s Emergency Department

Work is well underway to create a Children’s Emergency Department and improve maternity and gynaecology facilities at Stoke Mandeville Hospital, which will open late Autumn 2022.

In 2020 the Trust won a bid for £15m of capital funding which will enable us to offer upgraded, expanded facilities and a new overnight observation ward. Not only will the new building provide a dedicated area for children, it will also free up much-needed capacity for adult patients in the existing emergency department, as well as reduce overcrowding and improve infection control. The plans also include new facilities to improve access to our maternity and gynaecology outpatient services in a modern, purpose-built environment.

Referral to Treatment (RTT)

During 2021/22 the average performance for RTT for admitted pathways (i.e. those who required a stay in hospital) was 64.7% of patients waiting 18 weeks or less. Thanks to the efforts of our teams, the Trust has made good progress for the admitted pathway and is

now operating close to the pre-pandemic performance of 67.7% and an improvement on last year's performance of 61.7%.

However, unsurprisingly, performance for non-admitted pathways (i.e. those who were treated as outpatients and did not require an overnight stay in hospital) has deteriorated since last year with 67.9% of patients seen within 18 weeks compared to 75.6% in 2020/21 and 85.6% in 2019/20, Unlike some trusts, Buckinghamshire Healthcare NHS Trust kept open its waiting list during the pandemic. We are also seeing large volumes of people who chose to delay their treatment at the height of the pandemic, either through fear or not wanting to put extra pressure on the NHS, now ready to be treated.

Our focus remains on recovering patient waiting times. Through the hard work of colleagues and new innovative approaches, the Trust has significantly reduced the longest waits for its patients. Working more closely with patients to create individuals plans for their care has been at the heart of this. Pre-operative assessments were combined with outpatient appointments to create a one-stop shop approach for patients reducing the time and number of visits before operations. Operations were moved from inpatient stays to day cases meaning that patients did not have to stay overnight in hospital and more operations were able to be carried out. We also worked in partnership with other NHS trusts and private hospitals to offer more choice of locations for treatment and increase capacity for operations.

By March 2022 there were two patients waiting over 104 weeks for their treatment compared to seven in March 2021. Long waiting patients and those with the highest risk of clinical harm continue to be prioritised and booked accordingly. This prioritisation order is set out below:

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

Governance processes have been set up to monitor the number of patients waiting, length of wait and associated P category to manage risk from longer than desired waits.

At the end of February 2022 there were 36,240 patients with open pathways and waiting for assessment and/or treatment, with 4,429 waiting over 52 weeks. This is compared to September 2022 when there were 37,590 patients with open pathways and 5,160 waiting over 52 weeks.

Cancer

Cancer services have continued to be a priority and have remained open throughout the pandemic.

During 2021/22 there was an increase in patients referred into the Trust on a cancer pathway rising to 456 per week compared to 350 per week in 2020/21.

91.3% of these patients were seen for the first time within two weeks, against a target of 93%.

85% of cancer patients are expected to receive their first treatment within 62 days, and this was challenging in 2021/22 with 47% meeting the target. There has also been an increase in patients waiting over 104 days, rising to 50 over the winter period but decreasing to 18 in February 2022. We aim to diagnose and be able to inform the patients of next steps within 28 days, and 70.5% of patients met this timeline with a target of 75%.

Whilst it is disappointing that the Trust did not meet some of its targets during this year, this in part was because we continued to prioritise patients by clinical need. This means that patients who had already breached the target time-limit were not deprioritised in favour of patients who were about to breach. Governance processes are in place to ensure patients on our waiting lists are regularly reviewed by clinicians and we have continued to use telephone consultations.

Recovery is a priority, reducing the waiting time for treatment and decreasing the number of patients waiting. This will be achieved by increasing diagnostic capacity and theatre treatments.

Maternity Services

Throughout the last year, our obstetrics and midwifery teams have continued to provide maternity care throughout the antenatal, labour and postnatal period. During the year, 4,786 babies have been born either at home, the Aylesbury birth centre or the consultant-led labour ward at Stoke Mandeville Hospital.

During 2021/22, we were able to resume face-to-face appointments and reinstate the attendance of partners at scans and antenatal appointments. We were also able to welcome two birth partners during labour, which we know was really important to families.

Several quality service improvements have been made including:

- Achievement of stage 1 of our baby friendly initiative accreditation journey.
- Implementation of an enhanced maternal care pathway. This collaborative project between obstetrics, anaesthetics and midwifery enables more mothers with complex pregnancies and their babies to remain together after birth.
- Setting up a maternal mental health services pathway in collaboration with our partners in Bucks perinatal mental health team and Oxford Health to support those that needing expert psychological support during or after pregnancy.

Ockenden Report

The Ockenden Report was commissioned following a review at Shrewsbury and Telford Hospital NHS Trust in response to a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital.

Our maternity team committed to ensuring the seven immediate and essential actions and 12 clinical priorities of the interim Ockenden report published in December 2020 were met. These actions and priorities are directly linked to ensuring high standards of quality and safety in maternity care and that informed decision making underpins every person's pregnancy and birth experience.

Assurance was provided at the public board on 30 March 2022 that 120 of the 122 requirements had been met and all 122 requirements had been achieved by 2 April 2022.

The final Ockenden report was published on the 30 March 2022 and outlines a further 15 immediate and essential actions which all maternity services across the country should look to implement as soon as possible. The maternity team is committed to ensuring this happens.

We would like to thank the Maternity Voices Partnership who have made sure that the voice of women and birthing people has been heard throughout the year and kept our parents and families updated with any changes and support available. We will continue to work collaboratively to co-design services and work in partnership to provide inclusive, personalised maternity care that meets the needs of all our people and reduces health inequalities in the year ahead. We are grateful for the feedback from families received through the Maternity Voices Partnership and have captured some of these below:



Notification of high outlier status for National Neonatal Audit Programme (NNAP)

As part of its annual reporting process, the NNAP conducts unit level outlier analysis on six audit measures for 2020 data. The purpose of the outlier process is to identify and highlight variation, enable local review of the causes of that variation and stimulate quality improvement.

In January 2022, the Trust received notification from the Royal College of Paediatrics and Child Health confirming that Stoke Mandeville Hospital had been identified as achieving outstanding for the audit measure 'follow up at two years of age'.

Taking a leading role in our community

COVID-19 vaccination programme

The Trust continued to support the COVID-19 vaccination offer for the general public and by the end of March 2022 had delivered approximately 50,000 vaccinations to the local community of Buckinghamshire.

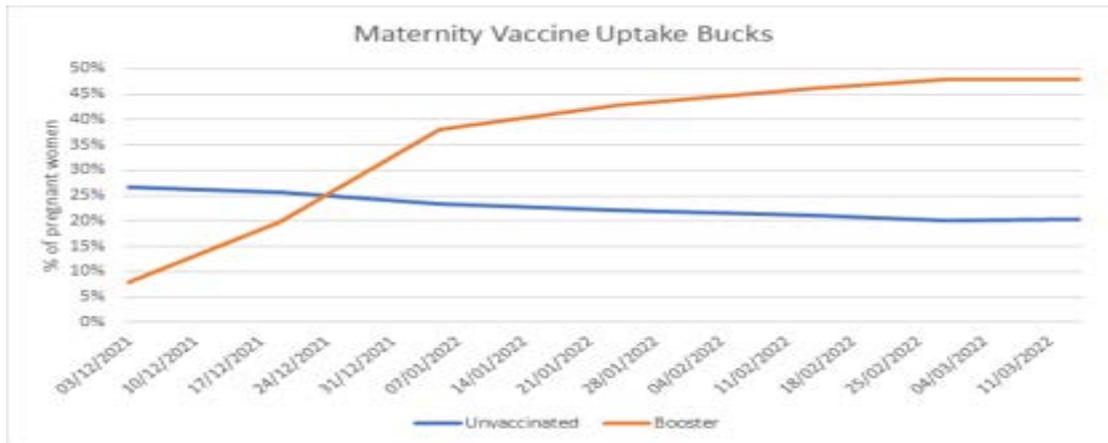
As part of the Trust's commitment to tackle health inequalities in Buckinghamshire there have been several vaccination sessions and informative webinars offered to vulnerable and hard-to-reach groups.

These included myth-busting webinars for those who were pregnant or planning to start a family, specialist high risk allergy clinics and specialist vaccination sessions for the LGBTQ+ community and those with learning disabilities or autism. These sessions for people in Buckinghamshire with learning disabilities or autism were fully booked and feedback was very positive,

"Thank you for the amazing job you did with our kids today. Neither of them batted an eyelid because of the lovely way you had set things up for them. In a world where we fight so hard for accommodations for our kids, it was a joy to see them so easily and skilfully accommodated today."

The Trust's aseptic pharmacist led the setting up, training and implementation of national policies in local vaccination centres across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS).

The Trust's Standard Operating Procedure for vaccinating pregnant women was shared and adopted across the BOB ICS. In November 2021, the Trust's vaccination team identified that pregnant women were less likely to have the COVID-19 vaccine. To make this as easy as possible for them, as well as being able to provide all the relevant information for pregnant women to make an informed decision, a vaccinator was available within the maternity unit. This proved to be a successful model which was subsequently adopted at a BOB ICS level and resulted in the introduction of maternity vaccine champions across the ICS.



Upper Limb Studio at the National Spinal Injuries Centre (NSIC)

The Upper Limb Studio has been highly commended in the Acute Sector Innovation of the Year category at the 2021 Health Service Journal (HSJ) Awards, recognising their diligence and commitment to the healthcare industry across the past 12 months.

Commenting on the commendation, HSJ Editor Alastair McLellan said, "We believe the Upper Limb Studio really holds the value of the HSJ Awards – in terms of sharing best practice, improving patient outcomes, and demonstrating innovation – at the centre of what they do."

The inspiring initiative, which started at the beginning of 2021, provides one-to-one and group therapy for spinal cord injured patients. This is carried out by Occupational Therapists who are specifically trained in the principles of Activity Based Restorative Therapy, which is an important and growing area of spinal cord injury research. Therapists will work with a patient using a range of carefully selected rehabilitation technology in a designated purpose-built environment to facilitate repetitive movement in order to achieve functional activities with a particular goal in mind such as feeding, drinking, return to driving, carrying out aspects of personal care, and return to work. Using technology to support their upper limbs during therapy helps patients gain greater confidence and independence following a spinal cord injury.



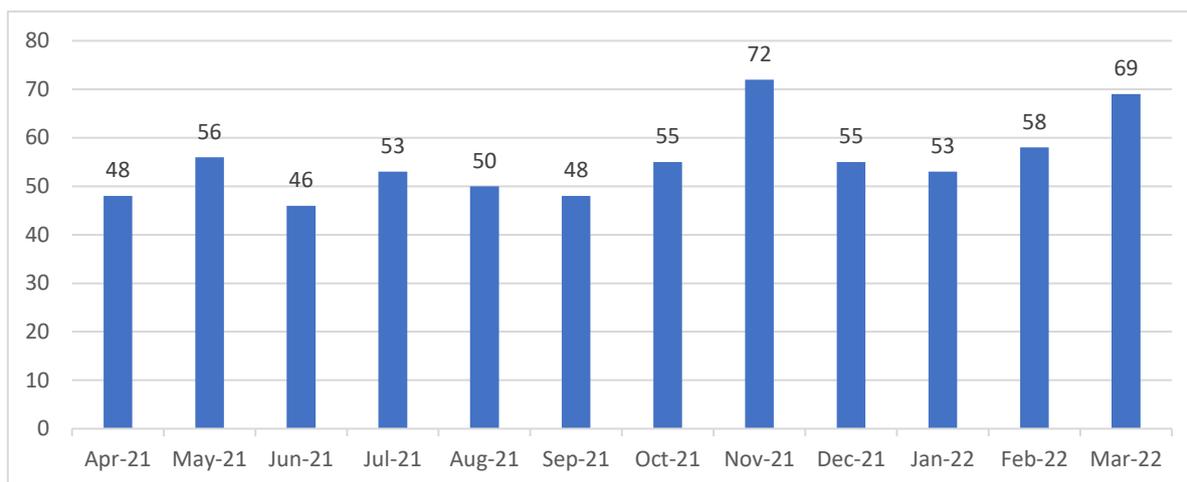
Patient Experience

Complaints

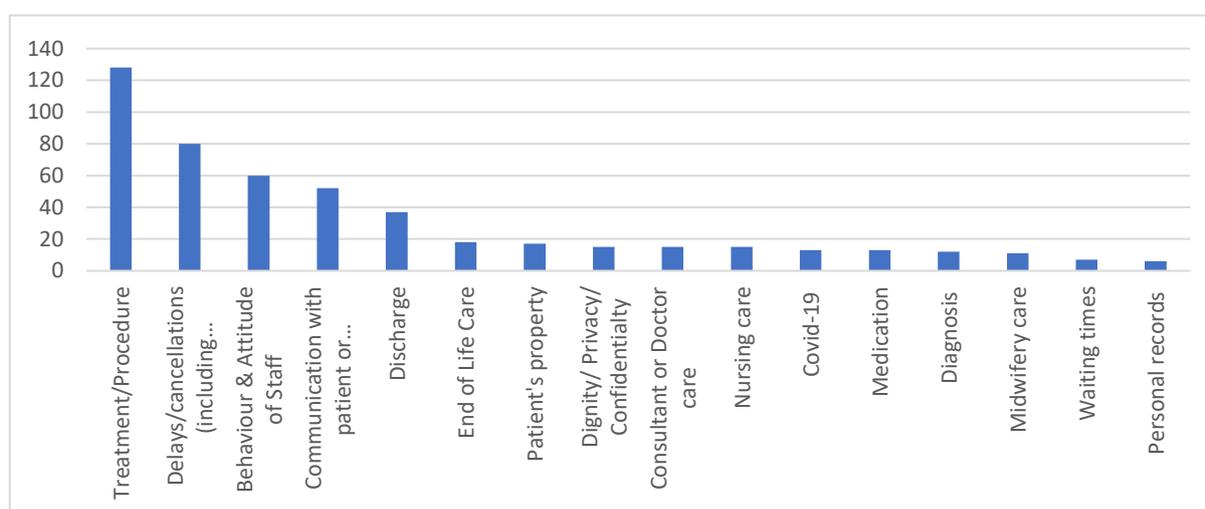
In 2021/22, the Trust received 663 formal complaints compared to 556 in 2020/21 – a 19% increase. Restrictions to visiting, changes to the hospital estate, and the move to remote appointments as a result of the pandemic, all impacted on patients' experience of the Trust's services. The Emergency Department (ED) received the highest number of complaints, reflecting the operational pressure within the department. Experience of treatment and procedures was the subject of the most complaints, followed by delays and cancellations.

We worked in partnership with the Trust Patient Experience Group and patient partners to develop new ways to support patients. This included implementing virtual visits, the Letter to Loved one service, volunteers in ED and wayfinding volunteers.

Monthly complaints received 2021/22 (total: 663)



Complaints themes 2021/22

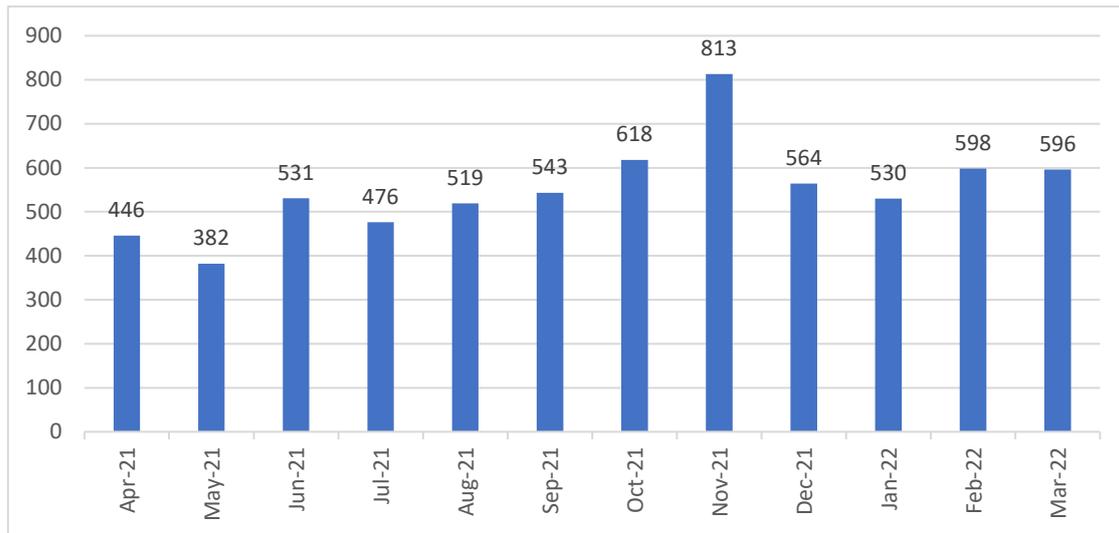


*complaints lower than 5 were not included

Patients Advice and Liaison Service (PALS)

In 2021/22 we recorded 6,616 PALS contacts with people seeking advice and information about our services – an increase of 40% compared to 2020/21 when 4,697 contacts were recorded. Delays and cancellations were the highest category after general information enquiries. These included appointment issues, surgery being delayed or cancelled and waiting times.

Monthly PALS contacts 2021/22 (total: 6,616)



Chaplaincy

The Spiritual & Pastoral Care team continued to offer support to patients, visitors and colleagues. A hospital stay can be emotionally and spiritually unsettling, making it harder for patients to cope with an illness or injury. Spiritual care involves exploring what matters most to patients and can include reflecting together on relationships, activities and beliefs; it has been available to everyone, whether a religious belief is held or not.

The chaplains supported patients receiving end of life care, at times using iPads when family members were not able to visit in person. The team conducted various religious and non-religious services, as well as emergency weddings. The team also provided spiritual support for colleagues, offering a safe environment and a friendly ear to those who were going through a tough time. We were grateful to welcome back volunteers during 2021/22 with 15 new volunteers recruited in September 2021.

**Celebrated emergency weddings for End of Life patients.
(Picture from an emergency wedding at Wycombe Hospital site on 24/04/2022)**



Patient Initiated Follow-up (PIFU)

Traditionally, regular follow-up appointments are arranged within a specific time frame, e.g. every 6 or 12 months. Some patients find these regular visits useful and reassuring but for others it can be frustrating or stressful coming to hospital if they do not feel they need to.

The Trust introduced Patient Initiated Follow-up for suitable patients. In practice this means the patient can arrange a follow-up with the clinical team looking after their care, when they feel they need it or if their systems get worse, within a given timeframe.

PIFU has benefits for both the patient and the Trust. It gives our patients more control over follow appointments, giving them access to support and guidance when they need it most, and for many people it means that they do not need to come to hospital as often. For the Trust, it means that there are fewer patients coming to hospital when they do not need to, freeing up appointments for those that do. It is also beneficial for the environment, reducing our carbon footprint by lowering the number of patients travelling to our hospitals unnecessarily.

By March 2023, the aim is that 5% of our patients will be able to initiate their own follow-up appointments.

Community Diagnostic Centre (CDC)

The Trust has opened a new diagnostics centre at Amersham Hospital. The centre will enable the Trust to offer more appointments for tests such as X-rays, ultrasound and blood tests, reducing waiting times and making it easier for the local community to access these services closer to home. In the future it is also planned that the CDC will offer tests and examinations for patients referred for investigation of heart and respiratory problems. Earlier, faster and more accurate diagnoses of health conditions will benefit our patients and help us improve the health of our local community.

Age-related Macular Degeneration (AMD)

The Trust's Age-related Macular Degeneration (AMD) Clinic celebrated its five-year anniversary with patients, local Macular Society representatives and leaders from across ophthalmology, optometry and the health service at Amersham Hospital in October 2021.

Over the last 5 years the team has conducted over 50,000 consultations with patients and delivered over 41,000 sight-saving injections.

Age-related macular degeneration (AMD) is a common condition for people from their 50s and 60s, and it is the biggest cause of certified sight-loss in adults in the UK. The exact cause is unknown but likely due to many factors such as a family history of AMD, smoking, being overweight and high blood pressure. This can happen gradually over several years with 'dry' AMD, or quickly over days, weeks or even overnight in the case of neovascular or 'wet' AMD. Patients with wet AMD require long-term regular consultations and treatment with injections in the eye at very precise intervals.

By setting up and delivering a service where these patients receive their treatment on time and in the most efficient and safe manner, the AMD clinic has ensured that patients in Buckinghamshire with wet AMD have the best chance of keeping their eyesight, maintaining independence and leading full lives.

The team was also able to adapt quickly to ensure that patients could continue to be treated safely throughout the pandemic at a time when many other teams were having to suspend services. They have also involved patients in research which has given them access to the latest treatments.

Corneal Cross-Linking Treatment

In June 2021, the Trust performed the first NHS corneal cross-linking treatment (CXL) in Buckinghamshire and Oxfordshire at Stoke Mandeville Hospital.

CXL is a treatment for an eye condition called keratoconus, which primarily affects young adults and which, if left untreated, can lead to visual loss and can necessitate more invasive corneal transplant surgery. CXL stops the condition progressing and stabilises the patient's vision.

Previously, our patients requiring CXL had to travel to London to access the closest NHS Provider. We are delighted that we can now offer this procedure here in Buckinghamshire, combining great care with easier access for people locally.

Corneal cross-linking treatment procedure



Improved aquatic therapy facilities at Amersham Hospital

In February 2022, the Trust was delighted to be able to welcome patients to the much-improved hydrotherapy pool at Amersham Hospital. During the COVID-19 pandemic many hydrotherapy facilities in the UK had to close and many have not been able to reopen.

The improved pool opens at a time when hydrotherapy is being promoted nationally for being incredibly important in supporting a variety of patient groups: for example, for post-surgical recovery, for pain management, for patients with rheumatism, for the rehabilitation of neurological patients and to enable certain patients to avoid the need for surgery procedures altogether. As such, hydrotherapy (or aquatic therapy) is considered a key element in the range of strategies that will help to reduce waiting lists in the wake of the pandemic.

With the improved facilities the team will be able to work with small groups of patients, instead of being limited to holding one on one sessions as the previous pool was so small. The bigger pool also enables the physiotherapists to offer an increased variety of aquatic therapy techniques. As well as increasing the size of the pool, improvements have been made to provide ease of access with improved safety measures including level access and non-slip surfaces. A new ceiling track hoist with chair and stretcher allows ease of access to all areas of the pool area and minimises the amount of manual handling required by staff. In addition, the original high ceiling over the pool has been lowered which allows better air temperature regulation and improves energy efficiency.

As a result of the upgraded facilities the hydrotherapy team at Amersham is looking forward to being trained in Ai Chi – an aquatic therapy technique with evidenced improvements in balance, pain, flexibility, mood, memory and function.

The improved aquatic therapy facilities at Amersham Hospital



Health Visiting Service

In February 2022, the Trust's Health Visiting Service Baby Friendly Initiative (BFI) accreditation was reassessed and successful. The assessors said that this reassessment was one of the best they have completed since the pandemic began.

We received great feedback from the assessors and from the mothers that were interviewed and received one of the highest scores ever from mothers, reporting that colleagues are always kind and considerate (98%).

Children and Young People

The Trust, together with its partners in health and social care, is working to support families in Buckinghamshire to provide the right healthcare support in the right setting at the right time.

Another year of the pandemic has had a profound impact on our children and young people that will continue to be felt across all our services for many years to come.

50-75% of our school nurse caseload now is to provide support for children who are struggling to cope emotionally. The service has been restructured so that it can provide a greater focus on early intervention and providing families with online resources and support. Ongoing assessment helps the team to identify emerging or increasing problems before crisis point is reached, providing swift escalation if required.

Our Children and Young People's Therapies Team has also felt the lasting impact of the pandemic. For example, the number of children requiring assessment for an education, health and care plan for speech and language and occupational therapy support rose by 35% from April 2020 to February 2022. To cope with the increased demand, the team launched a new microsite providing easier access to online resources in May 2020 and introduced a rolling programme of online occupational and speech and language therapy

webinars. Extending the support materials, information and advice available online has enabled the teams to continue to support families, schools and nurseries throughout the pandemic.

The pandemic has also impacted on our children's inpatient services. Since September 2020, Buckinghamshire, Oxford and Berkshire West (BOB) has seen a 294% increase in demand for CAMHS Tier 4 services, 50% of those are for young people with eating disorders.

This has resulted in high attendances and admissions to our children's inpatient ward. During 2021/22, we have appointed two CAMHS liaison workers, based on our inpatient ward, to support our colleagues and the young people they are caring for. The number of emergency admissions for children and young people has continued to rise since lockdown ended returning to pre-pandemic levels for example, from January-March 2022 our children's ward was at 90.9% occupancy compared with 79.9% for the same period in 2021 and 65% in 2020.

End of Life (EOL) Care

Our end of life care, rated outstanding in 2019, continues to improve. Figures from an audit in September 2021 show that 87% of EOL patients had a personalised care plan in place – a rise of 8% from 2020. This rise is due to the continued emphasis across the Trust on patient-centred care and the aspiration for all patients on our EOL pathway to receive a good death in line with their wishes and those of their loved ones.

We continue to gather and act on the feedback we receive from patients and families to improve the service experience for all our patients. We collaborate closely with all partners providing EOL across primary care teams, secondary acute and community services including Allied Health Professionals and with social service and third-party care providers. We liaise closely in terms of pharmacy medication provision, observations on patient deterioration and in sharing and facilitating patient and family wishes. We have also expanded our training and education to increase the number of staff with advanced skills in palliative and end of life care.

Hospital Navigator Scheme

The hospital navigator scheme, commissioned by Thames Valley Police, was setup in September 2021 in five participating trusts in the area including in our Emergency Department (ED) at Stoke Mandeville Hospital. The scheme aims to direct young people and adolescents to support and advice that can help steer them away from further injury resulting from self-harm, assault, maltreatment or intoxication.

The scheme is in support of the national violence reduction programme which promotes a public health-based approach to reducing violence among disadvantaged young people. Volunteers work alongside staff in ED who refer patients to the navigator scheme who have come into the department as a result of a violent incident or due to self-harm. In the

period September 2021 to January 2022 the Trust has vetted and trained four volunteers who have supported 23 people, directing them to the most appropriate help and support.

Environmentally friendly research and innovation centre

The Trust has partnered up with the Bucks Local Enterprise Partnership (LEP) to build a new research and innovation centre on the Stoke Mandeville Hospital Site.

The new three-story modular eco-build opened its doors in June 2021 offering modern agile working space to start-up small and medium sized businesses from across the region, as well as housing the Trust's own state-of-the-art Research and Innovation Department.

The centre will add value to the local economy by drawing in some of the brightest and best minds from across Buckinghamshire and beyond to work and collaborate with each other as well as with the Trust's Research and Innovation Department. This in turn will benefit our patients by giving our clinicians direct access to the latest digital health developments, medical technologies and artificial intelligence.

Thanks to our partnership with Bucks LEP, the centre will not only benefit the economy but is good for the environment too. It has been built with 99% recyclable materials, harvests rainwater, is energy efficiency and even features a living wall.

Research and innovation centre



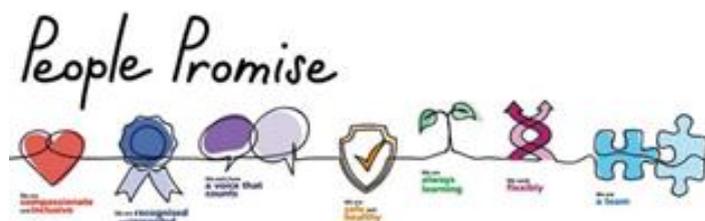
Ensuring our workforce is listened to, safe and supported

The COVID-19 pandemic has placed a significant burden on the NHS workforce. The emotional and physical toll the pandemic has taken on our colleagues should not be underestimated. The last two years have impacted us all in one way or another whether that is personally, professionally or both. During 2021/22 staff absence remained high. Whilst it peaked in January 2022, it remained high to the end of the financial year due to the virulent Omicron variant with colleagues either suffering from the virus or self-isolating

to protect the vulnerable and control the spread of COVID-19. This put additional pressure on our colleagues who were already dealing with an increased workload as they worked tirelessly to provide outstanding care to patients and reduce waiting times.

It is well-documented that when an excellent experience for colleagues is achieved, they become inspired to be the best people they can be at work which in turn delivers the best patient care. We have continued to support our people with the practical aspects of coming to work including suspending parking charges for colleagues, introducing agile working, offering BHT Assist (a free concierge service to help take the hassle out of everyday tasks) and an additional one-off well-being payment in March to help with the rising cost of living.

We know that we need to focus on each area of the NHS People Promise to deliver on our strategic priority of making the Trust a truly great place to work.



As part of this journey, based on the NHS People Promise and feedback from Trust employees, Thrive@BHT was launched in April 2021. It is our roadmap for how Trust colleagues can support each other and care for themselves to create a great place to work by:

- More and continued support for the physical and psychological health of colleagues
- Making sure we get the basics right, including more and improved rest areas and supporting colleagues to achieve a better work/life balance; and
- Creating a place where everyone feels they are treated fairly, with respect and kindness and are valued for the work they do.

This will be further embedded during 22/23 as we have been selected as 1 of 23 exemplar sites for the NHSE/I People Promise Retention Programme.

Supporting colleagues to look after their physical, psychological, and emotional wellbeing has remained a key priority in the Trust. We have been able to build upon the strong foundation of our in-house Occupational Health (OH) and Wellbeing Services, building capacity through a dedicated OH COVID-19 support team and adding to the Wellbeing teams counselling resource, to allow us to provide more outreach work and drop in facilities, for example on site in ICU.

Staff wellbeing

This year the Wellbeing team focus has been on providing a proactive outreach service to ensure all colleagues are aware of the support available and how to access it. This is reinforced through a weekly "Wellbeing Wednesday" newsletter which is sent to all colleagues. We continued with our dedicated professional in-house team of counsellors and wellbeing experts and during 2021/22 supported c1,000 requests for psychological

support and c150 colleagues have attended the proactive 'Understanding Stress, Building Resilience' course. We have delivered mindful sessions to over 200 colleagues and have Mindfulness Ambassadors, who make up part of our group of almost 100 wellbeing champions across the organisation. As part of the Peak one programme, we have provided 112 managers with 'Wellbeing for you and your teams' training.

REACT mental health training has been rolled with the aim of equipping managers, supervisors and those with caring responsibilities to confidently hold support and compassionate mental health and wellbeing conversations. A total of 445 people has been trained with more courses planned for 2022/23.

Recognising the profound impact that the pandemic has had on some of our colleagues we have expanded our Trauma Risk Management (TRiM) programme. TRiM originated in the UK Armed Forces and the model is based on 'watchful waiting' - keeping a watchful eye on individuals who have been exposed to a traumatic event, whether that person has been directly involved or involved from afar. The Trust now has 13 practitioners in place and 25 in training.

We have developed a new offering of half day rest and reflect sessions through social prescribing partnerships with Lindengate, a nature-based health and wellbeing charity based in Wendover, and HorseHeard, a charity which promotes and develops emotional health, wellbeing and resilience through innovative experiential learning programme with horses. During 2021/22 over 400 people have attended sessions at Lindengate or HorseHeard.

We have also provided physical wellbeing support, including a menopause café and wellbeing webinars on several topics, including support for financial wellbeing. We have a dedicated 'Wellbeing Wednesday' weekly bulletin to all colleagues.

Thanks to the Trust's estates team and volunteers relaxing outdoor spaces have been created for colleagues and patients including a courtyard garden at Amersham Hospital.

It is evident from the results that the positive action we are taking to support the health and wellbeing of our colleagues has been recognised and is appreciated. Questions relating to 'my organisation take positive action on health and wellbeing have increased from 39% in 2019 to 42% in 2020 and 68% in the latest survey – 12% ahead of comparable trusts.

Thanks to the Trust's estates team and volunteers relaxing outdoor spaces have been created for colleagues and patients including a courtyard garden at Amersham Hospital.



Courtyard garden at Amersham Hospital

In order to improve the environment for colleagues and patients within the Intensive care Unit (ICU) at Stoke Mandeville Hospital, the ceilings were replaced depicting sunshine and lights.

Brighter ceiling light system in ICU



Wingbee bus

In March 2022, the Trust was delighted to welcome the Wingbee mobile well-being lounge to its Wycombe and Stoke Mandeville Hospitals, giving colleagues the opportunity to take a break in a space away from their usual, and often high-pressured, working environments. The brainchild of two UK airline captains and a clinical psychologist, the Wingbee bus is provided by Project Wingman Foundation Ltd, a well-being charity that supports frontline healthcare staff.



Keeping Our Colleagues Safe

Keeping our colleagues safe will always be a key priority. In addition to ensuring that our colleagues have always had access to appropriate PPE, we have continued with the following measures:

Risk assessments

The COVID-19 risk assessment process is key tool in ensuring the safety of all our colleagues. This was put in place at the beginning of the COVID-19 pandemic to identify and mitigate colleagues' individual risks. Compliance is monitored monthly. New starters and volunteers are risk assessed before they take up their roles.

The Occupational Health team supports all colleagues who were 'shielding' under government guidance, or who have scored '@high' in their COVID-19 risk assessment, including overseeing any change in guidance and supporting colleagues to return safely to the workplace as we move towards 'living with COVID-19'.

Lateral flow testing

All colleagues who come on to site are required to self-test twice a week. This has been key in identifying colleagues who had contracted COVID-19 but were not showing any symptoms helping us to prevent the spread of COVID-19 keeping colleagues and our patients safe.

Management of COVID-19 Infections and Isolation

We established a dedicated COVID-19 team with Occupational Health, who managed all staff tested positive and any isolating staff on a daily basis, with support and guidance to the individual, their families and managers, including keeping colleagues informed and supported through a regular COVID-19 round-up bulletin regarding government guidance.

Staff vaccination

All colleagues have been offered the opportunity to have the COVID-19 vaccine and we continue with an 'evergreen offer' i.e. first, second and booster doses. This is in addition to the seasonal flu vaccine, which is offered to all colleagues. By February 2022, 97% of our colleagues had had their first dose of the COVID-19 vaccine, with 80% having had their second and booster doses.

The high uptake is testament to the excellent provision of the service comprising in-house clinical colleagues and new colleagues recruited in many cases from other industries and volunteers. This was supported by a targeted and comprehensive communications campaign which included webinars with expert panellists, a confidential helpline, the support of our staff networks as well as dedicated support from Occupational Health and Wellbeing team.

Listening to our colleagues

We were extremely pleased given just how busy our colleagues are that over 3,400 colleagues responded to the 2021 national staff survey. At 56% this response rate was well above the average for trusts in our sector which was 46%.

In 2021 the themes in the national survey were changed to align with the NHS People Promise so we cannot run a year-on-year comparison, but we are pleased that as a Trust we scored at or above the national average in 8 out of 9 of this year's themes. We are particularly proud of the fact that 'we are compassionate and inclusive' was the People Promise with the highest ranking and scoring. Significant improvements were seen in colleagues saying they have effective team meetings and that they felt secure to raise concerns about unsafe clinical practice. Questions about our workforce race equality standard showed measurable improvements from last year and whilst our scores are better than average, we know that we still have a considerable amount of work to do in this area.

It is evident from the results that the positive action we are taking to support the health and wellbeing of our colleagues has been recognised and is appreciated. Questions relating to 'my organisation take positive action on health and wellbeing have increased from 39% in 2019 to 42% in 2020 and 68% in the latest survey – 12% ahead of comparable trusts.

Building a Positive Speaking-up culture

The Freedom to Speak Up Guardian (FTSUG) is a designated role which provides a safe place for colleagues to raise concerns safely, without fear of detriment or blame, helping to improve the safety of our patients and colleagues. The FTSUG is a mandatory post for all NHS Trusts in England which also reports to the National Guardian Office thereby offering a level of independence.

Our 'Speaking Up' service has been expanded based on implementing an outreach model and introducing a small number of part-time FTSUG. This has enabled the Trust to increase the accessibility, diversity and visibility of the service, educating colleagues about

the importance of speaking up to the safety of patients and colleagues, achieving an incredible 3,600 outreach contacts in only 10 months.

To support the 'Speaking Up' service, a new 'Speaking Up Champion' role was launched in January 2022. Champions are volunteers, signposting colleagues who wish to raise concerns and promoting a positive Speaking Up culture in their own ward or department. We have already recruited 30 champions, with 19 already fully trained and supporting our outreach programme.

We are proud that our 2021 national staff survey results show that we have again significantly improved our score for colleagues feeling confident to raise clinical concerns – a 10% improvement over the past four years with results significantly better than comparable trusts.

Every year the Trust actively participates in October Speaking Up month. This year the annual and local campaign focused on the launch of mandatory 'Speaking Up' training for all NHS staff. To support this, the team delivered a varied programme of over 30 activities across the Trust.

The Trust also has a Guardian of Safe Working Hours who works closely with our junior doctors to ensure compliance with the 2016 junior doctors' contract. The FTSUG is also someone that they can speak to in confidence regarding any concerns that they have, and they work closely with the Guardian of Safe Working Hours to resolve any issues that are raised.

Trust wide daily safety huddle

Some colleagues reported feeling isolated and unsupported whilst working through the pandemic where operational pressure and staffing shortfalls at its peak due to COVID-19.

The senior nursing and midwifery leadership team identified that there was a need for a daily two-way communication between the Chief Nurse, senior nursing leadership team, heads of nursing and matrons to ensure that all colleagues felt supported, particularly during the Omicron surge, which resulted in high staff absence. As a result, daily safety huddles were established which provide support to senior colleagues, enables the sharing of ideas across the wider forum and facilitates decision-making regarding patient safety and staffing redeployment and patient flow support

The big 4 safety messages poster was introduced in January 2022 based on the quality issues identified, audits results and matrons' quality walkabout. The poster is published every two weeks with QR codes being added to allow all colleagues to report issues and suggest areas for improvement.



Ward Huddles

As a key part of the QI Strategy, the rollout of Quality Improvement Huddles in the wards has continued across the Trust. The ward huddles provide staff with a voice and enable those closest to everyday problems to make changes and improvements to their service improving quality of care, staff wellbeing, efficiency and safety.

In March 2022 there were 42 active QI Huddles within the organisation which have collectively achieved 954 improvements during 2021/22.

Ward huddles attended by different healthcare professionals



Evaluation Results: Staff Feedback



'Good way to get points across; I feel more listened to and part of the team.'

Isobel, HCA



Keeps the ward more organised and working more as a team.'

Mary, Staff Nurse



'Good way for everyone to have a voice, whichever band. Brings out things that not everyone would have thought of....brings improvements in necessary and unexpected areas.'

Jemima, HCA

Mandatory Declarations and Assurance

Mandatory Declarations and Assurance

All NHS Trusts are required in accordance with the statutory regulations to provide prescribed information in their Quality Accounts. This enables the Trust to inform the reader about the quality of our care and services during 2021/22 according to national requirements.

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

The processes for producing Quality Accounts in 2021/22 remain the same as previous years, with the exceptions that for NHS providers, there is no national requirement to obtain external auditor assurance. Approval of the Quality Account from within the Trust's own governance procedures is sufficient.

Statements of Assurance

During 2021/22 Buckinghamshire Healthcare NHS Trust provided and/or sub-contracted six NHS services. These were:

- Emergency Department (also known as Accident & Emergency)
- Acute Services
- Cancer Services
- Community Services
- Diagnostic, Screening and/or Pathology Services
- End of Life Care Services

The Trust has reviewed all the data available to them on the quality of care in these NHS services.

Clinical Audit and National Confidential Enquiries

During 2021/22, 37 national clinical audits covered relevant health services provided by the Trust.

During that period, the Trust participated in 95% (35/37) national clinical audits in which it was eligible to participate and 100% (3/3) of National Confidential Enquiries into Patient Outcomes and Deaths (NCEPOD) studies in which it was eligible to participate.

The national clinical audits that the Trust was eligible to participate in during 2021/22 are detailed in the table below. The table shows which audits the Trust participated in and the percentage of eligible/requested cases submitted.

AUDIT	Applicable overall	Data collection (yes/no)	2021/22 status	% eligible/requested cases submitted or reason for non-participation
CANCER				
Bowel Cancer (NBOCAP)	applicable	yes	participating	Continuous data collection
National Lung Cancer Audit	applicable	yes	participating	Continuous data collection
National Prostate Cancer Audit	applicable	yes	participating	Continuous data collection
GR-gastric Cancer (NOGCA)	applicable	yes	participating	Data submitted through the Oxford Regional Network
National Audit of Breast Cancer in Older Patients (NABCOP)	applicable	yes	participating	Continuous data collection
WOMEN AND CHILDREN				
Diabetes (Paediatric) Audit (NPDA)	applicable	yes	participating	100%
Maternal, New-born and Infant Clinical Outcome Review Programme	applicable	yes	participating	Continuous data collection
National Maternity and Perinatal Audit (NMPA)	applicable	yes	participating	Continuous data collection
National Neonatal Audit Programme (NNAP)	applicable	yes	participating	100%
National Audit of Seizures and Epilepsies in Children and Young People	applicable	yes	participating	Continuous data collection
National Asthma and COPD Audit Programme – Children & Young People Asthma	applicable	no	Registered but not submitting data	No data submitted due to COVID and staffing pressures
CARDIAC, DIABETES AND VASCULAR				
Myocardial Ischaemia National Audit Project (MINAP)	applicable	yes	participating	Continuous data collection
Cardiac Rhythm Management (CRM)	applicable	yes	participating	Continuous data collection
National Audit of Percutaneous Coronary Interventions (PCI)	applicable	yes	participating	Continuous data collection

National Cardiac Arrest Audit (NCAA)	applicable	no	not participating	Trust has its own audit process
National Heart Failure Audit	applicable	yes	participating	Continuous data collection
National Audit of Cardiac Rehabilitation	applicable	yes	participating	Continuous data collection
National Diabetes Audit – Adults	applicable	yes	participating	100%
National Vascular Registry	applicable	yes	participating	Data submitted by the Regional
Rheumatoid and Early Inflammatory Arthritis (NEIAA)	applicable	yes	participating	Continuous data collection
OLDER PEOPLE				
Falls and Fragility Fractures Audit Programme (FFFAP)	applicable	yes	participating	Continuous data collection
Sentinel Stroke National Audit Programme (SSNAP)	applicable	yes	participating	Continuous data collection
National Audit of Care at the End of Life	applicable	yes	participating	100%
National Audit of Dementia (spotlight audit)	applicable	yes	participating	100%
ACUTE				
National Asthma and COPD Audit Programme	applicable	no	participating	Continuous data collection
National Emergency Laparotomy Audit (NELA)	applicable	yes	participating	Continuous data collection
Case Mix Programme (ICNARC)	applicable	yes	participating	Continuous data
Elective Surgery (National PROMs Programme)	applicable	yes	participating	100%
Major Trauma Audit (TARN)	applicable	yes	participating	100%
National Joint Registry Audit (NJR)	applicable	yes	participating	Continuous data

BAUS Urology Audits (complex operations data)	applicable	yes	participating	100%
Emergency Medicine QiP – Consultant Sign Off	applicable	no	participating	Currently collecting data
Emergency Medicine QiP – Pain in Children	applicable	no	participating	Currently collecting data
Emergency Medicine QiP – Infection Control	applicable	no	participating	Currently collecting data
Inflammatory Bowel Disease (IBD) Programme	applicable	yes	participating	Continuous data collection
Society of Acute Medicine Benchmarking Audit (SAMBA)	Applicable	yes	participating	100%
OTHER				
Learning Disabilities Mortality Review Programme (LeDeR)	applicable	yes	participating	100%

National Confidential Enquiry into Patient Outcome and Death	BHT applicability	BHT participation	Participation rate
Transition from Child to Adult Health Services Study	applicable	participated	In progress 3/10 questionnaires submitted to date
Epilepsy study	applicable	participated	4/4 questionnaires submitted
Study of Crohn's Disease	applicable	participated	In progress 0/8 questionnaires submitted to date

National Audits

The reports of 39 national clinical audits were reviewed by the Trust. During 2021/22 and the following are examples of actions taken by the Trust to improve the quality of healthcare provided:

- **National Diabetes Inpatient Audit (NaDIA)** – This is an annual snapshot audit of diabetes inpatient care in England and Wales and is open to participation from hospitals with medical and surgical wards. NaDIA allows hospitals to benchmark hospital diabetes care and to prioritise improvements in service provision that will make a real difference to patients' experiences and outcomes. Following participation in this audit, the Trust has introduced a number of changes to improve patient care including appointing a consultant lead for inpatient diabetes care, prioritising diabetic patients with foot problems for admission to ward 6, providing ongoing staff training days and education sessions for the junior doctors, all wards to stock a range of insulin types in vials and the introduction of hypo boxes on every ward which include abbreviated guidance. The NaDIA is currently suspended, so it has not been possible to measure the impact of these changes.
- **Fragility Fracture Post-Operative Mobilisation National Audit** – This was carried out to better understand current practice regarding postoperative weight bearing for lower extremity fragility fractures in older patients. It looked specifically at the reviewing and documenting of weight bearing status. It is important for this group of patients to mobilise as soon as possible after surgery to help prevent post-op complications such as venous thromboembolism (VTE) or pressure sores. Early mobilisation also helps with rehabilitation and return to independence. British Orthopaedic Association Standards for Trauma (BOAST) state 'all surgery in the frail patient should be performed to allow full weight-bearing for activities required for daily living'. Often mobilisation is delayed because of confusion regarding a patient's weight bearing status. This audit looked at how well this information is documented in patients' notes, communicated between staff and recorded at discharge. Following completion of the audit, posters were displayed in the theatre offices to remind surgeons of the importance of documenting weight bearing status post op. Reminders were also included in the weekly Trauma Handover meetings. Following completion of these initiatives, documentation of weight bearing status on discharge increased from 32% to 59%.
- **UK Parkinson's Audit** – This audit measures the quality of care provided to people living with Parkinson's against a range of evidence-based guidance. The audit takes a multi-professional approach, involving Elderly Care and Neurology consultants, Parkinson's nurses, occupational therapists, physiotherapists and speech and language therapists who care for people with Parkinson's. Following participation in the audit, several assessment tools have been introduced for use at clinical appointments. These include an Activities of Daily Living (ADL) assessment tool, Non-motor symptoms checklist, cognitive assessment tool and a Mood/Anxiety/Depression assessment tool. These will help ensure evidence-based practice is followed when reviewing and assessing patients.

The reports of 82 completed local clinical audits were reviewed by the Trust during 2021/22 and the following are examples of actions taken to improve the quality of healthcare provided.

- **Intensive Care Unit (ICU) Record Keeping** – Recording of a thorough social history can better guide the treatment escalation plans for patients admitted to ICU. Results of a record keeping audit showed that when measured against a set of agreed standardised questions the quality of documentation for social history and frailty was poor. Following completion of the audit, a social history and frailty proforma was designed and trialled. A re-audit was carried out and a significant increase in the quality of documentation was found, with improvements in all domains. The new proforma is now part of the ICU admissions pack and helps guide patient escalation plans. Consideration is being given to extending the use of this proforma to other specialties including Trauma & Orthopaedics.
- **Nasogastric Tube (NG) Insertion Documentation Audit** - An audit of the documentation of nasogastric tube insertions in ICU patients against a set of standardised questions found that the quality of documentation was poor with important information missing from the clinical notes. Following completion of the audit, the NG tube Local Safety Standard for Invasive Procedures (LocSSIPP) was introduced in the department. A re-audit was carried out which showed an overall improvement in the quality of documentation for NG insertions in all but one domain. Without the use of the NG tube, LocSSIPP documentation was variable and poor and, in some cases, missing. The LocSSIPP documentation is now used to record all NG tube insertions in ICU.
- **Gastroenterology** – Results of a re-audit showed overall improvement in compliance with the British Society of Gastroenterology and the Association of Coloproctology of Great Britain and Ireland post-polypectomy and post-colorectal cancer resection surveillance guidelines. Data from the most recent audit show excellent compliance, particularly for patients with colorectal cancer and large non-pedunculated colorectal polyps. There was evidence of clear documentation found in endoscopy reports and clinic/patient letters of the need for surveillance with an appropriate timeframe recorded. There was also evidence of clearly stated justification if surveillance and/or timeframe was not requested.
- **Emergency Department (ED)** – An audit was carried out of patients presenting in ED with an unexplained collapse. Care was audited against NICE Guidelines: Transient Loss of Consciousness in over 16s (CG109) and Falls in Older People (CG161). The results showed that, whilst appropriate referrals were made, many patients did not have a formal diagnosis made. Following completion of the audit, a Collapse ?Cause Checklist was introduced in ED to aid clinicians when assessing patients and to ensure a formal diagnosis can be made and appropriate follow-up established to reduce harm. When a re-audit was carried out, documentation had improved in all parameters and more appropriate diagnoses and follow-ups were being made. The number of differential diagnoses also increased showing awareness is improving amongst clinicians.
- **Palliative Care** – The Purple Rose End of Life Care Plan (PREOLCP) was first introduced in the Trust in 2018. It consists of a six-page document which should be completed contemporaneously and filed in the patient's notes once the decision to

commence end of life care has been made. Since its introduction, annual audits have been carried out to review its use and level of completion and to identify any areas for development. Over the last two years regular education sessions for clinical colleagues have been run by the EoL Team to highlight the importance of using and fully completing the care plan. As a result, an increase in compliance has been seen from 52% in 2019, to 71% in 2020 and 87% in 2021. This year's audit identified the need for improvements in completion of the Daily Symptoms Control Assessments and this will be the focus of education sessions going forwards.

- **Plastic Surgery** – In line with NICE guidance all patients should have their venous thromboembolism (VTE) risk assessed, not just on admission but also prior to discharge from hospital. When the discharge notes of plastic surgery patients were reviewed it was noted that less than 30% had their VTE assessment repeated and documented prior to discharge, that where VTE prophylaxis was prescribed there was often no documented VTE assessment and there was no documented evidence that patients discharged with VTE prophylaxis had been given verbal or written information explaining VTE risks. Following completion of this audit, a programme of training was delivered, and prompts added to both the prescription chart and the discharge letter template to remind colleagues of the need for a VTE assessment on discharge.

Care Quality Commission

Buckinghamshire Healthcare NHS Trust is currently registered with the Care Quality Commission (CQC) under Section 10 of the Health and Social Care Act 2008. The Trust has not participated in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during 2021/22.

During February 2022, the Trust underwent an unannounced inspection against the five key lines of enquiry: Safe, Effective, Caring, Responsive and Well-led within two core services:

Medical care: which includes the broad range of specialties including those services that involve assessment, diagnosis and treatment of adults by medical interventions rather than surgery. Medical care also includes endoscopy services, including:

- acute assessment units (also known as medical assessment units)
- general wards
- specialty wards, including gerontology (also known as care of the elderly) wards.

Surgery: which includes planned (elective) surgery, day case surgery and emergency surgery, pre-assessment areas, theatres and anaesthetic rooms and recovery areas. The surgery core service also includes interventional radiology but not some specialist surgery, including caesarean section, which comes under the maternity core service.

A further, announced **Well-Led** inspection was undertaken at the end of February into March 2022. This Trust-wide assessment takes into account findings across well-led at

service level but is primarily undertaken at a Trust-wide level and includes an assessment of:

- the leadership and governance at Trust Board and Executive team-level;
- the overall organisational vision and strategy;
- organisation-wide governance, management, improvement; and
- organisational culture and levels of engagement.

The Trust expects to receive a draft report from the CQC early in 2022/23. Once finalised the report will be published on the CQC website and will be reported in detail by the Trust within the 2022/23 Quality Account including any areas for improvement identified within the report.

Following the last CQC inspection in 2019, the CQC placed a condition on our registration under Section 26 of the Health and Social Care Act 2008, specifically requiring the Trust to implement an effective system to ensure there are sufficient numbers of suitably qualified, skilled and experienced nurses, healthcare assistants (HCAs) and therapy staff throughout the community health inpatient wards to support the care and treatment of patients. The Trust has taken action to address this and during 2021 successfully applied to have the condition removed.

Further details of CQC inspections and the Trust's current ratings, summarised below, are available at www.cqc.org.uk/directory/RXQ.



Data Quality

The Trust submitted records during 2021/22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data relating to <i>admitted patient care</i> which included the patient's:	The percentage of records in the published data relating to <i>out-patient care</i> which included the patient's:	The percentage of records in the published data relating to <i>Accident and Emergency care</i> which included the patient's:
Valid NHS Number was 99.7% (National Average 99.7%)	Valid NHS Number was 100% (National Average 99.8%)	Valid NHS Number was 99.9% (National Average 98.0%)
General Medical Practice code 100% (National Average 99.7%)	General Medical Practice code 100% (National Average 99.6%)	General Medical Practice code 99.8% (National Average 99.1%)

The Trust's Information Governance Assessment Report is now completed through the Data Security and Protection (DSP) Toolkit. This is an online self-assessment tool that allows organisations to measure their performance against the national data. The deadline for submission of the 2021/22 Toolkit has been extended to 30 June 2022 and work towards achieving the required standard is underway.

The Trust will be taking the following actions to improve data quality:

- Implementation and monitoring of the new Data Quality Strategy to improve data quality. The strategy sets out the Trust's approach for the collection, monitoring, checking and validation of data. The strategy will promote and reinforce the corporate message that data quality is everyone's responsibility.
- The objective of the strategy is to maximise the accuracy, timeliness and quality of data recorded on the Trust's information systems. Initially, the focus of the strategy will be on clinical data and clinical information systems. Key operational data and statutory reporting will also be reviewed and improved.
- A data quality team continuously performs checks for missing NHS numbers, postcodes and GP practices and merges newly created duplicate records. Additionally, the Trust has started an initiative to improve the collection of patients' ethnicities.

The Department of Health Core Quality Indicators

The core quality indicators that are relevant to the Trust are detailed below. They relate to:

- Summary Hospital level Mortality Indicator
- Research and Innovation
- Patient Reported Outcome Measures
- Readmission rate into hospital within 28 days of discharge.

- The Trust’s responsiveness to the personal needs of its patients.
- NHS Friends and Family Test
- Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism
- Infection Prevention and Control
- The number of patient safety incidents reported and the level of harm

Summary Hospital Level Mortality Indicator (SHMI)

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The value of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period	2020/21	1.0663	1.0019	0.6951	1.1869
	2021/22	0.9937	0.9996	0.7161	1.1949
The banding of the SHMI for the Trust for the reporting period <ul style="list-style-type: none"> • Band 1 = Higher than expected • Band 2 = As expected' • Band 3 = Lower than expected 	2021/22	2	2		
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period	2020/21	50.0%	36.3%	8.1%	59.2%
	2021/22	60%	39%	11%	64%

The Trust considers that this data are as described for the following reasons:

SHMI data was obtained from NHS Digital’s Indicator Portal

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

- Continuous analysis and benchmarking of mortality data with support from Dr Foster Analytics.
- Utilising the Medical Examiner Service to enable an independent scrutiny of adult inpatient deaths in partnership with families and carers and identifying opportunities for learning.

An external audit of mortality coding concluded:

- The Trust has robust coding policies and procedures as well as a high level of compliance in terms of the timeliness of coding.
- There was evidence of liaison between clinicians and coders where there were specific queries concerning diagnoses.
- There was an effective forum (the Mortality Reduction Group) in place to review coding issues and is chaired by a senior clinician.

Research & Innovation

The Trust has been a research active hospital stretching back to its early days before there was a Research Department, through the work of Professor Sir Ludwig Guttmann and the world renowned National Spinal Injuries Centre. Since it was established in 2003, the Trust's Research and Innovation Department has continued to grow its portfolio of studies across all specialties such as Cancer Care, Cardiology, Plastics and Burns, Respiratory Medicine and Ophthalmology.

Fast forward 18 years, the department hit a major milestone by registering their 1000th research study on 21 July 2021. From a handful of researchers and support colleagues, the Research and Innovation Department has grown over the years to a dedicated team of around 35 core staff as well as support research staff across services such as Pharmacy, Pathology and Radiology.

A total of 1042 studies have been registered and during 2021/22, 3377 participants took places across 24 specialities. One of the research studies resulted in the development of the Upper Limb Lab in the National Spinal Injuries Centre, which was highly commended in the Acute Sector Innovation of the Year category at the 2021 Health Service Journal (HSJ) Awards.

Patient Reported Outcome Measures (PROMS)

PROMS measures health-related quality of life as reported by patients themselves. Measurements before and after a clinical intervention are used to understand the overall impact of that intervention and the associated health gain. They also provide us with a way of benchmarking performance standards to compare service provision and to detect variations in the standard of care delivered to patients. The latest data available is shown in the table below:

Prescribed Information	Reporting Period	Trust Score	National Average	Best Performer	Worst Performer
Hip replacement surgery- Oxford Hip Score	2018/19	22.4	22.2	24.4	19.1
	2019/20	22.1	22.1	24.4	18.5
	2020/21	N/A			
Knee replacement surgery -Oxford Knee Score	2018/19	17.2	16.7	19.8	13.7
	2019/20	17.5	17.1	19.8	13.4
	2020/21	16.7	16.8	19.7	11.5

The Trust considers that this data is as described for the following reason:

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

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

Reviewing the PROMS data at its monthly arthroplasty meetings.

Raising awareness amongst patients who have had surgery of the importance of completing the PROMS questionnaire. We are exploring how technology might be used to prompt patients to complete their forms.

Readmission Rates

The latest data available is shown in the table below:

Prescribed Information	Reporting Period	Trust Score	National Average	Best Performer	Worst Performer
Percentage of patients aged 0 to 15 readmitted within 30 days of admission	2019/20	16.2	12.5	6.3	18.6
	2020/21	15.0	11.9	6.6	19.2
Percentage of patients aged 16+ readmitted within 30 days of admission	2019/20	14.3	14.7	6.4	20.4
	2020/21	14.8	15.9	7.8	21.7

The Trust considers that this data is as described for the following reason:

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

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

Establishing the correct data set of patients as defined by NHSI/E.

Ensuring we are coding patients correctly when presenting the data included in the report.

Rectifying incomplete readmission data for analysis.

Responsiveness to the Personal Needs of Patients

The table below contains the indicator values for NHS Outcomes Framework indicator 4.2.

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the NHS Trusts and NHS foundation Trusts by NHS Digital with regards to the Trust's responsiveness to the personal needs of its patients during the reporting period.	2016/17	68	68.1	85.23	60.2
	2017/18	64.3	68.6	85	60.5
	2018/19	66.2	67.3	85	58.9
	2019/20	67	71.9	84.2	59.5
	2020/21	73.4	74.5	85.4	67.3

The national inpatient survey shows that the feedback we received in relation to our responsiveness to the personal needs of our patients has improved. We saw an improvement in experience related to the following:

99% said they were treated with dignity and respect (2019/20, 98%)

As in previous years doctors and nurses were highly regarded with 99% of patients having trust and confidence in nurses and 98% in doctors

The Trust saw a significant rise in patients rating the food as good or quite good up from 51% to 63%

There were improvements in some areas of discharge for example more patients reported staff discussing their needs for health and social care after discharge, while other areas, such as being given enough notice of discharge, saw a decline.

Key areas where improvement is required include waiting times for admission, patients feeling involved in decisions about their care and treatment, and aspects of the discharge process.

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

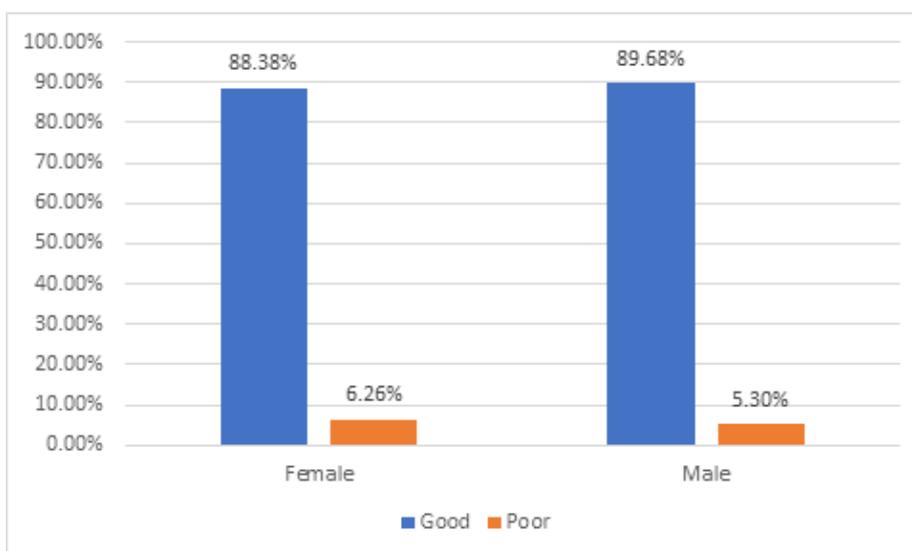
Enabling colleagues at all levels to make improvements in response to patient feedback.
Using patient experience data to drive improvement.
Involving patients and carers as partners in improvement.
The Trust has replicated the patient survey questions in the monthly matrons' quality walkabout and audit questions to enable monthly monitoring of local and Trust wide performance.

Friends and Family Test

NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to give their views after receiving NHS care or treatment.

Restrictions on visiting during the pandemic has affected patient satisfaction. The Trust has reviewed and eased visiting since the March 2022 in line with the national guidance on living with COVID-19 to support the improvement of patient experience.

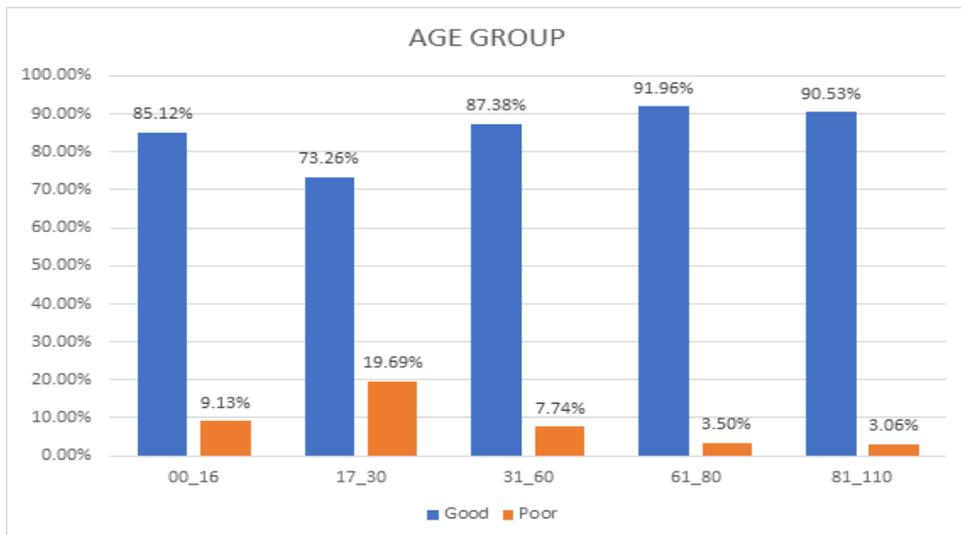
One of the questions asked in FFT is 'Overall how was your experience of our service?'. Experience is rated from very good to very poor. Patients are asked for demographic data, making it possible to understand patient satisfaction across a number of key protected characteristics. The following charts show the response rates, which have increased significantly compared to 2020/21, and satisfaction in 2021/22 by gender, age and ethnicity. Please note that they do not include the percentage of people who rated their experience as neither good nor poor.



Gender – 87,168 Responses:

The response rate was broadly similar for male and female patients with both genders responding to around 21.8%. Male patients accounted for 46% of all responses received and were slightly more satisfied with the service they received with 89.68% responding positively. Female patients using the Trust’s Maternity services responded to 11.3% of survey requests and overall returned more responses for other services.

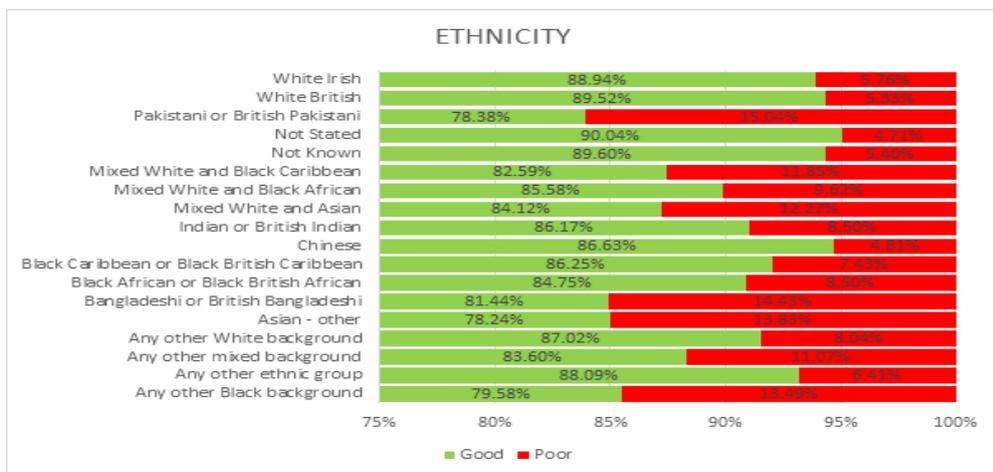
Age Group – 87,182 Responses



Following the trend of previous years, the age group with the highest response rate continues to be those aged 61 to 80, with 31.5% responding and the lowest response rate of 9.7% is from patients aged 17 to 30. Those aged 30 and under, including parents responding for paediatric patients responded to 11.9%, whilst those aged over 30 responded to 24.9% overall.

Patients aged over 60 were most satisfied with the service they received whilst 19.7% of patients aged 17 to 30 reported a poor experience.

Ethnicity – 87,182 Responses



Of those patients who gave their ethnicity, the most satisfied were White British, with again Pakistani or British Pakistani patients reporting the lowest satisfaction with 15% saying that

their experience had been poor or very poor followed by Bangladeshi or British Bangladeshi at 14.4%. We are currently working with Healthwatch Bucks to undertake in-depth research to understand they this is the case so that we can develop action plans to address any issues highlighted.

White British patients and service users had the highest response rate at 24.1%, the lowest response rate at 7.7% is from those recorded as Pakistani or British Pakistani.

Venous Thromboembolism (VTE)

Prescribed Information	Reporting Period	Trust Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2020/21 Quarter 3	96.5%	Data not available	Data not available	Data not available
	2021/22 Quarter 3	96.2%	Data not available	Data not available	Data not available

The Trust considers that this data is as described for the following reasons:

- Due to the impact of the COVID-19 pandemics, and the requirement to release capacity across the NHS to support the response, NHS England paused the collection and publication of some official statistics. As a result, VTE quarterly data was not reported by any trust during 2020-22. This pause means we are unable to provide national average, highest score and lowest score.
- The Trust continued to monitor monthly compliance at a local level and has been consistently compliant.

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

- Benchmarking the Trusts VTE in the national GIRFT/Thrombosis UK survey.
- A QI project has been completed in one area to reduce the number of unintentional omitted thromboprophylaxis doses, this will now be rolled out across the Trust.
- Focus for the next 12 months:
- Real-time monitoring of VTE compliance

- Audit
- Patient information
- Mechanical thromboprophylaxis
- Education programme
- Hospital acquired thromboembolism screening
- Roll out of missed Doses QI project
- Review current structure of team and build resilience to improve VTE prevention across the Trust.
- Apply for Exemplar Centre status once criteria is fully met

Infection Prevention and Control

The Trust continue to recognise the need for us to control healthcare associated infections (HCAs) and reiterate our commitment to keeping patients, family members and staff safe in this regard. The Infection Prevention Control (IPC) team has continued to strive for the highest standards in collaboration with our colleagues, patients and service users, visitors, external partners and contractors.

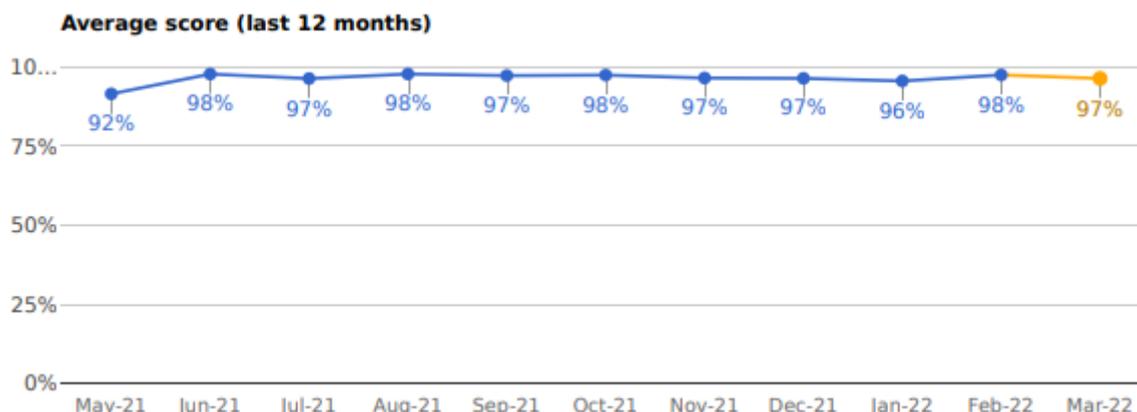
Once again, the COVID-19 pandemic has dominated the past year. However, the emergence and surge of the Omicron COVID-19 variant in December 2021 has led to significant challenges in managing ongoing transmission in our healthcare settings. Working in such a rapidly developing situation while maintaining our focus on IPC practice has required a comprehensive and collaborative effort in limiting the spread of infection among people who receive our care and visit Trust's hospital premises.

The IPC team managed periods of increased incidents and outbreaks of infections as they arose and monitored the impact of the outbreak on patients and staff and the implications for the organisation's operational delivery.

Specialist IPC advice plays a critical role in our ability to return to 'Living with COVID-19' across the organisation while also ensuring we stay prepared for any increase in cases and standard infection control precautions (SICP) are delivered to the highest possible level.

IPC audits were undertaken to ensure that policies, procedures, and best practices were applied, including hand hygiene and the correct wearing of personal protective equipment (PPE). Monthly audit is conducted through Tendable App (electronic audit) by frontline staff and validated by the IPC team. The hand hygiene and PPE audit demonstrated an average compliance of 97% in the last 12 months.

Hand hygiene and PPE audit monthly percentage compliance 2021/22



During 2021/22, the Trust continued to perform mandatory surveillance.

Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia

The Trust's bloodstream national target is set at zero; however, we have reported two cases of MRSA bloodstream infection. In one, the source was considered a line infection whilst the other was a collection contaminant. The care and management of peripheral line has been a focus of safety messages and monitored closely through a monthly audit by clinical staff.

Meticillin-susceptible *Staphylococcus aureus* (MSSA) bacteraemia

A total of 22 MSSA bacteraemia cases were apportioned to the Trust for 2021/2022. The Trust does not have a formal target for reducing MSSA bacteraemia cases. The bloodstream infection cases have been associated with the following sources of infection:

- skin and soft tissue infections
- peripherally inserted central catheter (PICC) line infection
- peripheral cannula
- discitis and pyelonephritis

All cases were reviewed, and root cause analysis was carried out to look for preventable causes when the source of infection was unknown, or device related.

MRSA and MSSA bacteraemia 2021/22

	2017/18	2018/19	2019/20	2020/21	2021/22
MRSA Bacteraemia	2	1	2	1	2
MSSA Bacteraemia	19	17	22	23	22

Clostridioides difficile infection

The Trust's national target for *Clostridioides difficile* (*C. difficile*) for 2021/22 was set at no more than 61 cases apportioned to the Trust in patients over the age of two years. The Trust reported 53 cases which is below the set target for the year. Out of the 53 cases reported, 47 were Hospital Onset Healthcare-Associated (HOHA) and six Community Onset Healthcare-Associated (COHA).

A case is apportioned as HOHA if the sample was taken in hospital more than two days after admission and apportioned as COHA if the patients were positive in the community but had been in hospital within the preceding 28 days.

The Trust continues to review all cases through root cause analysis (RCA) to identify any potential lapses in care or common themes that may have contributed to the infection. In addition, work continues to reduce the cases of *C. difficile*, which relies upon appropriate antibiotic prescribing and advice, the earliest detection of possible *C. difficile* cases and prompt isolation of patients with diarrhoea.

Gram-Negative Blood Stream Infections (GNBSI)

The Trust reported 61 cases of GNBSI in 2021/22 against the national target of 155. Since 2018/19, there has been a continued focus on using the Health Economy approach to reduce *Escherichia coli* bloodstream infections as they represented 55% of all Gram-negative bloodstream infections nationally. GNBSI cases can occur in hospitals; however, half of all community-onset cases have had some healthcare interventions from acute, primary or community care.

GNBSI	2017/18	2018/19	2019/20	2020/21	2021/22
<i>E. coli</i>	45	42	48	32	39
<i>Klebsiella</i> spp.	17	15	23	22	19
<i>Pseudomonas</i> spp.	16	12	15	8	3
TOTAL	78	69	86	62	61

Despite the COVID-19 pandemic, the Trust continues to undertake root cause analysis (RCA) for significant events such as hospital-acquired bloodstream infection cases, including Meticillin-susceptible *Staphylococcus aureus* (MSSA) and MRSA. The medical staff, ward nurses, infection control nurse, pharmacy, estates and facilities and microbiologist participated in these RCAs.

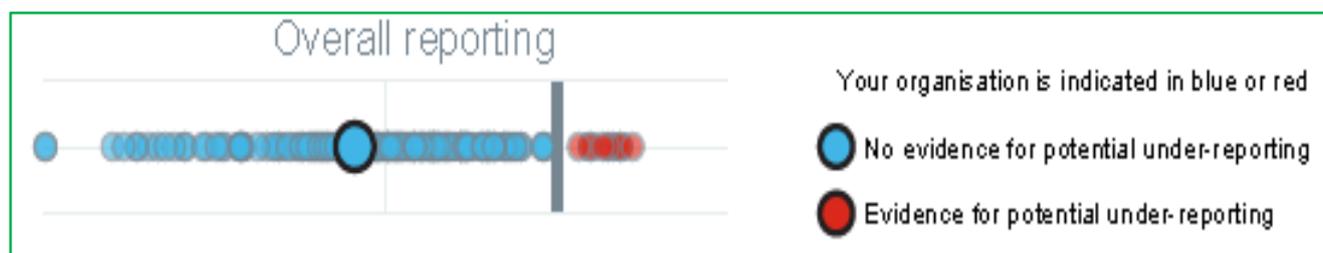
Patient Safety Incidents

Prescribed Information	Reporting Period	Trust Score	National Average	Highest Rate	Lowest Rate
Rate of patient safety incidents (per 1000 bed days) when benchmarked against medium acute Trusts	2019/20	51.4	51.5	125	27.9
	2020/21	60.1	58.4	118.7	27.2
Percentage of patient safety incidents resulting in severe harm or death when benchmarked against medium acute Trusts	2019/20	0.2%	0.3%	1.1%	0.0%
	2020/21	0.3%	0.5%	2.8%	0.0%

This verified data from NRLS includes incidents occurring between April 2020 and March 2021 and reported to NRLS by 31 May 2021 (published on 29 September 2021).

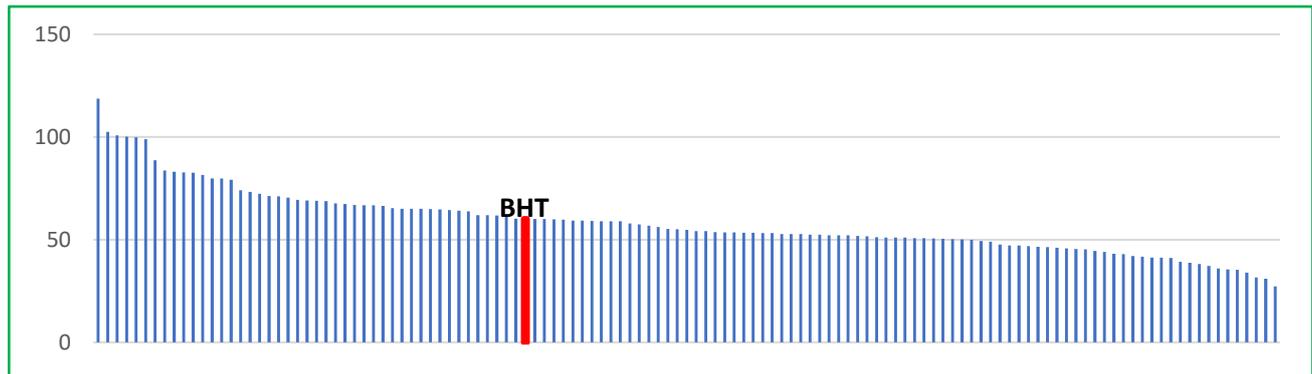
The Trust has effective processes in place to manage timely and accurate uploading of patient safety incidents to the NRLS. Fifty percent of its patient safety incident reports were submitted (reported) to NRLS by 12 days from the reported incident date. The Trust shows a slightly lower than average figure for patient safety incidents resulting in severe harm or death when benchmarked against other medium sized acute trusts.

Trust incident reporting benchmark: NRLS

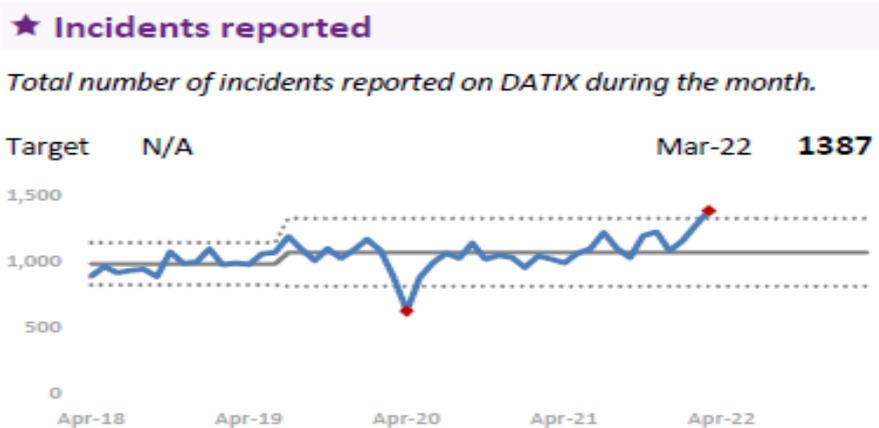


The chart below draws a comparison of the reporting rates of acute (non-specialist) organisations in England during 2020/21 and shows that the Trust is above average in the cohort.

Trust patient safety incidents per 1,000 bed days 2020/21 national benchmark



The NRLS considers that evidence of under-reporting is an indirect indicator of potential problems with an organisation’s culture around incident-reporting while an increase in reporting may indicate an improved reporting culture. The Trust has steadily increased incident reporting levels over time, including against the important metric of incidents per 1,000 bed days.



Patient Safety Alert compliance

The Central Alerting System (CAS) is the Department of Health’s electronic delivery and monitoring system for cascading National Patient Safety Alerts (NatPSAs) and other safety critical issues. The notifications contain a rationale for the alert and clear explanations of the risks and improvement actions required, with a completion deadline.

The Trust has an effective policy, underpinning standardised processes to respond to national alerts from the CAS. The Trust records its compliance with the alerts on the CAS website. In 2022/23 the Trust will also record the alerts and responses on a centralised incident reporting system, Datix, through a newly procured module, rather than manually tracking on spreadsheets.

Coordination of NatPSAs is carried out by the corporate Patient Safety team. The team works with senior managers and clinicians, including the Medical Devices Safety Officer, Pharmacy and Estates Teams, to facilitate compliance, capture assurance and monitor ongoing work or action plans required to address the issues raised by the alert, with the additional step of sign off by an Executive.

See table below for all National Patient Safety Alerts. The Trust was fully compliant with all the actions and obligations required for the 13 NatPSAs by the deadline of the 31 March 2022.

Reference	Alert Title	Action Status
NatPSA/2020/005/NHSPS	Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults	Action completed within CAS deadline
NatPSA/2020/006/NHSPS	Foreign body aspiration during intubation, advanced airway management or ventilation	Action completed within CAS deadline
NatPSA/2020/008/NHSPS	Deterioration due to rapid offload of pleural effusion fluid from chest drains	Action completed within CAS deadline
NatPSA/2021/002/NHSPS	Urgent assessment/treatment following ingestion of 'super strong' magnets	Action completed within CAS deadline
NatPSA/2021/003/NHSPS	Eliminating the risk of inadvertent connection to medical air via a flowmeter	Action completed within CAS deadline
NatPSA/2021/004/MHRA	Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121, Zentiva Pharma UK Ltd ...	Action completed within CAS deadline
NatPSA/2021/005/MHRA	Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particle ...	Action completed within CAS deadline
NatPSA/2021/006/NHSPS	Inappropriate anticoagulation of patients with a mechanical heart valve	Action completed within CAS deadline
NatPSA/2021/007/PHE	Potent synthetic opioids implicated in increase in drug overdoses	Action completed within CAS deadline
NatPSA/2021/008/NHSPS	Elimination of bottles of liquefied phenol 80%	Action completed

		within CAS deadline
NatPSA/2021/009/NHSPS	Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) ...	Action completed within CAS deadline
NatPSA/2021/010/UKHSA	The safe use of ultrasound gel to reduce infection risk	Action completed within CAS deadline
NatPSA/2022/001/UKHSA	Potential contamination of Alimentum and Elecare infant formula food products	Action completed within CAS deadline

Learning from Deaths

During 2021/22, 1,167 Trust inpatients died. This comprised the following number of deaths which occurred in each quarter of that reporting period.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Number of BHT deaths	240	289	321	317	1167
Number of Deaths Reviewed by Medical Examiner (ME)	240	289	321	317	1167
Deaths subject to Case Note Review (Structured Judgement Review SJR)	32	37	38	33	140
Serious Incident investigations	3	2	3	5	13
Deaths more likely than not to have been due to problems in care	1	1	2	1	5
Overall percentage of deaths more likely than not to have been due to problems in care	0.4%	0.3%	0.6%	0.3%	0.4%

Medical Examiner review of community deaths

The ME service will roll out the ME service to the community by April 2022. The first phase was for MEs to review deaths in Florence Nightingale House Hospice. Information regarding these reviews can be seen below. Roll out will continue during 2022/23 in collaboration with Buckinghamshire Clinical Commissioning Group and GP colleagues.

Florence Nightingale House	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Number of FNH deaths	51	65	58	68	242
Number of deaths reviewed by Medical examiner	51	65	58	68	242
Death subject to Case Note Review (Structured Judgement Review - SJR)	6	4	4	1	15
SI Investigations	0	0	0	0	0
Deaths more likely than not to have been due to problems in care	0	0	0	0	0
Overall Percentage of Deaths more likely than not to have been due to the problems in care	0%	0%	0%	0%	0%

Equality & Diversity

We have a diverse work group within the Medical Examiner (ME) service. Equality and Diversity Policy is embedded within the ME service and look after all persons without regard to age, ethnic or national origin, gender or sexual orientation, religion, or disability. We review care provided by the Trust to ensure there have been no inequalities in provision of care.

The Trust's ME service supports families to timely families to arrange arrangements for the bereaved families including faith communities to expediate burial within 24 hours.

Learning Disabilities

All learning disability deaths within the trust undergo ME screening process as well as a mandatory Structured Judgement Review (SJR) by the department the patient was cared in. A review by learning disability nurses will follow the SJR and an action plan is developed if any problems in care are identified.

Coroner's Office

ME service and the coroners have established a very good working relationship. We have regular meetings to discuss issues relating to the referrals, government updates and annual updates. The coroners have noted an increase in the accuracy of the referrals due to the involvement of the MEs in completing the death certificate.

Implementing the Priority Clinical Standards for Seven Day Hospital Service

The Seven Day Hospital Services Programme was paused due to the impact of the pandemic and the requirement to release capacity across the NHS to support the response. This programme was not reinstated during 2021/22.

Part 3: Quality Priorities 2022/23

In 2022/23, we will focus our quality priorities on the following three themes:

1. Patient safety
2. Better patient experience and outcomes
3. Improving the experience and wellbeing of our colleagues

Priority 1: Patient safety

We aim to build a safety culture within the organisation. A good safety culture in healthcare is one that strives for continuous learning, is open and transparent, has strong leadership and teamwork, and colleagues feel psychologically safe by having an environment where each individual feels they will be treated fairly and compassionately if they speak out and report any mistakes.

- A. Increase the number of incidents reported on the electronic incident reporting system compared to 2021/22
- B. 98% of reported incidents were of low harm, near misses or no harm
- C. Upgrade of the Trust's current incident reporting system including modules on incident reporting, risk management, complaints, safety alerts and litigation
- D. Delivery of a monthly Trust-wide learning forum including learning from incidents and complaints
- E. Maintain average rate of falls per 1,000 occupied bed day (OBD) of less than 6.6
- F. Zero MRSA bacteraemia
- G. Reduction in the number of nosocomial infections related to COVID-19 in comparison to 2021/22
- H. Clinical accreditation programme rolled out throughout the Trust's inpatient wards
- I. Mental Capacity Act Assessment (MCAA) template rolled out throughout the Trust
- J. HSMR (hospital standardised mortality ratio) of less than 100

Priority 2: Better patient experience and outcomes

Various published studies have indicated that there is an increased mortality rate among patients who experience delays in admission to an inpatient bed from the Emergency Department (ED). The Royal College of Emergency Medicine (RCEM) cited evidences and warned that long-waiting times in ED present a serious threat to patient safety (RCEM, 18th Jan 2022).

The Ockenden Report was commissioned following a review at Shrewsbury and Telford Hospital NHS Trust in response to a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. The report has identified 15 immediate and essential actions. These actions and priorities are directly linked to ensuring high standards of quality and safety in maternity care and that informed decision making underpins every person's pregnancy and birth experience.

Success will be measured through the delivery of the following milestones:

- A. Less than 2% of patients spending more than 12 hours in ED from arrival to departure
- B. Same Day Emergency Care (SDEC) receiving direct referrals from 999
- C. At least 70% of urgent community responses are within 2-hours
- D. At least 5% of outpatient attendances have been moved to Patient Initiated Follow-up (PIFU) pathway
- E. Commence implementation of midwifery continuity of carer
- F. Delivery of the Ockenden immediate and essential actions

Priority 3: Improving the experience and wellbeing of our colleagues

The health and wellbeing of our colleagues remains a top priority for the Trust. Colleagues have consistently strived to meet the needs of our patients working flexibly and adapting to national guidance to provide high quality, safe care during the pandemic and operational pressures. Looking after the wellbeing of our colleagues and enabling them to become the best they can ultimately results to better patients experience and outcomes. It is therefore essential to continue to prioritise our focus on the staff health and wellbeing during 2022/23.

This priority will be translated into the following key areas of action:

- A. Embedding the People Promise Priorities to make BHT a 'Great Place to Work'
- B. Increase Trust wellbeing outreach by 20% with increased counselling resources and increase wellbeing champions by 10%
- C. Opening of dedicated on-site health and wellbeing hub at Stoke Mandeville Hospital for all colleagues – with associated new ways of working and improved access
- D. At least 30 senior managers/leaders completed the 360 degrees programme
- E. Recruitment of additional 50 health care support worker post and 30 additional nursing associates.
- F. Recruiting and maintaining our nursing vacancy rate at 8.5% or below, with the associated decrease in the use of temporary staffing.
- G. 120 internationally educated nurses recruited and supported through our preceptorship programme
- H. Implementation of peer and patient led quality rounds with participation of Executive and Non-Executive Director

Statement from Buckinghamshire Clinical Commissioning Group



Buckinghamshire Clinical Commissioning Group

Study Centre
New County Offices
Walton Street
Aylesbury
HP20 1 UA

Tel: 01296 587220

Email: buckscg@nhs.net

14th June 2022

Dear Colleague,

Statement from Clinical Commissioning Group (CCG)

Buckinghamshire CCG, response to Buckinghamshire Healthcare NHS Trust
Quality Account 2021/2022

Buckinghamshire Clinical Commissioning Group (CCG) has reviewed the Buckinghamshire Healthcare NHS Trust (BHT) Quality Account against the quality priorities for 2021/2022. There is evidence that the Trust has relied on both internal and external assurance mechanisms, to provide a comprehensive Quality Account review.

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

We would like to recognise the incredible work the Trust has completed in responding to the Covid-19 pandemic and the collaboration that occurred with local system partners as a result. During the covid response we all adapted to the emerging situation and the candid, open and transparent partnership discussions supported this response. This was demonstrated in the further waves including with the onset of Omicron.

The Quality Account also demonstrates the Trust has made progress in a number of the Trusts quality priorities identified for the year under review. Whilst acknowledging the impact Covid-19 has had on the delivery of our local services. The Quality Account also recognises a number of achievements in a number of specialist areas.

The CCG will transition from the 1st of July 2022 into a new organisational form with the onset of Integrated Care Boards, however colleagues within the local system will continue to work as active partners in the place based local partnerships, providing support and advice to the team at BHT whilst also fulfilling a monitoring role in the new organisation.

The Quality Account highlights a need for continued quality improvement over, avoidable infections, falls prevention and management, management of VTE and management of pressure ulcers whilst recognising the achievements already made. Focussed work is required in relation to the support for the Emergency Department and the Urgent Care pathway and in terms of supporting the development of culture within the organisation, the organisation has made improvements and on the back of Covid and recovery this remains an area of focus so that the workforce feel supported and listened too. Diagnostic and treatment delays remain a persistent theme in SIs. A definitive workstream will be necessary to tackle harm from treatment and/or diagnostic delays exhibited by the frequency of delay related SIs. The use of the Trust's eObs platform should be used to monitor and escalate any deterioration of patients; this should aid in a reduction of delay related harm.

The creativity of approaches during the pandemic in terms of communication with patients and their carers is recognised and collaborative working with other partners to support this work such as the Maternity Voices Partnership (MVP), whilst also recognising the tremendous support and initiatives implemented to support staff through this very difficult time.

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

Yours sincerely,

A handwritten signature in black ink that reads "Debbie Simmons". The signature is written in a cursive, flowing style.

Debbie Simmons
Chief Nursing Officer
Buckinghamshire Clinical Commissioning Group

Statement from Healthwatch Bucks

Healthwatch Bucks response to Buckinghamshire Healthcare NHS Trust Quality Account

Thank you for providing Healthwatch Bucks with the opportunity to comment on the Trust's Quality Account prior to publication. We are the local health and social care champion for Buckinghamshire residents and have reviewed the account with this focus.

We would like to acknowledge that it has been another unprecedented year for the Trust as they continued to deal with Covid-19 and its impact. We thank all Trust staff for their unwavering commitment to provide a quality and safe service for the residents of Buckinghamshire.

There is much to congratulate the Trust in this year's account including the Trust's ongoing support for the COVID-19 vaccination programme, with additional sessions and webinars for vulnerable groups and demographics facing health inequalities. Although the account references 'hard to reach' groups on page 29, we hope the Trust would acknowledge that this term is now outdated.

We would also like to highlight the Trust's excellent collaborative working with the Maternity Voices Partnership in hearing the voices of women and birthing people and in co-designing services.

The previous year's Quality Account reported that a Long Covid specialist clinic that had recently been set up at Stoke Mandeville. In this year's account, it would have been helpful to see an update on this service and progress against the NHS England's Long Covid plan 2021/22.

We are pleased see that cancer services have remained a priority for the Trust and commend them for keeping these services open throughout the pandemic. Whilst it is obviously concerning that the Trust failed to meet its targets in relation to the services this year, we recognise that this was due to prioritising patients according to clinical need. We are reassured that there are clear processes in place to ensure regular review of patients on the waiting lists by clinicians but would have liked to hear about any holistic support patients on the waiting lists receive whilst they are waiting for treatment. In addition, we

welcome the Trust's recent response to our [Cancer services report](#) and recommendations, in which the experience of those receiving treatment for cancer during Covid was explored.

We commend the Trust on their considerable efforts to reduce waiting lists and the plans they have put in place to enable them to continue to do this. Taking into account the lower admission rates to elective care for those living in areas of deprivation ([place-based-approaches-for-reducing-health-inequalities](#)), we are keen to see a breakdown of waiting lists with a health inequalities focus. This could also help to identify any actions needed to ensure a more positive experience for all those on [waiting lists](#).

We note with concern that both the formal complaints and contacts to Patients Advice and Liaison Service have increased this year. We would like to understand more about how patient experience is valued and used to drive improvement in the Trust, particularly as 'Better patient experience and outcomes' are a key priority for the Trust in 2022/23. We are committed to supporting to the Trust in achieving this priority.

Regarding the Friends and Family Test ethnicity data, we note the continued lowest satisfaction rate being from those who identify as Pakistani, British Pakistani and Bangladeshi or British Bangladeshi. As the Account states, we are currently working with the Trust on a research project to help explore the issues and identify clear recommendations to address these.

We are concerned that the age bracket with the lowest response rate is from patients aged 17 to 30; also, the demographic who is reporting the highest rating for 'poor experience'. We would encourage the Trust to identify particular issues or themes that may be affecting this age range and to look at ways to encourage an increased response rate.

The charts in the Family and Friends Test (FFT) section, are shown as evidence of response rate (so how many people answered the FFT out of all the patients treated) and mentioned several times in the written commentary. However, the data illustrated in the charts relates to satisfaction rates. It would be useful to see the response rate charts broken down by gender, ethnicity, and age, to give more context to the satisfaction rates charts.

In addition, we are aware that FFT data is collected across different services (for example, inpatients, outpatients etc), so we are interested in whether there is any discernible

difference in satisfaction rates across these services, again according to age, gender, and ethnicity.

We continue to value the relationship we have with the Trust, one which balances our statutory local Healthwatch role of 'holding to account' with that of collaborative partnership working. We look forward to working with the Trust to ensure the collective voice of people using its services is heard, considered, and acted upon.

Zoe McIntosh, Chief Executive, Healthwatch Bucks

Statement from Health and Adult Social Care Select Committee

Statement from Health and Adult Social Care Select Committee

Buckinghamshire Council's Health and Adult Social Care (HASC) Select Committee holds decision-makers to account for improving outcomes and services for the residents of Buckinghamshire, as well as being statutory consultees on any proposed service changes. As a critical friend to the Trust, we are pleased to have an opportunity to comment on the Trust's Quality Account for 2021/22.

We would like to start by acknowledging the ongoing challenges and pressures facing our NHS colleagues and pay tribute to their continued hard work over the last year.

It is not clear from the Quality Account where the Trust is in delivering its three-year Quality Improvement Strategy but the improvements in reducing falls and the number of category 2 pressure ulcer cases were noted. We hope the quality improvements will continue to be embedded across the organisation over the coming years.

Following our comments in last years' quality account, we were pleased to see more examples of projects being delivered by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS), including the introduction of maternity vaccine champions across the ICS.

We were particularly interested to read about the following:

- Investment in the Children's Emergency Department and improvements to maternity and gynaecology facilities.
- The Upper Limb Studio at the NSIC being highly commended in the Acute Sector Innovation of the Year Category at the HSJ Award.
- A commendation received from the Oxford Intensive Care Society for the improvements made to patient pathways, quality of care for deteriorating patients and rehabilitation for long term intensive care patients.
- The reduction in inpatient falls from 13 to 2.
- The introduction of a maternal mental health services pathway, in collaboration with partners and the continued work of the Maternity Voices Partnership.
- Notification from the Royal College of Paediatrics and Child Health confirming that Stoke Mandeville Hospital had achieved outstanding for the audit measure "follow-up at two years of age".
- Tackling health inequalities through the Covid-19 vaccination programme.

- The first NHS corneal cross-linking treatment and improvements to the aquatic therapy facilities at Amersham Hospital, bringing crucial services closer to home for Buckinghamshire residents.
- The new Research & Innovation Centre, demonstrating partnership working with the Local Enterprise Partnership and leading on environmentally sound and energy efficient construction.

We highlight the following areas of concern and areas for improvement:

- **Patient Safety Incidents, Serious Incidents** – we are concerned to see between 10% and 15% increases in these areas, particularly as the Trust will see patient levels rise as we continue to recover from Covid. We appreciate that a revised approach to the management and review of these areas is in place and look forward to seeing significant improvements via both reporting systems.
- **End of Life care (EOL)** – whilst the quality account states that 87% of EOL patients had a personalised care plan (an 8% rise from 2020), we would like to see a target of 100% EOL patients having a personalised care plan.
- **Staff wellbeing** - we were pleased to read about the many initiatives being undertaken by the Trust to help support staff, including the expansion of the “Speaking Up” service. We recognise that recruitment and retention remain a key concern for all our health and social care partners and look forward to seeing the details about future workforce planning. We note that the Trust has successfully applied to have the CQC 2019 condition around ‘sufficient numbers of suitably qualified, skilled and experienced nurses, healthcare assistants and therapy staff throughout the community’ removed but would have liked to see more evidence of what actions have been put in place to ensure those staffing levels remain robust moving forward.
- **Readmission rates** – the readmission rates for 0-15-year olds remains an area of concern as the Trust is performing below the national average. We made the following comments last year “*we hope the coding, incomplete data and the establishment of the correct data sets will help to improve the results for next year*”, so we were disappointed to read that this has not been fully addressed this year.
- **Sepsis** – we continue to be concerned about this condition. We noted in last years’ account that the Trust achieved an annual mean target of 80% compliance against the performance measure of Suspicion to Needle Time. This year, the Trust reports that it reached 90% compliance (a target set by the Trust). The quality account mentions the introduction of the Eobs system so we would have expected a higher target and compliance rate.
- **Pressure ulcers** – we remain concerned about category 3 & 4 pressure ulcers, as cases have increased this year (56 cases compared to 46 last year) with 31 of cases occurring in the community. The quality account does not refer to initiatives specifically focussed on reducing pressure ulcers within the community setting. Whilst the number of category 2 Pressure Ulcers cases have decreased compared to last year, the numbers remain higher than the previous two years.

- **Patient Initiated Follow-up (PIFU)** – we commend the introduction of Patient Initiated Follow-up arrangements and the resulting benefits around reduced hospital visits, increased appointment availability and the reduction of the Trust’s carbon footprint. However, we would have liked to see more detail around the check and balance process to ensure crucial follow-up appointments are not deliberately avoided by reluctant patients.
- **Emergency Department** – we acknowledge the immense pressure on this department with a notable increase in attendances this year and remain concerned that this service will continue to be under pressure as demand increases to pre-pandemic levels over the coming months. A real concern remains around whether residents have a clear understanding of the different pathways - Primary Care (including pharmacies), NHS 111, Urgent Treatment Centre, Minor injuries, Minor Illness and Emergency Department and the circumstances in which each should be accessed. We would like to see a joint communications campaign to reinforce the key messages, where the terminology for the different services is clearly defined and consistently used thereafter.
- **Intermediate care** - we read with interest that at any one time around 80 patients are well enough to be discharged but require an additional package of care. This suggests that the business case for supporting sustainable intermediate care needs to be a key priority with all key partners and implemented as soon as possible.
- **Waiting lists** – we pay tribute to the hard work of colleagues in significantly reducing the longest waits for patients. We hope the close working with patients will continue as well as the partnership working to provide more choice of locations for treatment and increased capacity for operations.
- **Patient experience** – we are concerned to see that the number of complaints has increased this year alongside the number of contacts made to PALS. A quick comparison shows that November 2021 saw an increase in both, and we hope that analysis has taken place to understand the correlation and to ensure significant improvements are made this year.
- **The Seven Day Hospital Services Programme** – whilst recognising the reasons for not reinstating this during 2021/22, we hope this programme will be reintroduced soon, as these metrics provide key information on clinical standards.

General comments and observations

- **Community Diagnostic Centre (CDC)** – we are delighted to see new diagnostic services being introduced at Amersham Hospital and recognise the benefits they will bring. We also celebrate the collaboration with the local community to improve the outdoor spaces for the wellbeing of staff, patients, and visitors alike. We look forward to learning more about how CDC will continue to improve and how the Trust will roll out the next stage of their community hub project. A crucial element of that will be the detailed plan around how the Trust will continue to support

community respite beds for those that need them, which we will continue to monitor very closely.

- **CareCentric** - last years' quality account referred to the launch of CareCentric providing a single, secure, shared record for Buckinghamshire patients, including information from the Trust's acute and community hospitals, GPs, social care and Oxford Health. We were surprised that there was no mention of the progress made in this area in this years' quality account.
- **Long Covid clinic** – to help understand the impact of Covid, it would have been useful to have included some metrics around the number of patients seen at this clinic since its launch last year.
- **Health inequalities** – we welcome the work currently undertaken to tackle health inequalities and look forward to hearing more about this.
- **Maternity services** – we note the commitment by the maternity team to ensure the actions and clinical priorities of the interim Ockenden report were met and their continued commitment to ensuring that further actions are implemented. We would be interested to see the data to demonstrate the quality of improvements, particularly around the midwifery unit at High Wycombe. We would also like to see the recruitment and retention plans for the service.

Conclusion

Through its quality account, the Trust has demonstrated how hard it has worked to protect the most vulnerable and to keep its patients and colleagues safe.

We look forward to reviewing the findings of the CQC's latest inspection and scrutinising the next stages of the Trust's Clinical and Estate strategies.

We continue to welcome and support the Trust's open and transparent way of working with its partners and look forward to seeing more integrated and partnership working in the coming year – both locally and across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.

Submitted by Buckinghamshire Council's Health and Adult Social Care Select Committee, June 2022

Appendix 1 – Abbreviations

7DS	Seven Day Services
A&E	Accident and Emergency Department
ACB	Antimicrobial Care Bundle
AHSN	Academic Health Science Network
AMU	Ambulatory Medical Unit
BHT	Buckinghamshire Healthcare NHS Trust
BI	Business Intelligence
BME/ BAME	Black and Minority Ethnic
BOB	Buckinghamshire, Oxfordshire and Berkshire
CAHMS	Child Adolescent Mental health Service
CAP	Communications Advisory Panel
CARE values	Collaborate, Aspire, Respect and Enable
CCGs	Clinical Commissioning Groups
C.diff	Clostridioides difficile infection
CHSG	Community Hub Stakeholders Group
COCA	Community Onset Healthcare Associated
COVID-19	Coronavirus disease 2019
CQC	Care Quality Commission
CT	Computerised Tomography
CVAD	Central Venous Access Design
DOLs	Deprivation of Liberty
DSP	Data Security Protection
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
FFT	Friends and Family Test
FTSUG	Freedom to Speak Up Guardian

GDm	Gestational Diabetes App
GNBSI	Gram Negative Blood Stream Infections
GPs	General Practitioners
HCA	Healthcare Assistant
HOHA	Hospital Onset Healthcare Associated
HSCIC	Health and Social Care Information Centre
ICP	Buckinghamshire Integrated Care Partnership
ICS	Integrated Care System
ITU	Intensive Therapy Unit
JCNC	Joint Consultative Negotiating Committee
JMSC	Joint Management Staff Committee
LAC	Looked after Children
LeDer	Learning Disabilities Mortality Review
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer (or Questioning) and others
LPS	Liberty Protection Safeguards
MASD	Moisture Associated Skin Damage
MCA	Mental Capacity Act
ME	Medical Examiner
MRSA	Methicillin-resistant staphylococcus aureus
MSSA	Methicillin-susceptible staphylococcus aureus
NBM	Nil by mouth
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute of Clinical Excellence
NICU	Neonatal Intensive Care Unit

NOF	Fractured Neck of Femur
NRLS	The National Reporting and Learning System
NSIC	National Spinal Injuries Centre
PALS	Patient Advice & Liaison Service
PCN	Primary Care Networks
PCR	Polymerase Chain reaction
PEG	Patient Experience Group
PHE	Public Health England
PHSO	Parliamentary and Health Service Ombudsman
PROMS	Patient Reported Outcomes measures
PSED	Public Sector Equality Duty
Q1	Quarter 1, first quarter of the financial year (April-June)
Q2	Quarter 2, second quarter of the financial year (July-September)
Q3	Quarter 3, third quarter of the financial year (October-December)
Q4	Quarter 4, fourth quarter of the financial year (January-March)
RCA	Route Cause Analysis
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
SAU	Surgical Assessment Unit
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SJR	Structured Judgement Review
SMH	Stoke Mandeville Hospital
SOP	Standard Operating Procedures
SSNAP	Sentinel Stroke National Audit Programme
STNT	Suspicion to Needle Time

UK	United Kingdom
VPS	Visual Infusion Phlebitis
VTE	Venous Thromboembolism
WDES	Workforce Disability Equality Standard
WH	Wycombe Hospital
WHO	World Patient Safety Day
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Mortality Report – bi-annual report
Board Lead	Mr Andrew McLaren, Chief Medical Officer
Type name of author	Dr Mitra Shahidi, Consultant Respiratory Physician & Associate Medical Director for Patient Safety and Quality Mandy Chetland, Head of Medical Quality
Attachments	None
Purpose	Assurance
Previously considered	Mortality Reduction Group 23.03.2022 Quality & Clinical Governance 20.04.2022

Executive Summary

Since October 2020, our HSMR has consistently been “as expected” or “lower than expected”.

The Trust is 1 of 10 within the regional comparison (acute, non-specialist) group with an HSMR that is banded as statistically ‘lower than expected’ (November 2021 data). The Trust’s HSMR is ranked 7th out of the 18 regional acute, non-specialist Trusts.

RSM undertook an internal audit which confirmed:

- BHT has robust coding policies and procedures as well as high level of compliance in terms of the timeliness of coding.
- There was evidence of liaison between clinicians and coders where there were specific queries concerning diagnoses.
- There was an effective forum (the Mortality Reduction Group) is in place to review coding issues and is chaired by a senior clinician

RSM made four recommendations which have all been actioned.

Decision	The Board are requested to take assurance from the report		
Relevant Strategic Priority			
Outstanding Care <input checked="" type="checkbox"/>	Healthy Communities <input type="checkbox"/>	Great Place to Work <input type="checkbox"/>	Net Zero <input type="checkbox"/>
Implications / Impact			
Patient Safety	Monitoring and investigating/auditing our mortality to ensure we are providing the safe care and identifying any learning if a lapse in care is identified.		
Risk: link to Board Assurance Framework (BAF)/Risk Register	The Trust’s mortality rates are indicators of how well we care for our patients and may impact negatively on the Trust’s reputation.		
Financial	No financial implications.		
Compliance <small>Select an item. Select CQC standard from list.</small>	The standard for HSMR is 100.0.		
Partnership: consultation / communication	Collaboration with all divisions and the Dr Foster analyst at the Mortality Reduction Group Meeting as well as when investigating/auditing specific diagnoses.		

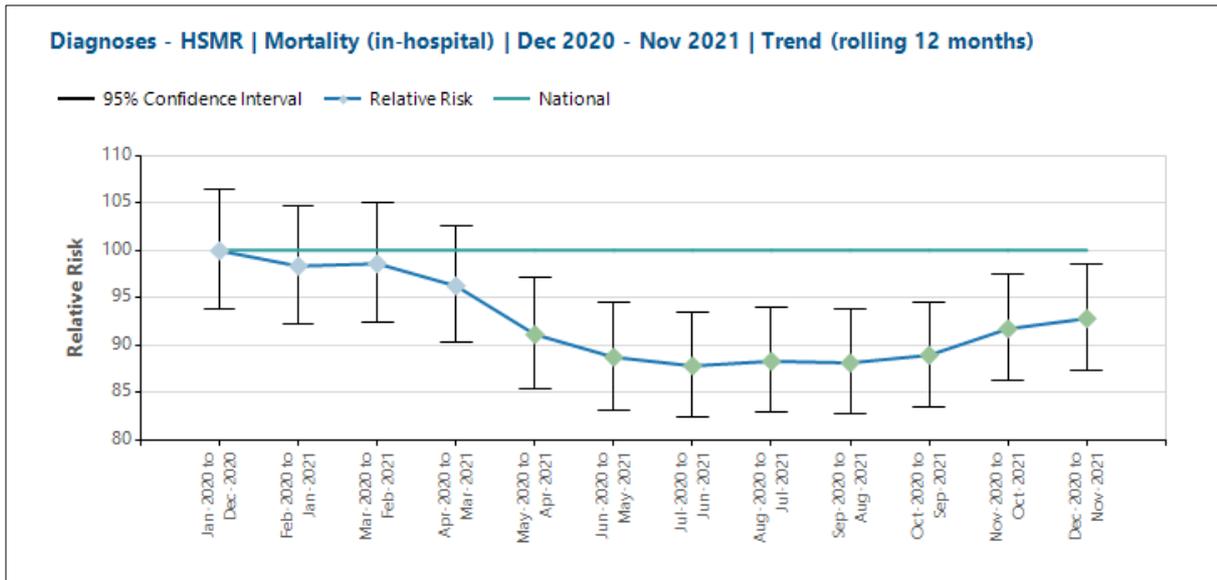
Equality	Mortality data does not discriminate against protected characteristics but can identify inequalities if mortality is higher in a particular group of people ie., age, gender, ethnicity, etc.
Quality Impact Assessment [QIA] completion required?	Not required for this paper.

Mortality Report

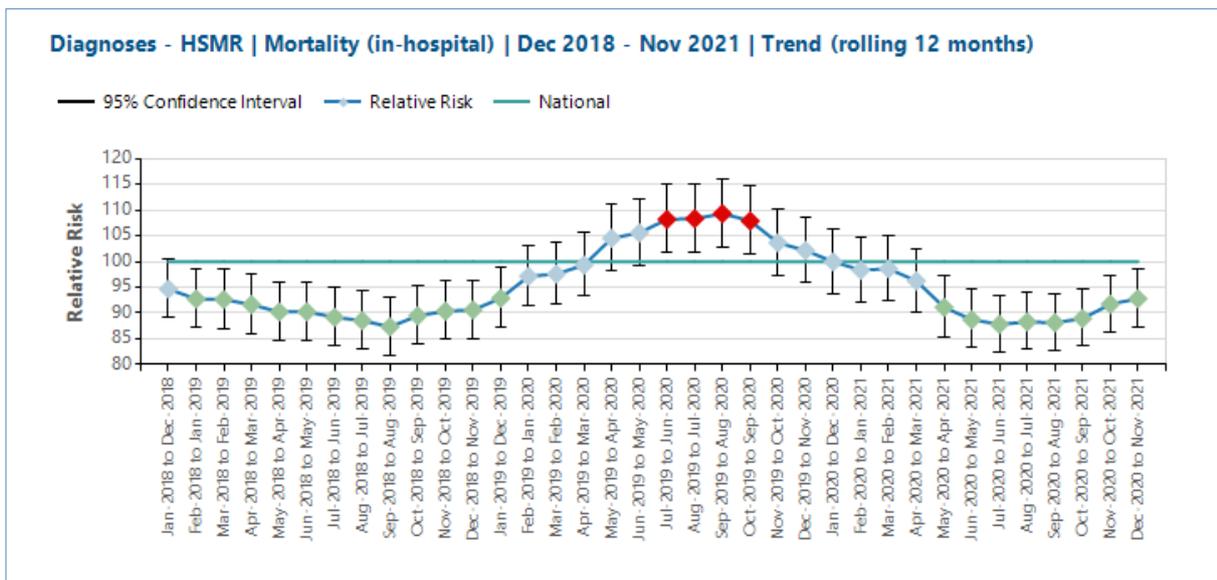
1 Hospital Standardised Mortality Ratio

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. Standardised rates allow comparison between organisations that deal with different patient populations.

The latest statistics from Dr Foster (November 2021), HSMR is 92.8 which is “lower than expected”.



Our HSMR was increasing since September 2019, when it became “higher than expected from June 2020 onwards. In March 2021, an investigation identified 3.5k records had not been uploaded and were subsequently resent for the October and November 2020. Data could not be resubmitted for the periods prior to October. The issue has now been resolved and since October 2020, our HSMR has consistently been “as expected” or “lower than expected”.

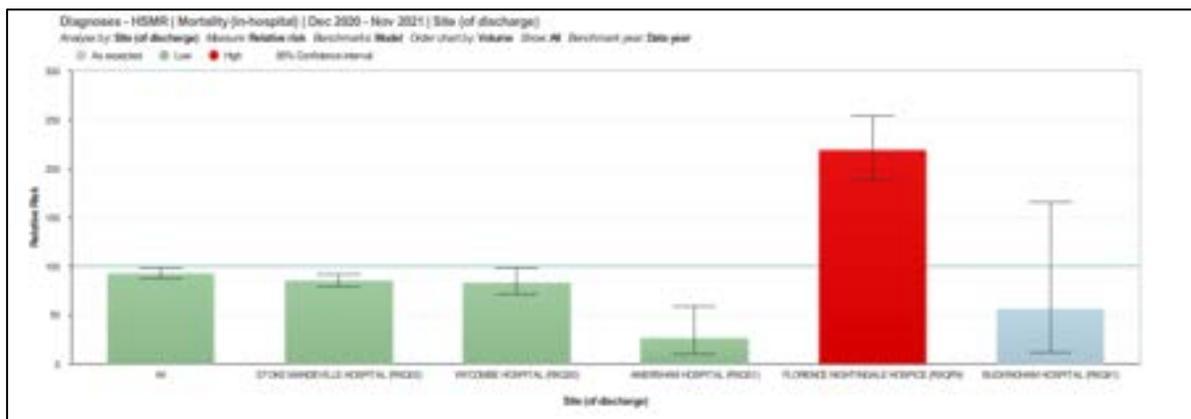


The Trust is 1 of 10 within the regional comparison (acute, non-specialist) group with an HSMR that is banded as statistically 'lower than expected' (November 2021 data). The Trust's HSMR is ranked 7th out of the 18 regional acute, non-specialist Trusts.



Crude mortality rate (Dec-20 to Nov-21) is 3.2% compared to 3.4% regional average and 3.2% national average (acute, non-specialist Trusts).

The proportion of non-elective spells (7.7%) and deaths (66.2%) with palliative care (HSMR) is well above the regional and national averages. However, this is to be expected with an onsite hospice.



2 Internal Audit

RSM carried out an audit of HSMR Coding as part of their annual internal audit plan for 2021/22. The objective of this review was to allow management to take assurance that effective processes are in place for mortality indicator coding to ensure that this is being undertaken in a timely and effective manner, with accurate and robust data used.

There conclusion was as follows:

“We confirmed robust coding policies and procedures were in place covering the clinical coding process, including detailed guidance for specific coding areas. There was clear evidence that staff competence and awareness was maintained through certification, internal team meetings, and sharing of information such as standard changes through departmental emails. Coding performance indicators reported a high level of compliance in terms of the timeliness of coding, and there was reporting of these indicators, including depth of coding, to the Trust Board, although we have noted one issue with the accuracy of reporting in one instance. There was evidence of liaison between clinicians and coders where there were specific queries concerning diagnoses. An effective forum (the Mortality Reduction Group) is in place to review coding issues and is chaired by a senior clinician”.

Actions identified in the report are below along with the outcomes:

Action	Outcome
Clinical review performed as part of deep dives will be clearly documented and signed off.	SOP created for deep dives and signed off by the Mortality Reduction Group. Patient Level deep dives are being documented and signed off as per RSM recommendations. - Completed
The Trust will ensure that Board reporting of key coding indicators reflects the underlying data, and that supporting BI data is retained to support the indicators actually reported in Board reports.	Completed
The Clinical Coding Process Audit Policy will be updated to specify the requirement that only senior coders are involved in the coding of mortality cases.	Completed
As a key metric that has experienced known issues in the last 12 months, the HSMR will be transparently included in the Trust's IPR and presented to the Board for scrutiny. If there are concerns with the timeliness of the data this could be indicated so the reader is aware of any limitations of the information reported.	Completed

3 Conclusion

From August 2019 through to June 2021, a lot of focus was put into understanding why the HSMR was rising. Once the issue had been identified and resolved, ongoing monitoring of mortality data continues with deep dives undertaken where a particular diagnosis group has more actual deaths than expected. This will continue and outcomes will be documented as per the recommendations from RSM.

4 Action required from the Board/Committee

The Board are requested to take assurance from this paper.

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Medical Appraisal & Revalidation Annual Board Report 2021/2022
Board Lead	Mr Andrew McLaren
Type name of Author	Sarah Klamut - Medical Appraisal & Revalidation Team
Attachments	2021-22 Medical Appraisal and Revalidation Annual Report Annex-D-annual-board-report-and-statement-of-compliance
Purpose	Assurance
Previously considered	EMC 28.06.2022 SWC 11.07.2022

Executive Summary

Medical Appraisal and Revalidation is regulated through the General Medical Council and the Responsible Officer is required to report to the Trust Board in public on an annual basis in regard to compliance of connected doctors with the process.

Appraisal was reduced in format during the initial Covid-19 pandemic but recommenced in April 2021. During 2021/22 464 doctors were connected to the Trust of whom 367 were required to complete an appraisal during the year. Appraisal compliance was 93% with only 26 doctors not successfully completing an appraisal.

The report is to provide assurance to the Trust Board that internal processes for Medical Appraisal and Revalidation are robust, and to report on the 21/22 activity.

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

The Executive Management Committee were assured on the process for locum medical staff, acknowledged the further work to do on medical statutory/mandatory training and clarified the Trust would be resuming job planning process following the paused over the previous two years.

This paper was considered by the Strategic Workforce Committee on 11 July 2022 where it was confirmed that more thorough monitoring with associated escalation had been put in place to maintain best compliance noting the challenges over the past two years.

Both Committees endorsed the statement for approval and signature by the Chief Executive.

Decision

The Board is requested to approve the report.

The Chief Executive Officer is asked to sign a Statement of Compliance Appendix 1 –NHS England and NHS Improvement Annex D – The Annual Board Report and Statement of Compliance. This is to confirm the Trust has reviewed the content of the report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Relevant Strategic Priority

Outstanding Care <input checked="" type="checkbox"/>	Healthy Communities <input checked="" type="checkbox"/>	Great Place to Work <input checked="" type="checkbox"/>	Net Zero <input type="checkbox"/>
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Implications / Impact	
Patient Safety	The report has no direct impact on patients.
Risk: link to Board Assurance Framework (BAF)/Risk Register	The report does not link to Board Assurance Framework or Corporate Risk Register
Financial	There are no financial implications related to this report
Compliance <small>Select an item. Select CQC standard from list.</small>	The Trust will continue to meet its compliance and legislative requirements. Trust Board is required to receive an annual report on Medical Appraisal and Revalidation.
Partnership: consultation / communication	The report is not required to consult with any partnership
Equality	The report references requirement of the Workforce Race Equality Standard (WRES) in relation to Revalidation deferrals
Quality Impact Assessment [QIA] completion required?	The report does not require a QIA



A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

<https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/>

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.¹ This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

- a) help the designated body in its pursuit of quality improvement,
 - b) provide the necessary assurance to the higher-level responsible officer,
- and
- c) act as evidence for CQC inspections.

¹ Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Buckinghamshire Healthcare NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

<p>Yes</p> <p>Action from last year:</p> <p>None</p> <p>Comments:</p> <p>The interim responsible officer Mr Andrew McLaren GMC No. 3277294 is now substantive in the RO role.</p> <p>Action for next year:</p> <p>None</p>
--

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

<p>Yes</p> <p>Action from last year:</p> <p>None</p> <p>Comments:</p> <p>Sufficient resources have been allocated</p> <p>Action for next year:</p> <p>None</p>
--

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes

Action from last year:

Continue to monitor medical appraisal & revalidation GMC connect activity.

Comments:

Audited monthly against GMC Connect and the Trust Electronic staff record

Action for next year:

None

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes

Action from last year:

Medical Appraisal & Revalidation Policy was reviewed and approved in January 22.

Comments:

Next review due in January 2025

Action for next year:

None

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

No

Actions from last year

None

Comments:

We have not had a peer review this year

Action for next year:

None

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes

Action from last year:

None

Comments:

All short term / locum doctors are supported to take part in the Trust clinical governance processes and have access to training and library facilities to support their continuing professional development. The Appraisal team also ensure that they are aware of their need to undertake appraisal & revalidation and have an appropriate connection to a Responsible Officer and have a booked appraisal date.

Action for next year:

None

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Yes

Action from last year:

Ensure all doctors undertake an annual appraisal from 1st April 2021 following cancelled appraisals during 20/21 due to the pandemic.

Comments:

Medical Appraisal resumed from 01 April 21. We did not adopt the Appraisal 2020 model.
Action for next year:
Further discussions with new appraisal lead to be held.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

N/A
Action from last year:
N/A
Comments:
N/A
Action for next year:
N/A

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board’s approval (or by an equivalent governance or executive group).

Yes
Action from last year:
Reviewed January 2022
Comments:
Next review due January 2025
Action for next year:
None

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes
Action from last year:
Additional appraisers trained in 2021
Comments:
None
Action for next year:

Further appraisers will be trained in 2022

5. Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers² or equivalent).

Yes

Action from last year:

Appraiser networks resumed in 2021

Comments:

None

Action for next year:

None

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes

Action from last year:

None

Comments:

All appraisals are reviewed by the medical Appraisal and Revalidation team.

Action for next year:

None

² <http://www.england.nhs.uk/revalidation/ro/app-syst/>

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	464
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	341
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	123
Total number of agreed exceptions	97

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

Action from last year:

All revalidation recommendations resumed in July 2021 following the GMC suspension due to the pandemic.

Comments:

Processed back log of revalidations in 2021

Action for next year:

None

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Action from last year:

None

Comments:

We support doctors to achieve revalidation readiness and discuss options to defer if required. Non engagement concerns are discussed with the RO and GMC ELA

Action for next year:

None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes

Action from last year:

None

Comments:

There are effective clinical governance processes in place for doctors

Action for next year:

None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

Action from last year:

None

Comments:

Doctors are provided with information on complaints and DATIX for discussion at appraisal.

Action for next year:

None

3. There is a process established for responding to concerns about any licensed medical practitioner's¹ fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

Action from last year:

None

Comments:

Any concerns regarding fitness to practise are dealt with under our Maintaining High Professional Standards policies and procedures and managed by the Medical HR Team.

Action for next year:

None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.³

<p>Yes</p> <p>Action from last year:</p> <p>None</p> <p>Comments:</p> <p>The Trust provide data in the Employee Relations PSED report (public sector equality duty)</p> <p>Action for next year:</p> <p>None</p>
--

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.⁴

<p>Yes</p> <p>Action from last year:</p> <p>None</p> <p>Comments:</p> <p>None</p> <p>Action for next year:</p> <p>None</p>
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³ This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

⁴ The Medical Profession (Responsible Officers) Regulations 2011, regulation 11:
<http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents>

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

<p>Yes</p> <p>Action from last year:</p> <p>None</p> <p>Comments:</p> <p>There are robust safeguard processes in place for responding to concerns about a doctor's practice.</p> <p>Action for next year:</p> <p>None</p>

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

<p>Yes</p> <p>Action from last year:</p> <p>None</p> <p>Comments:</p> <p>None</p> <p>Action for next year:</p> <p>None</p>
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Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- General review of actions since last Board report - **It is a requirement that the Trust Board receives an annual report on medical appraisal and revalidation at the Trust board in the month of July.**
- Actions still outstanding - **None**
- Current Issues – **No issues**
- New Actions: **None**

Overall conclusion:

Arrangements are in place to ensure doctors are appraised and revalidated to a standard that meets the requirements of the RO regulations and are working effectively. We closely monitor annual medical appraisal completion and are committed to continually improving and developing our systems to ensure potential non-engagement is dealt with quickly and effectively. The impact of the pandemic continues to affect appraisal and revalidation. Due to the cancellation of appraisal during the pandemic, there has been some loss of habit. Going forward though, this is being closely managed to ensure compliance with appraisal and Medical Revalidation is maintained.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Mr Neil Macdonald

Official name of designated body: **Buckinghamshire Healthcare NHS Trust**

Name: **Mr Neil Macdonald**

Signed:

Role: **Chief Executive Officer**

Date:

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

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Publication approval reference: PAR614

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Freedom to Speak Up Annual Report 2021 to 2022
Board Lead	Bridget O’Kelly, Chief People Officer
Type name of Author	Tracey Underhill, Lead Freedom to Speak Up Guardian
Attachments	Freedom to Speak Up Annual Report 2021-2022
Purpose	Assurance
Previously considered	EMC 05.07.2022 SWC 11.07.2022

Executive Summary

The Freedom to Speak Up Annual Report 2021 to 2022 is submitted to the Trust Board in Public for:-

- Assurance of progress and development with our ongoing work to build a positive speaking up culture across BHT. Objectives undertaken to the Trust Board last year are met.
- For information and update.

Decision	The Board is asked to note the report for assurance, information and update.
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Relevant Strategic Priority

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

Patient Safety	A positive speaking up culture underpins patient safety and good quality care
Risk: link to Board Assurance Framework (BAF)/Risk Register	Patient Safety and the quality of patient care – if staff don’t feel able to speak up. Recruiting and retaining high calibre staff to deliver good quality care.
Financial	Unnecessary costs are incurred if barriers prevent people speaking up e.g risk of preventable errors occurring, incidents, poor practice or declarations of fraudulent behaviours, or poor behaviour. There are also human and financial costs associated with cultures where staff are not supported to speak up.
Compliance <small>Select an item. Select CQC standard from list.</small>	NHS Contract, CQC, the NHS Constitution and NGO Trust Board and FTSU Guidance
Partnership: consultation / communication	N/A
Equality	Concerns raised can highlight inequalities or matters related to fairness.
Quality Impact Assessment [QIA] completion required?	N/A

Annual Report - 2021 to 2022

Freedom to Speak Up

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK



A message from our Chief Executive

“I am really pleased to see the positive impact expanding our FTSU team has made. We know the critical importance speaking up plays in the success of our, and any, organisation, and I am glad this has been further strengthened by expanding and diversifying the team. Of course, the power of speaking up comes from those who have the courage to do so, and I would particularly pay tribute, and offer my thanks, to them”.

Neil MacDonald
Chief Executive Officer

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK

A message from our Chief People Officer

“It is important that colleagues across the Trust feel safe and supported to be able to raise concerns in the interest of patient safety and staff experience. This report helps to demonstrate our progress in continuing to strengthen our positive speaking up culture. Learning locally and across the Trust from concerns raised through the Freedom to Speak Up team plays a key part in the improvement cycle”.

Bridget O’Kelly
Chief People Officer

Our priority: people are listened to, safe and supported.

Making sure colleagues feel safe and supported to speak up and heard is just one of the ways we demonstrate this at BHT..... it underpins patient and staff safety, quality of care and improvement.

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK

Executive Summary

The Freedom to Speak Up Guardian (FTSUG) is a designated role which provides a safe place for colleagues to raise concerns safely, without fear of detriment or blame, helping to improve the safety of our patients and colleagues. The Freedom to Speak Up Guardian is a mandatory post for all NHS Trusts in England which also reports to the National Guardian Office thereby offering a level of independence.

Despite the ongoing impact of COVID throughout the past year, there are exciting developments to report and good progress which include the expansion of our “Speaking Up” service based on implementing an outreach model and introducing a small number of part time newly trained Freedom to Speak Up Guardians. We have also fully met our objectives for this year.

Whilst implemented for a trial fixed term period the benefits this has brought; as outlined in the report below, underpins the positive news that the Freedom to Speak Up Service will continue as a team. This also further demonstrates the commitment of the Trust to this agenda, patient safety and it’s workforce. Expansion of the team has also helped us to improve accessibility, diversity, sustainability and choice. Furthermore, it has also enabled us to have better representation at the staff networks with designated Guardians offering support.

In just 10 months the team have achieved more than **3,600 colleague contacts** (*not to be confused with concerns raised*) via the outreach model and have been raising awareness and educating colleagues about the service, the role of the FTSUG and the importance of speaking up to support patient and staff safety. More than 130 members of staff have raised concerns over the past year and we have dealt with over a 100 new cases. Some key themes and learning from this year are the importance and impact of managers’ behaviours and actions; the importance of good change management the importance of cultural and intercultural competence for all colleagues and the impact of violence and aggression from an albeit small number of our patients and their families towards colleagues.

“October Speaking Up Month” was a great success and bigger than ever before. This year the annual national and local campaign focused on the launch of national “Speaking Up” training for all staff. The team delivered a 34 strong varied programme of related activities across the Trust, and more detail follows. In just a few months since, we have achieved more than **4,500 colleagues** completing the national Speak Up module of national online training since October.

Furthermore, the launch of our new “Speaking Up Champion” role in January of this year as well as the development of specific training, has been very successful with a positive response with over 30 members of staff from a wide range of staff groups This will serve to further strengthen our outreach and embed the important principles of “Speaking Up” at a very local level within teams and departments.

Finally, our recent national Staff survey results show that we have again significantly improved our score, for staff feeling confident to raise clinical concerns which provides a narrative of improvement of 10% over the past four years. This year also saw us achieve results that were assessed as significantly better when benchmarked with the average for other similar Trusts in relation to confidence of staff in raising any concerns and them being addressed.

Section 1: The national picture 2021/2022

The National Guardian Office (NGO) has been progressing with the “Freedom to Speak Up” agenda for those working in healthcare across the country and this section contains a few of the key headlines.

National Guardian Office (NGO) Key headlines 21/22

- Jayne Chidgey-Clarke was appointed as the new National Guardian with over 30 years of experience in the NHS starting life as a nurse. She has also worked in higher education, with NHSE, voluntary and private sectors and just prior to taking up her post with the NGO was a NED for a Clinical Commissioning Group in the South West.
- The NGO has seen continued growth of the national Freedom to Speak Up Guardian (FTSUG) network with more than 800 Guardians across the NHS, national bodies the independent sector, hospices and soon to include the ICS organisations going forward.
- The national Freedom to Speak Up Guardian survey results over the past year revealed around 73% of FTSUGs responding felt that the “Speak Up” culture had improved in the organisations they support, yet results showed a disappointing drop of 5% from the previous year to just 63% in those who said they felt their organisation had a positive “Speak Up” culture.
- The NGO reports a concerning and notable drop from 80% in 2020 to 71% in 2021 for senior leaders supporting workers to speak up and 11.5% of FTSUGs reported they felt their senior leaders did not understand the role.
- Fear of retaliation or detriment and the fear that nothing will be done if they do, remain the largest barriers to workers speaking up.

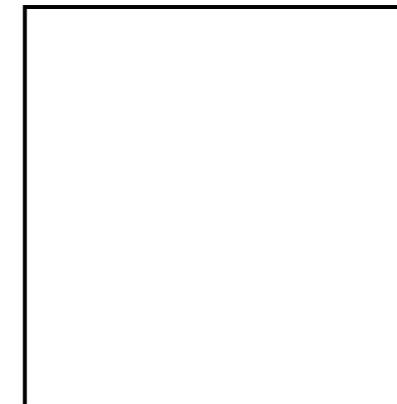
“Senior leaders must understand how important fostering a positive speaking up culture is for the success of their organisation, how it protects their workers, their patients and service users. I urge all leaders to use the results of this survey to prompt a conversation with their Freedom to Speak Up Guardian. The benefits speaking up brings can only be realised if leaders listen up and follow up. Guardians can be a significant source of support for leaders”.

*Jayne Chidgey-Clark – National Guardian
for the NHS*

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK

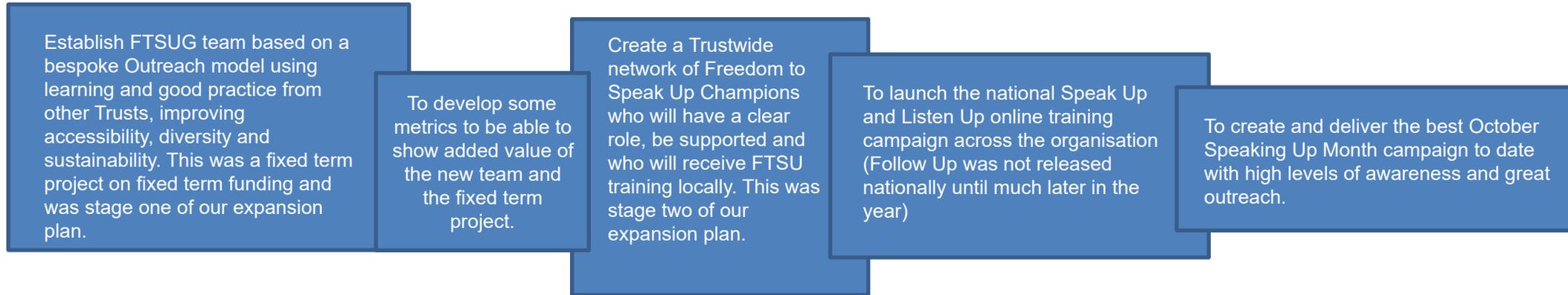


- The NGO has also launched the three packages of national online training for all workers, managers and senior leaders including Board members, Speak Up, Listen Up and Follow Up are the three modules
- They have developed a mandatory refresher training tool for all existing FTSUGs which will become annual.
- A revised package of support for new FTSUGs has been developed
- The NGO commissioned an important piece of research which BHT took part in; Difference Matters – Freedom to Speak Up and Race Equality Kline and Somra 2021.
- As a result of the Ockendon report, and the findings relating to colleagues feeling able to speak up, Jayne is now sitting on a national advisory group looking at recommendations.

Section 2:
Key areas of progress
for FTSU at BHT
2021/2022

This section provides a snapshot of some of the work undertaken this past year in support of continuing to build and progress a positive speaking up culture at BHT; despite the ongoing impact of the COVID pandemic.

In our Annual Report 20/21 we said that in 21/22 we would.....



Trust People Priority

Implementation of expansion plans for the FTSU service also serves as an example of how we demonstrate one of our Trust people priorities i.e that staff should feel safe, supported and listened to



FTSU Team
Four part time outreach FTSUG posts recruited. National and local training provided, internal opportunities for development flexible working and promotion

Metrics
More than **3,500 outreach contacts across acute and community services have been achieved in just 10 months.** Others follow in this report

FTSU Champions
More than **30** champions recruited since January 2022, despite COVID and winter pressures. Role defined and training created and delivered

Launch National Training
Speak Up, Listen Up, and Follow Up
4949 Colleagues have completed Speak Up **85.76%** since October

October Speaking Up Month
More than 34 varied awareness raising and participative activities run throughout the month incl an inclusive basketball match and Speakupulance

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK

Local Activity Concerns Raised 21/22

Quarter	2017/2018 Inaugural Year Cases	2018 / 2019 Cases	2019/2020 Cases	2020/2021 Cases (Covid)	2021/2022 Current Year Cases	Current Individuals
Q1 Cases	3 (Start-up quarter)	20	26	32	25	29
Q2 Cases	10	16	19	23	27	34
Q3 Cases	20	22	35	35	28	42
Q4 Cases	13	16	17	15	27	27
Year Totals	46	74	97	105	107	132

2017 to 2022 provides our first five years of BHT FTSU information. Across this period the **429** concerns raised, equates to **429** opportunities to make improvement, reduce risk and keep our patients and staff safe which might otherwise have been lost.

OUTSTANDING CARE

HEALTHY COMMUNITIES

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Changing the mindset

OUTSTANDING CARE

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Summary of those raising concerns in 2021 - 2022

Quarter	2021/2022 Current Year Cases	Current Individuals
Q1 Cases	25	29
Q2 Cases	27	34
Q3 Cases	28	42
Q4 Cases	27	27
Year Totals	107	132

During 2021 to 2022 we re-established the routine recording of ethnicity information for those raising concerns, but asked people to self define their ethnicity. This has been positive as it has helped to highlight the very rich diversity of our workforce.

A total of 107 individuals provided their ethnicity. For this report the summary groupings are :-

Black, Asian and Minority Ethnic Groups = 25% (27)

White Non British = 6% (7)

White British = 61% (67)

Other = 5% (6)

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Some examples of a range of outcomes Buckinghamshire Healthcare NHS Trust

A few examples to demonstrate the range of outcomes resulting from Concerns raised 2022

FTSU led listening events have been held, following an approach from a team. This resulted in a joint approach with management and a resulting action plan being put in place to address matters including changes affecting the way care is delivered, leadership support, behaviours, communication, environment matters and improving team dynamics

Covid risk assessments were quickly put in place following a concern raised after a service move and this had been overlooked in the new location. A colleague raised concerns about the lack of a safe screen and this was resolved immediately

A manager has now structured in a monthly drop in for their team colleagues with any speaking up issues, due to learning from a concern raised, they felt they wanted to do something to be more approachable / accessible.

Senior manager recognising the importance of visibility and accessibility helped to make staff feel more valued and listened to. Increased sense of approachability.

A manager was reminded of the need to follow up with individuals on long term sickness and policy requirements.

Colleagues are addressing behaviours that have been brought to their attention as being impactful in a negative way on colleagues.
A small number of managers have had awareness raised of their approach and style impacting on their team or colleagues in a way that has not been helping to maximise their potential.

Empowerment of a colleague to speak to managers themselves through support advice and help to boost confidence. The outcome was improved working relationships and colleague being recognized for their additional workload, resulting in promotion

Retention – A number of concerns have resulted in people choosing NOT to leave the organisation when at the outset of their concern they were thinking this was their only option.. Concerns addressed and colleagues retained.

A change in reporting lines resulted for an individual reporting stress and confusion at receiving mixed and inconsistent requests to themselves and their team one of whom were also affected by stress and poor behaviours This had occurred without intention and as a result of historical change over time without review. This positive change provided clear robust accountability for the postholder and their team, clarity of management line and responsibilities to the individual and team and Importantly clarity for the clinical team making the requests and their expectations.

Management were able to speak to their colleagues with regards to policies and procedures on use of mobile phone use, distributing the workload evenly and taking breaks as entitled to for the overall benefit of staff wellbeing and avoid burnout. Created an improved working environment

A team reported their work environment as not supportive of a positive Speaking Up culture and poor behaviours. Work has been done to address the behaviours and bespoke and focused work done with teams or individuals as necessary to help demonstrate how to build a positive Speaking Up culture. It is positive this is now being raised

An extensive range of conversations relating to interrelationship matters with co workers and managers to help support people get their concerns addressed and consider an informal route rather than opting for a formal route. This helps to reduce the number taking out formal HR procedures, which helps reduce personal stress, cost and unnecessary use of formal resources

Examples of individuals feeling they have been treated unfairly have been addressed examples include recruitment opportunities, promotions often resulting in people feeling assured that due process was followed and they have not been treated unfairly.

Multiple offers of information and referrals for personal coaching, wellbeing support and OD support, unions and specialist advice and support as required.

A few quotes from users of the BHT Freedom to Speak Up Service

Thank you very much for listening to my concerns and speaking to my line managers. It has been good to know there is someone who is taking my concerns seriously

Definitely, I felt very supported and I would have no hesitation in recommending the service to a colleague.

There is always need of a FTSG especially in a broad organisation such as the NHS

After receiving the support and care from the FTSUG it has given me the confidence to speak up and not be afraid

I have seen first, and second hand, how Speaking Up has had a positive impact on both an individual and team

I am grateful to work for an organisation which offers this kind of support. The only issue is the fact that the person who helped me is not a full time employee, therefore I often felt that things were happening and I could miss help as they weren't always available.

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Network of FTSU Champions

		NHS workforce	Bucks Population	BHT	34 Champion applications
Gender	Male	23.0%	49.0%	19.3%	8.8%
	Female	77.0%	51.0%	80.7%	88.2%
	Non binary	unknown	-	-	0.0%
	not declared	-	-	-	2.9%
Sexual orientation	LGBTQ+	2-3%	no data	1.2%	8.8%
	Heterosexual		no data	68.5%	82.4%
	not declared		no data	22.6%	8.8%
Ethnicity	White	77.9%	86.4%	69.0%	70.6%
	BAME	19.7%	13.6%	26.0%	23.5%
	not declared		-	5.0%	5.9%
Disability/ Long term condition	Disability/LTC	3.7%	13.0%	2.8%	23.5%
	none		-	87.1%	70.6%
	not declared		-	10.0%	2.9%
Religion and Belief	Christianity		60.0%	43.1%	35.3%
	Islam		5.1%	4.6%	8.8%
	Hinduism		1.2%	2.4%	2.9%
	Buddhism		0.4%	0.8%	0.0%
	Sikhism		0.9%	0.6%	0.0%
	Judaism		0.3%	0.1%	0.0%
	Other		0.4%	5.5%	8.8%
	Unknown		-	7.7%	-
	Atheism		-	9.3%	11.8%
	do not wish to disclose		-	25.8%	11.8%
none		24.0%	-	20.6%	

We are committed to building a diverse network of Freedom to Speak Up Champions from a broad range of roles and staff groups across the Trust. In January of this year we launched our recruitment campaign to recruit our champions.

Despite the impact of winter pressures and the impact of COVID, as of 31st March we had 29 applications and 11 trained, to date 35 colleagues have applied and 25 are trained.

A diverse network is important to us and the table shows our network of FTSU champions has strong representation of our BAME colleagues and in some cases is over represented e.g disability at 23.5%, LGBTQ+ and sexual orientation. However, males are under represented and this will be an area of focus for us going forward.

Having defined the role of the FTSU champion at BHT mindful of national guidance which is important for governance and good practice, role descriptions have been developed, we have created a bespoke training package and rolled out a widespread and ongoing recruitment campaign. All training sessions have been evaluated to date and a summary of results are shown in the next slide.

We can evidence a variety of over 67 actions or activities across our team to promote and recruit champions since January and look to build a strong and participative network with mutual learning and developmental opportunities which is already showing benefits.

Evaluations of FTSU Champion Training

Collated for period February 2022 to May 2022 4 months.
Participants attending Freedom to Speak Up Champion Training

	Strongly Agree	Agree	Neutral	Disagree
The aims of the training were clearly defined	22	5	0	0
The content was well structured and easy to follow	23	3	1	0
Participation and interaction were encouraged	23	3	1	0
I feel more confident for colleagues to approach me with their concerns	21	6	0	0
I am happy that I have a better understanding of the role of the FTSU champion	24	3	0	0
I feel happy that I understand what this role is and what it is not	26	1	0	0
I have a clear understanding of the importance of Confidentiality and Consent	26	1	0	0
I know how and where to signpost my colleagues	25	2	0	0
I would recommend my colleagues to consider becoming champions	21	6	0	0
It was good to meet members of the FTSU team	25	2	0	0
I felt able to speak up and ask questions	25	2	0	0

Overall participants rated their learning experience as follows:

Excellent = 26
Good = 1
Average = 0
Poor = 0

Some quotes of comments provided :

- Clear understanding of Role of FTSU and Champion Role
- Gained more confidence around the Role
- Inclusive Training
- Engaging
- Needs more time
- More resources for staff to show who are champions

“Thank you so much for the session yesterday. It was the first face to face training I have done since the pandemic and it was really good”.



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National Staff Survey 2021



Buckinghamshire Healthcare
NHS Trust

With over half the organisation responding the national staff survey results show just under 10% improvement over 4 years in staff feeling secure to raise concerns about unsafe clinical practice. (*Realistic improvement is usually at around 1-2 % per year*).

Responses to this question also achieved a “significant improvement”, this is one of two this year.

Confidence in concerns getting addressed across the Trust remains above average but it fell by 1% and is the first time to fall in four years.

This continues to bring encouragement and assurance of the positive journey the Trust has progressed in this area but is a reminder there is more work to do.

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National Staff Survey 2021



Buckinghamshire Healthcare
NHS Trust

These two questions are new questions with feeling safe to speak up about anything, Q21e in it's second year. It is an important question to help us measure our speaking up culture more broadly. Results show that we fell by 3.9% however, they also highlight this was a difficult year nationally for all. We remain 2.4% above those classed as average and we are not an outlier.

Q21f is a new question introduced this year.

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Actions, follow up and feedback when concerns are raised help colleagues feel heard.



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October Speaking Up Month 2021

The National Theme for this year was the new National Freedom To Speak Up Training, Speak Up, (all workers) Listen Up (all managers) and Follow Up (all senior leaders and Trust Board Members) , the latter module was still to be published at that point.

The exciting expansion of our FTSU team has enabled the expansion of our October Speaking Up Programme this year with a considerable range of no less than 34 activities delivered throughout the month. Locally, as well as delivering the national agenda we have tried to build a programme that touches on behaviours and their impact. A few examples of sessions and activities which included promoting completion of the national Staff survey and black history month also included:

- The importance of Psychological Safety, supported by our Chief Executive and Dr Clare Daniels our Chief Psychologist,
- Speaking Up and Black History month, resulted in a collaborative session exploring the challenges, with powerful input and experiences from Molly Chibvuri our matron for ICU,
- Patient Safety and Being the Best We Can Be explored with our Chief Nurse how the impact of a poor Speaking Up culture can impact on patient and staff safety.
- Collaborative working with SCAS resulted in another visit from their Speakuplance and we ran a” Keep Ups for Speaking Up” competition for both our staff and the paramedics. We held our first ever sport event in the programme with our “Shots Up” for Speaking Up and a really great and inclusive evening of fun basketball with a wheelchair user and spinal injury.

- October the 20th saw us all in green (*national colour for Speaking Up*) with our Trustwide Wear Something **Green Day**,
- Dr Matthew Size, Consultant Anaesthetist, did a bespoke session on Speaking Up for excellence and talked about Appreciative Inquiry (AI)
- In addition, the team were busy being out and about with stands, our selfie Speaking Up frame, they have been asking people to make pledges and of course taking lots of pictures.

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Next steps for the FTSU team 2022 to 2023

- **Nationally** – We await further information regarding the expansion of the role out of FTSUGS into social care and into the new ICS bodies.
- **Locally** – We look forward to a visit by the National Guardian (*confirmed for 28th July*)
- We will review the outreach model and using learning make relevant change to further progress where possible. (*31st August*)
- We will liaise with the FTSUGs of the top five organisations for results against the FTSU questions in the national staff survey to utilise learning from best practice. (*31st August*)
- We will look to focus recruitment on males colleagues to join our champions network (*31st December*)
- We will give focus to moving forward and building a strong FTSU champion network (*Ongoing*)
- We will participate in October Speaking Up Month 2022 and support the national campaign.
- We will continue with our ongoing journey to build a consistent positive Speak Up culture across the Trust and support our colleagues to feel safe to speak up at BHT in the interests of patient and staff safety and quality of care. (*Ongoing*)

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Corporate Risk Register (CRR)	
Board Lead	Karen Bonner Chief Nurse	
Name of author	Sandie Knight, Governance Manager	Reema D'Souza, Associate Chief Nurse for Governance and Regulatory Compliance.
Attachments	Corporate Risk Register	
Purpose	Assurance	
Previously considered	EMC 05.07.2022 Audit Committee 07.07.2022	

Executive Summary

This report outlines the corporate risks for the Trust. The risk management process is complied with in managing and mitigating the risks on the Corporate Risk Register (CRR).

There were 2 new risks escalated to EMC for approval for inclusion on the CRR:

- **CRR162/ Rad40** - No Interventional Radiology (IR) service available at BHT: the IR suite is condemned due to equipment failure. A business continuity plan is in place for 2-week wait and urgent patients with Oxford University Hospitals. The risk is scored at 16 with a target date of March 2023.
- **CRR163/IECC04** - There is a risk that the Discharge to Assess (D2A) beds and Home First packages of care will be closed to admissions severely compromising patient flow due to a reduction in patient discharges: The risk is scored at 25 with a target date of November 2022. The risk narrative is pending review by the COO.

EMC approved the inclusion of CRR162/Rad40 but did not approve the addition of risk CRR163/IECC04. Raghuv Bhasin has an action to review the risk and score.

There are 2 risks for de-escalation and approval sought to remove from the CRR:

- **CRR151/TP09-01** Failure of Critical Bleeps systems at Wycombe & Amersham Hospitals: The new system has been purchased awaiting installation and 18 2-way radios have been hired to mitigate in the event of a bleeps failure in the interim. The score has been reduced from 15 to 12 and the team will continue to monitor the risk on the IT divisional risk register until the installation has been completed in August 2022.
- **CRR116** – Failing Datix system: The new Datix version 14 went live on April 1st mitigating the risk of the incidents system failing. The score has now reduced to the target residual score and the risk can be removed from the CRR.

EMC approved the removal of risk CRR116 but requested that CRR151 remain on the CRR until the new Bleeps system has been installed in August.

EMC also requested the actions for CRR156 and CRR158 be changed to the Commercial Director, rather than EMC.

The Audit Committee queried whether the residual score was high enough for risk CRR155/FINT20. The Chief of Finance will review the risk to provide an updated narrative for this risk.

The Audit Committee queried the residual risk score for CRR163/IECC04 given mitigations were in place and requested a verbal report be made to the Trust Board in Private on 27th July.

The Audit Committee queried why three risks which lapsed at the end of June (CRR161, CRR143 and CRR139) had not yet been reviewed. At the Risk and Compliance Monitoring meeting on July 20th, the teams involved agreed a holding date for these risks of 31st August 2022 whilst they were being reviewed and confirmed these would be amongst the first to be added to the new Datix system following review.

Teams are undertaking full reviews of their risks in readiness for the migration to Datix and because of this some risks on the CRR have not yet been fully updated. 3 risks are due to lapse at the end of June and updates have been requested for these.

Decision	The Committee is requested to review and approve the risks for addition and removal from the Corporate Risk Register and note the updated actions.		
Relevant strategic priority			
Outstanding Care <input checked="" type="checkbox"/>	Healthy Communities <input type="checkbox"/>	Great Place to Work <input checked="" type="checkbox"/>	Net Zero <input type="checkbox"/>
Implications / Impact			
Patient Safety		Identifies any potential patient safety concerns	
Risk: link to Board Assurance Framework (BAF)/Risk Register		1. Provide Outstanding, cost-effective care 2. Taking a leading role in our community 3. Ensure our people are listened to, safe & supported.	
Financial		There can be a legal and financial impact if the Trust is non-compliant with appropriate and effective management of risks. The Trust may also suffer reputational damage from uncontrolled risk management.	
Compliance <small>Select an item.</small> Good Governance		Regulatory and legislative requirements.	
Partnership: consultation / communication		Consultation and Communication identified in updated actions	
Equality		The Trust is committed to the fair treatment of all patients and service users, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependents, sexual orientation, or any other personal characteristics.	
Quality Impact Assessment [QIA] completion required?		Not Applicable	

1. Purpose

This report updates the Committee on risks for addition and removal from the Corporate Risk Register. It provides oversight of the risk management process within the organisation and notifies mitigation actions for the risks within the Corporate Risk Register (CRR) (Appendix 2).

2. Background

The Divisional Director or their representative will identify all new and current risks scored at 15 or above on the Divisional and Corporate Service risk registers and bring these to the Associate Chief Nurse for Governance and the Risk and Compliance Monitoring Group (RCMG) attention every month. The RCMG will review the risks scored 15 and above on the Divisional and Corporate Service risk registers and guide the Executive Management Committee (EMC) to moderate these risks for the inclusion or exclusion from the CRR.

There is a regular review of CRR with the responsible Director during which the level of risks, mitigating actions, target dates and outcomes are discussed.

3. Updates:

The following Risks have been updated:

- **CRR27b/PS153** – HV/LV cabling: whilst the deadline has extended to August due to the change in contractors and additional requirements to the original plan, the installation of new parts and improved backup generators has reduced the risk of corrosive and system failure, therefore the score has been reduced from 5x4 to 5x3 to reflect this.
- **CRR88/PA27** – Patient Tracking: The target date and the current risk score remain unchanged.
- **CRR126/HR06/2022 (previously Covid-19 Ref 11)** - Increased impact on staff physical and psychological health and wellbeing from working during COVID-19 pandemic: The risk has been reviewed and actions updated however, the score and target date remain unchanged.
- **CRR130/PS177** – Tower Block at Wycombe Hospital: A further 40 panels are to be removed. Mitigations remain in place to protect staff and service users. The current target date of 30/09/2022 is correct for the survey work to be completed. The score and the target date remain unchanged.
- **CRR141/Paeds32** - Insufficient capacity Paediatric Decision Unit footprint: There are no updates to this risk. Mitigations remain in place and the target date and score remain unchanged. This risk will reduce once construction of the new Paediatric Unit has completed. This risk was discussed at the Audit Committee and an update to the target date from 31/08/2022 to December 2022 was agreed because there have been further delays in the progress of the build.
- **CRR146/Card01** - Ward 2a Environment: There are no updates to this risk. Mitigations remain in place awaiting the relocation of the ward.
- **CRR147/TO05-19** – Cyber incident disruption: Work continues in preparation for the DSP toolkit submission in June 2022 and quarterly reporting is in place to monitor. The target date and risk score remain unchanged.

- **CRR150** - Clinically inappropriate length of stay in Emergency Department (ED): Additional cubical capacity for triage and assessment is now in place in ED and the onsite UTC is reducing the volume of patients passing through ED. The Prism contract is coming to a close at the end of June and a revised action plan will be put in place following a detailed handover. The target date has been extended from April to June 2020 and the risk score remains unchanged pending further review until the action plan is in place.
- **CRR155/ FINT20** – Trust’s capital resourcing Insufficient to support objectives: there has been no changes to this risk this month.
The Audit Committee queried whether the residual score was high enough for the risk. The Chief of Finance will review the risk to provide an updated narrative for this risk.
- **CRR156** – Program Business Case going to Trust Board 29th June. The target date of March 2023 applies to completion of the Outline Business Case (OBC) however, the overall target date has been extended to March 2024.
- **CRR158/ Card01/PS221** – Ward 2a environment: there is currently no update to this risk. The ward relocation has yet to be confirmed so the target date and risk score remain unchanged.

EMC requested the actions for CRR156 and CRR158 be changed to the Commercial Director, rather than EMC.

- **CRR159/ HR03/2022** – Shortage of registered and unregistered nursing staff, which results in high reliance on temporary staffing: There is currently no update for this risk. The target date and risk remain unchanged.
- **CRR160/ HR02/2022** - Shortage of registered midwives and the establishment headcount increased in response to the Ockenden Report: There is currently no update for this risk. The target date and risk remain unchanged.

4. Lapsed Risks which require urgent review

The following risks lapsed at the end of June and are currently under review with the COO. We have agreed holding dates of 31st August for all three although it is likely the target dates will extend for all of them following review:

- **CRR161/Can21** – Non-compliance with 62-day Cancer standard: the score has been reduced from 20 to 15 as further mitigations have been put in place.
- **CRR143/S246** – Ophthalmology Service: A review is currently under way to consider additional services on the Amersham Hospital site.
- **CRR139/S244** – Clinical harm on extended waits for elective surgery: although there has been some reduction in the waiting list work is still ongoing to reduce this further.

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

The following risks have been escalated for EMC to approve for inclusion on the CRR

- **CRR162/ Rad40** - No Interventional Radiology (IR) service available at BHT: the IR suite is condemned due to equipment failure. The risk is scored at 16 with a target date of March 2023. The risk narrative is under review with the COO.

- **CRR163/IECC04** - There is a risk that the Discharge to Assess (D2A) beds and Home First packages of care will be closed to admissions severely compromising patient flow due to a reduction in patient discharges: The risk is scored at 25 with a target date of November 2022. The risk narrative and score is under review with the COO.

EMC approved the inclusion of CRR162/Rad40 but did not approve the addition of risk CRR163/IECC04. Raghuv Bhasin has an action to review the risk and score.

The Audit Committee queried the residual risk score for CRR163/IECC04 given mitigations were in place and requested a verbal report be made to the Trust Board in Private on 27th July.

6. Risks requiring EMC approval to remove from the CRR

- **CRR151/TP09-01** Failure of Critical Bleeps systems at Wycombe & Amersham Hospitals: The new system has been purchased although not yet installed. 18 2-way radios have been rented to mitigate in the event of a failure in the interim. The score has been reduced to 12 from 15 and the team will continue to monitor the risk on the IT divisional risk register until the installation has been completed in August 2022.
- **CRR116** – Failing Datix system: The new Datix version 14 went live on April 1st mitigating the risk of the incidents system failing. The score has now reduced to the target residual score of 2 and the risk can be removed from the CRR.

EMC approved the removal of risk CRR116 but requested that CRR151 remain on the CRR until the new Bleeps system has been installed in August.

7. Emerging Risk

A request for escalation to the CRR was made for the following risk at the RCMG on 20th June but the teams are collating further information before the risk is formally escalated:

SH41 - Sexual Health Services commissioned by Public Health at Buckinghamshire Council. The current tender award of 5 +2 years ended 31st March 2022. Commissioners have advised a competitive tender will take place later this year although timelines and bid details are not yet known. There is a risk of:

- loss of income to the Trust if the retendering is not awarded to BHT
- potential adverse impact on staff morale/retention during the tender process.
- destabilising integrated sexual health services - separate commissioning pathway for HIV treatment and care.

8. Planned improvement activities on Risk Management and Risk Register

- Upgrade to Datix system: The Risk Management Module launched in early June and the Governance team continue to work with the divisions to improve their risk registers in preparation for the migration to the new Datix platform. The new system will ensure management, assurance and governance around the risk journey across the organisation (Appendix 4).
- Review of Risk Management Policy: The policy has been reviewed and consultation has undertaken. It was approved for submission to EMC at TPSG on 14th June 2022 and

approved at EMC 28th June. The policy will now be submitted to the Audit Committee and the Trust Board for final ratification.

- Trust-wide risk management training programme: The training programme commenced in May and continues whilst the divisions review and migrate their risks.
- Review of divisional governance meetings: Scoping activity is currently being undertaken to review the structure of Divisional Governance meetings to standardise and strengthen the discussion in these meetings. Along with other governance elements, the governance meeting agendas will incorporate the moderation of the divisional risk register.
- Monthly meetings to review service level risk registers to support the service unit governance leads.
- Restructure to align CRR and BAF reporting based on best practice: Work continues to link the CRR to the Trust strategic priorities and BAF (Appendix 2).

9. Recommendation

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

10. Appendices

Appendix 1: Risk Grading:

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

Appendix 2: CRR

Appendix 3: Heat Map

Corporate Risk Register	Divisional Risk Register	Division	Date added to CRR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
									C	L	C x L					C	L	C x L
CRR 27B	PS153	Property Services	20/10/2017			The SMH main HV/LV electrical supply is insufficient for the current needs of the Estate and is not resilient. In addition, due to the discovery of corrosion on the existing equipment, the installation of a new joint box and replacement switch gear and cables is also required. If external supplies fail the internal back up support generators will only support the power needs of the site for 4 hours. This will affect all clinical and non clinical services.	25 (5x5)	A generator supply system which will provide emergency power to all of the site. This project will re-structure the power supply systems to provide secure services. Initial 4 hour back up will require extra fuel deliveries to allow continuation of generator support and Clinical services. Contract in place. Individual medical equipment has limited battery back up for approximately 30 minutes. New cabling and switch gear installed. Transformers and distribution panel installed.	5	3	15	Insufficient power supply Only one electrical supply cable, 2nd needed for resilience	The organisation contracted for this work has gone out of business and further contractors have been sought to complete the outstanding actions. A requirement for an additional transformer connector and a new generator have also been identified and will be included as part of this work. The project deadline has therefore been extended a further 3 months to August 2022. Risk owner: Head Of Estates Development	31/08/2022	Commercial Director	5	1	5
CRR 88	PA 27	Trust	19/02/2018	Provide outstanding, cost effective care	We will consistently meet or exceed quality (safety, experience, outcome) and performance standards	Risks within outpatient services in booking patients within the correct timescales. Includes, urgent, new referrals, injection appointments and injection follow ups. There is a risk that harm can come to patients if they are not tracked robustly and given follow up appointments in a timely fashion. This risk includes: Growing number of patients being placed on hold following an outpatient appointment for the following reasons: - added to waiting list - awaiting diagnostics - no outcome form - insufficient capacity - SOS Visibility has been restricted due to lack of reporting, and since reporting has been in place minimal operational review has occurred Patient placed in an On-Hold status as a result of insufficient capacity and COVID-19 reduction of services. Insufficient monitoring of hospital-initiated cancellations Clinical risk of patients potentially being 'lost to follow up' with the risk of delays in care and subsequent poor patient outcomes Patients referred by the e-referral system that are unable to book an appointment due to capacity constraints (ASIs). Hot spot specialities include Ophthalmology	25 (5x5)	To mitigate there is significant manual recoding and escalation reporting via APMG and live escalation reports, a weekly meeting with each ops team to discuss pressures. Despite this risk have continued. 6 week booking model and reporting introduced 2021 to allow operation teams to plan their capacity demand more effectively. Weekly reporting through Recovery EMC	4	4	16	Individual compliance by consultants in completing the e-outcome forms - supported by the Medical Director Ability to be able to track non-compliance with agreed standard operating procedures. Gaps sit with the individual specialities as per the performance management structure - Insufficient outpatient capacity - need to reduce follow up appointments	Access team to continue to escalate to each relevant service management team. CGL to circulate the need for all specialities to have this on their RR also - Ophthal, Derm, T&O, in particular	15/11/2022	Chief Operating Officer	4	2	10
CRR 126	HR06/2022 (was Covid-19RR ref 11)	Trust	01/04/2020	Ensure our people are listened to, safe and supported	We will deliver our 5 people priorities	Increased impact on staff physical and psychological health and wellbeing from working during COVID-19 pandemic. Specific risks include: increased pressure in work environment - wearing of PPE for prolonged periods, increased end of life patients, caring for colleagues, working in new environments	20	•Comprehensive staff occupational health offer - including direct referrals from OH into the Long Covid clinic for staff, new physio started end of May 22 to support more proactive engagement of MSK issues. Fit mask testing includes a range of mask sizes/types to accommodate individual needs. • Comprehensive Wellbeing team offer including regular wellbeing comms plan to inform and encourage self-care, psych-educational material and webinars. Colleagues actively participating in social prescribing support via Lindengate and Horsehead to support rest and reflect. Additional wellbeing team outreach support thanks to 3 new counsellors. Wellbeing partnering with HR and OD to support priority teams e.g. Theatres. We continue to drive REACT and MHFA training and train additional TRIM practitioners. • Weekly debriefs with CEO and regular communications (We need this explained)• Staff networks • Employee Assistance Programme (Vivup) in place for over a year offering 24/7 support and has been renewed for a further year. Good levels of awareness and use. • Building strong partnership with BOB Mental Health Hub for additional wellbeing support and they are also able to refer back to us for counselling support	4	4	16	Impact of sustained pressure of managing COVID-19 is evolving. Level of resignations in some departments affecting wellbeing of some of our colleagues. Ability of some departments to recruit staff.	Extra wellbeing resource enabling us to further extend our outreach and drop -in facilities to reach those who would not otherwise refer or access services. This builds on previous awareness levels raised by Winter/Thrive Care pack. Building a new wellbeing garden to facilitate onsite rest and reflection - complete Dec 22/Jan23 Wellbeing drop-ins continue for ICU colleagues and are being extended to other teams. Small team/group recovery sessions are being offered to priority teams including restorative wellbeing sessions for priority teams. High engagement, anti-bullying campaign mid June (ran for 6 months); to create and embed a culture of respect and kindness across the Trust. The Managing Violence, Aggression and Unacceptable Behaviour Policy was updated Dec 21/Jan 22 and will be supported with training/socialisation. Two interactive Health MOT kiosks installed (one at SMH and one at WH); we are evaluating usage and referrals coming in to wellbeing. Kiosks on a 6 month trial and will move to other sites during this period. BHT nurse-led Health & Wellbeing checks will be in place in May to further support physical and mental wellbeing. Peak 1 core management development mandatory for all elements BHT are one of 23 exemplar sites for NHS People Programme Retention programme. Through the programme we aim to improve our colleagues experience at work, making BHT a great place to work by improving psychological safety, team working, colleague rest areas and availability of healthy foods etc. Restorative Just culture programme is one year into a 2 year programme.	31/03/2023	Chief People Officer	4	2	8

Corporate Risk Register	Divisional Risk Register	Division	Date added to CRR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
									C	L	C x L					C	L	C x L
CRR130	PS177	Property Services	20/10/2020	Ensure our people are listened to, safe and supported	Our buildings and facilities will be great places to work and contribute to health and wellbeing of staff	Wycombe Hospital. The concrete panels installed on the exterior of the tower block are at risk of falling away from the main building to the ground due to deterioration of the cast iron clips installed when the tower was constructed. The structural integrity of the tower block is under investigation as the last survey has identified potential failures.	20	Scaffolding is currently erected with boarding to protect persons from smaller spalling concrete. Larger concrete panels which have been identified as concerns have been removed. Additional scaffolding and stronger boarding has been installed and following advice from structural engineers has been extended around the whole building.	5	3	15	No capital budget available for the works	Full condition survey to be completed by structural engineers - ongoing Decision on repair work to be agreed following recommendations made in survey. EMC has agreed to fund additional investigations on the external immediate structure (£527k) 31/05/2022. Further investigation and testing of the structure and concrete chemistry is required to determine the continued safe use of the building (as above) and should be completed by 30/09/2022. A further 40 panels to be removed from the tower. Continue to update the EMC and Trust Board on the Services and condition and patient experience.	30/09/2022	Commercial Director	5	1	5
CRR139	S244 (Previously CRR66/ S228)	Trust	18/02/2021	Provide outstanding, cost effective care	We will consistently meet or exceed quality (safety, experience, outcome) and performance standards	There is a risk of potential clinical harm attributed to patients waiting for elective surgery. This is as a result of the COVID - 19 pandemic where elective surgery was reduced. This has also affected the delivery and sustainability of the national standard for Referral to Treatment Time (RTT) There is an increased likelihood of 52-week breaches occurring in all surgical specialities and treating patients classified as P2 within the mandated four weeks.	20	RTT performance is monitored through: Weekly Patient Tracking List (PTL) meetings. Weekly Access Performance Management Group (APMG) meetings. Monthly Divisional Performance Meetings •Training programme established for IFR funding process and adherence to CCG criteria •Evidence Based Intervention monitoring •Recover capacity post COVID •Additional Waiting List Initiatives •Continuation of Vanguard facilities •Performance trajectories in line with National targets •Retaining elective activity in safe facilities •Full demand and capacity review of all specialities to be repeated by October 2021. Harm assessment completed for each patient on the waiting list (In Progress due for completion 30th November 2021) Individual clinical harm reviews for any 52-week breaching patient.(Ongoing for completion December 2021) •All appropriate appointments moved to virtual •Referrals of all surgical specialities to be vetted Priority post COVID-19 elective recovery planning in place •Maximise use of the Independent Sector •Outsource work via the ICS as appropriate •Business planning commenced to increase capacity in 21/22 •Patient communication: •20,000 letters to patients waiting first appointment •Refresh of prioritisation letters to patients on elective waiting list Trust wide RTT training programme completed.	4	5	20	Outpatient Clinic capacity is lower than 19/20. Elective capacity is lower than 19/20 Capacity restrictions due to IPC Capacity does not meet backlog demand. Inability to recruit to nursing and medical vacancies across the Trust. Patient choice to defer treatment NHSE expectation to reduce elective operating in times of pressure in the system.	Increasing the amount of day case and elective surgery in line with IPC recommendations (Reviewed weekly) Maximise use of IS facilities (Ongoing) Implement partial booking and Patient Initiated follow up which will support the teams to proactively plan the ambulatory pathways Management plan for all patients over 104 weeks (Reviewed 3 times Weekly) Prioritise capacity for highest clinical harm risk (Assessed Daily) Recovery trajectory monitored through APMG and oversight provided at the elective care recovery group in line with NHSE Phase 3 requirements PWC Action plan to further address backlog and improve theatre productivity - launched October 2021	30/06/2022	Chief Operating Officer	4	2	8

Corporate Risk Register	Divisional Risk Register	Division	Date added to CRR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
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CRR141	Paeds 32	Women, Children and Sexual Health Services	18/02/2021	Provide outstanding, cost effective care	We will consistently meet or exceed quality (safety, experience, outcome) and performance standards	Insufficient capacity within the Paediatric Decisions Unit footprint for ongoing treatment of children and young children leading to periods of overcrowding. Triage Process through Paediatric Decisions Unit inability to rapidly assess children who may be unwell	20	<ol style="list-style-type: none"> Weekly review of datix documenting the escalation into the outpatient area 5a and 5b. Review of complaints related to the PDU environment and waiting times. Daily review of patient attendance within PDU. BHT Guideline 279.1 Paediatric Decisions Unit (PDU) Triage Guideline. Contains overcrowding tool for escalation. Specific training for all nursing staff involved in triage as part of mandatory training. G.P. streaming of minor illnesses to support urgent care pathway. Use of outpatient area 5a and 5b to support early assessment of children and young people. Identification of those children and young people who can remain in waiting area awaiting review by medical staff Additional staffing for PDU overnight to support activity Paediatric Senior Nurse support out of normal working hours Emergency Department to support paediatric minor injuries flow to reduce triage times for children and young people who are acutely unwell. Additional temporary staffing for PDU overnight to support increase in overall activity enabling the ability to increase the number of triaging staff. Appointment of additional Matron to support the development of paediatric urgent care pathways 	5	4	20	<ol style="list-style-type: none"> Continued review of triage pathways including minor illness and minor injuries exploring alternative pathways for triage of these patients. Escalate to divisional board to support the physical expansion of PDU. provision of appropriate space 	<p>Creation of new bespoke Paediatric Emergency Department supported with funding provided by NHS Improvement, programme is underway and scheduled for completion August 2022</p> <p>Escalation plan agreed for autumn/winter 2021/2 – substantive recruitment to band 6 nurse posts to support escalation plus planned allocation of ward 9 to CYP until new observation area is constructed.</p>	30/08/2022	Chief Operating Officer	5	2	10
CRR143	S246 (Previously S245)	Surgery	20/05/2021	Provide outstanding, cost effective care	We will consistently meet or exceed quality (safety, experience, outcome) and performance standards	<p>As a result of the Covid-19 pandemic the ophthalmology service has a significant backlog of new and follow up glaucoma appointments (there are over 1300 new referrals and 5000 follow ups unable to be reviewed due to lack of capacity).</p> <p>This has decreased to 128 new referrals outstanding in January 22. This has been achieved through the use of an insourcing provider. However the number of FU patients has increased to 7346 (1196 from the Insourcing provider and 6150 Trust activity FUs).</p>	20	<p>Clear patient guidance for appointment schedule</p> <p>Engaged with Getting It Right First Time team for NHS Improvement to implement the high impact interventions for ophthalmology.</p> <p>Ophthalmology specific electronic patient record system now live across all sub-specialties and key to tracking Glaucoma patients.</p> <p>Glaucoma failsafe Officer in place and a pivotal part of the team.</p>	4	4	16	<p>Space for booking teams to be housed in one central location</p> <p>Availability of physical space in the Mandeville Wing to accommodate the required levels of activity</p> <p>Lack of nursing support for all the additional activity required within the department.</p> <p>Challenge to recruit high quality Fellows.</p>	<p>Reconfiguration of Amersham space (replicating the efficient clinic set – up currently used for AMD) to create an enhanced ophthalmic service with increased workflow and capacity. This would future proof the service for the next ten years. Full business case pending having been approved at EMC for service specification to be written.</p> <p>Continue virtual glaucoma outpatient clinics at WH and SMH utilising AHPs and nursing staff to support. This will increase the number of patients reviewed (c60 patients per week on each site).</p> <p>Working with NHSE national GIRFT South East of England programme - high volume glaucoma new clinics</p> <p>Business case for additional establishment now in place and included in the H2 funding</p>	30/06/2022	Chief Operating Officer	4	2	8

Corporate Risk Register	Divisional Risk Register	Division	Date added to CRR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
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CRR147	TO05 - 19 [IT309]	IT	29/07/2021		Taking a lead role in our community	Risk of disruption to Trust technology systems and services caused by cyber incidents.		<p>Cyber security accountabilities in place.</p> <p>Hardware & software patching up to date.</p> <p>Education and awareness of cyber risk.</p> <p>Regular auditing and monitoring of controls.</p> <p>Data Centre business case approved 04/12/2020.</p> <p>DSP Toolkit submitted on 30th June 2021.</p> <p>Quarterly reporting ongoing and monitored by the Caldicott Committee.</p> <p>CISO (Cyber Information Security Officer) started in February 2022.</p>	5	4	20	<ul style="list-style-type: none"> Cyber Security strategy Software moving out of mainstream vendor support 	<p>Cyber Security strategy being defined.</p> <p>Focus on IG Mandatory training compliance - to be achieved by 30/06/2022.</p> <p>DSP Toolkit Submission for June 2022 currently being worked on.</p> <p>The Datacentre and Network Infrastructure projects to be completed.</p> <p>Quarterly reporting - to continue.</p> <p>Action Owner: Technology Director</p>	31/03/2023	Chief Digital & Information Officer	5	2	10
CRR150		Integrated Medicine	28/10/2021		Provide outstanding, cost effective care	Clinically inappropriate length of stay in ED including time to Triage, treat and discharge or admit.		<p>Triage protocol incorporates (including Streaming Nr) Front Door Team. Treatment Nr to support Triage when Wait time increases. DTA times reported to site team and recorded on Medway. ED Consultant DTA.</p> <p>EOU admission packs are premade. Site team to prioritise DTA patients from EOU as part of the EOU SOP.</p> <p>Departmental and hospital escalation policy in use. Crowding tool used.</p> <p>Operational policy for medically expected patients.</p> <p>Acute care coordinator escalating to operational team when more than 5 patients are waiting to be seen by the medics.</p> <p>Use of EOU for appropriate ED patients to create capacity in the main department.</p> <p>Additional cubical capacity within ED for triage and assessment now operational</p> <p>Operational onsite UTC</p>	3	5	15	<p>DTA times rely on Snr Speciality Decision Maker</p> <p>Streaming Nr Vacancies</p> <p>Treatment Nr Vacancy and Triage capability of Treatment Nr</p>	<p>Triage training to be undertaken for Nr team including Treatment Nr</p> <p>Engaged Prism Improvement to support improvement programme around UEC - focus on A&E processes, standardising ward processes and discharge - the Prism contract is coming to a close at the end of June and following a detailed handover a revised action plan will be put in place</p>	30/06/2022	Chief Operating Officer	3	2	6
CRR151	TP09-01	IT	03/11/2021		Take a leading role in our community	<p>Failure of Critical Bleeps systems at Wycombe & Amersham Hospitals. Old equipment, with custom parts, 20+ years old. Recent & more regular failures have occurred to system. System is maintained on a "Best Endeavours" basis by supplier. Partial or total loss of system would mean delay in Cardiac Arrest calls going out or being missed totally.</p> <p>Equipment requires full replacement. System not capable of supporting smart devices. System is also located in a room with water ingress which could write off the entire system. System needs to be moved from current location</p>		<p>Daily test calls placed on each system.</p> <p>Support contract engaged for the next 12 months with A and T and this has been increased to 24/7 support</p> <p>Revised BCP plan documented and with Medirest Helpdesk</p> <p>Backup two-way radio system for BCP WH</p> <p>Emergency Mobile phones BCP AH</p> <p>Estates working to prevent water ingress</p>	4	3	12	<p>Unable to define time from failure to fix due to custom nature of system and parts available to fix - best endeavours</p> <p>No two-way radios at AH for BCP BCP mobile phones at AH have patchy coverage and each person has to be called</p> <p>Current bleeps system unlikely to integrate with new Trust 8x8 IP phone system</p> <p>Uncontrolled use of radio systems on site possible to interfere with critical bleeps</p>	<p>Business continuity plans are in place.</p> <p>A new bleeps platform has been purchased and installation work has commenced. Expected completion in August 2022 barring supply chain and PFI cabling delays</p>	31/08/2022	Chief Digital & Information Officer	2	2	4

Corporate Risk Register	Regional Risk Register	Divisional Risk Register	Division	Date added to CRR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
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CRR154	FINT22	Finance	09/02/2022	We will deliver a financially sustainable plan and improve our benchmarking in model hospital	Trust is unable to define / live within its financial envelope impacting on its ability to resource / deliver clinical, operational and strategic priorities	20	EMC, Finance Committee and Audit Committee scrutiny	5	4	20	Lack of national guidance	Detailed Action Plan to be developed and ratified by Finance Committee / Trust Board. Budget setting underway based on current / known guidance for Board approval/ratification. External financial review in progress to support Trusts financial sustainability/recovery	31/03/2023	Director of Finance	3	3	9		
CRR155	FINT20	Finance	23/02/2022	We will deliver a financially sustainable plan and improve our benchmarking in model hospital	Trust's Capital resourcing is insufficient to support objectives. As a Region and ICS, BHT's requirements are above allocation. Risk to system affordability and operational risk of maintaining the capital programme	20	Executive Directors to manage the delivery of strategic schemes, with CMG	3	5	15	CMG Ownership and assessment of project / deliverables	Capital Accountant to monitor CMG deliverables. Engagement with NHS/E to agree funding profile of strategic themes	31/03/2023		3	3	9		
CRR156	PS222	Property Services	14/02/2022	Our buildings and facilities will be great places to work and contribute to health and wellbeing of staff	<p>The ageing WH tower Block is showing signs of interior deterioration and is increasingly challenging to maintain in a condition that is suitable for modern healthcare provision. Asbestos is present throughout including floors, ceilings, service voids impeding remedial or improvement works as this adds significant costs and risks to repairs and projects. Water pipework - obsolete components. Difficult to remove under asbestos conditions presenting a legionella risk to staff and patients.</p> <p>Electrical infrastructure is obsolete and does not comply with HTM 06. All Patient services could be affected by failures in the electrical infrastructure.</p> <p>Poor patient environment experience i.e. space, door widths and access not compliant with modern healthcare standards (HBN's) and Equality Act.</p> <p>The ventilation is not compliant with current standards for healthcare services. All patients and staff may be exposed to airborne infection. All patients and staff are affected by excessively high temperatures during periods of hot weather. The Helpdesk is in the basement and subject to risk of water ingress which, if the system went down, would be catastrophic</p>	25	<ul style="list-style-type: none"> Asbestos surveys and register in place <ul style="list-style-type: none"> Annual review Asbestos analyst available All projects done under controlled conditions <ul style="list-style-type: none"> Continuous water testing Flushing regime in place Monitored by the Water safety Groups and IPC <ul style="list-style-type: none"> Water Safety Policy in place Water Authorising Engineer appointed Maintenance and inspection programmes in place <ul style="list-style-type: none"> Electrical Authorising Engineer appointed Generator cover available Authorised Persons (Electrical) in place Clinical services are having to adapt to the environment by providing equipment that is not necessarily the best choice for the patient. <ul style="list-style-type: none"> Portable Air Purifying Units in place Portable A/c units available Ventilation policy in place Authorising Engineer for ventilation appointed Ventilation validation carried out in Theatres Hot weather plan and IPC guidance available to staff 	5	4	20	<p>Ventilation and DDA access can only be improved by making interior structural changes requiring ward/ clinical area closures.</p> <p>Any improvement works will require an asbestos strip requiring ward closure and significant additional cost.</p>	<p>Property Services working with service leads to relocate services on the WH site.</p> <p>Programme business case to Trust Board 29/06/2022</p> <p>The outline business case should be completed by 31/03/2023</p> <p>Currently no residual risk score as there are no defined actions to resolve the risk</p> <p>Move services to new location.</p>	31/03/2024	Commercial Director					

Corporate Risk Register	Divisional Risk Register	Division	Date added to CRR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
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CRR158	Card01/PSZZ1		23/02/2022		Our buildings and facilities will be great places to work and contribute to health and wellbeing of staff	The interior condition of ward 2a has deteriorated and is increasingly difficult to maintain to the standard required to deliver effective clinical care. The Trust is in breach of CQC Regulation 15 and has been notified of this by CQC.		<p>Ward Staff:</p> <ul style="list-style-type: none"> Discharge planning on admission which has reduced length of stay. Clear and consistent cohorting of patients. Culture of safety via Quality improvement huddles, embedded Safety Huddles and DFMs. Strong Consultant and junior doctor presence. Consistent daily Ward round and twice daily Board rounds. Enhanced cleaning regime through COVID19. PPE champions in place. Enhanced IPC support and visibility 2a and HW site generally. Regular infection control inspections – monitored through Perfect Ward. <p>Estates staff:</p> <ul style="list-style-type: none"> Patch repairs made to floor Regular inspections Warning signage in place Portable Air Purifying Units in place Portable A/c units available Ventilation policy in place Authorising Engineer for ventilation appointed Ventilation validation carried out in Theatres Hot weather plan and IPC guidance available Asbestos surveys and register in place Annual review Asbestos analyst available Projects and repairs under controlled conditions 	5	4	20	<p>Asbestos is present throughout the construction including the floors, ceilings and service voids, impeding any remedial or improvement works.</p> <p>The flooring has deteriorated and can only be patch-repaired without closing the ward. The uneven surface is affecting patient movement in beds and trolleys and is a risk to patients and staff of manual handling and trip hazards.</p> <p>Ventilation not compliant with current standards for healthcare services with a risk of exposure to airborne infection. Patients and staff are impacted by excessively high temperatures during periods of hot weather.</p> <p>As the building fabric is beyond feasible repair the only option to resolve the risk is relocation of the service – there is no interim option available. Short term remedial work is undertaken as required but these are not long term solutions.</p>	<p>Future of the WH tower block being considered by the Trust Board. Once alternative location identified, a business case to be developed to secure funding for the service move.</p> <p>Currently no residual risk score as there are no defined actions to resolve the risk</p> <p>Long term solution: Relocation of the service</p>	31/03/2023	Commercial Director			
CRR159	HR03/2022	Trust	21/04/2022	Ensure our people are listened to, safe and supported	We will deliver our 5 people priorities	<p>Nursing - shortage of registered and unregistered nursing staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care, the wellbeing of permanently employed colleagues and the Trust financial position. The impact of working through the COVID-19 pandemic and an ageing workforce has led to increased turnover in some areas.</p>	20	<ul style="list-style-type: none"> Performance management of Recruitment Service - Strategic Workforce Committee. Performance management of Divisions Performance management of NHSP to ensure quality of temporary staff and high proportion of bank rather than agency staff. Daily safe staffing huddles to identify and review hot spots to assure that safe staffing levels are maintained at all times with the supply of bank/temporary workers as mitigation if required. Recruitment plan for all registered nursing and HCAs 	5	3	15	<p>Nursing establishments have been increased in some areas for 1/y 2022-23 as part of the safer staffing review work. This has increased our permanent vacancy levels for substantive roles.</p>	<ul style="list-style-type: none"> HCAs From January 2022, recruitment of HCAs moved to cohort recruitment, leading to over 60 job offers in under three months. Start dates are in line with induction. From May 2022, we have increased induction slots available for HCAs from 12 - 50 each month. Registered Nursing Recruitment of band 5 nursing to move to cohort recruitment from Q2, 2022. 120 international nurses due to arrive in cohorts through 1/y 22/23. First cohort due to arrive in Q1. From Q1 2021-22, working with University graduates from University of Bedfordshire and Buckinghamshire New University to recruit the maximum number of graduating students. (Target is 70% of cohort.) (82 nursing graduates and 17 nursing associate graduates in total) All nursing staff From April 22 we are one of twenty three exemplar sites for the national people promise retention 12 month programme. 	31/03/2023	Chief People Officer	5	2	10
CRR160	HR02/2022	Trust	21/04/2022	Ensure our people are listened to, safe and supported	We will deliver our 5 people priorities	<p>Midwifery - Target set to reduce vacancy rate to 5% by December 2022 in order to implement full midwifery continuity of care. With the national shortage of midwives, there is a risk that we will be unable to meet this vacancy level. The impact of working through the Covid-19 pandemic and an ageing workforce has led to increased turnover in these areas.</p>	20	<ul style="list-style-type: none"> Performance management of Recruitment Service - Strategic Workforce Committee. Performance management of Divisions Performance management of NHSP to ensure quality of temporary staff and high proportion of bank rather than agency staff. Daily safe staffing huddles to identify and review hot spots to assure that safe staffing levels are maintained at all times, with the supply of bank/temporary workers as a mitigation if required Recruitment plan for all midwifery posts monitored on a monthly basis 	5	3	15	<p>Midwifery establishments have been increased. This has increased our permanent vacancy levels for substantive roles.</p>	<ul style="list-style-type: none"> Registered Midwives Pro-actively working with the practice development team to encourage all graduates to join BHT. The aim is to have at least 10 graduates join as Band 5 preceptorship midwives in October 22. We will strengthen our established international recruitment approach - 6 international midwives due to arrive in Q2 1/y 22/23. Bespoke digital marketing campaign in conjunction with an experienced digital marketing company underway and due to go live in June 22. To optimise retention we will enhance educational and pastoral support. We will also offer flexible working patterns and strengthen the diversity of the maternity workforce. Working collaborative across the system with new LNMS workforce lead We are engaging in the direct workforce support offer from NHSE/I. Opportunities for rotational roles across the LNMS will be explored. A talent management programme with succession planning will be in place Increase student placement capacity Recruitment and retention practice development support role will be appointed through external funding (Q2) 	30/03/2023	Chief People Officer	5	2	10

Corporate Risk Register	Divisional Risk Register	Division	Date added to CRR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
									C	L	C x L					C	L	C x L
CRR161	CAN21	Specialist Services	21/03/2022		We will consistently meet or exceed quality (safety, experience, outcome) and performance standards	<p>For 12 consecutive months the trust has been non-compliant with the 62-day standard. This remains our biggest risk and most challenging pathway. The number of referrals has remained above baseline with winter pressures and a COVID backlog on pathways presentign an ongoing challenge.</p> <p>The number of 2WW GP referrals continues to rise above baseline and some service areas are consistently polling above 10 days due to both staffing and capacity issues.</p> <p>The delays in diagnostics significantly affects complex diagnostic pathways. Particularly a cohort of Urology, Lower GI, Breast and Gynaecological patients. This also includes a 4-6 week delay at OUH for patients requiring PET scans, which is significantly affecting the 62-day patient pathway. TP Biopsies continue to be challenged, with a 3-4 week turnaround.</p> <p>Theatre capacity for TCI's/POA capacity continues to be an ongoing issue.</p> <p>The 2WW and FDS targets present significant risk of breaching during January-March 2022 due to Radiology workforce challenges. Validated figures are available in the February 2022 Cancer report.</p>	25	<p>Considerable focus is being channelled through the CRG group alongside PRISM consultancy. Weekly reporting templates for each tumour site have been developed, to support the Cancer recovery trajectories and implementation plans.</p> <p>Significant effort is being made to reduce the number of long waiters >104 days and patients in 63-103 cohorts.</p> <p>Ongoing involvement and collaboration from TVCA.</p> <p>Firefighting for capacity/clinics via 2WW daily huddle (escalation policy followed e.g. DD's,APMG & Cancer Recovery Group)</p> <p>Cancer Recovery Plans implemented</p> <p>TVCA/ICS wide mutual aid collaboration in progress</p>	5	3	15	<p>Definitive communication required within patient letters as per national guidance</p> <p>Workforce challenges - insufficient FDS tracking support</p>	<p>PRISM workforce review/TVCA finance fixed term posts</p> <p>Actions via Cancer Recovery Group/TIP at tumour site level</p> <p>Mutual aid option with QVH</p>	30/06/2022	Chief Operating Officer	4	2	8
CRR162	Rad 40	Specialist Services	16/05/2022			20	<p>Routine lists have been cancelled. Surgical teams have been advised to review all urgent referrals and transfer to Oxford University Hospital as needed. Routine and urgent lists now being implemented as mobile bail out kit is available in the event of equipment failure. This is not a replacement for the interventional suite equipment. 06/05/2022- SLA with OUH in place for urgent and 2WW</p>	4	4	16	<p>in the event of equipment failure, lists will need to be cancelled</p> <p>06/05/2022-External organisation e.g.estates etc</p>	<p>06/05/2022- BCP implemented and regular meetings with GE and Siemens re upgrade of fluoroscopy room and Interventional suite</p> <p>BHT is working closely with colleagues at OUH to ensure that patients requiring this specific radiology service urgently can be accommodated at OUH if required.</p> <p>Prioritisation of installation with estates team</p>	31/03/2023	Chief Operating Officer	2	1	2	

Risk Profile – Corporate Risk Register – June 2022

Consequence	1	2	3	4	5
Likelihood	Key: ↑ = risk score has risen; ↓ = risk score has dropped; ⇔ = no change. The CRR changes on a monthly basis and the arrows indicate the change since the previous version (up to 4 changes)				
5				CRR139 - Potential clinical harm to patients on elective wait list (new 02/2021) ⇔⇔⇔ CRR140 – Outpatient services environment (new 02/2021) ⇔⇔⇔	CRR163 – D2A beds closed to admission (new 05/2022)
4			CRR151 – Critical Bleeps (new 11/2021)⇔↓↓	CRR88 – Patient tracking and appointments (new 02/2018)⇔⇔⇔ CRR143 – Ophthalmology Backlog (new 05/2021) ⇔⇔⇔ CRR126 – impact on staff physical and psychological health and well-being during covid-19 (new 04/2020)⇔↓⇔ CRR162 – Interventional Radiology service (new 05/2022)	CRR141 – Insufficient capacity within PDU (new 02/2021) ⇔⇔⇔ CRR149 – Inadequate physical ED environment (new 10/2021)⇔ CRR158 – Ward 2a environment (new 07/2021) ⇔⇔⇔
3			CRR85 – Shortage of Junior doctors (new 10/2017) ⇔↓⇔	CRR138 – Increased risk of infection due to poor ventilation (new 02/2021) ↓⇔⇔ CRR160 – Shortage of qualified Midwives (new 04/2022)⇔	CRR27b – HV/LV insufficient supply (new 10/2017)⇔⇔↓ CRR130 – Concrete building panel failure at WGH (new 10/2020)⇔⇔⇔ CRR135 – Trust non-delivery of Operating Plan (new 11/2020) ⇔⇔⇔ CRR147 – Disruption to Trust technology due to cyber incidents (new 07/2021) ⇔⇔⇔ CRR150 - Clinically inappropriate length of stay in ED (new 10/2021)⇔⇔⇔ CRR159 – Shortage of qualified nurses (new 04/2022)⇔⇔ CRR161 – Cancer pathway non-compliance (new 03/2022)⇔↓
2		CRR116 – Out of date Datix system functionality issues (new 11/2019)⇔⇔ ↓			
1					

To be removed from the Corporate Risk Register:

CRR151 – Critical Bleeps

CRR116 – Datix Incidents System

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Infection Prevention and Control Update
Board Lead	Karen Bonner, Chief Nurse and Director of Infection Prevention & Control
Type name of Author	Jo Shackleton, Head of Nursing for Infection Prevention and Control
Attachments	IPC update
Purpose	Assurance
Previously considered	None

Executive Summary

This report sets out the latest infection prevention and control proposals which approved and implemented across Buckinghamshire NHS Trust to support the increase prevalence of covid-19 both in the community and in the hospital.

There has been no change in guidance; BHT continue to follow National IPC Manual.

Proposals

- Review of universal mask wearing
- Agree mask wearing requirements for
- Front door services
- Review physical distancing in an area where mask are not worn
- Non-essential meeting to return to online (teams meeting)
- Stop Root cause analysis for probable and definite HOHA

Decision	The Board is requested to note this report.		
Relevant Strategic Priority			
Outstanding Care <input checked="" type="checkbox"/>	Healthy Communities <input checked="" type="checkbox"/>	Great Place to Work <input type="checkbox"/>	Net Zero <input type="checkbox"/>
Implications / Impact			
Patient Safety	Healthcare associated infection prevention is cornerstone of patient safety		
Risk: link to Board Assurance Framework (BAF)/Risk Register	Infection Prevention and Control Board Assurance Framework		
Financial	Healthcare associated infections cause significant cost to the healthcare system and individual		
Compliance Select an item. Select CQC standard from list.	Health and Social Care Act 2008 Care Quality Commission Guidance from Public Health England and NHSE/I		

	CQC compliance
Partnership: consultation / communication	Shared with Clinical Commissioning Group and wider system, Care Quality Commission
Equality	Patients who pose a known or potential infection risks are equally entitled to treatment. IPC measures to support their safe management should be in place to support this.
Quality Impact Assessment [QIA] completion required?	No

- This report sets out the latest infection prevention and control **proposals** which approved and implemented across Buckinghamshire NHS Trust to support the increase prevalence of covid 19 both in the community and in the hospital
- There has been no change in guidance BHT continue to follow National IPC Manual

Proposals

- Review of universal mask wearing
- Agree mask wearing requirements for
- Front door services
- Review physical Distancing in an area where mask are not worn
- Non-essential meeting to return to online (teams meeting)
- Stop Root cause analysis for probable and definite HOHA

Mask Wearing Guidance For Colleagues:

- Colleagues to wear fluid resistance surgical facemasks as part of personal protective equipment across all clinical areas
- Health and care Colleagues to wear FFP3 mask or RESP Hood as part of personal protective equipment for airborne transmission-based precautions
- Health and care Colleagues to wear FFP3 mask or RESP Hood as part of personal protective equipment in an area where their patients are untriaged. This would include AE/CSRU/PDU/SDEC/UTC etc.
- Where needed colleagues may wear FFP3/RESP Hood during an outbreak or high prevalence as direct by IPCT.
- Colleagues are, in general, not required to wear facemasks in non-clinical areas, e.g. offices and social settings, unless this is their personal preference or a risk assessment raises specific issues.

Updated Mask Wearing Guidance For inpatients

- Inpatients should be provided with a facemask on admission. This should be worn in multi-bedded bays and communal areas, e.g. waiting areas for diagnostics, if this can be tolerated and is deemed safe for the patient. They are not usually required in single rooms.
- Patients transferring to another care area should wear a facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination.
- The requirement for patients to wear a facemask must never compromise their clinical care, such as when oxygen therapy is required or where it causes distress, e.g. paediatric/mental health settings.

Updated Mask Wearing Guidance Non Healthcare Colleagues

In general not required to wear facemasks in non-clinical areas e.g. offices, social settings, unless this is their personal preference or there are specific issues raised by a risk assessment.

Some colleagues will prefer to continue to wear a mask, and this must be support and respected.

The guidance will be kept under constant review.

Updated Mask Wearing Guidance Mask Wearing For visitors:

- Visitors and individuals are required to wear a fluid resistance surgical facemask (FRSM) in all clinical areas including outpatient and DSU

Colleagues Mask Requirements Proposals

MASK Requirements	Collogues Clinical areas (Acute)	Collogues (community)
<p>In areas where attendance is unplanned/emergency. E.g. Emergency Department, CSRU, PDU, SAU, Eye Casualty, UTC, Maternity triage.</p> <p>In the community, if you cannot triage your patient before visiting, please ensure you wear a mask.</p>	<p>Yes FFP3/RESP HOOD</p>	<p>Yes FFP3/RESP HOOD</p>
<p>All other Clinical areas</p>	<p>Yes FRSM</p>	<p>Yes FRSM</p>
<p>When applying airborne Transmission Based precautions (IPC Respiratory Pathways)</p>	<p>YES (FFP3 or Hood)</p>	<p>Yes (FFP3 or Hood)</p>
<p>Non-clinical areas or social settings</p>	<p>No₁</p>	<p>No₁</p>

1. Consider physical distancing in all non-clinical areas where mask are not worn, if this can not be achieved it is recommended FRSM to be worn.
We recognise that some colleagues will prefer to continue to wear a mask, and this must be respected.

Patients and Visitors Mask Requirements Proposals

(Patients and Visitors) Personal Protective Equipment (PPE)

MASK Requirements	Patients	Visitors
Attending In areas where attendance is unplanned/emergency e.g., Emergency Department, CSRU, PDU, SAU, Eye Casualty, UTC, Maternity triage.	YES FRSM	YES FRSM
Outpatients	YES FRSM	YES FRSM
All clinical area	YES FRSM	YES FRSM
Confirmed or Suspected with a respiratory organisms (IPC Respiratory Pathways)	YES FRSM ¹	YES FRSM ¹
Non-clinical area or social settings	No	No

1. This should be worn in multi-bedded bays and communal areas, e.g. waiting areas for diagnostics, if this can be tolerated and is deemed safe for the patient. They are not usually required in single rooms, unless, e.g., a visitor enters

- Physical distancing has been a crucial measure in limiting the spread of COVID
- The World Health Organization continue to advise to stay at least one metre away from others to avoid coronavirus transmission and there is evidence indicating that there is a substantial difference in risk of exposure between maintaining a two-metre distance as opposed to a one metre distance - perhaps as much as two to ten times - although this will vary depending on the context.
- IPC are recommending that colleagues in areas where they are not wearing FRSM then they should try to maintain at least one metre if not two.
- Where possible non-essential face to face meetings should return to teams' meetings.

Meeting: Trust Board Public

27 July 2022

Agenda item	Annual Fire, H&S and Security Reports
Board Lead	Chief Commercial Officer, Ali Williams
Type name of Author	Fire Safety Manager, H&S Manager, Security Manager
Attachments	1: Annual Fire Safety Report 2: Annual H&S Report 3: Annual Security Report
Purpose	Assurance
Previously considered	Health & Safety Committee 13.06.2022 Strategic Workforce Committee 11.07.2022

Executive Summary

Attached are the Fire, H&S and Security annual reports which is intended to provide combined reports to help deliver assurance both internally and externally to satisfy the legal and legislative requirements from governing agencies such as the CQC, HSE and local Fire and Police authorities. All three safety disciplines are reported quarterly and monitored by the Trust H&S Committee.

The Security Service has made significant progress; our security provision at the Trust was found to be fully compliant with nationwide NHS England requirements, issued in October 2021. The team have also been formally recognised for its hard work and efficiency both externally (by Thames Valley Police) and internally at the Trust. We have opened two new operations centres allowing Security to manage the whole Trust from two central locations; reduced the number of the most serious incidents of abuse and assault against staff by 45% over the past 3 years; reduced the number of incidents of crime involving vehicles; upgraded the security lighting across the Trust.

Regarding fire safety, new fire alarm systems have been installed across Amersham and Wycombe hospitals, plus Harrington House. Fire Warden training has continued to be delivered to 50 members of staff and a programme of evacuation drills/exercises has been developed and continues to be delivered. The fire safety team carried out 45 full evacuation fire drills this year plus 75 simulation exercises.

In Health & Safety there have been no issues, contacts or visits from the Health and Safety Executive this year. The number of RIDDOR reportable incidents has remained stable for the past three years. There has been a 23% reduction in sharps injuries, 16% reduction in rate of accidents. A new digital COSHH management system has been rolled out this year and staff have received training. 71 colleagues have completed IOSH accredited training.

Decision	The Committee is requested to note these reports		
Relevant Strategic Priority			
Outstanding Care <input type="checkbox"/>	Healthy Communities <input checked="" type="checkbox"/>	Great Place to Work <input checked="" type="checkbox"/>	Net Zero <input type="checkbox"/>
Implications / Impact			
Patient Safety	Compliance with Fire, H&S and Security will ensure the safety of our patients, staff visitors and contactors.		

Risk: link to Board Assurance Framework (BAF)/Risk Register	Fire, H&S and Security risks are included on divisional risk registers and higher-level risks are included on the Corporate risk register.
Financial	Potential non-compliance with statutory requirements may lead to fines and litigation from personal injury claims.
Compliance <small>Select an item.</small> Safety	CQC Standard SAFE H&S at Work Act The Regulatory Reform (Fire Safety) Order
Partnership: consultation / communication	Collaborative working across the Trust through the Health & Safety Committee and EMC
Equality	In completion of these annual reports, the Trust has considered Health & Safety and Fire legislation which dictate those areas requiring consideration. Within these areas, this includes visitors, patients and staff and notes the Trust's commitment to the fair treatment of these groups regardless of protected characteristics.
Quality Impact Assessment [QIA] completion required?	Not required for annual report.

Annual Health & Safety report

2021 / 2022

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK



Executive Summary

This report outlines health and safety performance at Buckinghamshire Healthcare Trust for 2021/2022 and sets out key priorities for 2022/23.

Key highlights this year:

- 23% reduction in sharps injuries
- 16% reduction in the rate of accidents
- No issues, contacts or visits from the Health and Safety Executive this year
- The number of RIDDOR reportable incidents has remained stable for the past three years
- A new digital COSHH management system has been rolled out this year and staff have received training
- 71 colleagues have completed IOSH accredited training

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1. INTRODUCTION

All organisations have a legal duty to put in place suitable arrangements to manage health and safety. Ideally, this should be recognised as being a part of the everyday process of conducting business and/or providing a service, and an integral part of workplace behaviours and attitudes. Notwithstanding, a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced.

The Health and Safety Executive (HSE) are the regulatory body with responsibility for enforcing health and safety legislation. The HSE also fulfils a major role in producing advice on health and safety issues and practical guidance on the interpretation and application of the provisions of the legislative framework.

Regardless of the size, industry or nature of an organisation, the keys to effectively managing health and safety are:

- leadership and management (including appropriate and effective processes)
- a trained/skilled workforce
- an environment in which people are trusted and involved

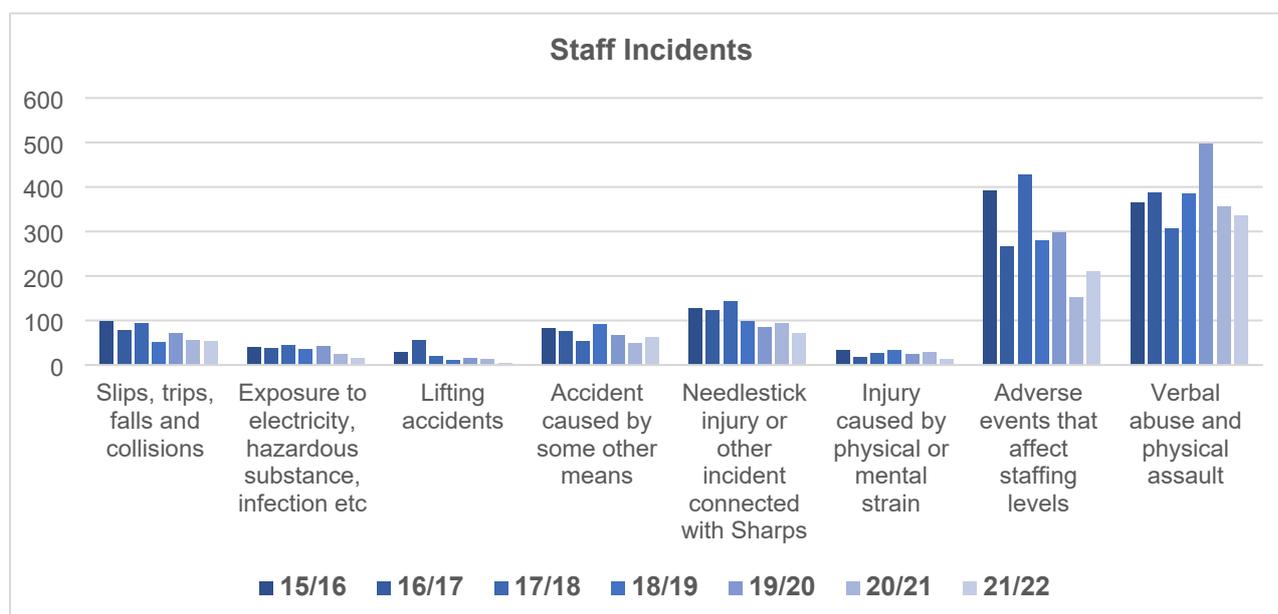
This annual report is to inform the Health and Safety Committee and the Executive Management Committee / Trust Board of any health and safety issues, incidents and trends in the Trust since the last report and provide a general update on relevant health and safety developments.

This report outlines health and safety performance at Buckinghamshire Healthcare Trust for 2021/2022 and sets out key priorities for 2022/23.

The purpose of the report is to inform the Health and Safety Committee, the Executive Management Committee and the Trust Board of any health and safety issues, incidents and trends in the Trust since the last report and provide a general update on relevant health and safety developments.

2. ACCIDENTS & INCIDENTS

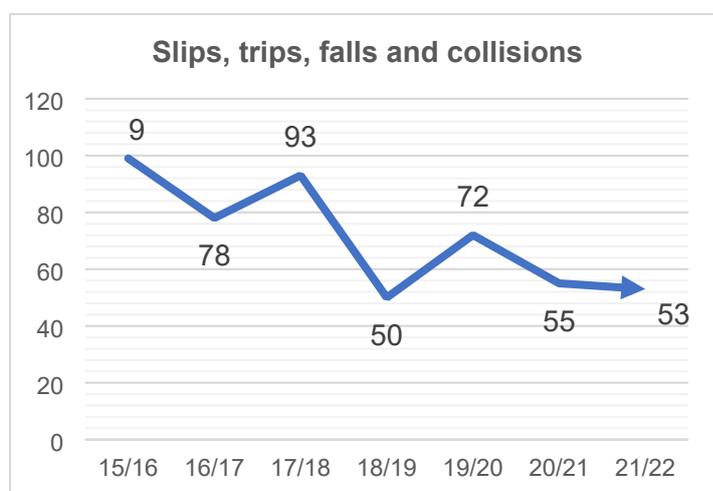
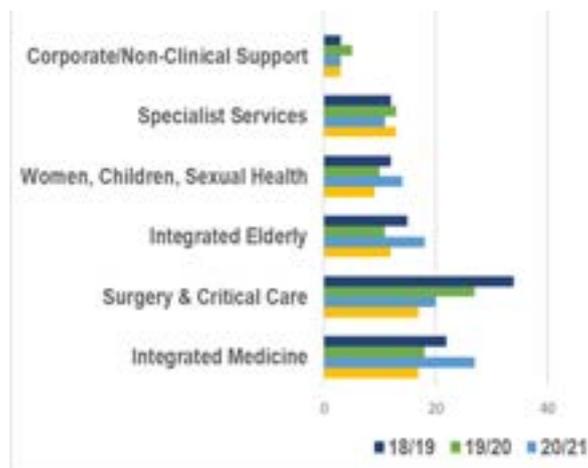
Below is a summary of reported accidents/incidents to staff in the last six years by type. The key areas of concern remain verbal and physical assaults and where staff report the effects of issues with the levels of staffing.



	15/16	16/17	17/18	18/19	19/20	20/21	21/22	+/-
Slips, trips, falls and collisions	99	78	93	50	72	55	53	3%
Exposure to electricity, hazardous substance, infection etc	40	38	44	36	41	24	15	37%
Lifting accidents	28	56	19	10	16	13	4	69%
Accident caused by some other means	82	75	52	91	67	48	63	31%
Needlestick injury or other incident connected with Sharps	128	122	143	99	85	93	71	23%
Injury caused by physical or mental strain	34	17	27	32	25	28	13	53%
Accident / Injury / Near Miss Totals	411	386	378	318	306	261	219	16%
Adverse events that affect staffing levels	391	266	427	280	298	151	211	39%
Verbal abuse and physical assault	364	388	306	385	497	355	335	5%

There has been an overall 16% decrease in injury accidents / near miss incidents reported when compared to the previous year's results. There has been nearly a 39% increase in adverse events that affect staffing levels as compared to 2020/21. It should be noted however that the 2021/22 figures are still lower than in previous years.

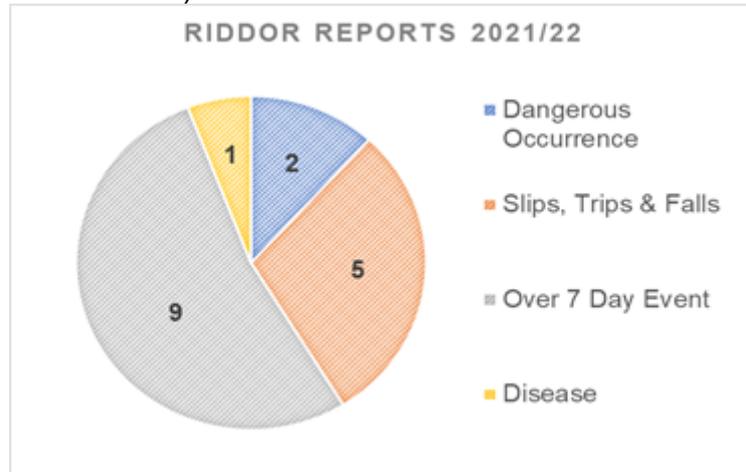
It is pleasing to also note the 23% reduction in **needlestick incidents** when compared to the previous year. This has been a focus over the last year with several different departments being involved. The table below indicates Divisional performance. The Covid pandemic response has resulted in more activity in certain areas and the increased use of inexperienced staff, which may explain the variations.



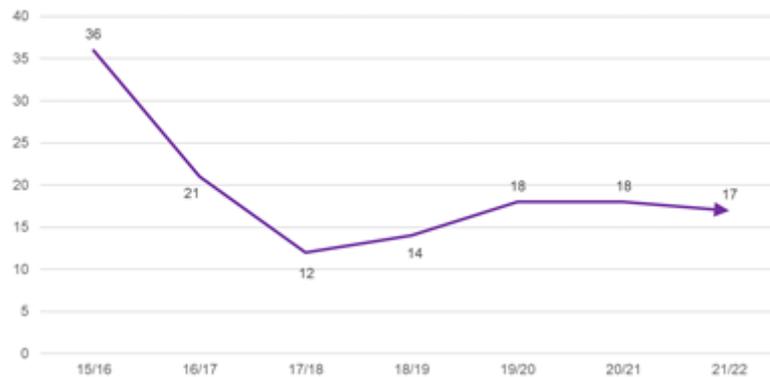
Slips, Trips, Falls and collisions have reduced by 3% in the previous 12 months. The committee should note, however, that these incidents relate to over half the RIDDOR reports the Trust has made to the Health and Safety Executive.

3. RIDDOR INCIDENTS

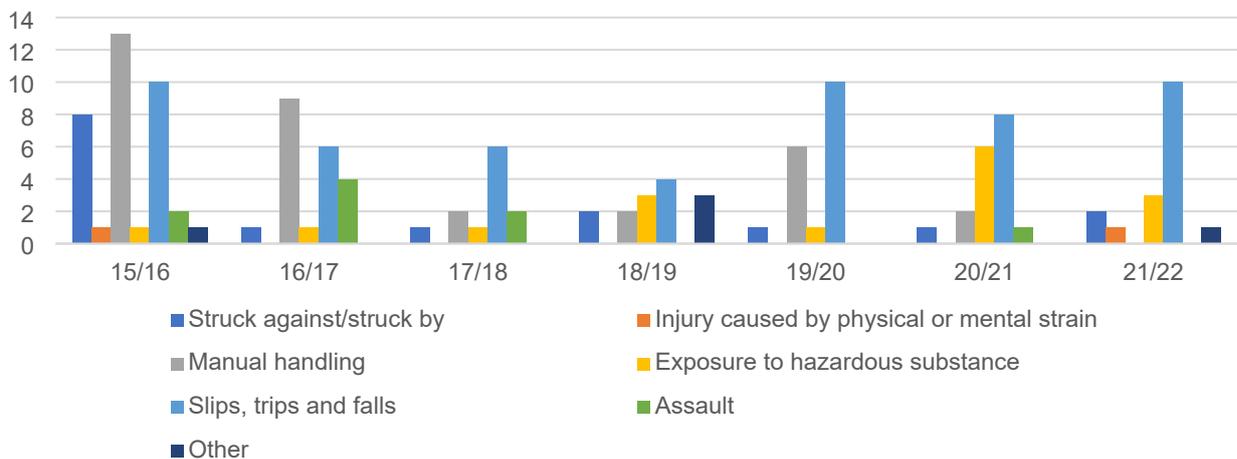
There have been 17 RIDDOR incidents reported to the Health and Safety Executive in 2021/22. The number of incidents reported has remained consistent for the last five years. Ten of these were in the slips, trips and falls category which resulted in six fractures and four members of staff incapacitated for normal duties for over seven days. Over seven-day injury, reporting has increased due to a greater understanding of RIDDOR linked to staff training. (See Appendix A for more details).



Total Number of RIDDOR Incidents Reported to HSE by Year



Number of Accidents/Incidents Reported to HSE by Category



4. TRAINING

All induction and maintenance of skills training (Pay Day) regarding Health and Safety has been conducted online. Divisional compliance with the Health and Safety module is detailed below: Overall compliance with training is currently 89%.

Division	Staff Count	Compliant	Target 90%
Corporate	755	682	90%
Division Integrated Medicine	1105	947	86%
Surgery & Critical Care	1172	1012	86%
Specialist Services	988	882	89%
Integrated Elderly Care	966	881	91%
Women's, Children's & Sexual Health	817	718	88%
TOTAL	5803	5122	88%

Training has been rolled out to Trust staff with a responsibility for C.O.S.H.H. using a new COSHH software management system. 32 managers and departmental COSHH representatives have been trained via MS Teams, mostly in 1:1 or 1:2 sessions to facilitate a bespoke experience. Further sessions are planned across all Divisions for 2022 / 2023.

The IOSH accredited 'Principles of Safety Management in Healthcare' programme has been very successful this year. Ten two-day courses have been completed and 71 colleagues now have the nationally recognised qualification.

5. REQUESTS FOR INFORMATION AND/OR VISITS FROM THE HSE

The HSE has not contacted the Trust this year.

6. HEALTH & SAFETY UPDATE

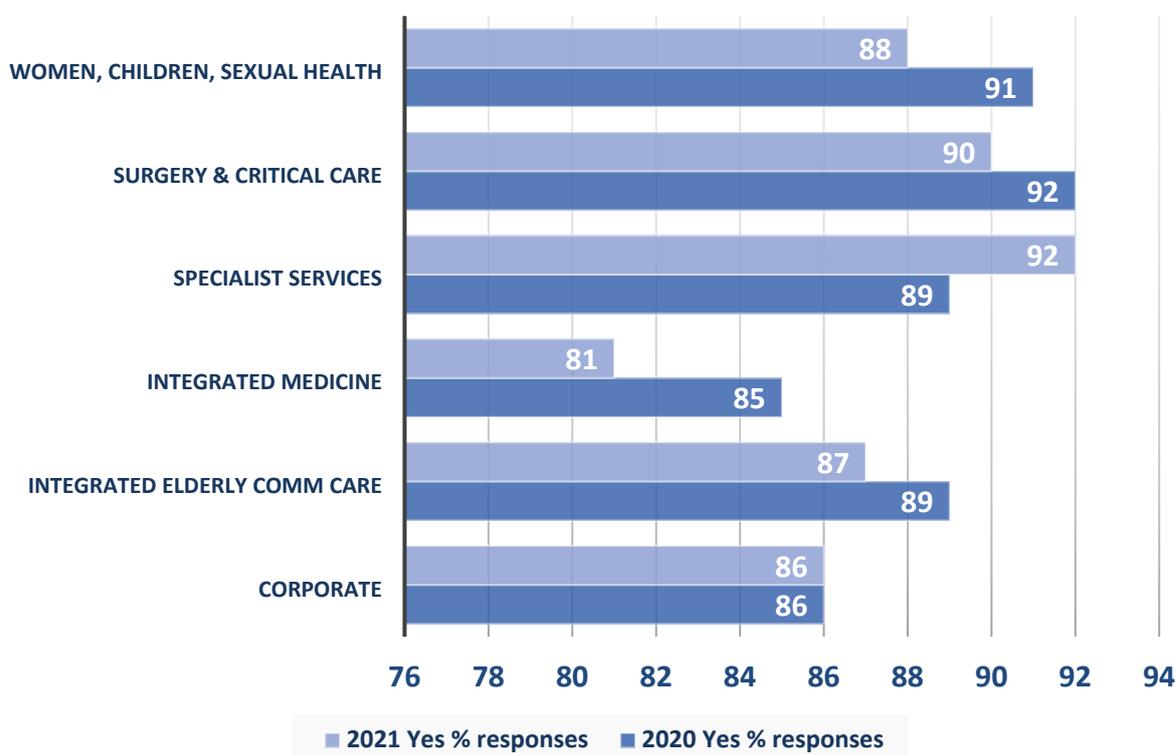
Covid-19

As with all departments, the Covid - 19 pandemic has significantly impacted the Health and Safety team. This involved providing advice on social distancing, room capacities, wayfinding, cleaning, oxygen monitoring, personal protective equipment, ventilation and conducting several Covid-related investigations. This work has resulted in much closer working relationships with other Trust Departments i.e. Occupational Health, Infection, Prevention Control, Human Resources as well as work at Divisional level.

Health and Safety Annual 'Self-Assessment'

The self-assessment audit was carried out in the Autumn of 2021, with 89 returns being received. Managers reported a compliance level of 88% when answering the 90 questions, which is 1% higher compared to 2020. The common areas of non-compliance were still the non-completion of lockdown procedures/exercises and anti-ligature risk assessments, but also a fall in training compliance. The Health and Safety Team are currently supporting these results by carrying out independent audits across various sites in the Trust.

Health & Safety Compliance % 2021/2020 Comparison by Division



Policies agreed at Health and Safety Committee 2021/22:

- BHT POL 067 – Manual Handling Policy
- BHT POL 138 – Water Safety Policy
- BHT POL 198 – Managing Violence, Aggression and Unacceptable Behaviour Policy
- BHT POL 082 – Security Policy
- BHT POL 142 – Management of Skin Exposure Risks at Work Policy
- BHT POL 039 – First Aid Policy
- BHT POL 060 – Prevention and Management of Occupational Natural Rubber Latex Allergy and Glove Use Policy
- BHT POL 101 – Health and Safety at Work Policy
- BHT POL 152 – Smoke-Free Site and Nicotine Management Policy
- BHT POL NEW – Ventilation Policy
- BHT POL 212 – Missing Patient Policy

6. KEY PRIORITIES 2022 / 2023 – ‘PROMOTING A POSITIVE HEALTH & SAFETY CULTURE

- 1. To achieve a year-on-year reduction of accidents and near misses across the Trust.**
- 2. Improve Accident Investigation competencies across Supervisory and Middle Manager levels.**
- 3. Maintain staff competencies through an accredited Institution of Occupational Safety and Health training programme.**

Institution of Occupational Safety and Health (IOSH)– during health and safety audits and engagements with colleagues across the Trust, it became clear that due to the turnover of staff and operational pressures, workplace risk assessments, together with a wider knowledge of health and safety in a healthcare setting were lacking. Funding was therefore secured to engage an external training company to deliver the IOSH accredited two-day ‘Principles of Safety Management in Healthcare’ course via MS Teams, which proved very popular. Although there were 100 spaces available, many staff had to either re-book or cancel due to staff shortages and work commitments. It is a key priority for 2022 to secure further funding to offer the same course to a new intake of colleagues during the late Spring/Summer months when hopefully winter pressures will have eased.

- 4. Maintain proactive Health and Safety Audits through all Divisions within the Trust.**
- 5. Expand knowledge and understanding of the COSHH management system.**

Control of Substances Hazardous to Health (COSHH) – cascaded training of the Sypol COSHH Management System purchased just before the pandemic had understandably been put on hold. The Health & Safety team received updated training in autumn 2021 and carried out 1:1 refresher training for the 3 out of 6 divisional representatives who were willing to start cascading it across their teams again. However, due to the pressure of work, it became evident that this was not possible, and therefore the Health and Safety Advisor has been training staff across the Trust on a 1:1 or 1:2 basis via MS Teams. We are now able to offer training via the NLMS booking system to larger groups, and this is a key priority for 2022

6. Increase levels of managerial support

Managerial support – during the past year it has become apparent that due to the turnover of staff, operational pressures and lack of sufficient training when managers are either promoted or inducted into the Trust, there is a significant lack of awareness of managerial health and safety responsibilities. The team give 1:1 support and training to managers to ensure that they are compliant with BHT policy and the law. It is a key priority for 2022 to raise awareness and introduce formal training for managers that will redress this gap in compliance

Appendix A – RIDDOR reports

Date	RIDDOR Category	Type of Incident	Nature of injury	Cause of injury / Incident
28/04/2021	Over 7-day event	Trip	Sprained ankle	Tripped over pothole – In community observing outdoor mobility practise.
04/05/2021	Dangerous Occurrence	Chemical Spillage	No injury	Chemical container not secured in machinery.
07/05/2021	Specified Injury	Fall	Fractured arm	Fall with no apparent hazard.
09/05/2021	Over 7-day event	Physical strain	Twisted bone and tendonitis	Injury to finger caused by repetitive clinical procedure
16/05/2021	Specified Injury	Fall	Fracture to foot and ribs.	Fall with no apparent hazard.
14/07/2021	Disease	Exposure to Virus	Covid-19	Inappropriate PPE worn in Covid area.
08/08/2021	Over 7-day event	Slip	Bruising	Slipped on wet floor.
09/08/2021	Over 7-day event	Struck by object	Ligament damage	Knee struck by door.
23/08/2021	Over 7-day event	Incision	Cut	Cut hand on metal skip.
13/09/2021	Specified Injury	Trip	Fracture to hand.	Misjudged step on external stairs.
01/10/2021	Over 7-day event	Slip	Cut hand / strained back	Slipped on wet moss – Working in the community.
30/11/2021	Over 7-day event	Trip	Bruising	Tripped over patient's walking aid.
21/12/2021	Dangerous Occurrence	Exposure to Virus	Needlestick	Pricked by needle – Carrier HIV+

Appendix B - Abbreviations

BHT	Buckinghamshire Healthcare NHS Trust
COSHH	Control of Substances Hazardous to Health
HSE	Health & Safety Executive
IPC	Infection Prevention & Control
IOSH	Institute of Occupational Safety & Health
NLMS	National Learning Management System
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences regulations
SMH	Stoke Mandeville Hospital

Annual Fire Safety report

2021 / 2022

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK



Executive Summary

The Trust is required to observe statutory requirements concerning effective precautions against fire, it has a clearly defined fire policy that reflects statutory requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). A nominated director accountable to the chief executive has Board responsibility for Fire Safety and a Fire Safety Manager is appointed who leads on all fire safety activities. An effective fire safety management strategy is in place. Fire safety protocols have been introduced and the existing protocols reviewed and updated.

There have been several key highlights to note this year:

- We have seen some major achievements in 2021-22 with new fire alarm systems being installed across all of Amersham and Wycombe hospitals, plus Harrington House.
- There have been no serious fire incidents in any of the Buckinghamshire Healthcare buildings. The occurrence of fire alarm activations continues to be a concern as we have seen a slight increase in the number of fire alarm activations. However, the increase can be associated with development works that have been carried out throughout Trust buildings and the continuing failure of the outdated fire alarm system at Wycombe Hospital.
- The number of unwanted fire signals attended by the Fire Service continues to fall. This has been achieved through the strict monitoring of the fire alarm system which allows us to highlight trends and resolve issues quickly to prevent further occurrences.
- Fire Warden training has continued to be delivered to 50 members of staff and a programme of evacuation drills/exercises has been developed and is continuing to be delivered. The fire safety team carried out 45 full evacuation fire drills this year plus 75 simulation exercises. A key finding from all these exercises was ensuring that staff wore the fire warden jerkin identifying their role.
- All trust areas have Operational Evacuation Plans velcroed to the wall enabling them to be removed immediately in the event of an emergency. The plans detail escape routes and on the reverse, there is a specific action card for the area concerned detailing the actions to take in the event of an emergency.
- Achieving mandatory training levels has been impacted by the pandemic but has achieved 82% compliance this year against a 90% target.
- A specific fire risk assessment format and fire risk assessment programme has been established and approved by the Chief Fire Officers Association. All Trust buildings were audited in 2021-2022 and continue to be audited on an annual basis. Significant risks have been placed on the Trust's Risk Register.

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1. INTRODUCTION

The Buckinghamshire Healthcare NHS Trust has a statutory responsibility to ensure that all the premises owned and operated by the Trust comply with current fire safety legislation and Department of Health guidance. The Trust must ensure that effective arrangements are in place for the management of fire safety and implement any necessary improvements or adjustments required which relate to an increased fire risk potential.

The purpose of this report is to inform the Trust Board of the current state of fire safety provision in all Trust premises and indicates where further fire safety-related improvements are necessary.

2. FIRE SAFETY POLICY & PROTOCOLS

Existing fire safety protocols continue to be reviewed and several new ones have been introduced and existing protocols updated, these will support the current fire safety policy for the management of fire safety and have been approved by the Health & Safety committee.

3. OPERATIONAL EVACUATION PLAN

To support the Trust in its objectives and to ensure resilience around critical internal incidents the operational evacuation plan has been reviewed. The plan provides detail and actions that should be taken by staff should an evacuation of part or all of the hospital be required. The department plans and action cards are continuously being reviewed to ensure that they provide up-to-date information concerning the department and building changes.

4. FIRE RISK ASSESSMENTS

For consistency, a specific fire risk assessment format and fire risk assessment programme has been established and all Trust buildings were audited in 2021-2022 and continue to be audited on an annual basis. The fire risk assessment format incorporates the HTM (Fire-Code) methodology of quantifying risk which was approved by the Chief Fire Officers Association and the associated action plan templates. The existing fire risk assessments are reviewed at regular intervals appropriate to the level of risk.

Table 1 provides information on the main risks associated with fire safety on the property services risk register that have been identified through the fire risk assessment audit programme.

Although compartmentation and associated walls and doors have been highlighted on the risk register, it must be understood that the Trust has made significant steps in reducing the associated risk through projects that have delivered improved compartmentation and early warning in the form of improved fire alarm systems.

Some buildings that posed a significant risk are and have been demolished reducing the risk to the Trust further and the new buildings are providing a safer modern environment concerning fire safety. Previous risks associated with old fire alarm systems have been eliminated with further projects taking place at Stoke Mandeville Hospital to vastly improve the life safety fire alarm systems.

Table 1 – Main risks associated with fire safety on the property services risk register

SIGNIFICANT FINDING	UNMITIGATED RISK	MITIGATIONS	RISK SCORE	ACTIONS TO ADDRESS	RESIDUAL RISK SCORE
<p>Subject: Containment of Fire Risk Number: PS038 Risk Score:8 Hazard: Compartmentation in the form of fire stopping and fire doors requires addressing.</p>	12	<ol style="list-style-type: none"> 1. Fire audits undertaken on an annual basis 2. Fire detection will give early warning should a fire incident occur 3. All staff receive fire training on an annual basis 4. Where projects are undertaken and containment requires addressing, this is completed as part of the project. 5. Survey completed to identify priority areas. 6. Fire door survey completed to identify priority areas. 7. On-going projects to identify compartmentation 	8	<ol style="list-style-type: none"> 1. Business case completed and presented to Capital Management Group for approval 2. Capital funds to be made available to complete works. 3. Architect and supplier to be contracted to prioritise and complete works. 4. Poor compartmentation in areas already identified is highlighted and improved within the property services project. 	4

5. TRAINING

Due to the Covid-19 pandemic, training levels continue to be impacted with many Divisions not able to meet the 90% threshold target. The fire safety team has delivered statutory face-to-face training to 1067 members of staff. Table 2 provides a breakdown of the number of staff that have undertaken both face-to-face and e-learning.

Table 2 – Number of staff who had undertaken training

Division	Staff Count	Compliant	% target 90%
Corporate	755	645	85.43
Division Integrated Medicine	1105	871	78.82
Surgery & Critical Care	1172	949	80.97
Specialist Services	988	833	84.31
Integrated Elderly Care	966	826	85.51
Women's, Children's & Sexual Health	817	633	77.48
TOTAL	5803	4757	81.97

6. FIRE EVACUATION DRILLS

The fire safety team have conducted many fire evacuation drills throughout the Trust during the period April 2021 to March 2022. The evacuation drills undertaken were either full evacuation of buildings or simulated evacuations of wards. All drills were carried out in a professional and timely manner by all staff and the main area of concern was staff were not wearing the Fire Warden vest identifying that they were the person to report to. Where repeated exercises were undertaken there were significant improvements in the wearing of the vests.

- SMH – 55 Simulated Evacuation Drills
- WH - 15 Full Evacuation 20 Simulated Evacuation Drills
- AH – 6 Full Evacuation Drills
- COMMUNITY – 24 Full Evacuation Drills

7. FIRE INCIDENTS

Throughout the period April 2021 to March 2022, there have been no serious fire incidents in any of the Buckinghamshire Healthcare buildings.

8. UNWANTED FIRE SIGNALS & FIRE ALARM ACTIVATIONS

Across the Buckinghamshire Healthcare sites, a total of 118 fire alarm activations occurred in the period 1st April 2021 - 31st March 2022, 29.7 % of these were related to cooking incidents involving toasters, 29.6% due to dust and system faults related to building works, and 16.1 % due to accidental activations. We had 4 unwanted fire signal activations. An unwanted fire signal is described by the Fire Service as fire alarm activation resulting in the Fire Service attending unnecessarily to a premise.

Table 3 provides a breakdown of the fire alarm incidents and their causes for Buckinghamshire Healthcare NHS Trust for the period 1st April 2021 to 31st March 2022. Table 4 provides a pictorial overview of the fire alarm incidents.

Table 3 - Fire Alarm Incident Causes

Cooking e.g. burnt toast, food left to long in microwaves	35
Steam e.g. plant room pipe leaks	16
Smoking	1
Dust e.g. created through contractor works	18
Aerosol Spray	8
Unknown	1
Other Fire Incident	0
Environmental	1
Accidental Activation e.g. persons accidentally pressing call points	19
False Alarm System Fault	17
False alarm good intent	0
False alarm malicious	2
Fire	0
*Danger of Fire	0
Chargeable Events	0
Totals:	118

* Danger of fire incidents relates to fluorescent light ballasts overheating within the older type light fittings, these are replaced following any incidents

Table 4 Pictorial overview of Fire Alarm Causes

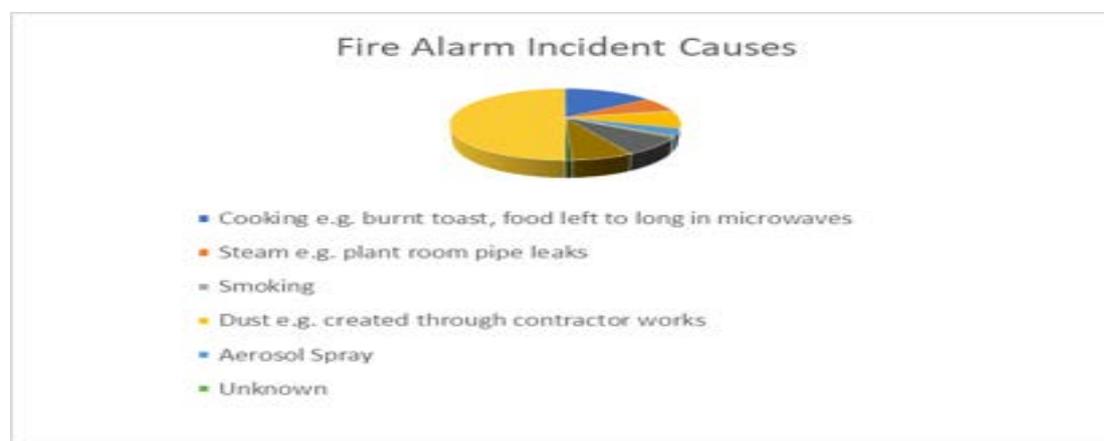


Table 5 below details the number of fire alarm activations across the Trust on a year-on-year basis making the distinction between the fire alarm activations and unwanted fire signals (UWFS). Although some years have shown an increase in the number of fire alarm activations, the number of unwanted fire signals attended by the Fire Service continues to fall. This has been achieved through the strict monitoring of the fire alarm system which allows us to highlight trends and resolve issues quickly to prevent further occurrences.

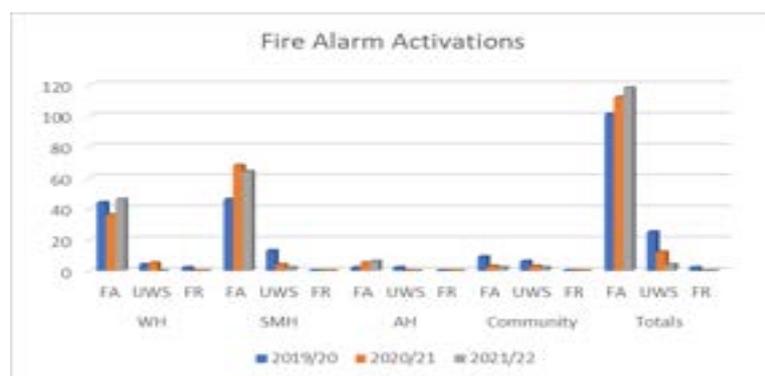
Table 5 - Fire Alarm Activations and Unwanted Fire Signals

Key:

- FA: Fire Alarm activation
- UWS: Unwanted Fire signal
- FR: Fire Incident

Year	WH			SMH			AH			Community			Totals		
	FA	UWS	FR	FA	UWS	FR	FA	UWS	FR	FA	UWS	FR	FA	UWS	FR
2019/20	44	4	2	46	13	0	2	2	0	9	6	0	101	25	2
2020/21	36	5	0	68	4	0	5	0	0	3	3	0	112	12	0
2021/22	46	0	0	64	2	0	6	0	0	2	2	0	118	4	0

Table 6 - Pictorial Overview of Fire Alarm Activations and Unwanted Fire Signals



Fire Safety Inspections

Due to the Covid-19 pandemic, Buckinghamshire Fire and Rescue Service has carried out no physical fire safety audits across any of our Trust buildings. However, the fire safety team have continued to provide updates to the Fire and Rescue Service concerning changes to our buildings and services during and post construction stages throughout the pandemic.

9. FIRE SAFETY ACHIEVEMENTS 2021/22

9.1 Covid-19 Pandemic

The covid-19 pandemic has brought and continues to bring a great number of challenges for the fire safety department with support required to many areas across the Trust with the installation and development of ward areas and departments to ensure that they delivered a safe environment for staff and patients delivering care.

9.2 Harrington House

A new fire alarm panel and subsequent fire alarm devices were installed within Harrington House accommodation. The introduction and installation of this new fire alarm system will ensure that the Trust continues to support its statutory fire safety requirements.

9.3 Fire Alarm System Amersham Hospital

A new fire alarm system has been installed across all parts of Amersham Hospital. The new system will replace the old closed protocol system where parts were not available, the new open protocol system will be easier to maintain and provide the Trust with a modern fit-for-purpose, cost-effective fire alarm system.

9.4 Fire Alarm System Wycombe Hospital

A new fire alarm system has been installed across all parts of Wycombe Hospital. The new system will replace the old closed protocol system where parts were not available and the new open protocol system will be easier to maintain and provide the Trust with a modern fit-for-purpose, cost-effective fire alarm system.

9.5 Fire Alarm System Stoke Mandeville Hospital

Due to the age and capacity of the fire alarm system at Stoke Mandeville Hospital works have commenced to upgrade the network of the fire alarm panels and replace those fire alarm panels that are unable to provide us with the future resilience required to allow us to develop parts of the Hospital further.

9.6 Projects

The fire safety team has been involved in a large number of projects in which support and guidance have been provided to both project managers and associated contractors. The projects which the team have supported are as follows:

Amersham

- IT Hub Hale Acre - demolition and reconfiguration internally
- Dermatology and Plastics - demolition and reconfiguration internally

Stoke Mandeville Hospital

- SDEC – refurbishment works
- Innovation Hub – consultations
- John Hampden Unit – demolition and reconfiguration internally
- Hairdressers – redevelopment of areas within the spinal injuries centre
- MRI scanner and associated project works – reconfiguration and refurbishment
- A&E Reception – reconfiguration and refurbishment
- Outpatients Department all phases – demolition – reconfiguration and refurbishment
- ICU department within PFI Day Surgery theatre recovery room – reconfiguration and refurbishment
- William Rathbone House – reconfiguration and refurbishment
- Vanguard Unit – a new building constructed
- Children’s A&E dept – a new building constructed

Wycombe Hospital

- Corporate Hub – reconfiguration and refurbishment
- Endoscopy Level 5 – reconfiguration and refurbishment
- Private patient’s suite – reconfiguration and refurbishment

Community Hospital sites

- Buckingham – reconfiguration and refurbishment
- Brookside – reconfiguration and refurbishment

10. FIRE SAFETY PRIORITIES 2020 – 2025

10.1 Fire Wardens and Evacuation Exercises

To support the Trust’s fire safety strategy Fire Warden training and a programme of evacuation drills/exercises have been developed and are continuing to be delivered.

10.2 Fire Compartmentation Trust Wide

The five-year capital programme commenced in November 2019 concerning compartmentation works across the Trust retained estate. The Fire Safety Manager and an advisor will be working

closely with the project managers to ensure that an appropriate plan of work is undertaken regarding the risks.

10.3 Fire Risk Assessments

The financial year 2022-23 will see the start of a new fire risk assessment review programme and the Fire Safety Manager and Advisor will continue to update and review all fire risk assessments relating to the buildings occupied by Buckinghamshire Healthcare NHS Trust.

Appendix A – Abbreviations

A&E	Accident & Emergency
AH	Amersham Hospital
BHT	Buckinghamshire Healthcare NHS Trust
COSHH	Control of Substances Hazardous to Health
FA	Fire alarm activation
FR	Fire Incident
HSE	Health & Safety Executive
ICU	Intensive Care Unit
IPC	Infection Prevention & Control
IOSH	Institute of Occupational Safety & Health
MRI	Magnetic Resonance Imaging
NLMS	National Learning Management System
PFI	Private Finance Initiative
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences regulations
RRO	Regulatory Reform Order
SDEC	Same Day Emergency Care
SMH	Stoke Mandeville Hospital
UWFS	Unwanted Fire Signal
WH	Wycombe Hospital

Annual Security report

2021 / 2022

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK



Executive Summary

Security is a service that can have a significant positive impact on the delivery of high-quality healthcare, with implications for staff, patients, property and assets. Delivering a robust security service across Buckinghamshire Healthcare NHS Trust (the Trust) increases personal safety, staff morale and productivity. It also safeguards valuable equipment for all who work at, or visit, our hospital sites.

The Security Service's key areas of focus in 2021 – 2022 were:

- **Site safety and security of Trust assets.** To upgrade the access control system and CCTV system to ensure we maintain our good security record, continue to deter crime and better investigate if an incident occurs.
- **Personal safety and reduction of crime against personal property.** To ensure every member of staff and every patient feels safe, so that the highest possible standard of clinical care can continue to be provided to patients.
- **Reduction of incidents.** To reduce the number of incidents of aggression against clinical staff.

The Security Service has made significant progress within these three areas and achieved its objectives for 2021-2022. In particular, we have opened two new operations centres allowing Security to manage the whole Trust from two central locations; reduced the number of the most serious incidents of abuse and assault against staff by 45% over the past 3 years; reduced the number of incidents of crime involving vehicles; upgraded the security lighting across the Trust in response to feedback from colleagues; and advised on security aspects of numerous projects. In addition, reassuringly, our security provision at the Trust was found to be already fully compliant with nationwide NHS England requirements, issued in October 2021, following security breaches at other Trusts.

The Security Service has also been formally recognised for its hard work and efficiency both externally (by Thames Valley Police) and internally at the Trust.

Our current areas of focus to address security risks going forward are:

- The continued roll-out of the new conflict resolution training and the formation of an Assault Response Team. This requires clinical teams to be released so they can attend training, in order to further improve the Trust's response to violent and unacceptable behaviours. We will continue to work with teams to ensure training can be attended.
- To increase the number of security officers, so a dedicated officer can be based within the Emergency Department at SMH.

This report outlines the Security Service's work during 2021 – 2022 and sets out its key priorities for 2022 – 2023.

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1. BACKGROUND & CONTEXT

The Security Service developed a 3-year Security Strategy in 2021 to provide a road map for the Trust to support the delivery of the Trust's strategic objectives and ensure compliance with industry and security best practices. The strategy incorporates the Security Service's principles, which are:

1. **Prevent and Deter:** We aim to identify security risks, provide solutions to combat those risks, discourage individuals who may be tempted to commit crime against the Trust and ensure that opportunities for security breaches to occur are minimised.
2. **Investigate, Sanction and Hold to Account:** We aim to investigate security incidents thoroughly and to the highest professional standards and, where appropriate, seek the full range of sanctions and redress where possible.
3. **Reassure and Protect:** We aim to implement and maintain systems and procedures that ensure the safety of all staff, patients and visitors to Trust sites.
4. **Inform and Involve:** We aim to raise awareness of security issues against the Trust and its staff and work with staff and stakeholders to highlight and minimise risks.
5. **Continuously Review:** Security issues are constantly evolving, and continuous re-evaluation and improvement is needed to ensure that we keep ahead of the problem.

Under these principles, the Security Service addressed three key areas of focus during the 2021 – 2022 year (personal safety; site security; and reduction of incidents). The progress made under each of the areas is set out below.

2. KEY ACHIEVEMENTS – SITE SECURITY

2.1 New Security Operations Centres

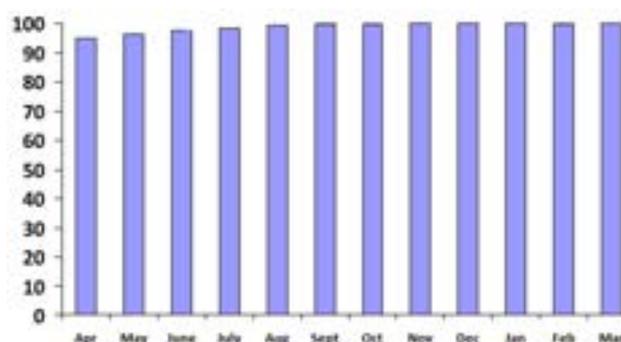
Two new centralised security control rooms (SOCs) have been installed at Stoke Mandeville and Wycombe Hospitals, vastly improving Security's ability to respond to incidents. The SOC's allow Security to manage the whole Trust from a central location, detect crime and accidents quickly, see immediately where resources need to be sent and respond speedily to incidents or lockdown a site, if necessary.

2.2 Security Systems: CCTV

The Security Service has worked exceptionally hard this year to ensure that on average 99% of cameras were fully operational throughout the year. This was against a backdrop of unprecedented issues with supplies, deliveries and sickness, due to the pandemic and global supply shortages.

We have also continued our programme of upgrading old cameras and have installed 40 new cameras on to the Trust's CCTV system. In addition, our camera footage continues to be used by Thames Valley Police to assist with their evidence-gathering.

Graph 1 – Percentage of cameras fully operational per month



2.3 Upgraded access control system

The upgrade of the access control system has continued with 49 new systems installed on entry points to buildings and within buildings.

A new system for controlling access to storage areas for medicines and drugs has also been installed with over 50 new keys issued to staff.

2.4 Mortuary review

The Security Service undertook full reviews of the Trust mortuaries to assess their compliance with new NHS England standards and provided updated risk assessments.

We were pleased to find that we were already fully compliant with the NHS England measures, but took the opportunity to enhance our security by adding new security cameras, intruder alarms and additional access control.

2.5 Maternity review

The Maternity services were reviewed in November 2021 by the Security Service and although the site is secure, additional security measures were implemented. A dedicated security officer has been introduced within the maternity building to provide support to staff and reassurance to patients. Upgraded access control and CCTV cameras have also been installed to strengthen screening of visitors and improve surveillance detection.

2.6 Projects

The Security Service has been heavily involved in numerous projects across the Trust, providing advice and support on all security-related matters, to ensure new projects incorporate measures necessary to deter crime, reduce security risks and ensure staff and patient safety.

Table 2 below details some of the projects that the Security Service has worked on during the 2021 – 2022 year.

Table 2 – Security service projects during 2021/2022

Site	Project
Amersham Hospital	New IT Hub within Haleacre
	Dermatology and Plastics
Stoke Mandeville Hospital	SDEC building
	Innovation Centre
	John Hampden Unit
	MRI Scanner and X-Ray
	A&E Reception
	Outpatients Department
	William Rathbone House
	Vanguard Units
	Car Park B redesign and build
	Oxygen upgrade project (VIE)
	Mortuary improvements
	Children's A&E and Women's Services
	Rainbow project
	External lighting upgraded
	Estates building access control upgraded
Wingman Project	
Pharmacy project	
COVID testing site relocation	
Olympic Lodge	

Wycombe Hospital	Corporate Hub
	Endoscopy Dept.
	Private Patients' unit
	Car Park B staff parking expansion
	Staff parking spaces increased
	Ward 7 Children's Ward
	Ward 11 security upgrades
	Phlebotomy project
Buckingham	Site reconfiguration and refurbishment
Brookside	Site reconfiguration and refurbishment

2.7 Security risk assessments, reviews and audits

The Security Service has completed over 80 risk assessments and reviews across the Trust and plans to increase this to around 100 in the next year, as departments and risks are evolving constantly.

3. KEY ACHIEVEMENTS: PERSONAL SAFETY

3.1 Upgraded lighting systems

In response to staff requests for improved lighting and to improve personal safety, the Security Service completed a Trust-wide lighting survey and oversaw the installation of new LED lights high-performance, low-energy lighting externally, along pathways and in car parks.

3.2 Reduction of crime against personal property

The Security Service implemented new security measures to target crime against vehicles and, as a result, has seen a dramatic decline in the number of incidents of crime involving vehicles in 2021-2022. In addition to introducing new measures, such as improved barriers and more CCTV coverage, we have also continued to maintain our strong partnership with Thames Valley Police to increase patrols and carry out covert operations.

3.3 Improved safety for vulnerable patients

We have installed new technology to protect vulnerable patients from leaving the Trust site without supervision. This includes new 'analytics kits' for facial recognition, which have been added to the camera servers and has improved the response time in identifying and tracing missing vulnerable patients on the CCTV system.

3.4 Improved conflict resolution training

The Security Service continues to provide a full programme of conflict resolution training to all staff, with online and face-to-face courses.

We have also brought the conflict resolution training in-house to enable a better, more tailored delivery of the course and reduce costs of having an out-sourced, externally provided training programme.

3.5 Updated policies

The Security Service updated the following policies for their 3-year review:

- BHT POL 198 – Managing Violence, Aggression and Unacceptable Behaviour Policy
- BHT POL 082 – Security Policy

4. KEY ACHIEVEMENTS: INCIDENT REDUCTION

The Security Service is pleased to note that the Trust has recorded a 45% decrease in the most serious incidents (racial abuse, sexual assault, missing vulnerable patients, physical assault, and

verbal abuse) since the 2019 – 2020 year, with a 10% decrease in incidents of verbal abuse in the past year.

We recognise that there were fewer visitors during the coronavirus pandemic, but we have seen patient footfall significantly increase during this year, compared to the previous 2 years, and have seen an increase in complex and challenging behaviours related to mental health issues since the start of the pandemic, so we are particularly pleased with the decrease in incidents that we have seen.

In addition, the Datix reporting system has recently been upgraded, which will help the Security Service to continue its analysis and reporting of incident trends and enable solutions to be found to minimise risks.

To ensure that we continue to provide the best security support, the Security Service has:

- Increased the number of security officers at Stoke Mandeville Hospital, with temporary dedicated security officers now in the Emergency Department and Maternity building.
- Provided additional conflict resolution training for ED staff.
- Created a Working Group on violence and aggression with clinical services to propose new solutions to address incidents. Following discussions within the Working Group, the Security Service created a 'Managing Violence and Aggression and Unacceptable Behaviour' training programme to raise awareness of our policy to reduce incidents of harassment, violence and aggression.

The chart in Appendix 1 highlights the key security incidents that the Security Service has responded to in the past year, compared to previous years. The figures identify that the Trust recorded 746 incidents during 2021 – 2022 and that abuse by patients and visitors (both verbal and physical) has been the greatest issue for the Trust.

5. RECOGNITION & COLLABORATION

5.1 Recognition for excellent work

Thames Valley Police formally sent a message of thanks to the Security Service for its support during a high-risk incident to help them to locate a vulnerable patient.

The Security Service received the Trust's "Bucks Excellence Report" this year for its "helpful and professional" service and "efficient and caring" attitude. The team was described as working "very hard in ensuring the hospital is safe". Further, "All individuals on the team are kind and hardworking. I just wanted to highlight that they are a huge part of the hospital service and their efforts should be recognised. Nothing is ever too much trouble, the team are always willing to help."

The Security Services was also nominated twice for a Trust CARE award this year for its hard work and support provided at Stoke Mandeville and Wycombe Hospitals.

5.2 Collaboration

The Security Service has continued to work closely with key external stakeholders, including Thames Valley Police, and also provided security support and advice to Bucks County Council to ensure the smooth running of the Paralympic Heritage Flame Lighting, which took place at Stoke Mandeville, Guttman Stadium on 28th February 2022.

We continue to work closely with our internal colleagues and formed strong partnerships with clinical services this year, during the review of their lockdown assessments and installation of security system, and with the Safety Working Group addressing bullying and harassment and

violence and aggression by re-writing the Managing Violence, Aggression and Challenging Behaviour policy and initiating a new training programme.

6. KEY PERFORMANCE INDICATORS SUMMARY 2021 / 2022

KPI	Objective	Current status
Security Operations Centre	<ul style="list-style-type: none"> To install a Security Operations Centre (SOC) at two sites (Wycombe and Stoke Mandeville Hospitals) this year. 	Achieved. Both SOCs operational.
Paxton Access Control	<ul style="list-style-type: none"> To install new access control on 20 doors this year, approximately 2 doors per month. 	Achieved. Installed on 49 doors (including in A&E, Pharmacy, Wards 7 and 11 WH and Spinal Centre).
Upgrade Paxton Net2 software	<ul style="list-style-type: none"> To install and upgrade the current Paxton Net2 access control software this year. 	Achieved. Software updated.
Medicine storage access control	<ul style="list-style-type: none"> To install new access control on drug and medicine cabinets this year. 	Achieved. Installed on drug cabinets, with 54 keys issued to staff.
CCTV server & analytics upgrade kits	<ul style="list-style-type: none"> To install a new Avigilon CCTV server at Stoke Mandeville Hospital and upgrade the older two servers with analytic packs this year. 	Achieved. New server installed. Both old servers updated with analytics packs.
CCTV cameras	<ul style="list-style-type: none"> To install 20 Avigilon CCTV cameras this year. 	Achieved. 38 new cameras installed (including in the Innovation Centre, Maternity, Wards in WH, Phlebotomy).
Conflict Resolution Train-a-Trainer	<ul style="list-style-type: none"> To train members of staff to deliver the conflict resolution training in-house this year. 	Achieved. Training programme implemented and Trust staff trained.
External lighting	<ul style="list-style-type: none"> To install LED lighting externally this year. 	Achieved. New LED lighting installed across SMH site, replacing old lighting.
Policy and procedure review	<ul style="list-style-type: none"> To review security policies and procedures this year. 	Achieved. Policies reviewed and updated: Security policy and Managing Violence, Aggression and Unacceptable Behaviour Policy.
Car park strategy	<ul style="list-style-type: none"> To create a car parking strategy this year. 	Achieved. Strategy written and submitted.
Incident reporting	<ul style="list-style-type: none"> To support the identification of an incident reporting system this year. 	Achieved. New system installed and operational.
Additional car parking SMH	<ul style="list-style-type: none"> To increase staff and contractor parking within Stoke Mandeville Hospital this year. 	Achieved. 180 new spaces created at SMH, including at Bucks Sports and Social Club.

7. KEY PRIORITIES 2022 / 2023

The demand on the Security Service continues to increase as clinical services accommodate more appointments to catch up on the backlog caused by the demands of the pandemic.

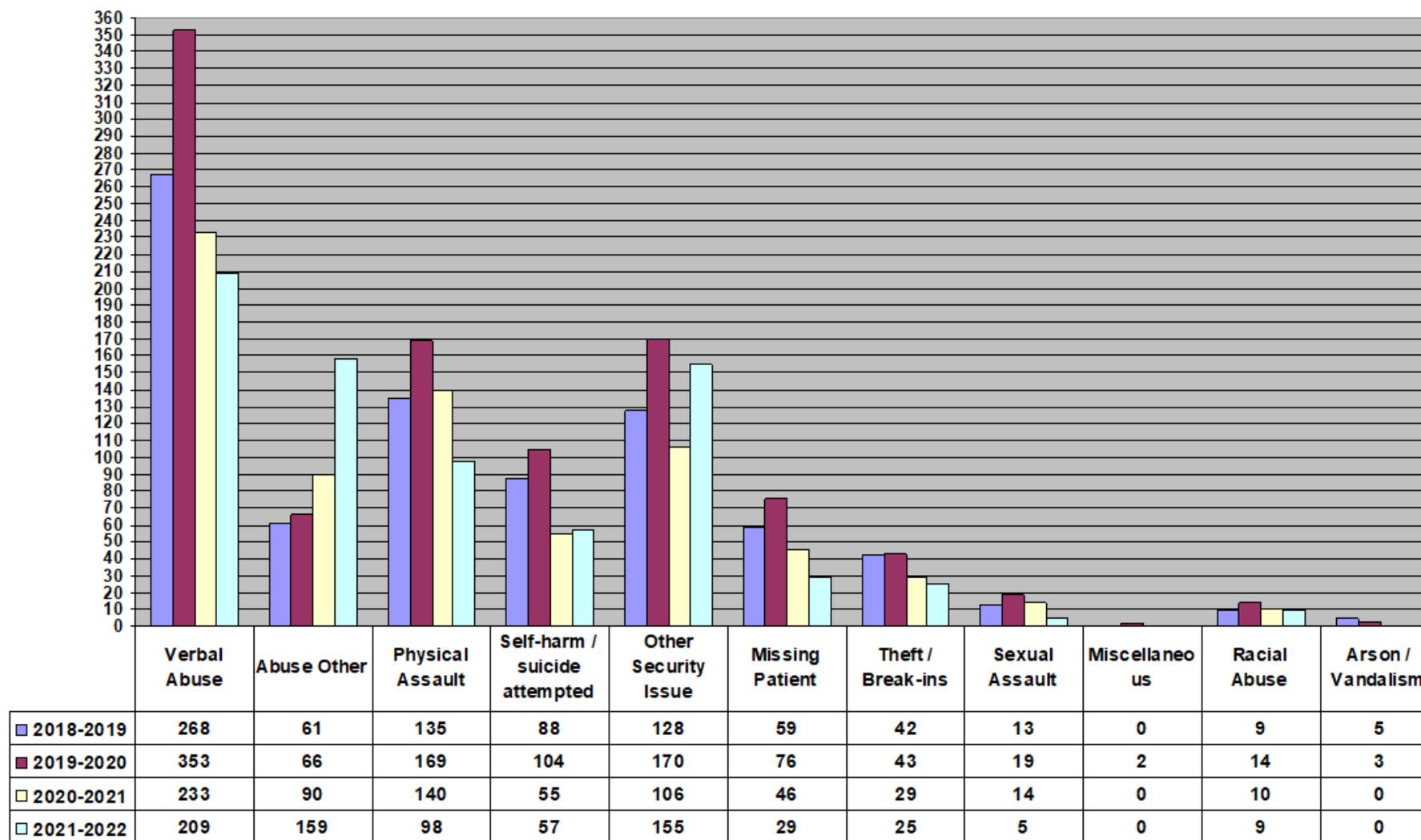
To address this, the Security Service plans to focus on the following areas, as set out in the Security Strategy and subject to the approval of capital funding, in the next year:

- Increased security officer provision.** Depending on availability of funding, 2 additional security officers will be employed, so that a dedicated officer can be based within the Emergency Department at SMH and provide immediate support, with a second officer to provide additional support to the wider clinical and security teams. Currently, officers are often required to attend multiple incidents at the same time. In the meantime, we will continue find innovative ways to address clinical staff's security needs and support the Trust's patients.
- Improved security systems.** New access control and CCTV cameras will continue to be installed at SMH, WH and Community sites.
- Improved personal safety measures.** Body camera and radio system and patient and asset tagging system.
- Training.** The 'Managing Violence and Aggression and Unacceptable Behaviour' training will continue, and the train-the-trainer Conflict Resolution training will also continue so that staff can deliver the training to their departments. This will lead to the creation of an Assault

Response Team at each of Stoke Mandeville and Wycombe sites. We will focus on ensuring collaboration with clinical teams so that staff can attend this vital training.

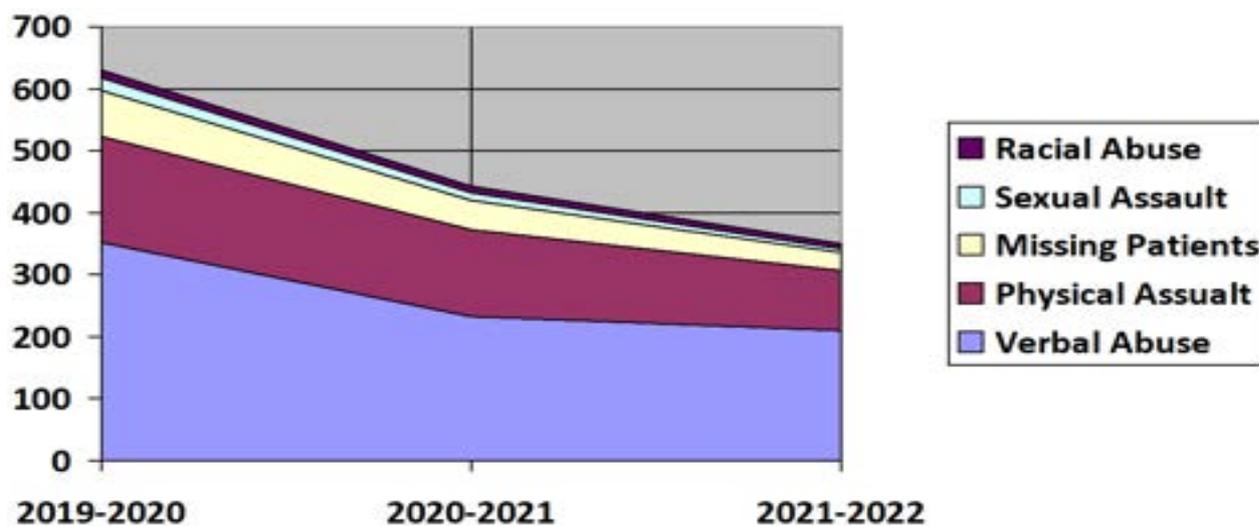
- **More secure car parking.** Further security provisions will be introduced in car parks, to deter crime and improve personal safety.
- **Continued strong partnerships with staff and external stakeholders.** We will enhance our relationships with colleagues across the Trust and maintain our good relationships with Thames Valley Police and other external stakeholders.
- **Protected environment.** We aim to introduce measures to reduce our carbon footprint, where possible, by for example, introducing more energy efficient systems, secure bicycle racks and electric car recharging points.

Appendix 1 – Trust-wide Datix incidents April to March 2022 and analysis



Note: "Abuse other" covers disruptive or aggressive behaviour and "other security issue" covers policy breaches, such as leaving doors and windows open or misplacing keys.

Appendix 2 – Trust-wide most serious reported Datix incidents for the past 3 years



2019-2020	2020-2021	2021-2022	Overall Percentage Reduction 2019-2022 Most Serious Datix Incidents
631	443	350	45%

Incidents	Percentage Reduction 2019-2020 vs 2021-2022
Racial Abuse	36%
Sexual Assault	74%
Missing Patients	61%
Physical Assault	42%
Verbal Abuse	41%

Appendix 3 – Abbreviations

A&E	Accident & Emergency
AH	Amersham Hospital
BHT	Buckinghamshire Healthcare NHS Trust
CCTV	Closed Circuit Television
ED	Emergency Department
SDEC	Same Day Emergency Care
SMH	Stoke Mandeville Hospital
WH	Wycombe Hospital

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Private Board Summary Report 25 May & 29 June 2022		
Board Lead	Trust Board Business Manager		
Type name of Author	Senior Board Administrator		
Attachments	None		
Purpose	Information		
Previously considered	N/A		

Executive Summary

The purpose of this report is to provide a summary of matters discussed at the Board in private on the 25 May and 29 June 2022.

The matters considered at these sessions of the Board were as follows:

- Serious Incidents Report
- Standards of Behaviour & Conduct Report
- External Audit
- Annual Report
- Place & System Briefing
- NED Walkabouts
- Integrated Performance Report
- Cyber Resilience and DSPT
- Monthly Finance Report
- Quality Account
- Digitisation of Paper records
- Programme Business Case for Hospitals Redevelopment Programme
- Trainee Leadership Board Survey Results

Decision	The Board is requested to note the contents of the report.		
Relevant Strategic Priority			
Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒
Implications / Impact			
Patient Safety	Aspects of patient safety were considered at relevant points in the meeting		
Risk: link to Board Assurance Framework (BAF)/Risk Register	Any relevant risk was highlighted within the reports and during the discussion		
Financial	Where finance had an impact, it was highlighted and discussed as appropriate		
Compliance <small>Select an item. Select CQC standard from list.</small>	Compliance with legislation and CQC standards were highlighted when required or relevant		
Partnership: consultation / communication	N/A		

Equality	Any equality issues were highlighted and discussed as required.
Quality Impact Assessment [QIA] completion required?	N/A

Meeting: Trust Board Meeting in Public

27 July 2022

Agenda item	Modern Slavery Act 2015	
Board Lead	Chief Executive, Neil Macdonald	
Type name of Author	Chief People Officer, Bridget O'Kelly	
Attachments	Modern Slavery Statement	
Purpose	Information	
Previously considered	None	

Executive Summary

The Modern Slavery Act was passed by Parliament in March 2015. The provisions of the Act came into effect in October 2015. The Trust is required to produce an annual public statement of the actions it has taken to meet requirements under the Act.

The Act consolidated slavery and trafficking offences, strengthened powers of enforcement and introduced tougher penalties. It also included a transparency clause requiring all UK based businesses with a turnover of over £36m or more to make an annual statement on the steps it has taken in the previous financial year to ensure its business and supply chains are free from Modern Slavery, which the Act defines as slavery, servitude, forced or compulsory labour and human trafficking.

The statement should be Board approved, signed by a Director and must be published on an organisation's website.

Decision	The Board is asked to note the Modern Slavery Statement 2021/22 for publication on the Trust Website
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Relevant Strategic Priority

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

Patient Safety	Potential victims have a 1 in 5 chance of contact with the NHS and staff receive training on how to take action as appropriate
Risk: link to Board Assurance Framework (BAF)/Risk Register	The Trust could receive adverse publicity and enforcement action if it fails to meet the requirements of the Act.
Financial	The Trust must meet procurement requirements under the Act. The Legislation can impose fines for non-compliance. The procurement department follow the appropriate guidance.
Compliance CQC Standards	In meeting the requirements of the Act, the Trust meets its legislative obligations and several of the CQC requirements such as <i>safety, dignity and respect</i> .

Partnership: consultation / communication	The statement will be shared with the Trust's staff side colleagues at one of their regular meetings
Equality	This report does not have any detrimental impact on any protected characteristics. It provides positive reinforcement of the need to protect vulnerable individuals.
Quality Impact Assessment [QIA] completion required?	N/A

Modern Slavery Act 2015 Section 54 - Slavery and Human Trafficking Statement

Modern Slavery Act 2015 Section 54 - Slavery and Human Trafficking Statement

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

Buckinghamshire Healthcare NHS Trust (BHT) aims to follow good practice and take all reasonable steps to prevent slavery and human trafficking. We are committed to ensuring that all of our employees are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that the individual may be or is at risk of modern slavery/human trafficking.

We are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. This statement sets out actions taken by BHT to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

Trust Structure and Principle Activities

BHT is a major provider of integrated hospital and community services for people living in Buckinghamshire and the surrounding area, including Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire), providing care to over half a million patients every year.

We are recognised nationally for our urology and skin cancer services and are a regional specialist centre for burns care, plastic surgery, stroke and cardiac services and dermatology. In addition, we provide specialist spinal services at our world renowned National Spinal Injuries Centre for patients from across England and internationally.

We are part of the Buckinghamshire Integrated Care Partnership which comprises of Buckinghamshire Healthcare NHS Trust and Buckinghamshire Council. The Buckinghamshire Integrated Care Partnership (ICP) is part of the wider Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS).

We procure goods and services from a range of providers. Contracts vary from small one-off purchases to large service contracts. All spend, aside from a few exceptions such as rates, is paid via PO. The Applicable Contract Terms Policy applies to any NHS organisation and states that where an NHS body issues a PO the standard Terms & Conditions apply.

Organisational policies in relation to slavery and human trafficking

BHT has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking.

The BHT Safeguarding Adult and Children Policy includes information on modern day slavery/human trafficking.

The BHT Incident Reporting Policy states that colleagues should report incidents of all types and this includes concerns regarding modern slavery and human trafficking. By using the local risk management system (Datix) appropriate teams, including safeguarding are made aware.

All colleagues have access to the BHT Safeguarding team for support and guidance when they are concerned about modern day slavery or trafficking.

BHT also has a team of Freedom to Speak Up Guardians who will provide support to an individual raising a concern; the role of the Freedom to Speak Up Guardian is covered at the Trust's monthly corporate induction.

Trust activities and policies are required to have an Equality Impact Assessment (EQIA) completed.

Assessing and managing risk and due diligence processes in relation to slavery and human trafficking

We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business.

The Trust reviews its Modern Slavery and Human Trafficking Statement on an annual basis and presents it at a Board meeting in Public. This demonstrates a public commitment, ensures visibility and encourages reporting standards.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain:

- The Trust adheres to the National NHS Employment Checks/Standards (this includes employees UK address, right to work in the UK and suitable references).
- The Trust has systems to encourage the raising and reporting of concerns and the protection of whistle-blowers.
- The Trust purchases a significant number of products through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour. Other contracts are governed by standard NHS Terms & Conditions. High value contracts are effectively managed, and relationships built with suppliers.
- The majority of our purchases utilise existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of Contract, these all have the requirement for suppliers to have suitable anti-slavery and human trafficking policies and processes in place. Where a suitable framework exists, we use them in preference to tendering. These are run by NHS procurement entities and are governed by NHS Standard Terms & Conditions.
- All suppliers are required by law to comply with the provisions of the UK Modern Slavery Act (2015). This will be reinforced where appropriate by Standard Selection Questionnaires as part of tender processes along with use of NHS Standard Terms and Conditions either direct with suppliers or through framework agreements. The NHS standard contracts govern how we engage with our suppliers and require compliance with relevant legislation, including the Modern Slavery Act 2015. The 2022 updates to these contracts strengthen our position on Modern Slavery, extending requirements and the option to terminate for breaches of social and labour laws.

Effective action taken to address modern slavery - Performance Indicators

The Trust is committed to social and environmental responsibility and has zero tolerance for Modern Slavery and Human Trafficking. Any identified concerns regarding Modern Slavery and Human Trafficking are escalated as part of the organisational safeguarding process. This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes BHT's slavery and human trafficking statement for the current financial year.

All employees have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance.

A Freedom to Speak Up Report is submitted quarterly to the Trust Strategic Workforce Committee and twice a year to the Trust Board. Any themes or trends are highlighted through these reporting mechanisms but should something be of concern such as trafficking or modern slavery these would be raised immediately either by exception reporting or direct to an executive director as appropriate.

Training on modern slavery and trafficking

Safeguarding training is mandatory for all colleagues and includes information on trafficking and modern-day slavery in order to promote the knowledge and understanding of escalating concerns via the Home Office national referral mechanism/duty to notify process.

Conclusion

The Board is asked to note this statement to be published on the Trust's website.

Acronym 'Buster'

A

- A&E - Accident and Emergency
- AD - Associate Director
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting
- AHP - Allied Health Professional
- AIS – Accessible Information Standard
- AMR - Antimicrobial Resistance
- ANP - Advanced Nurse Practitioner
- AGS – Annual Governance Statement
- AHSN – Academic Health Science Network
- AMU – Acute Medical Unit

B

- BHT – Buckinghamshire Healthcare Trust
- BME - Black and Minority Ethnic
- BMA - British Medical Association
- BOB – Buckinghamshire, Oxfordshire, Berkshire West
- BAF – Board Assurance Framework

C

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CCG - Clinical Commissioning Group
- CCU - Coronary Care Unit
- Cdif / C.Diff - Clostridium Difficile
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CDIO – Chief Digital Information Officer
- CIP - Cost Improvement Plan
- CQC - Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CRL – Capital Resource Limit
- CMO – Chief Medical Officer
- CN – Chief Nurse
- CNST – Clinical negligence scheme for Trusts
- COO – Chief Operating Officer
- CQC – Care Quality Commission
- CCO – Chief Commercial Officer
- CRR – Corporate Risk Register
- CYP – Children and Young People

D

- DBS - Disclosure Barring Service
- DH / DoH - Department of Health and Social Care

- DIPC - Director of Infection Prevention and Control
- DNA - Did Not Attend
- DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
- DNAR - Do Not Attempt Resuscitation
- DNR - Do Not Resuscitate
- DoLS - Deprivation of Liberty Safeguards
- DPA - Data Protection Act
- DSU - Day Surgery Unit
- DWP – Department for Work and Pensions
- DSPT – Data Security and Protection Toolkit

E

- E&D - Equality and Diversity
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EIA - Equality Impact Assessment
- EIS – Elective Incentive Scheme
- EPR - Electronic Patient Record
- EPRR - Emergency Preparedness, Resilience and Response
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record
- EAU – Emergency Assessment Unit
- EPS – Electronic Prescription Service
- ERF – Elective Recovery Fund

F

- FBC - Full Business Case
- FFT - Friends and Family Test
- FOI - Freedom of Information
- FTE - Full Time Equivalent
- FPPR – Fit and Proper Persons Requirement for Directors

G

- GMC - General Medical Council
- GP - General Practitioner
- GIRFT – Getting it Right First Time
- GPVTS – General Practice Vocational Training Scheme

H

- HAI - Hospital Acquired Infection
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEE – Health Education England
- HETV - Health Education Thames Valley
- HMRC – Her Majesty’s Revenue and Customs
- HSE - Health and Safety Executive
- HSMR – Hospital-level Standardised Mortality Ratio
- HWB - Health and Wellbeing Board
- HFMA – Healthcare Financial Management Association
- HSJ – Health Service Journal

I

- ICS – Integrated Care System
- ICB – Integrated Care Board
- ICP – Integrated Care Partnership
- IPR – Integrated Performance Report
- IPC – Infection Prevention Control
- I&E - Income and Expenditure
- ICU - Intensive Care Unit
- IG - Information Governance
- ITU - Intensive Therapy Unit / Critical Care Unit

J

- JAG - Joint Advisory Group

K

- KPI - Key Performance Indicator
- KLOE – Key Lines of Enquiry

L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LAC – Looked after Children
- LEP Local Enterprise Partnership
- LTP – NHS Long Term Plan

M

- MDT - Multi-Disciplinary Team
- MIU - Minor Injuries Unit
- MRSA - Meticillin-Resistant Staphylococcus Aureus
- MOFD – Medically optimised for discharge
- MSK - Musculoskeletal

N

- NED - Non-Executive Director
- NHS – National Health Service
- NHSE – National Health Service England
- NHSE/I – National Health Service England & Improvement
- NHSI – Nation Health Service Improvement
- NHSLA - NHS Litigation Authority
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NEWS – National Early Warning Score
- NHSBT – NHS Blood and Transplant
- NHSD – NHS Digital

O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy
- OUH - Oxford University Hospital

P

- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PBR - Payment by Results
- PBR Excluded – Items not covered under the PBR tariff
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PFI - Private Finance Initiative
- PHE - Public Health England
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PPE - Personal Protective Equipment
- PP – Private Patients
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty
- PDP – Personal Development Plan

Q

- QA - Quality Assurance
- QI - Quality Indicator
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework

R

- RAG - Red Amber Green
- RCA - Root Cause Analysis
- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment
- R&D – Research & Development

S

- SAU - Surgical Assessment Unit
- SCAS - South Central Ambulance Service
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident

- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SDEC – Same Day Emergency Care
- SEN – Special Educational Need
- SOC – Strategic Outline Case
- SOP – Standard Operating Procedure

T

- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

U

- UEC – Urgent Emergency Care
- UCB – Urgent Care Board
- UTC – Urgent Treatment Centre

V

- VfM - Value for Money
- VSM - Very Senior Manager

W

- WHO - World Health Organization
- WTE - Whole Time Equivalent
- WDES – Workforce Disability Equality Standard
- WRES – Workforce Race Equality Standard

Y

- YTD - Year to Date