Buckinghamshire Healthcare NHS
NHS Trust

Buckinghamshire Healthcare NHS Trust Annual report 2010 / 11

Where your needs always come first

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If you require our annual report in an alternative format, including in other languages or as an audio book, please contact the communications team on 01494 734959 or email: communications@buckshealthcare.nhs.uk. Alternatively you can write to: Communications Department, Buckinghamshire Healthcare NHS Trust, Amersham Hospital, Whielden Street, Amersham, Bucks HP7 0JD.

1. A few things about us

Buckinghamshire Healthcare NHS Trust is a major provider of hospital and community services, providing care to over half a million patients from Buckinghamshire and neighbouring counties every year.

Following the partnering of Community Health Buckinghamshire with the Trust in April 2010, we are now responsible for a significant proportion of NHS care in the county; from community health services provided in people's homes or from one of over 20 local bases, to acute hospital services at Stoke Mandeville and Wycombe.

Our ambition is to provide comprehensive and value for money care aimed at giving patients the right treatment, in the right place, at the right time. Over 6,000 highly trained doctors, nurses, midwives, health visitors, therapists, healthcare scientists and other support staff make up our workforce, caring for the full spectrum of patients from newborn babies to elderly people needing help to live independently at home.

As well as being a major provider of community and acute hospital care, we are renowned for our specialist services. Stoke Mandeville Hospital is home to the internationally recognised National Spinal Injuries Centre, one of only a few such centres of expertise in the UK. We are also a regional centre for burn care, plastic surgery and dermatology, and recognised nationally for our urology and skin cancer services.

Buckinghamshire Healthcare NHS Trust is an NHS provider organisation based in the South Central Strategic Health Authority area and our services are commissioned by primary care trusts and specialist commissioners. Our main commissioner is NHS Buckinghamshire, and they account for more than 70 per cent of the Trust's income.

2010/11 in numbers

- 148,433 new outpatient attendances at our hospitals
- 269,414 follow-up outpatient attendances
- 4,810 outpatient procedures performed
- 6,578 elective inpatient admissions
- 37,942 elective day case admissions
- 39,019 emergency admissions
- 105,371 number of people attending our emergency services

Where we are based

We provide inpatient facilities from two acute and five community settings in the county, and care closer to home from 20-plus venues such as health and leisure centres and GP practices. Our community health services include

adult community healthcare teams (district nursing, occupational and physiotherapy), services for children and families, intermediate care, health visitors, community dental services and palliative care.

Our acute hospitals

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

Our community hospitals and other settings

- 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 Hospital, Victoria Road, Marlow SL8 5SX
- Thame Community Hospital, East Street, Thame OX9 3JT
- Florence Nightingale House, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL
- Waterside Unit and Chartridge Ward, Amersham Hospital, Whielden Street, Amersham, HP7 0JD

Our administrative headquarters are based at Amersham Hospital.

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

2. Chairman's and chief executive's welcome and review

Welcome to our annual report for 2010/11. This year has been marked by real challenge but also many achievements across the broad range of services Buckinghamshire Healthcare NHS Trust now provides following integration with community services.

On 1 April 2010, Community Health Buckinghamshire staff transferred to our employment from NHS Buckinghamshire and we were delighted to welcome them. Following extensive engagement with staff and patients last summer, we were able to set the direction of travel for the Trust to streamline patient care pathways, and start to work through how best to optimise the use of our community and hospital resources to offer care closer to home. To reflect the nature of the new organisation we changed our name to *Buckinghamshire Healthcare NHS Trust* in November 2010.

Our five promises, drawn up with widespread patient and staff involvement in 2008, again provided the driving force behind efforts to establish our services as the first choice for the local community and focused our attention on what matters most to patients. Following on from our integration, we have reviewed our promises to ensure they are also relevant to the services we offer in the community, read about these on page 7.

Our estate received a number of makeovers this year including the opening of Chartridge Ward, to support the Waterside Unit within Amersham Hospital to provide rehabilitation care to patients before they return home, refurbishment at Thame and the reopening of the inpatient facility at Marlow, and the Wycombe birth centre, which reopened following extensive improvements to this standalone midwife-led service. We look forward to pushing forward further physical improvements in our hospitals during 2011/12 including the development of the hyper acute stroke unit at Wycombe Hospital.

Much of the work undertaken by the Trust over the last financial year has focused on the need to sustain and improve our patient care and quality of outcomes whilst increasing our efficiency and integrating services. The planned changes to government policy and direction has emphasised closer working with GPs and the new GP commissioning consortia. We are pleased to have a good relationship within Buckinghamshire, and as the commissioning function moves from primary care trusts to the consortia, we see a major focus of our work being to support them through this transitional period.

With hard work and commitment from all areas of the organisation, we are delighted to report a small surplus for 2010/11, and that our very challenging cost improvement programme of £29.8m was achieved in full. We expect 2011/12 to be equally challenging, however with the benefits of integration allowing us to reduce duplication, we are confident we can achieve our

financial goals and will work hard to ensure that this does not impact adversely on the quality of our services.

Our ambition to become an NHS Foundation Trust (FT) remains a major objective, and our plans are well advanced to achieve this status in 2012, which once achieved will provide us with a number of freedoms and give local people, patients and staff more of a say about their local NHS and in particular the way in which we intend to provide our services.

This has been another high achievement year in a really tough environment and together we want to say a big thank you to all our staff and volunteers for the great contribution they have made to the Trust over the past year, and we would also like to take this opportunity to thank you for your continued support and interest in our hospitals and community activities.

Graham Ellis, Chairman

Anne Eden, Chief executive

3. Our vision

Our vision for Buckinghamshire Healthcare NHS Trust is to be the first choice of healthcare provider for the people of Buckinghamshire and beyond because at Buckinghamshire Healthcare your needs always come first.

This principle guides everything we do, and led to the development of five promises. These promises, drawn up in partnership with patients and their representatives and updated during the year to reflect the integration of community services, are long-term commitments to make better what matters most to our users. The promises shaped our business plan and objectives for 2010/11 and are an ongoing commitment to provide:

- **Clean and safe practice**, clinics and hospitals so you never need to worry unduly
- **A caring, helpful and respectful attitude** from approachable teams, who listen to you, involve you in decisions about your care and ensure you're clear about what to expect
- **Respect for your time** with care closer to home, offering choice and flexibility with a minimum of delays and cancellations
- **Easy access to comfortable and modern facilities**, offering privacy and dignity, personal space and good healthy food
- The **best clinical care** from teams of skilled healthcare professionals, who help you improve and maintain your health.

The promises also reflect the ambitions of the national NHS Constitution, bringing together in one place what staff, patients and public can expect from the NHS.

We are committed to ensuring that our promises are reflected in all that we do, and to working closely with our staff to integrate the vision and values throughout the organisation.

The 2010/11 business plan

In 2010/11 we agreed a business plan that would ensure the continued and sustainable delivery of safe, high-quality services in our acute hospitals, whilst at the same time integrating this activity with the community services formerly provided by Community Health Buckinghamshire.

The business plan reflected the start of the process of shifting more appropriate care out of the acute hospitals and into community or home settings. The plan also recognised the development of specialist clinical networks to support a number of key services, and it provided a new basis from which the Trust restarted its journey to gain NHS Foundation Trust status in 2012.

4. The corporate objectives

We established 12 priorities for 2010/11 to provide practical direction for our staff to help implement our strategy and they were grouped under four headings.

In addition to our corporate objectives, we were expected to achieve against the national targets and standards.

This chapter charts progress in our twelve priorities for 2010/11.

1. **Integrate Community Health Buckinghamshire with Buckinghamshire Hospitals NHS Trust to form one new organisation**

    - achieve successful integration of Community Health Buckinghamshire with Buckinghamshire Hospitals NHS Trust.

2. **Drive up safety and quality – deliver the patient promises**

    - improve quality for patients
    - embed service standards into everyday practice
    - improve clinical outcomes for patients
    - deliver our vision with a highly motivated and engaged workforce by developing our staff.

3. **Maximising productivity, efficiency and cost-effectiveness**

    - finance best practice
    - operational best practice
    - clinical leadership and alignment to clinical workforce
    - improve the clinical environment for patients.

4. **Strengthen our future through effective partnership**

    - promote excellence in national and regional services
    - build a strong relationship with the Buckinghamshire community
    - secure a future as the key provider in Buckinghamshire.

1. Integrate Community Health Buckinghamshire with Buckinghamshire Hospitals NHS Trust to form one new organisation

We were delighted to welcome Community Health Buckinghamshire staff who transferred to our employment from NHS Buckinghamshire on 1 April 2010. With the creation of the division of community and integrated care, the Trust

has been able to make significant improvements through streamlining our care to simplify patients' journeys, and we are ensuring that we optimise the use of our community and hospital resources to bring care closer to home.

Last autumn, a number of engagement sessions were held with staff, GPs and the public to seek their views on how we could make better use of community hospitals and services. We are using their feedback to ensure community hospitals are better used to reflect the needs of the populations they serve within the resources available.

Working closely with the service redesign team, (the Patient Services Institute (PSI), several initiatives have been rolled out during the past year including:

- supported discharge for patients with chronic obstruction pulmonary disease (COPD) - to enable quicker discharge of patients back home
- increasing capacity in managing antibiotic therapy in the community - to enable more patients to receive antibiotic therapy at home
- cardiac outpatients now being seen in the community, and
- the redesign of the type II diabetic pathway to ensure people are treated in a appropriate setting.

To support end of life care, we have been reviewing the provision of dedicated end of life care beds at Buckingham Hospital and the possibility of also providing dedicated end of life care beds at Marlow Hospital.

A one off payment from the PCT enabled Chartridge Ward at Amersham Hospital to open in the autumn of 2010, to work alongside the Waterside Unit to provide rehabilitation care patients before they return home.

The adult community healthcare teams have also been instrumental in supporting early discharge of patients from the acute setting and preventing patients being admitted, especially those with long term conditions, such as COPD and heart failure. In April 2011, a new service specification took effect, which is enabling us to expand the number of patients that can be supported in the community and developing a 24/7 service; this will become fully operational over the coming months.

We are committed to developing our community hospitals and during the year refurbishment took place at Marlow, where inpatient beds were reopened, and at Thame where both staff and patients are delighted with the redecorated and improved facilities. Improvements have also been made at Amersham Health Centre, Oakridge Centre, Buckingham Hospital, and at Thame Health Centre Annexe to develop a base for the Thame adult community healthcare team.

During December the roll out of RiO as the primary patient record system in the community commenced. This is a great step forward in replacing the numerous paper and electronic systems previously in use and enabling more accurate recording of activity.

2. Drive up safety and quality – deliver the patient promises

Care Quality Commission registration

The Trust is required to register with the Care Quality Commission, who regulate and help improve care provided by the NHS. We achieved registration without conditions effective from 1 April 2010.

The Care Quality Commission has not taken enforcement action against Buckinghamshire Healthcare NHS Trust during 2010/11 and the Trust has not participated in any special reviews or investigations by the CQC during 2010/11.

Infection rates continue to drop at Buckinghamshire hospitals

Figures from the Health Protection Agency in July 2010 showed infections across the NHS in Buckinghamshire continue to remain low in our hospitals.

Over past year, the Trust has halved the rate of C.difficile infections in patients aged two and over, with just two cases per 10,000 bed days compared to four the previous year. The average rate across the UK was 3.6.

Figures also show that the Trust had below the national average of MRSA bacteraemia cases per 10,000 bed days, reporting 0.49 cases against an average of 0.50 nationally. This figure includes cases acquired within the community.

The figures support and reflect the hard work being carried out by every staff member who works in our hospitals. This is excellent news for our patients and staff as we continue to be vigilant and work hard to deliver on our promise to offer the safest care in clean and modern facilities.

With the integration of Community Health Buckinghamshire, we look forward to continuing our work in reducing the number of infections acquired in the community and in our hospitals and strive to achieve even better results next year. Following extensive refurbishment at a number of community sites over the year we are now in a much better position to meet this commitment.

Continuing to improve patient safety

Considerable work has taken place during the year in respect of the ongoing development and implementation of the organisation's patient safety processes.

The programme of executive safety walkabouts led by our chief executive, continued throughout the year. Walkabouts included areas such as medicine for older people, cardiology, National Spinal Injuries Centre (NSIC) and theatres and critical care. Safety and environmental issues were reviewed and

discussed during the walkabouts resulting in actions to be taken forward by staff present at the walkabout and clinical divisions.

The Trust is committed to the delivery of the South Central Strategic Health Authority 'Patient Safety First' workstreams including:

- reducing the incidence of patient falls. The Trust has a lead nurse for patient falls and a falls group is in place
- reducing the incidence of hospital acquired pressure ulcers. The Trust has an active pressure ulcer group and is currently developing a pressure ulcer strategy. All category three and four pressure ulcers are investigated and learning shared
- reducing the incidence of medication errors. The Drug Error Group meets regularly to review and discuss medication safety and errors.

The Trust approved a clinical audit policy and clinical audit programme to maintain and further develop its quality improvement processes. Implementation of the clinical audit policy and clinical audit programme is monitored within the governance structure and processes of the organisation.

During the coming year we will continue to build on patient safety processes and continue to engage patients, public and staff to not only celebrate good practice but to share lessons learned from areas identified for development.

Hospital standardised mortality ratios

When Dr Foster published their Good Hospital Guide in November 2010 we were named as one of 19 trusts with a higher than average Hospital Standardised Mortality Ratio (HSMR). Whilst we welcome results from independent reports such as this, it is important to put these results into context, recognising the excellent care provided by our staff every day.

We take patient safety very seriously and carefully monitor our mortality data on a regular basis, addressing any issues as soon as they arise which includes reviewing patient notes. Our ongoing analysis reveals that the actual number of people who die at our hospitals is low and there have been no significant issues with the care we provide; however, we never become complacent.

A 'Mortality Task Force' chaired by our medical director, was established to assess quality of care by reviewing clinical records, and to put a plan in place for improving our HSMR. In addition to detailed twice yearly reviews of the care of patients who die in hospital, we have been working systematically to improve the quality of our coding, particularly around palliative care, co-morbidities and low risk conditions. This has resulted in a steady reduction in the HSMR throughout 2010/11 bringing us much closer to other acute trusts.

Maternity services score well in patient survey

Mums who have given birth at our hospitals are very happy with their care, according to the Care Quality Commission (CQC).

A national survey asked women across the country about the care they received during pregnancy, labour and birth. Our results rated us as one of the top performing trusts in the region.

We are delighted that women are happy with many aspects of the services we provide to them during a special time in their lives. We have invested a lot of time developing our services over the past few years, investing £6million on developing a dedicated women and baby centre at Stoke Mandeville and, more recently, refurbishing Wycombe birth centre and investing in a range of birthing aids that enable natural movement during labour. However, we recognise there are still areas we need to improve on, including support for breastfeeding, patient education and post natal support.

Improving the environment

Improving and maintaining the physical settings where we deliver care is an ongoing challenge with an estate the size of ours, which now includes all our community sites. During the year around £5 million was spent on refurbishment programmes to upgrade the environment for patients.

Wycombe birth centre celebrating its first year: In October the Wycombe birth centre celebrated its first year as a standalone midwife-led service.

Our dedicated midwives have welcomed over 250 babies into the world in the past year at Wycombe, despite a short closure due to staff shortages, and we have heard from many women who have really appreciated having their baby in such a relaxed home-from-home environment.

Whilst the unit was temporarily closed during late summer, the Trust took the opportunity to completely refurbish the rooms and communal areas to create an environment that was even more homely and comfortable for women who are able to choose a natural birth.

In addition, we have developed a marketing plan to help increase the number of women choosing the centre as their first choice of birth centre, and figures are now showing a positive increase.

If you would like to find out more about the Wycombe Birth Centre, please visit the Trust's website at www.buckshealthcare.nhs.uk

The Trust provides a full complement of choices for women wishing to access our maternity service including homebirths, our two midwife-led birth centres and our new labour ward at Stoke Mandeville where mothers requiring more monitoring in labour can have their babies.

Thame Community Hospital improvement works: In the community, the refurbishment of Thame Community Hospital resulted in upgraded facilities for patients.

Improvement works were carried out to ensure the environment of the hospital met modern infection control requirements, allowing us to care for patients in clean and safe facilities. The works included refurbishing the inpatient area with new sinks, ceilings and lighting.

The hospital has a more welcoming feel and we can continue to deliver care to our patients whilst preventing infection in the newly improved inpatient ward.

Marlow Community Hospital beds reopen: A newly decorated and improved inpatient area at Marlow Community Hospital was completed late last year, allowing the inpatient beds to be fully utilised again.

Following integration, we were committed to reopening the beds at Marlow, which had been closed the previous year due to health and safety concerns.

The Trust spent £250,000 on the hospital's facilities, including correcting the supply of water and improving infection control. Work has also gone into eradicating mixed-sex facilities by relocating bathrooms so that there are now only single-sex washrooms.

In addition, the hospital has had a number of more general improvements to enhance the environment, including new ceilings and lights, and soft paint colours to give a more welcoming feel.

We were very pleased to be able to reopen the beds at Marlow Hospital and bring it back to being an integral part of the community and are very thankful for the support of the Marlow League of Friends in the hospital's development.

Improved car parking: To ensure we provide safe and clearer parking arrangements for both patients and the public, we have been working on plans to improve parking at our three main hospital sites at Amersham, Wycombe and Stoke Mandeville.

We are in the process of introducing a new permit system for staff and separate parking facilities for staff and patients, including new barriers, to ensure that vehicles are parked correctly in designated areas and to encourage the safe use of the hospital sites for staff, patients and visitors. Work is ongoing but during 2011/12 we hope people will start to see the benefits of the new arrangements.

A welcoming entrance: We are pleased to report that work to refurbish the entire main entrance at Wycombe Hospital, including providing a new reception, vending and seating area, and coffee bar, is near completion, with final work on the new restaurant to be finished during 2011. This now

provides visitors to Wycombe Hospital with a welcoming and warm environment with an increased range of facilities.

Patients enjoying 'excellent' food in local hospitals

Our Trust was one of 324 organisations to take part in the 2010 Patient Environment Action Team (PEAT) assessment which resulted in an 'excellent' review for the quality of our food.

This year's report rated the quality of food available at Amersham, Stoke Mandeville and Wycombe hospitals as 'excellent'. This is an improvement on last year's performance where Stoke Mandeville Hospital was assessed as 'good'.

The report looks at a range of areas, including food, cleanliness, bathroom facilities and décor. In addition the survey - carried out by a team including Trust staff and a patient representative - also looks at privacy and dignity standards.

The Trust made major improvements in patient's privacy and dignity and were rated as 'excellent' at both Stoke Mandeville and Wycombe, and 'good' at Amersham Hospital. Again this is a big improvement on the 2009 results, where Wycombe Hospital was rated 'acceptable' and Stoke Mandeville Hospital 'good'.

There has also been an improvement in the environment category with Wycombe Hospital moving from 'acceptable to 'good' while at Stoke Mandeville Hospital remains 'acceptable' and Amersham Hospital 'good'.

In addition, our community hospitals were awarded an overall rating of 'good' for privacy and dignity, patient environment and food. Buckingham Community Hospital scored 'excellent' for both food and privacy and dignity, Thame Community Hospital scored 'excellent' for food, and Florence Nightingale House, Aylesbury scored 'excellent' for privacy and dignity.

The assessment shows patients can be reassured that they will be treated in clean, safe hospitals where their privacy and dignity are paramount concerns.

The overall the assessment underlines that we're helping to make our promises, like safe care in clean hospitals, a reality.

Our hospitals have also been performing well when it comes to food safety standards with Buckingham Community Hospital and Stoke Mandeville Hospital being presented with an Elite Award by Aylesbury Vale District Council, for food businesses in north Buckinghamshire that have maintained consistently high food safety standards.

The council introduced the 'Scores on the Doors' award scheme to acknowledge the food hygiene standards, including food preparation, safety processes and kitchen cleanliness of outlets that are inspected regularly.

Improved treatment for emergency patients

We were delighted to improve the experience for patients using our accident and emergency services by reducing waiting times and achieving the national emergency access target.

Meeting this target means making sure that 95 per cent of patients receive treatment, are admitted or discharged within four hours of arrival in the accident and emergency departments. We achieved this standard for 97.2 per cent of patients (from Quarter 2, when the target and measurement was revised by the Department of Health) which makes us one of the best performing trusts in the south central strategic health authority area (which covers, Buckinghamshire, Berkshire, Oxfordshire, Hampshire and the Isle of Wight), and is a particularly significant achievement bearing in mind the harsh and busy winter.

Quality accounts 2010/11

From 2009/10 onwards all NHS trusts have to publish quality accounts to give information about the quality of the services being delivered.

Our quality accounts for 2010/11, which are approved by the Secretary of State, will be published in June and available on our website www.buckshealthcare.nhs.uk or from the communications department (communications@buckshealthcare.nhs.uk).

The quality accounts include:

- what we are doing well
- where improvements in service quality are required
- what our priorities for improvement are for the coming year
- how our organisation has involved people using our services, staff, and others with an interest in the organisation in determining areas for improvement.

3. Maximising productivity, efficiency and cost-effectiveness

Improving financial management to deliver better value for money

Our objective is to deliver quality services in a value for money way and robust financial management plays a key role in this process. Within the calculation of the income we receive is a built-in assumption that we will make efficiency savings of 4% per annum. This, together with the level of referrals we expected and acknowledgement that inflation is higher for certain types of spend such as drugs, meant that we faced 2010/11 needing to make cost improvements of £29.8million or approx 9%. We actually succeeded in reducing costs by £30.2million, helping us to achieve a surplus of £247,000.

This performance follows an assessment of 'adequate' for financial management in Autumn 2010, which followed a 'weak' assessment the year before. Although, overall the Trust demonstrated sound financial management and scored highly in most of the key areas, this adequate rating was a result of finishing the 2008/09 year in deficit. The Trust is assessed on a cumulative basis and could not obtain a higher rating because of the performance a year before.

The Audit Commission will no longer be assessing the Trust for financial management for 2010/11, but will continue to draw a conclusion on value for money. The key lines of enquiry that the Audit Commission follows will continue to be internally assessed and reports on this assessment presented to the Audit Committee.

Turnaround programme 2010/2011

The financial savings objective for the Trust during 2010/11 was to achieve a £29.8 million cost reduction through a turnaround programme focused around the following six workstreams:

- clinical productivity
- integration
- workforce
- property and estates
- procurement
- finance and IT

Delivery of the savings programme was largely through the divisions ensuring clinical engagement and support for cost improvement schemes. Central to the turnaround programme was the need to ensure safety and quality of patient care and this was assessed and monitored on an ongoing basis with each scheme having a clinical risk assessment prior to commencement.

Following integration we have been able to deliver efficiency and productivity gains by integrating our workforces to eliminate duplication and waste across patient pathways including heart failure, COPD, diabetes, neuro-rehabilitation and IV therapy, and by eliminating layers of management through the restructure of our clinically-led divisional structures. We have also managed to achieve significant service improvement and delivery of cost savings from the integration of corporate services and back office functions.

Bowel cancer screening programme now offered at Wycombe hospital

Wycombe Hospital has joined the National Bowel Screening Programme as an official screening centre. This followed the hospital's endoscopy unit, which

runs the centre, being awarded a national accreditation by the Joint Advisory Group (JAG).

The accreditation is a recognition of good practice and clinical leadership at a national standard. The visiting JAG team rated the endoscopy unit at Wycombe Hospital as one of the top five in the country.

The National Bowel Cancer Screening Programme aims to detect bowel cancer at an earlier stage when treatment is more likely to be effective. The programme provides specialist nurse-led screening clinics for people who receive a positive result from their test kit.

The Trust now provides two centres for national bowel screening at Wycombe Hospital since the beginning of September 2010 as well as at Stoke Mandeville since November 2009.

Accreditation award for heart scan services

Our echocardiography department is one of the first to be awarded departmental accreditation by the British Society of Echocardiography, for its high standards of service and expertise in the discipline of heart scans.

The British Society of Echocardiography departmental accreditation, which was awarded in July, establishes standards for echocardiography services and is a recognised benchmark of quality. It indicates to patients and healthcare professionals that an echocardiography department meets stringent quality standards.

An echocardiogram (heart scan) is a diagnostic test that uses ultrasound to acquire detailed, moving images of the heart.

Bucks breast service leads the way

We are delighted to become one of the first trusts in the UK to introduce OSNA (One Step Nucleic Acid Amplification) testing this year for sentinel lymph nodes in the breast. This technique means that approximately 20% of breast cancer patients, who used to have to come back to hospital for a second operation and second inpatient stay, can now all be treated within the same operation under the same anaesthetic.

This test not only saves money for the hospital and the healthcare economy in Bucks but most importantly provides real benefits to the patient by reducing the duration of treatment.

Physiotherapy pain programme chosen as an example of good practice

A new physiotherapy pain programme, called *Moving Forwards*, aimed at improving care, support and outcomes for patients with intermediate-term musculoskeletal pain (with a tendency to develop chronic conditions), was

chosen as a finalist for a one year Department of Health sponsored programme for service improvement.

One of only three selected projects in the south central strategic health authority area, the pain programme, masterminded by Brookside and Chesham physiotherapy team leads, has improved services for patients living with longer term problems in which pain is a dominant feature by helping patients understand and self-manage their pain.

The programme is designed to help people to understand and self-manage their pain. The scheme runs for one hour each week for five weeks and incorporates exercise with an explanation of how and why pain happens along with help to reduce pain.

Chlamydia testing in community pharmacies

A new initiative to offer chlamydia testing and treatment to all young people aged between 15-24 from three community pharmacies, was launched by the Buckinghamshire Chlamydia Screening Programme.

The three pharmacies - in High Wycombe, Aylesbury, and Chesham - provide free testing and treatment for chlamydia for young people.

Young people can ask a member of staff at these pharmacies for a free chlamydia test and if they do the test they will get the results within ten days by their preferred method of contact i.e. text or phone. Treatment, if necessary, is simple with usually one dose of antibiotics.

We are delighted to be able to offer chlamydia testing and treatment from these pharmacies as part of a pilot project, which we hope to expand as the project develops.

Improving care pathways

The Trust has a dedicated service redesign and development team. The Patient Services Institute (PSI) supports teams throughout the Trust by promoting 'Lean' principles and methodology (providing customer value, removing delay and waste, continuous improvement) and providing facilitation, data analysis, project management expertise and training. Key PSI projects in 2010/11 include:

Diagnostic Initiation Streaming (DIS)

Stoke Mandeville A&E have introduced a model for early senior clinical review and streaming of patients arriving in A&E. This means that patients are now seen more quickly by a doctor and/or nurse on arrival, to assess their immediate needs, start investigations and treatment where appropriate and then refer them on to the specialist medical and surgical teams if necessary. Average time from arrival to first review by the DIS team is now about 20 minutes; average time to onward specialist referral or discharge from first

review is 34 minutes. This is a great improvement on the previous service, which could mean waits as long as three hours for clinical review, and we are now looking to roll-out the service at Wycombe Hospital.

IV at home service

The new IV at home team of nurses is dedicated to delivering intravenous drug therapy to patients, who are medically fit but require antibiotics twice a day, in their own homes – previously these patients remained in hospital until their treatment was complete. Since start-up in July 2010, stages one and two are now fully established (delivery of short term and long-term antibiotics) with a saving of 1,620 bed days. Stage three (early intervention and management of cellulitis to avoid hospital admission) is in development and hope to go live in 2011/12.

COPD early supported discharge

The Chronic Obstructive Pulmonary Disease (COPD) discharge support service was introduced in November 2010. Specialist respiratory nurses provide intensive support during the first few days after the patient returns home, until the patient is ready to be transferred back to the care of their GP and the community teams. To date, 14 patients have been discharged under this scheme with an estimated saving of 100 bed days. Patients surveyed after three months are generally very pleased with service, which means they can leave hospital earlier than would normally be the case. One patient wrote: *"I cannot speak highly enough about the discharge support service. It was particularly pleasant being treated on such a personal level by the relevant member of staff. The connections between the GP, hospital staff and the COPD support scheme was reassuring. Thank you".*

Urgent care – short stay ward

As part of a Trust-wide exercise to re-model the non-elective care pathway for patients admitted to Stoke Mandeville Hospital, the Trust introduced a 'medical short stay' ward this year. Patients who are expected to be in hospital for less than two days are placed on this short stay ward, where the teams and services are focussed on fast tracking investigations and treatment and getting people home as soon as is possible.

Cohorting these patients allows the teams to use their time more efficiently, avoiding unnecessary delay and ensuring the shortest possible stay in hospital. This results in the better use of limited resources, meeting our service standard to help patients get their lives back quickly.

Productive care projects

The productive care projects have been designed by the NHS Institute for Innovation and Improvement, to redesign and streamline the way ward teams, theatres teams, units and individuals manage their time and work. The projects help to achieve significant and lasting improvements – predominately

in the extra time that they give to patients, as well as improving the quality of care.

The key to the success of the productive care projects is that improvements are driven by staff themselves, by empowering them to ask difficult questions about practice and to make positive changes to the way they work.

Productive ward

The productive ward project's core objectives are to increase the amount of time spent directly caring for patients at the bedside and therefore offer safer and more reliable patient care. We are pleased to say that one of our pilot wards doubled 'direct care time' within the first year of the project and decreased wasted 'motion' time (looking for medical equipment, patient notes etc) by a third.

The project looks at how nurses can cut down on tasks such as walking and looking for equipment. Ward teams can look at improving the efficiency of meal rounds, enabling staff to spend more time assisting patients with their nutritional needs. Wards have also introduced measures to help reduce the number of times nurses are interrupted when dispensing medicines - leading to a reduction in errors and more timely drug rounds.

This project was launched on 1 December 2008 on three wards and, since then, the rollout has continued and implementation is now taking place on twenty seven wards within the acute hospitals (Stoke Mandeville and Wycombe) and five community hospitals.

The productive operating theatre

The productive operating theatre looks at all aspects of the pathway for patients undergoing surgery in theatres. The programme focuses on improving quality in four areas: patient experience and outcome, reliability and safety of care, value and efficiency, and team performance and staff well-being. The approach involves staff using practical tools to measure and compare their performance locally as they make improvements to gain better quality and value for patients and taxpayers.

Now established at Wycombe Hospital, the productive operating theatre has also started this January in the new wing theatres at Stoke Mandeville Hospital, with more emphasis on theatre teams tackling delays once the patient is already in theatre. The foundations have now been laid to reap tangible positive results from the programme in 2011/12.

Productive community services

With community services playing a crucial role in the shape of the new NHS, and care being provided closer to patients' homes, the NHS Institute has designed a set of tools to help community teams increase their time with patients.

Typically, community teams spend a lot of time on activities such as travel, paperwork and administration, handovers with other staff and 'hunting and gathering' for equipment. Nearly a quarter of their time is spent in 'motion' – physically moving between locations, tasks and patients.

This project is relatively new, however, our 'showcase team' – the community midwifery teams based at Wycombe Hospital started implementing the project in January and aim to be completed by December 2011. Rollout to a further thirty one teams will take place over the next two years.

4. Strengthen our future

Becoming an NHS Foundation Trust

Our ambition to become an NHS Foundation Trust (FT) remains a major objective, which once achieved will provide us with a number of freedoms and give local people, patients and staff more of a say about their local NHS.

FT status will give us independence, offering more financial freedoms and allowing us to invest in service developments. It will allow us to be accountable locally by our staff, patients and the public (through our membership) who will have a greater say in how health services are developed.

All NHS trusts in the country must become an FT by 2014 and we are aspiring to obtain authorisation by September 2012. To become an FT we need to provide a sound business plan and financial model. We are currently reviewing our five year integrated business plan and are working with divisions to develop our clinical strategy.

Becoming an NHS Foundation Trust will enable us to:

1. build on our strategy of putting our service user's needs first every time, making it a consistent reality and not just a promise
2. continue to make improvements in the care we offer by forging deeper relationships with the community via our council of governors, who provide a more democratic and formalised way for local people to have a say on developments in the future
3. retain any financial surpluses to support the development of local services
4. have greater freedom and flexibility to respond to local priorities without the need for central government authorisation and be more responsive to the health needs of our local population as it grows and changes
5. strengthen partnerships and joint working with social services charities, local communities and other organisations
6. increase the contribution from staff in future decision-making by having staff as FT members and governors.

For more information about NHS foundation trusts, please visit www.buckshealthcare.nhs.uk/gettinginvolved

Improving information management and technology (IM&T)

A number of key IM&T projects have progressed through the last financial year, these include the design, build and testing of an upgraded Millennium care records system which will 'go-live' later this year. This upgrade will provide a significant number of benefits for staff and patients, and will provide the foundation for the Trust to begin to maximize the potential of an electronic patient record.

Community services will now be able to benefit from the implementation of RiO, an electronic patient records system for community health organisations, with phase one successfully launched during December. The project received high praise from both BT and the Southern Programme for IT for the high standard of the deployment.

RiO replaces the different clinical and patient administrative systems previously used by community services and is a real step towards an electronic patient record that will enable community staff to share information, support patient care and collect the information required to support our business and operational requirements.

The RiO project is being rolled-out in three phases and involves approximately 1,000 staff who have all been trained on the new system. Phase two, which included adult community services, was completed in April 2011, to be followed by phase three in August 2011 covering children's services.

In addition, a bespoke electronic patient record system has been introduced in the spinal unit and 'order communications' functionality has been piloted in several Trust departments, and will be rolled out across the organisation over the coming months

Keeping information safe

The Trust recognises the importance of managing information appropriately and securely and has a nominated executive director as the senior information risk owner (SIRO). This role is responsible for ensuring the Board has comprehensive and reliable assurance that appropriate controls are in place and that risks are managed in relation to all the information used for clinical, operational and financial purposes.

The Trust has self-assessed its performance on information governance using version eight of the information governance toolkit managed by Connecting for Health. The Trust's overall information governance submission for 2010/11 achieved a score of 72 per cent resulting in a 'satisfactory' rating. The main area of improvement was seen within 'information governance management'.

This relates to the information governance and risk infrastructure within the Trust ensuring that key information management responsibilities are in place.

Progress continued during 2010/11 on implementing and improving information risk controls including working towards 95 per cent of its staff undertaking information governance training by June 2011. Regular communication to staff on information handling, information security and best practice continues to be a priority for the Trust and is supported by policies and guidance.

The Caldicott and Information Governance committee, chaired by the Trust Caldicott Guardian, continues to oversee all work related to information governance.

The Department of Health requires NHS trusts to disclose serious untoward incidents relating to information governance in our annual report. These cover areas such as loss of data or confidentiality breaches. The Trust had no level three serious untoward incidents involving personal data and no other personal data-related incidents.

The Trust adheres to the Treasury's guidance on setting charges for information about our services, by providing this information free or at a low cost.

Emergency planning

Under the Civil Contingencies Act the Trust is designated as a level 1 responder. In order to fulfil its statutory duties for this, emergency planning is continually developing and updating its plans. November saw the appointment of a full time emergency planning officer working under the nominated lead executive director for this area. This has facilitated much progress to have been made, specifically with a review of plans following the Trust merger with community services.

A new 'command, control and co-ordination' document has recently been approved by the Trust Board, and this sets out a framework for managing any incident within the Trust. Revision of all the component plans, such as the major/mass casualty plan will take place over the coming year. Considerable training has already taken to support these plans, and 2011/12 will see a whole raft of new training, testing and exercises taking place.

The Trust also continues to keep its link with local resilience forums and has strong links with NHS Buckinghamshire and the Strategic Health Authority regarding emergency planning.

The Trust's emergency planning group has also been restructured, with good representation from all areas within the Trust, and is combining its planning to include contingency and business continuity.

Regular communications of these changes are sent to staff to keep them abreast of developments, including briefings at associate director and directors' forums, plus regular items in the Trust's staff bulletin and via team brief.

Reducing our impact on the environment

Environmentally the period between 2010 and 2011 proved another challenging year, involving a number of refurbishments and building projects along with site reorganisations and transfers. At Stoke Mandeville Hospital there has been the addition of the Paediatric Day Unit in the A&E area and the refurbishment of the Claydon Wing. This included reallocated foot print benefiting from a number of sustainability improvements. At Wycombe Hospital we have completed a number of significant asbestos removals to plant room areas and upgraded insulation. The asbestos removal works incurred significant energy usage through the provision of temporary chillers over several months to reduce the working temperature as required to comply with the asbestos regulations.

2010/11	**Usage**	**Cost in £**	**Tonnes CO2**	**% of Previous**
Electricity	22,382,118 kWh	1,746,481	10,284	109.5%
Gas	65,005,500*	2,022,300*	12,351*	105%*
Oil	24,664 Ltrs	15,538	89	57.4%
		Total	22,724	110%

**Estimated figures, actual figures not available at time of publication*

2009/10	**Usage**	**Cost in £**	**Tonnes CO2**	**% of Previous**
Electricity	20,435,000 kWh	1,653,000	8,787	104.4%
Gas	61,910,000 kWh	1,926,000	11,763	97.4%
Oil	43,000 Ltrs	20,200	118	66%
		Total	20,668	99.9%

2008/09	**Usage**	**Cost in £**	**Tonnes CO2**
Electricity	19,578,000 kWh	2,243,000	8,419
Gas	63,570,000 kWh	1,812,000	12,078
Oil	65,500 Ltrs	29,000	178
		Total	20,675

Water

There has been a high water usage, mainly at Stoke Mandeville Hospital, which has been largely due to the increased flushing of taps and a leak outside the ambulance station.

Year	Water Usage in M3	Cost in £
2008/9	239,000	358,500
2009/10	229,000	370,300
2010/11	1,103,891	1,735,411

Combined heat and power (CHP)
Stoke Mandeville Hospital

Year 2010/11		
How many CHP units operate on the site	No	1
What is the total full load rating of the CHP	KW	975
What is the fossil energy input to the CHP	KWh	10,741,595
What is the total thermal energy output of the CHP System	KWh	3,132,600
What is the total electrical energy output of theCHP System	KWh	3,822,781

Waste

There has been an up turn in clinical waste and a downward trend in the general waste. There has been a drive a Stoke Mandeville Hospital to increase the amount of waste for recycling. We will be investigating how we can increase the amount recycled at Wycombe and Amersham hospitals.

Year	2009/10		2010/11		% of General Waste Recycled	
	Tonnes	Cost	Tonnes	Cost		
Clinical Waste	920	399,400	1,005	458,116	2009/10	2010/11
General Waste	1020	112,100	668	63,090	16%	24.64%

5. Progress against national standards

The Trust has a robust performance monitoring framework in place, routinely measuring our business against a range of key performance indicators (KPIs). The framework allows the Trust Board to monitor performance in key areas, and supports our efforts to drive up quality, enhance patient experience, improve waiting times and deliver better, safer services.

KPIs are the nationally recognised method for calculating performance in NHS acute trusts and are defined by the NHS Information Authority. In 2010/11 the KPIs covered existing commitments and national targets set out by the Department of Health (DH) and Care Quality Commission; clinical quality, outcome and clinical efficiency indications and activity levels, workforce and health & safety indicators.

Highlights can be seen in the summary table below.

KPI	Type of indicator	Target	RAG rating	09/10 performance	10/11 performance
Total time in A&E: four hours or less	Existing Commitment	**95%**	●	**98.59%**	**97.2%** **(from Q2)**
Max. two week wait for rapid access chest pain clinics	Existing Commitment	**98%**	●	**99.5%**	**98.1%**
Delayed transfer of care	Existing Commitments	**<3%**	●	**3.61%***	**2.55%**
Access to genitourinary medicine clinic appointments offered within 48 hours	Existing Commitments	**>=98%**	●	**99.9%**	**99.96%**
Percentage of eligible patients with acute myocardial infarction who received primary PCI within 150 minutes of calling for professional help	Existing Commitments	**75%**	●	**83.3% (Apr – Dec 09)**	**84.0%**
Cancelled operations: % of elective patients cancelled on the day of surgery	Existing Commitments	**<0.8%**	●	**0.78%**	**0.58%**

KPI	Type of indicator	Target	RAG rating	09/10 performance	10/11 performance
Cancelled operations: Patients not readmitted within 28 days	Existing Commitments	**<5%**	🟡	**2.82%**	**7.42%**
Maintain two week cancer waits	National Priority Indicator	**>93%**	🟢	**94% ***	**98.9%**
Max 2 week wait for non symptomatic breast referrals	National Priority Indicator	**>93%**	🟡	**N/A**	**88.6%**
31 days diagnosis to treatment for all cancer	National Priority Indicator	**>96%**	🟢	**98.2% ***	**96.3%**
62 days urgent referral to treatment for cancer	National Priority Indicator	**>85%**	🟡	**88.6% ***	**84.6%**
%age within 18 week admitted pathway	National Priority Indicator	**90%**	🟢	**90.6%**	**90.0%**
%age within 18 week non-admitted pathway	National Priority Indicator	**95%**	🟢	**99.6%**	**98.0%**
MRSA Bacteraemia	National Priority Indicator	**5**	🟢	**12**	**2**
Clostridium difficile positive results	National Priority Indicator	**65**	🟢	**41**	**58**
% of women breast feeding at the time of discharge from giving birth	National Priority Indicator	**>77%**	🟢	**79%**	**80%**
Patients spending 90% of their time on a stroke unit	National Priority Indicator	**80%**	🔴	**70%**	**67.4%**
TIA indicator within 24 hours	National Priority Indicator	**45%**	🟢	**45.5%**	**71.9% (Q4)**
% of women who are smokers at the time of delivery	National Priority Indicator	**5.8%**	🟡	**6.7%**	**7.6%**

KPI	Type of indicator	Target	RAG rating	09/10 performance	10/11 performance
% unknown smoking	National Priority Indicator	**<5%**	●	**2.2%**	**1.7%**

A forward look

National targets remain essentially the same for 2011/12, though with some slight expansion on the A&E quality measures to underpin the four hour target.

In addition a number of local quality targets with our main commissioner, NHS Buckinghamshire have been agreed. These include CQUIN (Commissioning for Quality and Innovation) payment targets, aimed at driving up quality in certain areas:

- risk assessment for venous-thromboembolism
- all patients are offered access to stop smoking services before elective operations (including expectant mothers)
- dementia protocols are in place
- stroke patients are managed by the early supportive discharge team
- patients with long term conditions are managed by community services, reducing the number of admissions to hospital
- patient experience.

6. Partnership working with patients, the public other key stakeholders

Working in partnership and making sure we involve our patients, the public and other key stakeholders in the decisions we make, and act on their feedback, is central to achieving our vision and is a key element of our corporate objective 'Strengthen our future'. Highlights from 2010/11 are included in this section.

Membership

Despite our focus moving from building our membership in it's first year, to developing our membership; we have still seen a positive increase in our membership to 12,500. The membership remains largely representative and we continue to communicate with members via our twice-yearly newsletter, through our events, email, website and Twitter.

We value our members and appreciate the time and effort that many give to provide us with the patient perspective. Seeking the views of our patients is important to inform the changes and improvements we make. Below is a sample of how our members, carers and patients have been involved and what has been achieved.

Involvement

Over the past year there have been seven member involvement events which specifically seek the views of our members on service-related matters to inform improvement and development.

In addition, two public 'drop-in' events have taken place, providing information and raising awareness about services and sources of help and support. One was run in partnership will local health and social care organisations.

April 2010: Are we delivering our promises?
Three separate involvement workshops for those with a learning disability.

Delivered in partnership with Talkback, a charitable organisation which supports people with a learning disability, we asked participants if they thought we were delivering on our promises when they came into hospital. Their feedback was invaluable and consisted of both the positive and improvement areas.

May 2010: Service standards – our service, your care, your views matter
One year after their launch we asked members to tell us if they thought we were delivering on our service standards.

June 2010: Online poll to targeted groups of members
Are we delivering on our service standards?

The feedback and results of the event and the poll were analysed for common themes. Feedback from the poll suggested that patients had noticed an improvement in their patient experience since we introduced our service standards. Positive feedback complimented areas such as our performance in protecting privacy and dignity, ensuring cleanliness and staff were seen to act in a professional and courteous manner. However, areas still needing improvement were signage, some aspects of communication, taking ownership and our consistency in ensuring staff are friendly and approachable. Many positive comments were received about our staff and many were commended for going the extra mile.

Actions: Information from these activities were collated and analysed. It has been shared through presentations to senior nurses and management meetings, including the diversity steering group. A paper was written and submitted to our Trust Management Committee, which resulted in signage improvements receiving additional priority. An action plan was developed to address other specific improvement areas and further work to support embedding our service standards has been commenced.

June 2010: The new complaints process – help shape the development of our policy
Members' views were sought to inform the development of our policy following a change in national guidance.

Actions: This was a very productive workshop and all the feedback has fed into the development of our revised policy. Changes requested and included are a single point of contact, providing a variety of options on how the complaint is dealt with and keeping in touch throughout the whole process. For more detailed feedback please see our event reports on our member pages which can be found via www.buckshealthcare.nhs.uk/Getting involved/members-pages.htm

July 2010: Young at heart
A public 'drop-in' event aimed at older people, their family and carers. The aim was to provide a range of stands and information about services for older people. All local partner organisations were invited and over 21 stands were present on the day with interactive activity as well. We also sought the views of those attending on aspects of our discharge process and day hospital services.

August 2010: Carers' Voice 1 (April 2011 – Carers' Voice 2)
Our first involvement event run specifically for carers.

We wanted to better understand the carers' perspective on how well we communicate and involve when interfacing with our services. Supported by Carers Bucks, both this and the second session run in 2011 has provided valuable information.

Actions: Feedback has informed service redesign work and been fed back through the senior nurse forums, it is likely to result in some further initiatives

around improvements to help signpost information and sources of help following further analysis across the two events.

January 2011: Signage – Trust-wide project to improve signage
This was a significant theme raised through the feedback from events that took place from April – July, as well as other sources of feedback, which became clear was having an impact on patient experience. This resulted in a project to improve signage being given additional priority, and as part of this project a range of patient views were sought from different service user perspectives. Three involvement groups, two of which included 'on site demo walks', were arranged and feedback did result in changes and improvements to suggested design and proposals.

Actions: The implementation of our new signage is underway with a phased approach across our acute hospital sites, but early feedback is very positive with reports of a much improved patient experience. Amongst many other helpful comments suggested improvements to proposals were to include improved 'way out' signage, highlighting our car parks and directing people along the shortest route. For more detailed feedback please see our event reports on our member pages, which can be found on our Trust website.

February 2011: Patient safety event
This event was open to the public and aimed to share information about the work we have progressed in light of the findings from the inquiry at the Mid Staffordshire NHS Trust into care of the elderly. We also presented on our patient safety processes and how we learn as an organisation. We sought views on safety in the discharge process, medicines, food and nutrition and we asked what makes patients feel safe in hospital in four separate involvement workshops. Feedback from these groups was taken away by the relevant senior service leads who were present.

March 2011: Birthing choices – being pregnant
A drop in event to promote birthing choices in Buckinghamshire.

This public event aimed to provide information on health and wellbeing before, during and after pregnancy – this included a range of stands with clinical experts and information, as well as input from of some of our partner organisations.

We also sought the views of pregnant women attending, to inform the development of a Trust birthing choices leaflet. Evaluations received about the event were very positive.

In addition to the above, we also held a number of community engagement worksphops to seek the views of the public on how we could make better use of community hospitals and services, see page 9 for further details.

Principles for remedy

The Ombudsman's 'principles for remedy' state that an attempt to resolve

a complaint should be based on:

- getting it right
- being customer focussed
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement.

The Trust makes every effort to comply with these principles. We are always ready to apologise where our service has not been what the service user expected, and to put things right for complainants as promptly and appropriately as possible. Our aim is to use the lessons learned from complaints to make sure that same failure does not happen again.

Service Redesign and how we involved our patients.

The Trust has a long history of designing services with input from patients and carers. By asking what they would value from the new service we are able to incorporate elements which can take the service from good to great.

One example is the newly introduced COPD support discharge services (see page 19). Patients, carers and support groups such as Breathe Easy were asked to describe their experiences and articulate what they felt were the essential features for the new service. They wanted good communication at all times, a detailed understanding of their medications, guaranteed rapid access to help, via a single number, and a seamless service with common health records.

As a result, the new service uses a single integrated care record which stays with the patient, and we have designed an information leaflet which explains their condition and details of how to get help at any time of day or night. On discharge from hospital, the patient's GP and also the GP out-of-hours service, is informed and keeps a special note on their records in case they are called out.

Early feedback from patients is very positive – they report feeling safe and well informed, and appreciate the individualised care they receive when they first go home.

Patient Experience Group (PEG)

This group continues to thrive and has expanded this year with new organisations joining. Furthermore, integration with our community colleagues has resulted in staff representatives from our community services being welcomed to the group. The PEG has continued its valuable role in helping to maintain a regular two way dialogue between a range of service users, patients, carers and the Trust.

This year the PEG has:

- been instrumental in the development of a public web page to highlight work achieved in our Trust-wide 'Productive' ward and theatre programmes
- had several of it's members present at a Trust Board meeting, one included sharing their patient story and the others were in support of their involvement in undertaking the gap analysis for the Mid Staffordshire inquiry action plan
- has influenced improvements around time waiting for medicines to take home and when coming in for planned day procedures, improvements in the discharge process and general information provision
- continued to monitor the national inpatient survey action plan
- has taken receipt of a range of reports and action plans including the report on our gap analysis on the Mid Staffordshire NHS Trust inquiry, our learning disability action plan and the feedback from events
- has continued the invaluable role of providing a patient perspective and approval of all new patient information leaflets.

Local Involvement Networks (LINks)

The Buckinghamshire LINk has continued to evolve and develop and the Trust representative attends its monthly public meetings. The LINk has a designated point of contact within the Trust and the LINk chair and vice chair continue to have regular meetings with the chair and chief executive of the organisation. Members of the LINk steering group are invited to events and the Trust welcomes the opportunity to continue to develop a positive relationship.

The Overview and Scrutiny Committee (OSC)

The OSC is a well-established forum, carrying out a scrutiny role for public health services on behalf of the local population.

The Trust attends OSC public meetings on a regular basis providing information and input as requested. Issues covered during the year included the temporary closure of the Wycombe Birth Centre and plans to promote the unit, developing community health services following integration and the impact of the coalition governments' white paper on health.

In addition, the Trust welcomes the opportunity to engage with the OSC and has built on the positive relationship which exists by arranging a series of site visits to all our hospital and key community sites to give the OSC a clearer picture of our service provision.

Charitable and voluntary services partners

The Trust's charitable fund receives income which is made up of donations, legacies, activities for generating funds and investment income. The Trust is

immensely grateful to those people who remember the Trust when considering who to donate to or leave a legacy to in their will. These monies are used to enhance the services within the Trust focused on patients' welfare, staff welfare, research and general charitable hospital purposes. The Trust Board is the corporate trustee and a separate annual report and accounts are produced for the charity, which are available from the Trust.

We are indebted to groups such as the WRVS which are staffed almost exclusively by volunteers, for the significant contribution they make towards improving care for our patients.

The Trust has continued to benefit greatly from the work of Scannappeal, the League of Friends at Amersham and Wycombe and the Cancer Care and Haematology Fund at Stoke Mandeville Hospital. During the year these organisations have made significant donations of equipment and funding for projects for use throughout the Trust. Although these contributions are too numerous to detail individually, examples include equipment for a new laparoscopic theatre, cardiac imaging and ultrasound equipment and equipment for physiotherapy at Amersham. In addition there are other contributions that can make a real difference to a patient's experience including a gift at Christmas or plants for the gardens outside wards.

Following our integration, the Trust has taken over responsibility for the Florence Nightingale Hospice at Stoke Mandeville Hospital. Through the contribution made by the Florence Nightingale Hospice Charity important additional services are provided both within the hospice itself to patients and through the hospice at home work. The Trust recognises how valuable this work is in improving the care of patients.

7. Our staff

Supporting our workforce

Workforce

The Trust's Human Resources (HR) & Education, Learning and Development strategies, and workforce development plans aim to ensure that we have the right people with the right skills delivering care to our patients and service users and that we continue to build the right environment, culture and support for staff to deliver the Trust's objectives, promises and service standards.

Over the past 12 months we have been building and strengthening the following areas:

Organisation Development (OD) Pillars	HR Strategic aims
Leadership & management	Developing and enabling our leaders and managers
Service standards	Improving patient and customer satisfaction
Education, learning and development	Improving the quality of the education and training and development
Appraisal and performance systems Talent management and succession planning	Recruiting and retaining the best people talent Promoting diversity, equality of access and opportunity Promoting the trust as an employer
Staff engagement, health and wellbeing	Improving staff satisfaction and engagement
Service improvement and transformation	Improving our productivity and efficiency Improving the quality of our human resource management systems and processes Ensuring the right people are delivering care in the right places to our patients and service users

The Trust is one of the largest employers in the county and following the integration with Buckinghamshire community health services in April 2010 this took our number of directly employed staff in post to 4,815 (full time equivalent) and a staff headcount of almost 6,000 people. The number of directly employed staff has reduced during the year as a result of our mutually agreed resignation scheme and the restructuring of our corporate services and back office functions as part of our drive to improve quality, productivity and efficiency from these support functions.

An area for focus in the last year has been to tackle our temporary staffing costs. This has been a twofold approach to improve the quality and value for money of our temporary staff solutions through improved procurement and agreements with agencies. This has led to better contract management outcomes. However, overall there has been a continued need to use temporary staff to cover key vacancy and recruitment hot-spots as well as to respond to demand for our services, prevention and control of infection measures and sickness absence.

During 2010/11 a number of key work programmes were put in place to address key retention and recruitment issues. The Healthcare Assistant (HCAs) project set out to survey our healthcare assistants to listen to what they had to tell us about the actions we should take to reduce turnover, sickness absence rates, improve induction into the Trust and ensure access to development opportunities. As a result of this work both a bespoke recruitment, induction and development programme has been developed for our HCAs.

Another hotspot area for us relates to the anaesthetics medical workforce. A review of that workforce has led to the successful appointment of five consultant anaesthetists and this should lead to a significant reduction in the use of medical locums in this area and improve the quality of our service delivery.

Staff sickness absence

	2010-11	2009-10
Total days lost	**40,653**	35,263
Total staff years worked	**4,490**	3,933
Average working days lost	**9**	9

Occupational health and wellbeing

As part of the community health services integration we have created a single occupational health/workplace health function enabling us to offer the full range of support available to all employees of the trust. This has provided greater access for all staff across the county, benefiting staff and reducing disruption to frontline services.

Improved audit of both clinical and administrative functions has enabled more appropriate clinical practice to be implemented. Coupled with the updated fast tracking to physiotherapy and counselling services, staff are able to access the right support at the optimum time for them.

Health, safety and wellbeing and reducing sickness absence

Over the past 12 months the Trust has been implementing the nationally agreed recommendations from Dr Steve Boorman to improve the health, safety and wellbeing of staff, recognising that not only are these important factors that provide safe and effective patient care but that as providers of

health care to the wider population we have a duty to role model good health and wellbeing.

The introduction of a 'case manager' for sickness absence within the last six months has focussed on ensuring timely and appropriate interventions are being adopted in the management of ill health in the workforce, with the aim of getting staff back to work as quickly as possible. Improvements in triaging referrals to the Trust's occupational health service and reviewing of ongoing (long term sickness absence) cases has focused on speeding up the management process of sickness absence and has helped employees to return to work sooner or remain at work rather than go off sick.

Two of the main areas of ill health in the workforce are psychological health and wellbeing and musculoskeletal problems. The Trust's occupational health service provides fast track access to psychological (counselling) and physiotherapy services and these services provide support to a significant number of individuals who are able to continue working as a result of the support they are receiving. In addition, the Trust's dietetic department provides dietary advice and the county's stop smoking service provides support to quit smoking.

In addition to this, the Trust has also been providing management with the tools to support staff through challenging times with workshops around stress and stress prevention. Whilst there is much more to do as an employer to deliver Boorman's recommendations we are taking a preventive and proactive approach to avoiding and supporting ill health in staff. In 2011/12 we will be focusing on the drivers behind sickness absence in key areas in addition to continuing with the case management approach.

Flu vaccination campaign

The years' flu vaccination campaign achieved a very high level of take-up, much improved on previous years, 1,574 staff received the vaccine. Clinics ran throughout the four months of the campaign at a large number of locations and times.

E-rostering

The aim of the e-rostering project is to introduce computer based technology to plan staff rotas and to move away from paper-based systems. So far the project has been implemented across 44 wards, clinical areas and departments, with a further 15 areas to complete phase one.

Over 1,000 members of staff are now paid via a direct electronic link from Rosterpro to the Trust's payroll system and we are working towards the introduction of the new 'sickness absence interface' and the elimination of timesheets in all of these areas. On completion of phase one we will be introducing all the other wards/departments to electronic payroll thereby eliminating further paperwork for staff.

The system produces a number of reports for managers and staff to use in relation to the management of annual leave and sickness absence as well as contracted hours worked to ensure openness and transparency for all. Over the last year it has played a significant part in enabling the Trust to address issues in the sickness absence and annual leave management workforce projects.

Support with childcare

Over the past two years, Wycombe nursery has been involved with a national Government initiative called 'ECAT – Every Child a Talker' and have secured resources to run the project at the nursery. The aims are to ensure children are given the opportunity to gain essential language and communication skills needed in their education and later life. The nursery team have been trained in new ways of working and the children's skills have improved.

This facility has now been extended to Amersham nursery, new equipment has been purchased with the funding received and all children and staff have benefited through the project.

Education, learning and development

The Trust has a fully integrated, multi-professional Education, Learning and Development Team responsible for the delivery of the learning and development strategy. The work of this team includes:

- the delivery of statutory and mandatory training
- commitment to the NHS Skills Pledge - functional skills training – literacy, numeracy & IT skills
- apprenticeships in health, health & social care and business administration
- customer care
- supporting the future generation of healthcare professional
- clinical skills training and continuing professional & personal development
- management skills training & leadership development.

An appraisal and personal development planning system is in place within the Trust and its effectiveness is monitored monthly by the education, learning and development team and through the annual staff survey which saw some significant improvements in 2010 (an improvement of 10 per cent over our 2009 results).

Leadership

The Trust has invested significantly in leadership development for staff working in frontline roles. The 'leading and managing teams' programme enables frontline leaders and managers to identify their own leadership style through the use of tools and critically analyse how they lead and manage - self, people, resources and services to benefit the patient and service user.

Work is now underway to develop a middle manager/leader programme building on the successful foundations of the leading and managing teams programme. It is anticipated the programme will follow similar themes. We know from our staff survey results that we have to improve support from frontline managers to our staff so that they can deliver the best care possible to our patients and service users.

The Trust is working in partnership with a local higher education institute (HEI), the County Council and local private sector businesses to develop an Institute of Applied Leadership. The aim is to launch the institute in the summer of 2011. The Institute will have three main objectives to:

- deliver a range of learning and development opportunities for leaders
- create a community of practice for leaders across Buckinghamshire promoting scholarly and research activity
- create a portal for members by which they can communicate and collaborate.

Trust library service

In December 2010, the Trust library service website won a regional award for the best NHS library website in South Central SHA. The quality of the library service was recognised at a national level when the service won the inaugural Sally Hernando Award for Organisational Innovation in NHS Library and Knowledge Services 2010/11. Additional areas of good practice were also highlighted, including our work supporting the Formulary database and Staff Research Publications database.

The appointment of our clinical outreach librarian last year has enabled us to expand the range of information skills training provided, including the introduction of critical appraisal skills sessions. Requests for mediated literature searches to inform commissioning and clinical treatment decisions increased by 22.5 per cent over the past year.

Library book stock has been extensively updated to ensure that staff have access to relevant and up to date information to support clinical and management decisions. We have continued to extend the library service beyond the physical libraries through the introduction of additional electronic books, journals and other resources. BMJ Best Practice, a point-of-care resource providing evidence-based online healthcare information at the patient bedside or clinic was introduced in January 2011. We produce subject guides in over 20 specialties to help staff make the best use of our various

resources and in 2010 a specialist book collection was developed to support the health and wellbeing of staff.

Equality and diversity

In 2010 the Trust participated in the eighth annual NHS staff survey which looks as a number of measures including equality and diversity. 54 per cent of the sampling responded and the results indicate that in terms of equality and diversity the Trust is performing well. Overall 91 per cent of staff agreed that the Trust acts fairly in terms of career progression and promotion (national average for acute Trusts is 90%) and the percentage of staff that reported having received equality and diversity training increased from 42 per cent in 2009 to 47 per cent in 2010 which is encouraging. However, it is a concern that 11 per cent of staff reported that they had experienced discrimination from patients, relatives or other members of the public and/or from colleagues or managers in the last 12 months, with ethnic origin, age and gender being cited as the main causes.

We also continued to promote equality externally, with local organisations and within local strategic partnerships. In addition to participating in the Bucks Equality Network and Bucks Disability Employers Forum, the Trust attends the South Central Equality Network on a monthly basis. The Trust fully embraces and practices its policies for disabled employees and equal opportunities for all.

Launched in 2008/09, our black and minority ethnic (BME) staff networking group made great strides last year, securing substantial funding to support and improve diversity throughout the organisation by:

- raising the profile of ethnic minority issues and promoting cultural diversity throughout the organisation
- supporting and developing overseas and ethnic minority staff
- sharing good practice about ethnic minority patient/client care, aiming to make our services more user friendly to people from a BME background.

Acting on feedback, communications and consultation

Communication

The Trust has a well defined strategy which supports both written and face-to-face engagement and communication with the workforce to involve, update and inform staff about clinical, service and strategic developments.

Staff survey

The Trust recognises the importance of staff opinion and is always keen to receive feedback and to review and to work with staff to improve their experience of working for the Trust. Through participation in the annual NHS national staff survey the Trust gives staff the opportunity to comment on a wide range of topics that are important to them. In addition to this the

Department of Health uses the staff survey results to help define policy and inform the public and patients. The Trust also uses the data from the survey to help measure compliance with essential standards of quality and safety.

In 2010 the Trust participated in the eighth annual staff survey, achieving a response rate of 54 per cent of the sampling. Encouragingly the Trust's survey results showed some important areas of significant improvement and some areas where the results show room for improvement.

The improvements and areas of stability were around the provision of support and opportunities to maintain staff health, wellbeing and safety - less staff suffering work related injuries, and fewer incidents of violence and abuse from both patients and staff and effective action from the Trust towards violence and harassment.

Other areas of improvement related to the provision of clear roles, responsibility and rewarding jobs with a big increase in the number of staff appraised, and an increase in the number staff recommending the Trust as a place to work and receive treatment.

Disappointingly the staff experience has deteriorated in some of the areas relating to staff satisfaction but it is not surprising given the pace and level of organisational change and financial challenge the Trust has faced over the last 12 months. The Trust has an action plan in place to help improve levels of staff satisfaction and engagement and this will be a focus for the Trust in 2011/2012. It is of note that the main areas which support engagement and staff satisfaction are around workload, communication and staff feeling valued and all of these are areas which nationally the NHS in England needs to improve upon.

Consultation and negotiation

The Trust recognises and has developed a positive working relationship with its trades unions, staff organisations and professional bodies over many years. The Trust works with these bodies in a number of areas related to the staff experience including for example working conditions and pay, disciplinary and grievance, health and safety, harassment and bullying and improving the work lives of staff. In 2010/2011 the Trust worked closely with these consultative committees to ensure that all matters relating to organisational transformation were consulted upon and negotiated, reflecting a partnership approach.

Celebrating good practice

Annually the Trust runs a staff awards programme which relates to our promises and service standards and is well received within the organisation. The staff awards recognise and reward good practice and are now in their seventh year. 120 staff attended the awards ceremony in November 2010 in our Education Centre at Wycombe and we were delighted to welcome our guest speaker Lynn Faulds Wood who shared with us her battle with bowel

cancer. In 2010 we piloted a local recognition scheme which runs bi-monthly in the spinal unit and it is our intention to rollout this out across the rest of the organisation in 2011/12.

Service standards

Our service standards programme is one of the Trust's corporate objectives and is an important factor in our desire to drive up safety and quality for our patients and service users and provide a positive environment for staff to work in. Launched in 2009, the standards support the Trust's vision and values and focuses on the themes of:

- compassion and empathy
- communication and delivery
- courtesy and professionalism.

In 2010/11 we achieved our target of 70 per cent of the workforce to have received refresher training either face-to-face facilitated training, or via our e-learning package, as part of the Trust's statutory and mandatory training framework. Service standards is incorporated into our leadership and management development programmes and in 2010 we continued to focus on embedding the standards into many of the Trust's internal processes and procedures.

In 2010 we held an online poll and member event seeking feedback from members and patients asking them whether they felt the service standards were making a difference to their patient experience. We learned that there is good evidence of the service standards across the board but there is a lack of consistency depending on where and when you are seen. This will be the focus of the Trust's drive over the next 12 months; identifying other means of embedding the service standards and focussing on some of the more high pressure areas such as A&E, the acute wards and other 'front of house' staff as well as delivering the service standards training to our community based staff.

In June 2010 we were delighted to be runner up in the Healthcare People Management awards in the category organisational development for the service standards programme.

The service standards are not a time limited programme of work but a long term cultural change programme that the Trust is committed to.

8. Looking forward

Our 2011/12 objectives and challenges

Our objectives for the coming year reflect the strategic direction we established in 2010/11 as part of our developing NHS Foundation Trust application. They also reflect the drive to establish more integrated care pathways and services closer to home, with plans to support our successful and smooth partnering with community health services.

The objectives:

1. Improving quality and safety

- Improve **quality outcomes** with a focus to:
  - reduce harm in pressure ulcers, falls, VTE and urinary catheter associated infections as set out by the 'Safety Express' (safe care arm of QIPP)
  - ensure our **mortality ratio** as measured by the new metric is below the national average
  - demonstrate continued effective management of fluid balance as shown through the mortality reviews
  - ensure quality safety targets are met within CQUIN programme
  - ensure every complaint investigated results in an action plan, monitored through governance processes.

- Ensure we have a productive and motivated workforce to deliver **high standards in patient care** and a positive **patient experience** in line with our service standards.
  - ensure consistent high standards of nursing care through ward sister development and active monitoring of standards and care planning / documentation
  - agree and implement the **clinical leadership strategy** to ensure we have the appropriate clinical management capability and capacity
  - implement our **staff engagement**, health and well being plans to address feedback in our staff survey.

2. Transforming services

- Ensure consistency in high levels of clinical care for **stroke patients**.
  - implement the network recommendation to establish a hyper-acute stroke centre at Wycombe hospital to ensure patients from Buckinghamshire and east Berkshire receive 24 hour specialist care
  - 80% of patients admitted with a stroke to be cared for on a stroke ward for 90% of their time
  - implement early supported discharge for stroke patients to ensure an appropriate length of stay and best clinical outcomes.

- Improve the **urgent care pathway.**
  - ensure adult **community healthcare teams** are fully embedded into the community to prevent inappropriate attendances
  - actively support the implementation of **GP led urgent care centres** at both the Wycombe and Stoke Mandeville sites
  - enable ready access to general assessment in appropriate environments to prevent avoidable admissions
  - optimise appropriate **length of stay** in appropriate environment to ensure best clinical outcomes and facilitate appropriate discharge.

3. Service and site configuration that is fit for purpose

- Work in partnership with GP commissioners and PCT to develop an acute services reconfiguration plan.
  - Undertake far reaching and **representative involvement, engagement and consultation** to support the delivery of clinical strategy
  - work with clinicians from across the health community to develop a jointly-owned, clinically-driven business case for acute-service change
  - work with external stakeholders including SHA, NCAT, Gateway and OSC to gain formal agreement to the business case for change
  - **robust acute reconfiguration plan agreed with stakeholder and community agreement.**

- High quality healing environment.
  - commence development of Wycombe PFI to deliver urgent care
  - commence phase 1 of the **refurbishment of A&E** at Stoke Mandeville to support urgent care and GP-led centre
  - develop **central sterile services**.

4. Maximising efficiency, productivity and cost effectiveness

- Secure future in our own hands…
  - deliver an **8% efficiency target** within the framework of QIPP
  - fully embed **service line reporting**.
  - achieve milestones towards **NHS Foundation Trust** status with a target authorisation of 2012
  - make the best use of benchmarking information and maximise the use of IT
  - undertake an in-depth review of the best and most cost effective way to deliver clinical support services.

Promote excellence to **extend market reach** in flagship services including National Spinal Injuries Centre (Stoke Mandeville Hospital), vascular (Wycombe Hospital), elective treatment centre (Wycombe Hospital), burns &

plastics (Stoke Mandeville Hospital) and neurorehabilitation (Amersham Hospital).

Principal risks

There are risks in everything the Trust does and in 2009/10 a new risk management strategy was approved to ensure that everything possible is being done to meet our objectives and deliver safe and effective care.

Our main risk areas fall into the following categories: clinical risks, health and safety risks, workforce and recruitment risks, financial and business risks, estate and environmental risks and information governance risks. During 2010/11 we placed particular emphasis on managing clinical and financial risks, and the successful integration with community services. This is core to our ambition to provide improved pathways of care for patients, services closer to home and improved efficiency by using resources and our estate more effectively.

9. Our Trust Board

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

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

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

Directors and the register of interests

The register is maintained by the head of the executive office who holds the original signed declaration forms. These are available for inspection by contacting the head of the executive office on 01494 734851.

Name	Position	Interests Declared
Jane Bramwell	Non-Executive Director	Representative of Chesham Town Council on Dial A Ride Management Committee Husband Michael Brand is a Bucks County Councillor
Les Broude	Non-Executive Director	Works on a consultancy basis on career transition with Penna Plc that provides a coaching service to the NHS Family friend Chair of The Royal Hospital for Neuro-Disability
Graham Ellis	Chairman and Non-Executive Director	Non-Executive Director in Ministry of Defence, Defence, Equipment & Support (DE&S) and member of Audit Committee and Safety Board Non-Executive Member of Audit Committee, Oil & Pipelines Agency Non-Executive Chair to Safety Committee, Oil & Pipelines Agency Non-Political Parish Councillor for Preston Bissett, Buckingham Family friend works in community services, Bucks Healthcare NHS Trust
Anne Eden	Chief Executive	None

Juliet Brown	Joint Director of Strategy & System Reform	Director and Secretary for Shining Life Children's Trust (Charitable Co) charity involved in social work in Sri Lanka
Celina Eves*	Interim Director of Nursing & Patient Care Standards	Chairman for Ducklings Trust Charity – affiliated with Trust's maternity unit.
Ian Garlington	Director of Property Services	Director The Stoke Mandeville Hospital Postgraduate Society Ltd Trustee of the National Society for Epilepsy Trustee of Scannappeal
Keith Gilchrist	Non-Executive Director	Advisory work with LCA (Low Carbon Accelerator) Seed finance fund for low carbon development companies Son is a doctor based at Heatherwood & Wexham Park Hospitals
Malcolm Griffiths	Non-Executive Director	Director of Okio Limited, an IT/web design company Director of Bluespace Thinking, a consultancy company Chair of the South Central Patient Safety Federation
Sandra Hatton	Director of Human Resources & OD	None
Brenda Kersting	Non-Executive Director	Director of Tergo HR Lay Assessor for the National Clinical Assessment Service (NCAS) Independent Member of the Parole Board Non Executive Member of Parole Board Audit and Risk Committee
Samantha Knollys[1]	Joint Director of Strategy & System Reform	None
Dr Graz Luzzi	Medical Director	Trustee, Amersham Dermatological Research Trust (Amerderm)
Robert Peet	Chief Operating Officer	None
Sheryl Pope[2]	Director of Strategic Projects	Director/owner of Shine Coaching & Consultancy Ltd Member of Sparkles – charity providing speech therapy to children with Down's Syndrome
Lynne Swiatczak[3]	Chief Nurse & Director of Patient Care Standards	None
Tom Travers	Director of Finance & IT	None

*Interim April/May 2010
[1]On maternity leave from April 2010 to January 2011
[2]Maternity leave cover from April 2010 to January 2011
[3]Started in post June 2010

Directors' remuneration

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

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

The Executive directors are employed within a standard employment contract which provides for a six month notice period. On termination of employment the director would be entitled to contractual severance terms, such as lieu of notice pay and redundancy. Any payments above normal contractual levels would have to be approved by HM Treasury as an economic use of public funds before they were made.

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

Name	Date of appointment	End of term of office	Extension to tenure (if applicable)
Graham Ellis	01/10/2008	30/09/2012	
Les Broude	01/05/2007	30/04/2011	30/04/2015
Brenda Kersting	01/05/2007	30/04/2011	31/10/2014
Jane Bramwell	01/05/2007	30/04/2011	30/04/2013
Keith Gilchrist	01/05/2007	30/04/2011	30/04/2014
Malcolm Griffiths	16/07/2011	15/07/2011	30/11/2013

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

In 2010/11 there have been no significant awards or compensation payments made to past Directors, and no amounts are payable to third parties in respect of any director.

Membership of the remuneration committee during 2010/11:
Graham Ellis
Jane Bramwell
Les Broude
Keith Gilchrist
Malcolm Griffiths
Brenda Kersting.

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

Directors' remuneration

*Mrs S Knollys was on maternity leave from 1st April 2010 to 7th December 2010

	2010-11				2009-10		
Name and Title	Service as Director in year	Salary (bands of £5000) £	Other Remuneration (bands of £5000) £	Benefits in Kind Rounded to the nearest £100 £	Service as Director in year	Salary (bands of £5000) £	Other Remuneration (bands of £5000) £
Chairman Mr G Ellis	Full Year	20-25	-	-	Full Year	20-25	-
Non-Executive Directors Mr M Griffiths	Full Year	5-10	-	-	Full Year	5-10	-
Mr L Broude	Full Year	5-10	-	-	Full Year	5-10	-
Mr K Gilchrist	Full Year	5-10	-	-	Full Year	5-10	-
Ms J Bramwell	Full Year	5-10	-	-	Full Year	5-10	-
Mrs B Kersting	Full Year	5-10	-	-	Full Year	5-10	-
Chief Executive Ms Anne Eden	Full Year	155-160	-	TBC	Full Year	155-160	-
Chief Operating Officer Mr R Peet	Full year	110-115	-	-	06/07/09 - 31/03/10	80-85	-
Director of Finance Mr T Travers	Full Year	110-115	-	-	Full Year	110-115	-
Chief Nurse and Director of Patient Care Standards Ms S A Watson-Fisher	1/4/10-7/4/10	0-5	-	-	Full Year	95-100	-
Ms C Eves (Acting)	7/4/10-31/5/10	10-15			n/a	n/a	-
Ms L Swiatczak	1/6/10-31/3/10	75-80			n/a	n/a	-
Medical Director Dr G Luzzi	Full Year	45-50	125-130	-	Full Year	45-50	120-125
Director of Property Services Mr I Garlington	Full Year	100-105	-	-	Full Year	100-105	-
Director of HR and organisational development Mrs S Hatton	Full Year	90-95	-	-	Full Year	90-95	-
Joint Directors of Strategy & System Reform Mrs S Knollys*	Full Year	30-35	-	-	Full Year	55-60	-
Mrs J Brown	01/06/09 - 31/03/10	50-55	-	-	01/06/09 - 31/03/10	55-60	-

Directors' pension entitlements

Name and Title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2011	Lump sum at age 60 related to accrued pension at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Real Increase in Cash Equivalent Transfer Value	Employer's Contribution to stakeholder pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)				To nearest £100
	£000	£000	£000	£000	£000	£000	£000	£
Chief Executive Ms A Eden	0 - 2.5	5-7.5	55 - 60	165-170	1,009	1,086	(77)	(54,100)
Chief Operating Officer Mr R Peet	1.5 - 2.0	0-2.5	10-15	30-35	146	n/a	n/a	n/a
Director of Finance Mr T Travers	0 - 2.5	2.5-5	15-20	40-45	243	255	(12)	(8,300)
Director of Nursing Ms L Swiatczak	0 - 2.5	0 - 2.5	5-10	15-20	91	94	(3)	(2,100)
Director of HR and Organisational Development Mrs S Hatton	2.5-5	7.5-10	35 - 40	115-120	764	766	(3)	(1,900)
Joint Directors of Strategy and System Reform Mrs S Knollys*	0 - 2.5	0 - 2.5	0 - 5	10-15	37	42	(5)	(3,600)
Mrs J Brown	0 - 2.5	0 - 2.5	10 - 15	35-40	158	185	(27)	(18,700)
Director of Facilities and Estates Mr I Garlington **	0 - 2.5	n/a	0 - 5	n/a	23	29	6	4,500
Medical Director Dr G Luzzi	2.5-5	10-12.5	45-50	130-135	909	892	(17)	(11,800)

* Sam Knollys was on maternity leave from 1st April 2010 to 7th December 2010

** Ian Garlington is a member of the NHS Pension Scheme 2008 section and, as such, has no automatic entitlement to a lump sum.

In his budget of 22 June 2010 the Chancellor announced that the up rating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change expected from April 2011. As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in the calculations carried out by the NHS Pensions Agency that form the basis of the disclosure above, and are lower than the previous factors they used. The value of some members CETV has fallen as a result.

Audit committee

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

Les Broude	Non-executive director
Keith Gilchrist	Non-executive director
Malcolm Griffiths	Non-executive director
Brenda Kersting	Non-executive director.

Auditors

The Trust has been audited by the Audit Commission since 2008/09. Their total remuneration in 2010/11 was £211,500 (excluding VAT). Of this £196,000 was in respect of audit services for the financial statements. The remainder consisted of fees for the statutory audit and mandatory studies requested by the Department of Health, including the auditing of the Trust's separate Quality Accounts for 2010/11 and work under the National Fraud Initiative.

The Audit Commission has provided a declaration (an ISA 260 declaration of independence and objectivity) confirming that it has maintained independence from the Trust.

Directors' declaration in respect of audit

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

10. Our finances

Financial performance

Performance in year

We started the 2010/2011 financial year facing a general election. Although all parties had published their promises on NHS funding there was a level of uncertainty of what this meant in practice. In the short term we have received assurances that the NHS budget will be protected in real terms. However, as stated earlier in this report, the inflation rate experienced by the NHS tends to be higher than that for the whole population. The efficiency savings of 4% built into the 'tariff' that the income we generate is based on, the increasing level of referrals and the more expensive drugs and treatments that are being provided meant that we faced 2010/11 with the requirement to make savings of £29.8million if our costs were to be held below the income level we were expecting to receive. Although there are always seasonal variations in admissions in certain specialities, the harsh winter conditions resulted in escalation wards being opened to accommodate additional patients at unplanned expense, followed by an outbreak of norovirus at Wycombe which led to temporary ward closures. However, despite these difficulties, the Trust reported a surplus, before the impact of reversal of impairments in the previous year to the value of land and buildings, of £247,000. (The 2010 comparable figure was a surplus of £146,000.) That this has been achieved is a testament to all staff throughout the Trust.

There are two technical adjustments to the reported surplus that also need to be taken into account as those adjustments resulted from a change in the accounting treatment of certain transactions following the movement to International Financial Reporting Standards (IFRS) required of all NHS organisations. The retained earnings amount shown in the Statement of Comprehensive Income is £2,654,000, £2,407,000 higher than the surplus discussed above. This amount of £2,407,000 is for reversals of the impairments to the value of the Trust's buildings and dwellings that occurred in 2009/10 due to changes in the property market. In 2009/10 reductions in value totalling £28,236,000 were charged to the Income Statement. As discussed further below, there has been a smaller increase in value in 2010/11 which has led to a partial reversal of this impairment. The second is to take into account the way that Stoke Mandeville's PFI building is accounted for by including it on the Statement of Financial Position. Under previous accounting standards the Trust would have achieved a surplus of £1,026,000, £779,000 higher than reported. It should be emphasised that the PFI building does not cost the Trust any more and this is an accounting entry that would be expected to be reversed in later years. When assessing the Trust's performance, both in year and cumulatively, the technical adjustments above are removed. As a consequence the surplus of £1,026,000 is used by the Department of Health as the performance measure.

The Trust has a statutory duty to breakeven taking one year with another. The Trust has achieved breakeven this year, but prior deficits remain. In cases where the annual duty to break even is not achieved, it is required to breakeven over a three year cumulative period. This can be extended to five years in certain circumstances. In 2008/09, due to issues within the local health economy, the Trust made a deficit of £2.75million and it has therefore not achieved breakeven over three years. Due to the circumstances, the Strategic Health Authority has approved an extension to a five-year measure.

The Trust is also required to meet, or undershoot, certain targets in use of External Financing and Capital Resources. In 2010/11 the Trust achieved these targets within the levels that it is expected to meet.

The Trust improved its rating in the 'Use of Resources' assessment carried out by the Audit Commission from 'weak' in 2008/9 (caused by the financial deficit) to 'adequate' in 2009/10. This was the highest rating it could achieve as it had not 'broken-even' the year before. The Audit Commission will no longer be carrying out the full assessment, but will issue a 'Value for Money' conclusion as part of the annual accounts process.

Accounting policies

Expense recognition

Previously the accounts included a provision for leave earned by employees but not taken. The cost of leave earned but not taken by employees at the end of the period is normally recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period. In 2010/11 the Trust's policy on the carry forward of annual leave was changed so that all leave has to be taken during the financial year. As a result, the provision held in 2009/10 for the leave earned was released in year.

In 2010/11 there were a number of service redesigns and restructurings that took place throughout the Trust. As a result, a number of staff were made redundant and others left under the Mutually Agreed Resignation Scheme (MARS). The number of staff affected and the value of their exit packages are shown below. All exit packages were within contractual terms and no additional non-contractual payments were made.

Exit package cost band (including any special payment element)	Number and cost of compulsory redundancies	Number and cost of other departures agreed	Total number and cost of exit packages	Number and cost of departures in a) and b) where special payments have been made
	a	b	c	
<£20,001	11	25	36 (£341,000)	0 (£0)
£20,001 - £40,000	11	4	15 (£444,000)	0 (£0)
£40,001 - 100,000	16	5	21 (£1,366,000)	0 (£0)
£100,001 - £150,000	5	1	6 (£722,000)	0 (£0)
£150,001 - £200,000	3	0	3 (£512,000)	0 (£0)
>£200,000	1	0	1 (£189,000)	0 (£0)
Total	**47 (£2,784,000)**	**35 (£790,000)**	**82 (3,574,000)**	**0 (£0)**

Non-current assets

The Trust is required to report the 'fair value' of its non-current assets. In assessing the fair value, it takes into account the advice of experts, where appropriate. The District Valuation Office has advised the Trust that the value of its land has not changed since the beginning of the financial year, although buildings and dwellings have increased by 2.38%. Where the increase reverses the impairment to values charged to the Income Statement in the previous financial year the benefit has been credited to the Income Statement, otherwise the increase has been credited to the Revaluation Reserve.

There is a property in Whielden Street Amersham that is surplus to the Trust's requirements, consisting of 'Diamonds' and three terraced houses, currently used as office space. These are to be disposed of by sale and, as such, the Trust has reclassified them as 'Non-Current Assets Held for Sale'

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

Donations

We have been extremely fortunate again this year to benefit from support from Scannappeal, the Trust charities and the League of Friends; with the purchase of medical and other equipment exceeding £1,500,000. The equipment that was donated included an operating table (£164,000), laparoscopic equipment (£231,000), two anaesthetic monitors (£28,000 each), echocardiography equipment (£100,000), ultrasound equipment (£177,000) endoscopy equipment (£127,000) and a visual camera (£53,000). There have also been donations of smaller items of equipment for which we are very grateful.

In addition to the purchase of medical equipment, the Trust receives support from the charities in a number of other areas, including enhancing the environment for patients and supporting staff in training and health and wellbeing.

Pension liabilities

Past and present employees of the Trust are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme and is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the scheme is equal to the contributions payable to the scheme for the accounting period. Further details can be found in note 10 of the Trust's 2010/11 financial statements.

Financing arrangements

The Trust currently has two loans. The first is a capital loan which was taken out in September 2008, at a fixed interest rate of 4.88%, in order to support the Trust's significant capital programme in that year. At 31st March 2011 there was £3,500,000 outstanding, which is repayable at twice yearly instalments of £700,000 in September and March. The second is a working capital loan, which was taken out in March 2010 as a result of the reduced level of cashflow the Trust achieved due to the issues within the local health economy. This loan is at a fixed interest rate of 1.89 per cent and at 31st March 2011 there was £10,000,000 outstanding. This is repayable in twice yearly instalments of £1,250,000 in September and March.

At the beginning of 2010/11 it was anticipated that the Trust may need a further working capital loan of £5,000,000, but due to improved cash management there was no need for this loan.

During the financial period, the Trust incurred £442,000 in interest on its loans.

Under IFRS, the Trust is required to account for the private finance initiative schemes and any equipment held under finance leases by accounting for both the value of the asset and the future liability to pay. This future liability is shown on the Statement of Financial Position as 'borrowings'. The amount paid to our PFI partners is accounted for as either service charges for the services provided, or finance charges on the 'borrowing' for the buildings in the Income Statement. In 2010/11 the Trust accounted for £9,770,000 in finance charges in relation to the PFIs.

Cash flow

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

The Trust earns interest on its bank balances and is subject to interest rate fluctuations on these earnings. Interest rates are currently very low so the risk of them reducing by a material amount and thus reducing the Trust's income

earned is also considered to be low. The Trust's loans are at fixed interest rates so the Trust is not exposed to interest rate risk in respect of loans.

Interest earned on bank balances during the year amounted to £55,000.

Better payment practice code

The Better Payment Practice Code (BPPC) requires the Trust to aim to pay all valid NHS and non-NHS trade creditors by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance in 2010/11 is shown below:

	2010-11		2009-10	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**73,515**	**126,593**	65,130	117,749
Total Non NHS trade invoices paid within target	**50,153**	**96,243**	35,039	79,851
Percentage of Non-NHS trade invoices paid within target	**68.2%**	**76.0%**	53.8%	67.8%
Total NHS trade invoices paid in the year	**3,076**	**60,085**	3,033	17,201
Total NHS trade invoices paid within target	**2,212**	**51,813**	1,892	11,806
Percentage of NHS trade invoices paid within target	**71.9%**	**86.2%**	62.4%	68.6%

Although performance has improved in all categories following the receipt of the working capital loan in March 2010, it is still below that the target within the NHS (95%) and needs to be improved. There is an internal operational target of improving its BPPC performance in 2011/12. It has introduced an electronic procurement system which will assist this.

In May 2009, the government introduced a prompt payments code and undertook to pay all small businesses within 10 days of receipt of an invoice. The Trust has signed up to this code.

Management costs

9.4 Management Costs	**2010-11**	2009-10
	£000	£000
Management costs	**14,833**	13,026
Income	**345,367**	294,906
Management costs as a percentage of income	**4.3%**	4.4%

Management costs have reduced as a percentage on income due to the savings that have been made in management restructuring and the integration of CHB.

2011/12 and beyond

The White Paper 'Liberating the NHS' published in July 2010 opens up some opportunities and challenges for the Trust, particularly on who will be commissioning our services from 2013 onwards. We are committed to being the provider of choice for both acute and community services in mid and south Buckinghamshire in future years.

We are also firmly committed to achieving NHS Foundation Trust status. In order to do so we will need to continue, and improve upon, strong financial performance and financial management. Key to this will be remaining in financial surplus.

Initial indications are that the cost improvement programme for 2011/12 will be no less significant than that for 2010/11. Trust management is looking to develop its initial plans to maintain our absolute commitment to quality of services while meeting these challenging savings targets.

The Government have also announced the abolition of the Audit Commission, the Trust's external auditors. In the short-term their assessment of the Trust in the 'Use of Resources' will not take place for 2010/11, although they will continue to draw a 'Value for Money' conclusion. Following the abolition of the Commission, the Trust will need to appoint new auditors.

Summary financial statements

Statement of comprehensive income

	NOTE	2010-11 £000	2009-10 £000
Revenue			
Revenue from patient care activities	4	**323,217**	275,015
Other operating revenue	5	**22,150**	19,891
Operating expenses	7	**(327,274)**	(307,473)
Operating surplus/(deficit)		**18,093**	(12,567)
Finance costs:			
Investment revenue	12	51	32
Other gains and losses	13	**(5)**	0
Finance costs	14	**(10,293)**	(9,986)
Surplus/(deficit) for the financial year		**7,846**	(22,521)
Public dividend capital dividends payable		**(5,192)**	(5,569)
Retained surplus/(deficit) for the year		**2,654**	(28,090)
Other comprehensive income			
Impairments and reversals		**0**	(30,617)
Gains on revaluations		**1,884**	28,488
Receipt of donated/government granted assets		**1,522**	397
Reclassification adjustments:			
- Transfers from donated and government grant reserves		**(1,230)**	(1,370)
- On disposal of available for sale financial assets		**0**	0
Total comprehensive income for the year		**4,830**	(31,192)

Reported NHS financial performance position [Adjusted retained surplus/(deficit)]

Retained surplus/(deficit) for the year	**2,654**
IFRIC 12 adjustment	**779**
Reversal of previous impairment	**(2,407)**
Reported NHS financial performance position [Adjusted retained surplus/(deficit)]	**1,026**

A Trust's Reported NHS financial performance position is derived from its Retained surplus/(Deficit), but adjusted for the following:-

a) Impairments to Fixed Assets and Reversals. During 2009/10 the value of land, buildings and dwellings was significantly impaired due to movement in the property market. During 2010/11 this was partly reversed and part of the element that was charged to the Statement of Comprehensive Income in 2009/10 has been credited back in 2010/11. An impairment charge or subsequent reversal is not considered as part of the organisation's operating position.

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

All income and expenditure is derived from continuing operations.

Statement of financial position as at 31 March 2011

	31 March 2011	31 March 2010
	£000	£000
Non-current assets		
Property, plant and equipment	**253,598**	254,394
Intangible assets	**56**	0
Trade and other receivables	**2,692**	2,901
Total non-current assets	**256,346**	257,295
Current assets		
Inventories	**3,593**	3,272
Trade and other receivables	**17,746**	15,956
Other current assets	**147**	147
Cash and cash equivalents	**2,572**	723
	24,058	20,098
Non-current assets held for sale	**1,042**	0
Total current assets	**25,100**	20,098
Total assets	**281,446**	277,393
Current liabilities		
Trade and other payables	**(24,082)**	(17,999)
Other liabilities	**(27)**	(271)
DH Working Capital Loan	**(2,500)**	(2,500)
DH Capital Loan	**(1,400)**	(1,400)
Borrowings	**(1,632)**	(1,724)
Provisions	**(458)**	(1,153)
Net current assets/(liabilities)	**(4,999)**	(4,949)
Total assets less current liabilities	**251,347**	252,346
Non-current liabilities		
Borrowings	**(68,515)**	(69,939)
DH Working Capital Loan	**(7,500)**	(10,000)
DH Capital Loan	**(2,100)**	(3,500)
Trade and other payables	**(1,912)**	(2,187)
Provisions	**(1,432)**	(1,635)
Other liabilities	**(463)**	(490)
Total assets employed	**169,425**	164,595
Financed by taxpayers' equity:		
Public dividend capital	**154,724**	154,724
Retained earnings	**(33,835)**	(36,954)
Revaluation reserve	**32,289**	31,196
Donated asset reserve	**16,247**	15,629
Total taxpayers' equity	**169,425**	164,595

Statement of changes in taxpayers' equity

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Total
	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010-11					
Balance at 1 April 2010	154,724	(36,954)	31,196	15,629	164,595
Total comprehensive income for the year					
Retained surplus/(deficit) for the year	0	2,654	0	0	2,654
Transfers between reserves	0	465	(465)	0	0
Net gain on revaluation of property, plant, equipment	0	0	1,558	326	1,884
Receipt of donated/government granted assets	0	0	0	1,522	1,522
Reclassification adjustments:					
- transfers from donated asset/government grant reserve	0	0	0	(1,230)	(1,230)
Net actuarial gain/(loss) on pension discount rate	0	0	0	0	0
Balance at 31 March 2011	154,724	(33,835)	32,289	16,247	169,425

Statement of cash flows for the year ended 31 March 2011

	2010-11 £000	2009-10 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**18,093**	(12,567)
Depreciation and amortisation	**14,530**	12,506
Impairments and reversals	**(2,407)**	28,236
Transfer from donated asset reserve	**(1,230)**	(1,370)
Interest paid	**(10,263)**	(10,396)
Dividends paid	**(4,890)**	(5,569)
(Increase)/decrease in inventories	**(321)**	(632)
(Increase)/decrease in trade and other receivables	**(1,582)**	(3,865)
Increase/(decrease) in trade and other payables	**7,548**	(10,373)
Increase/(decrease) in other current liabilities	**(271)**	750
Increase/(decrease) in provisions	**(898)**	990
Unwinding of discount	**(35)**	(35)
Net cash inflow/(outflow) from operating activities	**18,274**	(2,325)
Cash flows from investing activities		
Interest received	**55**	31
(Payments) for property, plant and equipment	**(11,013)**	(11,792)
Proceeds from disposal of plant, property and equipment	**5**	3
(Payments) for intangible assets	**(56)**	-
Net cash inflow/(outflow) from investing activities	**(11,009)**	(11,758)
Net cash inflow/(outflow) before financing	**7,265**	(14,083)
Cash flows from financing activities		
Loans received from the DH	**0**	12,500
Loans repaid to the DH	**(3,900)**	(1,400)
Capital element of finance leases and PFI	**(1,516)**	(1,467)
Net cash inflow/(outflow) from financing	**(5,416)**	9,633
Net increase/(decrease) in cash and cash equivalents	**1,849**	(4,450)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**723**	5,173
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**2,572**	723

The financial statements are a summary of the full accounts and statements, and we are required to state that these might not contain sufficient information for a full understanding of the Trust's financial position and performance. The full accounts can be obtained on request by writing to:

Director of Finance & IT
Buckinghamshire Hospitals NHS Trust
Amersham Hospital
Whielden Street, Amersham
Buckinghamshire HP7 0JD
Or by telephoning: 01494 734755

11. Statement of directors' responsibilities in respect of the accounts

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

- apply, on a consistent basis, accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

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

By order of the Board

Anne Eden
Chief executive 6 June 2011

Tom Travers
Director of finance 6 June 2011

12. Statement of chief executive's responsibilities as the accountable officer of the Trust

The Chief Executive of the NHS has designated that the chief executive should be the accountable officer to the Trust. The relevant responsibilities of accountable officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

Anne Eden
Chief executive
Buckinghamshire Hospitals NHS Trust

6 June 2011

13. Statement of internal control

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

I am accountable to the Chairman of the Trust and the Chief Executive of South Central Strategic Health Authority (SCSHA). I am performance managed through appraisal undertaken by the Chairman of the Trust Board and the Chief Executive of SCSHA, who formally records comments on my performance at a full year appraisal meeting.

In addition, the SCSHA Executive Team meets regularly with the directors and me to formally review our performance in delivering the organisation's objectives. I work with partners across the health and social care economy through the Local Strategic Partnership, the Overview and Scrutiny Committee and with NHS Buckinghamshire. This includes performance and contract reviews, regular meetings with the executive team and the whole system recovery board.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can, therefore, only provide reasonable, and not absolute, assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives,
- evaluate the likelihood of those risks being realised, and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Buckinghamshire Healthcare NHS Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The risk management process is led by the Trust Board which is responsible for the overall governance of the Trust. The Board reviews the effectiveness of the system of internal control, including systems and resources for managing all types of risk. The Trust Board has led the process with the

approval of a Risk Management Strategy and Policy, which ensures that the Trust approaches the control of risk in a strategic and organised manner. The strategy describes the corporate and individual accountability for managing risk, the risk management process, the approach to training and how the success of the strategy will be monitored. Each executive director has leadership of a specific area of risk in addition to their corporate Board responsibilities. At the divisional level, risk management is led by the Divisional Chairs, Assistant Directors for Operations, Associate Directors of Nursing, together with senior managers.

Risk management training and awareness is included in the mandatory corporate induction programme and further specialist courses have been delivered to staff throughout the year, including training for senior managers and directors. Guidance on risk management is also provided to staff by specialist advisers that include:

- The Director of Infection Prevention and Control, and the Control of Infection Team
- The Head of Occupational Health
- The Health and Safety Adviser
- The Fire Safety Advisers
- The Radiological Protection Adviser
- The Chief Pharmacist
- The Child Protection Designated Nurse and Designated Doctor
- The Human Tissue Act Designated Individuals

The Board is committed to a culture of continual learning and quality improvement. The Board and its Committees receive feedback from audits, inspections and incidents. Sharing of good practice and continual learning relating to clinical risk is ensured through the Risk Monitoring Group. This group is the forum for monitoring of clinical risk issues identified by the Divisions and identified risk sub-groups. It provides assurance to the Healthcare Governance Committee that clinical risks are being appropriately reported and managed, and facilitates the dissemination of learning across the organisation.

4. The risk and control framework

The trust's strategy for managing its risk is to:

- adopt an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in the Trust's risk management strategy and its related policies
- manage risk as part of normal line management responsibilities and provide funding to address 'risk' issues as part of the normal business planning process
- undertake risk assessments on both existing, new and proposed activities to ensure that:
    - significant risks are identified

    - assessments are made of their potential frequency and severity
    - risks are avoided where possible, and minimised by implementing durable and effective controls.
    - risks are recorded on the Trust's risk register.
- ensure that the Board reviews the corporate risk register (significant risks) periodically and monitors the delivery of the Trust's objectives.
- use the risk register to inform the Trust's business planning and investment decision-making process so that informed decisions are made in the full knowledge of the level of risk.
- record the results of risk assessments on the Trust's risk registers and use them to ensure that any decision to accept risk is taken at an appropriate level in the Trust
- utilise internal and external audit, the healthcare compliance assessment and other assessments by independent regulatory bodies to provide assurance that risk is being managed appropriately

Within each clinical division there are clinical governance leads and teams attached to the Service Delivery Units, whose role is to ensure that

- risks within the division are identified through a process of risk assessment, prioritised, where possible eliminated, and, if not, minimised.
- the importance of managing risk is communicated to all staff within the division
- the Risk Monitoring Group is made aware of any unacceptable risks that cannot be managed within divisions
- data from incidents, claims and complaints etc. is reviewed to identify any trends or areas for retrospective action.

Each division also has a clinical audit lead, medical devices lead and control of infection link nurses.

Managers are responsible for ensuring effective risk management within their own area. More than 70 staff have been trained across the Trust to undertake risk assessments in their areas of work and to report these to their managers. The Risk Management Strategy also requires liaison with co-employers on broader risks.

The Risk Management Strategy applies to all staff employed by Buckinghamshire Healthcare NHS Trust as well as temporary, agency and contracted staff and stresses the need to involve public stakeholders, as appropriate, in the risk management process.

The Board Assurance Framework (BAF) provides the Trust with a tool for the identification and treatment of principal risks to the achievement of the organisation's objectives. It also provides a structure for the evidence to support (a) the Statement on Internal Control (SIC) and (b) the statement of compliance with national healthcare regulations.

Documented in the Board Assurance Framework are the controls in place to minimise principal risks and the assurances that these controls are effective.

Where gaps in control or assurance are identified, action plans are developed and put into place to address them. The BAF ensures that appropriate internal and external assurances are in place in relation to the management of all high-risk areas.

During 2010/11 gaps in control were identified through the Board Assurance Framework and mitigated accordingly. The following section provides more detailed review of gaps in control identified and mitigated in year; identified future risks; and additional supporting information.

4.1 In year major risks

4.1.1 Operational:

From the 1st April 2010 Buckinghamshire Hospitals NHS Trust vertically integrated with Community Health Buckinghamshire to form a new organisation. The merged organisation adopted the name Buckinghamshire Healthcare NHS Trust from 1 November 2010. This organisation now has responsibility for delivering acute and community services. The process of merging teams and processes has been a significant feature of 2010/11. This integration has provided opportunities to streamline care for patients.

The organisation conducted a self review against recommendations in the 'Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009' chaired by Robert Francis QC. This review was conducted with the support of patient representatives and was presented to the Board. For the majority of recommendations there was clear evidence of processes in place to deliver required outcomes. For the areas where it was identified that improvements could be made an action plan was developed. A gap in assurance was identified on the Board Assurance Framework in that the Essence of Care audit programme did not run at regular intervals through the year. A plan has been put in place to link the Essence of Care audit work with the Productive Series monitoring and with the use of the Safety Thermometer in 2011/12.

The organisation identified during the year that operational pressures impacted on the release of staff for training. An e-learning training package was put in place for all areas of mandatory training where such a mode of learning was appropriate. This reduced the length of time required for mandatory training. An appraisal programme is in place to ensure that staff receive the required mandatory and developmental training appropriate to them.

A gap in control was identified around the target of 80% of stroke patients spending 90% of their time on a stroke ward. This target has not been achieved in 2010/11. A plan is in place for the development of a Hyper-Acute Stroke Unit at Wycombe hospital operational from June 2011 which will provide the solution to this issue.

A gap in assurance has been identified with regard to demonstrating that more than 90% of eligible patients received appropriate thrombo-prophylaxis.

A process for capturing the data has been put in place and a steady improvement in the collection of this data has occurred through the year. There is a Venous Thrombo-Embolism (VTE) Committee in place chaired by the Medical Director. This committee has developed and is monitoring a VTE action plan based on guidance from the National Institute for Health and Clinical Excellence.

A gap in control was identified in relation to achieving enhanced benefit from the Care Records Information Technology System (CRS). The way in which CRS was set up led to a reliance on a centralized process making it inflexible to the specific needs of the service. This has impacted in particular on Information Technology systems in the Accident and Emergency department. A plan was put in place to separate the trust from other providers in the CRS domain and significant progress has been made to deliver this in conjunction with partner Trusts – final separation will occur in Q1 2011. This has enabled work to progress for the introduction of enhanced benefit in 2011/12.

A gap in control has been identified regarding failure to reduce length of stay in the Division of Medicine. A plan has been put in place to address this including monitoring of complex discharges, escalation of patients with prolonged length of stay to the Divisional Chair and changes introduced through the Urgent Care Work Stream, including a revised triage system in the AE department, a GP service at the Wycombe EMC, improved 7 day working in therapies and radiology, and revised professional standards for clinicians. Whilst much has been achieved, reduction of LOS within the Division of Medicine has not fallen to the consistently low level that is required and this remains a key workstream into 2011/2012.

A gap in control was identified by Internal Audit in relation to the lack of a backlog maintenance schedule. The trust currently relies on a risk based approach to identify necessary works. The backlog maintenance schedule is a work in progress and will be completed by the end of March 2012.

A gap in control was identified by Internal Audit associated with the rapid integration of the community health sites. Budgets for estates services were not set fully at the start of 2010/11. This issue was addressed and resolved within the year.

A gap in control was identified by Internal Audit associated with procurement processes in the organisation. An action plan has been put in place to address this, including the introduction of e-procurement.

4.1.2 Serious Incidents

The trust has followed the guidance from the Strategic Health Authority regarding the management of Serious Incidents. This has included the introduction of new categories of Serious Incidents including category 3 and 4 pressure ulcers, development of VTE within 100 days of hospital admission and serious harm from falls. The trust has declared one Never Event in 2010/11 relating to a mis-placed naso-gastric tube.

4.1.3 Financial risk

The most significant financial risk facing the Trust for 2010/11 was our ability to achieve our statutory duty to 'breakeven' given the forecast size of our savings plan. Savings of £29.8m were required to be made as a result of the efficiency savings built into the prices provided by the Department of Health, increased projected demand and inflation forecasts. In order to achieve breakeven the profit from the sale of the land at Stoke Mandeville was required and there was an identified risk that this would not be completed in year.

In order to manage these risks we undertook a number of mitigating actions:

- With the assistance of the Strategic Health Authority a 'Turnaround' team worked with the Trust over a number of months to ensure that savings identified were realistic and achievable, and assisted with the delivery of these. This work has been continued internally.

- A number of controls were put in place to ensure that all spend was appropriate and authorised, including a Workforce Panel authorising recruitment to all posts ,and non-pay expenditure having to be authorised by the Senior Management team.

- We worked with our PCT Commissioners closely to try to ensure that our income reflected the amount of patient care provided

- We rationalised our workforce which unfortunately led to a number of redundancies and staff leaving under the Mutually Agreed Resignation Scheme.

- We put in place plans to deliver the level of financial performance to break-even if the land sale was not completed.

As a result of the actions above savings of £30.2m were realised. Although the land sale was not completed, working with the local NHS economy ensured that we made a surplus, after technical adjustments, of £247,000.

4.2 Future Risks:

The Board has given consideration to threats coming up in the next 3 years which may have an impact on the organisation and provide a level of risk. These are briefly summarised below:

- Challenging savings plan for 2011/12
- Potential organisational and structural changes emerging in the light of the White Paper "Equity and excellence: Liberating the NHS"
- Continued challenges of data security
- Changes to the MPET budget may have an impact on training, in particular on doctors' training
- Increasing focus on developing the healthcare workforce and developing skills networks will require more detailed workforce

analysis. This will place a burden on existing capacity within Human Resources

- National Programme for IT – it is expected that within 3 years the central funding for the programme will cease. This may have an impact on funding for various IT functions in the organisation e.g. RIO

These risks will be managed in the way described in the risks and controls framework above through a process of assessment and intervention as required.

In particular, to address risks associated with the level of potential change as a result of the White Paper “Equity and excellence: Liberating the NHS”, the board has set its vision and corporate objectives in line with national guidance and will take appropriate action to deliver this.

4.3 Information Governance

The Trust recognises the importance of managing information and personal information in particular, appropriately and securely. The Senior Information Risk Owner (SIRO) is responsible for ensuring the board has comprehensive and reliable assurance that appropriate controls are in place and that risks are managed in relation to all information used for operational and financial purposes.

The Caldicott and Information Governance Committee monitors the performance of the Trust against the requirements of the Information Governance Toolkit. The Trust achieved a score of 2 in the Toolkit submission for 2010/11.

The Trust has had no level 3 serious untoward incident involving personal data.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. All policy and planning documents undergo a formal process of equality impact assessment before approval by the board and its sub-committees. No significant control issues have been identified.

4.4 Stakeholder Involvement

The Trust continues to maintain a good working relationship with the Buckinghamshire Health Overview and Scrutiny Committee and is working with the Buckinghamshire LINk which has a key role in ensuring the involvement of public stakeholders in areas of risks that may have an impact on them.

The Trust has a well established patient experience group which meets regularly and continues to maintain good attendance. It provides a valuable patient perspective. In addition, it facilitates a two way dialogue and an input of views from a wide range of patient groups. The Trust also shares information with the PEG, pro actively seeks views and asks them to provide

a monitoring role e.g. the national survey in patient action plan and patient information.

During 2010/11 the Trust continued to support our membership. A varied programme of member events facilitates broader involvement activity, offering the opportunity to listen to large groups of patients and to hear their views and ideas. A few key examples for 2010/11 include asking our patients about what makes them feel safer in hospital.

4.5 Pension Scheme Obligations

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

4.6 Registration with the Care Quality Commission

The trust has declared full compliance with the regulations for registration and has been registered with the Care Quality Commission for all services from 1 April 2010. The registration is without conditions. The trust continues to monitor itself against these regulations and has not found any significant control issues.

4.7 Energy efficiency

The trust is aware and committed to its responsibilities for carbon reduction, last year it updated and approved its sustainability management plan & this year committed identified internal resources to work on delivering the agenda. During the year we expect to complete climate change risk assessment and conclude our Adaptation Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The Head of Internal Audit has provided an opinion that there is good assurance that there is a generally sound system of internal control in place. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance that the controls are in place. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- The Trust's self assessment against Care Quality Commission regulations
- The annual report of the Trust's external auditors and regular reports from the Trust's internal auditors and the annual Head of Internal Audit Opinion.
- The quarterly Healthcare Governance Reports
- The maintenance of Level 1 compliance with the NHS Litigation Authority risk management standards for general and maternity services.
- South Central Strategic Health Authority monitoring and other benchmarking.
- Internal monitoring arrangements such as the monthly Board performance report.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee and Healthcare Governance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been supported by the following:

- The Board, which has responsibility for setting the overall direction, agreeing the Trust's principal objectives, assessing and managing strategic risks to the delivery of those objectives and monitoring progress through regular performance monitoring reports
- The Audit Committee, a non-executive committee, which works to a well-developed audit plan, monitors assurances provided and reports to the Board.
- The Healthcare Governance Committee, a non-executive committee, which reviews the Trust's risk registers.
- The Risk Monitoring Group, which reports to the Healthcare Governance Committee and also informs the Trust Management Committee of any urgent issues.
- Appraisal of the work of the executive directors and general managers.
- Internal Audit, which has reviewed and approved the Trust's assurance framework arrangements in 2010/11.
- External Audit reports
- The Internal Audit work plan based on risks identified through the assurance framework and risk register.

The Board has monitored progress against the top risks facing the Trust and assured itself that the strategic intent of the Trust appropriately addresses the risks facing the Trust and the continual improvement of the totality of its business. The Audit Committee has sought and received assurance from the Trust's Internal and External Auditors from the agreed audit programmes which have been developed through consideration of the gaps in assurance as identified by the Board Assurance Framework.

Significant Control Issues

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Buckinghamshire Healthcare NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Anne Eden
Chief Executive
Buckinghamshire Healthcare NHS Trust.

14. Auditors opinion and report

Independent auditor's report to the Board of Directors of Buckinghamshire Healthcare NHS Trust

I have audited the financial statements of Buckinghamshire Healthcare Trust for the year ended 31 March 2011 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

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

- the table of salaries and allowances of senior managers on page 48 and
- the table of pension benefits of senior managers on page 49.

This report is made solely to the Board of Directors of Buckinghamshire Healthcare NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the accounting statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of Buckinghamshire Healthcare NHS Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the Statement on Internal Control on which I report to you if, in my opinion, the Statement on Internal Control does not reflect compliance with the Department of Health's requirements.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Trust's responsibilities

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I am not required to consider, nor have I considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Basis of conclusion

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2010, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2011.

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

Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2010, I am satisfied that, in all significant respects, Buckinghamshire Healthcare NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2011.

Delay in certification of completion of the audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide assurance over the Trust's annual quality accounts. I am satisfied that this work does not have a material effect on the financial statements or on my value for money conclusion.

Maria Grindley
Engagement Lead, Audit Commission
Ground and 1st Floor,
Unit 5, Isis Business Centre,
Horspath Road, Cowley,
Oxford, OX4 2RD

6 June 2011

Appendix 1: Become a member of the Trust

As part of our aim to become an NHS Foundation Trust, we would like to invite you to become a member of the Trust. To become a member you can join on our website www.buckshealthcare.nhs.uk or request information from us at:

Membership office
Buckinghamshire Healthcare NHS Trust
Amersham Hospital
Whielden Street
Amersham
Bucks
HP7 0JD

Appendix 2: Feedback on annual report 2010/11

It is important our annual report is easy to read and understand, and it is available in a variety of versions, including in other languages and as an audio book, on request. In producing ours we have used guidance on content from the Department of Health, as well as learning from reports produced by other NHS trusts.

We value feedback on this year's report – please complete the feedback form below and post the page to the address shown. Alternatively, you may email your comments to communications@buckshealthcare.nhs.uk.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information in this annual report was easy to understand					
There was enough information about the Trust and its services					
There was enough information about the Trust's achievements					
There was enough information about the Trust's finances					
The layout of the document was clear					

Please post feedback to:

Communications
Buckinghamshire Healthcare NHS Trust
Amersham Hospital
Whielden Street
Amersham
Bucks HP7 0JD

Or telephone: 01494 734959

Or email: communications@buckshealthcare.nhs.uk

Appendix 3: Glossary

Acute hospital services Medical and surgical interventions provided in hospitals.
Accruals An accounting concept. In addition to payments and receipts of cash, adjustment is made for outstanding payments, debts to be collected and stock (items bought, paid for but not yet used). This means that the accounts show all the income and expenditure that relates to the financial year.
Auditors' Local Evaluation (ALE) ALE is the Audit Commission's assessment framework involving auditors making scored judgements on key areas of financial performance in NHS trusts. It assesses how well NHS organisations manage and use their financial resources, and forms the quality of financial management for non-foundation trusts within the Care Quality Commission's annual health check.
Agenda for Change Agenda for Change is the pay system for the majority of NHS staff.
Annual health check The annual health check produced by the Care Quality Commission involves the assessment and rating of the performance of each NHS organisation. The annual health check rating for the previous financial year is published in October.
Assets In general, assets include land, buildings, equipment, cash and other property.
Assurance framework (and Board Assurance Framework) The assurance framework provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the statement on internal control.
Audit commission They are an independent public body responsible for ensuring that public money is spent economically, efficiently, and effectively in the areas of local government, housing, health, criminal justice and fire and rescue services. They appoint the external auditors.
Better payment practice code The better payment practice code requires the Trust to aim to pay all valid non-NHS

invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.
Break-even (duty) A financial target. In its simplest form it requires the Trust to match income and expenditure.
Boorman Review This is the final report by Dr Steve Boorman of the independent NHS Health & Well-being review. Published in November 2009, it provides a set of recommendations for improvement in the provision of health and well-being across the NHS.
Capital Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if its costs exceed £5000 and its useful life expectancy is greater than one year.
Care pathway This is the route and interactions with healthcare services that a patient will take from their initial meeting with a GP to completion of their treatment.
Care Quality Commission (CQC) The Care Quality Commission provides an independent assessment of the standards of healthcare services, whether provided by the NHS, the private sector or voluntary organisations. The CQC replaces the Healthcare Commission.
Charitable funds Our charity, registered number 1053113 includes a general amenity fund (unrestricted), a research fund (restricted) and an endowment fund.
Chief Nurse's High Impact Actions for nursing and midwifery Eight high impact actions were unveiled by the chief nursing officer for England Dame Christine Beasley in 2009, following submissions from nurses and midwives on how their profession can contribute to improving healthcare, wellbeing and efficiency in services. They are available from the NHS Institute for Innovation and Improvement's website.
Choose and book It is the government's aim to allow patients to choose the hospital they are treated in. Patients needing elective treatment are offered a choice of four or five hospitals once their GP has decided that a referral is required. These could be NHS trusts, Foundation Trusts, treatment centres, private hospitals or practitioners with a special interest operating within primary care. Choose and book is a national service that, for the first time, combines electronic booking and a choice of place, date and time for first outpatient appointments.

Clinical division
The Trust's organisation management structure is based on six clinical divisions, each led by a divisional clinical chair who is a medical consultant supported by a lead nurse and general manager. The six divisions are:-

- clinical services
- community and integrated care
- medicine
- spinal and private patients
- surgery
- women and children.

Clostridium difficile (C. difficile)
Clostridium difficile is a bacterium that can cause an infection of the gut and is the major infectious cause of diarrhoea that is acquired in hospitals in the UK.

Commissioning
A continuous cycle of activities that underpins and delivers on the overall strategic plan for healthcare provision and health improvement of the population. These activities include stakeholders agreeing and specifying services to be delivered over the long term through partnership working, as well as contract negotiation, target setting, providing incentives and monitoring.

Community care
Healthcare care provided in a community setting such as at home or from a community hospital.

CQUIN (Commissioning for Quality and Innovation) payment targets
These new payment targets are aimed at driving up quality in certain areas. They have been developed to support implementation of *High Quality Care for All*.

Community Health Buckinghamshire (CHB)
CHB was the provider services arm of NHS Buckinghamshire (the primary care trust), and includes services such as district nursing, services for children and families, intermediate care, occupational and physiotherapy, community dental services, speech and language therapy and palliative care. CHB is now integrated with our Trust, with the staff's employment transferring in April 2010.

Connecting for health
This is the national programme for information technology aiming to bring modern computer systems into the NHS which will improve patient care and services.

Cost improvement programme

The ‘savings’ plan agreed for 2009/10.
Corporate trustee A corporate trustee is a corporation which has been appointed to act as a trustee of a charity. In the case of the NHS, the NHS Trust Board is the corporate trustee of our charitable funds.
Current assets Debtors, stocks, cash or similar whose value is, or can be converted into, cash within the next twelve months.
Disability equality scheme The Disability Discrimination Act amended in 2005 gives the Trust ‘general’ and ‘specific’ duties to promote disability equality. The Trust’s disability equality scheme (DES) explains how the Trust will promote equality for disabled and deaf staff and patients.
Eighteen week and cancer waits The NHS improvement plan gave a commitment that by December 2008 no one will have to wait longer than 18 weeks from GP referral to hospital treatment. However, many patients will be seen much more quickly. For example by December 2005, cancer patients were guaranteed a maximum two month wait from urgent GP referral to first treatment and a maximum one month wait form diagnosis to first treatment for all cancers.
Elective inpatient activity Elective activity is where the decision to admit to hospital could be separated in time from the actual admission, ie planned. This covers waiting list, booked and planned admissions.
Emergency inpatient activity Emergency activity is where admission is unpredictable and at short notice because of clinical need.
Executive directors The executive directors are senior employees of the NHS Trust who sit on the Board of Directors and will include the chief executive and finance director. Executive directors have decision-making powers and a defined set of responsibilities thus playing a key role in the day to day running of the organisation.
Francis Inquiry report Robert Francis QC published an inquiry report into Mid-Staffordshire NHS Foundation Trust following concerns about standards of care at the Trust, and an investigation and report published by the Healthcare Commission. The report makes 18 recommendations aimed at improving governance throughout the NHS which the

Department of Health accepted in full.
GDP Gross domestic product – a measure of the value of national economic activity.
Governance Governance arrangements are the 'rules' that govern the internal conduct of an organisation by defining the roles and responsibilities of key officers/groups and the relationship between them, as well as the process for due decision making and the internal accountability arrangements.
Health Protection Agency The Health Protection Agency (HPA) is an independent body that protects the health and well-being of the population. The agency plays a critical role in protecting people from infectious diseases and in preventing harm when hazards involving chemicals**,** poisons or radiation occur.
High Quality Care for All This national strategy for the NHS, by Lord Darzi and published in 2008, aims for everyone to be able to access uniformly, personalised high quality care; that is delivered as close to home as possible, and within the resources available.
ICT Information and communications technology.
International Financial Reporting Standards (IFRS) IFRS are the standards, interpretations and the framework adopted by the International Accounting Standards Board (IASB) to promote high quality financial standards globally.
Key performance indicators (KPIs) KPIs are the nationally recognised method for calculating performance in NHS acute trusts and are defined by the NHS Information Authority. In 2009/10 the KPIs covered existing commitments and national targets set out by the Department of Health (DH) and Care Quality Commission (CQC); clinical quality, outcome and clinical efficiency indicators and activity levels, workforce and health & safety indicators.
Local health economy The NHS organisations including GP practices, and voluntary and independent sector bodies involved in the commissioning, development and provision of health services for particular population groups.
MARS Mutually agreed resignation scheme.

Methicillin resistant staphylococcus aureus (MSRA)
This is a strain of a common bacterium which is resistant to an antibiotic called methicillin.

Millennium Care Records Service (CRS)
The care records service is the pivotal part of the national programme for IT (NPfIT), the aim being to provide an electronic health record for 50 million people in England, accessible by any authorised clinician.

National programme for IT (NPfIT)
The national programme for IT focuses on changes to IT in the NHS that will improve patient experience. The programme has four particular goals: electronic appointment booking, an electronic care records service, electronic transmission of prescriptions, and fast, reliable underlying IT infrastructure.

NHS Buckinghamshire
The local primary care trust and commissioner of NHS services for Buckinghamshire people.

NHS foundation trust (FT)
NHS foundation trusts have been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people.

NHS trusts
NHS Trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as commissioned by PCTs.

Non-executive directors
Non-executive directors, including the chairman, are Trust Board members but they are not full time NHS employees. They have a majority on the Board and their role is to bring a range of varied perspectives and experiences to strategy development and decision-making, ensure effective management arrangements and an effective management team is in place and hold the executive directors to account for organisational performance.

OPAT
Outpatient parenteral antimIcrobial therapy.

Order communications
An electronic system for the requesting and reviewing of test results. For example, pathology results.

Outpatient attendance
An outpatient attendance is when a patient visits a consultant or other medical outpatient clinic. The attendance can be a ‘first’ or ‘follow up’.

Overview and scrutiny committees (OSC)
OSCs have the power to scrutinise health services. This contributes to their wider role in health improvement and reducing health inequalities for their area and its inhabitants.

Patient administration system (PAS)
A computer system used to record information about the care provided to service users. The data can only be accessed by authorised users.

Patient Advice and Liaison Service (PALS)
All NHS trusts are required to have a Patient Advice and Liaison Service. The service offers patients information, advice, quick solution of problems or access to the complaints procedure. PALS are designed to offer on the spot help and information, practical advice and support for patients and carers.

Patient Services Institute

The Trust has a central service redesign and development team, the Patient Services Institute (PSI). The PSI supports the divisions by promoting Lean principles and methodology as well as providing facilitation, data analysis, project management expertise and training.

Payment by results (PbR)
Payment by results (PbR) aims to be a fair and transparent, rules-based system for paying NHS Trusts. It uses a national price list (tariff) linked to activity and adjusted for case complexity.

Picture archiving computer system (PACS)
PACS enables images such as x-rays and scans to be stored electronically and viewed on screens by doctors and other health professionals, creating a near filmless process and improved diagnosis methods.

Private finance initiative (PFI)
The private finance initiative (PFI) provides a way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects

Primary care
Family health services provided by family doctors, dentists, pharmacists,

optometrists, and ophthalmic medical practitioners.
Provisions Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required. Provisions are included in the accounts to comply with the accounting principle of prudence.
Quality account From 2009/10 onwards all NHS trusts have to publish quality accounts to give information about the quality of the services being delivered.
Revenue Expenditure other than capital. For example, staff salaries and drug budgets. Also known as current expenditure.
Ring-fenced Funding specifically designated for a purpose and which can only be used for that purpose.
RiO An electronic patient records system for community health organisations.
Risk register A register of all the risks identified by the organisation, each of which is assessed to determine the likelihood of the risk occurring and the impact on the organisation if it does occur.
Scannappeal An independent registered charity that's objective is to raise money for scanners and other life saving medical equipment for hospitals in Buckinghamshire.
Secondary care Care provided in hospitals.
Service standards The Trust's new service standards focus on themes around communication, courtesy, compassion and commentary. For the first time they set out the standards of behaviour we expect all of our staff to deliver, with every interaction, every day, with every patient or colleague.
Statement of internal control (SIC) The chief executive as the accounting officer is required to make an annual statement alongside the accounts of the Trust, which provides a high-level summary of the ways

in which risks are identified and the control systems in place.
Strategic health authority (SHA) Strategic health authorities are accountable to the Secretary of State for Health via the chief executive of the NHS and have a role to performance manage PCTs and local health systems. Our strategic health authority is south central.
Tariff / national tariff The national tariff underpins the implementation of the payment by results policy by providing a national price schedule for commissioning services for patients in England. The tariff is a schedule of prices for healthcare resource groups (HRGs). These HRG's cover a range of clinical procedures, treatments and diagnoses that cover a large proportion of hospital services in England.
Trust Board The Trust Board comprises the chairman, executive and non-executive directors and is the body responsible for the operational management and conduct of a particular NHS Trust.
Whole system reform In relation to our agenda this involves looking at the whole system of NHS care in Buckinghamshire, for example the organisations and professions involved, and improving it collaboratively.
Working capital Working capital is the current assets and liabilities (debtors, stock, cash and creditors) required to facilitate the operation of an organisation.