

**Meeting: Trust Board Meeting in Public**

**Date: Wednesday, 30 November 2022**

**Time: 09:30 – 12:00**

**Venue: Jubilee Room, The Gateway, Gatehouse Road, Aylesbury**

Start Time	Item	Subject	Purpose	Presenter	Encl.
09:30	1.	<ul style="list-style-type: none"> <li>Chair's Welcome to the Meeting, Meeting Guidance</li> <li>Apologies for absence</li> </ul>	Information	Chair	Verbal
	2.	Declaration of Interests	Assurance	Chair	Verbal

### General Business

09:35	3.	Patient Story	Discussion	Chief Nurse	Paper
	4.	Minutes of the last meeting held on: <ul style="list-style-type: none"> <li>26 October 2022</li> </ul>	Approval	Chair	Paper
	5.	Actions and Matters Arising	Approval	Chair	Paper
	6.	Chief Executive's Report <ul style="list-style-type: none"> <li>Acute Provider Collaborative MoU</li> </ul>	Information	Chief Executive Officer	Late Paper

### Board Sub-Committee Chair's Reports

10:05	7.	Audit Committee Chair Report	Assurance	Committee Chair	Paper
	8.	Quality and Clinical Governance Committee Chair Report	Assurance	Committee Chair	Paper
	9.	Finance and Business Performance Committee Chair Report	Assurance	Committee Chair	Paper
	10.	Charitable Funds Committee Chair Report	Assurance	Committee Chair	Paper
	11.	Strategic People Committee Chair Report	Assurance	Committee Chair	Paper

### Performance

10:20	12.	Integrated Performance Report	Assurance	Chief Operating Officer	Paper
	13.	Tier 1 & 2 Elective Recovery Programme; Board Self-Certification	Assurance	Chief Operating Officer	Paper

QUESTIONS FROM THE PUBLIC

COMFORT BREAK – 10 minutes

### Finance

10:50	14. Monthly Finance Report	Assurance	Chief Finance Officer	Paper
	15. BHT Charitable Fund <ul style="list-style-type: none"> <li>Resolution to Consolidate Funds</li> <li>Investment Policy</li> <li>Fundraising Policy</li> </ul>	Approval	Chief Finance Officer	Papers

## Quality

11:10	16. Mortality and Medical Examiner Annual Report	Assurance	Chief Medical Officer	Paper
	17. Maternity Services <ul style="list-style-type: none"> <li>Maternity and Neonatal Services in East Kent</li> <li>Ockenden Visit Feedback</li> </ul>	Assurance	Chief Nurse	Papers

## Risk and Governance

11:30	18. Corporate Risk Register	Assurance	Chief Nurse	Paper
	19. Board Assurance Framework	Assurance	Chief Executive Officer	Paper
	20. Committee Effectiveness	Assurance	Trust Board Business Manager	Paper

## Information

11:50	21. Net Zero Carbon Audit	Information	Chief Commercial Officer	Paper
	22. BHPL Annual Report	Information	Chief Commercial Officer	Paper
	23. Private Board Summary Report	Information	Trust Board Business Manager	Paper
	24. Trust Seal Report	Information	Trust Board Business Manager	Paper

## AOB

11:55	25. Risks identified through Board discussion	Discussion	Trust Board Business Manager	Verbal
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ANY OTHER BUSINESS

QUESTIONS FROM THE PUBLIC

Date of Next Meeting:  
25 January 2023, 9:30am

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

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

## **TRUST BOARD MEETINGS**

### **MEETING PROTOCOL**

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

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

Members of the public will be given an opportunity to raise questions related to agenda items in advance of the meeting by emailing: [bht.communications@nhs.net](mailto:bht.communications@nhs.net) or on the day of the meeting by texting or WhatsApp to 07920 590292.

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

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

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

David Highton  
Trust Chair

## THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

### **Selflessness**

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

### **Integrity**

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

### **Objectivity**

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

### **Accountability**

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

### **Openness**

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

### **Honesty**

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

### **Leadership**

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

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

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item 22</b>	Dylan's Story (Patient Story)
<b>Board Lead</b>	Karen Bonner, Chief Nurse
<b>Type name of Author</b>	Heather Brown, Patient Experience Improvement Manager
<b>Attachments</b>	None
<b>Purpose</b>	Discussion
<b>Previously considered</b>	Q&CGC 16.11.2022

### Executive Summary

This paper summarises the patient experience of an 18-year-old who was admitted to St Francis ward on the NSIC unit.

The patient was initially admitted for 1 week of rehabilitation which was extended due to his complex care needs and specialist management of a pressure ulcer, which includes the requirement of being on bed rest for a prolonged period of time.

Following a decline in Dylan's (the patient) mood due to the change in care arrangements and missing home, the play specialist along with staff on the ward, decided to intervene to try and improve Dylan's experience while in their care. Linking with our communications team, contact was made to Dylan's favourite football team.

The NSIC continues to develop an outstanding CYP service at Stoke Mandeville Hospital. As the only setting suitable for the care of CYP SCI patients it is key to listen to the voice of the child to ensure their experiences while in our care are the best they can be, both clinically and emotionally.

This story was noted by the Quality and Clinical Governance Committee on 16 November 2022.

Dylan's Story - <https://youtu.be/GbnLBFyR9F4>

<b>Decision</b>	The Board is requested to discuss the patient story and reflect and learn from the feedback provided.
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### Relevant Strategic Priority

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

<b>Patient Safety</b>	Impact on quality and safety standards and patient experience
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	None
<b>Financial</b>	Financial impact of clinical variation, avoidable harm and length of stay and complaints.
<b>Compliance CQC Standards</b>	Person centred care, safety, safeguarding, complaints, Duty of Candour compliance
<b>Partnership: consultation / communication</b>	Working with key stakeholders in quality, safety and experience including the paediatric wards.

<b>Equality</b>	Potential for inequality due to known health inequalities across the county. The current Covid-19 pandemic has been found to disproportionately impact on specific patient groups e.g. men, over 50s and BAME. Risk of discrimination of patients from diverse backgrounds and poorer socio-economic communities.
<b>Quality Impact Assessment [QIA] completion required?</b>	No - all policies impacting on activity referred to in this report have undertaken Equality Impact Assessments including: Duty of Candour and Being Open and Incident reporting including the Management of Serious Incidents

## 1 Introduction/Position

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

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

## 2 Problem

During his admission, Dylan's mood became low and was a concern to staff and his parents. He seemed to be struggling with the combination of prolonged bed rest, staying in his room, missing home/family/pets and especially missing his football. Dylan's home is in the north-east of the country, a 6-hour drive from Stoke Mandeville hospital making him feel isolated from what he knows and loves. Dylan also found it hard to be moved from a Children's ward to an adult respiratory ward during his recovery.

## 3 Possibilities

Dylan is a lifelong Newcastle football club supporter, season ticket holder, and attends matches on a regular basis. Any games he cannot attend in person he watches on television. He has met various members of the team on match days and during local hospital admissions.

As part of a collaborative piece of work to improve patient experience, the communications team reached out to our NHS colleagues in Newcastle who link with football charities. Within 48hrs staff had received a video message from one of the players. This was passed onto Dylan and his mum on the ward. We found out later that the message was from his favourite player. His mum sent the following response.

*'Omg thank you so much, he is buzzing he is going to send him a video back. Would you be able to get the message to Bruno please?'*

*It's definitely made his morning and now he is having an hour of the ventilator too'*

## 4 Proposal, conclusions recommendations and next steps.

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

A recent report (Good Childhood Report 2022) shows that children's happiness continues to decline. Young people are on average less happy with their life as a whole, school, friends and how they look than ten years ago. Young people are telling us what needs to change, and we must listen. By acknowledging and acting on Dylan's psychological wellbeing staff have

demonstrated the positive impact this can have on his medical outcomes. By improving Dylan's mood, he was able to spend time off his ventilator. A key step in Dylan's recovery and taking steps to get back to treatment closer to home.

## **5 Action required from the Board/Committee**

5.1 The Board is requested to:

- a) Reflect on the feedback provided by the patient and their family
- b) What learning can come from the feedback/story provided to either celebrate or learn from.

## Meeting: Trust Board Meeting in Public

Date: Wednesday, 26 October 2022

Time: 09.30 – 11.30

Venue: Jubilee Room, The Gateway, Aylesbury and streamed live to the public

### MINUTES

#### Voting Members:

Mr D Highton (DH)	Trust Chair
Mr N Macdonald (NM)	Chief Executive Officer
Ms K Bonner (KB)	Chief Nurse
Mr R Bhasin (RB)	Chief Operating Officer
Mrs N Gilham (NG)	Non-Executive Director
Mr J Lisle (JL)	Non-Executive Director
Mr A McLaren (AM)	Chief Medical Officer
Mr T Roche (TR)	Non-Executive Director

#### Non-Voting Members:

Mr D Dewhurst (DD)	Chief Digital Information Officer
Miss H Hornby (HH)	Board Affiliate
Dr M Johnson (MJ)	Board Affiliate
Mrs B O'Kelly (BOK)	Chief People Officer
Ms A Williams (AW)	Chief Commercial Officer

#### In attendance:

Miss J James (JJ)	Trust Board Business Manager
Mrs E Jones (EJ)	Senior Board Administrator (minutes)
Mrs Y Ahmed (YA)	Deputy Chief Finance Officer (via MS Teams)

#### 01/10/22 Chair's Welcome, introductions and apologies

The Chair welcomed everyone to the meeting. Apologies had been received from Adrian Hayter, Associate Non-Executive Director, Dipti Amin, Non-Executive Director, Rajiv Jaitly, Non-Executive Director, Mo Girach, Associate Non-Executive Director and Barry Jenkins, Chief Finance Officer; Yasmin Ahmed, Deputy Chief Finance Officer was attending in his place.

#### 02/10/22 Declarations of Interest

There were no additional declarations of interest declared.

#### 03/10/22 Minutes of the last meeting

The minutes of the last meeting held on 28 September 2022 were **APPROVED** as an accurate record.

#### 04/10/22 Actions and matters arising

The Board **APPROVED** the action log and noted the audit of the annual net zero was deferred until the November meeting to allow for further validation of energy data.

05/10/22

## Chief Executives Report

NM highlighted the 62-day cancer performance was of concern to the Board and the organisation and would be discussed in detail in the Integrated Performance Report agenda item.

The continued pressure in community and hospital services and emergency care and the increase in the numbers of patients medically optimised for discharge was highlighted. NM informed the Board of a productive session he and RB had held with colleagues from the Council and the Integrated Care Board looking at funding, investments, risk sharing, additional commissioning resource and support to wards around discharge coordination. NM noted the Olympic Lodge had opened in addition to other workstreams to support and mitigate the deterioration of performance.

NG queried if there was a trajectory which would show the impact of these initiatives. NM explained the detail was within the Winter Plan agenda item however it was noted it was difficult to be exact as there were large parts of the plan which were out of the Trust's control. NM stressed the importance of halting the continued deterioration and improvement going forward, noting the pressure the social care sector was under particularly due to cost of living challenges.

The Board **NOTED** the report.

06/10/22

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

NG updated the Board on the meeting held on 27 September, highlighting the ongoing medically optimised for discharge challenge, cancer performance and training compliance (noting this was improving month on month). There had been a deep dive into emergency care and winter planning. It was noted the month 6 finance report was tracking to plan however there were still mitigations to be delivered and a potential overrun on plan. Work was ongoing on compliance with procure to pay processes. The Committee were assured on progress re the Data Security Protection Toolkit and the contract for Cardiology Business Case which had been approved was recommended to Board for final approval. The bi-annual property services report had been noted including the new compliance with medical gas legislation.

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

07/10/22

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

KB updated the Board on the meeting held on 19 October highlighting assurance reports had been received covering learning from never events; updates and progress made on the Care Quality Commission action plan following the visit in February; Infection Prevention Control, noting a thematic review was taking place on Clostridium Difficile infections; Clinical harm reviews; paediatric early warning scores and mortality reviews. There were emerging risks around the harm review process and the Trust was triangulating incidents related to delays and documentation of the auditing scoring tool. It was noted there had been some early cases of flu and increasing numbers of Covid 19 cases.

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

08/10/22

## Organ and Tissue Donation Committee Chair Report

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

09/10/22

## Integrated Performance Report (IPR)

RB highlighted the challenges in the emergency care pathway, driven by an increase in the number of medically optimised for discharge patients. Cumulatively after a sustained period at the end of September of the Trust being at the highest escalation level of Opel 4, the Trust declared an internal critical incident at the beginning of October. Through

focussed effort this had been deescalated, and the Trust was now in a more stable position.

The urgent community response team had delivered a responsive service and increased referrals of over 20% due to working hard with primary care colleagues to support people in their own homes to prevent a potential admission or attendance at the Emergency Department. There had been good progress on the virtual wards programme which was on track to hit trajectory and was focussed on frailty and supporting people in their own homes or in care homes with remote care.

#### Quality and Safety

There were positive safety maternity indicators around perinatal care and a positive peer review by the regional maternity team had been received. The hospital standardised mortality ratio had returned to normal levels following issues due to a backlog in coding.

#### A Great Place to Work

There had been a focus on retention; a cost of living package had been launched to support colleagues; recruitment was ongoing with domestic graduates and overseas nurses to support a reduction in reduce vacancy rates. Temporary staffing levels were higher than forecast due to vacancy rates and continued operational pressures. Planning for winter included how best the Trust could resource these areas given the potential additional pressures to come.

#### Cancer Performance

The Trust had a significant 62-day performance backlog. Approximately 15% of the overall patient waiting list were waiting longer than 62 days which made the Trust an outlier regionally and nationally. An improvement trajectory was in place which was currently behind, driven by the delay in opening new capacity such as the skin cancer centre in Amersham which was now open; recruitment of staff and challenges in the development of tracking and validation teams. There had also been delays in moving to best practice pathways nationally however good progress was being made.

RB noted he and AM were engaged in detailed tumour site discussions with the teams in the major areas such as; skin, colorectal; urology and ear, nose and throat to understand the drivers of the backlog position and to put plans in place to reduce these. There had been significant changes in the past few weeks such as best practice pathway for prostate cancer which would speed up cancelled delivery. Additional capacity had been brought in through an additional provider in Dermatology to try and help clear the skin cancer backlog ahead of new staff starting later in the year and a new way of working to see 2-week wait patients for the colorectal pathway.

In response to a query from TR, RB noted there had been an increasing number of patients not attending appointments in outpatient services and to tackle this the Trust were sending out an increased number of reminders to patients and enabling two-way text messaging. The cost of missed appointments was also included in these messages, both financial and the cost to other patients on waiting lists. RB highlighted the work being done with AM on creating more bespoke services to patients such as out of hours working and virtual clinics.

JL queried if the Trust had enough capacity to meet future demand and what could be done now to enable the Trust to have more resilience going forward. RB explained detailed demand and capacity planning had been undertaken by individual tumour site which showed the Trust should have sufficient capacity to meet demand, however, there has been a significant increase in referrals in some tumour sites, so some remodelling would have to be undertaken, recognising this was a national issue and work was underway with primary care to improve the quality and speed of referrals. Regarding operational capacity; the teams were looking to provide a 24/7, 52-week service working flexibly with the cancer clinical teams to build multi-disciplinary resilience. AM highlighted the significant increase in cancer referrals reflecting the aging population and increase in obesity which was a cause of cancer. It was necessary to build resilience and focus on improving the health of colleagues and the population. AM

highlighted the Trust had retained the one stop pathway for breast patients although this had been difficult due to the volume of patients. Other initiatives were the fit testing of blood and stool samples which were changing pathways to best practice and reshaping the workforce allowing nursing and other clinical members to filter patients to get the right patients to a consultant quickly.

JL queried if it were possible to overbook patients for some screening appointments to ensure no slots were lost. RB explained the high volume 2-week wait clinics were already heavily booked. RB highlighted the clinical harm process in place for patients waiting over 62 days.

NM highlighted the Trust had not met the trajectory for the cancer 62-day standard and queried if there was any learning from a Board assurance point of view or whether there were different questions the Board should have asked to test the plan. RB noted the need to drill down into the processes and clinical pathways to gain assurance which the Board needed to reflect on.

DH noted the Trust was moving to best practice pathways and changing and developing the workforce but queried how quickly the Trust could move to follow these pathways to gain learning from others and what resilience and internal contingency there was within these pathways. RB explained job planning across all the specialities was underway to ensure there was enough capacity across the whole workforce not just consultants and this would feed into operational planning.

DH requested a breakdown of the cancer tumour site backlog came to Board.

**Action: Presentation of cancer backlog into individual tumour sites to Board – RB**

NG queried if there were barriers to recruit into the revised workforce models and whether specialists were attracted to the Trust. In addition, NG queried how existing staff working in the cancer teams were coping with the pressure they were under.

BOK explained there was a gap in supply and demand for specialist nurses and clinicians. However, the Trust was good at training and growing its own specialities and attracting nurses and clinicians who wished to progress their careers, and this would be built into realistic plans recognising training takes time.

BOK noted the health and wellbeing of the workforce was a focus for the organisation and whilst stress referrals were going up, the number of colleagues off sick due to stress was going down.

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

10/10/22

## Operating Plan

RB provided an update of progress against the operating plan and strategic objectives noting the following highlights:

- There had been a reduction in 78-week waiters; the skin cancer centre in Amersham was open which brought dermatology and plastics colleagues together with additional operating and consulting rooms.
- The CQC action plan was being worked through at divisional level before going to the Executive Management Committee.
- Virtual wards were being expanded with a focus on respiratory and frailty.
- The cost of living package for colleagues was having significant uptake which was likely to grow.
- There had been development of a new data centre with an upgrade of the patient administration system.

In response to a query from HH, RB noted there had been a joint CQC and Ofsted inspection in community paediatrics and children's therapies (SEND inspection) which highlighted the length of waiting times and work was ongoing with partners in the Council to

reduce these times. The work was being led clinically, reviewing patients and multi-disciplinary working to provide better services to children in the county.

In response to a query from TR, BOK explained the cost of living package included a Domestic Emergency Fund which was financially supported by the Trust's charity. The Strategic People Committee would review how this was working; however, it was clear it would need to continue to be resourced.

**Action: Strategic People Committee to monitor interest in Domestic Hardship Fund and uptake of available services.**

In response to a query from TR, NM highlighted the issues around medically optimised for discharge were significant for partners in the Council and work was ongoing to create a single integrated intermediate care service.

In response to a query from TR, AW explained the Centre of Excellence was an 8-week programme and a report would come back to Board.

**Action: Centre of Excellence report to come to Board in December – AW**

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

11/10/22

### Winter Resilience Plan

RB noted the winter would be challenging and the organisation would need to focus on risk, safety, the workforce and being agile in response. The following points were highlighted:

- A focus on admission avoidance with senior decision makers at the front door.
- There was a lack of beds at Stoke Mandeville and additional capacity would be opened including Olympic Lodge, the new paediatric building and virtual wards.
- Focussing on discharge and social needs; working with the Fire Service and Sodexo looking at both cleaning and support for patients to prevent barriers to discharge.
- Ensuring the right processes were in place to ensure flow through the hospitals.
- Resilience of the workforce which included the cost of living package, providing rest areas and the flu and Covid vaccines.
- Ensuring robust and accurate communication.
- Flexibility was important and agreeing escalation plans early to support patient care.

AM recognised there had been national conversations around interpreting healthcare risk suggesting clinical colleagues took more risk when discharging patients into the community and weighed up the risk of admitting a patient into hospital against not admitting. The risks of admitting the frail and elderly were deconditioning and exposure to hospital acquired infections. It was often better to maintain people in their own home with support. Current strategies were focused on how to avoid admission because this was safer for the patient and working with the medical team to focus on providing support in order for people to stay in the community which was a great strategy for the future.

KB noted the Trust was an Integrated Trust and therefore the community services were a key part of this strategy and were working hard on admission avoidance.

NM noted the critical challenge of the Trust being under significant pressure and the length of time patients were waiting for care compared to pre-pandemic, recognising the stress this caused for clinical teams and queried if teams were receiving reassurance around the psychology of this change recognising the Trust did not want to accept this as how it wished to delivery care in the future. KB explained the senior teams were visible and speaking to those involved on a regular basis to provide support and reassurance recognising the wellbeing services were there for everyone to access.

AM noted the need for clinicians to look at the wider picture, be aware of the backlogs in the cancer pathway and to work efficiently to deliver care and adopt new ways of working in a timely manner.

In response to a query from JL, RB noted metrics were measured on a 24/7 basis with statuses shared and close working with partners on approaching risk and understanding the different measuring metrics.

**Action: weekly reporting of Winter Plan metrics to EMC (RB)**

DH queried the latest situation regarding possible industrial action. BOK noted the RCN ballot was open until 2 November and other unions were moving to open ballots.

MJ queried best practice regionally and nationally around staff resilience. BOK explained the staff survey revealed the health and wellbeing offer and how people feel about speaking up the Trust was higher than average recognising the challenges around estates and the impact on colleagues and their access to rest areas which was being addressed for this winter. BOK noted she met with other local Chief People Officers on a weekly basis to share best practice.

In response to a query from DH, RB provided assurance the theatre currently being used for intensive care would be freed up for use by day surgery once the new paediatric building had opened.

AW thanked the garden volunteers for creating great outside spaces for colleagues to use.

The Board **APPROVED** the plan.

12/10/22

Finance report

YA provided an update on the month 6 financial position noting the Trust was reporting a £9.6m deficit which was slightly adverse of the plan. The detailed forecast was currently in line with the £17.6m deficit however the plan showed £15m mitigations needed to be developed to ensure the plan was met. Regarding clinical income, a couple of contracts were in the process of being negotiated which may cause a £1.7m risk if not agreed on a block basis. The capital position was currently forecasted to overspend by £5.9m. Mitigations were being looked at to ensure the CEDL limit was met and mitigations were currently at £1.7m. The capital position across the ICS was being reviewed as it was a system target and important to understand from system partners if there was any slippage to support the Trust's risk.

BOK noted F&BP Committee had looked at pay spend, noting this had gone up in month 6 and the temporary pay spend had gone down which reflected the 2022 agenda for change pay award paid to colleagues in September and an adjustment made to correct an error in reporting respectively. Work was ongoing with divisional teams to reduce temporary staffing spend by bringing in new colleagues whilst recognising operational demands.

In response to a query from JL around the radiology business case, RB noted these were extra costs due to installation issues noting that future cases would allow for cost overruns recognising the issues with the Trust's estate.

NG highlighted the extensive work ongoing between the finance team and divisional directors to obtain granular understanding of potential capital overruns and mitigations.

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

13/10/22

Annual Equality, Diversity and Inclusion Report (ED&I, WRES, WDES, PSED)

BOK commented on the progress made including the ethnic makeup of the Board and senior leaders and the improvements in recruitment processes. It was recognised there

was more work to do. The staff networks provided lived experiences and honest feedback to support moving forwards and making improvements.

NG noted bullying and harassment continued to be an issue and queried what more could be done in this area. BOK highlighted the work of the Freedom to Speak Up Guardian team and champions noting the number of formal issues being raised had reduced due to issues being addressed informally. Regarding violence and aggression from patients and their families, BOK noted the message being spread was this was unacceptable, and it was vital to give colleagues confidence to report incidents knowing they would be addressed appropriately.

NG queried the allyship partnering and working for leadership and queried how the Non-Executive Directors could become involved. BOK noted the whole Board would be involved and there had been good feedback from those who had taken part so far and all staff networks would have an Executive Director as a champion.

**Action: Allyship programme for Board members & each network to have a Board champion.**

NG commented on the high levels of lack of disclosure of sexual orientation and/or religion and queried why this was and how the Trust benchmarked against others. BOK noted this was being seen nationally and included disability, recognising there was a confidence and trust issue around what would be done with the data. BOK noted the importance of articulating the benefits which had been the case with race and ethnicity. BOK would check how the Trust compared in benchmarking with other Trusts.

**Benchmarking for disclosure of sexual orientation, religion and disability (NG/BOK offline)**

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

14/10/22 Risk Management Policy

The Board **APPROVED** the policy.

15/10/22 EPRR Assurance Report

The Board **APPROVED** the report for submission to NHS England.

16/10/22 NHS Blood and Transplant Contract

The Board **APPROVED** the contract.

17/10/22 Buckinghamshire Place Health & Wellbeing Strategy

NM noted the Health and Wellbeing Board was the statutory Place committee, responsible for setting the overall Health and Wellbeing Strategy for Buckinghamshire. The Trust played a key role in the delivery of the strategy and had taken leadership and responsibility for the Start Well part. This would need to become embedded into the Trust's overall strategy and would form part of the ICB strategy across the Integrated Care System. The Strategy would be launched both internally and externally and embedded into the Trust's strategic goals.

RB recognised the strategy was positive and created a challenge around how we reorient and focus conversations which aligned with longer term aims such as obesity linked to cancer; community paediatrics; cardiovascular disease; mental health challenges and the importance of these going into the planning for the next few years, where senior leaders in the organisation spend time, noting it was around integration and having the right services for the population.

DD, as the Trust's health and inequalities lead, noted the need for the Trust to enable this to be mobilised across the whole organisation.

The Board **NOTED** the report.

18/10/22 Private Board Summary Report

The Board **NOTED** the report.

19/10/22 Risks identified through Board discussion

- Current cancer performance against the 62-day target.
- National vacancy rates for some professional groups, for example nursing and social workers.
- Pending winter pressures following sustained operational pressure throughout the year so far.
- Unknown impact of potential industrial action.
- Risks to the financial plan noting c£15m of mitigations require development to achieve our planned year end position.
- Rising levels of violence and aggression from members of the public

20/10/22 Any other Business

There was no other business

QUESTIONS FROM THE PUBLIC

There were no questions from the public.

**Date of next Meeting: Public and Private Trust Board Meeting: 30 November at 09.30**

## Public Board Action Matrix

Action ID	Agenda Item	Summary	Target Date	Exec Lead	Status	Update
1342	Public Questions	Presentation of annual Net Zero audit	26/10/2022 30/11/2022	Chief Commercial Officer	Propose close	Within November Board meeting agenda (item for information)
1366	CEO Report	Review presentation and celebration of CARE awards within the Trust Board Meeting in Public	30/11/2022	Trust Board Business Manager	Propose close	To trial inviting CARE award winners to Board meetings in person from 2023
1454	IPR	Presentation of cancer backlog as individual tumour sites to Board	30/11/2022	Chief Operating Officer	Propose close	Within IPR
1343	Committee Chair Report - Charitable Funds	Update to the Board on the ethical framework of the Charity including climate change and net zero	14/12/2022	Chief Finance Officer	In Progress	Action on track for completion in line with December due date
1455	Operating Plan	Centre of Excellence report to Board	14/12/2022	Chief Commercial Officer	In Progress	
1457	Annual ED&I Report	Allocation of Executive Director Champion to each staff network	14/12/2022	Chief People Officer	In Progress	
1456	Annual ED&I Report	Allyship Programme for full Board including NED colleagues	25/01/2022	Chief People Officer	In Progress	
1367	Strategic People Committee Chair Report	Revised organisation approach to be considered and presented to Board regarding increasing complexity of and aggression from patients	29/03/2022	Chief Nurse	In Progress	Work initiated with security and psychology services to review policy, training and practices
1368	Safe Staffing	Integrated safe staffing report including medical and AHP colleagues within acute and community sites	29/03/2022	Chief Nurse/ Chief Medical Officer	In Progress	Workforce Leads from Chief Nurse and Chief Medical Officer teams to work on integrated/side-by-side presentation of nursing and medical data for next iteration of Safe Staffing report where possible, noting greater availability of metrics and mandatory reporting requirements for nursing staffing

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	Chief Executive's Report
<b>Board lead</b>	Neil Macdonald, CEO
<b>Type name of author</b>	Chloe Powell, CEO Business Manager; Hannah Mills, Director of Urgent & Emergency Care Improvement, BOB ICB
<b>Attachments</b>	Chief Executive's Report Appendix 1 – Department of Health & Social Care letter Appendix 2 – CARE value award winners Appendix 3 – Executive Management Committee and Transformation Board Appendix 4 – Place & System Briefing Appendix 5 – Acute Provider Collaborative Memorandum of Understanding
<b>Purpose</b>	Approval
<b>Previously considered</b>	None

### Executive Summary

This report aims to provide an update on key developments over the last month in areas that will be of particular interest to the Board, covering both Trust activity as well as that done in partnership with local organisations in Buckinghamshire (Place), and as part of the Buckinghamshire, Oxfordshire & Berkshire West Integrated Care System (BOB ICS; System).

Appended to this report is a letter from the Department of Health & Social Care regarding Adult Social Care Funding (Appendix 1), a list of the winners of our monthly CARE value awards (Appendix 2), a summary of Executive Management Committee and Transformation Board meetings in the last month to provide oversight of the significant discussions of the senior leadership team (Appendix 3), and a Place & System Briefing (Appendix 4).

Also appended is a Memorandum of Understanding (MoU) between Buckinghamshire Healthcare NHS Trust, Oxford University Hospitals NHS Foundation Trust and Royal Berkshire NHS Foundation Trust for the establishment of an Acute Provider Collaborative (APC; Appendix 5). The purpose of this collaborative is for the three organisations to work together in a cooperative and coordinated manner to achieve shared priorities and ultimately benefit the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) and the population it serves.

This MoU is being considered for approval by Boards of the respective provider organisations during November 2022. Annex A outlines the governance and proposed evolution of the APC.

<b>Decision</b>	The Board is requested to note the CEO report and approve the MoU.		
<b>Relevant Strategic Priority</b>			
<b>Outstanding Care</b> ☒	<b>Healthy Communities</b> ☒	<b>Great Place to Work</b> ☒	<b>Net Zero</b> ☒
<b>Implications / Impact</b>			
<b>Patient Safety</b>	Highlights activities in place to support high quality patient care.		
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Links to all strategic objectives of the BAF and highlights any risks of note to the Board.		
<b>Financial</b>	Provides an overview of the Trust financial position.		

<b>Compliance</b> Select an item. Select CQC standard from list.	Updates on any changing or new legislation or regulation of relevance to the Board.
<b>Partnership: consultation / communication</b>	Highlights partnership activities at Place and System
<b>Equality</b>	Highlights activities regarding equalities where relevant, including equality standards and health inequalities
<b>Quality Impact Assessment [QIA] completion required?</b>	Not required for this report.

## Chief Executive's Report

### National context

The Chancellor delivered his Autumn Statement earlier this month, which included a number of announcements relating to the NHS. A key ask was for the NHS, together with public services, to tackle waste and inefficiency, delivering better outcomes for patients and better value for taxpayers. NHS budgets will increase in 2023 and 2024 by £3.3 billion, and £8 billion will be available for the NHS and adult social care in England in 2024-25.

Recovery plans for urgent and emergency care and primary care systems will be published by the NHS in the new year, and the Department of Health and Social Care will publish an independently verified plan for the number of doctors and medical professionals the NHS will need in five, 10 and 15 years' time.

### Outstanding care

Key performance data are reported through the Integrated Performance Report (IPR) and supporting narrative provided. We continue to experience challenges in our emergency care performance in line with the national picture and recognise this does not reflect the high quality of care for all our patients that we aspire to. As part of our winter plan, two of our five key safety metrics are:

- Ability to free up a resus space in Emergency Department (ED) within 15 minutes at all times
- Sufficient staffing to oversee ED escalation areas and avoid ambulance handovers over 60 minutes

This month we re-opened part of our ED following significant refurbishment to improve the space for urgent patient care, as well as the working environment for ED colleagues. My thanks to the public for their patience while these important works took place.

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) have recently published perinatal mortality rates in 2020 (i.e. babies born after 24 weeks who die within 28 days of birth) and provide ratings for Trusts. The Health Service Journal (HSJ), and subsequently the Daily Mail and Daily Mirror, have run a story focusing on Trusts that were 'red rated'. In 2020, we helped to deliver 4,622 babies. Sadly 16 of these babies were stillbirths after 24 weeks and six died within 28 days of being born. We are committed to ensuring that parents-to-be can expect the highest levels of safety when they choose to have their baby with us. A copy of our full public statement is available [here](#).

Our organisation has a very active clinical research function, with studies across a wide range of specialties and in partnership within healthcare and with the academic sector. Despite the impact of the COVID-19 pandemic on clinical research recruitment, we are currently ranked 4<sup>th</sup> in the South East for recruitment numbers this year. This is a fantastic achievement and reflects the efforts of our brilliant Research & Innovation team as well as our numerous clinical colleagues engaged in improving patient outcomes through research. My thanks also to everyone who participates in these clinical studies.

Earlier this month we were honoured to be joined by His Majesty's Lord Lieutenant of Buckinghamshire, Countess Howe, who unveiled our Defence Employer Recognition Scheme plaques and met with Armed Forces colleagues, patients and their families. The Defence Employer Recognition Scheme is an important programme for organisations to pledge, demonstrate and advocate support to our Armed Forces colleagues and community. We currently hold a silver award and are working towards gold recognition. Representatives from

the Royal Air Force benevolent fund, Royal British Legion and local charity, HorseHeard, also attended the event along with Jonnie, a Shetland pony from HorseHeard.

David Highton and I were pleased to welcome Jacqui Rock, Chief Commercial Officer at NHS England, to our two acute sites at Wycombe and Stoke Mandeville, to conduct a strategic review of our estates. We were grateful for the opportunity to discuss our challenges and ideas to improve the environments in which we deliver care and patient experience.

As of month 7 we remain on trajectory to hit our financial plan at the end of the year. I would like to welcome Kishamer Sidhu who joins us as interim Chief Financial Officer. Kish brings a wealth of expertise to the Trust including experiences in healthcare as well as the private sector and I look forward to working with Kish particularly as we turn our attention to the business planning process for the next financial year.

### Healthy communities

Earlier this month I was pleased to have the opportunity to share an update with the Health and Adult Social Care Select Committee in Buckinghamshire on our partnership programme with Buckinghamshire Council integrated intermediate care. The webcast recording of this meeting is available [here](#).

We have now received details of the £500 million Adult Social Care Fund announced as part of the Government's 'Our Plan for Patients' issued in September 2022. A letter from the Department of Health and Social Care is appended to this report (Appendix 1). £300 million will be distributed to Integrated Care Boards (ICB), with the first tranche provided in December 2022, and the second in January 2023. We are working closely with our partners through this process.

I was delighted to attend our Family Nurse Partnership (FNP) Annual Review and 10-year anniversary celebration on 3 November 2022. This was an opportunity to hear from clients, and for friends and colleagues of the FNP to meet the team and the advisory board, and to see some of the methods and tools used by the FNP.

### Great place to work

Over the last two months I have visited all of our community sites specifically to spend time with the teams based across the county, to talk about our organisation-wide priorities for the coming months, and listen to things they are proud of, as well as any concerns they have for their services and service users.

Huge congratulations to Heidi Beddall, our Director of Midwifery, who is part of the 'Turning The Tide Oversight Group' which was named the winner in the NHS Race Equality Award category of this year's HSJ Awards. The Turning the Tide report described the experiences of Black, Asian and Minority Ethnic (BAME) maternity staff and women during the Covid-19 pandemic. One of the recommendations made in the report is to achieve 'equity in career development, opportunity and well-being', and it was the approaches taken to implement this recommendation that were the focus of the award submission. This included development of an anti-racism framework and clinical fellowship programme in collaboration with [CapitalMidwife](#), and development of a mentorship programme for BAME staff in collaboration with the Royal College of Midwives.

Congratulations to Karen Bonner, our Chief Nurse, who has been recognised as one of the 50 most influential BAME leaders in health. Please see the [story](#) on our website for further details.

Alongside Karen and Bridget O'Kelly, our Chief People Officer, I was honoured to be invited to the first Kalinga Convention and Regional Summit, the theme of which was

'Championing the Filipino Nurse'. Joined by external speakers from our Integrated Care System, the Royal Free London NHS Foundation Trust, and NHS England, it was a wonderful opportunity to speak with this community who are an increasingly large part of our organisation, and who provide so much support to our Filipino colleagues. My humble thanks to the Kalinga Filipino Buckinghamshire Health Professional Organisation for organising such a brilliant event.

With a diverse organisation can come challenges, and while we have made positive steps in creating an inclusive environment for our colleagues and patients, we always have more to do. We are currently running an Allyship programme for leaders and managers, recognising that these individuals hold privileged positions in terms of determining how inclusive our organisation is and feels.

The FIFA World Cup gave us opportunity to come together as teams and brighten up our respective corners of the Trust with decorations representing some of the countries competing in the tournament. While I had the privilege of judging the Amersham Day Nursery who so creatively and impressively represented the USA with their array of food, music, and handmade iconic American sites and costumes, it was Ward 4 who were awarded overall winners with their incredible efforts to represent Brazil. Congratulations to everyone who took part, and I hope our patients, visitors and service users also enjoy seeing their efforts.

## **Appendices**

Appendix 1 – Department of Health and Social Care letter Adult Social Care Discharge Fund

Appendix 2 – CARE value awards

Appendix 3 – Executive Management Committee and Transformation Board

Appendix 4 – Place & System Briefing

Appendix 5 – Acute Provider Collaborative Memorandum of Understanding



To:  
CEOs of Integrated Care Boards  
CEOs of Local Authorities  
Directors of Adult Social Services  
CEOs of NHS Acute Trusts  
CEOs of Mental Health Trusts  
CEOs of Community Trusts

Friday 18 November 2022

Dear colleagues,

### **Adult Social Care Discharge Fund – allocations, conditions and metrics**

I am pleased to share details of the £500 million Adult Social Care Discharge Fund (“the Fund”), which was announced as part of [Our plan for patients](#) on 22 September. I know this has been much anticipated since it was announced.

Delays to discharging people from hospital when they are fit to leave continue to be a significant issue and have been highlighted in the conversations I have had in recent weeks with local authorities (LAs), and social care and NHS providers. Not only does this mean fewer hospital beds available for those who need them; it also means people who would be better off recovering at home or in residential care are instead spending too long in hospital.

The Secretary of State and I thank you for your patience in waiting for further details.

We know all parts of the country are facing these challenges. The funding will be allocated to achieve the maximum reduction in delayed discharge:

- £200 million will be distributed to LAs, based on the adult social care relative needs formula (RNF).
- £300 million will be distributed to Integrated Care Boards (ICBs), targeted at those areas experiencing the greatest discharge delays. This is based on a combination of i) a fair-shares distribution based on 2022 to 2023 ICB weighted populations<sup>1</sup> (25% of ICB funding) and ii) a discharge metric flexed to reflect the size of the ICB weighted population (75% of ICB funding).

We expect you to pool the funding into the Better Care Fund (BCF). The funding will be provided in two tranches – the first (40%) in December 2022, and the second (60%) by the end of January 2023 for areas that have provided a planned spending report and fortnightly activity data, and have met the other conditions.

See Annex A for more details of the distribution approach.

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<sup>1</sup> [NHS England » Supporting spreadsheets for allocations 2022/23](#)

## **What the Fund will be used for**

The Fund can be used flexibly on the interventions that best enable the discharge of patients from hospital to the most appropriate location for their ongoing care.

Funding should prioritise those approaches that are most effective in freeing up the maximum number of hospital beds and reducing bed days lost within the funding available, including from mental health inpatient settings. Discharge to Assess (D2A) and provision of homecare is recognised as an effective option for discharging more people in a safe and timely manner.

Funding can also be used to boost general adult social care workforce capacity, through staff recruitment and retention, where that will contribute to reducing delayed discharges.

In some areas where there are particular delays to discharge of patients with long hospital stays – for instance those with particularly complex care needs – a concerted focus on supporting discharge of these patients may be important to free up hospital capacity.

## **Working together**

It is crucial that health and care systems and providers work together across health and social care to meet the care needs of people and make best use of available resources. This includes coming together as joint teams involving NHS organisations, local authorities and social care provider representatives, for instance under the umbrella of Integrated Care Partnerships. The Department expects to work with NHSE and local authorities to support the sharing of good practice and assess the impact of the Discharge Fund.

Partners will need to bring together information across health and social care to monitor and improve the functioning of the discharge pathway. Along with drawing on NHS information tools, NHS bodies and LAs should make use of the Capacity Tracker, at a minimum in line with the [Adult Social Care Provider Provisions statutory guidance](#), to identify vacancies when a patient requires bed-based care and is unable to return to their usual place of residence. Further information on Capacity Tracker requirements and recommendations can be found in annex B, **Funding conditions**.

Updated Hospital Discharge and Community Support guidance will be published to explain new legal requirements around discharge and enable relevant trusts to adhere to them accurately. The guidance has been produced with NHS England to cover the duty to cooperate and the duty to involve patients and carers in discharge planning as soon as it is feasible and where appropriate. I would like to underline the importance of considering the needs of carers who may bear much of the load of caring for someone when they are discharged from hospital and who will often need to be supported by professional health and social care workers.

## **Upcoming publications**

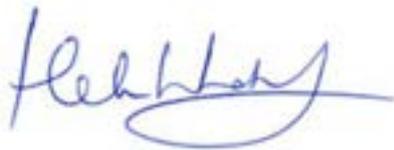
I want to be clear that the government recognises that discharge is just one of several pressures facing the provision of health and social care as we head into winter. For example, we also know that supporting people in their own homes is essential for the health of individuals and to avoid unnecessary admissions to hospital. We are absolutely committed to ensuring those providing and accessing care are prepared and supported to manage these

demands. We will publish our full package of support for adult social care in the coming weeks.

This will include an **Adult Social Care Winter Statement**, which will set out what steps are being taken to support the care sector this winter, and actions for local systems to ensure they are as resilient as possible during the colder months. It will include the updated **Hospital Discharge and Community Support guidance** mentioned above, and further details about the **National Discharge Frontrunners programme**. Finally, we will publish the **Workforce Recruitment and Retention Fund (WRRF) evaluation**, to support the sector to prepare for this winter and support local areas in developing their plans on how to best utilise the workforce portion of this Fund.

The past few years have been some of the most challenging those working in our health and care sector have faced, and you have shown incredible commitment and resilience throughout. Thank you for all that you do.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'Helen Whately', with a large, sweeping flourish at the end.

**Helen Whately MP**  
Minister for Social Care

## Annex A

### Summary of ASC Discharge Fund distribution approach

The Adult Social Care Discharge Fund will be pooled into the Better Care Fund (BCF) and divided as follows:

- £300 million will be allocated to ICBs using NHS England's methodology based on a combination of i) a fair-shares distribution based on 2022 to 2023 ICB weighted populations<sup>2</sup> (25% of ICB funding) and ii) a discharge metric flexed to reflect the size of the ICB weighted population (75% of ICB funding). For the 75% of ICB funding based on discharge data, the allocation shares are calculated as the ICB weighted population share weighted by the proportion of occupied beds with patients remaining in hospital who no longer meet the criteria to reside relative to the England proportion. All allocations are then rescaled by the same factor, to ensure the total matches the available quantum. We have used the published management information on the number of patients remaining in hospital who no longer meet the criteria to reside<sup>3</sup> and the number of adult general and acute occupied beds<sup>4</sup>. We have used the July to September averages, limited to acute trusts with published discharge data (acute trusts with a type 1 A&E department and excluding specialist trusts). Where there is only data published at trust level (e.g., occupied beds), we have used the 1-1 published trusts to ICBs mapping for financial planning and reporting purposes<sup>5</sup>, in line with the published discharge data.
- £200 million will be allocated to local authorities based on the Adult Social Care Relative Needs Formula. Where there have been LA boundary changes, we have used the same ASC RNF allocation shares as those in the Department of Levelling Up, Housing and Communities (DLUHC) final local government finance settlement for 2021 to 2022. This applies to the LA geography changes in April 2019 (Dorset, and Bournemouth, Christchurch and Poole unitary authorities) and in April 2021 (North Northamptonshire and West Northamptonshire unitary authorities).

A full list of the Fund's allocations can be found at

<https://www.gov.uk/government/publications/adult-social-care-discharge-fund-local-authority-and-integrated-care-board-icb-allocations>.

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<sup>2</sup> [NHS England » Supporting spreadsheets for allocations 2022/23](#)

<sup>3</sup> [Statistics » Hospital discharge data \(england.nhs.uk\)](#)

<sup>4</sup> [Statistics » Critical care and General & Acute Beds – Urgent and Emergency Care Daily Situation Reports 2022-23 \(england.nhs.uk\)](#)

<sup>5</sup> [Other NHS organisations - NHS Digital](#)

## Annex B

### Funding conditions

We have set out the conditions for receipt of Funds in an addendum to the BCF framework. LAs and ICBs will be requested to use the Fund to:

- prioritise those approaches that are most effective in freeing up the maximum number of hospital beds, and reducing the bed days lost within the funding available, to the most appropriate setting from hospital, including from mental health inpatient settings. Discharge to Assess (D2A) and provision of homecare is recognised as an effective option for discharging more people in a safe and timely manner. Residential care to meet complex health and care needs may be more appropriate for people who have been waiting to be discharged for a long time boost general adult social care workforce capacity, through staff recruitment and retention, where that will help reduce delayed discharges. This could include, but is not limited to, measures such as retention bonuses or bringing forward pay rises ahead of the new financial year.

To demonstrate this, LAs and ICBs will be asked to work together to provide:

- a plan for spending the funding, which will be an addition to existing BCF plans, due 4 weeks after funding conditions are published. This should outline how the LA plans to increase expenditure on discharge in comparison to their BCF plan. The Department expects to receive one planned spending report per LA;
- fortnightly activity reports, setting out what activities have been delivered in line with commitments in the spending plan. Spending plans should be submitted by 16 December 2022, and the first activity report should be submitted on 30 December 2022; and
- a final spending report provided to the Department alongside the wider end of year BCF reports by 2 May 2023.

The second tranche is contingent on receipt of an initial completed planning template (to be submitted 4 weeks after details of the Fund are published) and meeting of the funding conditions.

As a condition of funding, all local authorities, ICBs and trusts will need to engage with a review in January 2023. Where there are significant challenges, local areas will be offered a package of support to encourage improvement. In these cases, the expectation will be that local areas will implement the recommendations provided by the support programme teams.

There will also be an expectation that all ICBs, trusts and LAs fulfil any existing data collections and continue to engage with data improvement programmes already under way. This forms part of the requirements for receiving the second tranche of funding.

As a minimum social care providers must keep the required Capacity Tracker data updated in line with the [Adult Social Care Provider Provisions statutory guidance](#), however it is acknowledged that more frequent updates to bed vacancy data is essential for operational purposes. We recommend updating bed vacancy data daily, where possible, as this information can be used by local discharge and brokerage teams when planning patient

discharges. Keeping this data up to date is imperative for ensuring that patients are discharged to the right place for their specific care needs. It also assists with keeping both staff and residents as safe as possible by ensuring providers can accept admission of residents whose specific care needs can be met.

## **Annex C**

### **Monitoring**

Along with returns on the number of care packages purchased, the Fund will be monitored using the following metrics:

- the number of care packages purchased for care homes, domiciliary care and intermediate care (to be collected via a new template);
- the number of people discharged to their usual place of residence (existing BCF metric);
- the absolute number of people 'not meeting criteria to reside' (and who have not been discharged);
- the number of 'Bed days lost' to delayed discharge by trust (from the weekly acute sitrep); and
- the proportion (%) of the bed base occupied by patients who do not meet the criteria to reside, by trust.

These metrics have been selected because they are robust, timely, and minimise new burdens. Due to the nature of the Fund allowing for flexibility to respond to local challenges, we have not set overall targets for each of these metrics. Rather, these metrics should guide decisions on how systems spend the funding and will provide a picture during and after winter of the impact of that spend.

## Appendix 1 – Trust CARE values awards

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

August 2022

Category	Name	Role	Nomination	Nominated by
Collaborate	E-Rostering Team	Integrated Medicine	June & July are always busy months for rostering teams as the Trust prepares to welcome a new cohort of Doctors in Training. The centralised e-rostering team in Medicine is a brand-new team that has hit the ground running in ensuring safe medical staffing across the medical teams at BHT. They respond promptly to requests made of them and do their best to support colleagues in providing personal and compassionate care, every time. They have worked collaboratively together to rollout self-rostering for the first time to over 35 medical registrars and 15 A&E middle grades, ensuring colleagues are able to work more flexibly with an improvement in their work/life balance. They will have also produced rotas for over 75 new additional doctors joining the medical teams at BHT. This is a huge undertaking for a new team, and they have done this while also remaining upbeat and responding to the challenges of increased Covid-19 sickness and new escalation wards. We are proud of the work they have done so far - and know there is more to come! Thank you!	Staff
Aspire	Jackie Stacey	District Nurse Aylesbury ACHT	During a late shift (13:00 - 21:00) a colleague was experiencing a problem with a patient who required an ambulance however they were informed that an emergency ambulance wait was currently 15 hours; the patient was in pain and did not have any family/friends who could wait with them. Jackie, during her own time, returned to support her colleague and then waited with patient until 23:00 to liaise with the paramedics, ensure the patient was admitted safely and then lock up the house.	Staff
Respect	Sophie Bruce  Lisa Williams	Registrar  Nurse	Sophie was the registrar cannulating my daughter for her MRI. My daughter has 6 monthly MRIs and they are always traumatic for her and distressing for us, her parents. I always push for a care plan to be put in place or for someone to investigate Chloe's previous admissions to avoid the same situation happening again, but it never happens. Sophie, advocated for Chloe and has followed up to ensure a plan is put in place for future admissions for Chloe before I could even ask. She did everything she could to support Chloe and gave her plenty of breaks, rather than rushing to get the job done, which has often been the case in previous times. I could have selected any category as I feel Sophie's work ethic could be covered by all of them but chose respect as she really had Chloe's best needs and interests and is prepared to stand up for these." My daughter has 6 monthly MRIs with sedation. They never go smoothly and are always traumatic. Today we had Lisa, who witnessed how traumatic the canula process is for my daughter. Instead of just pushing through like all other times, she advocated for Chloe, saying how distressing it is for her and there has to be a better way (something we try and discuss every visit but nothing is ever done).	Patient Relative

			Lisa and the registrar Sophie worked as a team and have sent emails to relevant people to make Chloe's future visits better. Lisa not only cared for Chloe with compassion and a very high standard of care, but she looked after myself and my partner too. She knew when we needed support and she knew when we needed to be alone. This was our 5th MRI and by far the best care we have received. Another traumatic experience but made so much better by just one member of staff (as well as Sophie the registrar). We really feel Lisa and Sophie deserves recognition.	
Enable	Bruno Silva	Senior Implementation Co-ordinator  Informatics	As part of the team who delivered the new intensive care IT system (ICCA), Bruno volunteered to cover 7 night shifts over the 2 week go live support window to support ICU staff as they were getting familiar with using this new application for their role. The ensured that there was night cover for at least one of the sites during the go live window. This was over and above what would have been expected, and this also meant that the staff were supported at an uncertain time, transitioning from paper to an IT system. Thank you Bruno for all your help, I know the staff have greatly appreciated the support.	Staff

September 2022

Category	Name	Role	Nomination	Nominated by
Collaborate	Mike Adams	Ophthalmology consultant / Surgeon	I have nominated Dr Adams as I feel he provided exceptional care to my son, following an eye injury. My son was nervous at his appointments and Dr Adams and his whole team made him feel respected as a patient and put him at ease. On the day that he met Dr Adams, he had already been seen by 5 other BHT consultants, he was overwhelmed and feeling nervous. Dr Adams reassured him about the procedure he needed, his treatment of my son was efficient and caring, he has a chronic health condition unrelated to his eye injury and has been subjected to frequent hospital visits for years and will continue to do so. This was his first experience of visiting a hospital with an injury and he left feeling happy and well looked after. I would like to thank the whole Ophthalmology team that contributed to his care.	Patient Relative
Aspire	Alan Gibson	Lead ENP Emergency Department, SMH	We received the feedback below from a patient who had a positive interaction with Alan: I had to attend A&E following a dog bite which had clearly become infected. I thought long queues were inevitable and tried to get a Tetanus and antibiotics from my GP. Unfortunately, my GP was insistent that I went to A&E, which seemed crazy! My heart sank when I entered the A&E department and saw a room full of people. However, I was called in around 90 minutes after my arrival and was assessed and treated by a staff member called Alan who was such a breath of fresh air. He cleaned the wounds and advised that he would be giving me a tetanus and antibiotics. He advised me on aftercare and what to do if the infection spread. I was extremely impressed with his professionalism and efficiency. He is clearly very experienced and seemed to be genuinely passionate about his work. As someone who runs a healthcare company, I am acutely aware that employees like Alan are worth their weight in gold. I	Patient

			have no doubt that truth be told he probably does the work of 2 or 3 people on his own. Thank you, Alan,!	
Respect	Caroline Rose	Nursery Teacher Amersham Hospital Day Nursery	My son has recently graduated from Amersham Hospital Nursery. I cannot put into words how special this nursery is as a setting and how wonderful all the staff are who look after all the children here. My son who has medical needs and is non-verbal was supported with so much care and compassion by all the staff throughout his time here. His key worker Caroline has supported my son throughout many appointments at nursery, when different therapies such as SALT, OT and Physio have come to visit and assess him in his nursery setting. She has been a great support not just for my son, but for all the family. Caroline really is one in a million. Buckinghamshire Healthcare Trust are very lucky to have such wonderful members of staff running a nursery, that allow other BHT staff to return to work after having children.	Service User
Enable	Giruba Sakthivel Gregory Butler	Senior Information Analyst - Theatres	BHT is working towards introducing a new, high capability Health Intelligence Reporting tool called Microsoft Power BI. Giruba and Greg have whole heartedly supported this project by providing datasets, data logic and analysis to the software development team. They have also given their time to test prototype products giving constructive feedback in the process. They understand the potential that this tool can have in reducing patient waits for elective surgery, improving their experience and also enabling the Hospital to make better use of its human and financial resources at a time when the NHS is under enormous pressure. Their selfless sharing of time and knowledge has spurred the project forward.	Staff

October 2022

Category	Name	Role	Nomination	Nominated by
Collaborate	Sisters Alison Malanaphy, Maureen Malanaphy and Catherine Cueto	Ward managers Wards 4, 7 and 6	The teams from ward 4,7 and 6 all worked together to ensure the wedding of a patient on ward 7 was memorable. They provided a fantastic atmosphere. Staff brought in their own wine glasses from home, decorations and helped to set up. This is truly what nursing is about, demonstrating the CARE values and making a difference. Really proud of the teams.	Staff
Aspire	Louise Weatherill	Practice development nurse neonatal unit	Louise is the PDN on the Neonatal Unit and is passionate about the QI work on the NNU, over the past 12 months Louise has been working collaboratively with the TV network, the Trust QI team and the maternity team to ensure that the implementation of ensuring all babies born at <34 weeks gestation receive breastmilk within the first 24hrs of birth. Her enthusiasm, drive and commitment has seen incredibly positive results seen. Louise recently presented her results at a network meeting and she has received excellent feedback and commendations and been invited to share her project results at Thames Valley Mat Neo SIP shared learning event in march 2023.	Staff

Respect	Hazel Landymore	Advanced Occupational Therapy Practitioner	I have just moved to a new house and was struggling to get permission from the council for some work. Hazel took a phone consultation with me and this was resolved within 24 hours. I was starting to get quite poorly, both physically and mentally and her assistance was amazing.	Patient
Enable	Kirsty Taylor	Ward 3 - Paediatrics	Sadly, had a patient pass away on the ward, expected death but not so soon. I had never experienced a death in my career. Kirsty helped me through the whole process, enabling me to take care of my patient with the upmost respect in a seamless manner, respecting family wishes. Without Kirsty being in charge and guiding me I would have found a difficult situation so much more of a struggle. She ensured the ward continued to run like clockwork, making sure all members of staff were okay. She carried out a debrief at the end of shift. I can never thank her enough.	Staff

## Executive Management Committee and Transformation Board

### Executive Management Committee (EMC) 25 October to 22 November 2022

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

#### **Quality and Performance**

Cancer 62-day performance  
Emergency Preparedness, Resilience & Response  
Annual Report  
Care Quality Commission action plan  
Ockenden insight visit report  
Midwifery staffing six monthly report  
Maternity digital strategy  
Maternity screening report  
Maternity safety quarterly report  
East Kent report  
NHS England Tier 1 and Tier 2 Elective Recovery  
Programme Board Self-certification

#### **Money and estate**

Healthcare Financial Management Association  
(HFMA) financial sustainability assessment  
Waivers of Standing Financial Instructions

Carbon audit  
Business planning guidance

#### **People**

CARE value awards  
Flu and Covid-19 vaccination programme  
Temporary staffing  
Freedom to Speak Up Guardian quarter 2 report  
Supporting our colleagues' safety

#### **Governance**

EMC self-assessment and Terms of Reference  
Corporate risk register  
Board Assurance Framework  
Internal audit report  
*Several policies were approved*  
Minutes from EMC sub-committees

### Transformation Board

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

Transformation Board self-assessment  
Monthly finance report  
Efficiency plan  
Integrated Performance Report  
Integrated Elderly & Community Care deep dive  
Centre of Excellence deep dive  
Winter planning update  
Portfolio updates:

- Urgent and emergency care
- Planned care
- Cancer
- Temporary staffing
- Healthy communities

Energy resilience  
Quality Improvement projects on a page  
Public Sector Equality Duty Report Summary 2021/22

## Place and System Briefing

November 2022

Buckinghamshire Integrated Care Partnership (ICP) System Leaders meetings 8 November

Item	Summary	Impact
National issues	Discussion about the Council budget pressures, and the challenges with social care backlogs shared by other systems.	Council budget constraints could influence the availability of social care funding and thereby impact on the discharge of patients.
System issues	<p>Recognition of more work to do to progress the actions following the written statement of action for Special Educational Needs and Disabilities. Executive Director for Buckinghamshire will be taking forward with a focus on progressing the necessary contracts.</p> <p>In the context of preparedness for winter, agreement to share cost of living support programmes and ensure the pathway for referrals for economically vulnerable people is joined up.</p>	Cost of living challenges continue to impact colleagues and the local community.
ICS development	<p>CEO of BHT is joining the BOB Integrated Care Board as Partner Member.</p> <p>Executive Director for Buckinghamshire is developing an Integrated Care Strategy over the coming months, with a draft anticipated in December.</p> <p>Discussion regarding proposal to develop a place-based partnership for Buckinghamshire.</p> <p>The Integrated Care Board has appointed a Chief Finance Officer.</p>	<p>As Partner Member of the Integrated Care Board, the CEO of our Trust will have greater opportunity to offer insight and challenge at a system level.</p> <p>The Integrated Care Strategy for Buckinghamshire will complement the existing Health &amp; Wellbeing strategy for the county, and the Trust will have opportunity to review and input through the Health &amp; Wellbeing Board.</p> <p>A place-based partnership for Buckinghamshire would establish healthcare and local authority as equal partners.</p>
Health and care integration programme	Update on progress to date of the programme, including reduction of the number of discharge-to-assess beds, and improvement on medically optimised for discharge measures and length of stay. Discussed continued issues regarding funding and recognition that a sustainable model focused on improving patient outcomes needs to be developed with cost options.	Programme goal is to improve the experience of patients medically optimised for discharge.

Summary	Impact
Discussion regarding: <ul style="list-style-type: none"><li>• Non-executive director induction</li><li>• Cost of living</li><li>• Communications strategy with respect to operational pressures</li><li>• Sharing good practice</li></ul>	Continued partnership working and collaboration with organisations in the ICS



**Acute Provider Collaborative (APC)  
Memorandum of Understanding  
Between**

**Buckinghamshire Healthcare NHS Trust, Oxford University Hospitals NHS  
Foundation Trust and Royal Berkshire NHS Foundation Trust**

**Purpose**

The purpose of this Memorandum of Understanding (MOU) is to establish a good-faith foundation between the Parties for future collaborative efforts that are mutually beneficial. The Parties agree to work together in a cooperative and coordinated manner to achieve shared priorities that ultimately benefit the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) and wider population served, whether directly or indirectly.

This MOU does not obligate the Parties to provide funds or payment, nor does it bind Parties to any legal obligations but rather sets out the principles to be adopted to support the three statutory organisations working more collaboratively where there is joint benefit in doing so.

**Operating principles**

The Parties commit to the following operating principles to enhance delivery:

- To work openly and transparently, sharing knowledge and intelligence to inform aligned solutions where appropriate and possible to do so.
- Informed by the health needs of the population of BOB ICS, work together where there is opportunity to reduce health inequalities and improve equity of access.
- Support the exploration and identification of mitigations to service or performance challenges where working together will improve delivery outcomes.
- Reduce costs by doing things once across the three Parties where possible
- Encourage improved recruitment and retention within the system through the exploration, alignment and adoption of innovative staffing models

In agreeing priority areas of work there will be:

- Clear alignment of opportunities to the objectives of BOB ICS and wider NHS England Operating Plan requirements
- Tangible and quantifiable benefits of working together with a clear return on investment
- Strong clinical leadership and sufficient resource to support priorities with all Parties contributing

**Operational framework**

- An annual work plan will be developed and delivered by the APC Executive Delivery Group, framed by the operating principles.

- Delivery against the work plan and resulting benefits will be reported to Trust Chief Executives and Chairs of the APC members.
- An indicative development plan and reporting arrangements for the APC is detailed in Annex A

.....	.....
Neil MacDonald Chief Executive Buckinghamshire Healthcare NHS Trust	David Highton Chair Buckinghamshire Healthcare NHS Trust
Date:	Date:

.....	.....
Professor Meghana Pandit Chief Executive Oxford University Hospitals NHS Foundation Trust	Professor Sir Jonathan Montgomery Chair Oxford University Hospitals NHS Foundation Trust
Date:	Date:

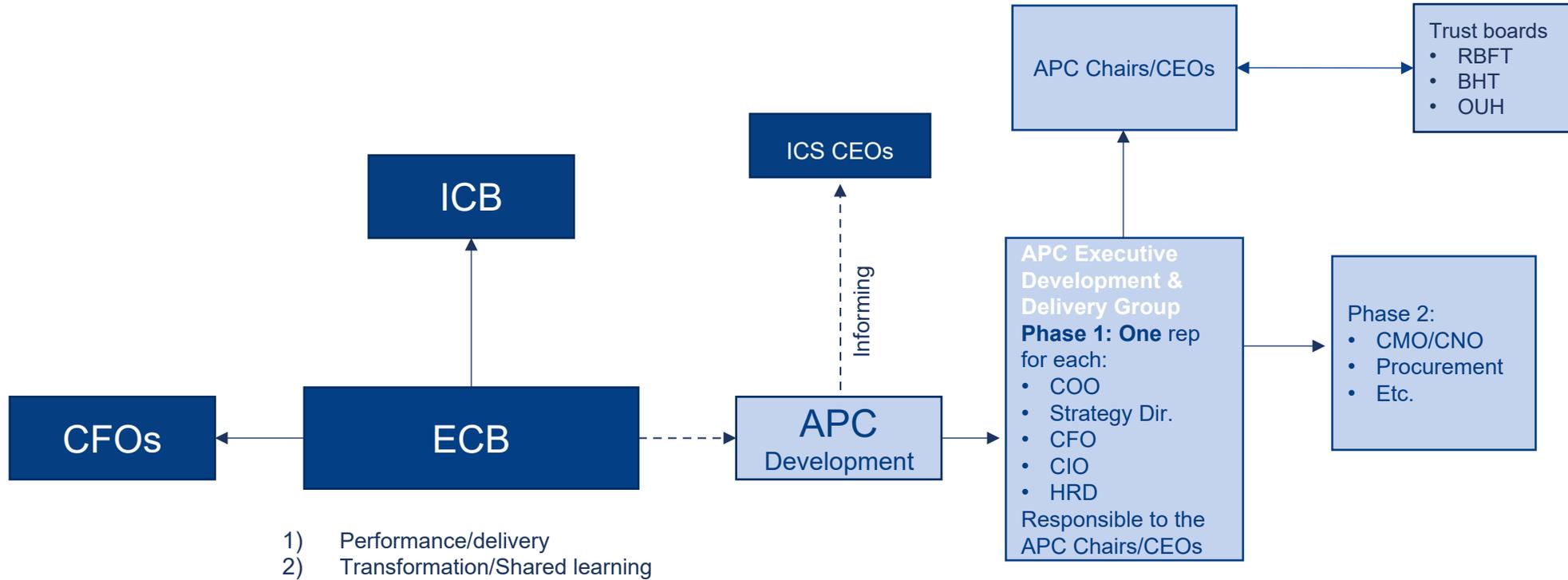
.....	.....
Steve McManus Chief Executive Royal Berkshire NHS Foundation Trust	Graham Sims Chair Royal Berkshire NHS Foundation Trust
Date:	Date:

# APC development

## Annex A

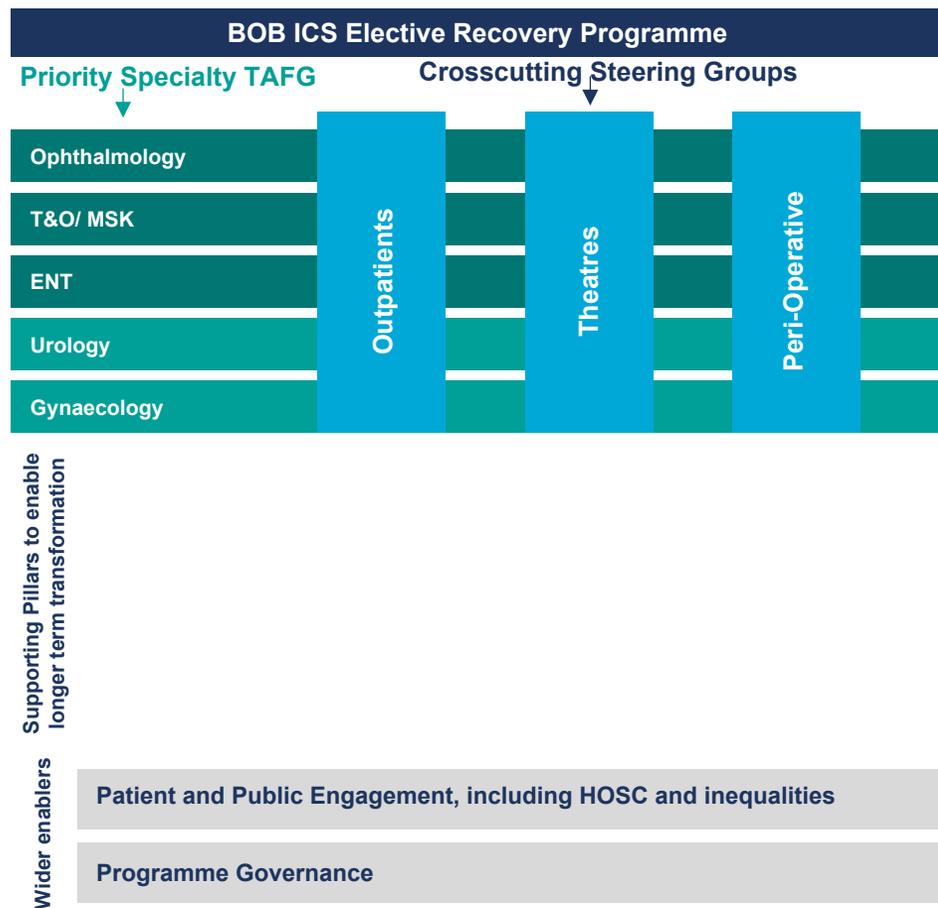
# BOB ICS APC Governance Overview

The proposed governance model for the APC and the link with the ICS Elective Care Board (ECB)



# Evolution of the Elective Recovery Programme

The Elective Recovery Programme (ERP) is a BOB ICS programme, which is overseen by the Elective Care Board (ECB). This governance structure has been in place since September 2021, prior to this there were similar groups operating under the Acute Collaboration Workstream. Currently the remit of the ERP covers five priority specialty Task and Finish Groups (TAFG) and three cross-cutting Steering Groups (SG) with each group having clinical and operational representation from all three Acute providers and is chaired by an Exec level SRO.



## Role of ECB to date

As the oversight forum for the Elective Recovery Programme the Board has prioritised the following across the workstreams:

- Understanding current position and pressures across the system within the particularly challenged areas
- Focuses on collaboration and system transformation, through learning from best practice and system successes
- Developing short term actions and understanding where the largest gaps and pressures are
- Workstream (TAFG/SG) level plans to deliver improved patient experience, performance and quality

## Future Role of ECB and the ERP more broadly

As the Board forms a governance role within the ICB, the ECB will expand slightly in remit to include the following, whilst still maintaining the strong existing structure:

- Clear visibility and oversight of performance of operational targets pertaining to elective care (including diagnostics)
- Develop Elective Recovery Pillar priorities and work with broader ICS programmes and structure to deliver against these
- Increased focus on tangible benefits and impact from cross-cutting themes to deliver specialty level improvements. Improved governance and connection across the SGs and TAFGs

# APC development FY22/23 and next steps

- The approach undertaken to progress APC formation is outlined below and has engaged key stakeholders from across the ICS. The key principles to this approach have been collaboration, transparency and fairness, and identifying opportunities that yield benefit from a system approach including both short term 'wins' for proof of concept, and medium to longer term strategic priorities.
- The governance of the APC will evolve from MOU and collaboration in year one (FY 22/23) through to formal delegation from ICB with Trust resource by FY24/25 aligned to operational planning and ICS strategic priorities. ICS wide programmes will transfer to the APC as the main delivery vehicle, with links to other collaboratives and partners as appropriate.



- Initial paper supported at ECB with approval to progress principles, function and form
- Workshop of CEOs/Execs across the ICS supported development of APC, proposing a number of possible areas for focus

- Agreement of CEOs/Chairs to form the APC via a MOU to confirm intent and operating principles/ framework for collaboration
- Recognition to move to more formal arrangements as APC matures and delegation from ICB is secured

- Bimonthly meeting of the APC Chairs/ CEOs to support briefings, updates and onward communication to Boards
- Formation of operating group of Trust nominated exec leads to input and lead APC development and delivery

## Next steps:

1. Draft MOU to developed with COOs/CFOs be shared with CEOs/Chairs in October for endorsement
2. Trusts to confirm exec leads to form APC Executive Development & Delivery Group (est. November)
3. APC work plan to be developed for 23/24 in Qu4, informed by ICS priorities and NHS Operating plan requirements

# Indicative Roadmap to APC delegation

It is the intention to develop a multi-year programme with the ambition to integrate the benefits of clinical networks and diagnostic workstreams within the APC, supported by a clinical priorities programme.

The initial core focus of the APC is proposed to be:

- Elective Recovery
- Areas of mutual financial benefits
- Digital alignment



# Acute Provider Collaborative – Emerging Opportunities

## Clinical opportunities

Tactical	Strategic
<ul style="list-style-type: none"><li>• Elective recovery - priority specialities and cross cutting areas (peri op, outpatients and theatres)</li></ul>	<ul style="list-style-type: none"><li>• Clinical services strategy – consideration to finance, activity, health inequalities and configuration</li></ul>
<ul style="list-style-type: none"><li>• MSK redesign</li></ul>	<ul style="list-style-type: none"><li>• Diagnostics strategy</li></ul>
<ul style="list-style-type: none"><li>• Diagnostics oversight</li></ul>	
<ul style="list-style-type: none"><li>• Wet AMD treatment change</li></ul>	

## Non clinical opportunities

Tactical	Strategic
<ul style="list-style-type: none"><li>• System wide change teams/improvement approach</li></ul>	<ul style="list-style-type: none"><li>• Digital roadmap linked to Electronic Patient Record</li></ul>
<ul style="list-style-type: none"><li>• Business intelligence</li></ul>	<ul style="list-style-type: none"><li>• Procurement – possibly with a lead provider</li></ul>
<ul style="list-style-type: none"><li>• Medical workforce in the BOB People strategy temporary workforce programme</li></ul>	<ul style="list-style-type: none"><li>• Corporate</li></ul>
<ul style="list-style-type: none"><li>• Workforce planning for some key acute pathways – e.g. ENT, diagnostics and midwifery</li></ul>	<ul style="list-style-type: none"><li>• Workforce wellbeing/support, including occupational health, MSK and MH support</li></ul>

## Report from Chair of Audit Committee

Date of Committee 04 November 2022

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Minutes of the previous meeting</b>	Minutes from the Audit Committee meeting on 1 September 2022	Approved	None	n/a	n/a
<b>Committee Self-Assessment</b>	Results of self-assessment survey and initial recommendations to address these	Assured – noting amendments to be made to the format to encourage participation next year	Set of clear Committee objectives (under development)	n/a	To note as part of the Committee Effectiveness report
<b>Corporate Risk Register (CRR)</b>	Outline of the Trust corporate risks including risks added and removed since the previous report	Assured – comments on specific risks to be taken back to executive leads within monthly 1:1 meetings; radiology reporting, HVLV completion, cyber security, Trust capital and medical specialist training	Dashboard reporting to be provided from Datix system	Reporting on radiology backlog to Finance & Business Performance Committee  Strategic People Committee to consider the national shortages in medical speciality colleagues and training	To discuss and take assurance from the updated risk register

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Board Assurance Framework (BAF)</b>	Outline of principal risks to the achievement of Trust strategic objectives in revised reporting format	Assured – noting a more comprehensive report, with actions driven by gaps in assurance	Clearer articulation of the feedback/closure loop on actions	n/a	To take assurance from revised BAF
<b>External Audit</b>	Verbal update on current position with External Audit	Noted – including risk related to position both locally and nationally	n/a	Ongoing work to confirm External Audit provider for BHT Charity for current year and main Trust auditor for next year  Confirmation of NHS experience of proposed External Auditor and further discussion with regional NHSI/E on issues we are seeing	None

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Internal Audit; Progress Report</b>	Update on progress with annual plan including presentation of two new reports: - Data Management (PA)* - Business Cases (RA)*	Assured – updates provided by Executive team noting potential risk to HOIA opinion for 2022/23 but also noting that IA work is directed at areas of risk and therefore the key to resolution is acting on identified and agreed actions.	Ongoing work on individual management actions	Reports shared with EMC with a specific request for expedited work on agreed actions and reducing requests for extensions to deadlines	n/a
<b>Internal Audit; Recommendations Follow Up Report</b>	Update on actions and recommendations followed up since last meeting	Assured – noting updates had been provided for all updates and more realistic deadlines being set and committed to	None	Monthly outstanding action report to EMC	n/a
<b>Local Counter Fraud Specialist (LCFS) Progress Report</b>	Update on outcomes of Counter Fraud work undertaken September-October 2022 including emerging risk, actions and mitigations and adherence to NHSCFA requirements	Assured	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Benchmarking Report</b>	Report allowing comparison of single tender waivers used within the Trust across a number of other NHS and health sector organisations	Assured – recognition of challenges related to last minute capital allocations and introduction of EMC review of STW reports	None	EMC to be reviewing the STW report with a view to reducing the necessity for STWs – particularly those classified avoidable and retrospective (see below)	n/a
<b>Single Tender Waivers (STW)</b>	Overview of STW between September-October 2022 including those considered to be avoidable and retrospective (revised report format)	Assured	Identification of barriers to following correct processes	Assurance requested from EMC re: consideration of waivers and multiple tenders	n/a
<b>Losses and Special Payments</b>	Summary of YTD losses including pharmacy and patient property	Assured	Information on pharmacy write offs being in line with shelf life (>1 year) to be reported	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Minutes of Finance &amp; Business Performance Committee</b>	Minutes from F&BP Committee Meeting 27 September 2022 (approved)	Noted	Review of annual workplan for Committees by Audit Committee in January 2023	n/a	n/a
<b>Minutes of Quality &amp; Clinical Governance Committee</b>	Minutes from Q&CG Committee Meetings; 21 September 2022 (approved)	Noted		n/a	n/a
<b>Minutes of Strategic Workforce Committee</b>	Minutes from SWC Committee Meeting 12 September 2022 (draft)	Noted		n/a	n/a

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

### Emerging Risks Identified:

- Radiology reporting backlog; further detail to be considered by the Finance & Business Performance Committee.
- Ongoing risks related to both the internal and external Wycombe Tower estate.
- Medical specialist training places nationally and the impact of this locally including ophthalmology.
- National shortage of specialty medical colleagues including radiologists and community paediatricians.
- Head of Internal Audit Opinion for 2022/23 noting the importance of closing assurance gaps through implementation of actions.
- Current position with External Audit appointment for the current year noting national picture.
- Data quality noting actions in place through internal audit work.
- Cost of living and impact on our colleagues.

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

**Date of Committee** 16 November 2022

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Meeting Minutes</b>	Minutes from the Q&CG meeting on 19 October 2022	Minutes approved	None	Refer to Audit Committee for noting	n/a
<b>Divisional Service Review; WCSH</b>	Deep dive into the Women, Children, Young People and Sexual Health Division (WCSH) including governance, strategy and key quality metrics	Assured	None	n/a	n/a
<b>Maternity and Neonatal Services in East Kent; Reading the Signals Report</b>	Summary of the East Kent maternity report and overview of immediate steps taken by the Trust	Assured – noting positive feedback from HSIB, outputs from internal review and proactive approach from maternity colleagues	Awaiting national steer on next steps  Ensure learning is applied Trust wide	None	To note and discuss

<b>Midwifery Staffing Report</b>	Overview of midwifery staffing and related safety issues for April-September 2022 in line with recommendations by the maternity incentive scheme	Assured – noting progress with active recruitment, wellbeing of colleagues through professional midwifery advocates and action planning related to the staff survey and the positive working relationships between midwifery and medical colleagues	None	n/a	n/a
<b>Antenatal and Newborn Screening Programmes Report</b>	Annual report for 2021-22 including programme updates, key achievements, incidents and education and training	Assured	None	n/a	n/a
<b>Ockenden Insight Visit Report</b>	Final report following the South East Regional maternity team visit in August 2022	Assured – noting the positive feedback provided	None	n/a	To take assurance

<b>Integrated Performance Report</b>	Monthly reporting on Trust quality metrics and actions/progress with actions to address negative variance	Assured – noting IPC and SI information was now included within the IPR. Assurance was provided on category 2 pressure ulcers and improved compliance with Treatment Escalation Plan (TEP) completion and complaint response timelines	None	n/a	Take assurance from quality metrics within the report
<b>Patient Experience Report</b>	Patient experience data for Q2 2022-23 including complaints, compliments, PALS and friends and family results plus an update on chaplaincy and Q3 plans	Assured	None	n/a	n/a
<b>NEWS CQUIN Report</b>	Overview of compliance with the National Early Warning Score (NEWS) CQUIN for Q1 2022-23	Assured	None	n/a – no longer required to come through to the Committee (oversight at alternative group)	n/a

<b>Safe Medical Staffing</b>	Update on the Safe Medical Staffing Programme including in Divisions of medicine and surgery, junior doctor exception reporting and education review	Assured – investment in medical staffing within medicine achieved intended benefits	None	Safe Medical Staffing Business Case post implementation review to be considered by F&BP Committee	n/a
<b>Clinical Effectiveness Report</b>	Overview of all activities reported to the Clinical Effectiveness Group during Q2 including clinical audit and clinical and NICE guidelines	Assured – including progress within management actions following Internal Audit Clinical Audit report	None	n/a	n/a
<b>Mortality &amp; Learning from Deaths Report</b>	Twice yearly report providing detail on mortality and the Medical Examiner service	Assured – Committee updated on issues with coding related to HSMR	None	n/a	To take assurance from the report
<b>GIRFT Report</b>	Twice yearly report detailing improvement projects in place following publication of specialty GIRFT reports. Summary of deep dives undertaken and national reports published.	Assured – efforts noted to integrate with QI and business planning processes	None	n/a	n/a

<b>Research &amp; Innovation Report</b>	Overview of challenges and successes from Q2 2022-23 including newly opened studies and a research portfolio summary	Assured – noting the significant amount of research undertaken by the Trust	Joint Research Committee with University of Buckingham	n/a	n/a
<b>Safe Staffing Report (Nursing)</b>	Detailed report on nursing and midwifery staffing for Q2 2022-23 with triangulation to key quality metrics	Assured	None	n/a	n/a
<b>Quality and Patient Safety Group Minutes</b>	Minutes of the meeting held on 27 October 2022	Noted	None	n/a	n/a
<b>Patient Story</b>	Story of 'Dylan' and his admission to St Francis ward within the National Spinal Injuries Centre	Noted	None	n/a	To watch and discuss the contents of the video
<b>Public and Patient Public Sector Equality Duty (PSED) Report</b>	Annual report for 2021-22 summarising Trust activity in line with objectives	Noted	None	n/a	n/a

**Emerging Risks noted:**

- Shortages in specialist staff groups within Children and Young People Services.
- Digital immaturity and impact on quality and safety agenda; noting plans and central funding in place for EPR.

**Report from Chair of Finance and Business Performance Committee**

**Date of Committee** 22 November 2022

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Meeting Minutes</b>	Minutes from the F&BP meeting 25 October 2022	Minutes approved	None	Refer to Audit Committee for noting	n/a
<b>Monthly Integrated Performance Review (IPR)</b>	Monthly reporting on Trust performance metrics and actions/progress with actions to address negative variance. Reporting defined by NHS System Oversight Framework, BHT Strategic Priorities and the 2022/23 Operating Plan	Assured – noting additional metrics on cancer performance, waiting list profiles and theatre productivity.  Committee informed re: drivers of coding issues and discussed provision of additional capacity and ambulance handover times.  Improvement in cancer performance and waiting lists more broadly recognised	Additional focus on analysis of community metrics noting limited availability of community metrics nationally when compared to acute	n/a – noting quality metrics discussed at the Quality & Clinical Governance Committee	For discussion and assurance

<b>Deep Dive; Virtual Wards</b>	Overview of virtual wards including implementation and roll out, milestones and trajectories and finance, governance and risk	Assured – noting virtual wards as part of comprehensive future service provision	Understanding of patient experience of virtual wards recognising the pace of change  Comprehensive organisational comms plan  Further consideration of how to develop ROI metrics, recognising that this is a new pathway being developed	n/a	n/a
<b>Monthly Finance Report</b>	Update on financial position at M07 including YTD headline position, divisional forecasts, balance sheet, capital and cash flow analysis	Assured – noting divisional accountability for budgets and recovery actions in place to enable delivery of the planned deficit  Mitigations in place for energy risk within the current financial year	Greater clarity on the capital position for next Committee meeting (December 2022) – actual versus predicted spend  Greater clarity on overall underlying financial position	n/a	Take assurance from the M07 report noting risks identified by the Committee and mitigations in place/under development
<b>M07 Forecast Outturn</b>	Update on current risk to the year end forecast and financial plan target with revised best, most likely and worst-case forecasts		Clarity on the income stream risk from other ICB – OPBR v block contract	n/a	n/a

<b>Transformation and Efficiency Update</b>	Monthly report on Trust Efficiency Plan including YTD actual against plan and update on priority initiatives	Assured	Build in productivity metrics into the long-term financial plan	n/a	n/a
<b>Strategic Review of Cardiology Services</b>	Review of options for relocation of Cardiology Services at Wycombe Hospital in view of non-compliance with CQC Regulation 15	Noted	None	n/a	Further consideration as part of detailed strategic Board discussion on Wycombe site
<b>Wycombe Key Worker Lease</b>	Update on work re: keyworker housing at Wycombe Hospital	Noted	None	Consideration by the BHT Charitable Funds Committee	n/a
<b>Trauma Consumables</b>	Proposal for system-wide long-term agreement for the supply of trauma consumables	Recommended to Board – noting level of clinical engagement and potential for greater future savings	Clarity on relevant governance workstream in future papers relating to Provider Collaborative	n/a	To approve

<b>Business Case Review; Safe Medical Staffing</b>	Post-implementation review of the Integrated Medicine Safe Medical Staffing business case	Assured – benefits of the investment recognised	None	Medical safe staffing within the emergency department; refer to Quality & Clinical Governance Committee for further consideration	n/a
<b>BHPL Annual Report and Accounts</b>	End of year audited accounts and annual report for Buckinghamshire Healthcare Projects Ltd	Noted	None	n/a	To note
<b>Net Zero Carbon Audit</b>	Results of the first audit of the Net Zero Roadmap published in 2021	Noted – including the Trust was behind plan with recovery actions in place	Provision of information on patient transport to hospital appointments	n/a	To note
<b>Committee Self-Assessment Action Plan</b>	Action plan encompassing recommendations from the Committee self-assessment survey results	Noted	None	n/a	To note as part of wider paper on Committee effectiveness

**Emerging Risks noted:**

- Risks to the current financial position including:
  - o Block contract v PbR; impact on income.
  - o Need for robust recovery plans to meet the planned year end deficit.
  - o Ongoing temporary staffing spend.
- Capital position; £5.6m overspend and potential breach of CDEL.
- Energy market; potential risk for the next financial year (2023-24).
- Net Zero Roadmap; behind plan for year 1 noting recovery actions in place.

**Report from Chair of Charitable Funds Committee**  
**Date of Committee 23 November 2022**

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Minutes of the previous meeting(s)</b>	Minutes from the meeting on 24 October 2022	Approved	None	n/a	n/a
<b>Charitable Funds Overview Report</b>	Overview of the Charitable Fund activities since the previous meeting including operational, financial and governance	<p>Noted – including a summary of the Charity Strategy published pre-pandemic noting the focus on proactive fundraising</p> <p>The Committee discussed the appropriate governance for increasing the maximum emergency domestic support fund balance should this be required</p>	None	n/a	n/a
<b>Risk Register</b>	New format of risk reporting covering all current risks to the Charity	Assured	Reformat into traditional risk register and present to next Committee meeting	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Wycombe Key Worker Lease</b>	Overview and update on work re: keyworker housing at Wycombe Hospital	Noted – including the rationale for this project, intended benefits and next steps	Committee raised and discussed relevant concerns to be considered further and addressed at next meeting	n/a	n/a
<b>Charitable Funds Activity and Financial Statements</b>	Statements as of 31 August 2022 including balance sheet, cash flow and open bids and legacies	Assured – noting previous discussions on the best approach to budget setting and need to revisit the processing of Charitable transactions from BHT to Charity  Plans for the annual audit were discussed	Consider production of updated forecast half yearly/quarterly once budget established next year	Audit Committee approval of External Auditor	n/a
<b>Portfolio Investment Report from Cazenove</b>	Update on the current investment portfolio value as of 31 October 2022	Noted	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Fundraising Update</b>	Update to the Committee on Fresh Fundraising activity since the last meeting, other fundraising channels and future plans	Noted – including challenges related to personnel changes in within the Charity team	None	n/a	n/a
<b>Bids for Approval</b>	Bid for the purchase of a mobile c-arm for spinal procedures	<p>Bid for c-arm noted, further information required ahead of Committee approval</p> <p>Committee discussed the importance of bids supporting the wellbeing of colleagues (to be able to deliver better patient care) and a need to proactively promote funds available within the Charity</p>	None	n/a	n/a

**Emerging Risks:**

- Specific risks listed within the risk register paper.
- Management of Charity noting limited resources and significant change within the team.
- Potentially higher rate VAT payments made in BHT rather than via charity; processing of transactions to be reviewed.

## Report from Chair of Strategic People Committee (SPC)

Date of Committee 14 November 2022

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Meeting Minutes</b>	Minutes from the Strategic Workforce Committee meeting on 12 September 2022	Approved	None	Refer to Audit Committee for review and assurance	n/a
<b>Terms of Reference (ToR)</b>	Periodic review of the Committee ToR	Approved	Approved subject to minor amendments; addition of 'retention' as a key Committee duty (as well as recruitment and resourcing) and reference to productivity	n/a	To approve
<b>Chief People Officer Report</b>	Update on key people developments since the previous Committee meeting (September 2022)	Assured – noting broad range of activities in place to support the cost of living crisis for colleagues and staff survey completion so far	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Freedom to Speak Up Guardian (FTSUG) Quarterly Report</b>	Q2 Report for 2022-23 (July-September) including national and local updates, key themes and next steps	Assured – noting work being undertaken to address the increase violence and aggression to colleagues. Ethnicity reporting data was welcomed	None	n/a	n/a
<b>Guardian of Safe Working Hours Quarterly Report</b>	Q2 Report for 2022-23 (July-September) including exception reports, issues raised and next steps	Assured – noting increased reporting following introduction of new system	None	n/a	n/a
<b>People Programme Update</b>	Update on people programmes including: - Recruitment, retention and resourcing - Culture and leadership - Supporting our people - Workforce planning and development - Productivity	Assured – noting continued reliance on temporary staffing and the impact and the impact of the focus on international recruitment more broadly; to both local and overseas colleagues  Risk raised by Audit Committee regarding shortage of radiographers considered	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>Integrated Performance Report (IPR)</b>	<p>Monthly reporting on Trust performance metrics and progress with actions aligned to the Strategic Priorities and the NHS System Oversight Framework</p> <p>September data discussed under 'A Great Place to Work'</p>	Assured – benefits of move to iAspire recognised including ease of completing stat/mand training and provision of a central point of contact for training and development	CDIO to provide detail for focussed push on Data Security training compliance	n/a	n/a
<b>Clinical Education Report</b>	Summary of key educational activities delivered across the Trust in H1 2022/23 (April-September)	Assured – including proactive work with schools by Bucks Health & Social Care Academy	<p>Bucks Health &amp; Social Care Academy seen as good practice regionally; work to be shared at the first BOB People Committee</p> <p>Refer to HEE the 'bulge' in forthcoming 18-year-old population in view of the narrow window to offer routes into health and social care careers to school leavers; consider how BHT will support this</p>	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>People Directorate Risk Register</b>	Review of 'People' risks within divisional and corporate risk registers	Assured – noting all risks were now within the Datix system	Actions and deadlines to be updated within Datix	n/a	n/a
<b>Staff Survey 2022</b>	Update on progress with Staff Survey completion rates across the Trust	Assured – noting champions in place and promotional and supportive activities planned  Committee advised on mechanisms in place to support confidentiality	SG asked to provide update re 'encouraging Doctors to participate as he was unable to attend the committee	n/a	n/a
<b>AOB: Industrial Action</b>	Update on ballots for professional staff groups	Assured – Committee acknowledged the emotional impact on colleagues	National planning response being coordinated by EPRR lead; centred around business continuity plans	n/a	Note potential risk

**Emerging Risks noted:**

- Continued high spend on temporary staffing.
- Incidents of violence and aggression toward colleagues, reflective of the national picture.

- Possible industrial action, noting regular updates provided to Board and national planning exercise underway.
- Compliance with Data Security training, noting improvement in stat/mand training compliance overall and benefits of iAspire system.

**Meeting:** Finance and Business Performance Committee

**22 November 2022**

<b>Agenda item</b>	Integrated Performance Report – For Review		
<b>Board Lead</b>	Raghuv Bhasin, Chief Operating Officer		
<b>Type name of Author</b>	Wendy Joyce, Director of Performance		
<b>Attachments</b>	Trust IPR October 2022		
<b>Purpose</b>	Assurance		
<b>Previously considered</b>	Transformation Board 15.11.2022 F&BPC 22.11.2022		

### Executive Summary

This document provides the Trust’s Integrated Performance Report for review. The report was discussed at the Transformation Board on 15 November 2022. Key points made in discussion include:

- Discussion of the challenges on the Urgent and Emergency Care pathway from the increasing numbers of Medically Optimised for Discharge patients. Discussion of the challenges we are facing ahead of winter, particularly in light of recent increases in flu, and whether our winter plans are sufficient. Recognition that we have tangible increases in capacity to come on stream in the coming weeks as well as new ways of working being trialled. A key focus is around admission avoidance which is particularly being worked on through changes to the acute medical model.
- Recognition of the continued good progress that has been made on international recruitment that is reducing our overall nursing and midwifery vacancy rates. There has been a significant influx of experienced overseas nurses in the Trust over the past few years which has been a real boon to the Trust.
- Noting the improvements that have been made on reducing the Trust’s cancer 62-day backlog.
- Noting the challenges regarding the coding backlog that is affecting the HSMR metric and is explained in more detail in the IPR.

The Finance and Business Performance Committee discussed this report on 22 November 2022 who also noted coding challenges and actions in place and the progress made on both 62-day cancer performance and waiting lists more broadly. The Committee had focussed discussions on ambulance handover times noting additional capacity that had been brought in to support ED flow and bed capacity and plans to implement the push model. Further analysis was to be provided on Community and productivity metrics. The Committee were also provided with a deep dive on virtual wards.

<b>Decision</b>	The Committee is requested to consider performance and risk impact			
<b>Relevant Strategic Priority</b>				
<b>Outstanding Care</b> ☒	<b>Healthy Communities</b> ☒	<b>Great Place to Work</b> ☒	<b>Net Zero</b> ☒	
<b>Implications / Impact</b>				
<b>Patient Safety</b>	Quality and Safety Metrics core part of the IPR			
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Multiple risks within the BAF; 1,4,5,6			
<b>Financial</b>	Financial reporting outlined in the outstanding care section of the report			

<b>Compliance CQC Standards Good Governance</b>	Well Led - Operational planning is a statutory requirement of NHS Trusts.
<b>Partnership: consultation / communication</b>	Trustwide development
<b>Equality</b>	Reducing health inequalities is a core part of our strategy and a core part of the planning requirements for the NHS. Health inequalities metrics included in the health Communities part of the IPR.
<b>Quality Impact Assessment [QIA] completion required?</b>	Not required

# Integrated Performance & Quality Report

October 2022

CQC rating (July 2022) - GOOD

OUTSTANDING CARE

HEALTHY COMMUNITIES

AND A GREAT PLACE TO WORK



# Integrated Performance & Quality Report

## Introduction & Contents

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

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

### Outstanding Care

Provide outstanding cost effective care

#### Operational Standards

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

- Elective Recovery
- Waiting List
- Activity
- Outpatients
- Cancer
- Diagnostics

#### Quality and Safety

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

#### Finance

### Healthy Communities

Taking a lead role in our community

#### Community Activity

- Community Contacts
- Caseload

#### Community Hospitals

- Length of stay
- Discharge Destinations

#### Community Productivity

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

### A Great Place to Work

Ensuring our people are listened to, safe and supported

#### People

- Vacancies
- Occupational Health
- Sickness
- Training

### Report changes this month

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

#### Added

- Acute open pathways waiting list profile
- Cancer 62 day backlog by tumour site
- Urgent community response referral levels

#### Removed

#### Changed

- Number of theatre cases changed to number of theatre cases per list

## Executive Summary

October saw the Trust under continued pressure on the Urgent and Emergency Care pathway as the numbers of Medically Optimised for Discharge patients rose further to their highest ever levels. This culminated in the Trust calling a critical incident on Thursday 6 October. Additional capacity, through the re-opening of the Olympic Lodge facility, came on stream in the second half of the month as part of the Trust's winter plan and helped to reduce pressures in the hospital. As a result the performance of indicators across the Urgent and Emergency Care pathway declined. The challenges in the emergency pathway were compounded by the continued outage of the AdAstra system, which supports the Urgent Treatment pathway at Stoke Mandeville Hospital, as a result of the Advanced cyber attack. This pathway and system has been reinstated at the start of November.

The Trust continues its good performance on reducing the number of people waiting 78 week waits for treatment and remains on track to have zero 78 week waiters by March 2023. In addition, following challenges in September there was a recovery in performance in reducing our cancer 62-day backlogs which although still behind trajectory have reduced significantly and as a result mean that Buckinghamshire is no longer a significant outlier in the South East region or nationally.

Further key points to note from an operational performance and healthy communities perspective include:

- Further improvement in theatre utilisation and the number of cases per list (a new metric focused on theatre productivity). This is despite continued challenges with our ageing theatre estate that has resulted in theatres unexpectedly out of commission for periods across October.
- A levelling off in our the size of our community waiting list with new data included in the profile of the waits in the community waiting list as requested by the Board.
- A stabilisation in the number of non-endoscopy diagnostic breaches following months of sustained increase with recovery plans particularly in Echocardiography starting to impact. Challenges remain regarding MRI capacity with new capacity in November available but absorbed by an increase in 2ww cancer referrals and therefore having limited impact on overall MRI backlog clearance.

Areas of focus for A Great Place to Work include:

- The recruitment and retention of the nursing workforce. We are pleased to have welcomed 70 overseas nurses to the organisation, with a further 38 planned to arrive before the end of the year. We have also been granted NHSE funding to extend this by a further 65 this financial year. Over 70% of our UK graduate nurses who have trained at the Trust are due to join us in the coming months.
- Temporary staffing spend year to date is higher than forecast – key drivers are vacancies and high levels of demand from operational pressures. We are recruiting to key areas and working with partners across the system to ensure consistent and best values rates of pay.
- Supporting our colleagues. Sickness levels are monitored daily – COVID-19 sickness absence has stabilised, but still a significant impact on our sickness absence rates.
- Our initiatives to support to colleagues on managing the impact of the cost of living crisis continue and have been well received to date, including a 'Cost of Living support' brochure sent to every colleagues home and we are holding regular listening events to ensure we remain responsive to need.

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

- Increasing trend in the reporting of incidents and excellence reporting testament to a good reporting culture within the organisation.
- Positive performance maintained across a range of maternity indicators
- One case of MRSA bacteraemia reported in October 2022. The patient was successfully treated with antibiotics, and good practice was identified in managing the placement of the patient and the MRSA decolonisation
- Hospital Standardised Mortality Ratio (HSMR) banded as statistically 'higher than expected'. This is a result of a two months coding backlog resulting from reduced capacity due to staff absences. The Trust crude mortality rate has remained consistent and is comparable with the regional and national rates. The total numbers of in-hospital deaths has been stable.

The IPR continues some new/reinstated metrics following Board feedback and further review of the report. These are:

- Waiting list profiles for RTT and community waiters to help forecast any challenges in delivery in future months.
- A breakdown of the cancer 62 day backlog by tumour site to highlight the key areas of challenge for the Trust.
- The number of theatre cases by list to better track theatre productivity alongside theatre utilisation metrics.
- Urgent community response referral levels to show more rounded view of this service alongside response times.

# Integrated Performance & Quality Report

## Overall Performance Summary



★ Ideally, each metric should be in one of the starred boxes which indicate the metric is currently achieving its target or is currently improving.

October 2022		Assurance		
		Pass 	Hit and Miss 	Fail 
Variance	<b>Special Cause - Improvement</b>  	★ Open pathway 78 week breaches	★ Cancer treatment levels - 31 day treatments VTE Assessments Community urgent 2 hour response Early Warning Score compliance	★ Open pathway 52 week breaches Diagnostic activity levels Nursing and Midwifery vacancy rate Trust vacancy rate
	<b>Common Cause</b>  	★ Overall size of the waiting list Theatre utilisation Outpatient appointment disruption Extended perinatal mortality Stillbirths per 1,000 cases Stillbirths total cases Pre term births <37+0 weeks	ED attendances Discharges by 5pm Cancelled elective operations Faster diagnostic standard (28 days) Incidents that are low/no harm Medication incidents Medication incidents as SIs Number of Falls Pressure Ulcers - cat 2 & 4 Pressure ulcers unstageable SIs confirmed Never events C. Difficile infections MSSA bacteraemia infections E.Coli bacteraemia infections Klebsiella spp bacteraemia infections Treatment escalation plan compliance Non critical care inpatient cardiac arrests Complaints received Friends and Family test - response rate Community average Length Of Stay Health Visitor appointments - 14 days Referrals into OH and Wellbeing - stress Sickness - Covid 19 Sickness - mental health Sickness - musculoskeletal Occupant health - management referrals response time FTSUG outreach	Seen by senior decision maker within 60 minutes Ambulance handovers within 15min, 30min & 60min Open pathway performance Elective activity Outpatient DNA rate Outpatient letters to GPs within 14 days Cancer wait times - 104 days Cancer screening Diagnostic compliance Endoscopic patients waiting > 6 weeks Non-endoscopic breaches Pressure Ulcers - cat 3 Pseudomonas aeruginosa bacteraemia cases Complaints response rate Friends & Family test - positive responses Average time to replace vacancies Sickness Data security awareness training Corporate Induction
	<b>Special Cause - Concern</b>  		Cancer wait times - 2 Week Waits Hospital Standardised Mortality Ratio (HSMR) MRSA bacteraemia infections 21 day LOS - Community Community waiting list size Employee relations cases closed	ED 4 Hour performance 12 Hour waits in ED Medically optimised for discharge patients Medically optimised for discharge bed days 21 day LOS - Acute Outpatient activity delivered remotely Cancer Performance - 62 day pathway Complaints outstanding at 90 days Turnover rate Statutory & Mandatory training



# Integrated Performance & Quality Report

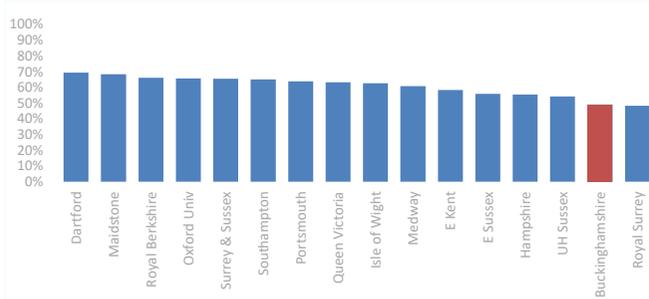
## Benchmarking Summary for South-East Region



Buckinghamshire Healthcare  
NHS Trust

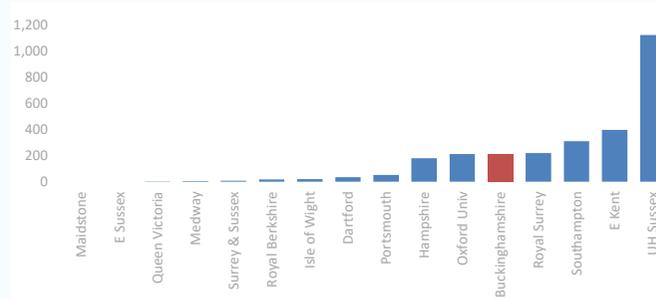
### RTT performance

South East RTT performance benchmarking - Sep-22



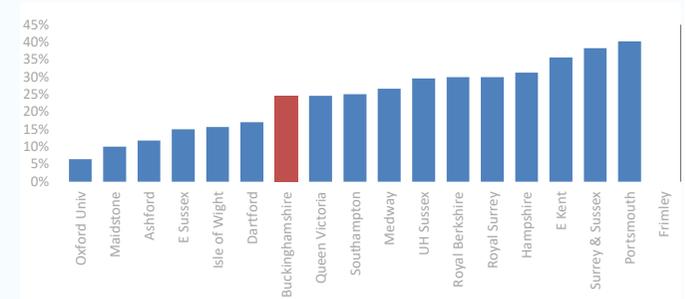
### 78 week waits

South East over 78 week waits benchmarking - Sep-22



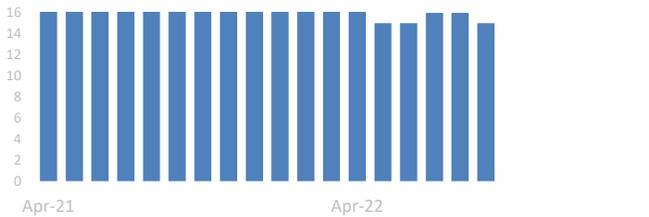
### Diagnostic performance

South East diagnostic performance benchmarking - Sep-22



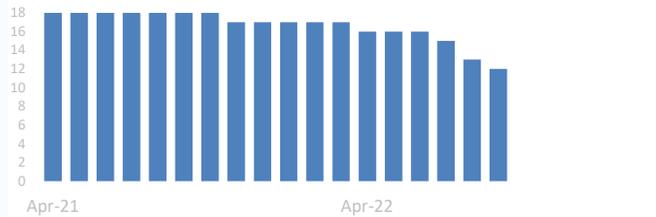
### RTT performance ranking

South East RTT performance benchmarking - historic rankings out of 16



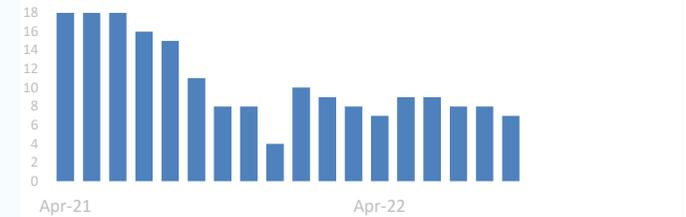
### 78 week waits ranking

South East over 78 week waits benchmarking - historic rankings currently out of 16



### Diagnostic performance ranking

South East diagnostic performance benchmarking - historic rankings out of 18



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

# Outstanding Care

## Operational Standards - Urgent & Emergency Care

### ED 4 hour performance

The 4-hr performance has deteriorated slightly. We have seen an increase in overall all type attendances, a contributing factor is the disruption to the department due to the Estates works, and flow challenges. The improvement strategies including the introduction of a UTC pathway, improved flow to our assessment areas / SDEC, and process to assess the ambulance and ambulant patients presenting to the Emergency Department continue to be embedded.

### 12 hour waits in ED

Rising numbers of Emergency Admissions is contributing to the number of persons remaining in the Emergency Department >12hrs.

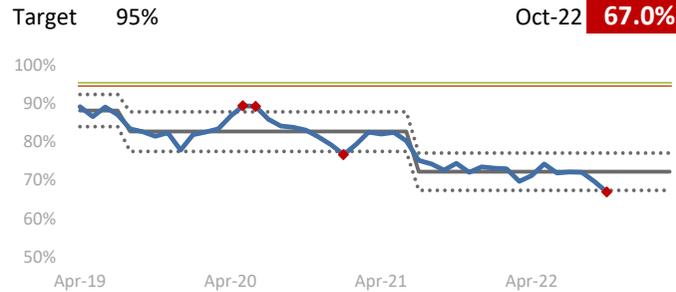
In this reporting period we have seen an increase in the number of 12hr stays in ED on last month which was 6.7%. The contributing factor is limited early flow to specialty wards. Our ambition is for this to be 2%, which is being supported with our improvement works; improved flows to our assessment areas / SDEC, introduction of the acute medical team attending the ED huddles 3 hourly, discussing all patients in the department, accepting them to the specialty teams earlier in their pathway and transferring to appropriate clinical areas to be seen.

### Seen by a Senior decision maker within 60 mins

Rising number of attendances and Emergency Admissions is directly impacting on this measure. We have introduced a Senior Decision Maker in both the Ambulance and Ambulant pathways to support improvement however this is variable due to staffing constraints, but we continue to learn and modify. Looking to increase the number of Senior Decision Makers through job planning between the hours of 8am –

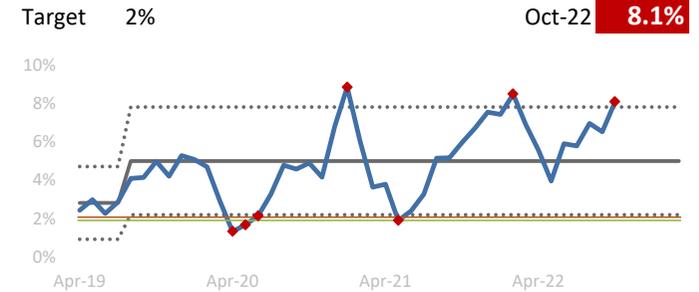
### ED 4 hour performance

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



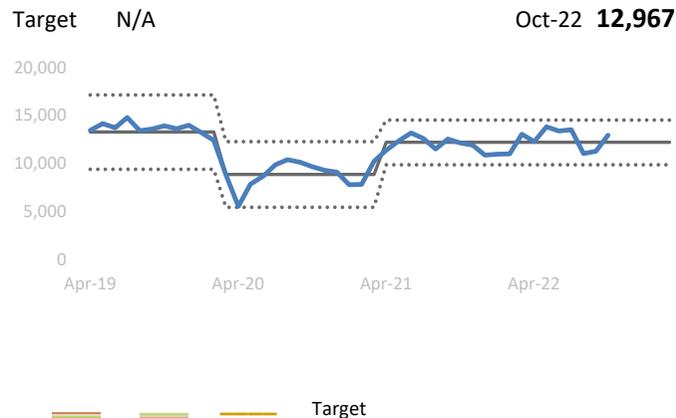
### 12 hour waits in ED

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



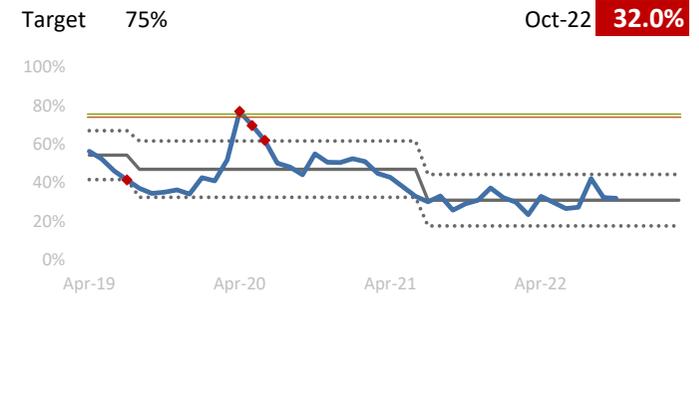
### ED attendances

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



### Senior decision-maker seen within 60 minutes

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



# Outstanding Care

## Operational Standards - Urgent & Emergency Care

### Ambulance handovers

In this reporting period we have seen an increase in ambulance conveyances to Stoke Mandeville Hospital.

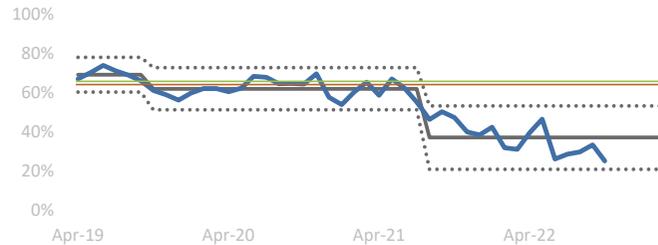
We have seen a deteriorating position in all handovers: within 15 mins; 30 mins and 60 mins, primarily impacted by capacity in our assessment area to offload timely together with the temporary reduction in capacity.

We have recently refreshed our process to assess all patients that present via ambulance supported by early senior decision makers and ECIST colleague's guidance and suggestions, which we continue to review and modify.

### Ambulance handovers within 15 mins

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

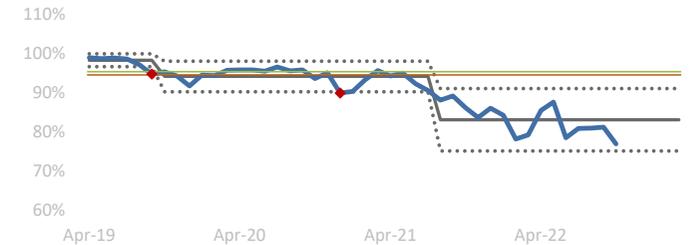
Target 65% Oct-22 **25.4%**



### Ambulance handovers within 30 mins

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

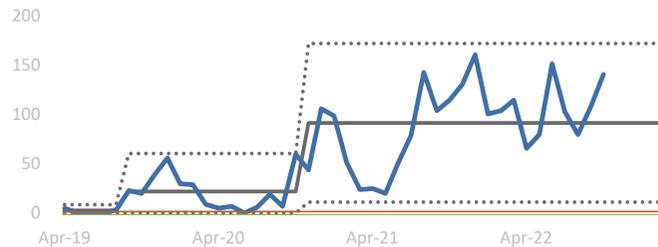
Target 95% Oct-22 **77.0%**



### Ambulance handovers over 60 mins

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

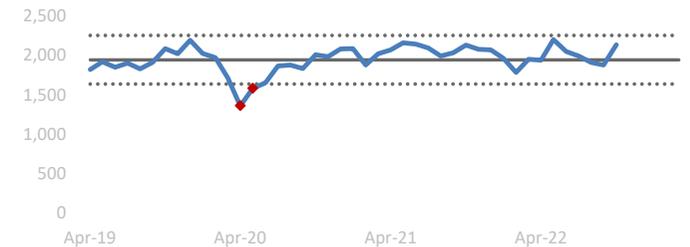
Target 0 Oct-22 **141**



### Ambulance arrivals

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

Target N/A Oct-22 **2,138**



— Target

# Outstanding Care

## Operational Standards - Urgent & Emergency Care

### Medically optimised for discharge

We have seen a steady increase of patients who are medically optimised for discharge in our acute beds. The delays in discharging patients from hospital are due to lack of capacity in social care and other NHS / Private providers / settings. We undertake daily MDT reviews of all known complex discharges and twice weekly we undertake a multiagency review of all patients over 14 days LoS.

Ongoing improvement work across our in-patient areas on board rounds and ward round processes, plan to roll out live bed boards which will support efficient ward updates and give live position on next steps for each patient.

Regular conversations are taking place at executive level with our system partners. The number of bed days lost due to being occupied by those who are Medically Optimised for Discharge could equate to an additional 500 patients being admitted within the month timely.

### 21 day LOS – Acute

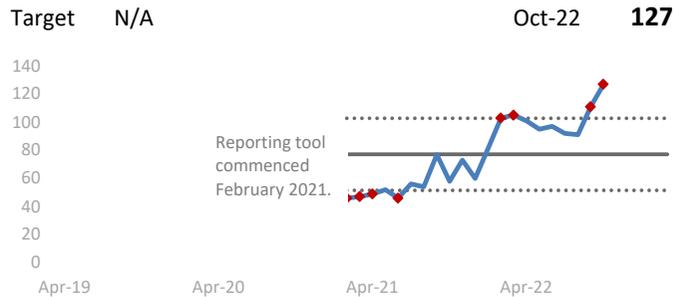
We have seen a slight decrease in patients remaining in hospital >21days on the last reporting period. It continues to remain high primarily due to lack of capacity in social care and other NHS / Private provider settings. We continue to maintain this as a focus with the daily MDT meeting reviews and twice weekly over 14 days LoS reviews.

### Discharges by 5pm

We continue our improvement work across our in-patient areas on board round and ward round processes. To support improvement, we have recruited discharge coordinators for each clinical area, whom will all be in post by end Nov 2022. The introduction of the live bed boards will aid capturing ward processes, delays and discharges, which are planned to be rolled out.

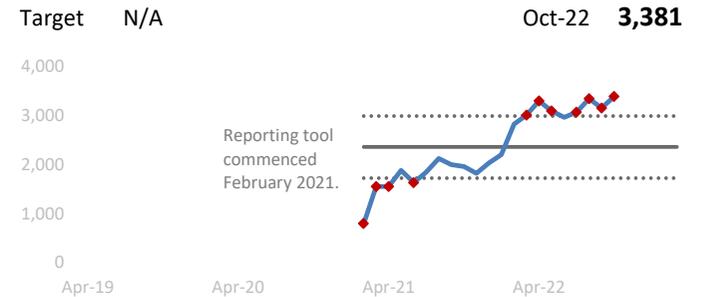
### Medically optimised for discharge

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



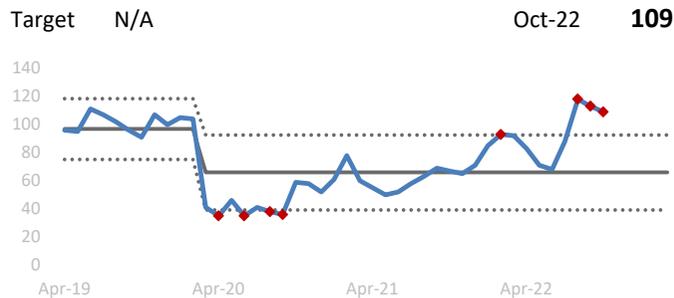
### MOFD Bed days lost

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



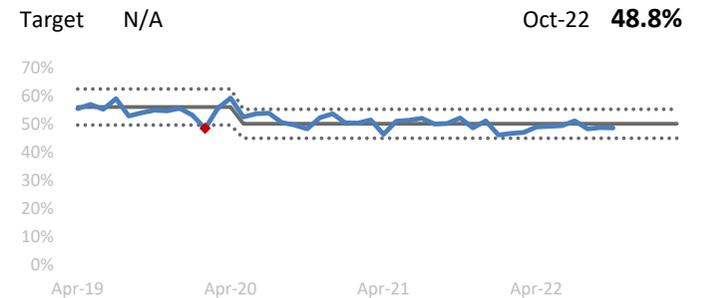
### 21 day LOS - Acute

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



### Discharges by 5pm

Proportion of inpatients discharged between 5am - 5pm of all discharges. Excludes maternities, deceased, purely elective wards and patients not staying over midnight.



Legend: Target

# Outstanding Care

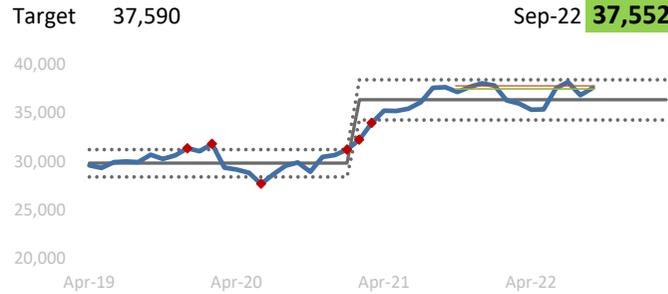
## Operational Standards - Elective Recovery

### Open pathways

Referral to treatment open pathways remain stable, more work to reduce the time patients are waiting is needed - eliminating 78 weeks initially and then 52 weeks - before progressing to RTT 18 week targets.

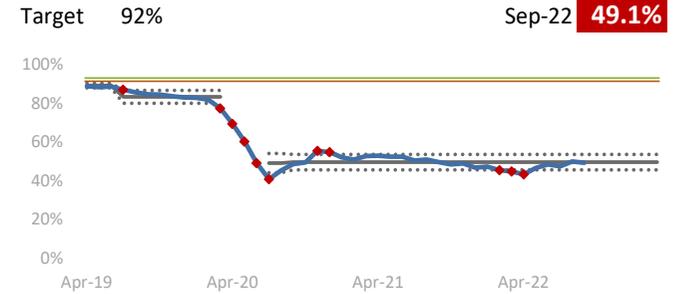
### Overall size of the waiting list

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



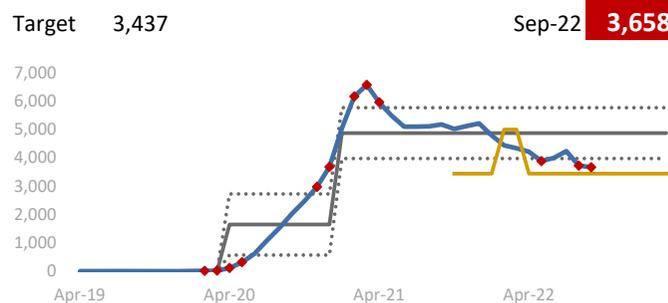
### Open pathway performance

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



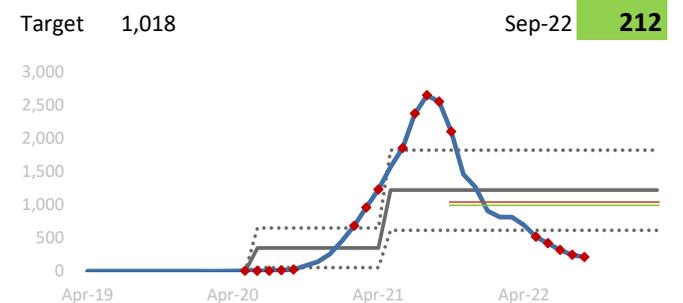
### Open pathway 52 week breaches

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



### Open pathway 78 week breaches

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



Target

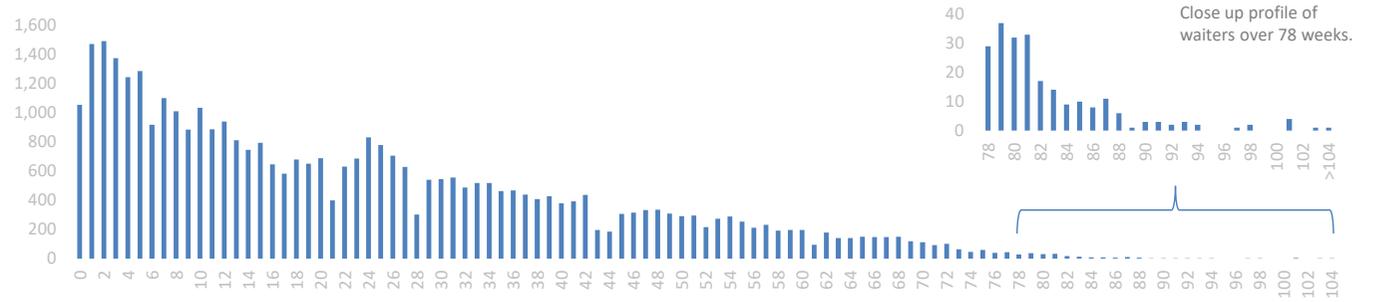
RTT data runs one month in arrears due to RTT submission date being later than IPR production date.

# Outstanding Care

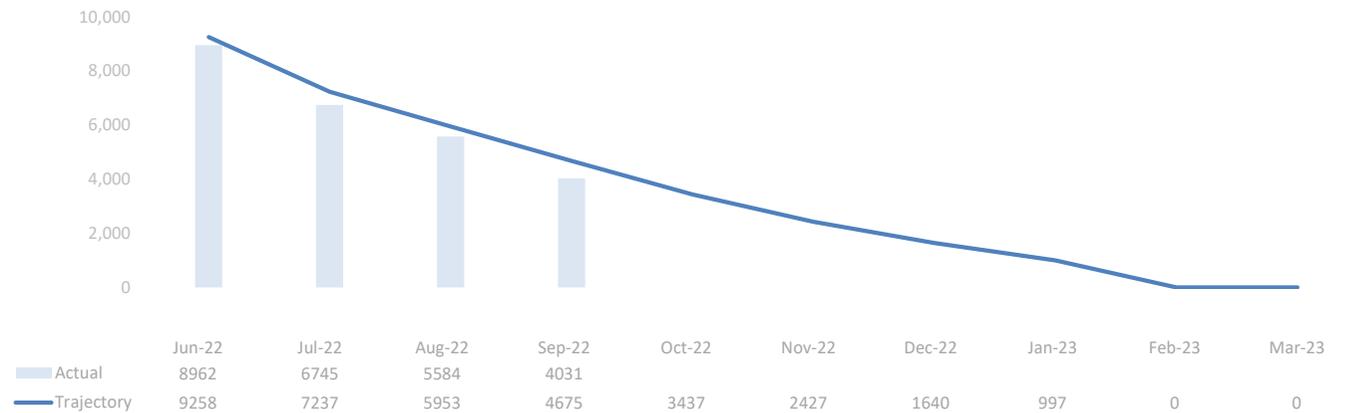
## Operational Standards - Elective Recovery

### Open pathways by weeks wait

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



### Open pathways - 78 week waits reduction trajectory



# Outstanding Care

## Operational Standards - Elective Recovery

### Theatre utilisation

Weekly booking density meetings with both booked admissions and services are going well and support with improvements being seen for utilisation.

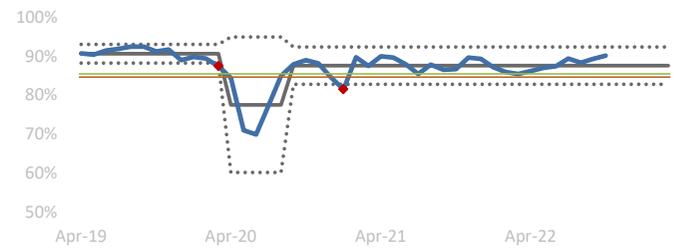
### Cancelled elective operations

Several cases were cancelled due to previous cases being significantly more complex than expected. A number of cases were cancelled due to estate issues and flooding.

### Theatre utilisation

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

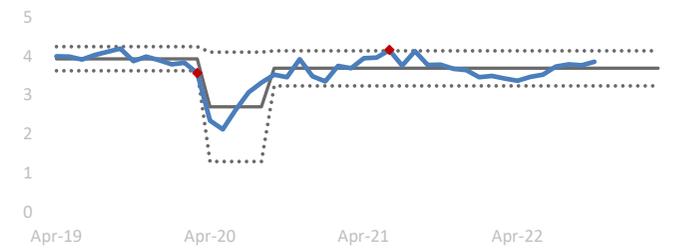
Target 85% Oct-22 **90.1%**



### Theatre cases per list

Number of theatre cases during the month divided by number of sessions during the month.

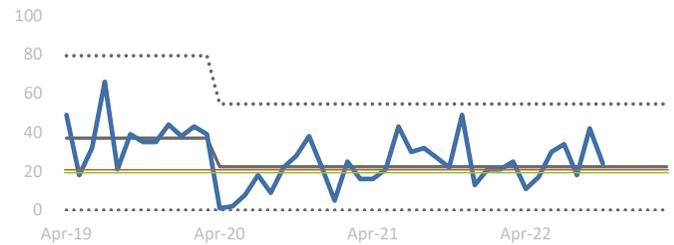
Target N/A Oct-22 **3.9**



### Cancelled elective operations

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

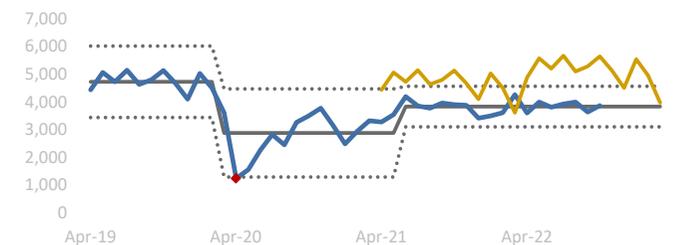
Target 20 Oct-22 **24**



### Elective Activity

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

Target 5,646 Oct-22 **3,876**



Target

# Outstanding Care

## Operational Standards - Elective Recovery

### DNA

The Trust has taken steps to improve communication with patients to try and reduce DNAs with initial written correspondence confirming appointments, followed by text messaging 7 and 2 days prior to the appointment date.

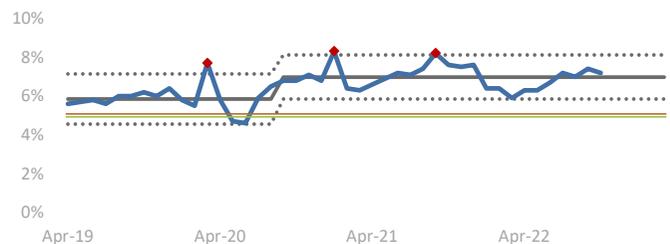
### Outpatient activity delivered remotely

Work to increase remote consultations continues with Divisions while adhering to clinical opinion regarding patient needs.

### Outpatient DNA rate

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

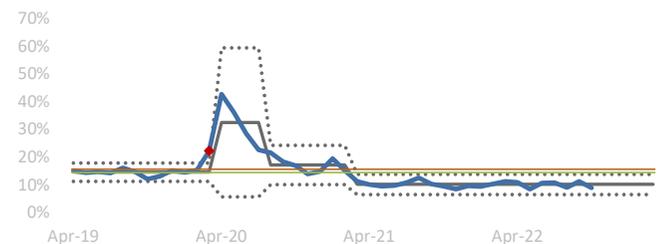
Target 5% Oct-22 **7.2%**



### Outpatient appointment disruption

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

Target 15% Oct-22 **9.0%**

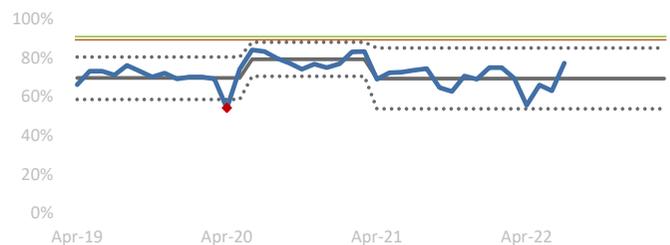


Latest data not available at time of report production

### Outpatient letters to GPs within 14 days

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

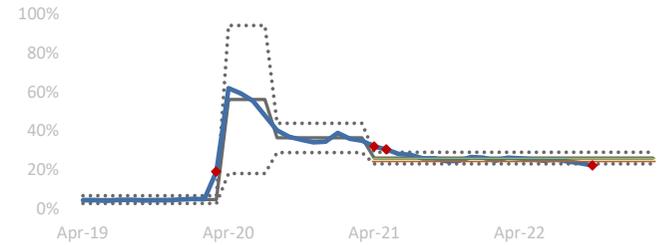
Target 90% Oct-22



### Outpatient activity delivered remotely

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

Target 25% Oct-22 **22.1%**



Target

# Outstanding Care

## Operational Standards - Elective Recovery

### 62 day pathway

Achieved performance of 52.1% against a trajectory of 62% in month. Variation due to the expected increase in additional activity was not delivered in month. This also impacted on the 31 day performance. The delay in the mobilisation of the skin centre at Amersham for plastics and impact of clinician sickness in key tumour site are the main reasons for the variation in activity and resulting impact against performance trajectory.

Delivered backlog position of 267 against a trajectory of 228 at month end. In addition to the causal factor described above delay in informing patients of the outcome of diagnostics was a significant contributory factor to the variation in performance. Actions continue in line with cancer improvement plan with a focus on validation and pathway improvement to continue performance delivery. The Trust backlog position in month is 10% compared to TVCA average of 15%; demonstrating the significant progress that has been achieved.

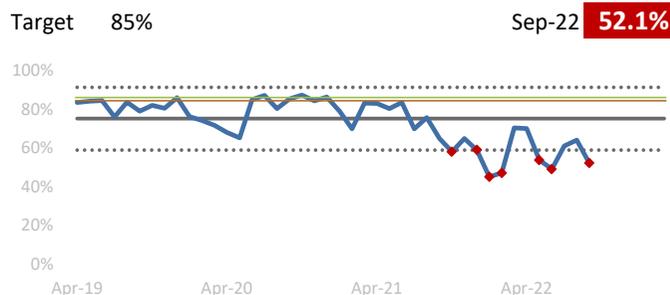
### 2ww

Work continue to ensure that patient have access within 14 days, improvements implemented in month include

- Prostrate best practice pathway
- Additional dermatology capacity at skin centre

### Cancer Performance - 62 day pathway

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



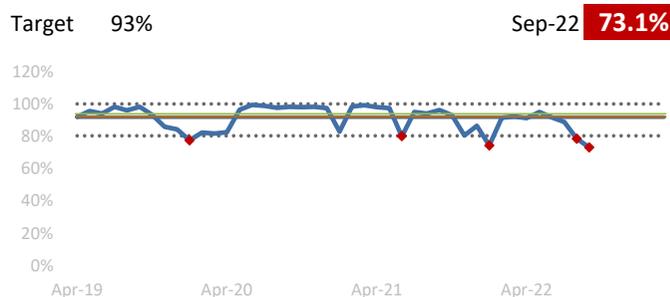
### Cancer Wait Times - 62 day waiters

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



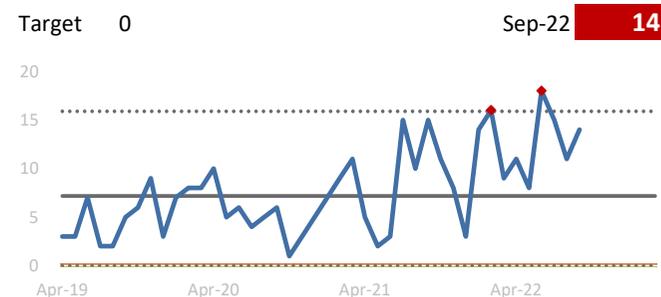
### Cancer Wait Times - 2WW

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



### Cancer Wait Times - 104 days

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



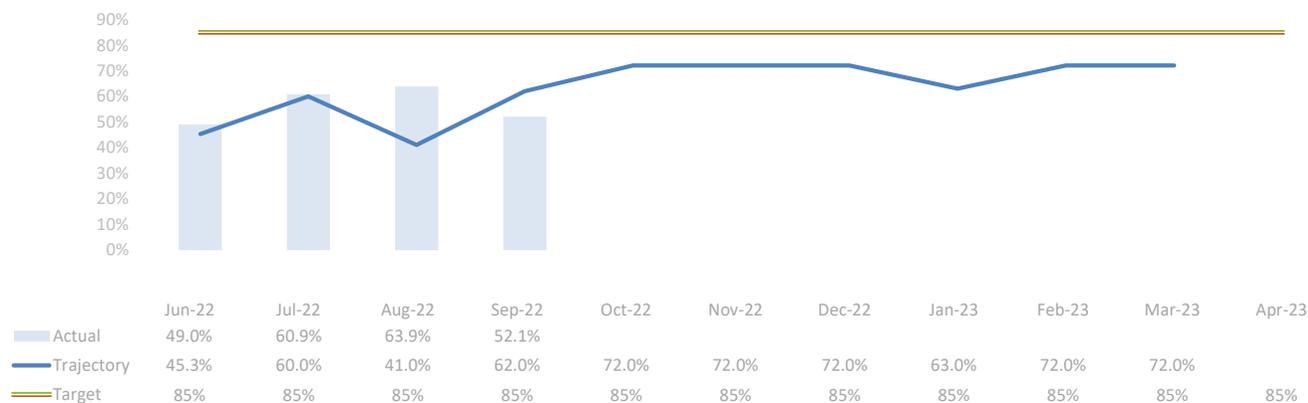
Target

Cancer data runs one month in arrears due to processing and reporting timescales of Open Exeter.

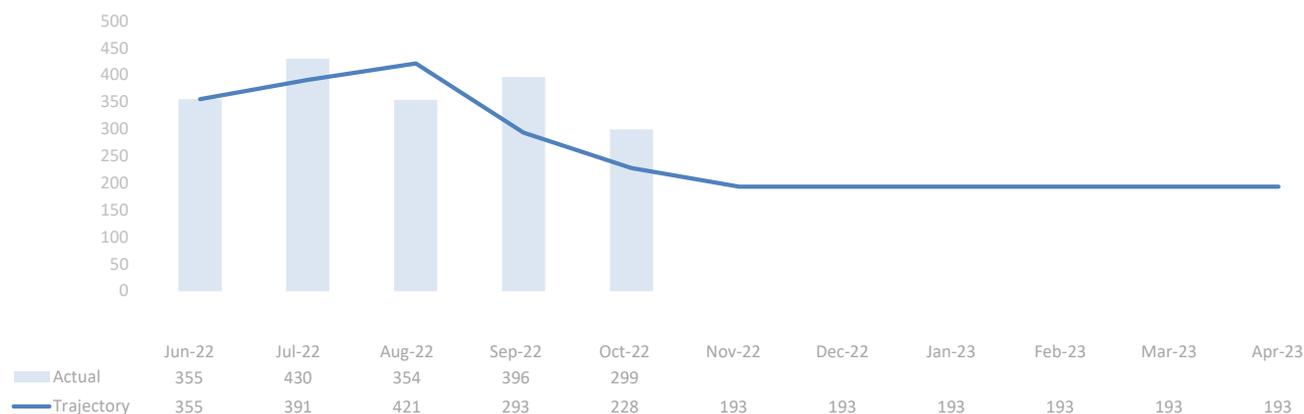
# Outstanding Care

## Operational Standards - Elective Recovery

### Cancer performance - 62 day trajectory



### Cancer backlog - 62 day waiters trajectory



# Outstanding Care

## Operational Standards - Elective Recovery

### Cancer backlog - 62 day waiters by tumour site

The number of cancer open pathways waiting > 62 days after an urgent suspected cancer referral at month end split by tumour site. Snapshot data taken weekly on a Wednesday between 3rd August and 2nd November 2022.

Tumour Site	Snapshot 02 Nov	Sparkline
Brain	0	
Breast	14	
Child	0	
Gynae	29	
Haem	4	
Head and Neck	37	
Lower GI	57	
Lung	5	
Skin	97	
Upper GI	22	
Urology	28	

# Outstanding Care

## Operational Standards - Elective Recovery



### 31 day treatments

Delivery of the 31 day target was impacted by the reasons described for other key cancer performance targets. The Improvement plan focus for the next period includes:

#### Dermatology

The service offers non face to face appointments, automatic upgrade from advice and guidance requests and use of digital images in line with the BPTP. Work is ongoing with colleagues in primary care to develop tele dermatology including the use of derma scopes. The service is developing plans to launch one stop "SPOT" clinics from December to meet the BPTP requirements.

#### Plastics

Skin centre ramp up plans being developed to fully utilise facility capacity. Developing plans to pilot one stop shop model.

#### Lower GI

51% of referrals received with Qfit in quarter 2 in line with TV CA trajectory of 50%.

CT offered where clinically appropriate in line with BPTP.

Currently model of care provides an initial consultation within 5 days but is not compliant with straight to test requirement of BPTP.

For patients with confirmed cancer CT, MRI or US should be offered with 7 days and work is ongoing to achieve this requirement.

#### Urology

Launched on 17 October service is compliant with BPTP criteria Straight to test for MPMRI. Dependent on results to biopsy within 9 days.

#### NSS

Transfer of NSS patients onto trackable system. Revised SOP for management of NSS discharge process. Commissioning infoflex bolt on to support active management. Migration of NSS to infoflex system.

### Faster diagnostic standard

Performance improved slightly in month due impact of:

- Limited diagnostic capacity particularly for breast patients
- Delay in communicating diagnostic results to patients

To address this the following actions have been completed:

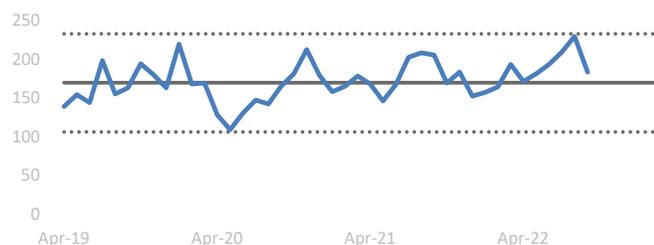
- Additional diagnostic capacity has been brought on line particularly CT and MRI
- Task and finish group established to eradicate delay in communicating to patients and ensure further pathway improvements

### Cancer screening

### Cancer treatment levels - 31 day treatments

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

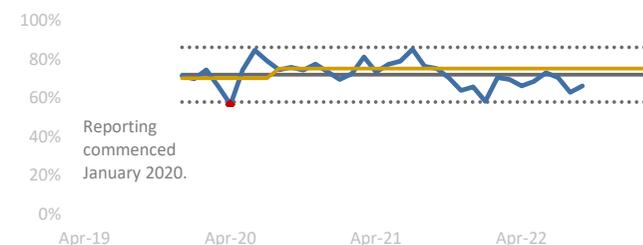
Target N/A Sep-22 **183**



### Faster diagnostic standard (28 days)

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

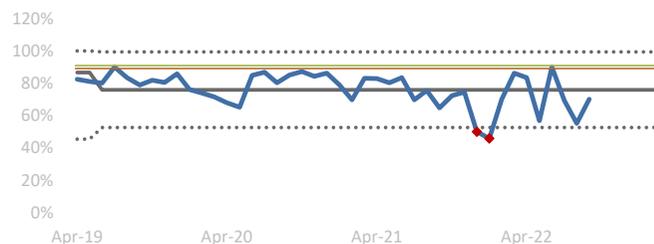
Target 75% Sep-22 **66.2%**



### Cancer screening

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

Target 90% Sep-22 **70.0%**



Target

Cancer data runs one month in arrears due to processing and reporting timescales of Open Exeter.

# Outstanding Care

## Operational Standards - Elective Recovery

### Diagnostics

Activity remains high, especially CT, DEXA, MRI and U/S. Staffing remains a challenge, especially in the Radiographic workforce.

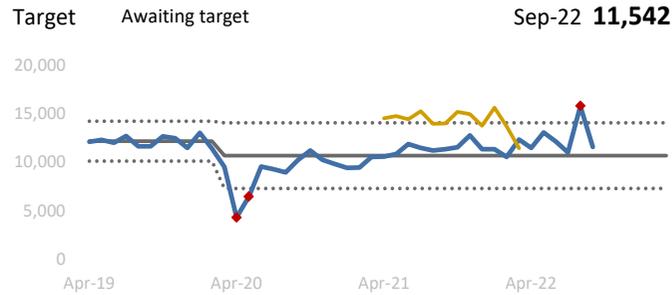
### Patients waiting >6 weeks (breaches)

We are not compliant in several areas, and mitigations are as follows:

- MRI – sending patients to OSD and PPG to reduce wait times. Urgent patients have been sent first so there will be a delay before waits reduce.
- CT – Cardiac CT remains a challenge, we are looking at engaging with the BMI to provide extra capacity, whilst also using OSD.
- U/S – extra lists are being undertaken to combat the rise in U/S waits.
- DEXA – weekend DEXA lists are planned to reduce the wait.

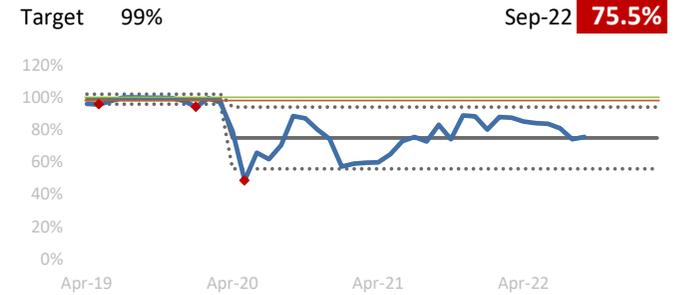
### Diagnostic activity levels

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



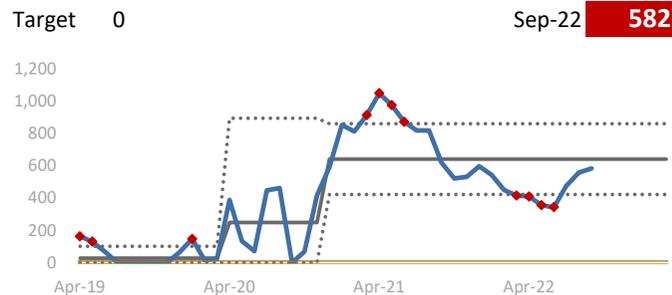
### Diagnostic compliance

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



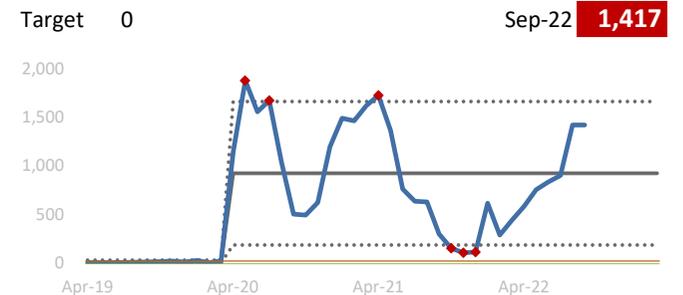
### Endoscopic patients waiting > 6 weeks

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



### Non-endoscopic DM01 breaches

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



Target

Runs one month in arrears due to DM01 submission date being later than IPR production date.

# Outstanding Care

## Operational Standards - Quality & Safety

### Incidents reported

There was an increase in the number of incidents reported in October 2022.

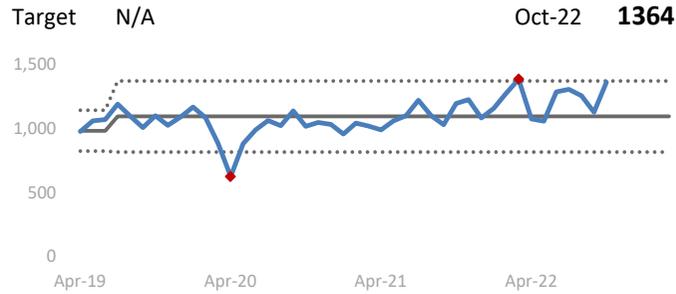
Majority of incidents reported are of no harm, near misses and low harm (97.8%). The Trust continues to promote good reporting culture of incidents and this is monitored by specialty through the Quality and Patient Safety Group.

### Excellence reporting

There has been an increasing trend in Excellence reporting since April 2022. The Trust learning forum "Reflect and Review" continues to be delivered monthly facilitated by the Quality Improvement team. Last month forum focused on achieving positive change and improving patient care through Appreciative Inquiry.

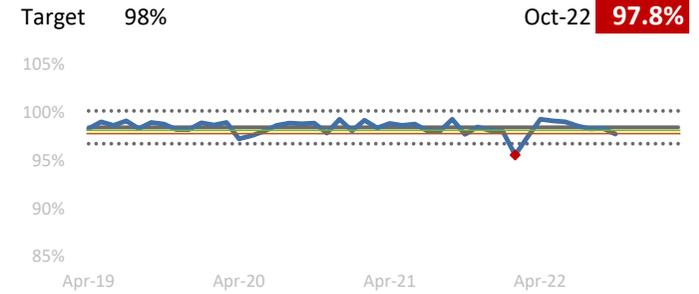
### Incidents reported

Total number of incidents reported on DATIX during the month.



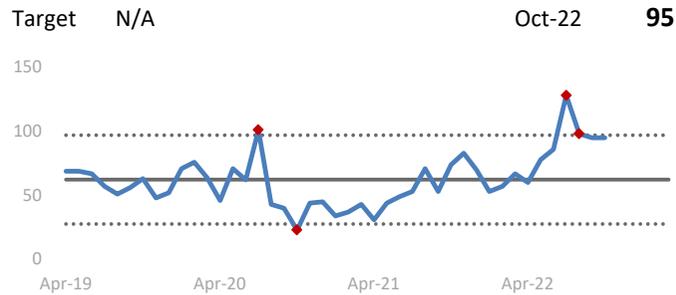
### Incidents that are low/no harm

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



### Excellence reporting

Total number of positive examples of great practice and care observed and reported via electronic Excellence form in month.



Target

# Outstanding Care

## Operational Standards - Quality & Safety

### Medication Incidents

Medication incidents within the normal variation and trends are being monitored. The number of prescribing incidents is higher this month compared with the monthly average prior to August 2022. This increase can partly be attributed to the process issue on prescribing medications and making it more efficient. This issue is being addressed directly by the Cancer Services team and quality improvement plan monitored through the joint Oncology and Haematology SDU Governance Committee. Pharmacy team will continue to monitor prescribing incidents closely to see if there are other trends emerging. No medication incident declared as Serious Incident (SI) in October 2022

The Trust participated in the annual medication safety week as part of international efforts to raise awareness about the importance of reporting suspected adverse reactions to national medicines regulatory authorities, such as Medicines and Healthcare products Regulatory Agency (MHRA).

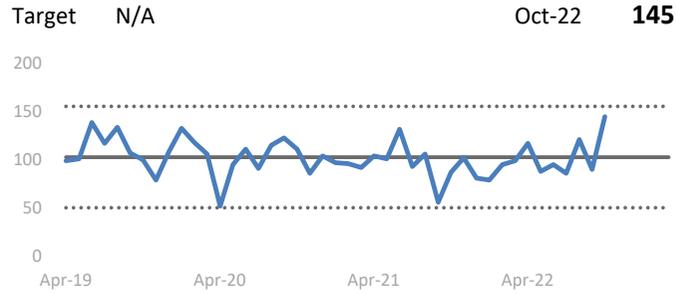
### Falls

Falls incidents within the normal variation and trends. The rate of inpatient falls reported in October 2022 was 5.2 per 1,000 occupied bed days (OBD) which is below the national average of 6.6 per 1,000 OBD.

Thematic analysis of inpatient falls incidents highlighted inability to fill enhanced care shifts for patients needing continuous supervision. Falls incidents trends by speciality are being addressed in local workstreams and reported through the Harm Free Care Group. The thematic review identified good practices including completion of falls documentation which continues to improve. Patient Falls leaflet ratified and due to be launched by December 2022.

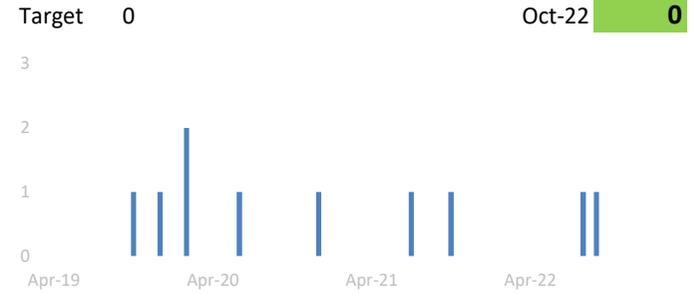
### Medication incidents

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



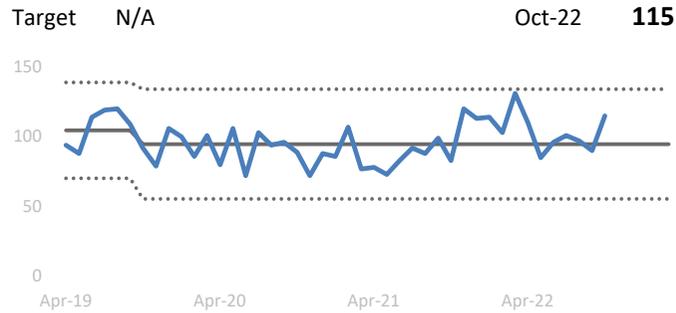
### Medication incidents as SIs

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



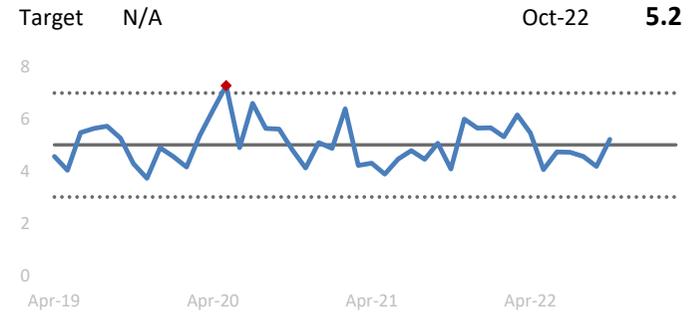
### Number of falls

Total number of patient falls reported on DATIX.



### Falls per 1,000 bed days

Rate of Inpatient Falls Incidents reported per 1,000 inpatient bed days.



Target

# Outstanding Care

## Operational Standards - Quality & Safety

### Pressure ulcers

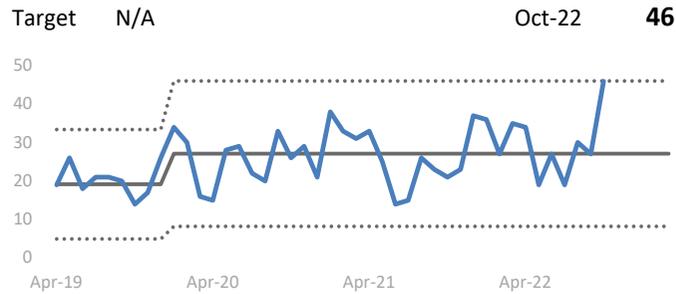
An increase across both acute and community settings for pressure ulcers (PU) in October 2022 which will be investigated by the tissue viability team and reported to the Harm Free Care Group monthly meeting.

There were six Category 3 PU reported. Investigations into these cases are still in progress and will be completed looking for any themes and contributing factors.

During the week 14-18 November the trust tissue viability team will be undertaking many awareness events to coincide with the national annual Stop the Pressure campaign. The team are also launching a new assessment tool for pressure ulcers (Purpose T) which is in line with national guidance from NHSE expected in the early part of 2023. The new assessment tool is quicker than previous models and focuses on solutions for those patients who require adjustments.

### Pressure ulcers - category 2

Number of acquired category 2 pressure ulcers.



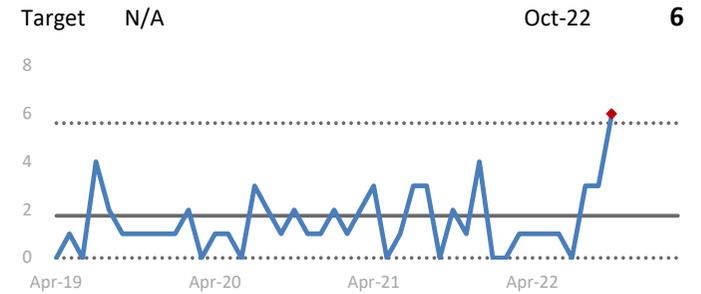
### Pressure ulcers - category 4

Number of acquired category 4 pressure ulcers.



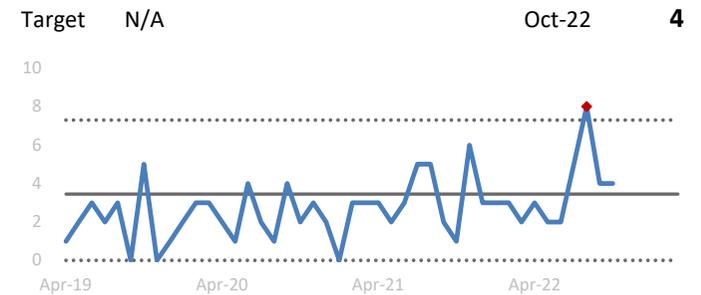
### Pressure ulcers - category 3

Number of acquired category 3 pressure ulcers.



### Pressure ulcers - unstageable

Number of acquired unstageable pressure ulcers.



Target

# Outstanding Care

## Operational Standards - Quality & Safety

### SIs confirm

No serious incidents declared as meeting Never Event criteria in October 2022. The Trust SIEDM panel continues to meet up weekly led by the Chief Nurse.

### HSMR

Banded as statistically 'higher than expected'. The increase in HSMR is as a result of a two months coding backlog resulting from reduced capacity due to staff absences.

The Trust crude mortality rate has remained consistent and is comparable with the regional and national rates.

June 2022 = Trust 3.3% compared to 3.4% regional average and 3.2% national average (acute, non-specialist Trusts).

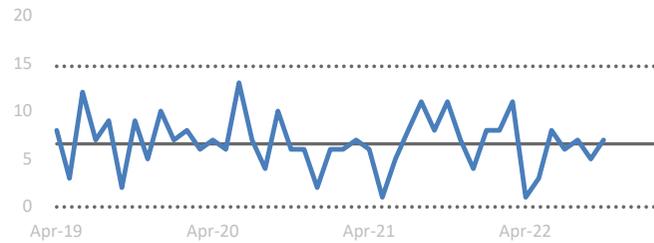
Trust Medical Examiner (ME) service reviewed 100% of in-hospital deaths which does not reflect the increase in HSMR: the total numbers of in-hospital deaths has been stable.

In order to ensure that we do not lose sight of any rise which is masked by coding, regular monitoring will continue of our crude rate, mortality rates within specific diagnoses, and ME data with oversight from the Mortality Reduction Group.

### SIs confirmed

The total number of Serious Incidents confirmed during the month.

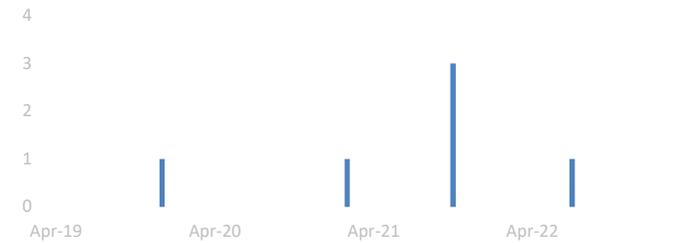
Target N/A Oct-22 **7**



### SIs declared as never events

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

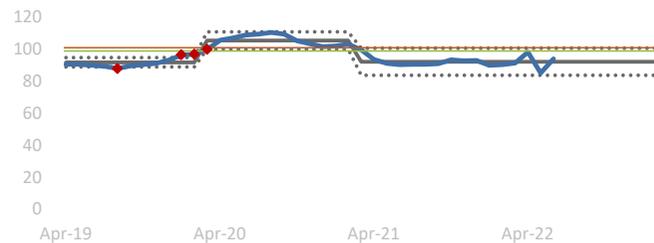
Target 0 Oct-22 **0**



### HSMR

Hospital Standardised Mortality Ratio (rolling 12 months).

Target 100 Jun-22 **94.0**



Legend: Target

HSMR runs in arrears due to data processing and publication times by Dr Foster.

# Outstanding Care

## Operational Standards - Quality & Safety

### MRSA

One MRSA bacteraemia case reported in October 2022. This latest case was identified in a patient with several complex conditions known to be colonised with MRSA, who had spent a significant time spent in another hospital before being transfer to the spinal unit. A post-infection review was undertaken, and the source of the infection was not identified. The patient was successfully treated with antibiotics, and good practice was identified in managing the placement of the patient and the MRSA colonisation; however, some key learning has been identified. An action plan has been developed and will be monitored through the divisional governance and performance meeting.

### C Diff

This month 9 cases of *Clostridioides difficile* infections (CDI) have been reported, YTD 34, which is 63% of the Trust threshold. Root cause analysis are undertaken on all cases of CDI. Antimicrobial stewards continue to conduct antibiotic review audits, which are reported locally with the expected actions taken.

Divisions continue to ensure compliance with hand hygiene and environmental decontamination to meet the required standard to prevent transmission. The infection prevention and control team along with the infection control doctor and antimicrobial pharmacist, continued to undertake a weekly review of all patients with a positive *Clostridioides difficile* toxins.

### MSSA BSI

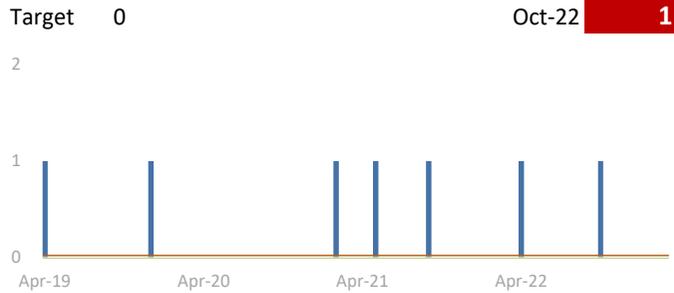
In October 2022, 4 cases of MSSA bacteraemia cases were identified. 12 cases YTD.

### E coli bacteraemia

In October, 3 case of E. coli bacteraemia were reported, 39 case YTD which is 48% of the Trust threshold

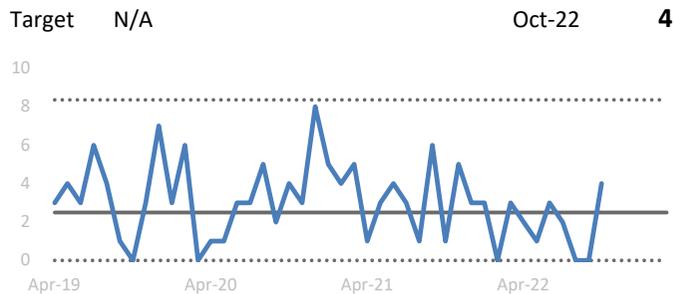
### MRSA bacteraemia

Number of MRSA cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



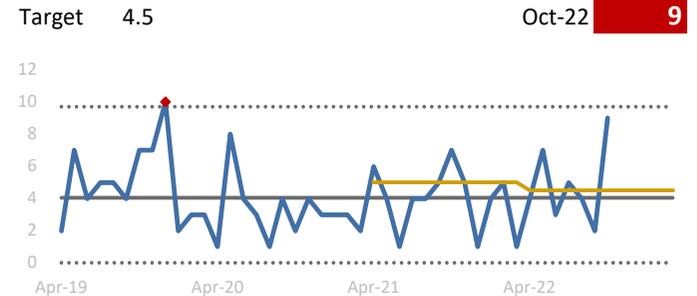
### MSSA bacteraemia

Number of MSSA cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



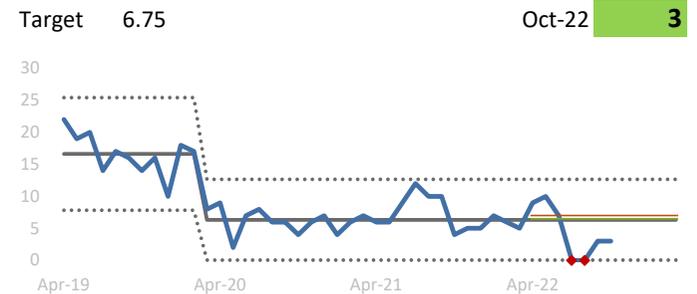
### Clostridioides difficile

Number of C-diff cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



### E Coli bacteraemia

Number of E-Coli cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



Target

# Outstanding Care

## Operational Standards - Quality & Safety

### Pseudomonas aeruginosa

In October, 2 cases of Pseudomonas aeruginosa bacteraemia were reported.

Works continue to reduce all healthcare associated Gram-Negative Bloodstream Infections (GNBSIs) in adults. This includes setting up a Trust-wide working group led by the Consultant Microbiologist Infection Control Doctor. The group will aim to establish initiatives to reduce GNBSIs and consider trajectories to measure progress. Initiatives are planned to reduce GNBSIs, mainly in preventing urinary tract infections (UTIs) and catheter-associated urinary tract infections (CAUTI).

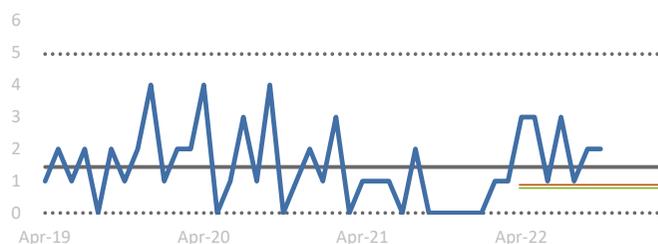
### Klebsiella spp bacteraemia

In October, 3 cases of Klebsiella spp bacteraemia were reported, 39 case YTD which is 71% of the Trust threshold.

### Pseudomonas aeruginosa bacteraemia

Number of Pseudomonas aeruginosa cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.

Target 0.8 Oct-22 **2**



### Klebsiella spp bacteraemia

Number of Klebsiella spp cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.

Target 2.8 Oct-22 **3**



Target

# Outstanding Care

## Operational Standards - Quality & Safety

### VTE

Trust continues to perform above the local set target for October 2022. VTE risk assessment compliance is 97% against the target of 95%.

### Treatment Escalation Plan

Decrease in compliance in comparison to previous month showing common cause variation. Focus on areas with reduced compliance in collaboration with the critical care outreach team (CCOT) and palliative medicine.

### Non critical care inpatient cardiac arrests

Two non-critical care inpatient cardiac arrests reported in October 2022. Cases are reviewed by Cardiac Arrest Review Panel.

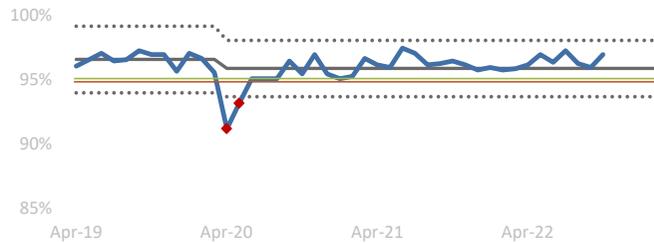
### Early Warning Score

Maintained compliance and in line with the Trust target of 99%

### VTE assessment

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

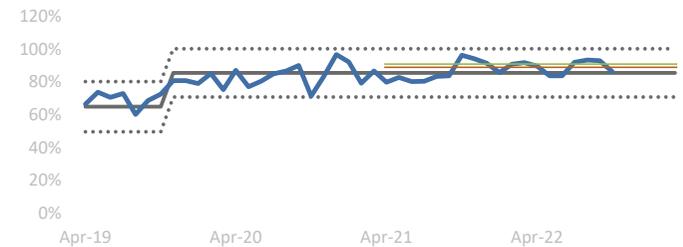
Target 95% Oct-22 **97.0%**



### Treatment escalation plan compliance

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

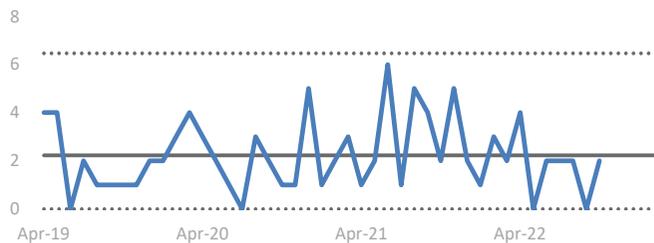
Target 90% Oct-22 **86.5%**



### Non-critical care inpatient cardiac arrests

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

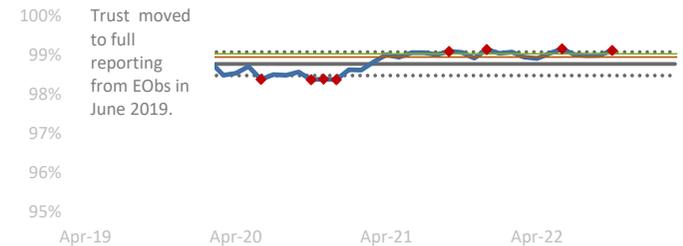
Target N/A Oct-22 **2**



### Early warning score

Percentage compliance with early warning score (EWS) completion.

Target 99% Oct-22 **99.1%**



Legend: Target

# Outstanding Care

## Operational Standards - Quality & Safety

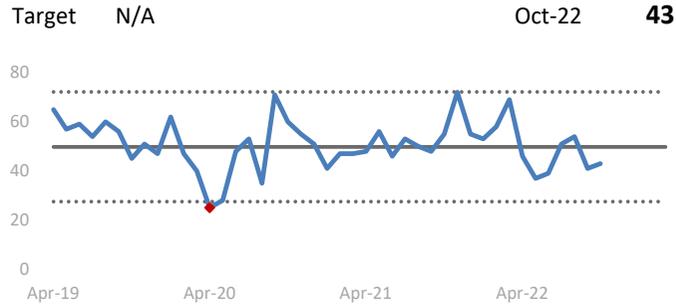
### Complaints

There were 43 complaints received in October 2022. Process for managing complaints has changed, with all complaints being followed up at 15 and 17 days for timely response. Meetings set up with the Divisions and the new patient relation manager is attending governance meetings.

Performance for 25 days response time is 57 % in October 2022. Divisional performance is monitored through monthly Divisional performance meeting with the Executive team. A newly recruited band 5 PALS officer will be starting on 5 December 2022. PALS is now offering a walk-in service three days a week from 11am-3pm.

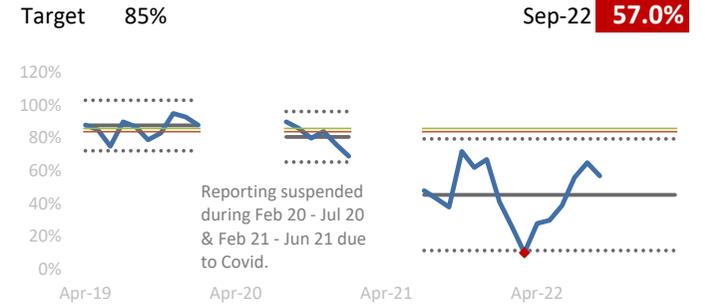
### Complaints received

Number of complaints received during the month.



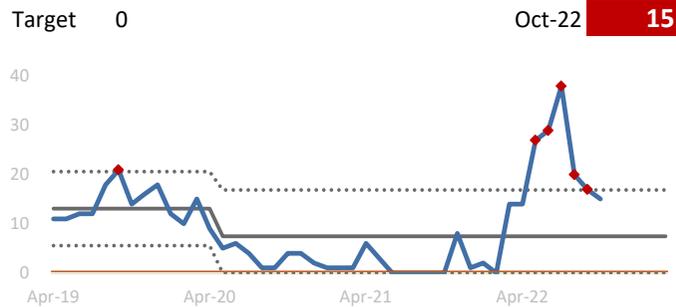
### Complaint response rate

Percentage of complaints responded to within 25 days of receipt.



### Complaints outstanding at 90 days

Number of complaints still open after 90 days.



Target

Response rate metric runs in arrears due to reporting not being possible until 25 days after month end.

# Outstanding Care

## Operational Standards - Quality & Safety

### Friends and family test

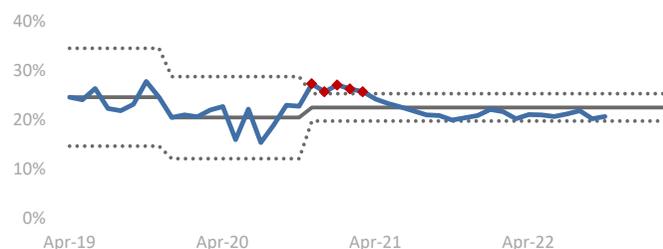
Slight improvement in overall response rate in comparison to previous month. Trust positive response at 89.3%. Approval ratings for inpatient, outpatient and community areas remain stable around 90%.

Continued collaboration with local teams on improvements using FFT feedback alongside complaints and PALS data. Continued collaboration with the QI team on embedding patient experience within quality improvement projects. A&E department (Majors) refurbishment completed in November 2022 with positive feedback from patient and staff.

### Friends and family test - response rate

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

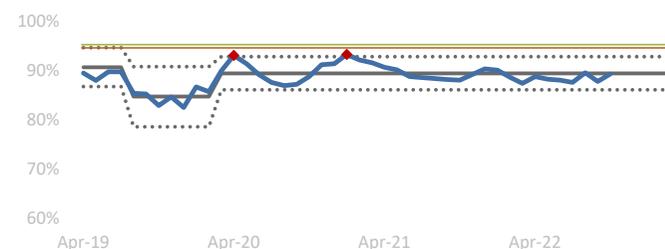
Target Awaiting target Oct-22 **20.7%**



### Friends and family test - positive responses

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

Target 95% Oct-22 **89.3%**



Target

# Outstanding Care

## Operational Standards - Quality & Safety

### Extended perinatal mortality

Extended perinatal mortality rate continues to sit below Trust target. Quarterly review from HSIB highlighted good family engagement from BHT referred cases, with 94% of cases involving families against a national average of 86%. 100% of eligible cases are referred to HSIB, despite this, the Trust received confirmation that overall referral rates are low. For those that are investigated the maximum number of safety recommendations is two, with a high percentage of investigations making no safety recommendations. There is continued compliance with reporting of all cases to MBRRACE within 7 days.

### Stillbirths

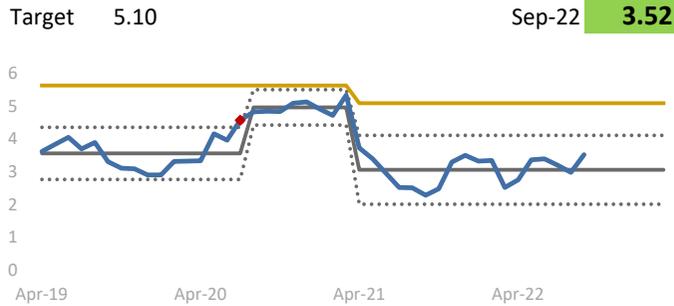
Both stillbirths reported were antenatal stillbirths of term babies. One woman was not fluent in spoken English and had a complex medical history, this will be reviewed via the perinatal mortality review tool (PMRT) process. The second stillbirth was a late termination of pregnancy for multiple fetal abnormalities.

### Stillbirths per 1000 cases

The stillbirth rate remains below Trust target. The Trust are compliant with Saving Babies Lives care bundle and have an antenatal detection rate of growth restricted babies above the national average.

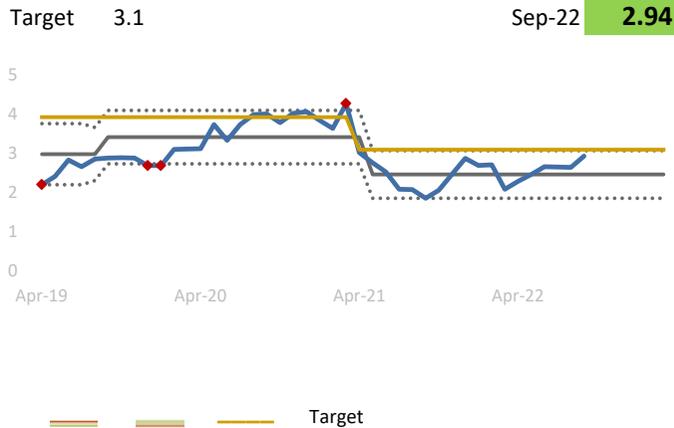
### Extended perinatal mortality

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



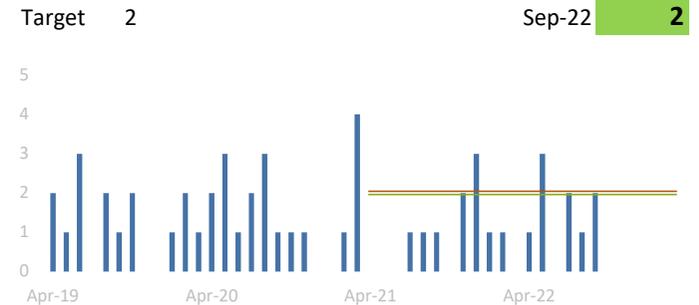
### Stillbirths - per 1,000 cases

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



### Stillbirths - total cases

Number of cases of stillbirths at 24 weeks or later.



# Outstanding Care

## Operational Standards - Quality & Safety

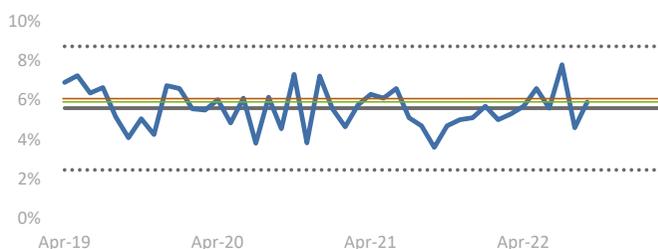
### Pre term births

The Trust work collaboratively with partnering maternity and neonatal units to deliver all seven elements of the BAPM preterm birth optimisation bundle and are achieving higher than average compliance across the board. The Trust is part of a team leading on a South East wide project to co-produce, with families, a programme of education aimed at maternity/neonatal units and the ambulance service to ensure extremely premature infants are born in the right location.

### Pre term births <37+0 weeks

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

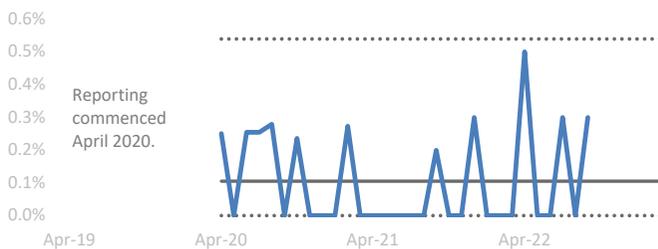
Target 6% Sep-22 **5.9%**



### Pre term births 16 - 23+6 weeks

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

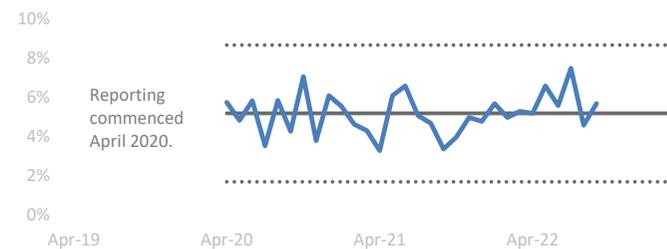
Target N/A Sep-22 **0.3%**



### Pre term births 24 - 36+6 weeks

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

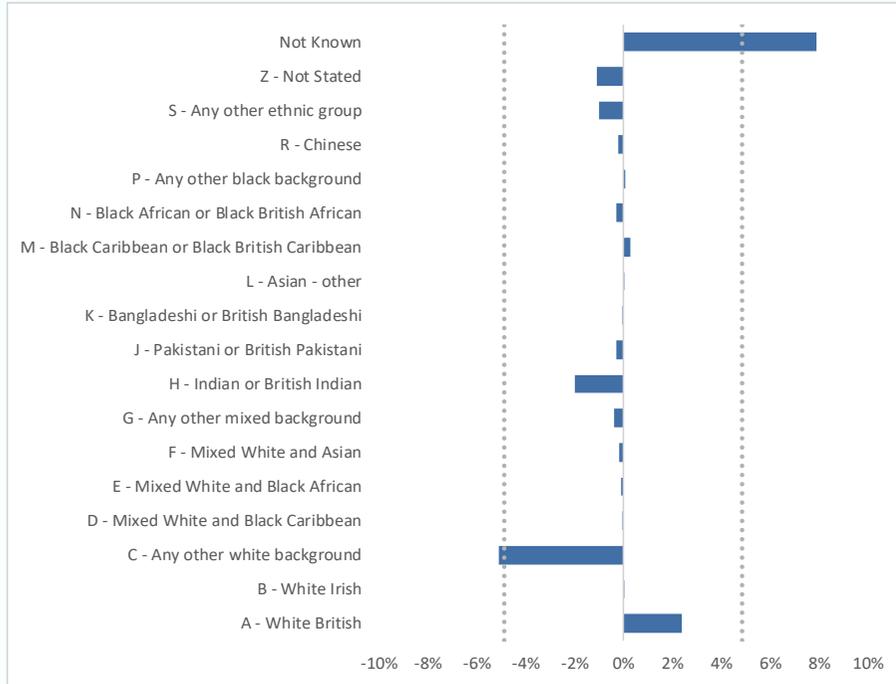
Target N/A Sep-22 **5.7%**



## Ethnicity and deprivation

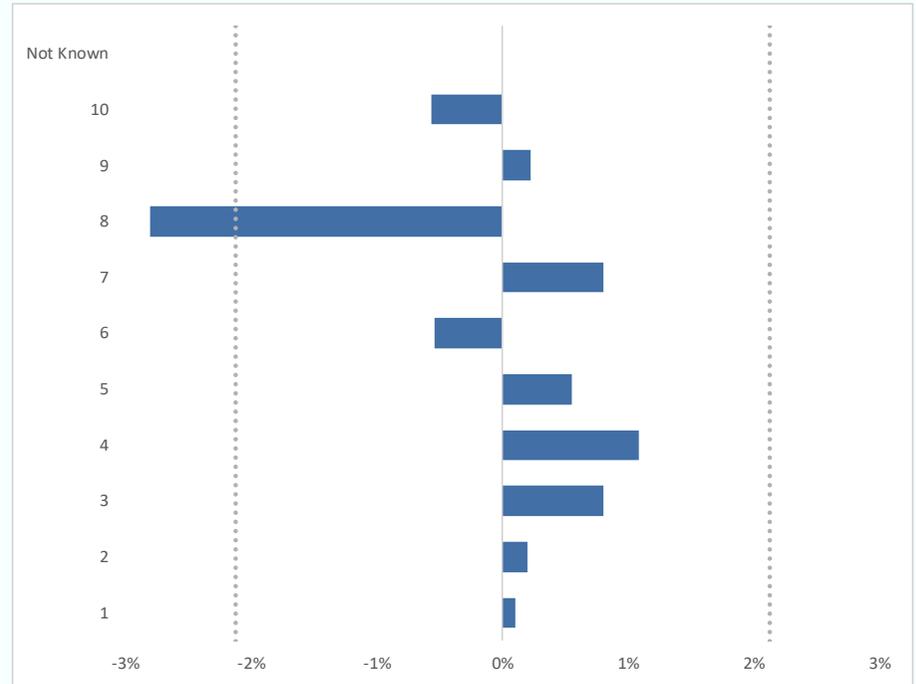
### Ethnicity comparison compared to Buckinghamshire Population by waiting list

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



### IMD comparison compared to Buckinghamshire Population by waiting list

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



Dotted lines are set at + / - 2 standard deviations from the mean (zero)

# Healthy Communities

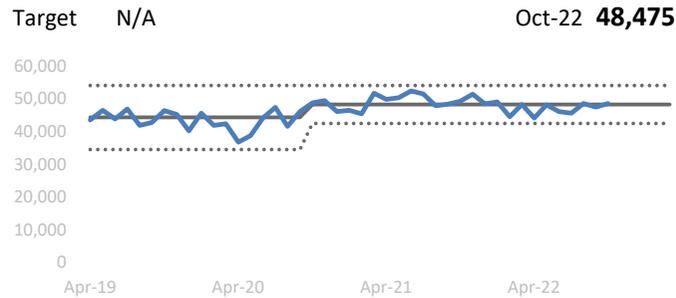
## Community Activity

2022 NHS Benchmarking comparisons:



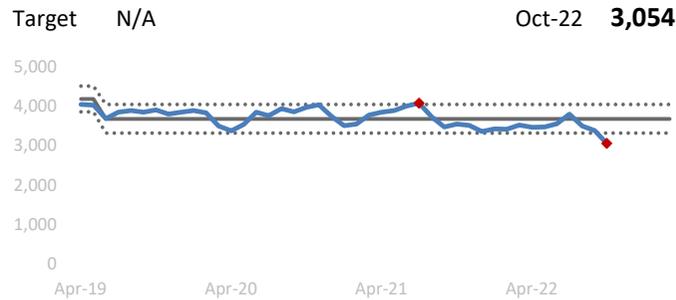
### Community contacts

Total number of attended community contacts in the month.



### Community District Nursing caseload

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



### Community RRIC caseload

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



Target

# Healthy Communities

## Community Hospitals

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

Designing a new discharge model for Buckinghamshire is underway. This will reduce the number of D2A beds and transition towards increased social care assessments taking place in hospital.

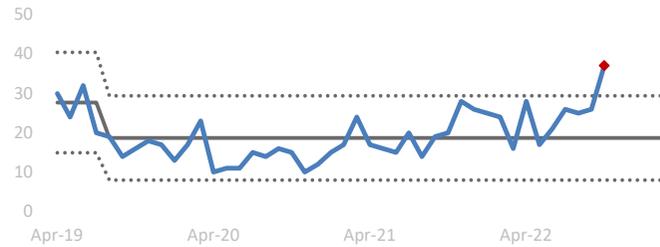
A recent analysis of Chartridge Ward, where adult social care assessments are taking place, shows that the average assessment time is over 30 days (including mental health and CHC where relevant).



### 21 day LOS - community hospitals

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

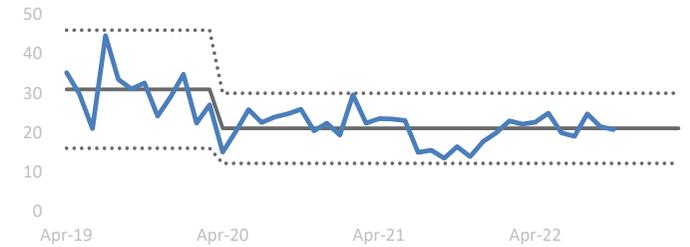
Target N/A Oct-22 **37**



### Average LOS - community hospitals

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

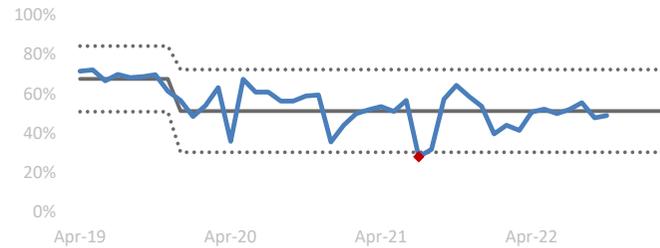
Target N/A Oct-22 **20.8**



### Discharges home

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

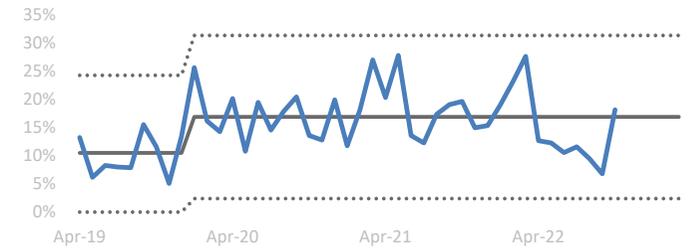
Target N/A Oct-22 **49.1%**



### Discharges to residential/care home

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

Target N/A Oct-22 **18.2%**



Target

# Healthy Communities

## Community Productivity

### Urgent 2 hour response

Breakdown for October:

Metric of response urgency	No. referrals month of October	No. triaged as needing that response urgently	No. seen within the response urgency time	% seen within the response urgency time
<a href="#">2 hour</a>	367	332	284	86%
2 - 24 hour	336	301	297	99%
24 - 48 hour	288	252	249	99%
<b>Total UCR referrals</b>	<b>991</b>	<b>885</b>	<b>830</b>	<b>94%</b>

### Health Visitor appointments

The Q2 data validated data for new birth visits by day 14 was 80%. 98% completed by day 21.

2% decrease from Q1 (82%) due to an increase in staff long term sick, Covid related sickness and annual leave.

There is a discrepancy between the CYP end of month data and the data in this report – This report shows 74% for September, end of month data reported by CYP was 84%.

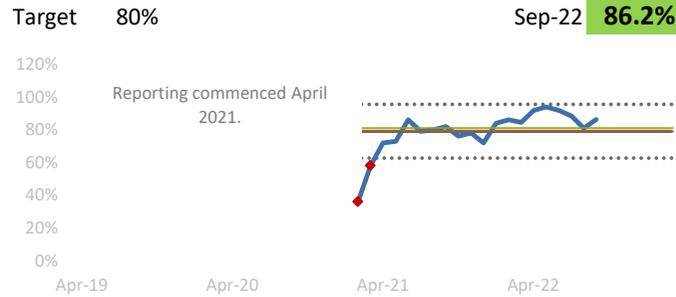
Detailed exception reporting and monitoring is ongoing and planned to remain in place until Dec 2022.

### Community waiting list

This is the first time that the community waiting lists have been shown in this way. It clearly highlights the amount of historical data quality issues that need addressing. Plans are in place to do this, but additional resource may be required. The Health Visiting waiters are not waiting but are 'open to the service' meaning they are on the caseload. This means they may never need to access the

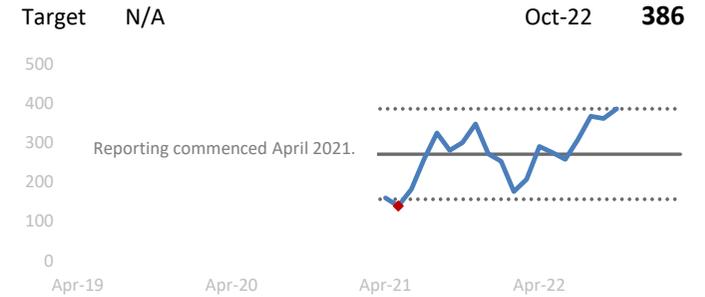
### Urgent 2 hour response

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



### Urgent community response referrals

Number of urgent referrals (2 hour) from community services or 111 received.



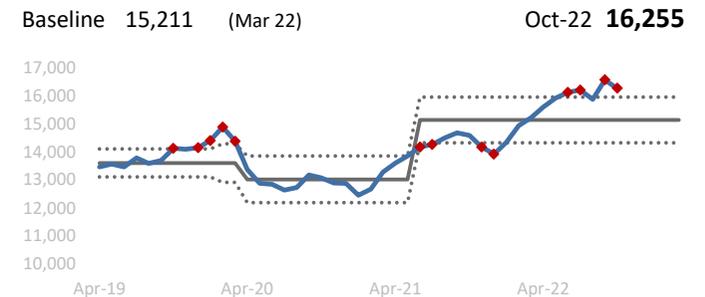
### Health Visitor appointments - 14 days

Percentage of new baby reviews carried out within 14 days of birth - over all births in the month (based on DOB in month).



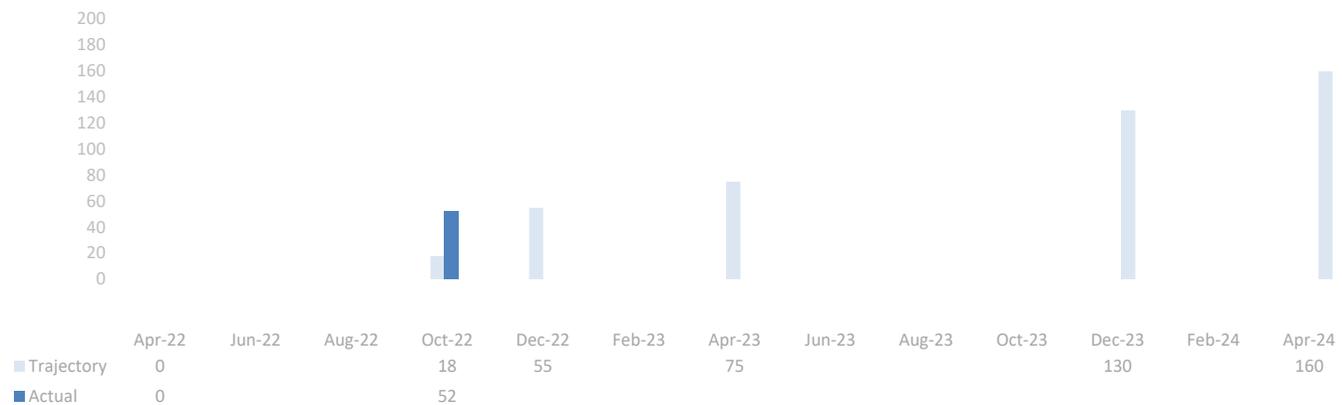
### Community waiting list size

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



Target

### Virtual ward beds trajectory



# A Great Place to Work

Ensuring our people are listened to, safe and supported

## Nursing and Midwifery Recruitment

The nursing vacancy rate reduced in month to 9% This will rise in November due to the planned increase in establishment. However, the impact of this year's International nurse recruitment programme, with PIN registrations coming through in next few months, we are forecasting a vacancy rate below 10% by the end of the f/y.

70 International Nurses have now arrived and a further 38 are scheduled to arrive by end of December. We have been successful in our bid for national funding for a further 65 international nurses in this f/y and interviews are ongoing. 2 out of our first of 17 international midwives arrived in October. Work continues with our bespoke UK recruitment campaign for midwifery in BHT across multi-media platforms.

## Turnover

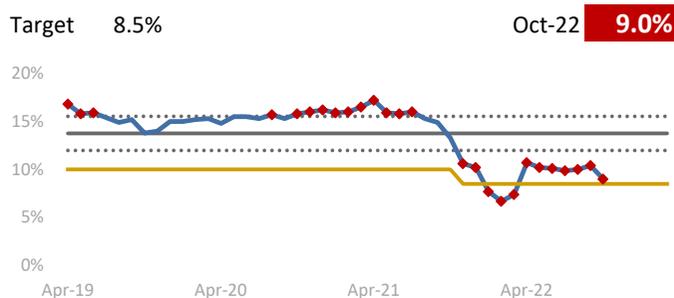
During October turnover has decreased by 0.2% to 14%, this is a consistent downward trend since May (14.9%) 82 colleagues left the Trust, of which 21 were registered nurses and midwives and 7 were healthcare assistants. 17 colleagues retired in October, with 6 returning We have launched a programme to promote flexible retirement options to support colleagues to stay at BHT, keep their skills and expertise in our workforce and also ensure they have a work life balance that suits their needs. At the end of October, the central resignation inbox was activated, allowing us to provide appropriate support options, for example; mediation, wellbeing, flexible hours or career coaching and then retain colleagues where possible.

## Recruitment

The Recruitment Team has a programme of work to improve customer experience and support hiring managers Work is ongoing to increase our brand awareness locally e.g. more social media presence and connections with parish councils to promote our careers page Healthcare support workers: Saturday assessment days are attracting new interest in these roles and we have made further improvements to the process so we can recruit to our target of 35 per month.

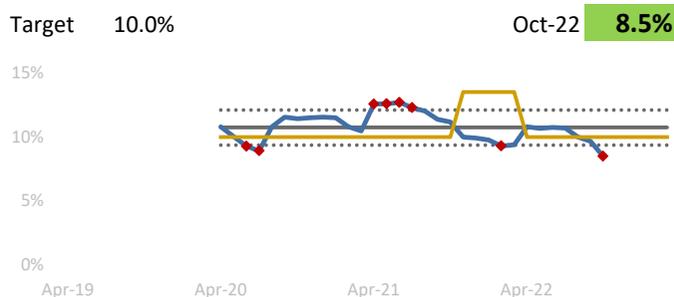
## Nursing and midwifery vacancy rate

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



## Trust overall vacancy rate

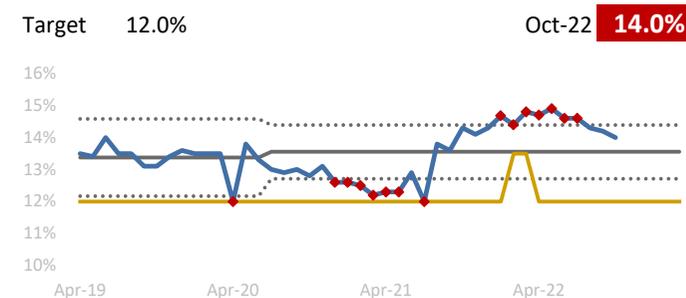
% number of all vacant FTE positions in Trust vs number of all FTE positions (occupied and vacant) in the Trust.



Target

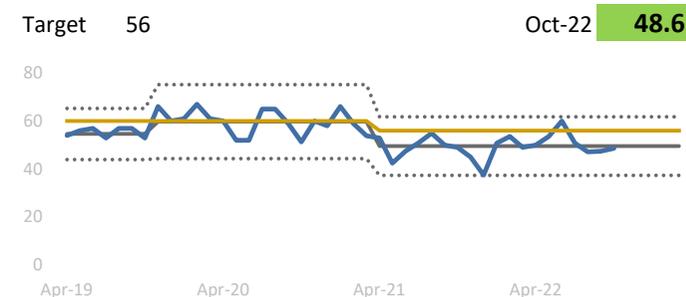
## Turnover rate

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



## Average time to replace vacancies

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



# A Great Place to Work

## Ensuring our people are listened to, safe and supported

### Sickness

COVID-19 related sickness absence stabilised during October, however data continues to be monitored daily, so we can remain responsive to need.

Muscular Skeletal (MSK) referrals into Occupational Health (OH) are processed quickly and feedback from sickness management health summits has been positive about the support offered.

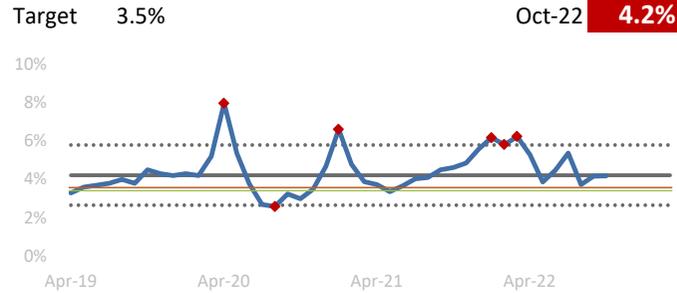
Mental health referrals into OH & Wellbeing remain high although actual sickness reported is remaining stable. OH are managing cases and the Wellbeing team are providing timely and appropriate support e.g. in house counselling or mindfulness interventions.

### Vaccinations - COVID 19 booster and seasonal flu

Vaccination for both COVID-19 and Flu continue to be provided at the Stoke Mandeville, Amersham and Wycombe sites, supplemented with peer vaccinators and support from occupational health. Uptake for Flu is at 33% and COVID-19 boosters are at 35%. Co-administration and single vaccinations are being offered

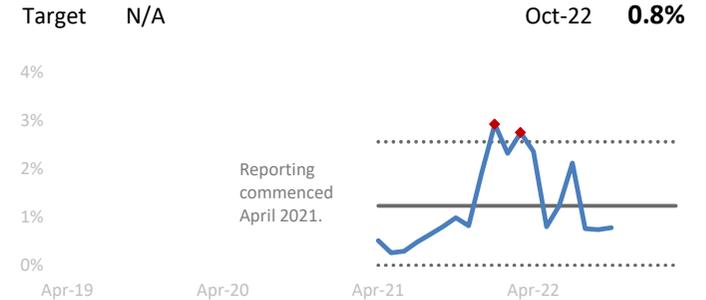
### Sickness

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



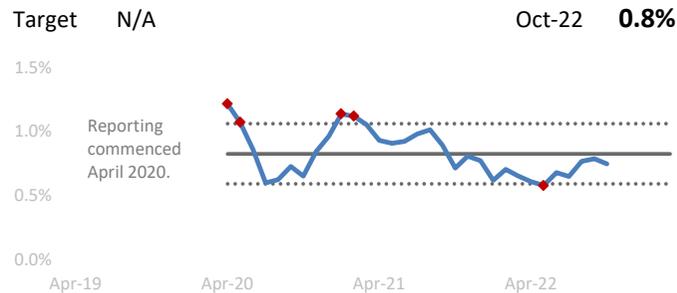
### Sickness - Covid 19

% total working hours lost because of sickness absences due to Covid 19 compared to the trust total working hours.



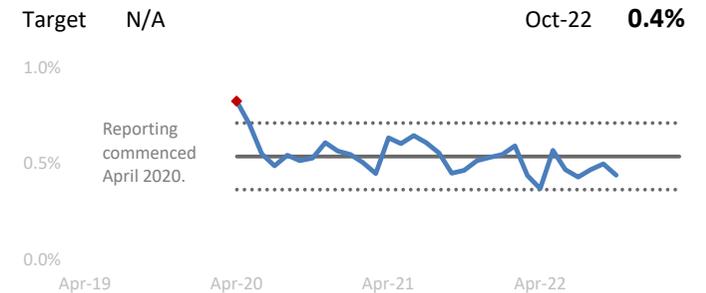
### Sickness - mental health

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



### Sickness - musculoskeletal

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



Target

# A Great Place to Work

## Ensuring our people are listened to, safe and supported

### Occupational Health Management Referrals

Stress referrals have increased to 129 this month. However, this is due to increase in supportive conversations (confidential assessment and signposting for early pro-active support). It is encouraging that these have not led to a greater need for counselling and a positive indicator of colleagues reaching out for support earlier, before longer term psychological support is required.

### OH and Wellbeing

The embedding of departmental health summits for sickness absence management are well received. Managers are discussing their concerns regarding staff health and wellbeing with HR and the OH&WB teams to identify interventions or advice. Health checks for staff have been extended to the Wycombe site in October. These are being well received by our colleagues and have resulted in onward referrals when issues have been identified.

Wellbeing team to increase support in response to organisational pressure points or incidents, to enable winter resilience and mitigate stressors.

Targeted MSK support in areas identified as high need by Occupational Health physiotherapists.

In anticipation of the impact of the cost of living crisis on colleagues we have implemented a dedicated workstream. To date, we have sent a support booklet to all colleagues, launched a hardship fund, a food collaborative, a £1 'kindness' meal pilot and a car sharing app. We are holding regular listening events to ensure we are delivering the right support to our colleagues in line with our 'Great Place to Work' key priority.

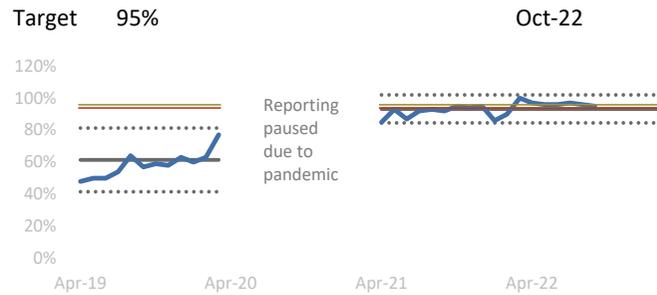
### Employee Relations

Increase in cases closed from 6.21 to 6.81 (per 1000 employees) – 5 cases were closed during October, across the medical and non-medical case-load.

Latest data not available at time of report production

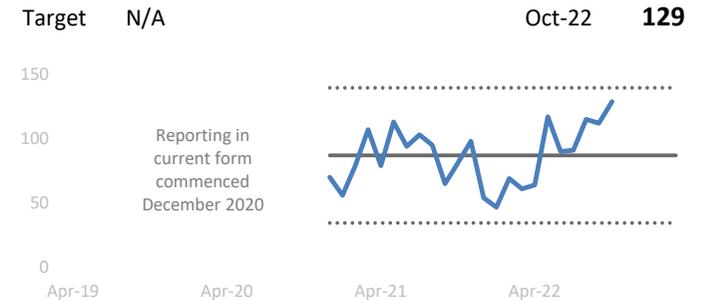
### Occupational Health Management referrals

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



### Referrals into OH and Wellbeing - stress

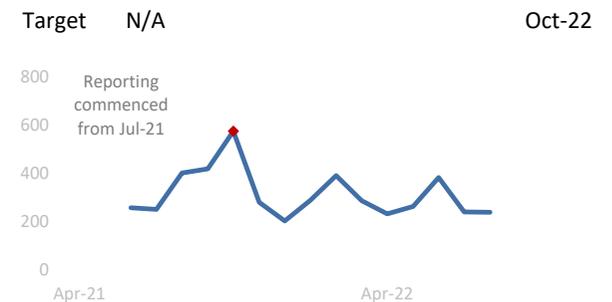
Referrals into Occupational Health and Wellbeing for stress per month.



Latest data not available at time of report production

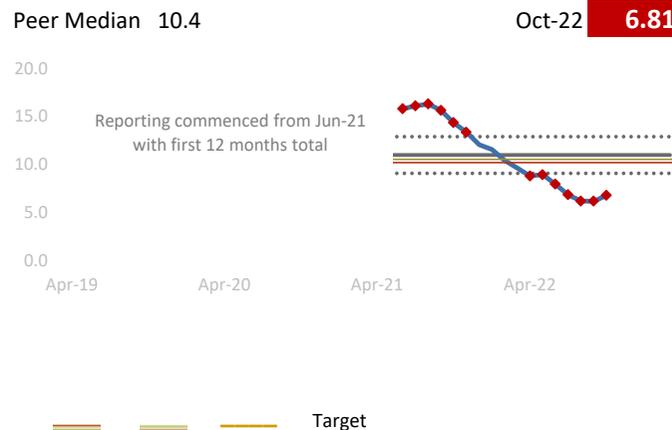
### FTSUG outreach contacts

Freedom To Speak Up Guardian Outreach contacts within month.



### Employee Relations Cases Closed

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



# A Great Place to Work

## Ensuring our people are listened to, safe and supported

### Data Security Awareness Training

The current training compliance as at 15.11.2022 is 91%, an improvement on the previous month.

This remains below the 95% compliance for this module. Reminder emails are sent to non-compliant staff each month and the Caldicott Guardian has sent a reminder to non-compliant medics.

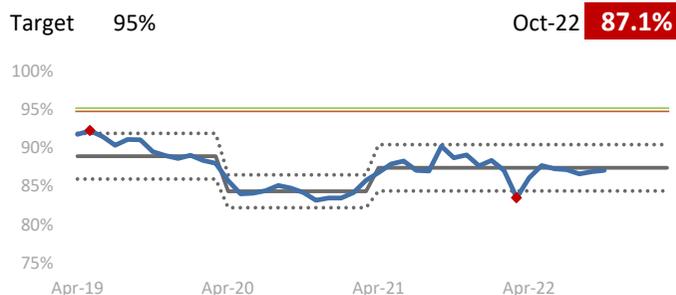
Regular reminder bulletins and newsletters are released.

### Corporate Induction

A 98% attendance record has been achieved at the BHT Welcome & Induction event. With positive feedback continually being received about the virtual BHT Welcome and Induction.

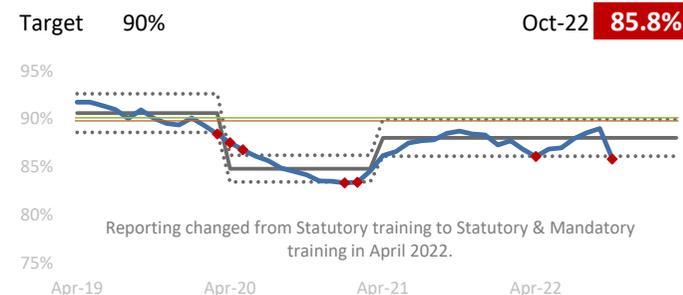
### Data security awareness training

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



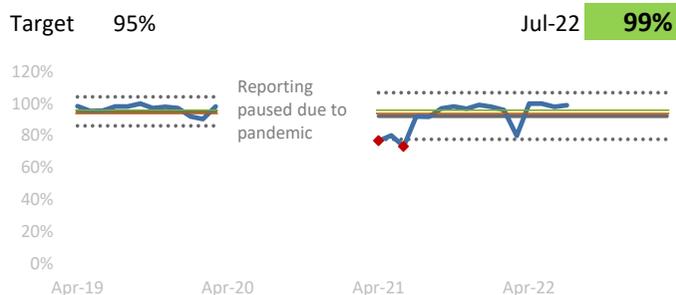
### Statutory & Mandatory training

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



### Corporate induction

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



Target

Induction metric runs in arrears due to reporting not being possible until 3 months after joining month.

# Integrated Performance & Quality Report

## SPC Charts

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

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

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

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

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

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

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

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

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

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



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

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

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

## Key to Variation and Assurance icons

### Variation

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

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

 Common cause - no significant change.

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

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

### Assurance

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

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

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

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

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	Elective Care Tier 1&2 Board Certification
<b>Board Lead</b>	Raghuv Bhasin, Chief Operating Officer
<b>Type name of Author</b>	Matan Czaczkes , Deputy Delivery Director
<b>Attachments</b>	Tier 1 and tier 2 ER programme
<b>Purpose</b>	Assurance
<b>Previously considered</b>	n/a

### Executive Summary

In a letter (see attached) dated 25 October 2022 NHS England required all tier 1 and tier 2 providers for elective care and cancer (those providers judged as greatest risk of not delivering national targets) to conduct a board self-certification relating to elective care and cancer provision and improvement by 11 November 2022.

The Trust undertook this self-certification which was signed off by the Chair and Chief Executive and submitted to NHS England by the required date. This paper provides the self-certification to the Board for assurance.

<b>Decision</b>	The Board is asked to take assurance from the self-certification
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### Relevant Strategic Priority

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

<b>Patient Safety</b>	Delays to diagnosis and treatment can impact patient safety.
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	1. Failure to consistently provide outstanding quality care that is compassionate, cost effective & safe
<b>Financial</b>	Significant investment has been made in cancer and elective recovery.
<b>Compliance CQC Standards Safety</b>	Safety – patients may be at risk from delays to their diagnosis and treatment
<b>Partnership: consultation / communication</b>	ICB and other local partners are aware of the cancer and elective backlogs at BHT
<b>Equality</b>	Delays to diagnosis and treatment affect all patients.
<b>Quality Impact Assessment [QIA] completion required?</b>	Harm is currently reviewed through the cancer and long waiter harms process that reports up to the Board

1. The self-certification and wider letter is an agglomeration of a range of previous letters and guidance from NHS England relating to elective care and cancer. The majority of actions are already underway and reported on.

2. A tracker has been developed to coordinate delivery of the requirements set out in the letter – both the 12 items in the self-certification and wider elements in the letter. This tracker and the actions therein are being built into the workplans for the planned care and cancer boards respectively within the Trust.
3. The self-certification that was used for sign-off by the Chair and CEO is set out at Appendix One. Our self-certification showed that eight of twelve criteria were assessed as being met in full with four assessed as being partially met. Of these:
  - a. Specific cancer pathway reports – detail is included in the November IPR so this is now met.
  - b. Delivering outpatient transformation programme – work is underway to deliver on the various outpatient targets but performance is not yet meeting national targets. A wider refresh of our outpatient transformation programme linked with that of the ICB focused on wider productivity and efficiency of outpatient services to improve patient experience.
  - c. Validation – an ongoing programme of validation is underway however the specifics set out in the letter are not currently in place and have resource implications. These resource implications and potential benefits are currently being worked through for review in the coming weeks.
  - d. Review model hospital productivity – all specialties currently review their Getting It Right First Time and wider model hospital metrics. A systematic, trust-wide programme is not yet in place but is under development as part of a wider productivity review.
4. The self-certification process has been a helpful check and challenge on the Trust's improvement programmes for cancer care and elective care respectively. There continues to be significant scope for improvement in both areas that are being considered by internal trust teams and monitored through the Transformation Board.

Appendix One – Self-certification table

Requirement	Has criteria been met?	Narrative update (three points max)	Impact, actions and delivery evidence
Nominated exec director for elective and cancer performance	Yes	The COO is the Executive Director for both cancer and elective performance supported by the Chief Medical Officer as Executive Sponsor for Planned Care.	
Regular Board reports on wider elective improvement plans	Yes	Progress against performance and plans via the Integrated Performance Report (IPR) and regular deep dives, including comparative performance locally/nationally	
78 week and 62 day trajectories in place	Yes	Trajectories in place and reported on to Board through the IPR. - Significant improvements made on 78 week waiters from over 2000 in November 2021 (over 25% of regional total) to under 200 in November 2022 (under 7% of regional total) - Trust is currently ahead of trajectory to have no 78 week waiters by March 2023 - Cancer 62-day backlog now under 300 (down from a peak of over 450 at the start of August) and at 10.3% of overall PTL.	Elective: As of 31 October the Trust was ahead of trajectory for 78 weeks by 63% (178 vs plan of 488)  Cancer: As of 31 October the Trust was 8.6% behind the trajectory for the proportion of the PTL which is over 62 days
Specific cancer pathway reports - Dermatology - Lower GI - Urology/Prostate	Partial	Elements contained within wider cancer plan as shared with sub-committees, but not yet an explicit paper on the three identified areas. This is planned for November through additional detail in the IPR. - Work ongoing to with primary care to increase dermatology referrals with images with regional support however needs significant focus across Thames Valley Cancer Alliance (TVCA) - QFIT % slightly lower than TVCA target with work underway with TVCA to increase % - needs significant focus across TVCA to increase %s - Best practice prostate pathway now in place	Dermatology A&G requests YTD average is 563 compared to 450 last calendar year  Current QFit test referral proportion: 52.3% vs TVCA target of 55%  Urology 62+ day waits down by 40% from end July to end October. New best practice prostate 'one stop shop' pathway live

Delivering outpatient transformation programme	Partial	Trust-wide outpatient transformation programme in place linked to ICS outpatient transformation programme. Reports on some outpatient outcome measures included in Board reporting with deep dive due at Board Committee shortly. Further work underway to revise outpatient programme as part of wider elective care strategy refresh.	Proportion of OPD as virtual: 21.9% vs target of 25%  PIFU pathways opened to date: 2924 - c.2.6% of pathways against ambition of 5% by year end  9.3 A&G per 100 1st vs target of 14. Total A&G have increased by 225 YTD compared to last year  Total OPD activity 5.6% lower in current year-to-date and then same time 19/20
Report on Super September impact	Yes	F&BP Committee received update on ophthalmology and T&O Progress and impact, which was the focus of the work carried on in BHT. Further super-charged clinics planned over the coming months to develop model for widespread implementation	OPD super charged week: 63% increase in productivity compared to normal scheduled activity in Trauma and Orthopaedics.
Received validation impact report	Partial	Updates on validation provided as part of wider performance updates. Detailed validation plan aligned to the letter not yet in place and currently under discussion given resource implications.	
Clinical prioritisation and target turnaround time report	Yes	Clinical prioritisation discussions and conversations have taken place. Review of turnaround times not yet been shared with board or sub-committees but turnaround times are being met when requests are put in as urgent. Further work underway to improve the pathways through a diagnostic task and finish group	2WW diagnostic turn around time 7.7 days vs minimum backstop of 10
Discuss theatre productivity at every trust Board	Yes	Theatre productivity metric build into the IPR with regular discussion at Board and sub-committees Independent Foureyes report shows BHT theatre productivity has improved significantly and theatre booking processes have been complemented and seen as an exemplar Significant estate challenges remain which routinely remove theatres from circulation and inhibit our productivity drive	September theatre utilisation was 89.3% against a target of 85%
Review model health system theatre productivity	Partial	Paper shared at F&BP on productivity and efficiency, including regional comparison. Next step is to build findings into productivity programme and resubmit to board All specialties currently reviewing their model hospital and GIRFT data as part of operational planning	Day base 'basket' rate for September was 97.9% compared to 92.8% in July

Confirm your SROs for theatre productivity.	Yes	Divisional Director for Surgery is the Delivery SRO and CMO as Executive Sponsor	
Diagnostic services meet minimum optimal utilisation standards	Yes	CT and MRI capacity within the trust is at 100% utilisation. Scanners are open 12hours per day Mon-Fri and 7 hours per day Sat-Sun. Discussions with BOB ICB have begun to understand and produce gap analysis against NHS Minimum standards	MRI & CT utilisations at 100%

To: NHS Trust and Foundation Trust chief  
executives and chairs

NHS England  
Wellington House  
133-155 Waterloo Road  
London  
SE1 8UG

25 October 2022

Dear colleague,

### **Next steps on elective care for Tier One and Tier Two providers**

On 18 October, NHS England wrote to the NHS outlining further plans to boost capacity and resilience for services over the coming challenging winter period. This letter now sets out immediate next steps for tier one and tier two of the elective recovery programme to ensure that our phase two objectives around 78 week waiters and 62 day cancer waits are met.

The NHS has delivered a massive reduction in patients waiting two years and is also now steadily reducing the number of people waiting more than 18 months and 62 days respectively. Activity levels compared to pre-pandemic are increasing but we can still do more. There is no one silver bullet, but through a combination of getting the basics right and data-led management and innovation, particularly on outpatient and diagnostic activity, we firmly believe that we can continue to make genuine progress.

We realise that there are a lot of asks on providers and that each of you will know best your local circumstances and what works well. However, through each wave of Covid over the past two years, hospitals have got better and better at protecting elective and cancer care. There are significant learnings from individual organisations across the country that can make a huge difference if adopted collectively. That is why we are now asking all colleagues to step up efforts on all of the measures outlined below. With this in mind, we ask that you complete the Board self certification, (see appendix A) to allow us to support you where you are having the greatest challenges. The fundamentals that we have, collectively, proven to work are:

#### **Excellence in the Fundamentals of Waiting List Management**

Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance. All patients past 62 days for cancer and 78

weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.

## **Validation**

The validation and review of patients on a non-admitted waiting list is important for the appropriate use of outpatient capacity and to provide clean visible waiting lists to ensure timely and orderly access to care. There are three phases to validating waiting lists that providers are required to undertake routinely – technical, administration and clinical and, following on from guidance sent out on 16 August available [here](#), we expect providers to meet this timeline:

a) By 23rd December 2022

Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated\* in the previous 12 weeks should be contacted

b) By 24th February 2023

Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated\* in the previous 12 weeks should be contacted

c) By 28th April 2023

Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated\* in the previous 12 weeks should be contacted

## **Appropriate surgical and diagnostic prioritisation**

We know that 85% of patients waiting longer than 62 days from their referral for urgent suspected cancer are waiting for a diagnostic test. For cancer in particular, the significant demand for additional diagnostic capacity means that Trusts need to adhere to the [maximum timeframes](#) for diagnostic tests within each tumour-specific Best Practice Timed Pathway, but should at all times have a maximum backstop timeframe of 10 days from referral to report. Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.

Trusts should ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single PTLs across the system. Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved, and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity.

Surgical prioritisation should continue to follow the guidance set out in the [letter of 25 July](#), providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.

### **Cancer pathway re-design for Lower GI, Skin and Prostate**

There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally.

#### *Lower GI: Full Implementation of FIT in the 2ww pathway*

As set out in the [joint guidance on FIT](#) issued by the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland (ACPGBI), and reinforced in [this letter](#), most patients with suspected colorectal cancer symptoms but a FIT of fHb <10 µg Hb/g, a normal full blood count, and no ongoing clinical concerns should not be referred on a LGI urgent cancer pathway. Where referred, teams should not automatically offer endoscopic investigation but consider alternative, non two week wait, pathways as set out in the letter.

#### *Full implementation of teledermatology in the suspected skin cancer pathway*

All Trusts should work with their ICS to implement teledermatology and digital referral platforms to optimise suspected skin cancer pathways and reduce unnecessary hospital attendances to tackle the backlog and meet increasing demand. NHS England's [guidance on the implementation of teledermatology pathways](#) is endorsed by the British Association of Dermatologists and supports a Best Practice Timed Pathway for skin cancer which has been published this week.

Implementation will require provision for dermoscopic images to be taken for Urgent Suspected Cancer Skin cancers. This could be delivered by primary care, a separately contracted service delivered by primary care, in a community image taking hub setting, or by medical illustration departments in secondary care. Capacity must be in place for daily dermatologist triage of images, as either additional activity or as part of existing job plans. Following triage, the consultant or a member of their team should communicate with the patient (via telephone, video or face-to-face consultation) and be booked directly for surgery and receive appropriate preoperative advice and counselling if required.

### *Full implementation of the Best Practice Timed Pathway for prostate cancer*

All provider Trusts should implement the national 28-day [Best Practice Timed Pathway for prostate cancer](#), centred on the use of multiparametric MRI (mpMRI) before biopsy. Using pre-biopsy mpMRI means patients can be triaged towards a biopsy so at least 25% can avoid it, over 90% of significant cancers can be diagnosed on imaging and fewer insignificant cancers are diagnosed. Use of local anaesthetic transperineal biopsy where clinically indicated provides increased accuracy and reduced risk of infection, without the resource intensity of procedures done under general anaesthetic.

Implementation will require all patients to be booked in for both mpMRI and biopsy at the point of triage, with triage taking place no later than 3 days from the date the referral is received. Ring-fenced mpMRI slots should be in place – weekly demand analysis from radiology requesting systems should be used to inform the level at which this is set, with frequency of mpMRI slots sufficient to support delivery of timely biopsy. Maximum use of local anaesthetic transperineal prostate biopsy should also be ensured, with general anaesthetic biopsy used only where clinically indicated or for patient preference. Pre-biopsy mpMRI and biopsy procedures should take place no later than 9 days from the date the referral is received.

### **Outpatient transformation**

Outpatients make up around 80% of the total waiting list and it is crucial that, over the winter period, providers continue to keep a strong operational focus on providing these services. Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.

- a) As part of this, trusts are asked to continue the expansion of [patient initiated follow up \(PIFU\)](#) to all major outpatient specialties, especially increasing the volume of PIFU activity in specialties where it is now well established.
- b) Continue to deliver [at least 16 specialist advice requests](#) per 100 first outpatient appointments. Providers are asked to focus efforts on pre-referral advice models.
- c) Further initiatives to support outpatient follow-up (OPFU) reduction should also include improved and standardised discharge procedures and more effective administrative processes – including focusing on reducing DNAs in outpatient settings
- d) In order to enable a personalised approach for outpatients and where it is clinically appropriate to do so, outpatient appointments should continue to be delivered via video and telephone, at a rate of 25% of all outpatient appointments. Remote consultation guidance and implementation materials can be found on NHS Futures [here](#).

## **Surgical and theatre productivity**

It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter. As such we expect providers to:

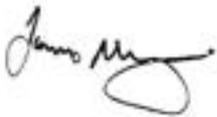
- a) Review the senior responsible officer(s) (SROs) and oversight arrangements in relation to theatre productivity and strengthen these if necessary. Ideally, it should consist of a senior manager working 'shoulder-to-shoulder' with a senior clinician – to succeed we need both groups working together.
- b) Drive up theatre utilisation to 85%, underpinned by the cases per list standards set out within the GIRFT high volume low complexity (HVLC) programme.
- c) Make elective surgery daycase by default, delivering daycase rates across all surgery of 85%, and helping to free up valuable inpatient beds for complex work.
- d) Maximise Right procedure right place, taking simple surgical procedures out of theatre into procedure rooms, eg hand surgery, cystoscopy, hysteroscopy
- e) Adopt best practice pre & peri-operative medicine pathways to reduce issues of under booking of lists, on the day cancellations, and pro-longed length of stay, as well as providing better care for patients.
- f) Optimise the booking & scheduling processes, ensuring that patients are ready for surgery prior to being offered a surgery date, with an embedded data driven, clinically led approach.
- g) Not performing those interventions identified as 'must not do' on EBI lists 1 and 2 and following the stated process for those List 1 and 2 interventions that should only be performed after applying the specific criteria.

## **Board Self-certification**

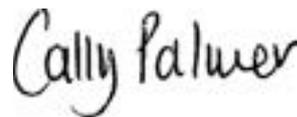
As part of the above priorities, we are asking each provider to undertake a Board self certification process and have it signed off by Trust Chairs and CEOs by November 11, 2022. If you are unable to complete the self certification process then please could you discuss next steps with your Regional team. The details of this self certification can be found at Appendix A.

Thank you for all of your continued hard work in addressing what are two critical priorities for the NHS over the winter period. Please share this letter with your Board, key clinical and operational teams and relevant committees, and do email [england.electiveopsanddelivery@nhs.net](mailto:england.electiveopsanddelivery@nhs.net) should you have any questions.

Yours sincerely,



**Sir James Mackey**  
National Director of Elective Recovery  
NHS England



**Dame Cally Palmer**  
National Cancer Director  
NHS England

**The Chair and CEO are asked to confirm that the Board:**

- a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.
- b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.
- c) Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.
- d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.
- e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.
- f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.
- g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.
- h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.

- i) Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.
- j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.
- k) Confirm your SROs for theatre productivity.
- l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.

Signed by CEO

Date:

Signed by Chair

Date:

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	2022/23 Month 7 Finance Report
<b>Board Lead</b>	Kishamer Sidhu, Interim Chief Finance Officer
<b>Type name of Author</b>	Yasmin Ahmed, Deputy Chief Finance Officer
<b>Attachments</b>	Month 7 Finance Committee Report
<b>Purpose</b>	Assurance
<b>Previously considered</b>	Transformation Board 15.11.2022 F&BPC 22.11.2022

### Executive Summary

- 2022/23 I&E month 7 year to date (YTD) headline position of £10.9m deficit, which is £0.2m adverse to the YTD plan.** In month, the Trust received additional income from HEE of £0.8m. In month expenditure increased in bank pay £0.4m, clinical supplies and drugs expenditure due to increased activity.
- Forecasts have been prepared showing a total of £14.6m of mitigations to be developed across the clinical divisions.** The divisional forecasts are based on current run rates, increased investments and confirmed efficiency savings for 2022/23. Additional meetings have taken place during the month to review the forecasts in greater detail.
- Clinical Income** is reporting contracts are pending for Frimley ICB, Northampton ICB and NW London ICB as they are requesting contracts based on a cost per case basis as opposed to a block arrangement. This has been escalated to the BOB ICB and NHSE as will cause a £2.5m cost pressure to the Trust if contracts are not agreed as Block.
- Capital, Balance Sheet and Cash Flow** will require careful and regular monitoring over the remainder of the year. The programme is currently reporting a potential overspend risk of £5.6m by the end of the year if the overspend is not offset by mitigations to the same value. A large portion of the overspend sits in property services relating to A&E Paeds £2.7m and Radiology equipment installation £3m. At the time of reporting, potential mitigations of £2m have been identified.
- Based on current forecast projections, the Trust does not anticipate seeking cash support in 2022-23 however this will be continually and actively monitored throughout the year.

This report was considered at Transformation Board on 15 November and the Finance and Business Performance Committee on 22 November 2022. Risks related to the planned year end deficit and the capital position were acknowledged and discussed.

<b>Decision</b>	The Board is requested to take assurance from the paper.		
<b>Relevant Strategic Priority</b>			
<b>Outstanding Care</b> ☒	<b>Healthy Communities</b> ☒	<b>Great Place to Work</b> ☒	<b>Net Zero</b> ☒
<b>Implications / Impact</b>			
<b>Patient Safety</b>	Any impacts on patient safety are identified and addressed as part of the Trust and divisional integrated performance review process		
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	BAF 2 – Failure to deliver our annual financial plan		
<b>Financial</b>	See Executive Summary in paper		

<b>Compliance NHS Regulation Good Governance</b>	Monthly reporting is provided to the committee to provide assurance. The financial position is reported to NHSE/I on a monthly basis as part of the regulatory oversight process
<b>Partnership: consultation / communication</b>	This report is shared with partners across the ICP, ICS and regulators, as required.
<b>Equality</b>	Any material equality impacts of expenditure are identified and addressed as part of the budget setting process
<b>Quality Impact Assessment [QIA] completion required?</b>	Impact assessments of budget setting and planning were undertaken during the Operating Planning round for 2022/23. See CIP Productivity and Transformation report for further information.

Finance Report Month 7 - 31st October, 2022



# Contents

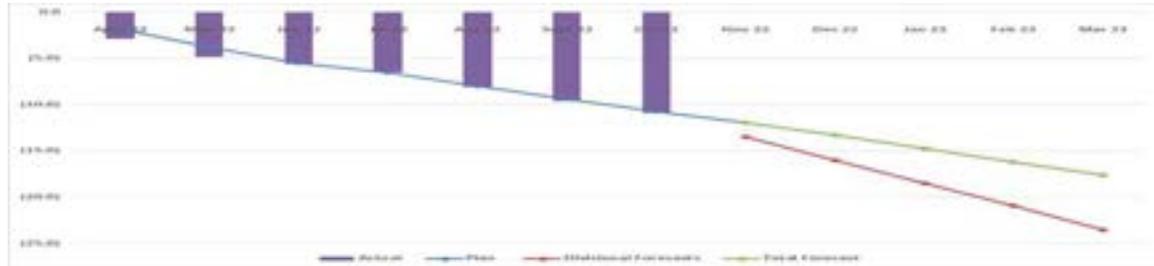
Page 3	Financial performance
Page 4	Key Highlights: Income
Page 5	Key Highlights: Expenditure (Pay & Workforce)
Page 6	Key Highlights: Expenditure (Non Pay)
Page 7	Divisional Position
Page 8	Balance Sheet
Page 9	Balance Sheet
Page 10	Cash Position
Page 11	Capital Position
Page 12	Glossary and Definitions

## Financial performance

**Table 1 - Income and expenditure summary**

(£m)	In Mth Plan	In Mth Actuals	In Mth Variance	YTD Mth Plan	YTD Actuals	YTD Variance	Annual Plan
Contract Income	43.1	43.4	0.3	299.7	299.7	0.0	513.7
Other income	2.5	4.5	2.0	20.9	26.8	5.9	35.1
<b>Total income</b>	<b>45.6</b>	<b>47.9</b>	<b>2.3</b>	<b>320.6</b>	<b>326.5</b>	<b>5.9</b>	<b>548.8</b>
Pay	(28.3)	(29.1)	(0.8)	(197.8)	(200.7)	(2.9)	(338.4)
Non-pay	(15.3)	(17.0)	(1.7)	(110.8)	(115.1)	(4.3)	(189.1)
<b>Total operating expenditure</b>	<b>(43.6)</b>	<b>(46.1)</b>	<b>(2.5)</b>	<b>(308.5)</b>	<b>(315.8)</b>	<b>(7.3)</b>	<b>(527.5)</b>
<b>EBITDA</b>	<b>2.0</b>	<b>1.8</b>	<b>(0.2)</b>	<b>12.1</b>	<b>10.7</b>	<b>(1.4)</b>	<b>21.4</b>
Non Operating Expenditure	(3.3)	(3.1)	0.2	(22.8)	(21.6)	1.2	(39.0)
<b>Retained Surplus / (Deficit)</b>	<b>(1.3)</b>	<b>(1.3)</b>	<b>(0.0)</b>	<b>(10.7)</b>	<b>(10.9)</b>	<b>(0.2)</b>	<b>(17.6)</b>

**Graph 1 - Income & Expenditure YTD position & Forecast**



### Executive Summary

- The Trust reports a £10.9m deficit position YTD, £0.2m adverse to plan.

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

- Each division has prepared and reviewed a divisional forecast at month 7 based on current run rates, increased investments and confirmed efficiency savings. The overall current forecast position shows that £14.6m of mitigations need to be developed for the Clinical divisions to deliver these areas in line with plan. The forecast for Corporate areas are £1.0m favourable to plan.

- Contract income is in line with plan YTD.

- Other income totals £26.8m YTD, £5.9m favourable to plan. This is primarily driven by Education & Training monies, £3.1m YTD and additional non recurrent local authority and ICB service development funding, £2.9m.

- The Clinical Divisional Budget Plan for the year totals £390.7m. YTD the clinical divisions report a £8.8m adverse variance to this plan which is primarily driven by additional spend within the Integrated Medicine Division and Surgery & Critical Care Division. Further details of the key drivers of this overspend are detailed on page 7 of this report.

- YTD pay costs total £200.7m, £2.9m adverse to plan. Key drivers of this adverse position include medical staffing spend and temporary staffing usage to cover operational pressures. Further details and actions being taken are provided on page 5.

- YTD non-pay costs total £115.1m, £4.3m adverse to plan. Overspends continue on Independent Sector costs totalling £3.6m YTD and drugs £0.7m overspent YTD. In addition, consultancy costs report a £1.0m overspend YTD however these costs are not expected to continue in the second half of the year. These overspends are partly offset with clinical supply underspends totalling £1.2m YTD. Energy costs are being assessed, but are likely to be significant and an additional risk in delivery of the plan in future months. Further details are provided on page 6.

- Non operating expenditure reports a £1.2m favourable variance YTD relating to Depreciation charges.

## Key Highlights: Income

### NHS Income and Activity

• The contract income position totals £299.7m YTD which is in line with plan. The Trust is awaiting details of additional income agreed outside of the block agreement from BOB ICB. Contracts are pending for Frimley ICB, Northampton ICB and NW London ICB as they are requesting contracts based on a cost per case basis as opposed to a block arrangement. This has been escalated to the BOB ICB and NHSE as will cause a £2.5m cost pressure to the Trust if contracts are not agreed as Block.

• Elective recovery funding (ERF) received by the Trust as part of our contract baseline values, are subject to repayment (income clawback) where the weighted activity levels in 2022/23 fall below the 104% and 110% targets of 19/20 levels. If the rules set out in national planning guidance were to be strictly applied to activity levels then this would create additional YTD financial risk but guidance from NHSE is that no provisions are made YTD on expected underperformance. The integrated performance report (IPR) has details on current activity levels compared to 2019/20.

• The Statistical Process Control Chart (Graph 2) for Contract Income shows income is close to the mean with a few exceptions. The February 2021 position includes £2.6m additional monies received from NHSE relating to funding support for lost income during the Covid-19 pandemic and the March 2021 position includes further income received to cover income lost during the Covid-19 pandemic totalling £2.8m. The increase in contract income in September 2021 relates to the back-dated medical and agenda for change pay award income and the additional BOB ICS ERF allocation. The March 2022 position includes an additional £2m received from Bucks CCG. The increase in income in month 3 reflects agreed changes to income for the June 2022 Final Plan submission, and M6 reflecting pay award funding for the previous 6 months.

**Table 2 - Breakdown of Contract Income**

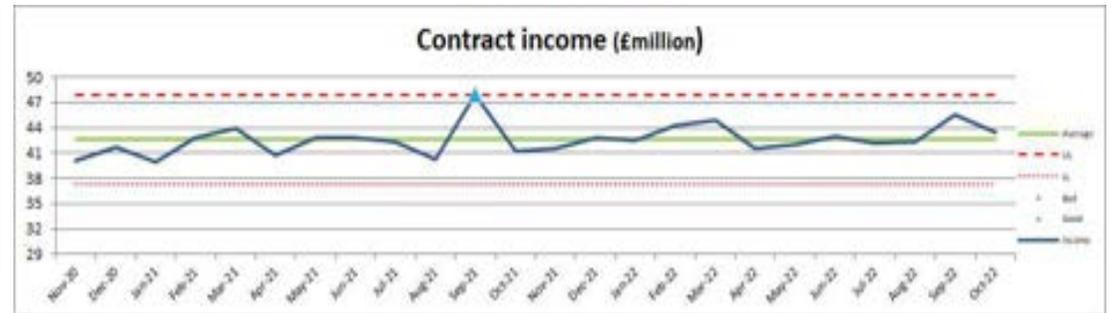
Commissioner (£m)	Annual Budget Total 2022-23	YTD Budget	YTD Actuals	YTD Variance
BOB ICS	345.2	201.0	201.2	0.2
Other NHS	36.5	21.3	21.1	(0.2)
Specialist Commissioners	76.7	44.7	44.7	(0.0)
Other Income	2.9	1.7	1.7	0.0
Bucks Council	14.0	8.1	8.1	(0.0)
Covid	11.1	6.5	6.5	0.0
Growth	13.9	8.1	8.1	0.0
ERF	13.4	8.2	8.2	(0.0)
<b>Total</b>	<b>513.7</b>	<b>299.7</b>	<b>299.7</b>	<b>0.0</b>

### Other Income

**Table 3 - Breakdown of other income**

Category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Research	1.2	0.6	1.1	0.5
Education And Training	11.4	6.7	9.7	3.1
Non-NHS PPS & Overseas Visitors	3.5	2.0	1.6	(0.4)
Injury cost recovery scheme	1.2	0.7	0.5	(0.2)
Donated Asset Income	1.0	0.6	0.6	0.0
Other Income	16.9	10.3	13.3	2.9
<b>Total</b>	<b>35.1</b>	<b>20.9</b>	<b>26.8</b>	<b>5.9</b>

**Graph 2 - Contract Income Statistical Process Control (SPC) Charts**



• Other Income (Table 3) is £5.9m favourable to plan YTD .

• Private Patient and Overseas work is £0.4m adverse to plan YTD.

• Donated Asset Income is in line with plan YTD. Any variance reported against donated asset income is removed when calculating the bottom line financial position as the full impact of donated asset income and depreciation is removed when calculating the final position.

• Education and Training income is £3.1m favourable to plan YTD, due to a combination of non recurrent income received in year and a favourable recurrent income position.

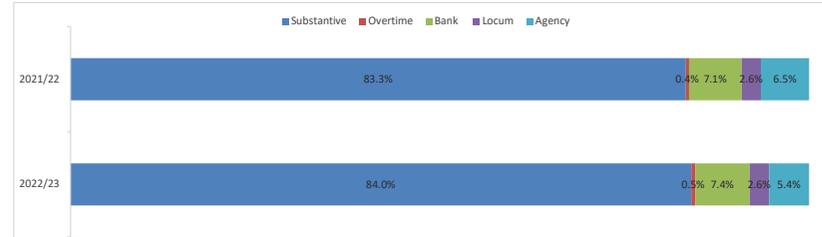
• Other income is £2.9m favourable to plan. This is mainly due to non-recurrent and project income from local authorities and not a trend that is expected to continue.

## Key Highlights: Expenditure (Pay & Workforce)

**Table 4 - YTD pay position**

Pay category (£m)	YTD Budget	YTD Spend *	YTD Variance	% of Total Pay Bill	Last Year YTD Spend	Last Year % of Total Pay Bill
Substantive	196.5	168.7	27.8	84.0%	155.7	83.3%
Overtime	0.0	1.1	(1.1)	0.5%	0.8	0.4%
Bank	0.9	14.8	(13.9)	7.4%	13.3	7.1%
Locum	0.4	5.3	(4.9)	2.6%	4.9	2.6%
Agency	0.0	10.9	(10.9)	5.4%	12.2	6.5%
<b>Total</b>	<b>197.8</b>	<b>200.7</b>	<b>(2.9)</b>	<b>100.0%</b>	<b>186.8</b>	<b>100.0%</b>

**Graph 2 - YTD pay position**



• Pay expenditure totals £200.7m YTD, £2.9m adverse to plan. Key pressure areas in pay include Integrated Medicine Division, £4.7m YTD where acuity and high sickness levels have driven high temporary staffing usage in Emergency and Acute Medicine and the Surgery & Critical Care Division, £0.9m YTD with pressure areas including waiting list initiative payments and Medical locum usage. This is partly offset by a favourable position in provisions.

• The YTD pay position includes the pay award within the divisional positions and this cost has been matched with budget. Bank staff will receive their pay award in November and a provision for this cost is included within the year to date position totalling £0.7m.

• The 2021-22 pay position included a year end provision relating to annual leave to be taken in the 2022-23 financial year totalling £5.8m. £3.4m of this has been released in the position YTD with the remainder to be released as we move through the financial year as staff take their annual leave. The budget plan also assumes this will be released so does not drive any variance against plan.

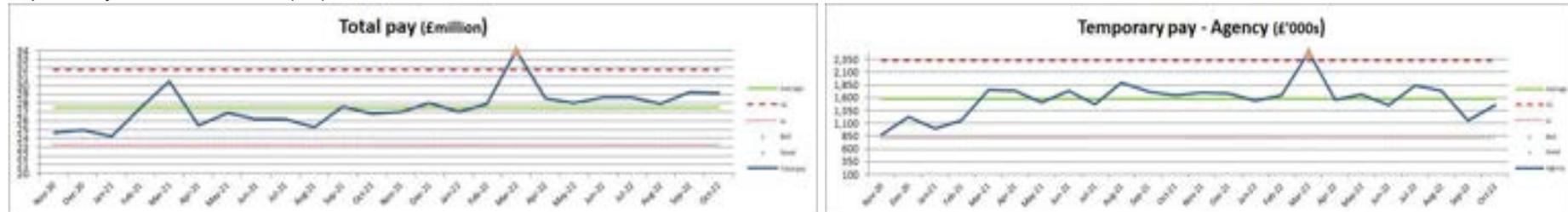
• Temporary staffing expenditure (Bank, Agency & locum) totals £31.0m for the year, £5.3m in month. A large proportion of this is offset by underspends against substantive budgets, £27.8m underspent YTD (See table 4 above). Agency expenditure totals £1.5m for the month, £10.9m YTD. Key usage areas include Emergency Medicine, IT, Radiology, Medicine for Older People and Acute Medical wards. Month 7 agency spend has increased by £0.4m compared to month 6 levels however this relates to the recoding of invoices away from agency to other spend categories in month 6. Bank and locum costs increased by £1.1m in month 7 compared to month 6. The key change here is the recoding of the bank pay award provision due to be paid next month which has been reassigned to bank expenditure in month 7 from substantive expenditure in month 6 totalling £0.7m. In addition, bank costs have increased in month 7 due to changes in bank rates for ODP staff within Theatres, £0.1m and a £0.2m increase in bank costs within Integrated Medicine.

• 2020-21 year end provisions for the working time directive payments and ongoing flowers legal case payments continue to be held in the balance sheet position as at month 7 and will be released to match spend as and when this comes through.

• The forecast outturn on pay is an £11.5m adverse variance. Key drivers of this are the continuation of the issues noted above in the year to date position and CIP delivery not on plan. In addition, budgets for winter funding will be included in month 8 and a detailed review of recruitment assumptions is taking place with the Chief Executive and Chief Finance Officer during November.

• The Pay Statistical Process Control Charts are detailed below (Graph 3/4). Key highlights include the increase in total pay costs in February 2021 and 2022, relating to provisions for the Flowers legal case, unsocial hours claims and payment of consultant CEA awards. The increase in total pay costs in March 2021 and 2022 includes payment of the bank winter incentive payments and year end pay related provisions as noted above. The drop in pay costs in April 2022 reflect the one of adjustments made to the position in month 12 and the release of 1/12th of the annual leave accrual. The increase in agency costs from January 2021 onwards relates to management of the wave of the Covid -19 pandemic. The increase in agency costs in March 2022 relates to H2 investment costs. The increase in total pay costs in September 2022 relates to payment of

**Graphs 3/4 - Pay Statistical Process Control (SPC) Charts**



**Table 4B - Staffing Actuals & Forecast - Temporary staffing breakdown**

£000's	Actual								Forecast					
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Total YTD	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total Forecast
Agency	1,579	1,684	1,460	1,844	1,738	1,126	1,456	10,886	1,458	1,355	1,335	1,328	1,328	17,692
Bank	1,868	1,947	1,913	1,939	2,134	1,897	3,065	14,764	2,097	1,939	2,063	2,052	2,050	24,965
Locum	740	773	817	572	874	756	780	5,312	638	596	574	565	567	8,252
<b>Total Temporary Staffing</b>	<b>4,187</b>	<b>4,404</b>	<b>4,189</b>	<b>4,356</b>	<b>4,746</b>	<b>3,779</b>	<b>5,301</b>	<b>30,962</b>	<b>4,193</b>	<b>3,890</b>	<b>3,972</b>	<b>3,946</b>	<b>3,945</b>	<b>50,909</b>
Substantive Spend	24,480	23,832	24,522	24,337	23,218	25,552	23,826	169,766	25,689	25,842	25,859	25,870	25,972	298,998
<b>Total Pay Spend</b>	<b>28,667</b>	<b>28,236</b>	<b>28,711</b>	<b>28,693</b>	<b>27,963</b>	<b>29,331</b>	<b>29,127</b>	<b>200,728</b>	<b>29,882</b>	<b>29,732</b>	<b>29,831</b>	<b>29,816</b>	<b>29,917</b>	<b>349,907</b>
Plan	27,565	27,823	27,755	27,461	27,601	31,263	28,313	197,781	27,980	28,054	28,180	28,202	28,165	338,362
Variance to Plan	-1,102	-413	-957	-1,232	-362	1,932	-814	-2,947	-1,902	-1,678	-1,651	-1,614	-1,751	-11,544

## Key Highlights: Expenditure (Non Pay)

**Table 5 - YTD non-pay position**

Non-Pay category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Drugs	50.2	29.3	30.0	(0.7)
Clinical supplies	40.0	23.2	22.0	1.2
Other non-pay	98.9	58.3	63.1	(4.8)
<b>Total Expenditure</b>	<b>189.1</b>	<b>110.8</b>	<b>115.1</b>	<b>(4.3)</b>

• Non-pay expenditure totals 115.1m YTD, £4.3m adverse to plan.

• Key drivers of the YTD position include:

• Independent sector usage is £3.6m adverse to plan YTD, with spend in Integrated Medicine and Surgery & Critical Care. This overspend is partly offset within Surgery by underspends in clinical supplies (£1.2m YTD).

• Other non pay pressure areas include establishment expenses, £0.6m overspent YTD including £0.3m on property maintenance and miscellaneous expenditure including consultancy costs totalling £1m. PFI expenditure reports a £0.3m overspent YTD.

**Table 6 - YTD drugs position**

Drug Categories (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
PBR Drugs	11.3	6.6	7.9	(1.3)
PBR excluded Drugs	37.0	21.6	20.9	0.7
Other Drug Items	1.9	1.1	1.2	(0.1)
<b>Total expenditure</b>	<b>50.2</b>	<b>29.3</b>	<b>30.0</b>	<b>(0.7)</b>

• The YTD position includes ROE PFI credits totalling £2.7m which is in line with plan. The negotiations have reached a point where BHT has been issued with a credit note. The agreement is expected to be formally signed by all parties in the near future.

• Drugs expenditure totals £30.0m YTD, which is £0.7m adverse to plan. This mainly relates to Integrated Medicine and is split across PBR and non PBR drugs, and across a number of SDUs.

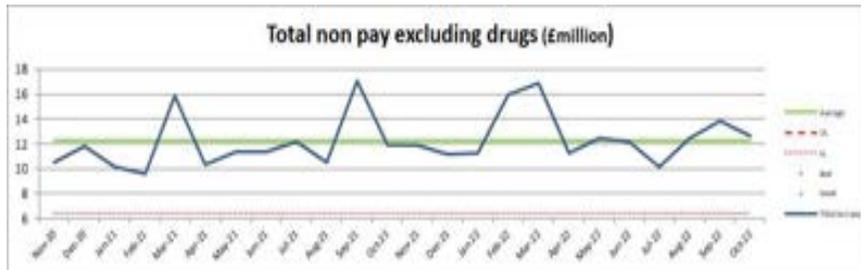
• There is a risk to energy costs in the second half of the year, due to the end of a fixed price agreement and the global price of energy. This is significantly reduced by the governments recent announcement, which is being assessed.

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

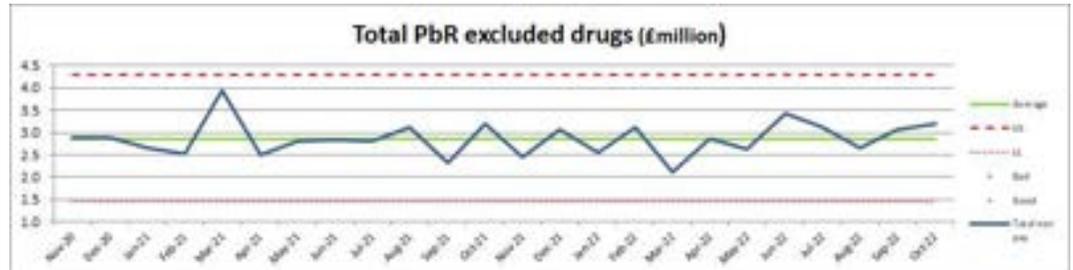
- March 2021 costs are above the mean average as activity levels begin to increase after the short Feb. The August 2021 position includes a £1.0m VAT reclaim and the September 2021 cost increase relates to ERF non pay expenditure. The increase in non pay expenditure in February & March 2022 relates to expenditure incurred for IT cyber and windows 10 licences and site works including roof repairs and demolition works, along with the reassessment of capital / revenue expenditure hitting the non pay expenditure position. The decrease in July 2022 relates to ROE PFI credits received. The increase in Sept 22 relates to a number of areas with relatively small increases inc IS use, training & consultancy.

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

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



**Graph 6 - Non Pay Statistical Process Control (SPC) Charts**



**Divisional Position**

**Breakdown of financial position by division**

**Table 7 - Divisional income and expenditure**

Division / (£m)	YTD Budget	YTD Actuals	YTD Variance against Plan	Annual Plan	Forecast Outturn	Variance Plan to Forecast	Position Signed Off by Divisions*	Current Month Run Rate						
								M01	M02	M03	M04	M05	M06	M07
Integrated Medicine	(55.5)	(63.5)	(8.0)	(94.2)	(106.8)	(12.6)	Yes	(8.8)	(8.6)	(8.8)	(9.2)	(8.9)	(9.7)	(9.5)
Integrated Elderly Care	(27.4)	(27.2)	0.3	(46.9)	(47.3)	(0.3)	Yes	(3.8)	(3.5)	(3.7)	(3.8)	(3.8)	(4.6)	(4.0)
Surgery And Critical Care	(65.8)	(67.4)	(1.6)	(112.6)	(114.6)	(2.0)	Yes	(8.9)	(9.5)	(9.4)	(9.3)	(9.4)	(10.6)	(10.3)
Women and Children	(28.6)	(28.2)	0.4	(49.2)	(49.4)	(0.2)	Yes	(3.9)	(3.8)	(4.1)	(4.2)	(3.5)	(4.6)	(4.2)
Specialist Services	(51.2)	(51.0)	0.2	(87.7)	(87.2)	0.5	Yes	(7.4)	(7.0)	(6.9)	(7.5)	(7.0)	(8.0)	(7.1)
Mitigations to be developed	0.0	0.0	0.0	0.0	14.6	14.6		0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total Clinical Divisions</b>	<b>(228.5)</b>	<b>(237.3)</b>	<b>(8.8)</b>	<b>(390.7)</b>	<b>(390.7)</b>	<b>(0.0)</b>		<b>(32.8)</b>	<b>(32.4)</b>	<b>(32.9)</b>	<b>(33.9)</b>	<b>(32.7)</b>	<b>(37.6)</b>	<b>(35.1)</b>
Chief Executive	(2.3)	(1.8)	0.5	(3.9)	(3.9)	(0.0)	Yes	(0.3)	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.3)
Chief Operating Officer	(2.1)	(3.8)	(1.7)	(3.6)	(5.3)	(1.7)	Yes	(0.5)	(0.5)	(0.4)	(0.3)	(0.9)	(0.8)	(0.3)
Commercial Director Mgmt	(0.0)	0.1	0.2	(0.0)	(0.0)	0.0	Yes	0.0	0.0	0.0	0.0	(0.1)	0.1	0.0
Finance Dept.	(4.2)	(4.1)	0.1	(7.0)	(6.7)	0.3	Yes	(0.6)	(0.6)	(0.5)	(0.6)	(0.4)	(0.8)	(0.6)
Information Technology	(9.6)	(8.9)	0.7	(16.4)	(15.9)	0.5	Yes	(1.3)	(1.2)	(1.3)	(1.3)	(1.3)	(1.4)	(1.2)
Property Services	(33.6)	(33.7)	(0.1)	(57.4)	(58.2)	(0.8)	Yes	(5.2)	(5.4)	(5.1)	(2.5)	(5.6)	(5.1)	(4.9)
Human Resources	(0.4)	1.4	1.8	(0.7)	0.8	1.5	Yes	0.1	0.6	(0.0)	0.1	0.2	(0.1)	0.7
Medical Director	(0.3)	(0.1)	0.2	(0.5)	(0.2)	0.3	Yes	(0.0)	0.0	0.0	(0.0)	(0.0)	(0.0)	(0.1)
Nursing Director	(10.3)	(10.4)	(0.0)	(17.8)	(17.6)	0.2	Yes	(1.5)	(1.5)	(1.5)	(1.4)	(1.5)	(1.5)	(1.5)
PDC And Depreciation	(16.6)	(15.8)	0.8	(28.4)	(27.5)	0.9	N/A	(2.5)	(1.7)	(2.2)	(2.3)	(2.4)	(2.4)	(2.4)
H2 Investments	0.0	0.0	0.0	0.0	0.0	0.0	N/A	(0.2)	0.2	0.0	0.0	0.0	(0.0)	0.0
Mitigations to be developed	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total Corporate</b>	<b>(79.4)</b>	<b>(77.0)</b>	<b>2.4</b>	<b>(135.8)</b>	<b>(134.6)</b>	<b>1.1</b>		<b>(11.8)</b>	<b>(10.5)</b>	<b>(11.2)</b>	<b>(8.4)</b>	<b>(12.2)</b>	<b>(12.4)</b>	<b>(10.5)</b>
Contract Income	299.7	299.7	0.0	513.7	513.7	(0.0)		41.4	41.9	42.9	42.2	42.3	45.6	43.4
Corporate Services / Provisions	(2.5)	3.4	5.9	(4.9)	(5.5)	(0.6)		0.1	(0.7)	0.3	(0.9)	0.9	2.8	0.8
Donated Asset Reporting Adj	0.0	0.3	0.3	0.0	(0.5)	(0.5)		0.1	(0.4)	0.1	0.1	0.0	0.1	0.1
<b>Retained Surplus / (Deficit)</b>	<b>(10.7)</b>	<b>(10.9)</b>	<b>(0.2)</b>	<b>(17.6)</b>	<b>(17.6)</b>	<b>(0.0)</b>		<b>(2.9)</b>	<b>(2.0)</b>	<b>(0.7)</b>	<b>(0.9)</b>	<b>(1.7)</b>	<b>(1.5)</b>	<b>(1.3)</b>

**Key reasons for YTD divisional variances are as follows:**

**Integrated Medicine (£8.0m overspend YTD)**

Pressure areas include recovery insourcing costs for Dermatology £1.3m adverse, Drugs spend above last year's levels, £0.9m adverse. SMH UTC pathway additional costs, £1.4m adverse, Front Door hospital pressures, £1.1m adverse and escalation expenditure, £1.3m adverse. IM Medical Consultant vacancies and gaps in rota being covered by agency and locum at a premium are £0.3m adverse and non delivery of CIP, £1.0m adverse.

**Integrated Elderly Care (£0.3m underspend YTD)**

Areas of overspend include Home First Project, £0.4m adverse, additional medical staffing costs driven by activity pressures and locum and agency usage, £0.4m adverse and £0.2m adverse MFOP Wards & Mudas, due to activity. These overspends are partly offset by vacancies in Therapies and the Locality Teams.

**Surgery & Critical Care (£1.6m overspend YTD)**

Key pressure areas include Medical staffing costs due to waiting list initiative (WLI) activity, £0.4m, locum/agency premiums £0.7m adverse and Independent Sector spend, £1.9m adverse. These overspends are offset by favourable variances across Nursing, £0.9m due to vacancies across Theatres & ICU, and Clinical Supplies underspends due to lower than planned activity, £1.2m.

**Women & Children (£0.4m underspend YTD)**

Pay underspends in Nursing with favourability of £0.6m reported due to vacancies in CYP & Midwifery. All nursing vacancies are actively being recruited to with 20 new Midwives due to be in post by FY end. High Medical Staff costs with a reported £0.2m overspend YTD across Paediatrics and O&G due to locum cover for rota gaps, maternity leave, long term sickness and restricted duties cover for on calls, along with increased non elective activity in Paediatrics.

**Specialist Services (£0.2m overspend YTD)**

Favourability within drugs, £0.5m and Income, Mortuary receipts & CDC income, £0.2m are offset with overspends on Clinical Supplies & Services, £0.6m YTD driven by MRI scanners costs and other contracts and equipment.

**Property Services (£0.1m overspend YTD)**

The small over spend position year to date mainly relates to pressures on maintenance expenditure. There is significant further risk on maintenance over spends over the winter period along side pressure on energy and utility costs.

**Information Technology (£0.7m underspend YTD)**

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

**Chief Operating Officer (£1.7m overspend YTD)**

Pay costs of senior bank and agency staffing and consultancy costs from Q1 & Q2 drive the YTD overspend.

**Corporate Services & Provisions (£5.9m underspend YTD)**

Corporate services are where central provisions are held for items including the impact of bad debt and balance sheet adjustments. In addition, corporate services holds the remaining unallocated annual CIP target which will be allocated out to divisions and individual budget lines once schemes are identified. Central provisions included in the budgeted plan are also reported here including contingency and sickness reserves.

## Balance Sheet

### Statement of financial position

**Table 9 - Balance Sheet summary**

Statement of financial position / (£m)	Planned Position	YTD Position	Variance to Plan	Change from Prior Month
Non-current assets	347.7	347.1	0.6	(0.5)
Cash and cash equivalents	22.1	22.3	(0.2)	(7.0)
Trade and other current assets	37.5	36.1	1.4	4.7
<b>Total Assets</b>	<b>407.3</b>	<b>405.5</b>	<b>1.8</b>	<b>(2.7)</b>
Current Borrowing	(2.2)	(2.2)	0.0	0.4
Other Current liabilities	(72.9)	(74.4)	1.5	0.9
Non Current Borrowing	(43.9)	(41.2)	(2.7)	0.0
Other Non-current liabilities	(1.5)	(1.5)	0.0	0.0
<b>Total Liabilities</b>	<b>(120.5)</b>	<b>(119.3)</b>	<b>(1.2)</b>	<b>1.3</b>
<b>TOTAL NET ASSETS</b>	<b>286.8</b>	<b>286.2</b>	<b>0.6</b>	<b>(1.4)</b>
PDC and Revaluation reserve	410.0	410.0	0.0	0.0
Income and Expenditure Reserve	(123.2)	(123.8)	0.6	(1.4)
<b>TOTAL EQUITY</b>	<b>286.8</b>	<b>286.2</b>	<b>0.6</b>	<b>(1.4)</b>

- Non Current assets have decreased by £0.5m from the prior month. This is due to £1.4m of capital additions, offset by the in month depreciation charge of £1.7m and a reduction of £0.2m in injury cost recovery scheme debtor. The variance to plan is due to the underspend on the profiled capital programme of £0.1m with the remainder on planned depreciation.
- The closing cash balance is £7m lower than previous month due to higher temporary staff payments in month in line with the plan.
- The closing Trade and other current assets movement compared to prior month is £4.7m higher compared to previous month due to increased debtor balance of £6.6m as explained below and the allocation of the year end PDC debtor of £1.3m which was settled in month 6.
- Non Current / Current Borrowing are both lower than plan pending capitalisation of "Right of Use" assets and the associated liability under IFRS 16.
- Remaining changes in the statement of financial position are consistent with the reported £11.3m (£9.8m in month 6) deficit prior to technical adjustments.

### Accounts Receivable

**Table 10 - Accounts Receivable**

#### Month 7

(£m)	Current	31-60 days	61-180 days	6 mths - 1 year	1 year - 2 years	More than 2 years	Total
NHS	7.2	0.2	2.5	0.2	0.1	0.7	10.9
Non-NHS	1.6	0.6	1.0	0.5	0.5	0.8	5.0
<b>Total</b>	<b>8.8</b>	<b>0.8</b>	<b>3.5</b>	<b>0.7</b>	<b>0.6</b>	<b>1.5</b>	<b>15.9</b>
% of total	55%	5%	22%	4%	4%	9%	100%

- Debtors have increased by £6.6m from £9.3m in month 6 to £15.9m in month 7.
- The majority of this increase in debtors is due to a current month invoice to Health Education England of £5.9m.
- Overdue has increased by £1.1m from £6m in month 6 to £7.1m in month 7.
- Top 5 overdue debts at month 7 are:
  - 1 - Oxford University Hospitals NHS FT £1.5m
  - 2 - Buckinghamshire Council £1.1m
  - 3 - Buckinghamshire CCG £0.7m
  - 4 - Oxford Health NHS Foundation Trust £0.7m
  - 5 - University of Buckingham £0.3m

#### Month 6

(£m)	Current	31-60 days	61-180 days	6 mths - 1 year	1 year - 2 years	More than 2 years	Total
NHS	0.7	0.2	2.5	0.2	0.1	0.7	4.4
Non-NHS	2.6	0.1	0.4	0.4	0.5	0.9	4.9
<b>Total</b>	<b>3.3</b>	<b>0.3</b>	<b>2.9</b>	<b>0.6</b>	<b>0.6</b>	<b>1.6</b>	<b>9.3</b>
% of total	35%	3%	31%	7%	6%	17%	100%

The table has been revised to extend the the age bandings. This is to provide more visibility of the age of debt over 180 days.

## Balance Sheet

### Accounts Payable

**Table 11 - Accounts Payable**

#### Creditors

(£m)	Current	30-60 days	60-90 days	90-120	>120 days	Total
NHS	0.0	0.0	0.0	0.0	0.0	0.0
Non-NHS	0.0	-0.1	-0.2	0.1	-0.1	-0.3
% of total	0%	42%	75%	-38%	21%	100%

The creditors table reflects creditors which have been fully processed on the ledger and are awaiting payment. These are being paid as quickly as possible to maintain cash flow to our suppliers.

#### Invoice Register

	Total Value (£m)		Total Count		0-30 days		31-60 days		61-180 days		6 months to 1 year		1 year to 2 years		More than 2 years	
	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty
Month 7	5.8	1,129	1.8	107	0.4	42	1.7	173	1.0	235	0.6	485	0.2	87		
Month 8	3.1	770	0.7	75	0.5	67	0.5	136	0.6	173	0.4	213	0.3	106		
Month 9	5.4	748	3.3	98	0.3	47	0.6	133	0.5	145	0.3	218	0.3	107		
Month 10	2.7	683	0.6	48	0.2	41	0.6	129	0.5	145	0.4	212	0.3	108		
Month 11	2.9	553	0.9	63	0.4	35	0.6	102	0.6	113	0.2	160	0.2	80		
Month 12	2.1	315	0.6	64	0.2	26	0.5	49	0.5	64	0.2	74	0.2	38		
Month 1	4.0	335	2.6	70	0.5	48	0.3	56	0.2	63	0.3	62	0.2	36		
Month 2	4.5	387	2.6	91	0.6	44	0.7	88	0.2	61	0.3	65	0.2	38		
Month 3	3.4	328	1.2	68	0.7	39	0.9	88	0.1	35	0.3	64	0.2	34		
Month 4	2.9	368	1.2	80	0.4	49	0.6	94	0.2	41	0.3	66	0.2	38		
Month 5	7.1	419	4.7	82	0.9	72	0.9	109	0.2	46	0.2	67	0.2	43		
Month 6	4.0	425	1.4	67	0.4	39	1.5	139	0.3	67	0.2	69	0.2	44		
Month 7	2.4	442	0.3	84	0.0	45	1.4	124	0.3	77	0.2	63	0.2	49		

Non NHS	Total Value (£m)		Total Count		0-30 days		31-60 days		61-180 days		6 months to 1 year		1 year to 2 years		More than 2 years	
	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty
Month 7	5.9	3,292	2.6	804	0.7	355	1.2	825	0.7	551	0.5	531	0.1	226		
Month 8	5.3	3,109	1.8	757	1.0	356	1.0	648	0.8	531	0.5	551	0.1	266		
Month 9	7.4	3,561	3.1	907	1.5	489	1.4	743	0.7	556	0.5	581	0.1	285		
Month 10	5.7	3,250	1.4	556	1.5	446	1.4	821	0.7	567	0.5	558	0.2	302		
Month 11	6.5	2,714	3.4	720	0.7	247	1.1	643	0.5	401	0.6	401	0.2	302		
Month 12	10.2	2,493	6.6	673	1.8	364	0.7	480	0.3	317	0.6	328	0.2	331		
Month 1	6.8	2,386	3.7	642	1.2	361	1.1	512	0.4	316	0.3	295	0.2	260		
Month 2	6.5	2,407	2.2	520	1.8	391	1.7	580	0.4	334	0.3	297	0.1	285		
Month 3	6.4	2,598	1.7	546	1.7	388	2.1	699	0.5	365	0.3	307	0.2	293		
Month 4	5.5	2,607	1.4	550	1.0	348	2.1	744	0.6	374	0.3	328	0.2	263		
Month 5	8.4	3,128	3.5	839	1.5	504	2.2	815	0.7	413	0.3	342	0.2	215		
Month 6	6.4	2,599	2.3	451	1.2	430	1.7	815	0.6	375	0.3	330	0.2	198		
Month 7	10.0	2,762	5.2	650	1.6	332	1.8	807	0.9	418	0.3	349	0.2	206		
<b>Total M7</b>	<b>12.4</b>	<b>3,204</b>	<b>5.5</b>	<b>734</b>	<b>1.6</b>	<b>377</b>	<b>3.1</b>	<b>931</b>	<b>1.2</b>	<b>495</b>	<b>0.6</b>	<b>412</b>	<b>0.4</b>	<b>255</b>		

The Invoice Register at Month 7, which details invoices awaiting processing as they cannot be matched to an order or receipt, totalled £12.43m. In Value terms this is £2.046m more than the previous month. During the period the number of invoices held on the register increased by 180 (from 3024 in month 6 to 3204 in month 7). The value of invoices with a invoice date longer than 30 days increased by 308k and the count increased by 180. In month 7 those invoices less than 30 days old made up 44% (value) and 23% (count), in month 6 these totals were 36% and 17% respectively. The increase in Non NHS is due to 3 large capital invoices amounting to £3m received in month which are expected to be resolved and paid in Month 8.

Top 5 reasons for invoices being held on the register:

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

### Better Payment Practice Code

**Table 12 - Better Payment Practice Code**

	Count Total	Count Pass	% Pass	Total (£m)	Pass (£m)	% Pass
NHS	1,473	1,140	77%	36,479	33,449	92%
Non-NHS	38,445	34,922	91%	191,881	173,181	90%
Total	39,918	36,062	90%	228,360	206,630	90%

Adherence to the BPPC requires 95% of suppliers to be paid within 30 days of invoice date. Our reporting process is now more aligned to BOB ICS partners ensuring consistency of approach. NHS invoices remain an area of challenge. Compliance by number has deteriorated by 1% compared to month 6 due to Blood and Transplant invoices where the order had not been raised in a timely manner. Additionally, there were issues around Oxford University Hospitals with no Purchase orders for services procured by IM&T, Haematology, Oral Max, Maternity and Dermatology departments (invoice values totalling almost £900k)

## Cash Position

### Cash

**Table 13 - Cash summary position**

£'000	Actual Apr-22	Actual May-22	Actual Jun-22	Actual Jul-22	Actual Aug-22	Actual Sep-22	Actual Oct-22	Forecast Nov-22	Forecast Dec-22	Forecast Jan-23	Forecast Feb-23	Forecast Mar-23	22/23
<b>INCOME</b>													
Clinical Income	40,875	42,070	43,021	43,106	42,645	43,249	42,387	42,771	42,771	42,771	42,771	42,771	511,207
Clinical Income top up / Covid / Growth			1,802	0	0	1,829	0	0	0	0	0	0	3,631
Education and Training	229	3,175	0	0	3,259	0	0	5,850	0	0	0	2,100	14,613
Other Income	2,355	1,916	1,018	1,045	873	1,583	757	600	600	600	600	600	12,547
HMRC vat reclaim	2,144	3,693	0	1,198	2,029	160	1,678	1,300	1,600	1,600	1,600	2,800	19,802
Payroll Support						2,850	1,014	492	492	492	492	492	6,324
PDC capital	0	0	0	0	0	0	0	0	0	0	0	7,662	7,662
Other Receipts	630	2,759	781	444	1,331	847	460	650	650	650	650	650	10,502
<b>TOTAL RECEIPTS</b>	<b>46,232</b>	<b>53,612</b>	<b>46,622</b>	<b>45,793</b>	<b>50,137</b>	<b>50,518</b>	<b>46,296</b>	<b>51,663</b>	<b>46,113</b>	<b>46,113</b>	<b>46,113</b>	<b>57,075</b>	<b>586,287</b>
<b>PAYMENTS</b>													
Pay Costs - Substantive	(25,133)	(24,338)	(24,209)	(24,112)	(24,233)	(26,664)	(27,741)	(25,406)	(25,406)	(25,406)	(25,406)	(25,406)	(303,459)
Pay Costs - Temporary Staffing	(4,916)	(3,575)	(4,354)	(3,287)	(3,809)	(1,567)	(5,409)	(4,100)	(4,100)	(4,100)	(4,100)	(4,100)	(47,417)
Creditors	(17,421)	(15,773)	(14,239)	(15,501)	(9,656)	(14,934)	(13,252)	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)	(175,776)
Creditors - Capital Spend	(9,274)	(2,785)	(1,901)	(2,229)	(577)	(2,321)	(1,061)	(5,000)	(1,750)	(1,000)	(1,750)	(7,000)	(36,648)
NHSLA	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	(1,324)	0	0	(13,239)
PDC Dividends	0	0	0	0	0	(2,566)	0	0	0	0	0	(3,726)	(6,292)
PFI CHARGE	(5,097)	(4,426)	(4,451)	(4,473)	(4,728)	(4,230)	(4,461)	(4,450)	(4,450)	(4,450)	(4,450)	(2,700)	(52,366)
<b>TOTAL PAYMENTS</b>	<b>(63,164)</b>	<b>(52,221)</b>	<b>(50,478)</b>	<b>(50,926)</b>	<b>(44,327)</b>	<b>(53,606)</b>	<b>(53,247)</b>	<b>(55,280)</b>	<b>(52,030)</b>	<b>(51,280)</b>	<b>(50,706)</b>	<b>(57,932)</b>	<b>(635,198)</b>
<b>NET CASH FLOW IN PERIOD</b>	<b>(16,932)</b>	1,391	(3,856)	(5,133)	5,810	(3,088)	(6,951)	(3,617)	(5,917)	(5,167)	(4,593)	(857)	(48,911)
<b>OPENING CASH BALANCE</b>	51,046	34,114	35,505	31,649	26,516	32,325	29,237	22,286	18,669	12,752	7,585	2,992	51,046
<b>CLOSING CASH BALANCE</b>	<b>34,114</b>	<b>35,505</b>	<b>31,649</b>	<b>26,516</b>	<b>32,325</b>	<b>29,237</b>	<b>22,286</b>	<b>18,669</b>	<b>12,752</b>	<b>7,585</b>	<b>2,992</b>	<b>2,135</b>	<b>2,135</b>

- Clinical Income receipts forecast has been aligned to the Income and expenditure assumptions as per the operating plan.
- Total Receipts in month 7 decreased from £50.5m to £46.2m due to lower clinical income / top up and Payroll support received in month.
- VAT reclaim decreased in October as expected due to timing differences in invoices loaded onto the system the September.
- PDC Capital receipts include £4.3m to support the ICS agreed capital programme of £20m. In addition it is anticipated that there will be PDC receipts for the community diagnostic centre and ophthalmology.
- Pay costs have been forecast based on trend with no allowance for planned efficiencies not yet delivering.
- The pay award was paid in September and Substantive pay cost is higher in October as expected due to tax and pension payments in arrears relating to pay increase. Temporary staffing pay costs increased in month 7 as predicted last month due to the catch up.
- The PDC dividend payment in month 6 will be reduced by the year end closing receivable of £1.3m. Dividends in year will be collected on the basis of the operating plan calculations.
- Based on current forecast projections and the information available at present, the Trust will not need cash support in 2022-23 however this will be continually monitored throughout the year.

## Capital Position

**Table 14: Capital Overview: M07 2022-23**

Capital Expenditure	£m	Annual Plan	Annual Forecast	Variance	YTD Plan	YTD Actual	Variance	Prior Month YTD Actual
Medical Equipment		2.8	3.0	(0.3)	0.6	2.2	(1.6)	1.7
Property Services		11.5	16.5	(5.0)	11.2	9.0	2.2	8.6
Information Technology		8.7	9.0	(0.3)	3.1	4.0	(0.9)	3.6
General		1.6	1.6	0.0	1.0	0.7	0.3	0.4
Assumed Mitigation*		0.0	(5.6)	5.6				
<b>Total Capital Expenditure</b>		<b>24.6</b>	<b>24.6</b>	<b>0.0</b>	<b>15.9</b>	<b>15.8</b>	<b>0.1</b>	<b>14.4</b>
Funded By Trust		20.0	20.0	0.0	14.9	15.2	(0.3)	14.0
PFI Lifecycle		1.6	1.6	0.0	1.0	0.6	0.4	0.0
Donated		1.7	1.7	0.0	0.0	0.0	0.0	0.4
PDC		1.3	1.3	0.0	0.0	0.0	0.0	0.0
<b>Total Capital Funding</b>		<b>24.6</b>	<b>24.6</b>	<b>0.0</b>	<b>15.9</b>	<b>15.8</b>	<b>0.1</b>	<b>14.4</b>

**Table 15: Capital Detail: M07 2022-23**

	£'000	Capital Resource	Adjust	Revised Capital Resource
BOB/ICS Allocation		20,000		20,000
PFI Lifecycle		1,640		1,640
Donated			1,693	1,693
CDC PDC			859	859
LIMS DDCP			260	260
Digital Pathology DDCP			140	140
				-
<b>Total</b>		<b>21,640</b>	<b>2,952</b>	<b>24,592</b>

**Table 16: Capital Expenditure Plan**

Capital Expenditure Plan	BOB/ICS	Lifecycle	PDC Plan	ERF	Donated	NHS	TIF	Salix	2022/23 Total	YTD Expend	Forecast M8-M12	FY Expected Expend	FY Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Medical Equipment	1,091				1,693				2,784	2,183	865	3,048	(264)
Property Services	10,622		859						11,481	8,960	7,493	16,453	(4,972)
Information Technology	8,287		400						8,687	3,974	5,058	9,032	(345)
General		1,640							1,640	679	961	1,640	0
	20,000	1,640	1,259	-	1,693	-	-	-	24,592	15,796	14,377	30,173	(5,581)

YTD position: The capital programme is reporting a spend of £15.8m against a budget of £15.9m

Forecast Outturn: The programme is currently reporting a potential overspend risk of £5.6m by the end of the year if the overspend is not offset by mitigations to the same value. At the time of reporting, potential mitigations of £2m have been identified.

Capital forecasts between now and year end require refinement by the project leads in terms of:

- Ensuring reported actual spend is supported by timely completion certificates
- Feeding back on the profiling of spend over next 5 months and actively working with finance to mitigate the forecast overspend and bring capital expenditure within the budget.
- Inflationary rises continue to create a significant risk to the delivery of the programme.
- The A&E paediatric development expected completion date remains mid-December.

A large portion of the overspend sits in property services relating to A&E Paeds £2.7m and Radiology equipment installation £3m.

Month 7 YTD capital spend is £15.8m against a plan of £15.9m

CRL Funding is made up of BOB/ICS £20m, PFI Lifecycle £1.6m, Donated £1.7m, CDC £0.9m and DDCP £0.4m

## Glossary and Definitions

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

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	BHT Charitable Fund
<b>Board Lead</b>	Kishamer Sidhu, Interim Chief Finance Officer
<b>Type name of Author</b>	Jane Lucas, Interim Head of Charities Arati Das, Interim Associate Director Finance
<b>Attachments</b>	Appendix 1; Resolution to consolidate funds Appendix 2; BHT Pol 147 Charitable Funds Investment Policy Appendix 3; BHT Pol 300 Fundraising Policy
<b>Purpose</b>	Approval
<b>Previously considered</b>	CFC 24.10.2022

### Executive Summary

This paper provides a summary on the following three distinct areas previously considered by the Charitable Funds Committee:

- Resolution to Consolidate Funds (Appendix 1)
- Investment Policy (Appendix 2)
- Fundraising Policy (Appendix 3)

#### **Resolution to Consolidate Funds for submission to Charity Commission**

Background: The Resolutions set out in Appendix 1 are for submission to the Charity Commission and relate specifically to this external clarification. Once this piece of work is complete, we will review all funds, their designations, and determine if there are benefits to making further changes.

These resolutions mark the end of 5 years' work to review the charitable funds including the funds of the linked charities. The Charity has taken advice from specialist charity lawyers to successfully reach this stage.

At present there are 46 linked charities shown on our Charity Commission page. Of these, 41 will be included in the main charity and the present situation of two historic governing documents will be clarified to one. Passing the resolution today could allow the seven hospital amenity funds to be amalgamated in the future.

It will give us one main charity with the remaining linked funds being one endowment fund (the DM Piercy Fund) and 4 others as follows:

- Spinal Injuries Children
- Spinal Injuries Research
- Spinal Amenity
- Diabetes Fund

The consolidation has been agreed by the Charity Commission and once passed will be registered with them for the fund and governing document alterations to be made. Any further consideration of our internal organisation of funds can be considered once this important legal process has been completed.

#### **Investment Policy**

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

Charity is expected to exist in perpetuity and investment, or asset values should be maintained and increased to facilitate this.

The policy update allows for property as an additional option for investment alongside the investment portfolio.

**Fundraising Policy**

This new policy has been formulated to provide clear guidance to all BHT employees in terms of fundraising for BHTCF. It provides guidance to the BHTCF Finance Team when dealing with charitable funds, especially procedures that should be observed in recognising both Income and Expenditure incurred in terms of fundraising.

It sets out to provide an overarching understanding of fundraising procedures - referring to the Fundraising Code of Practice for guidance and adherence.

<b>Decision</b>	The Board is requested to approve: (1) The resolutions set out in Appendix 1 for submission to the Charity Commission (2) The amended Investment Policy (3) The new Fundraising Policy
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**Relevant Strategic Priority**

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

<b>Patient Safety</b>	No impact on patient safety.
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	n/a
<b>Financial</b>	No financial impact; fund clarification only
<b>Compliance</b>	In line with Charity Law
<b>Partnership: consultation / communication</b>	n/a
<b>Equality</b>	Included within the Appendices as relevant.
<b>Quality Impact Assessment [QIA] completion required?</b>	Not required

## RESOLUTION TO CONSOLIDATE FUNDS

Buckinghamshire Healthcare NHS Trust Charitable Fund (the 'Charity')

Extract of wording for resolutions

### Introduction

The trustee has undertaken a long-term exercise to address the structure of the Charity's funds and linked charities with a view to consolidating and streamlining the number of separate funds and linked charities. This work covered three related but distinct areas:

The trusts on which Buckinghamshire Healthcare NHS Trust (the 'NHS Trust') as sole corporate trustee of the Charity holds the Charity's general fund;

The linked charities listed on the Charity's entry on the Charity Commission register; and

A number of funds treated as restricted by the Charity which relate to specific hospitals.

The Charity took legal advice and its legal advisers wrote to the Charity Commission on 12 July 2022 setting out the Charity's proposed approach to these three issues as detailed further in these resolutions and in the 12 July letter and accompanying spreadsheet of linked charities as produced to the meeting. The Charity Commission responded on 15 September to confirm that the Commission did not object to the approach proposed by the Charity and its legal advisers.

### General fund

The Charity's general funds are governed by a declaration of trust dated 29 January 1996 (the '1996 Governing Document') with NHS-wide objects reflecting the statutory remit. A model declaration of trust was made over a general amenity fund dated 20 March 1997 which adopted an alternative formula of "wholly or mainly for the South Buckinghamshire NHS Trust" and which is a separate linked charity with registration number 1053113-2. Despite extensive enquiries and review of historic documents it remains unclear why this subsequent declaration was entered into.

The trustee considers that the funds held within the general amenity charity under the 20 March 1997 declaration of trust were received as unrestricted funds for the Charity held for the statutory remit of the wider objects and that the outdated objects no longer provide a suitable and effective method of using the funds held and therefore in accordance with Clause F of the 20 March 1997 declaration of trust it is resolved that:

the general amenity fund governed by the 20 March 1997 declaration of trust be and is hereby dissolved and the funds previously held by the Charity as part of the general amenity fund instead be returned and held on the objects of the declaration of trust dated 29 January 1996 as Buckinghamshire Healthcare NHS Trust Charitable Fund (previously South Buckinghamshire NHS Trust Charitable Fund); and

The Charity Commission be sent a copy of this resolution and asked to remove the general amenity fund linked charity 1053113-2 from the register of charities.

## Hospital General Amenity Funds

The Charity holds seven general amenity funds named after seven hospitals operated by the NHS Trust as follows:

General Amenity Stoke Mandeville Hospital – Acute Hospital;

Amersham Hospital General Amenities – Acute Hospital;

Wycombe General Hospital General Amenities Fund – Acute Hospital;

Buckingham Hospital - Community Hospital;

Chalfont and Gerrards Cross - Community Hospital;

Marlow Hospital - Community Hospital; and

Thame Hospital - Community Hospital.

These funds are not linked charities and the trustee cannot find any evidence of any legal restriction or any model declaration of trust in relation to these funds.

The trustee considers there is no identifiable legal restriction in relation to these funds and believes they are legally unrestricted and held for the statutory remit as part of the Charity's general charitable funds held under the Charity's 1996 Governing Document. The Charity Commission has confirmed that it agrees with the trustee's proposed action in treating these funds as legally unrestricted.

It is therefore resolved that based on there being no identifiable legal restriction and the elapse of time, these seven funds be treated as unrestricted.

## Linked Charities

The Charity has also undertaken an extensive review of its linked charities. A large number of these linked charities are governed by model special purpose charity declarations made in the period 1996-1997. The dissolution provision in the model special purpose charity declarations refers to Stoke Mandeville Hospital Charitable Fund, the funds of which now form part of the Charity.

The trustee considered the detailed spreadsheet prepared by the Charity and its advisers and which had been sent to the Charity Commission as part of the submission and noted the following categories of linked charity:

Linked charity 1053113-3: this is addressed under paragraph 2 above.

Linked charity 1053113-2: the governing document for this research charity dated 20 March 1997 cannot be found. There are no funds in this Charity. The Charity has proposed and the Charity Commission has agreed that this charity can be removed from the register.

The following linked charities have been identified as having zero balance. Having been spent out these can therefore be removed from the register:

1053113-4

1053113-10

1053113-24

1053113-25

1053113-39

1053113-45

Linked charity 1053113-40 has a missing governing document, though the Charity Commission's records indicate the governing document was dated 9 January 1997, the same date as many of the other linked charity model special purpose declarations. As proposed to the Charity Commission and as agreed by the Commission, the trustee considers it reasonable to operate on the basis that the relevant declaration of trust contained the dissolution provision as with the other identical declarations made on the same date.

The remaining 32 linked charities are governed by model special purpose declarations of trust and the dissolution provision generally refers to Stoke Mandeville Hospital Charitable Fund, the funds of which now form part of the Charity. The trustee cannot find any historic evidence of a legal restriction.

Given there is no evidence of any legal restriction on any of these funds and given the time elapsed and given the approach outlined in section 6 of the Charity Commission's guidance for NHS charities and given the express agreement of the Charity Commission to the course proposed it is resolved that in accordance with the relevant dissolution clauses for the 33 charities set out in paragraphs 4.2(d) and 4.2(e) above the linked charities be and are hereby dissolved such that all the funds held within the 33 relevant linked charities henceforth form part of the Charity's general funds held for the full extent of the statutory remit.

It was further resolved that the Charity Commission be requested to remove the further eight linked charities set out in paragraphs 4.2(a), 4.2(b) and 4.2(c) above from the register on the basis they have no funds in them and are spent out.

October 2022 Version 9.0

## CHARITABLE FUNDS INVESTMENT POLICY

### Summary of Changes:

This version has been updated for changes to investment requirements

<b>Version:</b>	<b>9.0</b>
<b>Approved by:</b>	<b>Charitable Funds Committee</b>
<b>Date approved:</b>	<b>TBC</b>
<b>Ratified by:</b>	<b>Executive Management Committee</b>
<b>Date ratified:</b>	<b>TBC</b>
<b>Consultation:</b>	<b>Charitable Funds Committee</b>
<b>Name of originator/author</b>	<b>Revision: Jane Lucas Interim Head of Charity Original Policy: Nelson Garcia-Narvaez / Charities Head of Finance</b>
<b>Lead Director</b>	<b>Barry Jenkins – Director of Finance</b>
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8.3	0	Update	Charitable Funds Committee  Board	05/02/2019  31/07/19
8.4	0	Update	Charitable Funds Committee  Board	28/05/2020  27/01/21
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9.0	0	Formal Review	Charitable Funds Committee Trust Policy Subgroup Executive Management Committee Board **Provisional dates	24/10/22 08/11/22 29/11/22**  30/11/22**

## Associated Documents

BHT Ref	Title	Location/Link
n/a	Investing charity funds: regulatory perspective	<a href="https://www.gov.uk/government/publications/investing-charitable-funds">https://www.gov.uk/government/publications/investing-charitable-funds</a> <a href="https://www.gov.uk/government/publications/charities-and-investment-matters-a-guide-for-trustees-cc14">https://www.gov.uk/government/publications/charities-and-investment-matters-a-guide-for-trustees-cc14</a>
n/a	Trustee Act 2000	<a href="http://www.legislation.gov.uk/ukpga/2000/29/contents">http://www.legislation.gov.uk/ukpga/2000/29/contents</a>
n/a	Charity Act 2011	<a href="https://www.legislation.gov.uk/ukpga/2011/25/contents">https://www.legislation.gov.uk/ukpga/2011/25/contents</a>
n/a	Charity Act 2016	<a href="http://www.legislation.gov.uk/ukpga/2016/4/contents/enacted">www.legislation.gov.uk/ukpga/2016/4/contents/enacted</a>
n/a	SORP 2015 and 2019 – FRS 102	<a href="https://www.gov.uk/government/publications/charities-sorp-2005">https://www.gov.uk/government/publications/charities-sorp-2005</a>
n/a	Regulations 2008	<a href="http://www.legislation.gov.uk/uksi/2008/629/contents/made">www.legislation.gov.uk/uksi/2008/629/contents/made</a>
	<a href="https://www.gov.uk/government/publications/charities-and-investment-matters-a-guide-for-trustees-cc14">Charities and investment matters: a guide for trustees (CC14)</a>	<a href="https://www.gov.uk/government/publications/charities-and-investment-matters-a-guide-for-trustees-cc14">https://www.gov.uk/government/publications/charities-and-investment-matters-a-guide-for-trustees-cc14</a>

## CONTENTS

Section	Title	Page
<b>1</b>	<b>Introduction</b>	<b>1</b>
<b>2</b>	<b>Scope and Purpose</b>	<b>1</b>
<b>3</b>	<b>References and Definitions</b>	<b>2</b>
<b>4</b>	<b>Roles and Responsibilities</b>	<b>3</b>
	4.1 The Board	3
	4.2 Charitable Funds Committee	3
	4.3 Investment Manager	3
	4.4 Trust Finance Staff	3
<b>5</b>	<b>Consultation and Dissemination</b>	<b>4</b>
<b>6</b>	<b>Monitoring Compliance with the Policy</b>	<b>4</b>
<b>7</b>	<b>Investment Strategy</b>	<b>5</b>
	7.1 Investment Objectives	5
	7.2 Risk Profile and Asset Allocation	6
	7.3 Ethical Considerations	6
	7.4 Investment Powers	6
	7.5 Review of Policy	6
<b>8</b>	<b>Related Policies</b>	<b>6</b>
<b>Annex 1</b>	<b>Asset Allocation</b>	<b>8</b>

# Charitable Funds Investment Policy Document

## **1. Introduction**

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

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

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

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

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

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

## **2. Scope and Purpose**

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

The purpose of this policy is to facilitate effective management of funds, whether these are invested or held as liquid assets, to achieve the objectives of the Charity in the immediate and longer term in conjunction with identification and understanding of the risks to the Charity. The Charity is expected to exist in perpetuity and investment, or asset values should be maintained and increased to facilitate this.

### **3. References and Definitions**

The main Charities Commission website provides further details on the responsibilities of Charities and Trustees for investment management (CC14), as detailed above. Only elements of the guidance that is relevant to this Charity have been produced here.

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

#### **Definitions:**

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

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

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

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

Common Investment Funds and Charity Authorised Investment Funds: are collective investment schemes that only charities can invest in and are charitable in law.

Charity Authorised Investment Funds (CAIFs) were announced in the 2015 Budget and were a new type of charity pooled investment structure which largely replicated Common Investment Funds (CIFs) existing features with two main benefits for investors; stronger financial regulation and lower costs. CIFs were not regulated by the FCA, hence the new CAIF structure was introduced to strengthen the financial regulation of charity funds whilst retaining their charitable status. CAIFs will have dual regulation, as they will have improved regulatory oversight from the FCA as a UCITS fund, but the ongoing regulation of its charitable status will be the responsibility of the Charity Commission. The transition to an authorised fund (rather than an unregulated one) meant that the investment management fee would be VAT exempt.

CPI: The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services.

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

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

## **4. Roles and Responsibilities**

### 4.1 The Board

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

### 4.2 Charitable Funds Committee

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

### 4.3 Investment Manager

The investment managers appointed will be responsible for investing the available funds as far as possible to fulfil the investment objectives laid out below. They will provide quarterly reports to the Charitable Funds Committee. They will take into account any concerns raised by the Committee in the allocation or performance of the funds and the Trustees stance on ethical investment. There will be a formal review of investment managers every three years which will include a decision on whether a retender is appropriate.

### 4.4 Trust Charity Staff

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

## **5. Consultation and Dissemination**

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

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

## **6. Monitoring Compliance with the Policy**

The Trustees wish to monitor the performance of the investments carefully and will seek quarterly valuations and reviews of performance of investments held by the Fund Manager. Whilst the precise mechanics will depend on the independent professional advice given to the Trustees, it is proposed that performance should be measured against one of the industry standard measures such as the ARC (Asset Risk Consultants).

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

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

## **7. Investment Strategy**

### **7.1 Investment Objectives**

As stated above, it is not the Trustee's primary aim to accumulate funds and the investment strategy set out below is written with this in mind. Accordingly, a portion of the total funds will be held back as short term monies or working capital (assets which are capable of being released to generate cash quickly, or cash) with the rest being invested in assets that achieve growth through income and capital growth. These assets can be made up of an investment portfolio and also of other assets, such as property, held to give both an income and capital growth. The proportion of the invested portfolio is set as a minimum value of 60% of the total. This percentage allows a total of 40% to be invested in other assets such as property. The decision on each project will be taken separately and will include expected and defined returns where possible. The decision on whether any discussion with the Charity Commission is appropriate will be made on a case by case basis.

The Trustees objectives are:

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

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

Subject to the recommendations of our independent adviser, the funds will be invested on a discretionary basis by the purchase of pooled funds, collective investment schemes, Common Investment Funds [CIFs] and Charity Authorised Investment Funds (CAIFs).

The investment principles of the Trustees are to ensure: -

- (a) A balance between income (interest or dividends) and capital growth whilst adopting an appropriate medium to long-term risk profile, accepting that this will **impose a degree of volatility in performance (\*A)**
- (b) The maintenance of the 'real' value of the capital within the portfolio or other investments after allowing for the effects of inflation but before any strategic change in historic expenditure levels.
- (c) That they are prepared to realise capital gains if achieved from the invested part of the portfolio if there is a bona fide charitable purpose for them.
- (d) A total growth figure, over the long term, of CPI plus 4% per annum for funds under investment. With an income expectation of a yield of 1.5%. For investments outside the portfolio the expected returns should be at least 2% higher than that expected from the portfolio. Each investment should be approved with expected returns defined at the start and each should be assessed individually on the merits of that proposal.
- (e) That the administrative burden on the Trustees is kept to an acceptable minimum.
- (f) That they receive independent professional advice on the value of an investment.
- (g) That there is in place monitoring of the performance of the investments.

Investments are expected to operate under a total return approach, where spending can be taken from both income and capital returns. Currently income returns are budgeted to be spent.

Monies from invested funds are realisable mostly within 10 days or for some specific property funds usually within three months. Other funds invested in property or other assets are not expected to be realisable in this way and the proportion is thus limited to 40% of total assets.

## 7.2 Risk Profile and Asset Allocation

The Trustees are bound by the rules for Charities on investments and have adopted a strategy, which avoids speculation and high risk, while accepting **a reasonable degree of volatility of returns (\*B)**. They will spread the invested portfolio over a number of different investment classes such as UK equities, overseas equities, bonds, property and cash and have considered and agreed a limited amount of exposure to non-traditional assets like hedge funds and absolute return funds, subject to clear restrictions. These are agreed with the investment manager and are defined in annex 1.

Changes to asset allocations will be reported to Charitable Funds Committee.

## 7.3 Ethical Considerations

The Trust encourages responsible investment. The Charitable Funds Committee regularly reviews the investment portfolio, and individual investments, or sectors, may be excluded if perceived to conflict with the objectives and wider mission of the Charity e.g. tobacco.

The Trustees are committed to appointing investment managers who are actively involved in applying Environmental, Social and Governance (ESG) criteria across the investment process including being an integral part of their research process. They believe it is the responsibility of capital owners to ensure that capital is deployed where possible in investments that make a positive contribution to reducing these risks.

## 7.4 Investment Powers and Reporting

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

The investment managers will provide monthly reports to Trust finance staff and will report quarterly to the Charitable Funds Committee (CFC). Ad hoc online reporting will also be available for Trust staff. They will present in person at CFC meetings twice a year.

## 7.5 Review of Policy

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

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

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

## 8. Related Policies

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

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

**Annex 1**

**Asset Allocations**

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

	<b>Asset Type</b>	<b>Agreed %</b>
1	UK Equities	40% – 90%
2	Global/Overseas Equities	
3	Fixed Interest	0% – 30%
4	Alternatives (including property)	0% – 40%
5	Cash	0% – 20%

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

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

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

The Committee requires that any changes to the above asset allocations are reported as soon as we are informed by the Investment Manager. This allows any implications to be discussed and agreed or alternative action taken.

# FUNDRAISING POLICY

March 2022 Version 1.1 Issue 0.1

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

<b>Version:</b>	1.1
<b>Issue:</b>	0.1
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<b>Approved by:</b>	Charitable Funds Committee
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<b>Author:</b>	Manoj Patel (Charitable Funds Financial Officer) and Nelson Garcia-Narvaez (Charities Head of Finance)
<b>Lead Director:</b>	Barry Jenkins - Chief Finance Officer
<b>Name of Responsible Individual/ Committee:</b>	Charitable Funds Committee
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## Document History

**Title**

Version	Issue	Reason for change	Authorising body	Date
1.0	1.0	New Policy Document	Charitable Funds Committee Board	May 2022 November 2022

**Issue dates and Validity:**

In the case of hard copies of this policy the content can only be assured to be accurate on the date of issue marked on the document. The most up to date policy will always be available on the Buckinghamshire NHS Trust intranet site.

<https://intranet.buckshealthcare.nhs.uk/>

**Associated documents**

BHT Ref	Title	Location/Link
	Charity Fundraising Events	<a href="http://www.gov.uk">Charity fundraising events: exemptions - GOV.UK (www.gov.uk)</a>
	Fundraising Events: Exemptions	<a href="http://www.gov.uk">Fundraising events: exemption for charities and other qualifying bodies - GOV.UK (www.gov.uk)</a>
	Fundraising Legally and Responsibly	<a href="http://www.gov.uk">Fundraising legally and responsibly - GOV.UK (www.gov.uk)</a>
	Strategic Statement on the Charity Commission's Regulation of Fundraising	<a href="http://www.gov.uk">Strategic statement on the Charity Commission's regulation of fundraising - GOV.UK (www.gov.uk)</a>
	Memorandum of Understanding: Charity Commission and the Fundraising Regulator	<a href="http://www.gov.uk">Memorandum of Understanding: Charity Commission and the Fundraising Regulator - GOV.UK (www.gov.uk)</a>
	Code of Fundraising Practice by the Fundraising Regulator - Guidance	<a href="http://www.fundraisingregulator.org.uk">Code of Fundraising Practice   Fundraising Regulator</a>
	Fundraising Regulator's Code of Fundraising Practice	<a href="http://www.fundraisingregulator.org.uk">English-Code-of-Fundraising-Practice-October-2019.pdf (fundraisingregulator.org.uk)</a>
	Fundraising Topics	<a href="http://www.fundraisingregulator.org.uk">Fundraising topics   Fundraising Regulator</a>

	Article on Fundraising Practice	<a href="#">Four small words of great significance: the key values of fundraising practice   Fundraising Regulator</a>
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## Contents

Section No	Title	Page No
1	<b>Introduction</b>	6
2	<b>Purpose</b>	6
3	<b>Scope</b> 3.1 The Charity Commission 3.2 Fundraising Regulator	7
4	<b>Roles and Responsibilities</b> 4.1 Appeal Committee 4.2 Fundraising Manager 4.3 Fundraising Communications and Engagement Officer 4.4 Fundraising Assistant 4.5 Fundraisers	7
5	<b>Ethical Framework</b> 5.1 Ethical Fundraising Criteria 5.1.1 Acceptance Criteria 5.1.2 Avoidance Criteria	8
6	<b>Fundraising Activities, Principles and Guidance</b> 6.1 Fundraising by staff on the hospital property/premises 6.2 Fundraising by Associated/Affiliated Charities 6.3 External Charities 6.4 Appeals 6.5 Public Collections 6.6 Raffles and Lotteries 6.7 Sponsored Events 6.8 Collection Boxes 6.9 Charity Challenge Events 6.9.1 London Marathon 6.10 Fundraising in Schools 6.11 Fundraising using the corporate sector 6.12 Legacy Fundraising 6.13 Ward Donations	9
7	<b>False Representation</b>	14
8	<b>Corporate Partnerships</b>	14
9	<b>Individuals and Organisations Recognition of Donations - Procedure</b> 9.1 Donor Recognition Opportunities 9.2 Naming Principles 9.3 Types of Naming	15

	<b>9.4 Naming Approval Process</b>	
<b>10</b>	<b>Communications and Advertising</b>	<b>17</b>
<b>11</b>	<b>Charity Brand and Fundraising Literature</b>	<b>17</b>
<b>12</b>	<b>Social Media, Media, VIP, Press, Radio and TV</b>	<b>17</b>
<b>13</b>	<b>Photography</b>	<b>17</b>
<b>14</b>	<b>Volunteers</b>	<b>18</b>
<b>15</b>	<b>The Charities Protection and Social Investment Act 2016</b>	<b>18</b>
<b>16</b>	<b>Breach of this policy</b>	<b>18</b>
<b>17</b>	<b>Dissemination</b>	<b>18</b>
<b>18</b>	<b>Equality Impact Assessment</b>	<b>19</b>

### Related Policies:

This policy should be read in conjunction with other relevant Buckinghamshire Healthcare NHS Trust (BHT) organisational policies, including but not limited to:

#### Management of Charitable Funds Policy

[Management of Charitable Funds Policy & Procedures - Buckinghamshire Healthcare Intranet \(buckshealthcare.nhs.uk\)](https://buckshealthcare.nhs.uk)

#### Information Governance Policy

[Information Governance Policy - Buckinghamshire Healthcare Intranet \(buckshealthcare.nhs.uk\)](https://buckshealthcare.nhs.uk)

#### Data Protection Policy

[Data Protection Policy - Buckinghamshire Healthcare Intranet \(buckshealthcare.nhs.uk\)](https://buckshealthcare.nhs.uk)

#### Social Media Policy

[Social media policy - Buckinghamshire Healthcare Intranet \(buckshealthcare.nhs.uk\)](https://buckshealthcare.nhs.uk)

Please note that all these policies are on the **Trust's Intranet Site**.

[Policies - Buckinghamshire Healthcare Intranet \(buckshealthcare.nhs.uk\)](https://buckshealthcare.nhs.uk)

## 1. Introduction

Public trust is vital to the charity and Buckinghamshire NHS Trust Charitable Fund (BHTCF)'s vision and mission must, in order to succeed, be transparent and accountable to donors, stakeholders, government agencies and future patrons.

This document reflects charity law and guidance issued to NHS Bodies by the Charity Commissioners for England and Wales. The 'NHS Charitable Funds Guide' from the Charity Commission sets out in some detail the legal requirements and best practice to be followed by NHS Bodies. It can be accessed at <https://www.gov.uk/government/publications/nhs-charities-guidance>

BHTCF Corporate Trustee (being Buckinghamshire Healthcare NHS Trust) recognises its statutory obligation to ensure that all fundraising should be undertaken in accordance with the Charity's governing document, objectives and regulations from the Charity Commission, the Fundraising Regulator and other regulatory bodies, including legislation on data protection, money laundering and bribery. The Charity will comply with the Fundraising Regulator <https://www.fundraisingregulator.org.uk/>. Compliance includes treating people fairly and with respect, explaining our cause in a way which does not mislead people, and being sensitive to people who may be in vulnerable circumstances.

Key to gaining donor trust is keeping to established guidelines for handling donations and other business practices. The Charity will expend funds in accordance with the wishes of the donors.

Accounting and Reporting by Charities: Statement of Recommended Practice ("SORP - FRS 102") requires trustees to mention in their annual report the performance of material fundraising activities against the fundraising objectives that they have set. The report should also mention if any material expenditure was incurred to raise the income. Finally, the report should explain the effect the expenditure will have on raising income for the current and future periods

Income from fundraising activities will fall under income from other trading activities. The activities should be clearly identified as to their nature and the income generated. Expenditure incurred by the Charity in fundraising activities should also be clearly identified.

For additional information and clear guidance of the Trustee's Policy on how the Charitable Funds are to be managed, especially procedures around income and expenditure, please refer to the Management of the Charitable Funds Policy and Procedures. [Management of Charitable Funds Policy & Procedures - Buckinghamshire Healthcare Intranet \(buckshealthcare.nhs.uk\)](#)

## 2. Purpose

The policy is to provide clear guidance to all BHT employees in terms of fundraising for BHTCF. It provides guidance to the BHTCF Finance Team when dealing with charitable funds, especially procedures that should be observed in recognising both Income and Expenditure incurred in terms of fundraising.

It sets out to provide an overarching understanding of fundraising procedures - referring to the Fundraising Regulators Codes of Practice for guidance and adherence.

It should also be noted that a number of policies that are necessary for fundraising are also relevant to the whole charitable fund e.g. Information Governance, Confidentiality, and Acceptable Use of Electronic Communication and have been written to be organisation-wide rather than by department. Whilst not included in this document they must be adhered to by the Fundraising Team.

This policy applies to all BHT staff, including those with honorary contracts, volunteers, part time staff and Non-Executive Directors. This policy will also apply to external contractors or staff working on the premises in outlets e.g. Costa.

### 3. Scope

#### 3.1 The Charity Commission

The Charity Commission for England & Wales is the organisation that regulates all charitable organisations. All NHS Charities are within the jurisdiction and regulation of the Charity Commission for England and Wales.

Details of general functions of the Charity Commission for England and Wales under the Charities Act 2011 as amended by the Charity Act 2016 can be found here: [The Charity Commission - GOV.UK \(www.gov.uk\)](https://www.gov.uk).

#### 3.2 The Fundraising Regulator

The Fundraising Regulator is the independent regulator of charitable fundraising in England, Wales and Northern Ireland. The Code of Fundraising Practice (the code) sets out the responsibilities that apply to fundraising carried out by charitable institutions and third-party fundraisers in the UK. This code should be observed at all times. For further information, please refer to <https://www.fundraisingregulator.org.uk/>

Additional information regarding the **Charitable Purpose, Structure, Registration and Objectives** of funds is provided in the Management of The Charitable Funds Policy and Procedures. [Management of Charitable Funds Policy & Procedures - Buckinghamshire Healthcare Intranet \(buckshealthcare.nhs.uk\)](https://buckshealthcare.nhs.uk)

### 4. Roles and Responsibilities

This policy has been prepared taking into consideration charity regulations and guidance established by regulatory organisations. Therefore, all BHT members of staff who deal with charitable funds are responsible for following this policy and must ensure they adhere to it.

An NHS body that has accepted and holds or administers trust property or funds for charitable purposes will be acting as charity trustee in respect of that property or funds. BHT holds and administers the charitable funds as a corporate body known as the Corporate Trustee.

The CFC (Charitable Funds Committee) reports to the Corporate Trustee and is responsible for the development, management and implementation of the policy, with the assistance of the BHTCF's Head of Finance and Governance, and the Charitable Funds Team.

All BHT employees are expected to familiarise themselves with the charitable fundraising principles set out in this policy and comply with them at all times.

If any member of staff is in any doubt about any matter relating to the issue of fundraising for BHTCF, then they should contact the Charitable Funds team for guidance on 01494 734773.

The Roles and Responsibilities for the **Trusteeship and the Board, Charitable Funds Committee (CFC), Chief Financial Officer and Trust Employees** are stated in the Management of the Charitable Funds Policy and Procedure. [Management of Charitable Funds Policy & Procedures - Buckinghamshire Healthcare Intranet \(buckshealthcare.nhs.uk\)](https://buckshealthcare.nhs.uk)

## 4.1 Appeal Committee

In general terms, the Appeal Committee is responsible for ensuring the progression of the appeal strategy in order that it meets the overall fundraising appeal target as well as the management of the Charitable Fund's Appeal fundraising activities. For more information refer to the Appeal Committee Terms of Reference on the intranet site.

## 4.2 Fundraising Manager

The post of Fundraising Manager is critical in providing the leadership required to build the fundraising capacity of the charity. The purpose of this role is to ensure that the charitable fund's fundraising is well managed with clear strategic plans that reflect best practice with clear performance benchmarks.

## 4.3 Fundraising Communications and Engagement Officer

The post of Fundraising Communications and Engagement Officer will be responsible for the communications and marketing strategy to increase awareness of the charity and recruit new supporters and volunteers to enable the charity to raise funds to provide projects and equipment which are above and beyond the remit of the NHS and enhance patient experience

## 4.4 Fundraising Assistant

The Fundraising Assistant position is a critical role to support the Fundraising Manager in the effective development and smooth running of the fundraising function at BHTCF so that ultimately unrestricted funds can be maximised.

## 4.5 Fundraisers

Anybody who would like to raise money at one of the Trust's sites must contact the Charity Team with details of the activity for review and approval. This should set out details of the fundraising activity e.g. tombola, raffle, cake sale, sponsored walk etc. and when and where the event will take place.

## 5 Ethical Framework

All charitable opportunities or partnerships need to be in line with the Trust's vision, mission and values. <https://www.buckshealthcare.nhs.uk/our-organisation/about-us/>

### 5.1 Ethical Fundraising Criteria

Both BHT as the Corporate Trustee of BHTCF, as well as BHTCF, have a duty to demonstrate to the Charity Commission that they have acted in the best interest of BHTCF. They also need to ensure that any association with a particular donor does not compromise BHTCF's ethical position, harms its reputation or put any future funding at risk.

BHTCF will seek to avoid receiving donations from companies which are involved in unethical activities including, but not limited to, the following:

- Animal exploitation
- Armaments and nuclear weapons
- Human Rights Abuse/Oppressive regimes
- Environmentally damaging practices
- Poor employment practices
- Alcohol

- Tobacco
- Gambling
- Pornography and sex related industries
- Criminal activity

The responsibility of the judgement on whether the charity should refuse a donation is delegated from the Charitable Funds Committee to the Head of Charity. If necessary, a decision will be referred to the Charitable Funds Committee for further deliberation.

### 5.1.1 Acceptance Criteria

BHTCF accepts voluntary donations and other forms of voluntary support, such as volunteering or gifts in kind from individuals, companies and other organisations on the following conditions:

- It will result in benefit to patients within BHT or the wider NHS.
- If a gift is offered for a specific purpose that it supports the Charity's objectives
- It is feasible to apply the donation in a way that is consistent with donors' wishes, given the operational constraints and strategic priorities of the NHS.
- The Charity is able to fulfil reasonable obligations attached to the gift/ donation, for example a requirement to report back to donors on the public benefit achieved as a consequence of the gift.

### 5.1.2 Avoidance Criteria

BHTCF will not accept voluntary donations and other forms of voluntary support where any of the following criteria apply:

- The support is known, suspected to be or derives from the proceeds of crime.
- The support derives from a source conflicting with the Charity's ethical fundraising criteria.
- Acceptance is likely to deter actual or potential supporters from future support
- Acceptance would involve onerous obligations, for example the upkeep of an unsuitable building, the cost of which might outweigh the benefit.
- Support is offered in an attempt to procure privileged access to treatment for the donor or persons linked to the donor.
- Support is offered in an attempt to procure privileged access to NHS contracts
- Acceptance would be in contravention of the Bribery Act 2010.
- Acceptance would compromise the Charity's status as an independent registered charity.

## 6. Fundraising Activities, Principles and Guidance

The Charity Team will provide all the fundraising tools and help needed to help make an event, run by an individual or group, a success. A response to an application will be given as soon as possible but please note that a decision cannot be made immediately, and the Charity Team needs time to consider each application on an individual basis. Please consider timings in any event planning that is undertaken.

Fundraisers are responsible for ensuring that:

- Approval is obtained before undertaking any fundraising activities from BHT and the CFC
- Approval from Buckinghamshire Council is obtained (where required)

- All fundraising activities are carried out in accordance with both BHT's and BHTCF's policies and guidance
- All monies raised are paid to the Charitable Fund as soon as possible
- All health and safety requirements are met.

Neither BHT and/or BHTCF will accept liability for any expenditure incurred by a third party in connection with any fundraising activity unless permission has been given beforehand.

Fundraising on wards and within private patient areas is forbidden and only in exceptional circumstances will it be considered. Patients are the main priority and their needs come above all. Anybody fundraising in an unapproved location will be asked to stop immediately.

Patients, visitors or staff are not to be directly approached to ask for donations; anybody fundraising must be mindful that they are in a hospital environment.

All donations, legacy enquiries or gifts for BHTCF must be directed through the central fundraising team.

### **6.1 Fundraising by staff on Trust property/premises**

Participation in fundraising activities by staff is voluntary and should not be imposed on individuals. Any fundraising that takes place on Trust premises must be first approved by the Charity Team before any event is agreed and any dates are set.

Any staff who would like to fundraise for a different charity can do so on a one-off basis only and on a specific date. The fundraising must not extend past one day and the Charity Team must be informed of the event. If fundraising for a different charity to BHTCF, the event cannot be held in any public forum or be patient facing and must be confined to staff areas only.

If staff members wish to fundraise on site during a specialist promotional day/month for a national charity (for example, Breast Cancer, Macmillan Coffee Mornings, Poppy Appeals or Alzheimer's Society), they must consult with the central fundraising team beforehand.

BHT and BHTCF encourages fundraising for individual wards and departments but this must be done under the appropriate hospital charity brand and agreed with the Charity Team and the Communication Department in advance. This is because BHTCF is the regulated charity with its own charity number and therefore the public have confidence that their donations are protected and used in accordance with charity legislation. BHTCF Team will give guidance on how to fundraise for a specific department.

### **6.2 Fundraising by Associated/Affiliated Charities**

Associated/Affiliated charities are independent charities that are linked specifically to BHT Hospitals and fundraise in their entirety for the benefit of BHT, its staff and patients e.g. Scannappeal, CCHF, etc. BHT will continue to prioritise the activities of these charities on site as 'preferred partners' wherever possible.

To avoid any reputational, financial risk or collateral damage to BHT and BHCT, BHT should receive annual confirmation that the activities of these charities adhere to the Fundraising Regulator and Charity Commission regulations and guidance.

### **6.3 External Charities**

External charities are not permitted to fundraise on any of the Trust sites, without prior approval of the central fundraising team.

Patient facing national charity collections are only permitted in exceptional circumstances and for a limited time, the details of which must be agreed in advance with the Fundraising Manager to minimise any impact on the BHT charity fundraising. These may include:

- The Royal British Legion poppy sales
- National fundraising days such as Macmillan Coffee morning – these will be permitted only as a joint fundraiser with the BHTCF, where there is a link to a department/clinical area

Information leaflets provided by other charities can be displayed if these are regarding healthcare services in support of patients.

## 6.4 Appeals

The Charity's appeals will be the responsibility of both the CFC and Appeal Committee.

Where an appeal is undertaken for a specific reason or project (such as for a piece of medical equipment), the appeal should clearly state what will happen to the monies raised if the appeal either exceeds or fails to reach its target in accordance with Section 222 of the National Health Service Act [National Health Service Act 2006 \(legislation.gov.uk\)](https://www.legislation.gov.uk).

The only exception to this is when first making the appeal, the trustees include a suitable statement in which they clearly indicate that, in the event they cannot deliver the main purpose of the appeal, they reserve the right to use the funds for similar charitable purposes. An appeal fund established on that basis is ultimately considered as unrestricted but clearly the trustees should designate the fund for the purposes of the appeal.

If no plans are made with regards to unspent appeal money, BHTCF may have to apply to the Charity Commission for permission before the funds can be used for an alternative purpose.

To enable funds from a specific appeal be clearly identified as such, a new fund should be established.

## 6.5 Public Collections

If a fundraiser intends to make house-to-house or street collections within Buckinghamshire, a licence is required from Buckinghamshire Council. At all times, the Charity Team should also be kept informed.

The term "house-to-house" includes visits to pubs, factories and offices as well as domestic dwellings.

This type of fundraising is not normally approved due to various difficulties in verifying that the monies raised have been paid over to BHTCF.

If BHTCF does perform door to door fundraising, it will need to be aware of current fundraising laws and legislation on this. For further information, please refer to:

<https://www.fundraisingregulator.org.uk/code/specific-fundraising-methods/legacies>

## 6.6 Raffles and Lotteries

These activities have to be approved by the Fundraising Manager and must be reported to the CFC.

There are two main types of raffle or lottery:

- Incidental non-commercial lotteries
- Society Lotteries

Both are regulated by the Gambling Act 2005.

### **Incidental non-commercial lotteries**

- These include raffles and tombolas
- Prizes must not exceed £50
- Incidental to 'exempt entertainments' (e.g. fetes, golf days, discos)
- The proceeds (after deduction of expenses) are applied for charitable purposes
- No cash prizes are given
- The sale of tickets and the announcement of results is carried out during the entertainment and on the premises where it is being held

### **Society Lotteries**

- Public lotteries which do not fall within the definition of incidental non-commercial lotteries e.g raffle on a ward.
- A raffle for which tickets are sold several days in advance of the draw

Society lotteries must be licenced and all lotteries must be organised in line with the rules laid down by the Gaming Commission – please visit the link below for further details:

[Licensees Hub - Gambling Commission](#)

The Gaming Commission website will also provide information on other types of lotteries that are run.

## **6.7 Sponsored Events**

Advice on sponsorship forms, including format and wording, can be obtained from the Fundraising Manager. Final approval on the forms must be obtained from BHTCF before they are used.

All outstanding monies should be collected promptly and paid to BHTCF. Completed sponsorship forms should accompany the monies BHTCF receives.

## **6.8 Collection Boxes**

The use of collection boxes for the Charitable Fund will only be authorised by BHTCF. Details can be obtained from the BHTCF Charity Finance Team.

Where collections boxes are used, they must be treated as controlled stationery and that:

- Unused collection boxes are kept securely, and access is limited
- Each box is allocated a unique ID number
- The collection box is issued sealed
- A record is kept as to where each box is located along with its seal number
- Each recipient of a collection box should confirm in writing that they have received the box
- Collection boxes should be visited and collected on a regular basis
- Two nominated BHTCF employees should open and count the monies collected on BHT premises

## **6.9 Charity Challenge Events:**

As standard practice, the participation in these events will be in line with the terms and conditions established by BHTCF and the tour/ charity challenge company.

BHTCF will conduct due diligence regarding the tour company and ensure that events comply with Package Travel and ATOL regulations.

BHTCF will approve all promotional material and advertisements.

### 6.9.1 London Marathon

The Charity acquire London Marathon Gold Bonds annually. Each year, the BHTCF secures a few places (usually five), which are split to fundraise for both the Haematology Department (3 places) and BHT General Amenity Fund (2 places). Fundraisers are encouraged to register their interest by emailing [charity@buckshealthcare.nhs.uk](mailto:charity@buckshealthcare.nhs.uk) and completing the event registration fund.

The places are allocated in line with the information provided in the event's registration form and the amount being pledged. The Charity has been accepting potential runner's pledges equal or over £1,500 in order to secure one of the places.

For further information related to the London Marathon, please visit [Home - TCS London Marathon](#)

### 6.10 Fundraising in Schools

BHTCF sees fundraising in schools as a useful engagement tool in gaining children's understanding of what BHTCF does, supporting the curriculum and raising awareness of social and care issues. Whilst not a substantial income generator, the role schools play in promoting a greater awareness of both BHTCF and the wider NHS charities movement.

As with all fundraising, there are particular regulations relating to schools fundraising. There are some activities which cannot be undertaken by children and young people without adult involvement including street and house-to-house collections, raffles, events involving alcohol etc.

BHTCF has a duty of care to make sure that all regulations and procedures relating to school fundraising are adhered to in line with the Fundraising Regulator – a copy of the codes followed by BHTCF can be found here - <https://www.fundraisingregulator.org.uk/code/working-with-others/fundraising-involving-children>

### 6.11 Fundraising using the corporate sector

Guidelines and procedures must be set up at the beginning of each relationship and preparation undertaken right at the beginning as in this competitive age the reasons for a company working with a charity are seldom purely philanthropic.

A written agreement governing the relationship between the company and the charity should be drawn up. This ought to be approved and understood by all parties.

The Fundraising Ethical Procedure stated in this policy should be observed when a partnership with a company or organisation is being evaluated.

Any corporates wishing to fundraise for BHTCF should contact the Charity Team who will then consider whether the corporate falls within the parameters of the Trusts values and ethical policies. Any decision to enter into a fundraising arrangement or corporate partnership for charitable purposes with a corporate will be considered and approved by the CFC following receipt of a proposal from the corporate.

Tax and VAT issues must be considered very carefully to ensure that the charity does not unwittingly undertake taxable trading. A good basic test is to ask whether the commercial third party concerned will receive any benefit from the relationship – for example, increased profile for the company's activities or products.

## 6.12 Legacy Fundraising

The Fundraising Regulator Codes and Fundraising guidance established a series of criteria to be observed by charities to ensure that legacy fundraising is undertaken in a professional, responsible and sensitive manner. These can be found at <https://www.fundraisingregulator.org.uk/code/specific-fundraising-methods/legacies>

In all cases of legacy fundraising, BHTCF should and will:

- Always be respectful of donors in respecting their wishes and preferences.
- Treat donors fairly, responding in an appropriate time and manner
- Ensure Fundraisers take responsibility for their actions.
- Ensure fundraising is carried out in line with the required Codes of Fundraising Practice.

All legacy notifications should be passed directly to BHTCF team for administration and to ensure that the Charity is receiving the correct amount of monies due. Discussion should not take place with any executors regarding proposed spend of the legacy without referral to BHTCF team. A legacy register is kept by the BHTCF team and is updated on a monthly basis. The CFC is updated at each meeting on legacy income and of prospective legacies where these are notified by Smeeth & Ford or the executors.

## 6.13 Ward Donations

Where it is not possible to direct potential donors to the BHTCF team, e.g. out of office hours, for expediency or when patients, families and visitors may wish to donate direct to a department or ward, the following procedures must be followed.

- All wards and departments are issued with charity donation envelopes for the purpose of collecting donations from patients, families and staff.
- Anybody wanting to donate on a ward or department must be given one of the envelopes which they can deposit their donation and seal themselves.
- All cheques should be made payable to: **'Buckinghamshire Healthcare NHS Trust Charitable Fund'**, detailing any fund to be credited i.e. 'Stoke Mandeville General Amenity Fund'.
- The donation should then be taken to the Cashiers or Charity Office by the donor. If the donor is unable to do this, then the sealed envelope can be received by staff and should be kept safely until it can be taken to the Charity office. This must be done within 48 hours of receipt.
- BHTCF team will record each donation, process for banking and issue an acknowledgment/ thank you letter to the donor.
- If the donation is made to the Ward without further instruction, then the amount will be banked under the General Fund. However, a record of each individual ward donation will be kept and available upon request.

## 7 False Representation

All fundraising must be authorised and undertaken in accordance with this policy. The use of both BHT's and BHTCF's name, brand or any implied association that has not been approved will be considered as false representation and appropriate action will be taken, including rejection of funds and criminal and civil action.

## 8 Corporate Partnerships

BHTCF welcomes co-operative relationships with companies from a wide range of sectors and industries and our collaboration could consist of one or several of the following:

- Staff fundraising
- Supplier fundraising and fundraising from other stakeholders
- Cause related marketing (i.e. a commercial activity by which the business and the charity form a partnership with each other to market an image, product or service for mutual benefit).
- Sponsorship (i.e. cash or in kind paid in return for access to exploitable commercial potential)  
Payroll Giving Donations/matched funding
- Employee involvement and volunteering
- Gifts in Kind
- Royalties
- Events

All potential partnerships and initiatives will be considered on a case by case basis. The Charity's overarching principles for corporate partnerships are:

- Integrity and openness
- Maintenance of independence
- Mutual benefit for all parties

## **9 Individuals and Organisations - Recognition of Donations Procedure**

This procedure gives a framework for donations from individuals and organisations to provide clear guidance that ensures acknowledgment and recognition is equitable, consistent and appropriate. It complies with all relevant legislation as set out in the Fundraising Regulator Code of Fundraising Practice and follows Charity Commission guidance.

This procedure applies to all significant donations to BHT or BHTCF including where recognition has been requested or offered as part of a major appeal.

### **9.1 Donor Recognition Opportunities**

The range of recognition opportunities is as follows:

- The naming of buildings, particular areas such as bays, wards, departments, equipment and other areas.
- The use of art, sculpture and other aesthetic features which can creatively acknowledge support or recognitions.
- Memory tree naming opportunities; leaves can be purchased with different options for sizes and length of time.
- In memory benches and trees.
- Acknowledgment on plaques or photos within the hospital.
- Acknowledgement by letter, certificates, newsletters, press releases, at events, on the BHTCF and BHT websites and intranet.

All donors will receive a thank you letter from the Fundraising team. Donations over £5,000 will be acknowledged by the Charitable Funds Committee Chair and donations over £50,000 will be acknowledged by the Trust Chair/CEO.

### **9.2 Naming Principles**

The naming of buildings, facilities, services and equipment should be kept to a minimum. Over time names run the risk of losing their significance or being named informally to a more functional title. In most cases a functional title is preferable, and recognition be acknowledged in other ways.

The general principles of naming in recognition of donations shall be dependent on the amount given in relation to the cost of the item and it is therefore necessary for each to be considered on its individual merits by the Charitable Funds Committee and referred to the Trust's Executive Committee if appropriate.

The CFC will work to the following guideline with regards to naming:

- a. BHT will consider the naming of a building or area where a donor provides a minimum donation of £250,000 or 50% of the capital cost of the building/ area.
- b. BHT will consider attaching a plaque to equipment where a donor has contributed a minimum of £50,000 or more than 50% of the equipment cost.

The CFC will also decide on the time period for which the recognition will be in place, and the following should be considered:

- a. Naming will be time limited.
- b. Where the naming is no longer in the best interests of the trust and/or the donor it will be changed.
- c. Naming rights will not extend beyond the normal life of the item

### 9.3 Types of naming

- a. Individual – an individual major benefactor, if this involves the use of the name of a deceased person, the approval must be on the agreement of that person's next of kin.
- b. Organisation – a major benefactor, whether charitable trust/foundation, commercial organisation or local fundraising group.

In all cases, the naming of a building or area must include a functional reference – e.g. the Rothschild Cancer Centre.

Where the Charitable Funds Committee (CFC) offers to name a ward/building etc. in recognition of such a gift, BHTCF should firstly consider the acceptance and refusal procedure to ensure compliance before identifying a suitable and appropriate feature/facility.

CFC reserves the right to withdraw such named recognition in the future if it subsequently transpires that the source of funding does not meet with the Charity's acceptance and refusal procedure and/or HMRC rules and/or if the donor's behaviour and association could bring either the Trust or the Charity into disrepute.

The naming of Trust buildings or equipment shall be based on the following principles:

- Enhance and maintain the Trust's and Charity's image and reputation in the community
- Strengthen internal and external relationships and partnerships
- Provide consistent, equitable and appropriate naming opportunities to supporters of the Trust/Charity
- Support the future plans of the Trust.

An agreement outlining the terms of any naming opportunity will be signed by the donor and the Head of Charity following agreement by the CFC and Board.

### 9.4 Naming Approval Process

- a. Buildings and areas require the CFC approval and EMC approval if appropriate. No commitment

regarding naming shall be made prior to approval by the Charitable Funds Committee. Each proposal must be made in writing.

- b. Plaques or photos, art, sculpture and other environmental features require the CFC approval.
- c. Acknowledgement in fundraising materials, in newsletters, at events, display boards, on the appeal and Trust website and through the media – require approval by the Fundraising Manager and/or Communications Team.

## 10 Communications and Advertising

Any support / promotion / guidance in regard to marketing and advertising of a fundraising event, should be stated when requesting support and it will be considered as part of the whole application.

Guidance on communications and advertising can be provided by the Charity Team or Communications Department.

It is to be noted that the BHTCF fundraising team has limited communications resources and although support can be provided there may be limitations to the level of communications and advertising we can provide.

## 11 Charity Brand and Fundraising Literature

The use of the charity brand (logo, charity name and charity number) will be agreed through the Charity Team.

Any literature, including brochures used to attract support, shall be coordinated through the Charity Team, the Communications Department and relevant departments.

The Buckinghamshire Healthcare NHS Trust Charitable Fund registration number, 1053113, should be included on all marketing material.

The Fundraising Manager or The Head of Finance and Governance will have the final decision on the use of the charity brand on any literature.

## 12 Social Media, Media, VIP, Press, Radio and TV

It shall be the responsibility of the Charity Office, with the support of the Communications Department, to initiate the preparation of all public statements concerning fundraising.

The Charity has adopted BHT's policies related to Media, Social Media and VIP policies. Please refer to BHT's Intranet Site listed next.

- [media policy](#) – listed under the comms drop down heading on our [policy page in the documents library](#) on CAKE
- [social media policy](#) – listed under the comms drop down heading on our [policy page in the documents library](#) on CAKE
- [VIP policy](#) – also listed under comms on our [policy page in the documents library](#) on CAKE

## 13 Photography

Any person who is photographed has to sign a consent form, which has been provided by the Trust Communications Team. This is necessary for your own photography, our inhouse photographers and for any press photography.

Any photography should be in a private space that does not have any person who has not consented in the photograph and no information written on the walls behind.

The Charity has adopted the Trust's Policy for Photography of patients by non-medical photography department staff. Please refer to the Trust's Intranet Site (<https://intranet.buckshealthcare.nhs.uk/documents/photography-of-patients-by-non-medical-photography-department-staff/> )

## **14 Volunteers**

BHTCF does not have its own charity volunteers, therefore assistance from BHT's Voluntary Services Department may be required. The Charity Office will coordinate the required volunteers .

## **15 The Charities (Protection and Social Investment) Act 2016**

The Charities (Protection and Social Investment) Act 2016 expressly excludes charities established by statute (which includes NHS Charities) from the power to make social investment.

BHTCF will comply with the provisions set out in the fundraising sections of the Charities (Protection and Social Investment) Act 2016 [Charities \(Protection and Social Investment\) Act 2016 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2016/19) These help charities demonstrate their commitment to protecting donors and the public, including vulnerable people, from poor fundraising practices. Part of the requirement is for registered charities to have their accounts audited.

## **16 Breach of this policy**

Any breach of this Fundraising Policy, particularly with regards to health and safety, will be treated as a potential disciplinary issue and will dealt with through BHT's disciplinary procedure.

## **17 Dissemination**

This policy will be posted on both the BHT's external website and the staff intranet. It will also be distributed to the BHTCF Charity Finance Team as well as to the Communications Team.

## EQUALITY IMPACT ASSESSMENT

### Screening - Initial Assessment

#### Stage – 1

The screening process must be used on all new policies, projects, service reviews and staff restructuring. If you are not able to determine why your proposal has a positive/ negative / neutral effect on patients, services users or staff you will require a more detailed analysis and need to conduct a full equality impact assessment.

Questions	Answers
1. Brief summary of the project/ policy including the main aims and proposed outcomes.	<b>The policy defines the fundraising policy for the Charity</b>
2. Could the proposed strategy, policy, service change, or function have a direct or indirect effect on patients, service users, staff or local community?  Please explain your answer.	<b>Yes, we will offer a wide range of opportunities and activities in respect of raising funds. We are aware that some opportunities we offer are not accessible by all; but are sensitive to this in the balance of what we promote and ensure that we encourage ideas from all.</b>
3. Could the proposal have a positive or negative effect on patients, service users, staff or local community by the protected characteristics (age, disability, gender, gender re-assignment, marriage & civil partnership, pregnancy & maternity, race religion or belief, sexual orientation?  Briefly explain your answer by considering each characteristic and	<b>Age Discrimination Groups</b>  <b>Disability Groups</b>  <b>Gender Groups</b>  <b>Gender Reassignment</b>  <b>Marriage &amp; Civil Partnership</b>  <b>Pregnancy &amp; Maternity</b>  <b>Ethnic Groups</b>  <b>Faith Groups</b>

<p>state the impact on each group.</p> <p><b>**Please ensure you write a response for each characteristic**</b></p>	<p><b>Sexual Orientation Groups</b></p> <p>There is a neutral effect on all characteristics.</p> <p>We are open to suggestions on fundraising from anyone and encourage any challenges and would promote a diverse range of events.</p>
<p>4. Is there any indication or evidence (including from engagement / consultation with relevant groups) that different groups have or will have different needs, experiences, issues, and priorities in relation to the proposals? Or do you need more information?</p>	<p><b>Not at this stage. We aim to be inclusive and encourage wide participation.</b></p>
<p>5. What measures are you proposing to take to mitigate /reduce the impact of your proposal for any of the protected characteristics, within patients, service users or staff?</p>	<p><b>Awareness for all staff involved in fundraising and specific training for key individuals to initiate best practice.</b></p> <p><b>All future fundraising developments should be undertaken with awareness of best practice.</b></p> <p><b>Consideration of initiatives that promote inclusion. Also, collaboration with other charities (local and some specialist national charities) which encourages participation locally and nationally.</b></p>
<p>6. Are there any measures that you can take to produce a positive impact for any of the protected characteristics, within patients, service users or staff?</p>	<p><b>For legacy giving the patient information leaflet has been recently reviewed. This is open to everyone as are the will writing services.</b></p>

<b>Signed off by</b>	
<b>Name of lead officer:</b>	<i>Jane Lucas</i>
<b>Signature &amp; date:</b>	<i>31/10/22</i>
<b>Name of Executive Lead</b>	<i>Barry Jenkins</i>
<b>Signature &amp; date:</b>	

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	Mortality and Medical Examiner Report
<b>Board Lead</b>	Mr Andrew McLaren, Chief Medical Officer
<b>Type name of Author</b>	Dr Mitra Shahidi, Deputy CMO Quality & Patient Safety Mandy Chetland, Head of Medical Quality Dr Helen Pegrum, Consultant Palliative Care
<b>Attachments</b>	None
<b>Purpose</b>	Assurance
<b>Previously considered</b>	Q&CGC 16.11.2022

### Executive Summary

The rolling HSMR for the 12-month period up to July 2022 is banded statistically “as expected” and “lower than expected”.

Over the past year our Medical Examiners have continued to review all BHT acute deaths. Deaths in Florence Nightingale House (FNH) hospice have been reviewed by MEs since March 2021.

Work is well underway to integrate scrutiny of community deaths into the ME service. Team has expanded with further recruitment to support the requirement to scrutinise an additional 2,000 deaths per annum.

Links established with Mental health, private care and paediatrics regarding community deaths and referral pathways are being developed and using EMIS to review community care.

There is likely to be a request for a 7-day service going forwards. The details of this are yet to be determined. From 1st April 2023 a death cannot be registered without ME review. An electronic medical certificate of cause of death (MCCD) will be launched in 2023.

The Quality and Clinical Governance Committee took assurance from this report including mitigating actions following issues with coding.

**Decision** The Board is requested to take assurance from this report

### Relevant Strategic Priority

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

<b>Patient Safety</b>	Monitoring and investigating/auditing deaths and mortality rates to ensure we are providing the safe care and identifying any learning if a lapse in care is identified.
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	BAF Risks 1 and 8. The Trust’s mortality rates are indicators of how well we care for our patients and may impact negatively on the Trust’s reputation.
<b>Financial</b>	No financial implications.
<b>Compliance</b> <small>Select an item. Select CQC standard from list.</small>	The standard for HSMR is 100.0
<b>Partnership: consultation / communication</b>	Collaboration with certifying doctors, Coroners, GPs, ICB, regional and national ME leads to establish community roll out of ME scrutiny of deaths

	Collaboration with all divisions and the Dr Foster analyst at the Mortality Reduction Group Meeting as well as when investigating/auditing specific diagnoses.
<b>Equality</b>	ME services engage with bereaved families to explain the MCCD, help answer any medical questions and listen to any concerns they may have regarding their loved one. The ME service also supports timely arrangements for faith communities wishing to expedite burial within 24 hours. Mortality data does not discriminate against protected characteristics but can identify inequalities if mortality is higher in a particular group of people ie., age, gender, ethnicity, etc
<b>Quality Impact Assessment [QIA] completion required?</b>	Not required for this paper

## Mortality

### Hospital Standardised Mortality Ratio (HSMR)

The HSMR is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. Standardised rates allow comparison between organisations that deal with different patient populations.

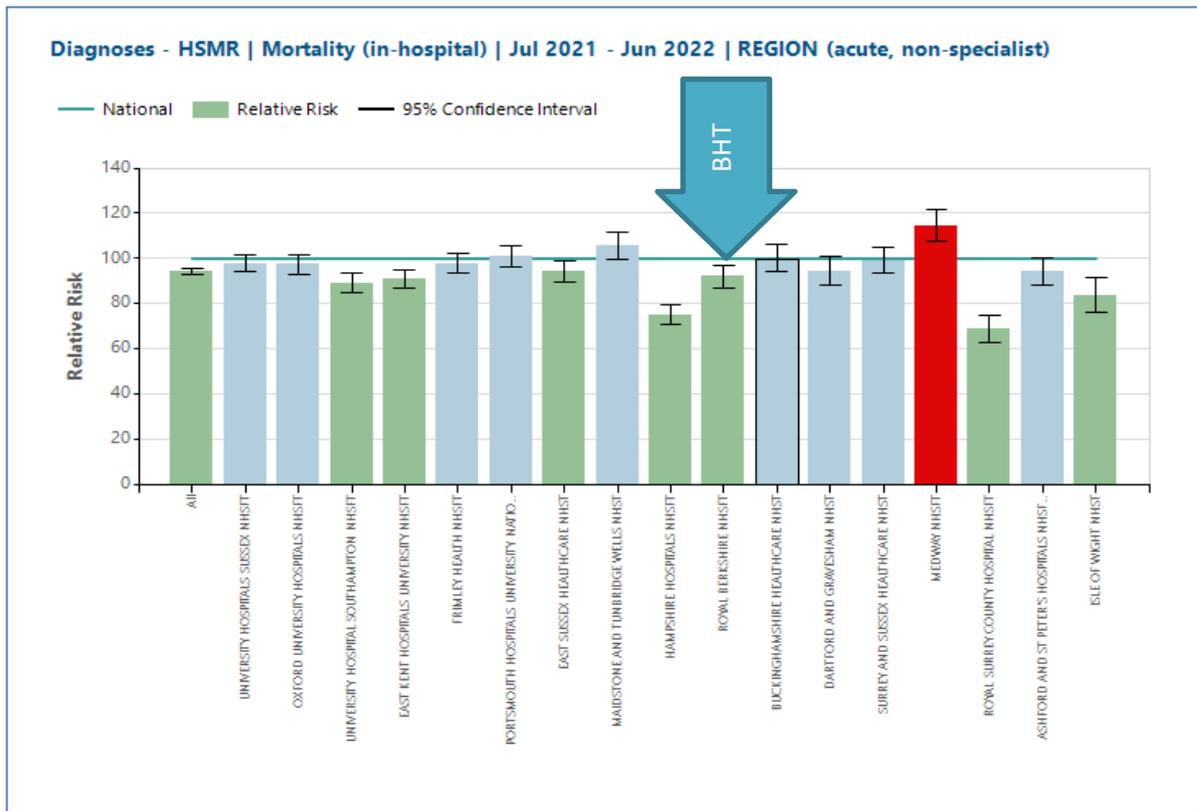
The rolling HSMR for the 12 month period up to July 2022 is banded statistically “as expected” and “lower than expected” (Fig. 1).



(Figure 1)

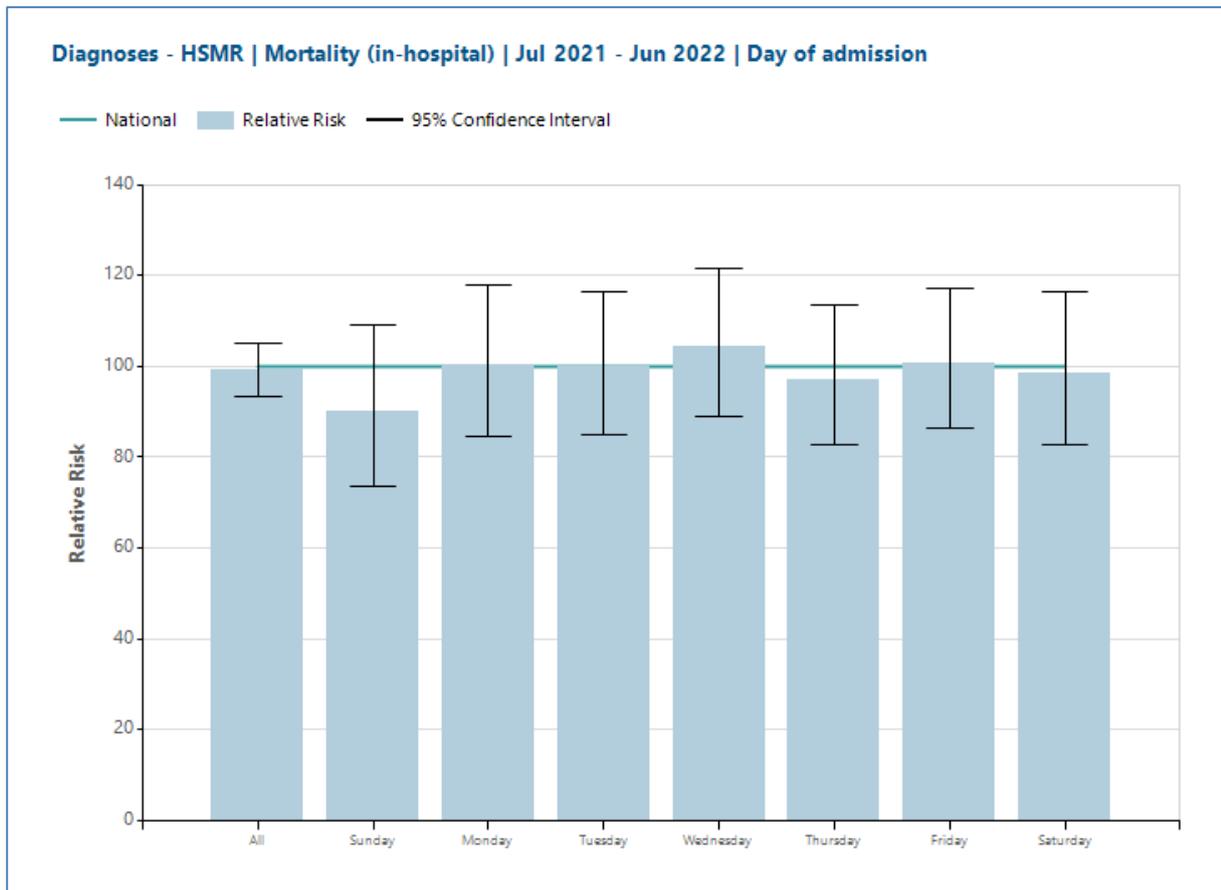
Crude mortality rate is 3.3% compared to 3.4% regional average and 3.2% national average (acute, non-specialist Trusts).

Buckinghamshire Healthcare Trust is 1 of 7 within the regional comparison (acute, non-specialist providers) with an HSMR that is banded as statistically ‘within expected’ (Fig. 2).



(Figure 2)

Weekend and weekday (emergency) admissions for the 12 month period is banded as statistically 'within expected' (Fig.3).

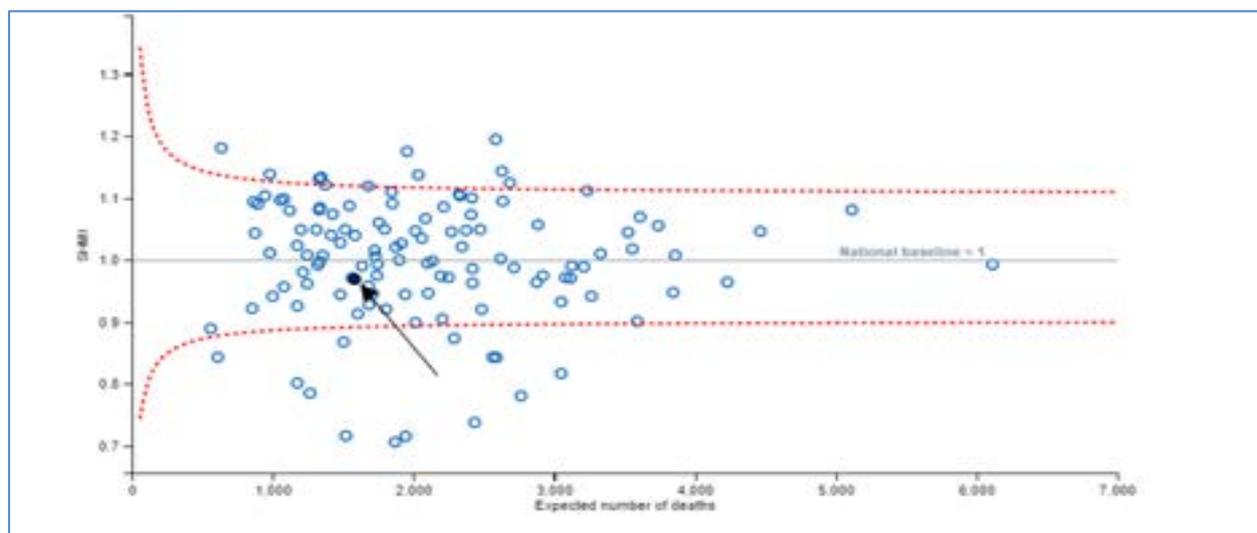


(Figure 3)

## Summary Hospital-Level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

For the period May 2021 to April 2022, SHMI is banded as statistically 'within expected' (97.23). BHT's position nationally is shown in figure 4 below.



(Figure 4)

## Medical Examiners

The National Medical Examiner (ME) Service is now well established across England and Wales. The emphasis this year has been on extending the ME service into the community. From 1st April 2023 the system will become statutory and all, non-coronial, deaths will require ME review before they can be registered.

For our BHT based ME service this will require review of an additional 2000-2500 deaths with input needed from GP practices with whom we have been actively engaged for the last 18 months. Support has also been obtained from BOB ICS and the Regional Medical Examiner to encourage GP practices to start using the service.

There is a risk that if GP practices are not engaged with the ME service by end March 2023 deaths of their patients in the community will not be registered in a timely manner resulting in delays to funeral arrangements.

Medical Examiners Services are hosted within Acute Trusts and funded by NHS England via an invoice system. There is a separate line of professional accountability; this independence is overseen by the National Medical Examiner and Regional Medical Examiners. There are also Regional Medical Examiner Officers. This team provide leadership, support and on-going development to the system.

## The Role of Medical Examiner

The Medical Examiner attempts to call all bereaved relatives at least twice. If unable to receive an answer this is documented on the Medical Examiner Screening Form. Non applicable calls include those relating to coroner's post-mortem and coroner's inquest.

Support for certifying doctors is paramount. BHT Medical Examiner Service have introduced the flexibility to take phone calls from certifying doctors to expedite death certification and/or coroner's referrals.

Referrals to the Coroner in Quarter 4 averaged 18% of BHT deaths with 3.4% of the total deaths going to Coroner's inquest. Overall, in 2019 there were 53 Coroner's inquests from BHT deaths compared with 50 in 2018.

The ME Service supports timely arrangements for the bereaved including faith communities wishing to expedite burial within 24 hours. There is an Out of Hours system in place for faith deaths, however the ME service is currently provided from Monday to Friday. There is likely to be a request for a 7 day service going forwards. The details of this are yet to be determined.

No death can be registered after 1st April 2023 without ME review.

### Acute Trust Deaths

- Over the past year our Medical Examiners have continued to review all BHT acute deaths. They have scrutinised 788 deaths from January to August 2022.
- The MEs have also supported doctors with referrals to the Coroner.
- 10.5% of cases have been selected for Structured Judgement Review.
- There have been 40 Excellence reports over the last 6 months from ME scrutiny and family feedback
- There have been 167 complements received over the last 6 months from families

### Community Deaths including FNH and Community Hospitals

- Deaths in Florence Nightingale House (FNH) hospice have been reviewed by MEs since March 2021.
- 173 FNH deaths have been reviewed between January to August 2022.
- Work is well underway to integrate scrutiny of community deaths into the ME service.
- 2.8 WTE Medical Examiner Officers and 0.1 WTE Medical Examiner have been recruited. Further ME recruitment is underway to recruit up to budget from NHSE to support the requirement to scrutinise an additional 2,000 deaths per annum.
- Links established with Mental health, private care and paediatrics regarding community deaths.
- Developing referral pathways and using EMIS to review community care.
- Visiting virtually or in person Bucks GP practices.
- Met with Undertakers to disseminate information re new service.

### Medical Examiner Training and Digitalisation

The Royal College of Pathologists continue to offer mandatory e-learning in addition to all Medical Examiners attending face to face training. On completion Medical Examiners as members of the Royal College of Pathologists are awarded the post nominals 'RCPATHME'. All Medical Examiners have completed their training except for those newly employed who have their training booked.

The Royal College of Pathologists also offer National Medical Examiner Officer Training. Our Senior MEO regularly facilitates this training and our newly appointed MEOs have attended.

The first Joint Coroner and ME training has taken place and locally we have 6 monthly meetings between MEs and our local Coroner.

The national database is still unavailable, so we are using existing data collection methods.

There is a new Electronic MCCD coming in the new year

We invoice NHSE for the ME and MEO costs and provide them with a comprehensive dataset on a quarterly basis.

### Mortality Data Q2 July-September 2022

	July	Aug	Sept

<b>Number Adult BHT Deaths</b>	99	92	<b>80</b>
Total % Medical Examiner Screens by month end	100%	100%	100%
<b>Total selected for SJR review</b>	<b>10%</b>	<b>12%</b>	<b>10%</b>
<b>Number SI investigations</b>	<b>0</b>	<b>0</b>	<b>0</b>
Total number of Deaths with Learning Disability	0	0	0
Compliments	25	24	22
<b>Excellence Reporting</b>	<b>7</b>	<b>5</b>	<b>10</b>

### **Structured Judgement Reviews (SJR)**

The SJR process is still on-going in accordance with the Royal College of Physicians guidelines. We are currently looking at a database to hold this information.

The Mortality nurse post is currently vacant but the senior MEO is supporting colleagues in clinical governance regarding the SJR process.

### **Dissemination of Learning**

- Quarterly meetings with registrars and Coroners officers
- 6 monthly meetings between MEs and Buckinghamshire Coroner next one in November 2022
- Regular ME meetings

### **Action required from the Board/Committee**

For assurance

(Meeting: Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	Maternity and Neonatal Services in East Kent: Reading the Signals Report
<b>Board Lead</b>	Karen Bonner, Chief Nurse
<b>Type name of author</b>	Heidi Beddall, Director of Midwifery
<b>Attachments</b>	Maternity and Neonatal Services in East Kent: Reading the Signals (within NED Reading Room. Available from <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/111111/Maternity_and_neonatal_services_in_East_Kent_Reading_the_signals_report.pdf">Maternity and neonatal services in East Kent: 'Reading the signals' report - GOV.UK (www.gov.uk)</a>
<b>Purpose</b>	Discussion
<b>Previously considered</b>	SDU governance meeting and divisional quality board EMC 8.11.2022 Quality Committee 16.11.2022

### Executive Summary

The Maternity and Neonatal services in East Kent: reading the signals Report was published on October 19<sup>th</sup> 2022. The report follows an investigation of the maternity services in two hospitals, the Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020. The report highlights failings in maternity and neonatal services that directly impacted patient safety.

The report states that had care been given to the nationally recognised standards; the outcome could have been different in:

- 97 (48%) of the 202 cases assessed
- 45 of the 65 baby deaths (69%) of these cases

The report highlights how the Trust failed to read the signals and missed the opportunities to put things right and identifies four key areas for action:

1. Monitoring safety performance – finding signals among noise
2. Standards of clinical behaviour – technical care is not enough
3. Flawed teamworking – pulling in different directions
4. Organisational behaviour – looking good while doing badly

The report must be a catalyst for tackling embedded, deep-rooted problems across maternity and neonatal services nationally.

Whilst awaiting a national steer from NHS England on the mandatory actions that all maternity services must take in response to the East Kent report, it is duly diligent for this Trust to consider the key areas for action.

A meeting of key stakeholders has been arranged for January to discuss measuring performance in maternity and neonatal care.

This report was considered by the Executive Management Committee on 8 November 2022. The Committee were informed that a steer on the ask for provider Trusts was awaited following the publication and there was currently no timeline for this. Positive feedback had been received from HSIB confirming the Trust was not an outlier in terms of reporting and there were no concerns related to culture. The Director of Midwifery reported requesting a review of perinatal mortality cases, the process for which included an external peer.

The East Kent report was subsequently considered by the Quality and Clinical Governance Committee on 16 November 2022 who emphasised the importance of sharing learning from this report trust wide. The reason for focussing on maternity services was noted alongside acknowledgement that themes from the East Kent report could apply across all services.

### Decision

The Board is requested to discuss the contents of this report.

Relevant strategic priority			
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
Implications / Impact			
<b>Patient Safety</b>		The East Kent report highlights failings in maternity and neonatal services that have directly impacted patient safety. Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.	
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>		BAF 1 – Failure to provide care that consistently meets or exceeds performance and quality standards. BAF 8 – Failure to learn, share good practice and continuously improve.	
<b>Financial</b>		Patient safety in maternity and neonatal services is essential to minimising litigation costs	
<b>Compliance CQC Standards</b>		Safety Good governance Person centred care Duty of candour Complaints	
<b>Partnership: consultation / communication</b>		Maternity voices partnership BOB local maternity and neonatal system	
<b>Equality</b>		The East Kent report does not highlight inequalities in care, but all women should receive safe, effective, responsive care personalised to their specific clinical, social and emotional needs in order to reduce health inequalities and improve outcomes. All families should be treated with kindness, compassion and candour.	
<b>Quality Impact Assessment [QIA] completion required?</b>		No	

## 1 Introduction/Position

The maternity and neonatal services in East Kent report: Reading The Signals was published on October 19<sup>th</sup>, 2022. The report follows an investigation of the maternity services in two hospitals, the Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020.

## 2 Problem

The report highlights failings in maternity and neonatal services that have directly impacted patient safety. The consequences of not recognising and taking the opportunities for improvements in clinical care and culture were stark.

The report states that had care been given to the nationally recognised standards; the outcome could have been different in:

- 97 (48%) of the 202 cases assessed
- 45 of the 65 baby deaths (69%) of these cases

Harm to women, babies and their families was not restricted to physical damage. The report highlights the disturbing effects of the repeated lack of kindness and compassion on the wider experience of families, both as care was given and later in the aftermath of injuries and deaths.

The report states that the individual and collective behaviours of those providing care in the maternity and neonatal services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020, and lay at the root of the pattern of recurring harm.

The report highlights how the Trust failed to read the signals and missed the opportunities to put things right. Key themes where failures occurred were:

- team working
- professionalism
- compassion
- listening
- actions after safety incidents
- trust responses including at board level such as focusing on reputation management and reducing liability through litigation which got in the way of patient safety and learning
- actions of regulators

### **3 Possibilities**

The East Kent report clearly states that since the report of the Morecambe Bay Investigation in 2015, maternity services have been the subject of more significant policy initiatives than any other service. Yet, since then, there have been major service failures in Shrewsbury and Telford, in East Kent, and (it seems) in Nottingham. If we do not begin to tackle this differently, there will be more.

For that reason, the East Kent report is somewhat different to the usual when it comes to recommendations. It has not sought to identify detailed changes of policy directed at specific areas of either practice or management. This approach has been tried in previous investigations into maternity care such as Morecambe bay and the Ockenden review as well as other non maternity healthcare enquiries, and it does not prevent the recurrence of remarkably similar sets of problems in other places.

The Report identifies four key areas for action that must be addressed if the cycle of supposedly one-off catastrophic failures in maternity and neonatal services is to be broken.

- 1: Monitoring safety performance – finding signals among noise
- 2: Standards of clinical behaviour – technical care is not enough
- 3: Flawed teamworking – pulling in different directions
- 4: Organisational behaviour – looking good while doing badly

### **4 Proposal, conclusions recommendations and next steps.**

The report highlights failings in maternity and neonatal services that have directly impacted patient safety.

The consequences of not recognising and taking the opportunities for improvements in clinical care and culture were stark.

The report must be a catalyst for tackling these embedded, deep-rooted problems across maternity and neonatal services nationally.

Whilst awaiting a national steer from NHS England on the mandatory actions that all maternity services must take in response to the East Kent report, it would be duly diligent for this Trust to consider the key areas for action.

A meeting of key stakeholders has been arranged for January to discuss measuring performance in maternity and neonatal care.

It is essential that risk-sensitive outcome measures are reported, genuine outliers are identified, and improvements made as required. In addition, performance metrics must be considered in the context of:

- Themes from complaints and service user feedback
- Family engagement in investigations
- Culture surveys
- Feedback from external bodies such as HSIB, royal colleges, CQC
- NHS staff survey results
- Freedom to speak up themes
- Board level Maternity safety champions feedback from walkarounds

## **5 Action required from the Board/Committee**

5.1 The Board is requested to:

- a) Discuss the contents of the report.

### **Appendices**

Maternity and Neonatal Services in East Kent: Reading the Signals

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	Ockenden Insight Visit 09 August 2022
<b>Board Lead</b>	Karen Bonner, Chief Nurse
<b>Type name of Author</b>	Heidi Beddall, Head of Midwifery
<b>Attachments</b>	BHT Ockenden Insight Visit 09 August 2022 Final Report
<b>Purpose</b>	Assurance
<b>Previously considered</b>	EMC 1 November 2022 Quality Committee 16.11.2022

### Executive Summary

The first Ockenden report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust was published on 11<sup>th</sup> December 2020.

7 immediate and essential actions were required for all maternity units. 49 questions made up of 122 evidence requirements had to be met to achieve compliance with the 7 immediate and essential actions.

External review in October 2021 identified that the Trust was partially compliant with the 49 questions.

Internal self-assessment in March 2022 deemed that the Trust had achieved full compliance with the 49 questions.

On 9<sup>th</sup> August 2022, the Trust had an Ockenden insight visit by the South East regional team. The visiting team have confirmed that self-assessment was largely accurate.

The report states:

- There are no questions with non-compliance
- There are 44 questions with full compliance
- There are 5 questions where a greater level of assurance would be beneficial

The report notes one incidental finding regarding the building work that has impacted the maternity unit.

The report sets out 9 recommendations to address the 5 areas of partial compliance and the issues related to the building work.

The maternity team have agreed a 3 month timeframe to address the 9 recommendations.

This report was considered by the Executive Management Committee on 1 November 2022. The Committee discussed lessons learned by BHT's assurance processes and the opportunity to discuss further how BHT internally assess. The committee was assured by the report.

The Quality and Clinical Governance Committee were also assured by the report on 16 November 2022. The positive feedback from the visit was highlighted and the Committee acknowledged twice daily Consultant ward rounds were now in place.

<b>Decision</b>	The Board is requested to take assurance		
<b>Relevant Strategic Priority</b>			
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>

Implications / Impact	
<b>Patient Safety</b>	The interim Ockenden report set out immediate actions, clinical priorities and learning for all maternity services.
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Ockenden compliance BAF Risk 1
<b>Financial</b>	Patient safety in maternity and neonatal services is essential to minimising litigation costs
<b>Compliance CQC Standards Safety</b>	Safety Person Centred Care Good Governance Fit and proper staff
<b>Partnership: consultation / communication</b>	BOB Local maternity and neonatal system (LMNS), Bucks Maternity Voices Partnership (MVP)
<b>Equality</b>	All women should receive safe, effective, responsive care, personalised to their specific clinical, social and emotional needs in order to reduce health inequalities, clinical variation and improve outcomes.
<b>Quality Impact Assessment [QIA] completion required?</b>	No

## 1 Introduction/Position

The first Ockenden report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust was published on 11<sup>th</sup> December 2020.

7 immediate and essential actions were required for all maternity units.

49 questions made up of 122 evidence requirements had to be met to achieve compliance with the 7 immediate and essential actions.

## 2 Problem

Internal self assessment in March 2022 deemed that the Trust had achieved full compliance. The Trust public board was appraised of self assessed compliance levels on March 30<sup>th</sup> 2022.

On 9<sup>th</sup> August 2022, the Trust had an Ockenden insight visit by the South East regional team, led by regional chief midwife Kaye Wilson.

The insight visit final report was received on 14<sup>th</sup> October 2022 (See Appendix 1).

The report demonstrates that the Trust has made excellent progress since the external assessment, in October 2021 and that the self-assessment was largely accurate.

The report states:

- There are no questions with non compliance
- There are 44 questions with full compliance
- There are 5 questions with partial compliance

The report notes one incidental finding regarding the building work that has impacted the maternity unit.

### **3 Possibilities**

The report sets out 9 recommendations to address the 5 areas of partial compliance and the issues related to the building work.

### **4 Proposal, conclusions recommendations and next steps.**

The maternity team have agreed a 3 month timeframe to address the 9 recommendations. Sustaining compliance with the 7 immediate and essential actions will be tracked and monitored through the maternity compliance and assurance meetings and divisional board.

### **5 Action required from the Board/Committee**

5.1 The Board is requested to:

- a) Take assurance

### **APPENDICES**

Appendix 1: BHT Ockenden Insight Visit report

# Buckinghamshire Healthcare NHS Trust

## Maternity Services – Overview findings of Regional and System Insight Visit

9th August 2022

### Contents

1. Introduction – Visit Purpose	3
2. Introduction – Visiting Team	4
3. Summary of Assurance & Insight Visit Review of Ockenden IEAs Status	5
4. Key Headlines	6-8

5. Recommendations & Support Offer

9-10

6. Full Assessment

11-39

## Introduction - Visit Purpose

The Assurance & Insight visit to Buckinghamshire Healthcare NHS Trust Maternity Services was completed on the 9th August 2022.

The purpose of this visit was to provide assurance against the 7 Immediate and Essential actions from the Interim Ockenden Report from 2020. The Insight Visit Team used an appreciative enquiry and a learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

Evidence was reviewed and conversations were held with members of the executive team, senior leadership team and frontline staff representing a range of midwifery, obstetric, anaesthetic and support job roles.

This report outlines the achievements and areas for improvement for the Trust identified at these visits in relation to the requirements outlined in the National Commissioning Support Unit (CSU) Assessment used in 2021:

1. Enhanced Safety
2. Listening to Women & Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well-Being
7. Informed Consent
8. Workforce Planning and Guidelines

The visiting team would like to express sincere thanks to all the Trust staff and Maternity Voices Partnership (MVP) engaged in this process for their welcome, participation and willingness to share their thoughts and experience of the BHT maternity services.

## Introduction - Visiting Team

- Kaye Wilson – NHS England SE Regional Chief Midwife
- Emma Taylor – NHS England SE Regional Service User Voice Lead | MVP
- Sian Summers – NHS England SE Senior Quality Improvement Manager
- Liz Stead – BOB LMNS Deputy SRO
- Margaret Beattie – SHIP LMNS SRO
- Sudhanshu Malla – NHS England SE Regional MTP Support Administrator

## Summary of Assurance & Insight Visit Review of Ockenden IEAs Status

IEA	Trust Dec 2021 Compliance	Trust Position as declared in presentation	Ockenden Visit in 9 <sup>th</sup> Aug 2022	Compliance - Breakdown						
1. Enhanced safety				Q1	Q2	Q3	Q4	Q5	Q 6	Q7
2. Listening to women and families				Q11	Q13	Q14	Q15	Q16		
3. Staff training and working together				Q17	Q 18	Q 19	Q21	Q22	Q23	
4. Managing complex pregnancy				Q24	Q25	Q26	Q27	Q28	Q29	
5. Risk assessment throughout pregnancy				Q30	Q31	Q33				
6. Monitoring fetal well-being				Q34	Q35	Q36	Q37			
7. Informed consent				Q39	Q41	Q42	Q43	Q44		
Workforce Planning				Q45	Q46	Q47	Q48			
Guidelines				Q49						

	No Question
	Compliant
	Partially Compliant

NB: Missing questions were removed by the National CSU team in the December 2021 Assessment

BHT demonstrated that significant progress had been made since December 2021 when the Trust demonstrated partial compliance against all IEAS. At our visit, the Trust demonstrated full compliance against IEA 1, IEA 3, IEA 4, IEA 6 and Guidelines. The key elements related to partial compliance involved risk assessment, PCSP, outstanding audit, MVP and service user engagement, and obstetric workforce planning.

## **IEA 1 - Enhanced Safety**

The Trust demonstrated full compliance with all 16 evidence requirements.

- A well established process for PMRT is in place and audit confirmed 100% compliance with parental notification and external review
- The Trust have fully implemented the perinatal quality surveillance system, and have robust processes in place for SI and moderate harm review. Learning from incidents is shared and staff reported a supportive culture.

## **IEA 2 - Listening to Women & Families**

The Trust demonstrated compliance with 16 of the 18 evidence requirements. The outstanding area relates to strengthening NED engagement, documentation and the reporting and follow-up of actions.

- It was noted that Board and Safety Champions meetings allow for constructive challenge.
- Staff reported that Safety Champions walkarounds made the connection from board to floor more real
- A good working relationship was described between the DoM/HoM and MVP lead.
- Some excellent examples of MVP engagement work were shared and we considered the work with the Pakistani community to be a true exemplar

## **IEA 3 – Staff Training and Working Together**

Excellent progress has been made by the Trust with full compliance demonstrated across all 18 evidence elements.

- Robust process are in place and were clearly articulated

- There is a strong MDT approach to learning and training and staff gave positive feedback about the quality of training and support received
- Live drills, simulation training and human factor training are in place and positively received by staff
- Twice daily consultant-led ward rounds are well-established on labour ward and staff articulated the impact on safety and also with communication between staff groups.

## **IEA 4 - Managing Complex Pregnancy**

Excellent progress has been made by the Trust with full compliance demonstrated across all 14 evidence elements for IEA 4.

- Robust processes and comprehensive SOP in place with clearly defined referral pathways described
- MMN and FM pathways are shared with a good MDT approach
- Audits completed and demonstrate compliance

## **IEA 5 – Risk Assessment Throughout Pregnancy**

12/15 evidence elements are compliant in IEA 5.

- Further work is required around the use and auditing of risk assessment and Personalised Care & Support Plans (PCSP). This issue has emerged as a regional theme and a support package to address this will be developed and implemented by the Regional Team.
- Well written SOP with clear guidance on actions to be undertaken at each antenatal appointment is in place

## **IEA 6 – Monitoring Fetal Wellbeing**

Excellent progress has been made by the Trust with full compliance demonstrated across all 18 evidence elements.

- The two leads weekly run fetal monitoring meetings( physical and virtual). These are open forums which include students; Review and take lead on related SIs and update training material to reflect recent cases; Induction for Drs; Support for those not passing training competency package • Staff feedback positively about the quality of training, learning sessions and support • Flat hierarchy described by staff

## **IEA 7 – Informed Consent**

Compliance demonstrated in 13 out of 14 elements in IEA 7.

- The gap analysis has been undertaken, but reviewing of information is ongoing.

- The co-produced action plan has been paused due to staffing issues.

## **Workforce (WF) & NICE Guidelines (G)**

Full compliance is demonstrated in 8/10 elements. The 2 outstanding elements relate to compliance with the LMNS workforce planning and Trust obstetric workforce planning.

- The manifesto for Strengthening Midwifery Leadership has been met with the appointment of the Director of Midwifery
- Evidence around midwifery workforce planning available and submissions to board reviewed, but no evidence available around obstetric workforce planning.

### **Incidental finding:**

- At the time of our visit, a significant amount of building work was taking place which impacted the maternity unit. The entrance to the maternity unit had recently changed and accessing the areas was difficult with unclear signage in place. A recommendation was made during our initial feedback to address this as a priority. The Trust welcomed our feedback and we have subsequently received confirmation and photos confirming that this has been addressed.
- Due to the changes in place, access from the obstetric theatre to the ward area was through a public area. A solution should be found to address this.
- We learned that the MVP had not been involved in the discussions and plans regarding the changes described. We recommend that changes in care pathways and environment are co-designed wherever possible.

# Recommendations

1. Trust to ensure that that actions resulting from NED/MVP meetings are documented and tracked.
2. The NED and MVP should continue to develop their relationship and work more closely
3. Audit of place of birth discussion to be repeated in September 2022
4. A PCSP should be available for women where English is not their first language.
5. Audit of 5% of records demonstrating a risk assessment occurred at every contact is required
6. Review of patient information subsequent to the gap analysis to be completed.
7. Co-produced action plan to be completed.
8. Access from the obstetric theatre to the ward area is currently through a public area. A solution should be found to address this.
9. We recommend that changes in care pathways and environment are co-designed wherever possible.

## Offers of Support to Trust

1.

- Support was given by the Regional Lead on the visit to discuss the requirements for PCSPs and Risk Assessments

2.

- A regional review on PCSP is planned to identify the support required for all Trusts.

# Full Assessment



The KLOEs used within all SE Ockenden Visits are based on the CSU Assessment Document used in 2021 and include all evidence elements that were assessed as non-compliant further to the final assessment letter sent to the Trust in December 2021.



Additionally there are a selection of 'Standard Questions' were agreed by the SE Regional Team from all the CSU 2021 evidence elements and were used to provide confirmation that the changes made by the Trust since the Interim Ockenden Report are now embedded in practice.

## IEA 1 Enhanced Safety

- IEA 1 is comprised of 7 questions
- 16 pieces of evidence are required to demonstrate full compliance with IEA 1.
- The Trust demonstrated compliance with 13/16 at the Dec 2021 CSU assessment
- The following table shows compliance with the 16 pieces of evidence in IEA 1 following the Ockenden Insight Visit.

IEA 1				
Question   Evidences ⑦	1	2	3	4
Q 1 - Dashboards	Compliant	Compliant	Compliant	Compliant
Q 2 - External review of SIs	Compliant	Compliant	No Question	No Question
Q 3 - SIs to Board/LMNS	Compliant	Compliant	Compliant	No Question
Q 4 _ PMRT	Compliant following Visit	Compliant	No Question	No Question
Q 5 _ MSDS	Compliant	No Question	No Question	No Question
Q 6 _ HSIB	Compliant	No Question	No Question	No Question
Q 7 _ PCQSM	Compliant following Visit	Compliant	Compliant following Visit	Compliant

NB: Missing questions were removed by the National CSU team in the December 2021 Assessment

KEY	No Question
	Compliant
	Compliant following Visit
	Partially Complaint
	Non Compliant

Overall Question Compliance	
IEA1	RAG
Q1 Dashboards	
Q2 External review	
Q3 SIs to Board/ LMNS	
Q4 PMRT	
Q5 MSDS	
Q6 HSIB	

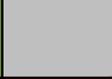
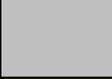
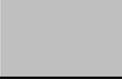
# IEA1 Enhanced Safety -1

Q7 PCQSM	
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Q 4 Using the National Perinatal Mortality Review Tool to review perinatal deaths.	
<b>EVIDENCE REQUIRED</b>	<b>4.1 Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.</b>
EVIDENCE ATTAINED	Audit documents seen showing relevant elements undertaken. Tool completed collectively at monthly meetings and good representation at group including bereavement with external and trainee membership. ToR specifies quoracy. Learning is shared including through training and newsletter.
OUTCOME	Compliant
Q 7 Plan to implement the Perinatal Clinical Quality Surveillance Model	
<b>EVIDENCE REQUIRED</b>	<b>7.1 Full evidence of full implementation of the perinatal surveillance framework by June 2021.</b>
EVIDENCE ATTAINED	Elements already in place but new SI framework and upgraded datix system have improved process. Monthly clinical governance meeting reviews moderate harm cases.
OUTCOME	Compliant
<b>EVIDENCE REQUIRED</b>	<b>7.2 LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.</b>
EVIDENCE ATTAINED	SOP has been discussed at LMNS board meeting. LMNS report template being revised.
OUTCOME	Compliant

## IEA 2 Listening to Women & Families

- IEA 2 is comprised of 5 questions
- 18 pieces of evidence are required to demonstrate full compliance with IEA 2.
- The Trust demonstrated compliance with 13/18 at the Dec 2021 CSU assessment
- The following table shows compliance with the 18 pieces of evidence in IEA 2 following the Ockenden Insight Visit.

IEA 2							
Question   Evidences 7	1	2	3	4	5	6	
Q 11 - NED							
Q 13 - Service user feedback							
Q 14 - Bimonthly safety champion meetings							
Q 15 - Service user feedback							
Q 16 - NED							

NB: Missing questions were removed by the National CSU team in the December 2021 Assessment

<b>KEY</b>		No Question
		Compliant
		Compliant following Visit
		Partially Compliant
		Partially Compliant following visit

# IEA2 Listening to Women & Families -1

Q 11 Non-executive director who has oversight of maternity services	
<b>EVIDENCE REQUIRED</b>	<b>11.1 Evidence of how all voices are represented</b>
EVIDENCE ATTAINED	Executive team attend some MVP meetings. 1-2-1 meetings with MVP take place and discussions were noted to be open. Team is receptive to challenge and new ideas but it was reported that MVP work and actions are not always followed up. Documentation of the meetings, including an action log would support this process.
OUTCOME	Partially Compliant
<b>EVIDENCE REQUIRED</b>	<b>11.4 Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions</b>
EVIDENCE ATTAINED	Walkabouts take place but we saw no evidence of subsequent actions. During discussions it was acknowledged that the relationship between the NED and the MVPs could be strengthened which would help ensure triangulation with other areas of the NED's work.
OUTCOME	Partially Compliant

**Recommendation 1:** Trust to ensure that that actions resulting from NED/MVP meetings are documented and tracked. **Recommendation 2:** The NED and MVP should continue to develop their relationship and work more closely

<b>EVIDENCE REQUIRED</b>	<b>11.6 NED JD</b>
EVIDENCE ATTAINED	JD provided for NED role although it is not maternity specific.
OUTCOME	Compliant

Overall Question Compliance	
IEA2	RAG
Q11 NED	Yellow
Q13 Service user feedback	Green
Q14 Bimonthly safety champ meetings	Green
Q15 Service user feedback	Green
Q16 NED	Green

# IEA2 Listening to Women & Families -2

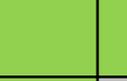
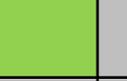
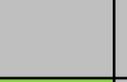
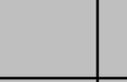
Q 14 Trust safety champions meeting bimonthly with Board level champions	
<b>EVIDENCE REQUIRED</b>	<b>14.1 Action log and actions taken.</b>
EVIDENCE ATTAINED	Trust champion meetings and walkarounds described as being with supportive critical friend . Action log seen and “you said we did” safety poster showing actions taken for staff to view.
OUTCOME	Compliant
Q 16 Non-executive director support the Board maternity safety champion	
<b>EVIDENCE REQUIRED</b>	<b>16.2 Name of NED and date of appointment</b>
EVIDENCE ATTAINED	Name and date of appointment provided .
OUTCOME	Compliant
<b>IEA Overall Outcome</b>	Partially Compliant for IEA 2- Listening to Women & Families

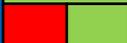
Overall Question Compliance	
IEA2	RAG
Q11 NED	Yellow
Q13 Service user feedback	Green
Q14 Bimonthly safety champ meetings	Green
Q15 Service user feedback	Green
Q16 NED	Green

# IEA3 Staff Training and Working Together

- IEA 3 is comprised of 6 questions
- 18 pieces of evidence are required to demonstrate full compliance with IEA 3.

- The Trust demonstrated compliance with 7/18 at the Dec 2021 CSU assessment
- The following table shows compliance with the 18 pieces of evidence in IEA 3 following the Ockenden Insight Visit.

IEA 3							
Question   Evidences 7	1	2	3	4	5		
Q 17 - MDT Training							
Q 18 - Cons. Ward Rounds							
Q 19 - Ring-Fenced Funding							
Q 21- 90% MDT Training							
Q 22 - Cons Ward Rounds							
Q 23 - MDT Training Schedule							

KEY		No Question
		Compliant
	 	Compliant following Visit
		Partially Compliant
		Non Compliant

NB: Missing questions were removed by the National CSU team in the December 2021 Assessment

# IEA3 Staff Training and Working Together -

1

Q 17 Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	
<b>EVIDENCE REQUIRED</b>	<b>17.1 A clear trajectory in place to meet and maintain compliance as articulated in the TNA.</b>
EVIDENCE ATTAINED	Clearly articulated process . Monthly monitoring of dashboard where all elements are provided.
OUTCOME	Compliant
<b>EVIDENCE REQUIRED</b>	<b>17.2 LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.</b>
EVIDENCE ATTAINED	Monthly monitoring is fed into the LMNS and there is Trust Board oversight. The BOB quality & safety lead facilitates sharing and discussion. The governance team brings feedback from LMNS to Trust.
OUTCOME	Compliant

Overall Question Compliance	
IEA3	RAG
Q17 MDT Training	Green
Q18 & Q22 Cons. Ward Rounds	Green

Q23 MDT Training Schedule	Green
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# IEA3 Staff Training and Working Together -

EVIDENCE REQUIRED	17.5 Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been in place.
EVIDENCE ATTAINED	Plans are in place to ensure compliance.i.e. MDT compliance at training ensured by backfill for anaesthetists to enable attendance
OUTCOME	Compliant

Q19 RingFenced Funding	
Q21 90% MDT Training	

2

Q23 MDT Training Schedule	
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# IEA3 Staff Training and Working Together -

Q 18 Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	
<b>EVIDENCE REQUIRED</b>	<b>18.1 Evidence of scheduled MDT ward rounds taking place since December, twice a day, day &amp; night. 7 days a week (e.g. audit of compliance with SOP)</b>
EVIDENCE ATTAINED	The ward rounds started in April 22. IT issues have compromised electronic data capture in past but compliance audit, vanguard approach and exception reporting are now in place.
OUTCOME	Compliant

Q 19 External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	
<b>EVIDENCE REQUIRED</b>	<b>19.1 Confirmation from Directors of Finance</b>
EVIDENCE ATTAINED	CEO letter confirming protected training fund from CNST refunds allocations.
OUTCOME	Compliant

Overall Question Compliance	
IEA3	RAG
Q17 MDT Training	Compliant
Q18 & Q22 Cons. Ward Rounds	Compliant

Q23 MDT Training Schedule	Compliant
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# IEA3 Staff Training and Working Together -

EVIDENCE REQUIRED	19.5 MTP spend reports to LMS
EVIDENCE ATTAINED	Robust process articulated including weekly triumvirate finance meeting.
OUTCOME	Compliant

Q19 RingFenced Funding	
Q21 90% MDT Training	

3

Q23 MDT Training Schedule	
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# IEA3 Staff Training and Working Together -

Q 21 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	
<b>EVIDENCE REQUIRED</b>	<b>21.1 A clear trajectory in place to meet and maintain compliance as articulated in the TNA.</b>
EVIDENCE ATTAINED	Clearly articulated process . Monthly monitoring of dashboard where all elements are provided.
OUTCOME	Compliant
<b>EVIDENCE REQUIRED</b>	<b>21.3 LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.</b>
EVIDENCE ATTAINED	Monthly monitoring is fed into the LMNS and there is Trust Board oversight. Plans are in place to ensure compliance at training ensured by backfill for anaesthetists to enable attendance
OUTCOME	Compliant

Overall Question Compliance	
IEA3	RAG
Q17 MDT Training	Compliant
Q18 & Q22 Cons. Ward Rounds	Compliant

Q23 MDT Training Schedule	Compliant
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# IEA3 Staff Training and Working Together -

Q 22 Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	
<b>EVIDENCE REQUIRED</b>	<b>22.1 Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day &amp; night; 7 days week (E.G audit of compliance with SOP)</b>
EVIDENCE ATTAINED	The ward rounds started in April 22. IT issues have compromised electronic data capture in past but compliance audit, va approach and exception reporting are now in place.
OUTCOME	Compliant

Q19 RingFenced Funding	
Q21 90% MDT Training	

4

Q23 MDT Training Schedule	
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# IEA3 Staff Training and Working Together -

Q 23 The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

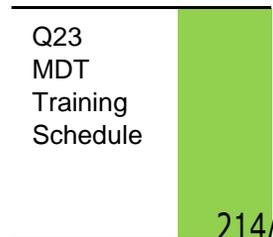
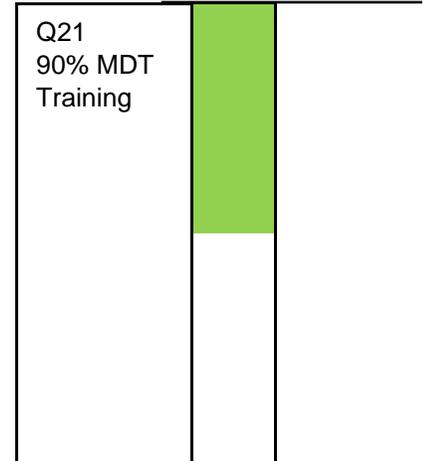
<b>EVIDENCE REQUIRED</b>	<b>23.1 A clear trajectory in place to meet and maintain compliance as articulated in the TNA.</b>
EVIDENCE ATTAINED	Clearly articulated process . Monthly monitoring of dashboard where all elements are provided.
OUTCOME	Compliant

<b>EVIDENCE REQUIRED</b>	<b>23.2 LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.</b>
EVIDENCE ATTAINED	Monthly monitoring is fed into the LMNS and there is Trust Board oversight. The BOB quality & safety lead facilitates sharing and discussion. The governance team brings feedback from LMNS to trust.
OUTCOME	Compliant

Overall Question Compliance	
IEA3	RAG
Q17 MDT Training	Compliant
Q18 & Q22 Cons. Ward Rounds	Compliant
Q19 RingFenced Funding	Compliant

Q23 MDT Training Schedule	Compliant
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# IEA3 Staff Training and Working Together -



# IEA 4 Managing Complex Pregnancy

- IEA 4 is comprised of 6 questions.
- 14 pieces of evidence are required to demonstrate full compliance with IEA 4.
- The Trust demonstrated compliance with 8/14 at the Dec 2021 CSU assessment
- The following table shows compliance with the 14 pieces of evidence in IEA 4 following the Ockenden Insight Visit.

IEA 4			
Question   Evidences 7	1	2	3
Q 24 - MMC Criteria	Non Compliant	Compliant	No Question
Q 25 - Named Consultant	Non Compliant	Compliant	No Question
Q 26 - Complex Pregnancies	Compliant	Non Compliant	No Question
Q 27 - SBLCBv2	Non Compliant	Non Compliant	Compliant
Q 28 - Named Cons/Audit	Compliant	Non Compliant	No Question
Q 29 - MMC	Compliant	Compliant	Compliant

NB: Missing questions were removed by the National CSU team in the December 2021 Assessment

KEY	No Question
	Compliant
	Compliant following Visit
	Partially Compliant
	Non Compliant

Overall Question Compliance	
IEA 4	RAG
Q24 MMC Criteria	Green
Q25 Named Consultant	Green
Q26 Complex Pregnancies	Green
Q27 SBLCBv2	Green
Q28 Named Cons/Audit	Green

# IEA4 Managing Complex Pregnancy - 1

Q29  
MMC

Q 24 Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre

<b>EVIDENCE REQUIRED</b>	<b>24.1 Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians</b>
EVIDENCE ATTAINED	Audit demonstrates 100% compliance against criteria. The lead consultant for maternal medicine has good links both with external colleagues and internal teams.
OUTCOME	Compliant

Q 25 Women with complex pregnancies must have a named consultant lead

<b>EVIDENCE REQUIRED</b>	<b>25.1 Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.</b>
EVIDENCE ATTAINED	Audit undertaken and there is clarity on who the lead consultant is for women with complex pregnancies
OUTCOME	Complaint

Q 26 Complex pregnancies have early specialist involvement and management plans agreed

<b>EVIDENCE REQUIRED</b>	<b>26.2 SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.</b>
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EVIDENCE ATTAINED	Comprehensive SOP covering referral criteria, pathways for onward referral and routes.
OUTCOME	Compliant

Overall Question Compliance	
IEA 4	RAG
Q24 MMC Criteria	Green
Q25 Named Consultant	Green
Q26 Complex Pregnancies	Green
Q27 SBLCBv2	Green
Q28 Named Cons/Audit	Green

# IEA4 Managing Complex Pregnancy - 2

Q29  
MMC

Q 27 Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	
<b>EVIDENCE REQUIRED</b>	<b>27.1 Audits for each element.</b>
EVIDENCE ATTAINED	Audits for each element seen with action plans. No completed actions plans or learning seen.
OUTCOME	Compliant
<b>EVIDENCE REQUIRED</b>	<b>27.2 Guidelines with evidence for each pathway</b>
EVIDENCE ATTAINED	SOP/ Guidelines seen for each element with clear version control and review dates.
OUTCOME	Compliant
Q 28 All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	
<b>EVIDENCE REQUIRED</b>	<b>28.2 Submission of an audit plan to regularly audit compliance</b>
EVIDENCE ATTAINED	Plan in place for regular audits and time allocated to undertake them.
OUTCOME	Compliant

# IEA 5 Risk Assessment Throughout Pregnancy

- IEA 5 is comprised of 3 questions.
- 15 pieces of evidence are required to demonstrate full compliance with IEA 5.
- The Trust demonstrated compliance with 7/15 at the Dec 2021 CSU assessment
- The following table shows compliance with the 15 pieces of evidence in IEA 5 following the Ockenden Insight Visit.

IEA 5									
Question   Evidences ⑦	1	2	3	4	5	6			
Q 30 - Risk assessment	Green	Red	Green	Red	Yellow	Red	Green	Green	Grey
Q 31- Place of Birth RA	Red	Green	Red	Green	Green	Green	Grey	Grey	Grey
Q 33 - RA recorded with PCSP	Green	Green	Red	Yellow	Red	Yellow	Green	Green	Green

NB: Missing questions were removed by the National CSU team in the December 2021 Assessment

<b>KEY</b>		No Question
		Compliant
		Compliant following Visit
		Partially Compliant
		Partially Compliant following visit

# IEA5 Risk Assessment Throughout Pregnancy -

1

Q 30 All women must be formally risk assessed at every antenatal contact so that they have continued access to care provided by an appropriately trained professional		Overall Question Compliance	
EVIDENCE REQUIRED	30.2 Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrate compliance of the above.	IEA5	RAG
EVIDENCE ATTAINED	The PCSP document within the notes was reviewed. This is currently only available in English. An audit was reviewed and did not demonstrate compliance. The LMNS is developing a new PCSP.	Q30 Risk assessment	Yellow
OUTCOME	Partially Compliant		
EVIDENCE REQUIRED	30.3 Review and discussed and documented intended place of birth at every visit.	Q31 Place of Birth RA	Green
EVIDENCE ATTAINED	Audit showed that place of birth was not discussed at every visit in any of the sets of notes reviewed. Due for reaudit in September 22 to see if actions identified have improved this element.	for reaudit	
OUTCOME	Partially compliant	Q33 RA recorded with PCSP	Yellow
<b>Recommendation 3:</b> Audit of place of birth discussion to be repeated in September 2022			
EVIDENCE REQUIRED	30.4 SOP that includes definition of antenatal risk assessment as per NICE guidance.		
EVIDENCE ATTAINED	Well written SOP with clear guidance on actions to be undertaken at each appointment		

# IEA5 Risk Assessment Throughout Pregnancy -

OUTCOME	Compliant
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2

		Overall Question Compliance	
Q 31 Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.		IEA5	RAG
<b>EVIDENCE REQUIRED</b>	<b>31.1 Evidence of referral to birth options clinics</b>		
EVIDENCE ATTAINED	SOP for referral to consultant midwife seen which covered birth options clinics.	Q30 Risk assessment	
OUTCOME	Compliant		
<b>EVIDENCE REQUIRED</b>	<b>31.2 Out with guidance pathway.</b>	Q31 Place of Birth RA	
EVIDENCE ATTAINED	SOP for Out with Guidance seen.		
OUTCOME	Compliant	Q33 RA recorded with PCSP	
<b>EVIDENCE REQUIRED</b>	<b>31.3 Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrate compliance of the above.</b>		
EVIDENCE ATTAINED	Audit seen and PCSP in place in notes reviewed although this is only available in English. Risk assessment a undertaken. The LMNS is developing a new PCSP.		
OUTCOME	Compliant		

# IEA5 Risk Assessment Throughout Pregnancy -

**Recommendation 4:** A PCSP should be available for women where English is not their first language.

3

Q 33 A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.		Overall Question Compliance	
		IEA5	RAG
<b>EVIDENCE REQUIRED</b>	<b>33.3 Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrate compliance of the above.</b>	Q30 Risk assessment	Yellow
<b>EVIDENCE ATTAINED</b>	Only 1% audit for this element was seen.		
<b>OUTCOME</b>	Partially Compliant	Q31	Green
<b>Recommendation 5:</b> Audit of 5% of records demonstrating a risk assessment occurred at every contact is required		Place of Birth RA	
<b>EVIDENCE REQUIRED</b>	<b>33.4 Review and discussed and documented intended place of birth at every visit.</b>		Yellow
<b>EVIDENCE ATTAINED</b>	Although Audit of 1% of notes showed that risk assessment occurred, place of birth was not discussed at every visit. Reauditing in September 22 to see if actions identified have improved this element.	Q33 RA recorded with PCSP	
<b>OUTCOME</b>	Partially Compliant		
<b>IEA Overall Outcome</b>	Partially Compliant for IEA 5 – Risk Assessment Throughout Pregnancy		

# IEA 6 Monitoring Fetal Well-Being

- IEA 6 is comprised of 4 questions.
- 18 pieces of evidence are required to demonstrate full compliance with IEA 6.
- The Trust demonstrated compliance with 10/18 at the Dec 2021 CSU assessment
- The following table shows compliance with the 18 pieces of evidence in IEA 6 following the Ockenden Insight Visit.

IEA 6									
Question   Evidences 7	1	2	3	4	5	6	7	8	
Q 34 - Leads in post	Compliant	Non Compliant	Compliant	Compliant	Non Compliant	Compliant	No Question	No Question	No Question
Q 35 - Leads expertise	Non Compliant	Non Compliant	Compliant	Compliant	Non Compliant	Compliant	Compliant	Compliant	Compliant
Q 36 - SBLCBv2	Non Compliant	Non Compliant	Compliant	Compliant	No Question	No Question	No Question	No Question	No Question
Q 37 - 90% MDT Training	Non Compliant	Compliant	Compliant	Compliant	No Question	No Question	No Question	No Question	No Question

KEY	No Question
	Compliant
	Compliant following Visit
	Partially Compliant
	Non Compliant

# IEA6 Monitoring Fetal Well-Being -

NB: Missing questions were removed by the National CSU team in the December 2021 Assessment

90% MDT  
Training

# IEA6 Monitoring Fetal Well-Being -

Overall Question Compliance	
IEA6	RAG
Q34 Leads in post	
Q35 Leads expertise	

90% MDT  
Training

1

Q36 SBLCBv2	
Q37	

Q 34 Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	
<b>EVIDENCE REQUIRED</b>	<b>34.2 Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.</b>
EVIDENCE ATTAINED	The two leads weekly run fetal monitoring meetings( physical and virtual). These are open forums which include students; Review and take lead on related SIs and update training material to reflect recent cases; Induction for Drs; Support for those not passing training competency package

90% MDT Training

# IEA6 Monitoring Fetal Well-Being -

OUTCOME	Compliant
EVIDENCE REQUIRED	<b>34.4 Name of dedicated Lead Midwife and Lead Obstetrician</b>
EVIDENCE ATTAINED	Names provided, lead midwife also has PDM role at present.
OUTCOME	Compliant
Q 35 The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	
EVIDENCE REQUIRED	<b>35.1 Consolidating existing knowledge of monitoring fetal wellbeing</b>
EVIDENCE ATTAINED	The leads represent the Trust at regional/AHSN and national fetal monitoring meetings
OUTCOME	Compliant

# IEA6 Monitoring Fetal Well-Being -

Overall Question Compliance	
IEA6	RAG
Q34 Leads in post	
Q35 Leads expertise	

90% MDT  
Training

2

Q36 SBLCBv2	
Q37	

Q 35 The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	
<b>EVIDENCE REQUIRED</b>	<b>35.2 Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision</b>
EVIDENCE ATTAINED	CTG meeting to discuss cases and offer for support and debrief if required. Personal support if colleagues have problems with competency training.
OUTCOME	Compliant

90% MDT  
Training

# IEA6 Monitoring Fetal Well-Being -

<b>EVIDENCE REQUIRED</b>	<b>35.4 Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.</b>
EVIDENCE ATTAINED	The leads represent the Trust at regional/AHSN and national fetal monitoring meetings
OUTCOME	Compliant
Q 36 Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	
<b>EVIDENCE REQUIRED</b>	<b>36.1 Audits for each element</b>
EVIDENCE ATTAINED	Audits for each element seen with action plans. No completed actions plans or learning seen.
OUTCOME	Compliant

# IEA6 Monitoring Fetal Well-Being -

Overall Question Compliance	
IEA6	RAG
Q34 Leads in post	
Q35 Leads expertise	

90% MDT  
Training

3

Q36 SBLCBv2	
Q37	

Q 36 Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	
<b>EVIDENCE REQUIRED</b>	<b>36.2 Guidelines with evidence for each pathway</b>
EVIDENCE ATTAINED	SOP/ Guidelines seen for each element with clear version control and review dates.
OUTCOME	Compliant

90% MDT  
Training

# IEA6 Monitoring Fetal Well-Being -

Q 37 Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

<b>EVIDENCE REQUIRED</b>	<b>37.1 A clear trajectory in place to meet and maintain compliance as articulated in the TNA.</b>
<b>EVIDENCE ATTAINED</b>	Clearly articulated process . Monthly monitoring of dashboard where all elements are provided.
<b>OUTCOME</b>	Compliant
<b>IEA Overall Outcome</b>	Fully Compliant for IEA 6 – Monitoring Fetal Well - Being

90% MDT  
Training

# IEA 7 Informed Consent

- IEA 7 is comprised of 5 questions.
- 14 pieces of evidence are required to demonstrate full compliance with IEA 7.
- The Trust demonstrated compliance with 5/14 at the Dec 2021 CSU assessment
- The following table shows compliance with the 14 pieces of evidence in IEA 7 following the Ockenden Insight Visit.

IEA 7					
Question   Evidences 7	1	2	3	4	
Q 39 - Accessible Information, Place of Birth	Green	Red	Green	Grey	Grey
Q 41 - Decision making and Informed Consent	Red	Green	Red	Green	Grey
Q 42 - Women's Choices Respected	Red	Green	Red	Green	Grey
Q 43 - Service User Feedback	Green	Green	Green	Green	Grey
Q 44 - Website	Red	Yellow	Red	Green	Green

# IEA7 Informed Consent -

KEY		No Question
		Compliant
		Compliant following Visit
		Partially Compliant following visit

NB: Missing questions were removed by the National CSU team in the December 2021 Assessment

# IEA7 Informed Consent -

Overall Question Compliance	
IEA7	RAG
Q39 Accessible Information Place of Birth	
Q41 Decision making and Informed Consent	
Q42 Women's Choices Respected	
Q43 Service User Feedback	

Q 39 Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	
<b>EVIDENCE REQUIRED</b>	<b>39.2 Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.</b>
EVIDENCE ATTAINED	Gap analysis undertaken and actions rag rated. MVP, Consultant midwife and Better Births midwife all involved in analysis. Reviewing of patient information is ongoing and leaflet review committee includes MVP. Good opportunities for co-creation noted.
OUTCOME	Compliant

**RECOMMENDATION 6:** Review of patient information to be completed.

Q 41 Women must be enabled to participate equally in all decision-making processes	
<b>EVIDENCE REQUIRED</b>	<b>41.1 An audit of 1% of notes demonstrating compliance.</b>
EVIDENCE ATTAINED	Audit undertaken however it only covered those referred to consultant midwives, this could be extended to Obstetric and general midwifery notes too.
OUTCOME	Compliant
<b>EVIDENCE REQUIRED</b>	<b>41.2 CQC survey and associated action plans</b>

EVIDENCE ATTAINED	Learning boards have included this element and staff are aware of the actions arising.
OUTCOME	Compliant

## 2

Q 41 Women must be enabled to participate equally in all decision-making processes	
<b>EVIDENCE REQUIRED</b>	<b>41.3 SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.</b>
EVIDENCE ATTAINED	SOP seen and staff are aware that communication is key and that this area is audited.
OUTCOME	Compliant
Q 42.1 Women's choices following a shared and informed decision-making process must be respected	
<b>EVIDENCE REQUIRED</b>	<b>42.1 An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.</b>
EVIDENCE ATTAINED	Audit of 5% of notes looking at whether women's choices following a shared and informed decision-making process, were respected was seen . However this only covered consultant midwife notes it would be reasonable for this to cover obstetric and general midwifery notes too.
OUTCOME	Compliant

# IEA7 Informed Consent -

<b>EVIDENCE REQUIRED</b>	<b>42.2 SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.</b>
EVIDENCE ATTAINED	SOP seen and staff reported that communication is key and that this area is audited.
OUTCOME	Compliant

## 3

Q 44 Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	
<b>EVIDENCE REQUIRED</b>	<b>44.1 Co-produced action plan to address gaps identified</b>
EVIDENCE ATTAINED	Action plan paused due staffing issues. Some quick fix improvements already done. Staff planned to be in place Sept/October.
OUTCOME	Partially compliant

**RECOMMENDATION 7:** Co-produced action plan to be completed.

<b>EVIDENCE REQUIRED</b>	<b>44.2 Gap analysis of website against Chelsea &amp; Westminster conducted by the MVP</b>
EVIDENCE ATTAINED	Gap analysis undertaken and actions rag rated. MVP, Consultant midwife and Better Births midwife all involved in analysis.
OUTCOME	Compliant
<b>EVIDENCE REQUIRED</b>	<b>44.4 Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.</b>
EVIDENCE ATTAINED	Gap analysis undertaken and actions rag rated. MVP, Consultant midwife and Better Births midwife all involved in analysis. Reviewing of patient information is ongoing and leaflet review committee includes MVP.

OUTCOME	Compliant
IEA Overall Outcome	Partially Compliant for IEA 7 – Informed Consent

36 |

# Workforce Planning & Guidelines

- Workforce Planning & Guidelines is comprised of 5 questions.
- 10 pieces of evidence are required to demonstrate full compliance with WF & G.
- The Trust demonstrated compliance with 4/10 at the Dec 2021 CSU assessment
- The following table shows compliance with the 10 pieces of evidence in WF & G following the Ockenden Insight Visit.

Workforce Planning & Guidelines					
Question   Evidences 7	1		2		3
Q 45 - Clinical Workforce Planning	Red	Yellow	Red	Yellow	Green
Q 46 - Midwifery Workforce Planning	Green		Grey		Grey
Q 47 - D/HoM Accountable to Executive Director	Green		Grey		Grey
Q 48 - Strengthening Midwifery Leadership	Red	Green	Red	Green	Grey
Q 49 - Guidelines	Red	Green	Red	Green	Green

37 |

KEY	Grey	No Question
	Green	Compliant
	Red and Green	Compliant following Visit
	Yellow	Partially Compliant
	Red	Non Compliant

NB: Missing questions were removed by the National CSU team in the December 2021 Assessment

Overall Question Compliance	
WFP & G	RAG
Q45 Clinical Workforce Planning	Yellow
Q46 Midwifery Workforce Planning	Green
Q47 D/HoM Accountabl e to Exec Dir	Green

# Workforce Planning

Q48  
Strengthening  
Midwifery  
Leadership

Q 45 Demonstrate an effective system of clinical workforce planning to the required standard	
<b>EVIDENCE REQUIRED</b>	<b>45.1 Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan</b>
EVIDENCE ATTAINED	Confirmation received that workforce planning is in development at LMNS level.
OUTCOME	Partially compliant
<b>EVIDENCE REQUIRED</b>	<b>45.2 Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.</b>
EVIDENCE ATTAINED	Midwifery Workforce Planning timetable for sub-board quality committee and HoM staffing reports to board supplied. No evidence re review of Obstetric workforce planning.
OUTCOME	Partially compliant
Q 48 Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	
<b>EVIDENCE REQUIRED</b>	<b>48.1 Action plan where manifesto is not met</b>

EVIDENCE ATTAINED	As Director of Midwifery has now been appointed the Manifesto has been met.
OUTCOME	Compliant
<b>EVIDENCE REQUIRED</b>	<b>48.2 Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care</b>
EVIDENCE ATTAINED	Gap analysis done and DoM appointed as main gap and no action plan as felt it was met.
OUTCOME	Compliant
<b>38IEA Overall Outcome</b>	Partially Compliant for Workforce planning

Overall Question Compliance	
WFP & G	RAG
Q49 Guidelines	

## Guidelines

Q 49 Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	
<b>EVIDENCE REQUIRED</b>	<b>49.1 Audit to demonstrate all guidelines are in date.</b>
EVIDENCE ATTAINED	Audit programme and plan shown. All guidelines recorded with date for review and person responsible on spreadsheet. Maternity has the highest number of guidance documents and the lowest number of out of date guidelines in all the Trust.
OUTCOME	Compliant

<b>EVIDENCE REQUIRED</b>	<b>49.2 Evidence of risk assessment where guidance is not implemented.</b>
<b>EVIDENCE ATTAINED</b>	Clear risk assessment and mitigation process for out of date guidance that can't be updated. AHSN & Trust joint decision document on FIGO based intrapartum fetal monitoring adoption rather than NICE guidelines provided as evidence.
<b>OUTCOME</b>	Compliant
<b>IEA Overall Outcome</b>	Compliant for Guidelines

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	Corporate Risk Register (CRR)
<b>Board Lead</b>	Karen Bonner Chief Nurse
<b>Name of author</b>	Sandie Knight, Governance Manager Reema D'Souza, Associate Chief Nurse for Governance and Regulatory Compliance
<b>Attachments</b>	Appendix 1 – Corporate Risk Register Appendix 2 – Heat Map Appendix 3 – Risk Matrix
<b>Purpose</b>	Assurance
<b>Previously considered</b>	EMC 01.11.2022 Audit Committee 04.11.2022

### Executive Summary

This report outlines the corporate risks for the Trust. The risk management process is complied with in managing and mitigating the risks on the Corporate Risk Register (CRR).

There was 1 new risk escalated to EMC for approval for inclusion on the CRR:

- **Datix Risk 92** - Delays in all Radiology reporting due to Radiologist shortage: the risk was escalated in October as 11,000+ scans not being reported including at least 350 2ww. Currently scored at 20 with a target date of June 2023.

01/11/2022: EMC approved the addition of the risk to the CRR but requested the description be reviewed to convey the full extent of the risk and include a trajectory with timelines for improvement.

As of 22/11/2022, the figures have reduced from 11k+ to 7987 unreported scans, 117 of these are 2ww/ urgent, 67 of which are confirmed 2ww.

As one of the mitigation, the team are finalising details for a Limited Liability Partnership (LLP) contract to progress the backlog and a paper was submitted to EMC 22/11/2022 for approval of the contract.

A breakdown of the outstanding scans, the scoring methodology and possible projections once the LLP is in place will be reported to the Quality and Patient Safety Group (24/11/2022). A considerable reduction in the outstanding figures is anticipated by the end of Dec/ early January 2023 when the risk will be reviewed further.

The following 4 risks have been moderated and the scores reduced. EMC was requested to approve these for de-escalation from the CRR:

- **Datix Risk 53** – Increased staff absences due to Covid-19
- **Datix Risk 52** – Increased impact on staff physical and psychological health and wellbeing from working during COVID-19 pandemic

Both risks have been moderated as part of the review for the migration to Datix and have been reduced from 16 to 12. Monitoring for these risks will continue on the People Directorate divisional register.

- **Datix Risk 185** – Clinical harm on extended waits for elective surgery: Work continues to reduce the list and get the surgical facilities back on line. The target date has been reviewed from 08/2022 to 31/03/2023. As part of the Datix migration review the risk score has been moderated to a 12 from 20 and the target score from 8 to a 6.
- **Datix Risk 119** – Patient Tracking: although work continues to reduce the backlog, the current risk score remains unchanged. The COO and the Director for Business Recovery have initiated a task and finish group to progress reduction of the backlog. This risk is due for review January 2023. As part of the Datix migration review the risk score has been moderated to a 12 from 20 and the target score from 12 to a 9.

01/11/2022: EMC approved the de-escalation of:

- Datix Risk 53
- Datix Risk 52
- Datix Risk 185

but did NOT approve the de-escalation of:

- Datix Risk 119

01/11/2022: EMC requested that where a risk had previously been approved for de-escalation but requested to remain on the CRR either by EMC or Audit Committee, a note be added to the update to state this.

Further feedback from EMC 01/11/2022 and Audit Committee 04/11/2022 has been actioned and included in the report.

Currently 15 out of 16 of the CRR level risks have been transferred to Datix and quality checks are being undertaken with the teams directly and via the Risk and Compliance Monitoring Group as the work progresses. The transition to Datix has been hindered by sustained site pressures but there are now over 180 risks on the system. Reporting for this month continues on the existing spreadsheet of risks however future reports will contain details from the Datix system.

Since the report was submitted to EMC, there is now only 1 CRR risk outstanding for transfer to Datix and this is under review with the team.

<b>Decision</b>	The Committee is requested to review and approve the risks for addition and removal from the Corporate Risk Register and note the updated actions.		
<b>Relevant strategic priority</b>			
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input type="checkbox"/>	<b>Great Place to Work</b> <input type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
<b>Implications / Impact</b>			
<b>Patient Safety</b>		Identifies any potential patient safety concerns	
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>		Links to strategic objectives listed within the Board Assurance (BAF) report	

<b>Financial</b>	There can be a legal and financial impact if the Trust is non-compliant with appropriate and effective management of risks. The Trust may also suffer reputational damage from uncontrolled risk management.
<b>Compliance</b> <small>Select an item.</small> <b>Good Governance</b>	Regulatory and legislative requirements.
<b>Partnership: consultation / communication</b>	Consultation and Communication identified in updated actions
<b>Equality</b>	The Trust is committed to the fair treatment of all patients and service users, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependents, sexual orientation, or any other personal characteristics.
<b>Quality Impact Assessment [QIA] completion required?</b>	Not Applicable

### 1. Purpose

This report updates the Committee on risks for addition and removal from the Corporate Risk Register. It provides oversight of the risk management process within the organisation and notifies mitigation actions for the risks within the Corporate Risk Register (CRR) (Appendix 2).

### 2. Background

The Divisional Director or their representative triumvirate will identify all new and current risks scored at 15 or above on the Divisional and Corporate Service risk registers and bring these to the Associate Chief Nurse for Governance and the Risk and Compliance Monitoring Group (RCMG) attention every month. The RCMG will review the risks scored 15 and above on the Divisional and Corporate Service risk registers and guide the Executive Management Committee (EMC) to moderate these risks for the inclusion or exclusion from the CRR.

There is a regular review of CRR with the responsible Director during which the level of risks, mitigating actions, target dates and outcomes are discussed.

### 3. Updates:

Currently 14 out of 18 of the CRR level risks have been transferred to Datix and quality checks are being undertaken with the teams directly and via the Risk and Compliance Monitoring Group (RCMG) as the work progresses. The transition to Datix has been hindered by sustained site pressures but there are now over 150 risks on the system. Reporting for this month continues on the existing spreadsheet of risks however future reports will contain details from the Datix system. The RCMG will continue to monitor the progress of the risk migration and on 21<sup>st</sup> November will be undertaking a further deep dive into the risks to quality check and challenge the data.

Since the report was submitted to EMC, there is now only 1 CRR risk outstanding for transfer to Datix and this is under review with the team.

The following Risks have been updated:

- **Datix Risk 118** – HV/LV cabling: the completion date is now planned for early November 2022. 04/11/2022: Audit Committee requested further details about the reason for the delay in completion: Confirmation is awaited regarding the removal of asbestos from the cabling ducts that will house the new cabling connection to the service tower. This work is currently planned

for 28<sup>th</sup> November to 1<sup>st</sup> December. On completion, PTL, Enerveo and UKPN will be required to complete testing and commissioning but this is unlikely to happen until early January due to varying availability between the three companies. For this reason the target date will extend a further 2 months to January 2023.

- **Datix Risk 43** – Insufficient capacity in PDU: Insufficient capacity within the Paediatric Decisions Unit footprint for ongoing treatment of children and young children leading to periods of overcrowding. The new build is currently on target for December 2022. (EMC on 30/08/2022 approved de-escalation of this risk but the Audit Committee on 01/09/2022 requested it remain on the CRR until the new building is functional).
- **Datix Risk 225** – Cyber incident disruption: The long-term mitigation for this risk will be the move to the new data centre and servers, and preparatory work is under way to get infrastructure in place for this.  
Current actions and target dates:
  - Focus on IG Mandatory training compliance - to be 85% compliance achieved by 01/12/2022.
  - DSP Toolkit Submission for June 2022 (68% achieved), by December 2022 to be 85% compliant.
  - The Datacentre and Network Infrastructure projects to be completed:
    - Data Centre (Including operating systems and VMware versions): 31/03/2023
    - Networks phase 1: Summer 2023
    - and phase 2: Summer 2024.

A request for re-wording of the risk description has been requested and is under review with the IT team.

- **CRR150** (This risk is yet to be reviewed and migrated to Datix) - Clinically inappropriate length of stay in Emergency Department (ED): The target date remains at the end of December and an update to the actions will be provided in the next report. Migration to Datix has been expedited via RCMG 21/11/2022 along with a request for update to the risks details.
- **Datix Risk 226** Failure of Critical Bleeps systems at Wycombe & Amersham Hospitals:
  - The crash bleeps are set up and ready to be distributed to clinical teams once help desk confirm that they are ready to go live to clinical teams. Pagers will then be rolled out to clinical teams over a two day period.
  - Amersham infrastructure cabling expected to be completed 27/10/2022: Multitone servers scheduled to be commissioned and ready by 14/11/2022. Crash bleep roll out to Amersham Porters and clinical staff expected 16/11/2022
  - Non-Emergency Bleeps - WIP with PABX suppliers, awaiting audit feedback that will identify any duplicated phone numbers across the 3 hospitals.
  - 8x8 Integration - Hardware has been ordered for technical integration – to be rolled out.
  - Ofcom - Currently in a test phase. Test plan to be drafted (network resilience testing), BCP to be confirmed, DR plan also to be confirmed.

The target date has extended to 30/11/2022 from 30/09/2022 due to timing of the cabling and commissioning and the predicted residual score has been moderated from 2x2 to 4x2

*05/07/2022: The request to de-escalate this risk following a reduction in the score from 15 to 12 was not approved. EMC requested the risk remain on the CRR until the installation had been completed.*

- **Datix Risk 234** - Delivery of the 2022-23 Financial Plan:

- **Datix Risk 224** - Trust's capital resourcing Insufficient to support objectives : A further update has been requested for this risk.

04/11/2022: The Audit Committee requested the actions for both Finance risks be made more robust. The Finance teams have reviewed these and will be providing an update once the new Interim Chief Finance Officer is in place for sign off.

The following 3 risks pertain to the Tower Block at Wycombe Hospital:

- **Datix Risk 184** – Wycombe Tower Block Interior: Following review, the score remains at 20
- **Datix Risk 56** – Concrete Panels and support columns on the Tower Block at Wycombe Hospital: the score has reduced from 20 to 16 due to mitigations now in place.

01/11/2022: EMC challenged the scoring of risks **184** and **56** above. Following investigation it was confirmed the two risk scores had been transposed during migration but have now been corrected on Datix.

- **Datix Risk 190** - Wycombe Tower Block Ward 2a environment - breach of CQC regulation 15: the score remains at 20

An emergency planning-led resilience exercise was undertaken on 17th September 2022, to review Business Continuity Plans (BCPs) for all the departments affected. The second table-top exercise was delayed due to service changes during the period of national mourning for the death of HM Queen Elizabeth II, and will be rescheduled in the next few weeks. The teams are expected to report to EMC mid-December.

Currently the lack of capital funding is halting the progress of the Outline Business Case (OBC) and no target date has therefore been provided until the business case is in place. A review date of November 2022 has been agreed. Property Services report 6-monthly into the Finance and Business Performance Committee and the Health & Safety Dashboard is submitted to the Strategic People Committee regularly.

- **Datix Risk 51** – Shortage of registered and unregistered nursing staff, which results in high reliance on temporary staffing:
- **Datix Risk 50** - Shortage of registered midwives and the establishment headcount increased in response to the Ockenden Report:

The vacancy rates have remained static for both **51** and **50**, the risks will be impacted once the international recruits progress through the process and obtain their Pins. The scores remain at 15 for both risks.

- **Datix Risk 93** – Non-compliance with 62-day Cancer standard: the key controls and the current gaps have been updated. The service is in the process of training an external tracking team to help with the current backlog. There are currently 3 posts out to advert. TVCA are also supporting with training current staff. MBI support with the validations. All Standard Operating Procedures to be reviewed by March 2023.
- **Datix Risk 36** - Interventional Radiology: the score has increased from 16 to 25 due to the complete loss of service. The completion date for works is 9<sup>th</sup> December 2022, however the service start date is yet to be confirmed.  
01/11/2022: EMC challenged the increase in score to 5x5. This risk has been scored against the Service/business interruption Environmental impact domain - the score denotes

the complete loss of the service rather than an impact to patient safety. This was reviewed in RCMG on 21/11/2022 and the decision taken to retain the score at 5x5.

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

There are currently no lapsed risks on the CRR.

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

The following risk was escalated for EMC to approve for inclusion on the CRR

- **Datix Risk 92** - Delays in all Radiology reporting due to Radiologist shortage: the risk was escalated in October as 11,000+ scans not being reported including at least 350 2ww. Currently scored at 20 with a target date of June 2023.

01/11/2022: EMC approved the addition of the risk to the CRR but requested the description be reviewed to convey the full extent of the risk and include a trajectory with timelines for improvement.

As of 22/11/2022, the figures have reduced from 11k+ to 7987 unreported scans, 117 of these are 2ww/ urgent, 67 of which are confirmed 2ww.

As one of the mitigation, the team are finalising details for a Limited Liability Partnership (LLP) contract to progress the backlog and a paper was submitted to EMC 22/11/2022 for approval of the contract.

A breakdown of the outstanding scans, the scoring methodology and possible projections once the LLP is in place will be reported to the Quality and Patient Safety Group (24/11/2022). A considerable reduction in the outstanding figures is anticipated by the end of Dec/ early January 2023 when the risk will be reviewed further.

#### 6. Risks requiring EMC approval for de-escalation from the CRR

There were 4 requests for EMC approval for de-escalation from the CRR this month:

- **Datix risk 53** – Increased staff absences due to Covid-19
- **Datix risk 52** – Increased impact on staff physical and psychological health and wellbeing from working during COVID-19 pandemic

Both risks have been moderated as part of the review for the migration to Datix and have been reduced from 16 to 12. Monitoring for these risks will continue on the People Directory divisional risk register.

01/11/2022: EMC approved the de-escalation of the above 2 risks.

- **Datix Risk 185** – Clinical harm on extended waits for elective surgery: Work continues to reduce the list and get the surgical facilities back on line. The target date has been reviewed from 08/2022 to 31/03/2023. As part of the Datix migration review the risk score has been moderated to a 12 from 20 and the target score from 8 to a 6.

Monitoring for this risk will continue on the Surgery and Critical Care divisional risk register.

01/11/2022: EMC approved the de-escalation of this risk.

- **Datix Risk 119** – Patient Tracking: although work continues to reduce the backlog, the current risk score remains unchanged. The COO and the Director for Business Recovery have initiated a task and finish group to progress reduction of the backlog. This risk is due for review January 2023. As part of the Datix migration review the risk score has been moderated to a 12 from 20 and the target score from 12 to a 9.

Monitoring for this risk will continue on the Specialist Services divisional risk register.

01/11/2022: EMC did NOT approve de-escalation of this risk stating that more work was required to manage the risk. The team will provide an update in the next report round.

## **7. Planned improvement activities on Risk Management and Risk Register**

- Risk management module on Datix system: The Divisional and Corporate Service teams are continuing to transfer their risk registers onto Datix.
- Review of Risk Management Policy: the revised policy has been ratified and published.
- Trust-wide risk management training programme: The training programme commenced in May and continues whilst the divisions review and migrate their risks.
- Review of divisional governance meetings: Scoping activity is currently being undertaken to review the structure of Divisional Governance meetings to standardise and strengthen the discussion in these meetings. Along with other governance elements, the governance meeting agendas will incorporate the moderation of the divisional risk register.
- Monthly meetings to review service level risk registers to support the service unit governance leads.

## **8. Recommendation**

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

## **9. Appendices**

**Appendix 1:** CRR

**Appendix 2:** Heat Map

**Appendix 3:** Risk Matrix

Datix ID	Division	Date added to CFR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates ( <b>bold</b> ) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
								C	L	C x L					C	L	C x L
118	Property Services	20/10/2017	Ensure our people are listened to, safe and supported Our buildings and facilities will be great places to work and contribute to health and wellbeing of staff		The SMH main HV/LV electrical supply is insufficient for the current needs of the Estate and is not resilient.  In addition, due to the discovery of corrosion on the existing equipment, the installation of a new joint box and replacement switch gear and cables is also required.  If external supplies fail the internal back up support generators will only support the power needs of the site for 4 hours.  This will affect all clinical and non clinical services.	25 (6x5)	A generator supply system which will provide emergency power to all of the site.  This project will re-structure the power supply systems to provide secure services.  Initial 4 hour back up will require extra fuel deliveries to allow continuation of generator support and Clinical services. Contract in place.  Individual medical equipment has limited battery back up for approximately 30 minutes.  New cabling and switch gear installed. Transformers and distribution panel installed.	5	3	15	Insufficient power supply Only one electrical supply cable, 2nd needed for resilience  Supply chain resilience	Confirmation is awaited regarding the removal of asbestos from the cabling ducts that will house the new cabling connection to the service tower. This work is currently planned for <b>28th November to 1st December</b> . On completion, PTL, Enerveo and UKPN will complete testing and commissioning but this is unlikely to happen until early January due to varying availability between the three companies. The target date will extend a further 2 months to <b>January 2023</b> .  Risk owner: Head Of Estates Development	31/01/2023	Commercial Director	5	1	5
119	Trust	19/02/2018	Provide outstanding, cost effective care We will consistently meet or exceed quality (safety, experience, outcome) and performance standards		Risks within outpatient services in booking patients within the correct timescales. Includes, urgent, new referrals, injection appointments and injection follow ups.  There is a risk that harm can come to patients if they are not tracked robustly and given follow up appointments in a timely fashion. This risk includes:  Growing number of patients being placed on hold following an outpatient appointment for the following reasons: - added to waiting list - awaiting diagnostics - no outcome form - insufficient capacity - SOS  Visibility has been restricted due to lack of reporting, and since reporting has been in place minimal operational review has occurred Patient placed in an On-Hold status as a result of insufficient capacity and COVID-19 reduction of services. Insufficient monitoring of hospital-initiated cancellations Clinical risk of patients potentially being 'lost to follow up' with the risk of delays in care and subsequent poor patient outcomes Patients referred by the e-referral system that are unable to book an appointment due to capacity constraints (ASi's). Hot spot specialities include Ophthalmology	25 (6x5)	Manual recoding and escalation reporting via APMG and live escalation reports, a weekly meeting with each ops team to discuss pressures. 6 week booking model and reporting introduced 2021 to allow operation teams to plan their capacity demand more effectively.  Task and Finish group which meets regularly has been set up to focus on resolving this	4	3	12	Individual compliance by consultants in completing the e-outcome forms - supported by the Medical Director Ability to be able to track non-compliance with agreed standard operating procedures. Gaps sit with the individual specialities as per the performance management structure - Insufficient outpatient capacity - need to reduce follow up appointments	Access team to continue to escalate to each relevant service management team.  CGL to circulate the need for all specialities to have this on their RR also - Ophthal, Derm, T&O, in particular	31/01/2023	Chief Operating Officer	3	3	9
56	Property Services	20/10/2020	Ensure our people are listened to, safe and supported Our buildings and facilities will be great places to work and contribute to health and wellbeing of staff		Concrete Panels and support columns on the Tower Block at Wycombe Hospital: The concrete panels installed on the exterior of the tower block are at risk of falling away from the main building to the ground due to deterioration of the cast iron clips installed when the tower was constructed.	20	Scaffolding is currently erected with boarding to protect persons from smaller spalling concrete. Larger concrete panels which have been identified as concerns have been removed.  Additional scaffolding and stronger boarding has been installed and following advice from structural engineers has been extended around the whole building.	4	4	16	No capital budget available for the works	Full condition survey to be completed by structural engineers - ongoing  Decision on repair work to be agreed following recommendations made in survey. EMC has agreed to fund additional investigations on the external immediate structure (£527k) 31/05/2022.  Further investigation and testing of the structure and concrete chemistry is required to determine the continued safe use of the building (as above) and should be completed by 30/09/2022.  A further 40 panels to be removed from the tower.  Continue to update the EMC and Trust Board on the Services and condition and patient experience.	30/11/2022	Commercial Director	5	1	5

Datix ID	Division	Date added to CFR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates ( <b>bold</b> ) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
								C	L	C x L					C	L	C x L
43 (47-rejected)	Women, Children and Sexual Health Services	19/02/2021	Provide outstanding, cost effective care we will consistently meet or exceed quality (safety, experience, outcome) and performance standards		Insufficient capacity within the Paediatric Decisions Unit footprint for ongoing treatment of children and young children leading to periods of overcrowding.  Triage Process through Paediatric Decisions Unit inability to rapidly assess children who may be unwell	16	Weekly review of Datix documenting overcrowding Review of complaints related to the PDU environment and waiting times Monthly review of attendance to PDU Guideline 279, escalation tool Use of Outpatient area in Corridor 5 to support early assessment and lack of capacity during times of surge Additional staffing to support at peak times of activity Paediatric Senior Nurse on call rota to support decision making outside of normal working hours Isolation of infectious patients according to Trust guidelines Respiratory checklist to be completed on triage	4	3	12	Reliance on temporary staffing to provide UTC pathway leads inability to provide a consistent service	Creation of new bespoke Paediatric Emergency Department supported with funding provided by NHS Improvement, programme is underway and currently scheduled for completion <b>November 2022</b>  Escalation plan agreed for autumn/winter 2021/2 – substantive recruitment to band 6 nurse posts to support escalation plus planned allocation of ward 9 to CYP until new observation area is constructed.  The target date of 31/08/2022 has been extended to 31/12/2022 following further delays in the build of the new unit. (Agreed at Audit Committee 07/07/2022)	31/12/2022	Chief Operating Officer	2	1	2
225	IT	29/07/2021	Taking a lead role in our community		Risk of disruption to Trust technology systems and services caused by cyber incidents.  There is a risk within the Virtualisation platform due to the VMware version being outdated, there is additional risk within the operating systems due to their age, currently the Trust is running on 127 2008 servers. On-premise Data centre hardware i.e. Servers and Network equipment is 8 years old, increasing the likelihood of failure that will cause a knock-on impact to applications and therefore clinical services.		Cyber security accountabilities in place. Hardware & software patching up to date for operating systems. Education and awareness of cyber risk. Data Centre project in progress - 80% of servers have been moved over to this. DSP Toolkit submitted on 30th June 2021.	5	4	20	• Software moving out of mainstream vendor support • Cyber Security strategy being defined • Vendor support for software being reviewed. Application patching	Focus on IG Mandatory training compliance - to be 85% compliance achieved by <b>01/12/2022</b> .  DSP Toolkit Submission for June 2022 (68% achieved), by <b>December 2022</b> to be 85% compliant.  The Datacentre and Network Infrastructure projects to be completed: Data Centre (Including operating systems and VMware versions): <b>31/03/2023</b> Networks phase 1: <b>Summer 2023</b> and phase 2: <b>Summer 2024</b> .	31/03/2023	Chief Digital & Information Officer	5	2	10
	Integrated Medicine	28/10/2021	Provide outstanding, cost effective care We will consistently meet or exceed quality (safety, experience, outcome) and performance standards		Clinically inappropriate length of stay in ED including time to Triage, treat and discharge or admit.		Triage protocol incorporates (including Streaming Nr) Front Door Team. Treatment Nr to support Triage when Wait time increases. DTA times reported to site team and recorded on Medway. ED Consultant DTA. EOU admission packs are premade. Site team to prioritise DTA patients from EOU as part of the EOU SOP. Departmental and hospital escalation policy in use. Crowding tool used. Operational policy for medically expected patients. Acute care coordinator escalating to operational team when more than 5 patients are waiting to be seen by the medics. Use of EOU for appropriate ED patients to create capacity in the main department. Additional cubical capacity within ED for triage and assessment now operational Operational onsite UTC	3	5	15	DTA times rely on Snr Speciality Decision Maker Streaming Nr Vacancies Treatment Nr Vacancy and Triage capability of Treatment Nr	The team are reviewing the mitigation plan which is reported to the Urgent and Emergency Care Board on a monthly basis.  The target date has been extended to end of December.	31/12/2022	Chief Operating Officer	3	2	6

Datix ID	Division	Date added to CFR	Strategic Priority	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
								C	L	C x L					C	L	C x L
226	IT	03/11/2021	Take a leading role in our community	Our buildings and facilities will be great places to work and contribute to health and wellbeing of staff	There is a risk: of loss of 2222 emergency bleeps, key bleep groups and non-emergency bleeps at Wycombe and Amersham hospitals  If: the bleeps system should failure  Resulting in: potential harm to patients.		<ul style="list-style-type: none"> <li>* A number of 2 way radios at SMH (20) and emergency mobiles (25) are available at SMH, (with further 15 at WH and 5 at AH) to be deployed in the event of bleep failure.</li> <li>* ISDN red phones installed by IT in to all clinical ward areas to support resilience in event of bleep or landline outage.</li> <li>* The Switch over to the newly installed Bleeps system for Emergency Bleeps at SMH site took place Mid - Feb 2021.</li> <li>* 68 critical emergency bleep devices upgraded with new devices for SMH site.</li> <li>* The Non-Emergency solution rolled out at SMH site mid Feb 2021 - Appear App</li> <li>* Crash bleeps is now live at Wycombe Hospital and it operational.</li> <li>* Pages have been tested, programmed and distributed to porters, site managers and support staff.</li> <li>* Medirest are now using the new Multitone bleeps service for communication with all support staff.</li> <li>* 8x8 Integration - Solution design complete and approved.</li> <li>* Ofcom - Licenses are now in place (SMH, WH and AH license now approved and awaiting payment to be made to ofcom).</li> <li>* Support contract for Ofcom also in place and active.</li> </ul>	4	3	12	<ul style="list-style-type: none"> <li>* Not enough back up mobiles or radios available for all Emergency bleep holders (68).</li> <li>* Staff awareness of plans and process to rollout and operate 2 way radios and emergency mobiles.</li> <li>* Number of 2 way radios and emergency mobiles available is currently at minimum.</li> <li>* Wycombe Hospital/Amersham Hospital bleep system experiencing intermittent issues with inadequate support contract.</li> <li>* Inconsistent radio and mobile phone network coverage on Trust sites is unreliable.</li> <li>* New system to cover Amersham Hospitals critical bleeps has not yet been implemented.</li> <li>* Need to continue to ensure that all staff at Wycombe Hospital are comfortable and familiar with all operational aspects of the service and then cascade training and knowledge transfer to all desk staff at Wycombe.</li> </ul>	<ul style="list-style-type: none"> <li>* The <b>crash bleeps</b> are set up and ready to be distributed to clinical teams once help desk confirm that they are ready to go live to clinical teams. Pages will then be rolled out to clinical teams over a two day period.</li> <li>* <b>Amersham Infrastructure Cabling</b> expected to be completed <b>27/10/2022</b>: Multitone servers scheduled to be commissioned and ready by <b>14/11/2022</b>. Crash bleep roll out to Amersham Porters and clinical staff expected <b>16/11/2022</b></li> <li>* <b>Non Emergency Bleeps</b> - WIP with PABX suppliers, awaiting audit feedback that will identify any duplicated phone numbers across the 3 hospitals.</li> <li>* <b>8x8 Integration</b> - Hardware has been ordered for technical integration – to be rolled out.</li> <li>* <b>Ofcom</b> - Currently in a test phase. Test plan to be drafted (network resilience testing), BCP to be confirmed, DR plan also to be confirmed.</li> </ul>	30/11/2022	Chief Digital & Information Officer	4	2	8
234	Finance	09/02/2022	We will deliver a financially sustainable future.	Trusts financial sustainability	Delivery of the 22-23 Financial Plan.  Trust is unable to define / live within its financial envelope impacting on its ability to resource / deliver clinical, operational and strategic priorities	20	EMC, Finance Committee and Audit Committee scrutiny	5	4	20	Lack of national guidance	Detailed Action Plan to be developed and ratified by Finance Committee / Trust Board.  Budget setting underway based on current / known guidance for Board approval/ratification.External financial review in progress to support Trusts financial sustainability/recovery	31/03/2023	Director of Finance	3	3	9
224	Finance	23/02/2022	We will deliver a financially sustainable future.	Trusts financial sustainability	Trust's Capital resourcing is insufficient to support objectives. As a Region and ICS, BHT's requirements are above allocation. Risk to system affordability and operational risk of maintaining the capital programme	25	Executive Directors to manage the delivery of strategic schemes, with CMG	4	5	20	CMG Ownership and assessment of project / deliverables	Capital Accountant to monitor CMG deliverables. Engagement with NHS/E to agree funding profile of strategic themes	31/03/2023		4	5	20
184	Property Services	14/02/2022	Our buildings and facilities will be great places to work and contribute to health and wellbeing of staff	The ageing WH tower Block is showing signs of interior deterioration and is increasingly challenging to maintain in a condition that is suitable for modern healthcare provision. Asbestos is present throughout including floors, ceilings, service voids impeding remedial or improvement works as this adds significant costs and risks to repairs and projects. Water pipework - obsolete components. Difficult to remove under asbestos conditions presenting a legionella risk to staff and patients. Electrical infrastructure is obsolete and does not comply with HTM 06. All Patient services could be affected by failures in the electrical infrastructure. Poor patient environment experience i.e. space, door widths and access not compliant with modern healthcare standards (HBN's) and Equality Act. The ventilation is not compliant with current standards for healthcare services. All patients and staff may be exposed to airborne infection. All patients and staff are affected by excessively high temperatures during periods of hot weather. The Helpdesk is in the basement and subject to risk of water ingress which, if the system went down, would be catastrophic	25	<ul style="list-style-type: none"> <li>• Asbestos surveys and register in place <ul style="list-style-type: none"> <li>• Annual review</li> </ul> </li> <li>• All projects done under controlled conditions <ul style="list-style-type: none"> <li>• Continuous water testing</li> <li>• Flushing regime in place</li> </ul> </li> <li>• Monitored by the Water safety Groups and IPC <ul style="list-style-type: none"> <li>• Water Safety Policy in place</li> <li>• Water Authorising Engineer appointed</li> </ul> </li> <li>• Maintenance and inspection programmes in place <ul style="list-style-type: none"> <li>• Electrical Authorising Engineer appointed</li> <li>• Generator cover available</li> <li>• Authorised Persons (Electrical) in place</li> </ul> </li> <li>• Clinical services are having to adapt to the environment by providing equipment that is not necessarily the best choice for the patient. <ul style="list-style-type: none"> <li>• Portable Air Purifying Units in place <ul style="list-style-type: none"> <li>• Portable A/c units available</li> <li>• Ventilation policy in place</li> </ul> </li> <li>• Authorising Engineer for ventilation appointed</li> <li>• Ventilation validation carried out in Theatres</li> </ul> </li> <li>• Hot weather plan and IPC guidance available to staff</li> </ul>	5	4	20	<ul style="list-style-type: none"> <li>Ventilation and DDA access can only be improved by making interior structural changes requiring ward/ clinical area closures.</li> <li>Any improvement works will require an asbestos strip requiring ward closure and significant additional cost.</li> </ul>	<ul style="list-style-type: none"> <li>Property Services working with service leads to relocate services on the WH site.</li> <li>The outline business case should be completed by 31/03/2023</li> <li>Rebuild the Tower Block</li> </ul>	31/03/2026	Commercial Director	4	4	16	

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								C	L	C x L					C	L	C x L
190		23/02/2022		Our buildings and facilities will be great places to work and contribute to health and wellbeing of staff	The interior condition of ward 2a has deteriorated and is increasingly difficult to maintain to the standard required to deliver effective clinical care. The Trust is in breach of CQC Regulation 15 and has been notified of this by CQC.	25	<p><b>Ward Staff:</b></p> <p>Discharge planning on admission which has reduced length of stay. Clear and consistent cohorting of patients. Culture of safety via Quality improvement huddles, embedded Safety Huddles and DFMs. Strong Consultant and junior doctor presence. Consistent daily Ward round and twice daily Board rounds. Enhanced cleaning regime through COVID19. PPE champions in place. Enhanced IPC support and visibility 2a and HW site generally. Regular infection control inspections – monitored through Perfect Ward.</p> <p><b>Estates staff:</b></p> <ul style="list-style-type: none"> <li>Patch repairs made to floor</li> <li>Regular inspections</li> <li>Warning signage in place</li> <li>Portable Air Purifying Units in place</li> <li>Portable A/c units available</li> <li>Ventilation policy in place</li> <li>Authorising Engineer for ventilation appointed</li> <li>Ventilation validation carried out in Theatres</li> <li>Hot weather plan and IPC guidance available</li> <li>Asbestos surveys and register in place</li> <li>Annual review</li> <li>Asbestos analyst available</li> <li>Projects and repairs under controlled conditions</li> </ul>	5	4	20	<p>Asbestos is present throughout the construction including the floors, ceilings and service voids, impeding any remedial or improvement works.</p> <p>The flooring has deteriorated and can only be patch-repaired without closing the ward. The uneven surface is affecting patient movement in beds and trolleys and is a risk to patients and staff of manual handling and trip hazards.</p> <p>Ventilation not compliant with current standards for healthcare services with a risk of exposure to airborne infection. Patients and staff are impacted by excessively high temperatures during periods of hot weather.</p> <p>As the building fabric is beyond feasible repair the only option to resolve the risk is relocation of the service – there is no interim option available. Short term remedial work is undertaken as required but these are not long term solutions.</p>	<p>Request emergency capital funding for new modular build</p> <p>Long term solution: Relocation of the service</p>	31/03/2023	Chief Nurse	0	0	0
51	Trust	21/04/2022	Ensure our people are listened to, safe and supported	We will deliver our 5 people priorities	<b>Nursing</b> - shortage of registered and unregistered nursing staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care, the wellbeing of permanently employed colleagues and the Trust financial position. The impact of working through the COVID-19 pandemic and an ageing workforce has led to increased turnover in some areas.	20	<ul style="list-style-type: none"> <li>Performance management of Recruitment Service - Strategic Workforce Committee. <ul style="list-style-type: none"> <li>Performance management of Divisions</li> </ul> </li> <li>Performance management of NHSP to ensure quality of temporary staff and high proportion of bank rather than agency staff.</li> <li>Daily safe staffing huddles to identify and review hot spots to assure that safe staffing levels are maintained at all times with the supply of bank/temporary workers as mitigation if required.</li> <li>Recruitment plan for all registered nursing and HCAs</li> </ul>	5	3	15	<p>Nursing establishments have been increased in some areas for f/y 2022-23 as part of the safer staffing review work. This has increased our permanent vacancy levels for substantive roles.</p>	<p><b>HCAs</b></p> <ul style="list-style-type: none"> <li>From January 2022, recruitment of HCAs moved to cohort recruitment: job offers have been made to 80 HCAs to date (Aug); further recruitment events are scheduled.</li> <li>From May 2022, increased induction slots available for HCAs from 12 - 50 each month.</li> </ul> <p><b>Registered Nursing</b></p> <ul style="list-style-type: none"> <li>Recruitment of band 5 nursing to move to cohort recruitment from Q2, 2022.</li> <li>120 international nurses due to arrive in cohorts through f/y 22/23. The first cohort of 20 nurses arrived in July; a further 21 nurses scheduled to arrive in Aug 2022.</li> <li>From Q1 2021-22, working with university graduates from University of Bedfordshire and Buckinghamshire New University to recruit the maximum number of graduating students. The target is 70% of cohort (82 nursing graduates and 17 nursing associate graduates in total) - to recruit 69.3 wte; currently all graduates have been offered positions.</li> </ul> <p><b>All Nursing Staff</b></p> <p>From April 22 the Trust is one of twenty three exemplar sites for the National People Promise retention 12 month programme.</p>	31/03/2023	Chief People Officer	5	2	10
50	Trust	21/04/2022	Ensure our people are listened to, safe and supported	We will deliver our 5 people priorities	<b>Midwifery</b> - Target set to reduce vacancy rate to 5% by December 2022 in order to implement full midwifery continuity of care. With the national shortage of midwives, there is a risk that we will be unable to meet this vacancy level. The impact of working through the Covid-19 pandemic and an ageing workforce has led to increased turnover in these areas.	20	<ul style="list-style-type: none"> <li>Performance management of Recruitment Service - Strategic Workforce Committee. <ul style="list-style-type: none"> <li>Performance management of Divisions</li> </ul> </li> <li>Performance management of NHSP to ensure quality of temporary staff and high proportion of bank rather than agency staff.</li> <li>Daily safe staffing huddles to identify and review hot spots to assure that safe staffing levels are maintained at all times, with the supply of bank/temporary workers as a mitigation if required</li> <li>Recruitment plan for all midwifery posts monitored on a monthly basis</li> </ul>	5	3	15	<p>Midwifery establishments have been increased. This has increased our permanent vacancy levels for substantive roles.</p>	<p><b>Registered Midwives</b></p> <ul style="list-style-type: none"> <li>Pro-actively working with the practice development team to encourage all graduates to join BHT. Job offers made to all graduates; target to recruit 10.97 wte as Band 5 preceptorship midwives in October 22.</li> <li>We have strengthened our established international recruitment approach. 17 international midwives have arrived to date (Aug), a further 6 midwives due to arrive in Q2. A bespoke digital marketing campaign: currently all photography, marketing and engagement sessions are prepared in readiness for the dedicated website and social media campaign to be launched in Sept 2022.</li> <li>Recruitment and retention practice development support role to be appointed through external funding (Q2).</li> </ul>	30/03/2023	Chief People Officer	5	2	10

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								C	L	C x L					C	L	C x L
93	Specialist Services	21/03/2022		We will consistently meet or exceed quality (safety, experience, outcome) and performance standards	<p>For 12 consecutive months the trust has been non-compliant with the 62-day standard. This remains our biggest risk and most challenging pathway. The number of referrals has remained above baseline with winter pressures and a COVID backlog on pathways present an ongoing challenge.</p> <p>The number of 2WW GP referrals continues to rise above baseline and some service areas are consistently polling above 10 days due to both staffing and capacity issues.</p> <p>The delays in diagnostics significantly affects complex diagnostic pathways. Particularly a cohort of Urology, Lower GI, Breast and Gynaecological patients. This also includes a 4-6 week delay at OUH for patients requiring PET scans, which is significantly affecting the 62-day patient pathway. TP Biopsies continue to be challenged, with a 3-4 week turnaround.</p> <p>Theatre capacity for TCI's/POA capacity continues to be an ongoing issue.</p> <p>The 2WW and FDS targets present significant risk of breaching during January-March 2022 due to Radiology workforce challenges. Validated figures are available in the February 2022 Cancer report.</p>	25	<p>Twice weekly 62+ report focusing on the next steps, actions sent to DDS and GMS. MBI appointed for tracking and validation, starting 14/09/22. Trajectories for each tumour site have been developed. Trajectories to manage backlog over 62+ have been developed and are shared on a weekly basis with NHS England.</p> <p>Significant effort is being made to reduce the number of long waiters &gt;104 days and patients in 63-103 cohorts.</p> <p>Infoflex bolt added onto BHT systems to allow for better tracking of patients.</p> <p>Ongoing involvement and collaboration from TVCA.</p> <p>Capacity and Demand analysis complete</p> <p>Processes have been aligned with ICS peers</p> <p>Skin cancer centre in Amersham opened</p> <p>Diagnostic pathways have been revised</p> <p>Data quality control process implemented.</p>	5	3	15	<p>Awaiting Infoflex bolt</p> <p>Implement new processes to reduce requirement for validation</p> <p>Revise and agree data-driven SLA's with tertiary provider</p> <p>MDT coordinators and Tracker to be trained by TVCA on both tracking and validation.</p> <p>Harm review process to be implemented for patient over 104 days.</p> <p>Consistency of tracking and validation of PTL.</p> <p>Out of date SOPS</p>	<p>Existing MDT trackers have now all been trained. This will be ongoing for new staff. 3 posts out to advert.</p> <p>TVCA supporting training current staff as its quite a new team.</p> <p>MBI to help support with the validations.</p> <p>Cancer access policy draft to include finalised process</p> <p>All SOPS to be reviewed by <b>Mar 2023</b></p>	31/03/2023	Chief Operating Officer	4	2	8
36	Specialist Services	16/05/2022			<p>No Interventional Radiology (IR) service available at BHT because the IR suite is condemned due to equipment failure.</p>	20	<p>Routine lists have been cancelled.</p> <p>Surgical teams have been advised to review all urgent referrals and transfer to Oxford University Hospital as needed.</p> <p>Routine and urgent lists now being implemented as mobile bail out kit is available in the event of equipment failure. This is not a replacement for the interventional suite equipment.</p> <p>06/05/2022- SLA with OUH in place for urgent and 2WW</p>	5	5	25	<p>in the event of equipment failure, lists will need to be cancelled</p> <p>06/05/2022-External organisation e.g. estates etc</p>	<p>Capital Accountant to monitor CMG deliverables. Engagement with NHSI/E to agree funding profile of strategic themes</p>	31/03/2023	Chief Operating Officer	2	1	2
<b>New Risk</b>																	
92	Specialist Services	01/10/2022			<p>Delays in all radiology reporting due to radiologist shortage.</p> <p>This includes 2WW reporting.</p> <p>Current position as of 22/11/2022, the figures have now reduced from 11k+ to 7987 outstanding: 117 of these are 2ww/ urgent, 67 of which are confirmed 2ww</p>		<p>Some of the services such as cold reporting and non-urgent lists are cancelled or delayed to facilitate the urgent services.</p> <p>4-way are outsourced for reporting OOH (8pm - 7am).</p> <p>Service agreement with 4-ways</p> <p>Urgent reporting is prioritised as best as possible in line with reporting SOP</p> <p>Manual recoding and escalation reporting via APMG and live escalation reports, a weekly meeting with each ops team to discuss pressures.</p> <p>6 week booking model and reporting introduced 2021 to allow operation teams to plan their capacity demand more effectively.</p> <p>Task and Finish group which meets regularly has been set up to focus on resolving this</p>	5	4	20	<p>1. Shortage of 2 Radiologist currently.</p> <p>2. Huge backlog of unreported/delayed reporting for scans across the Trust</p>	<p>Finalise details for a Limited Liability Partnership (LLP) to allow the radiologists to progress the backlog. Contract for approval at EMC <b>22/11/2022</b></p> <p>Paper to EMC early <b>December 2022</b></p> <p>Commence LLP project (if approved) <b>Dec 2022</b></p> <p>Review late December early <b>Jan 2023</b></p> <p>Recruit to 2 vacant posts.</p>	30/06/2023	Chief Operating Officer	1	3	3

### Risk Profile – Corporate Risk Register – November 2022

Consequence	1	2	3	4	5
Likelihood	Key: ↑ = risk score has risen; ↓ = risk score has dropped; ⇔ = no change. The CRR changes on a monthly basis and the arrows indicate the change since the previous version (up to 3 changes)				
5			<b>CRR150</b> - Clinically inappropriate length of stay in ED (new 10/2021)⇔⇔⇔	<b>224</b> – Trust capital resourcing (new 02/2022) ⇔⇔⇔	<b>36</b> – Interventional Radiology service (new 05/2022)⇔⇔↑
4			<b>226</b> – Critical Bleeps (new 11/2021) ↓⇔⇔ <b>185</b> - Potential clinical harm to patients on elective wait list (new 02/2021) ⇔⇔↓	<b>184</b> – Aging Tower Block WGH (new 02/2022)⇔⇔ ↓	<b>56</b> – Concrete building panel failure at WGH (new 10/2020)⇔⇔⇔ <b>225</b> – Disruption to Trust technology due to cyber incidents (new 07/2021) ⇔⇔⇔ <b>234</b> – Delivery of 22-23 financial plan (new 02/2022) ⇔⇔⇔ <b>190</b> – Ward 2a environment (new 07/2021) ⇔⇔⇔ <b>92</b> – Radiology reporting delays (new 10/2022)
3				<b>119</b> – Patient tracking and appointments (new 02/2018)⇔⇔↓ <b>52</b> – impact on staff physical and psychological health and well-being during covid-19 (new 04/2020)⇔↓ ↓ <b>43</b> – Insufficient capacity within PDU (new 02/2021) ⇔⇔⇔ <b>53</b> – Increased Staff absence Covid-19 (new03/2022) ⇔⇔↓	<b>118</b> – HV/LV insufficient supply (new 10/2017)⇔⇔↓ <b>51</b> – Shortage of qualified nurses (new 04/2022)⇔⇔⇔ <b>50</b> – Shortage of Midwifery staff (new 04/2022) ⇔⇔⇔ <b>93</b> – Cancer pathway non-compliance (new 03/2022) ↓⇔⇔
2					
1					

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

- 53** - Increased Staff absence Covid-19
- 52** - impact on staff physical and psychological health and well-being during covid-19
- 185** - Potential clinical harm to patients on elective wait list

## Risk Matrix

Consequence Score (severity levels) and examples of descriptors					
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
<b>Impact on the safety of patients, staff or public (physical / psychological harm)</b>	<p>Minimal injury requiring no/minimal intervention or treatment.</p> <p>No time off work</p>	<p>Minor injury or illness, requiring minor intervention</p> <p>Requiring time off work for &gt;3 days</p> <p>Increase in length of hospital stay by 1-3 days</p>	<p>Moderate injury requiring professional intervention</p> <p>Requiring time off work for 4-14 days</p> <p>Increase in length of hospital stay by 4-15 days</p> <p>RIDDOR/agency reportable incident</p> <p>An event which impacts on a small number of patients</p>	<p>Major injury leading to long-term incapacity/disability</p> <p>Requiring time off work for &gt;14 days</p> <p>Increase in length of hospital stay by &gt;15 days</p> <p>Mismanagement of patient care with long-term effects</p>	<p>Incident leading to death</p> <p>Multiple permanent injuries or irreversible health effects</p> <p>An event which impacts on a large number of patients</p>
<b>Quality/complaints/audit</b>	<p>Peripheral element of treatment or service suboptimal</p> <p>Informal complaint/inquiry</p>	<p>Overall treatment or service suboptimal</p> <p>Formal complaint (stage 1)</p> <p>Local resolution</p> <p>Single failure to meet internal standards</p> <p>Minor implications for patient safety if unresolved</p> <p>Reduced performance rating if unresolved</p>	<p>Treatment or service has significantly reduced effectiveness</p> <p>Formal complaint (stage 2) complaint</p> <p>Local resolution (with potential to go to independent review)</p> <p>Repeated failure to meet internal standards</p> <p>Major patient safety implications if findings are not acted on</p>	<p>Non-compliance with national standards with significant risk to patients if unresolved</p> <p>Multiple complaints/ independent review</p> <p>Low performance rating</p> <p>Critical report</p>	<p>Totally unacceptable level or quality of treatment/service</p> <p>Gross failure of patient safety if findings not acted on</p> <p>Inquest/ombudsman inquiry</p> <p>Gross failure to meet national standards</p>

## Risk Matrix

<p><b>Human resources/ organisational development/staffing/ competence</b></p>	<p>Short-term low staffing level that temporarily reduces service quality (&lt; 1 day)</p>	<p>Low staffing level that reduces the service quality</p>	<p>Late delivery of key objective/ service due to lack of staff</p> <p>Unsafe staffing level or competence (&gt;1 day)</p> <p>Low staff morale</p> <p>Poor staff attendance for mandatory/key training</p>	<p>Uncertain delivery of key objective/service due to lack of staff</p> <p>Unsafe staffing level or competence (&gt;5 days)</p> <p>Loss of key staff</p> <p>Very low staff morale</p> <p>No staff attending mandatory/ key training</p>	<p>Non-delivery of key objective/service due to lack of staff</p> <p>Ongoing unsafe staffing levels or competence</p> <p>Loss of several key staff</p> <p>No staff attending mandatory training /key training on an ongoing basis</p>
<p><b>Statutory duty/ inspections</b></p>	<p>No or minimal impact or breach of guidance/ statutory duty</p>	<p>Breach of statutory legislation</p> <p>Reduced performance rating if unresolved</p>	<p>Single breach in statutory duty</p> <p>Challenging external recommendations/ improvement notice</p>	<p>Enforcement action</p> <p>Multiple breaches in statutory duty</p> <p>Improvement notices</p> <p>Low performance rating</p> <p>Critical report</p>	<p>Multiple breaches in statutory duty</p> <p>Prosecution</p> <p>Complete systems change required</p> <p>Zero performance rating</p> <p>Severely critical report</p>
<p><b>Adverse publicity/ reputation</b></p>	<p>Rumours</p> <p>Potential for public concern</p>	<p>Local media coverage –</p> <p>short-term reduction in public confidence</p> <p>Elements of public expectation not being met</p>	<p>Local media coverage –</p> <p>long-term reduction in public confidence</p>	<p>National media coverage with &lt;3 days service well below reasonable public expectation</p>	<p>National media coverage with &gt;3 days service well below reasonable public expectation. MP concerned (questions in the House)</p> <p>Total loss of public confidence</p>

## Risk Matrix

<b>Business objectives/ projects</b>	Insignificant cost increase/ schedule slippage	<5 per cent over project budget  Schedule slippage	5–10 per cent over project budget  Schedule slippage	Non-compliance with national 10–25 per cent over project budget  Schedule slippage  Key objectives not met	Incident leading >25 per cent over project budget  Schedule slippage  Key objectives not met
<b>Finance including claims</b>	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget  Claim less than £10,000	Loss of 0.25–0.5 per cent of budget  Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget  Claim(s) between £100,000 and £1 million  Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget  Failure to meet specification/ slippage  Loss of contract / payment by results  Claim(s) >£1 million
<b>Service/business interruption Environmental impact</b>	Loss/interruption of >1 hour  Minimal or no impact on the environment	Loss/interruption of >8 hours  Minor impact on environment	Loss/interruption of >1 day  Moderate impact on environment	Loss/interruption of >1 week  Major impact on environment	Permanent loss of service or facility  Catastrophic impact on environment

Likelihood score	1	2	3	4	5
<b>Descriptor</b>	Rare	Unlikely	Possible	Likely	Almost certain
<b>Frequency</b> How often might it/does it happen	This will probably never happen/recur  <0.1 %	Do not expect it to happen/recur but it is possible it may do so  <0.1 – 1%	Might happen or recur occasionally  1 – 10%	Will probably happen/recur but it is not a persisting issue  10 – 50%	Will undoubtedly happen/recur, possibly frequently  >50%

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	Board Assurance Framework (BAF)
<b>Board Lead</b>	Neil Macdonald, Chief Executive Officer
<b>Type name of Author</b>	Joanna James, Trust Board Business Manager
<b>Attachments</b>	Board Assurance Framework_Board_November 2022
<b>Purpose</b>	Assurance
<b>Previously considered</b>	EMC 01.11.2022 Audit 04.11.2022

### Executive Summary

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

Followed the revised report shared with the Board in September 2022, individual meetings have been held with all Executive Directors to review the content of this report and provide further detail on actions. The aim is not to duplicate information; in some cases other existing action plans with corresponding oversight arrangements are signposted.

This report was considered by the Executive Management Committee on 1 November 2022 and Audit Committee on 4 November 2022 in conjunction with the Corporate Risk Register. An update is provided within the summary page of the BAF report.

### Decision

The Committee is requested to:

- Review the range of risks and use the information to inform strategic decision making.
- Consider the assurances in place, identifying gaps in controls/assurances and challenge these accordingly, identifying further actions required as appropriate.
- Review the emerging risks identified at Board and Board Committee meetings and consider reflection of these within the current BAF and CRR, paying attention to those not within these frameworks and the actions in place to mitigate.

### Relevant Strategic Priority

<b>Outstanding Care</b> ☒	<b>Health Communities</b> ☒	<b>Great Place to Work</b> ☒	<b>Net Zero</b> ☒
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### Implications / Impact

<b>Patient Safety</b>	Patient safety is fundamental across all risks within the BAF but specifically Principal Risk 1; Failure to provide care that consistently meets or exceeds performance and quality standards. The risk appetite statement notes the Trust will not accept any risk that materially impact the safety of patients.
<b>Risk: link to Board Assurance Framework (BAF)</b>	This report relates to all risks within the BAF and provides a clear link to risks within the Corporate Risk Register.
<b>Financial</b>	Financial considerations are evident throughout the BAF, particularly related to

	Risk 2; Failure to deliver the Trust's annual financial and activity plans.
<b>Compliance CQC Standards Good Governance</b>	An effective, comprehensive process is required to be in place to identify, understand, monitor and address current and future risks to the organisation and this is supported by effective use of the BAF.
<b>Partnership: consultation / communication</b>	The Trust recognises long-term sustainability depends on relationships with strategic partners within the ICS. Risk 3; Failure to work collaboratively and effectively with external partners.
<b>Equality</b>	Specific attention given to issues related to equality in Risk 5; Failure to support improvements in local population health and a reduction in health inequalities and Risk 6; Failure to deliver on our People Priorities.
<b>Quality Impact Assessment [QIA] completion required?</b>	Not applicable

## Board Assurance Framework

### Contents

1.0 Introduction .....	1
2.0 Strategic Objectives .....	2
2.1 Strategic Objective 1 .....	2
2.2 Strategic Objective 2 .....	6
2.3 Strategic Objective 3 .....	7
2.4 Strategic Objective 4 .....	8
2.5 Strategic Objectives 5 & 6 .....	9
2.6 Strategic Objective 7 .....	10
2.7 Strategic Objective 8 .....	11
2.8 Strategic Objective 9 .....	12
3.0 Emerging Risks; Board & Board Committees .....	13
4.0 Action required from the Board / Committee .....	16
6.0 Heatmap – Residual Risk .....	17
7.0 Risk Appetite Statement .....	18
8.0 Risk Matrix .....	19

## **1.0 Introduction**

This report provides the Board with an opportunity to discuss the range of risks confronting the organisation, any gaps in controls/assurances and the level of risks that this creates to support further strategic decision making.

Following the revision of the Board Assurance Framework (BAF) risks and reporting, seen by the Executive Management Committee (EMC) in August 2022 and Audit Committee and Trust Board in September 2022, individual meetings have been held with all Executive Directors to review the content of this report and provide further detail on actions. The aim has not been to duplicate information with regards to mitigating actions; in some instances, the reader is signposted to other existing action plans and where these are monitored. It is recognised that some gaps in assurance remain without actions and the Executive Team recognise where further work is required.

Following discussion with the Chief Operating Officer and the Chief Nurse, Principal Risk 1 has been split into three discrete areas:

1a) Reducing long waits.

1b) Providing safe emergency care.

1c) Management of risk and clinical governance.

Following discussion with the Chief Commercial Officer and the Chief Digital Information Officer, Principal Risk 7 has been split into two discrete areas:

7a) Estates

7b) Digital

This iteration of the report was presented to the Executive Management Committee on 1 November 2022 and further detail was planned for risks related to community and Children and Young People (CYP) services and finance. On 4 November 2022, the report was considered by the Audit Committee who noted the importance of closing the assurance loop on actions within the BAF and that actions were driven by identified gaps in assurance. Additional focus has been given to Principal Risk 2 by the Deputy Finance Directors and further scrutiny was planned for Principal Risk 4 by the Deputy Chief Nurse.

The BAF report is now available for colleagues on CAKE (Trust intranet) and this will be updated on a bi-monthly basis in line with publication at Trust Board. A presentation covering Risk Management, including the BAF, was provided to the Leadership Briefing on 22 September 2022.

## **2.0 Strategic Objectives**

Each strategic objective is detailed on the following pages.

## 2.1 Strategic Objective 1

<b>Strategic Objective 1</b>		<b>To consistently meet or exceed quality and performance standards</b>			
<b>Strategic Priority</b>		Provide outstanding, high value care ("Outstanding Care")			
<b>Principal Risk</b>		1. Failure to provide care that consistently meets or exceeds performance and quality standards including safety, experience and outcome: a) Reducing long waits. b) Providing safe emergency care. c) Management of risk and clinical governance.			
<b>Executive Lead</b>		Chief Operating Officer (1a, 1b) Chief Nurse (1c)	<b>Oversight Committee</b>	Finance & Business Performance Committee* Quality & Clinical Governance Committee*	
<b>Inherent Risk</b>	<b>Residual Risk</b>	<b>Risk Appetite</b>	<b>Related Corporate Risk Register Entries</b>		
Impact 4 Likelihood 5 Total Score 20	Impact 3 Likelihood 4 Total Score 12	Minimal-Cautious (2-3)	CRR88	Booking & tracking of patients within Outpatients	
			CRR150	Inappropriate length of stay in Emergency Department	
			CRR161	Non-compliance with 62-day cancer standard	
<b>Last Review</b>	Chief Nurse 13 October 2022 Chief Operating Officer 25 October 2022		CRR162	No interventional radiology service available at BHT	
			CRR164	Backlog of radiology reporting	
<b>Movement in Risk</b>	None				
<b>Strategic Threats</b> <i>What might cause this to happen?</i>	<b>Effect</b> <i>What might the effect be?</i>	<b>Existing Controls</b> <i>How are we managing the risk?</i>	<b>Assurance Record</b> <i>What evidence do we have for the effectiveness of the controls? What level is this assurance?</i>	<b>Action Required</b> <i>Where are our gaps in assurance? What actions are required?</i>	
<b>1a. Reducing long waits</b>					
Inadequate infection, prevention and control due to estates infrastructure  Variation in the productivity of clinical service lines  Inadequate oversight of harm caused by COVID-19 pandemic.  Underutilisation of effective data and Business intelligence.	- Staff resilience. - Clinical, operational, financial and regulatory consequences - Challenging/costly to clean clinical areas effectively. - Potential for hospital acquired infections. - Failure to maximise clinical resources to reduce waiting lists and meet regulatory standards - Harm caused by delayed treatment - Political mistrust/lack of confidence in management.	- Cleaning audits, completed in line with National Standards of Healthcare Cleanliness - Nominated cleaning lead and processes for audit and reporting in line with the requirements of CQC Regulation 15 and Health and Social Care Act Code of Practice - Daily IPC huddles. - Infection control audits (monthly). - Adhoc outbreak meetings. - Quarterly IPC committee. - Optimisation of available capital investment; prioritisation of business cases for maintenance. - PFI investment. - Planned care transformation workstream. - GIRFT reviews. - Productivity metrics. - Flag function on Datix. - Reporting into theatre management group. - Prioritisation of waiting lists by clinical risk and long wait status. - System-wide COVID harms group. - Elective care trajectory monitoring.	- Outputs from relevant meetings (level 1) - Monthly reporting on performance metrics through IPR (1). - Records of deep dives/escalation calls (1). - Cleaning audit reports (1). - Terms of reference and outputs of IPC Committee (2). - Outputs of monthly Capital Management Group (1). - Use of CAFM system (2). - Monthly reporting to Transformation Board (1). - GIRFT reporting/outputs of Board (3). - Theatre dashboard (1). - Audit of appropriateness of risk allocation (1). - Triangulation with Datix reporting (1). - CQC insights report (3). - Dr Foster report (3). - IQVIA report (3). - Maternity safety reports (1).	<b>Action:</b> RTT Improvement Programme – oversight by F&BPC through deep dive programme  <b>Action:</b> Cancer Improvement Plan – oversight by F&BPC through regular cancer reporting  <b>Action:</b> Endoscopy Improvement Programme – oversight by F&BPC through deep dive programme	

		<ul style="list-style-type: none"> <li>- Divisional performance reviews.</li> <li>- Cancer board.</li> <li>- External audits/reviews.</li> <li>- Suite of dashboards to monitor performance.</li> </ul>	<ul style="list-style-type: none"> <li>- Mortality report/learning from deaths (1).</li> <li>- Litigation report (1).</li> <li>- National inpatient survey results (3).</li> <li>- Safeguarding reports (1).</li> <li>- External reviews (3).</li> </ul>	
<b>1b. Providing safe emergency care</b>				
<p>Inability to control demand for services or primary/social care capacity</p> <p>Inability to reform the urgent care pathway</p> <p>Inadequate infection, prevention and control due to estates infrastructure</p>	<ul style="list-style-type: none"> <li>- Overcrowding and extended length of stay within ED.</li> <li>- Ambulance handover delays</li> <li>- Staff resilience.</li> <li>- Clinical, operational, financial and regulatory consequences</li> <li>- Challenging/costly to clean clinical areas effectively.</li> <li>- Potential for hospital acquired infections.</li> <li>- Harm caused by delayed treatment</li> <li>- Political mistrust/lack of confidence in management.</li> </ul>	<ul style="list-style-type: none"> <li>- Incident response structure; Gold/Silver/Bronze.</li> <li>- Site management processes including regular ED huddles</li> <li>- Place-based delivery board.</li> <li>- Place-based escalation protocol, admission avoidance and discharge action plans.</li> <li>- Long stay deep dives</li> <li>- Discharge escalation calls with partners.</li> <li>- Place UEC Board.</li> <li>- Paeds ED development</li> <li>- Cleaning audits, completed in line with National Standards of Healthcare Cleanliness</li> <li>- Nominated cleaning lead and processes for audit and reporting in line with the requirements of CQC Regulation 15 and Health and Social Care Act Code of Practice</li> <li>- Daily IPC huddles.</li> <li>- Infection control audits (monthly).</li> <li>- Adhoc outbreak meetings.</li> <li>- Quarterly IPC committee.</li> <li>- Optimisation of available capital investment; prioritisation of business cases for maintenance work.</li> <li>- PFI investment.</li> <li>- Divisional performance reviews.</li> <li>- External audits and reviews.</li> <li>- Dashboards for performance monitoring.</li> </ul>	<ul style="list-style-type: none"> <li>- Outputs from relevant meetings (level 1)</li> <li>- Outputs from ED huddles (1).</li> <li>- Monthly reporting on performance metrics through IPR (1).</li> <li>- Records of deep dives/escalation calls (1).</li> <li>- Cleaning audit reports (1).</li> <li>- Terms of reference and outputs of IPC Committee (2).</li> <li>- Outputs of monthly Capital Management Group (1).</li> <li>- Use of CAFM system (2).</li> <li>- Monthly reporting to Transformation Board (1).</li> <li>- GIRFT reporting/outputs of Board (3).</li> <li>- CQC insights report (3).</li> <li>- Dr Foster report (3).</li> <li>- IQVIA report (3).</li> <li>- Maternity safety reports (1).</li> <li>- Mortality report/learning from deaths (1).</li> <li>- Litigation report (1).</li> <li>- National inpatient survey results (3).</li> <li>- Safeguarding reports (1).</li> <li>- External reviews (3).</li> </ul>	<p><b>Action:</b> UEC Improvement Plan (COO) – oversight by F&amp;BPC through deep dive programme</p> <p><b>Action:</b> Winter Plan (COO) – oversight by F&amp;BPC through deep dive programme</p> <p><b>Action:</b> MOfD Improvement Plan (COO) – oversight by F&amp;BPC through deep dive programme</p>
<b>1c. Management of risk and clinical governance</b>				
<p>Variation in clinical service lines</p> <p>Organisational governance not always being easy to navigate and enabling of change</p>	<ul style="list-style-type: none"> <li>- Inadequate ward-board assurance.</li> </ul>	<ul style="list-style-type: none"> <li>- Clinical accreditation programme.</li> <li>- Quality audits via Tendable.</li> </ul>	<ul style="list-style-type: none"> <li>- Data reported through Tendable app; reported to Q&amp;PSG/Q&amp;CGC (level 2).</li> </ul>	<p><b>Action:</b> Roll out of clinical accreditation programme including community services (Associate Chief Nurse) – date TBC</p>
			<p>Assurance Level <b>MODERATE</b></p>	

\*See Committee framework for clarity in individual metrics

## 2.2 Strategic Objective 2

<b>Strategic Objective 2</b>		<b>To deliver a financially sustainable plan and improve our benchmarking in model hospital</b>		
<b>Strategic Priority</b>		Provide outstanding, high value care (“Outstanding Care”)		
<b>Principal Risk</b>		2. Failure to deliver our annual financial plan.		
<b>Executive Lead</b>		Chief Finance Officer	<b>Oversight Committee</b>	Finance & Business Performance Committee
<b>Inherent Risk</b>	<b>Residual Risk</b>	<b>Risk Appetite</b>	<b>Related Corporate Risk Register Entries</b>	
Impact 3 Likelihood 5 <b>Total Score 15</b>	Impact 3 Likelihood 4 <b>Total Score 12</b>	<b>Minimal-Cautious (2-3)</b>	CRR154	Delivery of the 2022-23 Financial Plan
			CRR155	Trust capital resourcing insufficient to support objectives
<b>Last Review</b>		Deputy Finance Directors 02 November 2022		
<b>Movement in Risk</b>	None			
<b>Strategic Threats</b> <i>What might cause this to happen?</i>	<b>Effect</b> <i>What might the effect be?</i>	<b>Existing Controls</b> <i>How are we managing the risk?</i>	<b>Assurance Record</b> <i>What evidence do we have for the effectiveness of the controls? What level is this assurance?</i>	<b>Action Required</b> <i>Where are our gaps in assurance? What actions are required?</i>
Underlying organisational financial deficit  Fixed envelope funding model  Lack of long-term financial strategy  Structural financial challenges  Mismatch demand and availability of Trust level capital  Burden of cost from the pandemic  Inflationary pressures	- Negative impact on ICS financial position - Reduced opportunities for service investment - Block contract for locally commissioned services which does not reflect the cost of meeting regulatory standards. - Route to financial security unclear - Inability to deliver strategic plans and maintain activity at required levels. - Loss of opportunities in estates and digital transformation. - Structural change to our business operating model.	- Scrutiny from Finance and Business Performance Committee. - Financial Deep Dives. - Continued search for new financial schemes/income generating proposals. - Annual Cost Improvement Programmes (CIP). DEBBIE. - Proactive engagement with regulators and System colleagues. . - Robust budget setting and monitoring processes. - Continual engagement with NHSI regarding inherent risks. - Continue to seek alternative funding solutions to address the capital funding gap. - Financial governance framework in place. - Monthly review of capital plan by CMG and F&BPC. - Agreed 2022/23 budget, submitted to ICS. - Annual capital plan/programme. - System relationships. - Targeting of productivity opportunities through Model Hospital System and patient level costing data.	- Budget setting and monitoring processes in place (1). - Monthly finance reports (1). - Monthly monitoring of CIPs (1). - Outputs of relevant meetings including minutes of F&BPC (1). - Financial deep dives (2). - Output of divisional review meetings for financial deep dives (2). - Commercial strategy (1) - Meetings between Deputy CFOs and Regional NHSE representative on month end position; output of meeting (3). - Fortnightly system meetings; providers and ICB (3). - Monthly BOB Senior Finance Group CFO meeting outputs (3) - NHSE South East CFO Meeting (3) - 2022/23 budget agreed as part of System Financial Plan (2) - Allocated capital as part of System Financial Plan (3)	Historic issues underpinning organisational deficit to be addressed as part of the negotiation on new sources of funding through the ICB <b>Action:</b> Plan to address the underlying revenue deficit and capital backlog (as part of the Long Term Financial Strategy) (CFO) – Date TBC  Finalisation of longer term financial plan to support medium term financial sustainability <b>Action:</b> Long Term Financial Strategy (CFO) – Date TBC  Ongoing commercial initiatives to increase income and reduce Trust cost. <b>Action:</b> As per Commercial Strategy (oversight through FBPC)  <b>Action:</b> Refresh of financial governance framework (linked to refreshed performance framework) (COO/CFO) – Date TBC

				<p><b>Action:</b> Development of KPIs and financial information being available through Power BI (CDIO) – March 2023</p> <p><b>Action:</b> System transformation programme to address pathways in the most efficient way (TBC) – Date TBC CEO/CFO/CL Groups</p>
			<p>Assurance Level <b>MEDIUM</b></p>	

## 2.3 Strategic Objective 3

<b>Strategic Objective 3</b>		<b>Work with our partners and engage people</b>		
<b>Strategic Priority</b>		Take a leading role in our community (“Healthy Communities”)		
<b>Principal Risk</b>		3. Failure to work effectively and collaboratively with external partners		
<b>Executive Lead</b>		Chief Commercial Officer	<b>Oversight Committee</b>	Trust Board Finance & Business Performance Committee
<b>Inherent Risk</b>	<b>Residual Risk</b>	<b>Risk Appetite</b>	<b>Related Corporate Risk Register Entries</b>	
Impact 4 Likelihood 5 <b>Total Score 20</b>	Impact 3 Likelihood 3 <b>Total Score 9</b>	<b>Open (4)</b>	n/a	n/a
<b>Last Review</b>	Director of Clinical Partnerships 11 October 2022 Chief Commercial Officer 17 November 2022			
<b>Movement in Risk</b>	None			
<b>Strategic Threats</b> <i>What might cause this to happen?</i>	<b>Effect</b> <i>What might the effect be?</i>	<b>Existing Controls</b> <i>How are we managing the risk?</i>	<b>Assurance Record</b> <i>What evidence do we have for the effectiveness of the controls? What level is this assurance?</i>	<b>Action Required</b> <i>Where are our gaps in assurance? What actions are required?</i>
Inability to work with partners to deliver new models of elective care/discharge  Failure to secure necessary infrastructure changes linked to Buckinghamshire growth strategy  Not realising Trust potential as an anchor institution  Failure to align with Council and Partners for ICP Strategy  Local uncertainty	- Missed opportunities to remodel future elective/discharge pathways - Impact on public trust/confidence - Services not aligned to community needs.	- CEO participating in ICS Senior Leaders Group & Chair in ICS Chairs Group. - Integrated Programme Board established; oversees governance of integration work and new model for discharge. - Acute Provider Collaborative (new models of elective care) - New arrangements for Integrated Partnership Board (joint CEO for decision making) - Pathology Network - Thames Valley Radiology Network; chaired by BHT Dir. - Access to proposals for housing developments including responses in terms of health impact - Bucks ICP Estates Group. - Involvement with Bucks dev. plans. - Playing an active role in community; support for local voluntary and community groups to foster engagement.	- MoU in place for Provider Collaborative (3). - Outputs of Partnership Board and Programme Board (3). - MoU in place for Pathology Board, Trusts signed up to LOAs (3). - Annual report for Thames Valley Network. MoU and LOAs in place. Signed up to workforce strategy (3). - Regional funding secured by networks and disseminated to Trusts (3). Database access & outputs (3). - One Public Estate Strategy (2). - Outputs of System meetings (2). - Contracts and specifications (2). - PPEDI group records (2).	Collaborative development of S106 policy with Bucks Council. <b>Action:</b> Confirm date/owner  Awaiting local plans <b>Action:</b> ICP strategy (Dec 2022) ICB strategic delivery plan (Mar 2023)
			<b>ASSURANCE LEVEL HIGH</b>	

## 2.4 Strategic Objective 4

<b>Strategic Objective 4</b>		<b>Ensure children get the best start in life</b>		
<b>Strategic Priority</b>		Take a leading role in our community ("Healthy Communities")		
<b>Principal Risk</b>		4. Failure to provide consistent access to high quality care for Children and Young People (CYP)		
<b>Executive Lead</b>		Chief Nurse	<b>Oversight Committee</b>	Quality & Clinical Governance Committee
<b>Inherent Risk</b>	<b>Residual Risk</b>	<b>Risk Appetite</b>	<b>Related Corporate Risk Register Entries</b>	
Impact 5 Likelihood 5 <b>Total Score 25</b>	Impact 4 Likelihood 3 <b>Total Score 12</b>	<b>Minimal-Cautious (2-3)</b>	n/a	(risk within Divisional Risk Register under consideration for escalation)
<b>Last Review</b>	Director of Clinical Partnerships 11 October 2022 Chief Nurse 13 October 2022			
<b>Movement in Risk</b>	None			
<b>Strategic Threats</b> <i>What might cause this to happen?</i>	<b>Effect</b> <i>What might the effect be?</i>	<b>Existing Controls</b> <i>How are we managing the risk?</i>	<b>Assurance Record</b> <i>What evidence do we have for the effectiveness of the controls? What level is this assurance?</i>	<b>Action Required</b> <i>Where are our gaps in assurance? What actions are required?</i>
Inability to reform paediatric urgent care pathway  No urgent care pathway in community paed  Inability to recruit appropriately skilled/qualified clinical staff  Insufficient funding available  Demand from schools for educational input from health  Waiting times for community paediatrics and therapy services; potential for harm	- Services do not provide care in a timely and affordable manner	- Director of Transformation for Community Services in place for adults (and children's therapies) - Scrutiny of Children and Young People (CYP) community services by QCGC Committee. - SEND written statement of action, scrutinised by CQC and OFSTED. - Scrutiny by Commissioners (monthly). - Move to MDT working model. - SDU Lead in place. - Deputy Divisional Director in place directly working with CYP. - Recruitment of full-time pharmacist and 0.6 wte GP	- Outputs of relevant meetings (level 1). - SEND report (3). - SEND action plan, oversight by QCGC (2).	<b>Action:</b> Review of acceptance and triage criteria, clinics, admin and JDs (Director of Clinical Partnerships) – update April 2023; 12 month plan.  Lack of estates plan for therapies accommodation at SMH
			<b>ASSURANCE LEVEL MEDIUM</b>	

## 2.5 Strategic Objectives 5 & 6

<b>Strategic Objective 5</b>	<b>Use population health analytics to reduce health inequalities and improve outcomes in major disease</b>			
<b>Strategic Objective 6</b>	<b>Improve the wellbeing of communities</b>			
<b>Strategic Priority</b>	Take a leading role in our community ("Healthy Communities")			
<b>Principal Risk</b>	5. Failure to support improvements in local population health and a reduction in health inequalities			
<b>Executive Lead</b>	Chief Digital Information Officer	<b>Oversight Committee</b>	Finance & Business Performance Committee	
<b>Inherent Risk</b>	<b>Residual Risk</b>	<b>Risk Appetite</b>	<b>Related Corporate Risk Register Entries</b>	
Impact 3 Likelihood 4 <b>Total Score 12</b>	Impact 3 Likelihood 3 <b>Total Score 9</b>	<b>Open (4)</b>	n/a	n/a
<b>Last Review</b>	Chief Digital Information Officer 10 November 2022			
<b>Movement in Risk</b>	None			
<b>Strategic Threats</b> <i>What might cause this to happen?</i>	<b>Effect</b> <i>What might the effect be?</i>	<b>Existing Controls</b> <i>How are we managing the risk?</i>	<b>Assurance Record</b> <i>What evidence do we have for the effectiveness of the controls? What level is this assurance?</i>	<b>Action Required</b> <i>Where are our gaps in assurance? What actions are required?</i>
Inequalities in access to care  Failing to use integrated care records and data to manage population health	- Continued growth of the health inequality gap - Preventative health strategies and clinical services not aligned to community needs	- Equality impact assessments. - Index of Multiple Deprivation data. - Patient and Public Equality Diversity and Inclusion (PPEDI) group. - Use of protected characteristics/geography in reporting for e.g. complaints/serious incidents. - Waiting list delivery assessment by ethnicity. - Access to Shared Care Record (SCR). - Reporting/benchmarking on population health management.	- EQIA policy (level 1). - EQIA documents within service change/business cases (level 1). - PPEDI review of EQIA process (level 2). - Deprivation & ethnicity reporting within monthly IPR (level 1). - Meeting notes/actions from PPEDI meetings (level 1). - Public health reporting/benchmarking (level 3). - Patient Experience annual report (level 1). - SCR utilisation reports (level 2). - Public health reporting (level 3). - HWB Place-based strategy (level 3).	Consistency in completion of EQIA.  Capability to analyse population health reports.  Facilitation of simple access to SCR for clinicians.  Cohesive ICS strategy on use of population health data to manage patient care and support strategic decision making.  Clear understanding of link between Trust actions and outcomes
			<b>ASSURANCE LEVEL MEDIUM</b>	

## 2.6 Strategic Objective 7

<b>Strategic Objective 7</b>		<b>Deliver our people priorities</b>			
<b>Strategic Priority</b>		Ensure our workforce are listened to, safe and supported ("A Great Place to Work")			
<b>Principal Risk</b>		6. Failure to deliver on our people priorities related to recruitment & resourcing, culture & leadership, supporting our staff, workforce planning & development and productivity.			
<b>Executive Lead</b>		Chief People Officer	<b>Oversight Committee</b>	Strategic People Committee	
<b>Inherent Risk</b>	<b>Residual Risk</b>	<b>Risk Appetite</b>	<b>Related Corporate Risk Register Entries</b>		
Impact 4 Likelihood 4 <b>Total Score 16</b>	Impact 4 Likelihood 3 <b>Total Score 12</b>	<b>Minimal (2)</b>	CRR159	Shortage of nursing staff; registered and unregistered	
			CRR160	Shortage of registered midwives	
			CRR157	Staff absences due to COVID-19 (for removal from CRR)	
<b>Last Review</b>	Chief People Officer 21 November 2022	CRR126	Impact of staff health and wellbeing from COVID-19 pandemic (for removal from CRR)		
<b>Movement in Risk</b>	None				
<b>Strategic Threats</b> <i>What might cause this to happen?</i>	<b>Effect</b> <i>What might the effect be?</i>	<b>Existing Controls</b> <i>How are we managing the risk?</i>	<b>Assurance Record</b> <i>What evidence do we have for the effectiveness of the controls? What level is this assurance?</i>	<b>Action Required</b> <i>Where are our gaps in assurance? What actions are required?</i>	
Insufficient levels of qualified, experienced staff and training opportunities.  Cost of living (nationally)  Pandemic related negative impact on morale, wellbeing and retention  Variations in organisational culture and behaviours  Workforce not always feeling the organisation is safe  Organisation is not always inclusive and does not always treat people equally	- Retention challenges - High levels of temporary staffing. - Low staff resilience and wellbeing negatively contributing to engagement, productivity, happiness at work and potentially the quality of care provided - Higher than optimal levels of bullying - Negative impact on staff engagement and productivity - Reputational damage. - Consequential impact on patients care.	- Trust-wide recruitment plans in place (international, national and grow-your-own). - Bucks Health & Social Care Academy facilitating non-medical career pathways. - NHS Professionals partnership contract to support bank fill rather than agency. - Regional system programme to develop sustainable system approach to management of temporary staffing - BOB ICS Senior Leadership Group. - Staff reporting of sickness through First Care, monitored by OH. - Trust sickness absence management policy. - Comprehensive vaccination programme. - Comprehensive support package via Thrive@BHT. - FTSUG outreach model. - Regular JMISC meetings. - Monthly ED&I committee including staff network chairs. - Opportunities for staff to feel listened to; listening meetings. - FTSUG including outreach model. - Health & Safety Committee provides opportunity for staff feedback. - WRES and WDES actions. - Staff networks in place. - Involvement of unions in policy development.	- Monthly reporting on vacancy rates through IPR (level 1). - International recruitment programme reported through Transformation Programme (level 1). - Divisional performance reports including bank and agency spend (level 1). - Contract management with NHSP to ensure quality of temporary staff (level 2). - Firstcare reporting (level 2). - FTSUG reporting (level 2). - GOSWH reporting (level 2). - Uptake of Thrive reports (SPC) (level 1). - Annual staff survey (level 3). - Quarterly Pulse survey (level 2). - Monthly reporting through Transformation Board (level 1). - Outputs of relevant meetings (level 1). - Risk registers (level 2). - WRES/WDES action plans (level 2). - PSED annual reports (level 3). - EQIAs (level 2). - Papers to SWC and Board (level 1). - Staff survey (level 3). - Gender Pay Gap reporting (level 1). - ICS People Strategy (level 2). - Safe staffing reports; (level 1).	National shortage of registered nurses <b>Action:</b> Recruitment workstreams (see CRR)  Inequal experience for BAME colleagues <b>Action:</b> As per WRES action plans; monitored through SWC  Difference in experience across the Trust - Identified through Staff Survey; feeds into Divisional Risk Registers where appropriate.	
			<b>ASSURANCE LEVEL MEDIUM</b>		

## 2.7 Strategic Objective 8

<b>Strategic Objective 8</b>		<b>Our buildings and facilities will be great places to work and contribute to the health and wellbeing of staff</b>			
<b>Strategic Priority</b>		Ensure our workforce are listened to, safe and supported ("A Great Place to Work")			
<b>Principal Risk</b>		7. Failure to provide adequate buildings and facilities. a) Estates b) Digital			
<b>Executive Lead</b>		Chief Commercial Officer (Estates) Chief Digital Information Officer (Digital)	<b>Oversight Committee</b>	Finance & Business Performance Committee* Strategic Workforce Committee*	
<b>Inherent Risk</b>	<b>Residual Risk</b>	<b>Risk Appetite</b>	<b>Related Corporate Risk Register Entries</b>		
Impact 4 Likelihood 4 <b>Total Score 16</b>	Impact 4 Likelihood 4 <b>Total Score 16</b>	<b>Cautious (3)</b>	CRR147	Risk of disruption to Trust technology through cyber incidents	
			CRR27B	SMH main HV/LV electrical supply	
			CRR130	Wycombe Tower concrete panels	
<b>Last Review</b>	Chief Digital Information Officer 10 November 2022 Chief Commercial Officer 17 November 2022		CRR156	Wycombe Tower; suitability for provision of healthcare	
			CRR158	Interior condition of ward 2a	
			CRR131	Failure of critical bleeps at Wycombe & Amersham Hospitals	
<b>Movement in Risk</b>	None				
<b>Strategic Threats</b> <i>What might cause this to happen?</i>	<b>Effect</b> <i>What might the effect be?</i>	<b>Existing Controls</b> <i>How are we managing the risk?</i>	<b>Assurance Record</b> <i>What evidence do we have for the effectiveness of the controls? What level is this assurance?</i>	<b>Action Required</b> <i>Where are our gaps in assurance? What actions are required?</i>	
<b>7a. Estates</b>					
Lack of capital  Ageing estates	- Low compliance with regulatory requirements - Staff leave due to feeling unsafe. -	- Estates and Net Zero Strategy - Clinical strategy - CMG - QFM – prioritise through this. - PFI contracts; facilities management - Accommodation strategy -	- Annual reports; H&S, Fire, Security (level 1). - Property services report (level 1). - PAM report (level 2). - Strategy updates (level 1). - Minutes of CMG (level 1). - Compliance with legislation (level 2). - PLACE assessments (level 3) - Model Health System (level 3) - ERIC returns (level 3) - H&S Dashboard (level 2)	Significant backlog maintenance within the estate	
<b>7b. Digital</b>					
Digital immaturity leading to service disruption and preventing wider service transformation  Lack of detailed intelligence to drive quality improvement initiatives	- Low compliance with regulatory requirements - Continued reliance on paper based/manual information flows - Lack of data limits potential improvements	- DSPT audit. - Extensive existing IT stabilisation programme - IT Performance monitoring.	- Reporting against DSPT to EMC, FBPC and Board quarterly (level 2). - Digital strategy in place (level 1). - Outputs from relevant meetings (level 1). - EPR readiness review (level 3).	Gaps in infrastructure and unsupported systems.  Digital Strategy requires updating. <b>Action:</b> Revised Digital Strategy; workshop planned for November 2022 (CDIO)	
			<b>ASSURANCE LEVEL MEDIUM</b>		Stabilisation of IT infrastructure and modernisation of apps to be completed. <b>Action:</b> (CDIO)

## 2.8 Strategic Objective 9

<b>Strategic Objective 9</b>		<b>Maximise opportunities for improving, sharing good practice and learning</b>		
<b>Strategic Priority</b>	Ensure our workforce are listened to, safe and supported ("A Great Place to Work")			
<b>Principal Risk</b>	8. Failure to learn, share good practice and continuously improve.			
<b>Executive Lead</b>	Chief Medical Officer	<b>Oversight Committee</b>	Quality & Clinical Governance Committee	
<b>Inherent Risk</b>	<b>Residual Risk</b>	<b>Risk Appetite</b>	<b>Related Corporate Risk Register Entries</b>	
Impact 3 Likelihood 4 <b>Total Score 12</b>	Impact 3 Likelihood 3 <b>Total Score 9</b>	<b>Open 4</b>	n/a	n/a
<b>Last Review</b>	Head of Quality – 15 November 2022			
<b>Movement in Risk</b>	None			
<b>Strategic Threats</b> <i>What might cause this to happen?</i>	<b>Effect</b> <i>What might the effect be?</i>	<b>Existing Controls</b> <i>How are we managing the risk?</i>	<b>Assurance Record</b> <i>What evidence do we have for the effectiveness of the controls? What level is this assurance?</i>	<b>Action Required</b> <i>Where are our gaps in assurance? What actions are required?</i>
Gaps in learning following incidents or against best practice  Not being an organisation where innovation and new ideas can always thrive and be easily adapted	<ul style="list-style-type: none"> <li>- Missed opportunities to improve patient outcomes/experience.</li> <li>- Non-systematic approach to learning.</li> <li>- Inefficiencies, processes not completed in a timely manner, erosion of desire to innovate and improve.</li> <li>- Inadequate foresight of organisational risk.</li> <li>- Inability to transform care and clinical models in a way that is fit for the future.</li> </ul>	<ul style="list-style-type: none"> <li>- Reflect and Review learning forum (monthly)</li> <li>- Monthly reporting on Serious Incidents</li> <li>- Nursing Learning forum</li> <li>- Patient safety meeting (monthly)</li> <li>- Upgraded Datix risk management platform</li> <li>- Analysis of Datix reports (weekly, monthly)</li> <li>- Weekly review panel for Serious Incidents</li> <li>- Board and Committee workplan.</li> <li>- Benchmarking.</li> <li>- Board and Committee structures.</li> <li>- Review of governance framework.</li> <li>- Innovation centre; hub for R&amp;I teams and space for teams to come together and share good practice.</li> <li>- Digital infrastructure upgrades.</li> <li>- Roll out of QI programme.</li> </ul>	<ul style="list-style-type: none"> <li>- SI reports, meeting minutes and actions (level 1).</li> <li>- Meeting notes/actions from patient safety meeting (level 1).</li> <li>- Outputs of relevant meetings (level 1).</li> <li>- Outcomes of external reviews (level 3).</li> <li>- External governance report (level 3).</li> <li>- R&amp;I Strategy (level 1).</li> <li>- QI plans (level 1).</li> <li>- Quality Strategy (level 1).</li> <li>- R&amp;I Annual Report (level 1).</li> </ul>	<p>Inability for Datix to identify trends within reporting (not possible on upgraded version)</p> <p>Clarity of organisational and governance structures <b>Action:</b> Review of governance structures (Deputy Chief Nurse) – Date TBC</p> <p><b>Action:</b> Corporate Governance section on CAKE; repository for information (Trust Board Business Manager) – 30 November 2022</p> <p>New 'Reflect and Review' forum <b>Action:</b> Evaluate effectiveness (Quality Improvement Lead) – 30 November 2022</p>
			<b>ASSURANCE LEVEL MEDIUM</b>	

### 3.0 Emerging Risks; Board & Board Committees

Month	Meeting	Risks Noted
Sept 2022	Audit	<ul style="list-style-type: none"> <li>- Head of Internal Audit (HOIA) opinion for 2022-23 with continued partial assurance opinions noting recommendations from such reports improve practices across the Trust.</li> <li>- Deterioration of Wycombe Tower noting work ongoing on a decant plan (BAF Risk 7).</li> <li>- Cybersecurity both locally and related to the recent cyberattack on Advanced clinical systems resulting in downtime of Trust eFinancial platform (BAF Risk 7).</li> <li>- Pharmacy losses noting these may be exaggerated due to additional stock ordered during the pandemic.</li> </ul>
	F&BP	<ul style="list-style-type: none"> <li>- Level of uncertainty and risk over the coming winter months and impact on people and performance, noting work ongoing on a draft winter resilience plan for publication in October 2022 (BAF Risk 1).</li> <li>- Significant and widespread staffing challenges; affecting multiple services and groups of colleagues (BAF Risk 6)</li> <li>- Risks to overall £17m deficit plan including (BAF Risk 2): <ul style="list-style-type: none"> <li>o Significant rise in energy prices.</li> <li>o Predicted winter pressures and associated increased spend.</li> </ul> </li> <li>- Requirement for capital (BAF Risk 2).</li> <li>- Robustness of contract management and accountability processes.</li> <li>- Significant ongoing risks related to current Wycombe Tower estate (BAF Risk 7).</li> </ul>
	Q&CG	<ul style="list-style-type: none"> <li>- Nursing (10.3%) and midwifery (25%) vacancy rates; vacancies currently being filled using temporary staffing noting improvement trajectory for midwifery staffing (BAF Risk 6)</li> <li>- Pending winter pressures with potential impact on nursing staffing and subsequently on quality metrics (BAF Risk 1)</li> <li>- Partial compliance with the Maternity Incentive Scheme (CNST) with potential financial implication of non-compliance and challenges in the sustainability of current workload for maternity teams; noting plans to recruit a dedicated member of staff to support the assurance function.</li> </ul>
	SPC	<ul style="list-style-type: none"> <li>- Cost of living and the impact on our people (BAF Risk 6).</li> <li>- Aggression aimed at our people both in the Community and on our sites.</li> </ul>
	Public Board	<ul style="list-style-type: none"> <li>- Inflationary pressures including energy prices and volatility in the market (BAF Risk 2).</li> <li>- Impact of cost of living on colleagues noting the package of support which has been welcomed by the Board.</li> <li>- Increased complexity of patients within our care and the impact of this on our people (BAF Risk 6).</li> <li>- The increase in incidents of violence and aggression towards colleagues with a need to revise the organisational approach to this.</li> <li>- Delivery of our CIP programme and specific risks within this noting those mitigations in place (BAF Risk 2).</li> <li>- Interventional radiology service (CRR).</li> <li>- Potential of industrial action over the autumn months.</li> </ul>
	Private Board	<ul style="list-style-type: none"> <li>- Potential litigation from HOHA COVID-19 cases with no centralised guidance in place.</li> </ul>

Oct 2022	F&BP	<ul style="list-style-type: none"> <li>- Risk to overall £17m deficit financial plan including (BAF Risk 2): <ul style="list-style-type: none"> <li>o Mitigations yet to be developed; c£15m clinical and c£4m corporate, noting some improvement since M05.</li> <li>o Predicted winter pressures and potential associated increased spend.</li> <li>o Significant potential for extending the final deficit position by c£7m.</li> </ul> </li> <li>- Current cancer performance (BAF Risk 1).</li> </ul>
	Q&CG	<ul style="list-style-type: none"> <li>- Results of the Clinical Harm Review process and incidences of harm related to delays (BAF Risk 1).</li> <li>- Concerns regarding lack of robust documentation identified by the PEWS audit, ?reflective of wider issues with documentation.</li> <li>- Respiratory viruses; early presentation of seasonal flu coupled with ongoing COVID-19 cases.</li> </ul>
	Public Board	<ul style="list-style-type: none"> <li>- Current cancer performance against the 62-day target (BAF Risk 1).</li> <li>- National vacancy rates for some professional groups, for example nursing and social workers (BAF Risk 6).</li> <li>- Pending winter pressures following sustained operational pressure throughout the year so far (BAF Risk 1).</li> <li>- Unknown impact of potential industrial action.</li> <li>- Risks to the financial plan noting c£15m of mitigations require development to achieve our planned year end position (BAF Risk 2).</li> <li>- Rising levels of violence and aggression from members of the public.</li> </ul>
	Private Board	None escalated

For those risks highlighted in the above table, the table overleaf pulls together actions held by the Board Committees where these have been set to address these risks.

Risk(s)	Action Details	Committee Matrix	Action Owner	Due Date
Head of Internal Audit (HOIA) opinion for 2022-23 with continued partial assurance opinions noting recommendations from such reports improve practices across the Trust.	Comprehensive and pragmatic approach to the management of long dated actions (ref. 1377)  Continue with internal audit plan 2022/23	Audit	Trust Board Business Manager	12 Jan 2023 (next review)
Pharmacy losses noting these may be exaggerated due to additional stock ordered during the pandemic	Continued monitoring/oversight by the Committee	Audit	Chief Finance Officer	12 Jan 2023 (next review)
Robustness of contract management and accountability processes	Multiple actions regarding contracts covering; oversight, regular review, scheduling within workplan (ref. 1359, 1358, 1328, 1290)	F&BP	Chief Finance Officer Chief Operating Officer Trust Board Business Manager	As per individual actions
Partial compliance with the Maternity Incentive Scheme (CNST) with potential financial implication of non-compliance and challenges in the sustainability of current workload for maternity teams; noting plans to recruit a dedicated member of staff to support the assurance function	Continued monitoring/oversight by the Committee; quarterly maternity safety reports	Q&CG	Chief Nurse	21 Dec 2022 (next review)
Aggression aimed at our people both in the Community and on our sites  The increase in incidents of violence and aggression towards colleagues with a need to revise the organisational approach to this  Rising levels of violence and aggression from members of the public	Revised organisation approach to be considered and presented to Board regarding increasing complexity of and aggression from patients (ref: 1367)  Senior HR Team to consider this item for the risk register	Public Board  SPC	Chief Nurse  Chief People Officer	29 Mar 2023  14 Nov 2022 (completed)
Potential of industrial action over the autumn months  Unknown impact of potential industrial action	Ongoing updates to EMC, SPC and Board	Public Board	Chief People Officer	As required

Potential litigation from HOHA COVID-19 cases with no centralised guidance in place	Proactive engagement with NHSE/NHSR in conjunction with regional Medical Director colleagues (ref: 1354)	Public Board	Chief Medical Officer	26 Oct 2022 (completed)
Concerns regarding lack of robust documentation identified by the PEWS audit, ?reflective of wider issues with documentation	Bi-annual documentation audit	Q&CG	Chief Nurse	15 Mar 2023
Respiratory viruses; early presentation of seasonal flu coupled with ongoing COVID-19 cases	Continued monitoring/oversight by the Committee	Q&CG	Chief Nurse	13 Dec 2022 (next review)

#### 4.0 Action required from the Board / Committee

The Board is requested to:

- a) Review the range of risks and use the information to inform strategic decision making.
- b) Consider the assurances in place, identifying gaps in controls/assurances and challenge these accordingly, identifying further actions required as appropriate.
- c) Review the emerging risks identified at Board and Board Committee meetings and consider reflection of these within the current BAF and CRR, paying attention to those not within these frameworks and the actions in place to mitigate.

## 6.0 Heatmap – Residual Risk

<b>Catastrophic (5)</b>					
<b>Major (4)</b>			<p>4. Failure to provide consistent access to high quality care for Children and Young People (CYP)</p> <p>6. Failure to deliver on our people priorities</p>	<p>7. Failure to provide adequate buildings and facilities.</p>	
<b>Moderate (3)</b>			<p>3. Failure to work effectively and collaboratively with external partners</p> <p>5. Failure to support improvements in local population health and a reduction in health inequalities</p> <p>8. Failure to learn, share good practice and continuously improve</p>	<p>1. Failure to provide care that consistently meets or exceeds performance and quality standards.</p> <p>2. Failure to deliver annual financial and activity plans</p>	
<b>Minor (2)</b>					
<b>Negligible (1)</b>					
	<b>Rare (1)</b>	<b>Unlikely (2)</b>	<b>Possible (3)</b>	<b>Likely (4)</b>	<b>Almost Certain (5)</b>

## **7.0 Risk Appetite Statement**

*Buckinghamshire Healthcare NHS Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners.*

*The Trust has the lowest tolerance for risks that materially impact on the safety of our patients and colleagues and we will not accept these. We recognise that decisions about our level of exposure to risk must be taken in context but are committed to a proactive approach. We have a greater appetite for risk where we are persuaded there is potential for benefit to patient outcomes/experience, service quality and/or value for money. The Trust has the greatest appetite to pursue innovation and challenge current working practices where such positive gains can be anticipated whilst operating within appropriate governance arrangements and regulatory constraints.*

*Where we engage in risk strategies, we will ensure they are actively monitored and managed and would not hesitate to withdraw our exposure if benefits fail to materialise. Our risk appetite statement is dynamic and its drafting is an iterative process that reflects the challenging environment facing the Trust and the wider NHS. The Trust Board will review the risk appetite statement annually.*

## 8.0 Risk Matrix

	<b>Consequence Score (severity levels) and examples of descriptors</b>				
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Domains</b>	<b>Negligible</b>	<b>Minor</b>	<b>Moderate</b>	<b>Major</b>	<b>Catastrophic</b>
<b>Impact on the safety of patients, staff or public (physical / psychological harm)</b>	Minimal injury requiring no/minimal intervention or treatment.  No time off work	Minor injury or illness, requiring minor intervention  Requiring time off work for >3 days  Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention  Requiring time off work for 4-14 days  Increase in length of hospital stay by 4-15 days  RIDDOR/agency reportable incident  An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability  Requiring time off work for >14 days  Increase in length of hospital stay by >15 days  Mismanagement of patient care with long-term effects	Incident leading to death  Multiple permanent injuries or irreversible health effects  An event which impacts on a large number of patients
<b>Quality/complaints/audit</b>	Peripheral element of treatment or service suboptimal  Informal complaint/inquiry	Overall treatment or service suboptimal  Formal complaint (stage 1)  Local resolution  Single failure to meet internal standards  Minor implications for patient safety if unresolved  Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness  Formal complaint (stage 2) complaint  Local resolution (with potential to go to independent Review)  Repeated failure to meet internal standards  Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved  Multiple complaints/independent review  Low performance rating  Critical report	Totally unacceptable level or quality of treatment/service  Gross failure of patient safety if findings not acted on  Inquest/ombudsman inquiry  Gross failure to meet national standards
<b>Human resources/organisational development/staffing/ competence</b>	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/service due to lack of staff  Unsafe staffing level or competence (>1 day)  Low staff morale  Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff  Unsafe staffing level or competence (>5 days)  Loss of key staff  Very low staff morale  No staff attending mandatory/key training	Non-delivery of key objective/service due to lack of staff  Ongoing unsafe staffing levels or competence  Loss of several key staff  No staff attending mandatory training /key training on an ongoing basis

<b>Statutory duty/ inspections</b>	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
<b>Adverse publicity/ reputation</b>	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
<b>Business objectives/ projects</b>	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
<b>Finance including claims</b>	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
<b>Service/business interruption Environmental impact</b>	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

RISK SCORING MATRIX					
	Severity				
Likelihood	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	Board Committee Effectiveness
<b>Board Lead</b>	Joanna James, Trust Board Business Manager
<b>Type name of Author</b>	Joanna James, Trust Board Business Manager
<b>Attachments</b>	Committee Effectiveness Action Plan
<b>Purpose</b>	Assurance
<b>Previously considered</b>	n/a

### Executive Summary

On an annual basis, Board Committees are required to undertake a self-assessment regarding Committee effectiveness. This paper outlines the process by which this was completed and a summary action plan. The collective results of surveys were considered by the relevant Committee who approved the recommendations. The actions within Appendix I will be monitored through individual Committee action matrices going forwards.

<b>Decision</b>	The Board is requested to note the recommendations to improve Board Committee effectiveness and take assurance from the action plan in place.
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### Relevant Strategic Priority

<b>Outstanding Care</b> ☒	<b>Healthy Communities</b> ☒	<b>Great Place to Work</b> ☒	<b>Net Zero</b> ☒
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### Implications / Impact

<b>Patient Safety</b>	A sound and effective framework of governance supports an environment within which high quality safe healthcare can be delivered
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	BAF Risk 8 – Failure to learn, share good practice and continuously improve
<b>Financial</b>	Good governance is the foundation of strong financial performance
<b>Compliance CQC Standards Good Governance</b>	Good governance in healthcare is considered to be a system whereby NHS organisations are accountable for continuous improvement and safeguarding high standards of performance
<b>Partnership: consultation / communication</b>	The action plan has been written in conjunction with Board Committee members
<b>Equality</b>	In order to embed ED&I within the organisational culture, this should be considered at Board level. Initial surveys were sent to members and regular attendees to ensure a broad range of views and opinions were considered.
<b>Quality Impact Assessment [QIA] completion required?</b>	No – n/a

## **1 Introduction**

On an annual basis, all NHS Provider Board Committees are required to undertake an annual self-assessment of effectiveness which has been completed this year through an anonymous survey to Committee members and regular attendees.

Based on the results of these surveys, initial recommendations were presented to each Committee. Once discussed and approved, these were collated and form the basis of the action plan attached.

## **2 Board Committees**

The following were included within the self-assessment process:

- a) Audit Committee (results discussed November 2022)
- b) Finance and Business Performance Committee (results discussed July 2022)
- c) Quality and Clinical Governance Committee (results discussed July 2022)
- d) Strategic People Committee (results discussed September 2022)

A template questionnaire by the Healthcare Financial Management Association (HFMA) was utilised for the Audit Committee survey whilst guidance from the Chartered Governance Institute formed the basis for the surveys for b) – d).

## **3 Action Plan**

The table in Appendix 1 provides further information on those recommendations agreed by the Committees. Actions will be monitored through individual Committee action matrices.

## **4 Conclusions and Next Steps**

The process for the next annual review of Committee effectiveness will be built into the annual workplan for 2023-24.

## **5 Action required from the Board/Committee**

The Board is requested to take assurance from the actions underway to improve Committee effectiveness.

Committee Effectiveness Action Plan

Finding	Relevant Committee	Recommendation	Committee Decision	Action Owner	Target Date	Status
<b>Terms of Reference (ToR)</b>						
Lack of clarity regarding review and approval of ToR.	Strategic People Committee (SPC)	Review and approve ToR	Agreed	Trust Board Business Manager	14/11/2022	Approved by Committee subject to minor amendments. For ratification by Trust Board.
	Finance & Business Performance Committee (FBPC)	Review and approve ToR	Agreed	Trust Board Business Manager	09/12/2022	In progress
		ToR for the Electronic Patient Record (EPR) Oversight Group	Agreed	EPR Programme Director	13/12/2022	In progress
	Quality & Clinical Governance Committee (Q&CGC)	Review and approve ToR	Agreed	Trust Board Business Manager	13/12/2022	In progress
Committee objectives	Audit Committee	Clear set of Committee objectives	Agreed	Trust Board Business Manager	12/01/2023	In progress
<b>Meeting Papers</b>						
Late circulation of meeting papers	Strategic People Committee (SPC)	(a) Quality standards for publication of meeting papers and process for considering late papers with Committee Chair  (b) Retrospective audit of late papers; individual meetings with relevant Executive lead for consistently late submissions	Agreed	(a) Trust Board Business Manager	(a) 31/12/2022	(a) To be included within the Meeting Standard Operating Procedure (SOP) - in progress  (b) To be completed
	Quality & Clinical Governance Committee (Q&CGC)			(b) EA Team	(b) 09/12/2022	
	Finance & Business Performance Committee (FBPC)					
Quality of meeting papers	Finance & Business Performance Committee (FBPC)	Confirm template/standard for meeting papers including Executive Director review and sign off process	Agreed	Trust Board Business Manager	31/12/2022	To be included within the Meeting SOP - in progress
		Regular bitesize report writing training sessions	Agreed	Chief Operating Officer/ Trust Board Business Manager	31/03/2023	To be included within the Operational Excellence Programme - programme in development
Specific paper findings	Finance & Business Performance Committee (FBPC)	Review of Monthly Finance Report	Agreed	Deputy Finance Director	22/11/2022	Complete (action 1327)
Standard of presentations to Committee (by invitees)	Finance & Business Performance Committee (FBPC)	Provide introduction and standard guidance to presenters to Committees	Agreed	Trust Board Business Manager	31/12/2022	To be included within the Meeting SOP - in progress
	Quality & Clinical Governance Committee (Q&CGC)					
<b>Committee Membership</b>						
Number of NED members	Strategic People Committee (SPC)	Review of membership; additional NED member	Agreed	Trust Chair/ Trust Board Business Manager	14/11/2022	Complete
<b>Training Needs</b>						
Survey responses suggestive of unmet training needs	Strategic People Committee (SPC)	In view of limited detail provided; conduct a training needs analysis and factor in relevant training to Committee workplans	Agreed	Trust Board Business Manager	31/01/2023	In progress
	Quality & Clinical Governance Committee (Q&CGC)					
<b>Audit Committee</b>						
Data quality	Audit Committee	Consider addition to internal audit plan for 2023/24	Not agreed - internal audit confirmed Data Quality considered as part of all internal audit reports	n/a	n/a	n/a
Changes in Accounting Standards		Schedule training session for Committee members	Agreed	Trust Board Business Manager	31/03/2023	In progress
Lack of clarity regarding visibility of key documents		Circulate to Committee members: - Formal charter defining roles & responsibilities of IA - Notification of RSM compliance with Public Sector IA Standards - Confirmation of GT independence	Agreed - Committee had been sighted on documents but requested re-circulation of these	Trust Board Business Manager	25/11/2022	Complete
Management of actions		Maintained focus by Executive Management Committee and Audit Committee	Agreed	Chair of Audit Committee	12/01/2023	Regular monitoring through scheduled Audit Committee meetings
Timing of Meetings		Timings on agenda	Circulation of comments and questions ahead of meeting to facilitate preparedness of Executive Team	Agreed	Trust Board Business Manager	04/11/2022
		Committee Members			12/01/2023	In progress

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	Net Zero - Carbon Audit		
<b>Board Lead</b>	Chief Commercial Officer		
<b>Type name of Author</b>	Commercial Director		
<b>Attachments</b>	Carbon Audit		
<b>Purpose</b>	Information		
<b>Previously considered</b>	EMC 08.11.2022 F&BP 22.11.2022		

### Executive Summary

To progress the NHS ambition to become Carbon net Zero by 2040, the Trust published its Net Zero Roadmap in 2021. This paper provides the first audit of progress against plan. We have delivered a reduction of circa 360 tonnes of carbon since the original 2019 assessment but is currently behind on the trajectory as included in its Roadmap, by 1,540 tonnes. This is because some activities are pushing carbon output upwards, whilst some of the improvements made to reduce carbon are offsetting these, causing overall output levels to decline and not achieve the reductions as much as would be anticipated.

Carbon reduction gets harder to deliver the more efficient an organisation becomes. This challenge is made harder by the fact that the Trust is only fully in control of circa 20% of its emissions, 60% being influenceable, and 20% not yet able to be removed, but requiring either future solutions to be found or offsetting. Completion of current in train projects: the Energy Infrastructure Project at Wycombe, the conversion to LED lighting at SMH, and go live on the Waste Removal Project inclusive of anaerobic digester and treatment plant, will recover back to trajectory, albeit with some time slippage. However, to remain on plan, carbon emissions are required to be reduced by 10% by 2024. The Finance and Business Performance Committee (F&BPC) noted this audit as an emerging risk, given the level of reduction is behind plan, but received assurance that plans are in progress over the coming 12 months to address this.

In addition to F&BPC this paper was considered by the Executive Management Committee on 8 November 2022. The Committee recognised the importance of the net zero agenda and the impact of individual behaviours as well as the need for collaborative working both nationally and regionally. The Trust were noted to ahead of regional colleagues with both an approved and audited roadmap and the anaerobic waste digester although progress was slightly behind plan. Work to quantify the impact of the reduction in travel between sites was requested as well as to equate cost and carbon. The need to employ a lead for coordinating all relevant workstreams was raised, particularly in view of the statutory requirements related to the net zero agenda and the Committee requested the Chief Commercial Officer consider how this could be funded.

<b>Decision</b>	The Board is requested to note the Carbon Audit.
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### Relevant Strategic Priority

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

<b>Patient Safety</b>	The move to zero carbon will aid better health outcomes with regard respiratory diseases.
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	No specific risk.
<b>Financial</b>	Delivery of Zero Carbon will have a significant financial cost.

<b>Compliance CQC Standards Good Governance</b>	The NHS has committed to be Carbon Zero by 2040.
<b>Partnership: consultation / communication</b>	All partners and stakeholders understand the commitment to move to zero net carbon.
<b>Equality</b>	The Trust is committed to fair treatment of all patients, service users, visitors and staff, regardless of age, colour, disability, ethnicity, gender, nationality, race, religion or belief, sexual orientation or any other personal characteristics.
<b>Quality Impact Assessment [QIA] completion required?</b>	Not required.

## 1 Introduction/Position

The NHS has committed to net zero emissions for the care they provide (the NHS Carbon Footprint) by 2040, and zero emissions across their entire scope of emissions (the NHS Carbon Footprint Plus) by 2045. The base year for measurement is 1990, and subsequent reductions are measured against this baseline, with 80% required to be delivered by 2032.

The Trust published a Net Zero strategy and Carbon Zero Roadmap in 2021, utilising 2019 carbon output data, and set itself targets on a four-year cycle. The initial period required an annual reduction of 10% against 1990 baselines by 2024. This was received by the region as an exemplar programme and the Trust is being recognised for its innovative approaches, particularly within the estate. BHT also now chairs the BOB net zero programme as part of the ICB.

The pandemic significantly impacted carbon output and now that a more stabilised operational environment is back, an audit has been undertaken to assess the changes in carbon output over the last two-years and establish where the trust is in relation to its zero carbon roadmap.

## 2 Problem / Issues

The demand on healthcare and thus units of activity delivered are ever increasing, and the methods of delivery becoming ever more technologically based and complex. The number of medical devices has increased over the two-year audit period with increases in diagnostic devices, many coming online in response to the pandemic, but the carbon impact has been high with output increasing in this area by circa 50%. The increasing digitisation and spend in IT has similarly increased carbon output in this intervention category by circa 300 tonnes. These elements combined are pushing carbon output upwards, and thus some of the improvements made to reduce carbon are offsetting these, causing overall output levels to decline and not achieve the reductions as much as would be anticipated.

Implementing carbon beneficial solutions often has a cost initially with potential savings later, but also some improvements increase the usage of other carbon producing elements, ahead of alternative energy sources being available, i.e. heat pumps burn more electricity but do help reduce gas consumption. (Electricity being cleaner than gas, but more expensive.)

Some intervention areas fluctuate year on year depending upon specific activity undertaken, for example in the audit period the trust has built a new Innovation Centre, and is building a Paediatric A&E, and as such construction carbon output has increased from 122 tonnes in 2019 to 919 tonnes in 2021. Included in this increase also will be the construction of the Energy Infrastructure Project at Wycombe aimed at de-steaming the site and converting to LED lighting to reduce future carbon output.

Some intervention projects take time to drive actual reduction, with the Wycombe Energy Infrastructure Project for example having a 20-month implementation programme.

Updated carbon factors for 2021 were used to calculate the emissions for the majority of categories compared with the 2019 exercise, such as electricity, water, medicines, medical devices, non-medical devices, construction and business services. These carbon factors were obtained from certified government sources. This approach allowed for a more accurate carbon calculation but will have impacted the overall progress made. In addition, it was also identified that an error had occurred in the 2019 data with regard level of kWh gas consumption.

### 3 Progress to date

With the combined elements that are pushing carbon output upwards, plus the updated carbon factors and recalculation, the 2021 carbon footprint of the trust has been calculated at **42,768** tonnes of CO<sub>2</sub> per annum, which is a decrease of **359** tonnes compared to the 2019 data.

This is **1,540** tonnes higher than the figure required to align with the roadmap to Net Zero emissions for the trust. However, this is a net effect and without the schemes that have been put in place to date, the carbon output would have risen more significantly.

The key changes are below

-  Emissions from Natural Gas consumption have increased slightly (from 7,767 tonnes to 8,349 tonnes). Increases in gas consumption from the 3 main hospitals has been the driver of this.
-  Medical Gas usage has increased which has subsequently increased carbon emissions from this category.
-  Anaesthetics usage has decreased which has subsequently decreased carbon emissions from this category.
-  An increase in the catalogue and non-catalogue spend on medicines and medical devices has increased carbon emissions from these categories.
-  Emissions from electricity have reduced due to a reduction in usage and a reduction in the carbon factor of electricity. All hospital sites apart from SMH and Chalfont have decreased their use.

In 2019, a total of 2,809,193 kg of CO<sub>2</sub>e were produced from using medical gases throughout the Trust, contributing to 6.51% of the overall emissions. This value was forecasted to increase slightly due to slight increases in the Buckinghamshire population. Emissions did increase to 3,275,807 kg of CO<sub>2</sub>e in 2021 contributing to 7.7% of the overall emissions.

Regarding Anaesthetics, the significant reduction in desflurane usage has had a large impact in reducing emissions from this category. Emissions have reduced by ~70% from 2019 to 2021 which is much quicker than expected. The specific changes in anaesthetic usage and the associated carbon emissions are below:

- Desflurane – 86.2 litres were used in 2019 which equated to 318,222 kg of CO<sub>2</sub>e. However, in 2021, 16.08 litres were used, equating to 59,362 kg of CO<sub>2</sub>e.
- Isoflurane – 2.3 litres were used in 2019 equating to 1,748 kg of CO<sub>2</sub>e. No isoflurane was used in 2021.
- Sevoflurane – 275.3 litres were used in 2019 equating to 53,959 kg of CO<sub>2</sub>e. In 2021, the amount of Sevoflurane used increased to 304 litres equating to 59,584 kg of CO<sub>2</sub>e.

The Estate Strategy is delivering on the plan to evacuate and demolish old and inefficient buildings such as Building 3 at SMH and Dashwood at Wycombe, and these improvements are yet to feed into reduced carbon output / energy usage.

A decarbonisation delivery plan is being developed that assesses building by building the action required, and provisional costs associated with delivery. This will help shape not only the Estate

Strategy in terms of site rationalisation, but also future Public Sector Decarbonisation Scheme bids to secure funding to invest in improved and more carbon efficient infrastructure.

BHT have signed up to the **NHS Plastics Pledge**, a commitment along with our PFI partners to reduce single use plastics where possible. The Trust has delisted most commonly used single use consumables eg plastic cutlery from its supply catalogue.

The Trust swapped all sterile and non-sterile gowns to reusable during Covid, as part of an NHS wide trial, which has been continued owing to its' operational success, but has also reduced single use material consumption.

The trust is working with BOB Carbon Zero Group and various satellite project workstreams such as the Thames Valley Sustainable Operating Pathways, looking at reducing and cleaning medical gas usage and the potential elimination of nitrous oxide etc

#### **4 Key recommendations and next steps.**

Emissions from Natural Gas will significantly reduce as the trust electrifies its buildings and installs more heat pumps. A number of projects are ongoing within the trust to move from gas to electric heat pumps. It is recommended that these projects continue and extend across all trust buildings.

The energy efficiency of the buildings also needs to be improved in line with the targets set out within the net zero carbon roadmap (Clinical Areas to target 150 kWh/m<sup>2</sup>/year & Non-clinical areas to target 70 kWh/m<sup>2</sup>/year).

Emissions from medical gas usage have the potential to be decreased following changes in practice to reduce the amount of Nitrous Oxide usage, as well as improvements in the efficiency of scavenging and recovery systems.

To achieve net zero by 2040, The Trust will need to bridge the gap more rapidly to get back on track to deliver the planned annual reduction. This represents a reduction of circa 2,300 per annum, 460 tonnes of which are deemed under the direct control of the Trust, 1,380 influenceable, and 460 tonnes at this point subject to future technological advancements or offsetting. Given a key focus will be on activities that we will need to influence at regional level, it is recommended that the Trust appoint a sustainability manager to co-ordinate and deliver the accelerated plans that we now need to achieve.

It is also recommended that executives incorporate their net zero GEMBA walks in December to concentrate on visiting areas where we the most carbon reduction in the next 12 months could be achieved, for example waste, nitrous oxide and single use plastics reduction in theatres, digital outpatients.

#### **5 Action required from the Board/Committee**

The Board is requested to note the Carbon Audit.

Net Zero Roadmap - Carbon Footprint  
Audit  
2021 Data Review



<b>Project Name</b>	<b>Net Zero Roadmap - Carbon Footprint Audit</b>
	[Title]
<b>Description</b>	Carbon Footprint 2021 Data Audit
<b>Ref. No.</b>	NHS-NZI-CFA-00
<b>Issue</b>	02
<b>Revision</b>	02
<b>Date</b>	02 Nov 2022
<b>Prepared by</b>	Beatriz Fernandes
<b>Reviewed by</b>	Sam Luker
<b>Approved by</b>	Phillipa Grant
	<i>AESG has prepared this report in accordance with the instructions of their Client for their sole and specific use. Any other persons who use any information contained herein do so at their own risk.</i>



# Contents

- 1 Introduction ..... 4**
- 1.1 Background & Context.....4
- 1.2 Purpose.....4
- 1.3 Scope & Boundary .....4
- 2 Methodology..... 5**
- 2.1 Calculation & Validation .....5
- 2.2 Updated Carbon factors .....6
- 3 Preceding Work..... 8**
- 4 Current data..... 11**
- 4.1 Review against projections .....12
- 5 Review ..... 13**
- 5.1 Scope 1.....13
  - 5.1.1 *Category 1 Natural Gas*.....13
  - 5.1.2 *Category 2 Anaesthetics*.....15
  - 5.1.3 *Category 3 Staff Business Travel* .....16
  - 5.1.4 *Category 4 Medical Gases*.....16
- 5.2 Scope 2.....17
  - 5.2.1 *Electricity*.....17
- 5.3 Scope 3.....19
  - 5.3.1 *Category 1 Embodied Carbon Medicines* .....19
  - 5.3.2 *Category 2 Embodied Carbon of Food & Catering* .....20
  - 5.3.3 *Category 3 Water Consumption*.....21
  - 5.3.4 *Category 4 Embodied Carbon of Business Services* .....22
  - 5.3.5 *Category 5 Embodied Carbon of Non-Medical Equipment* .....23
  - 5.3.6 *Category 6 Embodied Carbon of Metered Dose Inhalers* .....24
  - 5.3.7 *Category 7 Embodies Carbon of Medical Devices* .....26
  - 5.3.8 *Category 8 Embodies Carbon of ICT Equipment*.....27
  - 5.3.9 *Category 9 Embodies Carbon of Construction*.....27
  - 5.3.10 *Category 10 Transmission/distribution and Well to Tank* .....28
  - 5.3.11 *Category 11 Waste*.....29
  - 5.3.12 *Category 12 Patient & Visitor Travel*.....30
  - 5.3.13 *Category 13 Employee Commuting*.....31
  - 5.3.14 *Category 14 Commissioned Health Services outside NHS*.....32
  - 5.3.15 *Category 15 Other*.....32
- 6 Ongoing projects & Initiatives..... 34**
- 7 Recommendations ..... 36**



# 1 Introduction

## 1.1 Background & Context

The NHS's carbon emissions are currently equivalent to 4% of England's total carbon footprint of which the Buckinghamshire Healthcare NHS Trust is a contributor. Over the last 10 years, the NHS as a whole has implemented measures to reduce its impact on climate change, which will also lead to benefits in the clinical outcomes. The NHS has committed to net zero emissions for the care they provide (the NHS Carbon Footprint) by 2040, and zero emissions across their entire scope of emissions (the NHS Carbon Footprint Plus) by 2045.

## 1.2 Purpose

As part of BHT's aim for decarbonisation and drive towards Net Zero, the trust is committed to monitoring carbon emissions and keeping track of the decarbonisation progress. The purpose of this Carbon Audit is to ascertain the impact of the work undertaken between the initial Net Zero Carbon Roadmap and today, and to provide feedback and recommendations moving forward. This check in process allows the trust to identify priority areas and allocate where necessary work needs to be carried out.

This audit calculated the Scope 1, 2 and 3 carbon emissions of the trust for the year 2021, comparing against the previous data from 2019. It also analyses how accurate the forecasted emissions estimations were, to improve and adjust the forecasting methods in the future.

## 1.3 Scope & Boundary

This report analyses the carbon emissions for the following Hospitals and health facilities under the Buckinghamshire Healthcare NHS Trust:

- Amersham Hospital
- Stoke Mandeville Hospital
- Wycombe Hospital
- Alexandra house
- Brookside Clinic



- Chalfonts & Gerrards Cross Community Hospital
- Chichester House
- Marlow Community Hospital and Health Centre
- Oakridge Centre
- Rayners Hedge Rehabilitation Unit
- Thame Community Hospital and Annex

## 2 Methodology

### 2.1 Calculation & Validation

As per the previous audit process, a complete evaluation of the BHT carbon footprint was conducted to calculate the carbon emissions for the year 2021. This was carried out using a two-way approach, combining 'bottom-up' validation (drawing on a range of inputs from BHT, including local travel, buildings and medicines data) with 'top-down' modelling (drawing on financial activity data). This is described in more detail in the subsequent 'Methodology' section of this document.

The information was gathered through a series of workshops and meetings with different parts of the trust to ensure that all the available data was captured and that it was suitably validated.

The BHT carbon footprint was quantified for the categories outlined within the scope of this report in table 1. Emissions within scopes 1, 2, and 3, as well as 'out of scope' patient and visitor travel emissions, from 1990 to 2020. The estimates blend:

- Location-generic (top-down) results for categories that can only be measured in economic terms, or that are too complex to model physically. Financial information is combined with environmentally extended input output (EEIO) carbon intensities per unit spend (kgCO<sub>2</sub>e/£).
- Product and location-specific (bottom-up) results for categories that can be measured and described physically. Organisational data collections of activity (units of energy, waste, travel miles, etc) are combined with carbon factors from BEIS.



## Bottom-up Projections

For categories that can be measured and described physically (bottom-up), historical trends and known interventions have been used to create independent assumptions for each category of emissions. Both activity (changes in energy use, travel, spend, etc) and carbon intensities are combined to produce a forecast of emissions for each year to 204970.

## Top-down Projections

For categories that can only be measured in economic terms, expenditure has been modelled in line with Office for National Statistics (ONS) and Office for Budget Responsibility (OBR) published projections of health expenditure and the BHT proportion of this in England has been calculated using known expenditure figures. The data collected was applicable across varying annual periods, with some data such as gas and electricity consumption available for numerous years, and other data only available for a couple of years (medical gases). Therefore, scenarios were modelled to understand the emissions from the BHT over the entire study period, going back to the 1990 baseline (backcasting), as well as forward towards 2040 (forecasting).

### 2.2 Updated Carbon factors

Updated carbon factors for 2021 were used to calculate the emissions for the majority of categories compared with the 2019 exercise, such as electricity, water, medicines, medical devices, non-medical devices, construction and business services. These carbon factors were obtained from certified government sources. This approach allowed for a more accurate carbon calculation, for example, by using different carbon factors for the different medical devices used and summing the total emissions for that category. Other carbon factors were updated in 2021 and thus needed adjustments in the updated calculations.



Table 1: Methodology for data collection and projecting for all categories

Category	Bottom-up or Top-down	Source	Actual Data
<b>Scope 1</b>			
<u>Cat 1 – Fossil Fuel Combustion</u>	Bottom-up	Gas consumption	2021
<u>Cat 2 – Anesthetics</u>	Bottom-up	Anesthetic consumption	2021
<u>Cat 3 – Staff Business Travel</u>	Bottom-up	Vehicle fuel consumption	2021
<u>Cat 4 – Medical Gases</u>	Bottom-up	Medical gas consumption	2021
<b>Scope 2</b>			
<u>Cat 1 – Electricity</u>	Bottom-up	Electricity consumption	2021
<b>Scope 3</b>			
<u>Cat 1 – Medicines</u>	Top-down	Total £ Spent	2021
<u>Cat 2 – Food &amp; Catering</u>	Top-down	Total £ Spent	2021
<u>Cat 3 – Water Consumption</u>	Bottom-up	Water consumption	2021
<u>Cat 4 – Business Services</u>	Top-down	Total £ Spent	2021
<u>Cat 5 – Manufacturing</u>	Top-down	Total £ Spent	2021
<u>Cat 6 – Metered Dose Inhalers</u>	Bottom-up	Inhaler prescription data	2021
<u>Cat 7 – Medical Devices</u>	Top-down	Total £ Spent	2021
<u>Cat 8 – ICT Equipment</u>	Top-down	Total £ Spent	2021
<u>Cat 9 – Construction</u>	Top-down	Total £ Spent	2021
<u>Cat 10 – WTT</u>	Bottom-up	Fuel and electricity consumption	2021
<u>Cat 11 – Waste</u>	Bottom-up	Waste consumption	2021
<u>Cat 12 – Patient &amp; Visitor Travel</u>	% contribution towards carbon footprint has been aligned with overall NHS carbon assessment.		
<u>Cat 13 – Employee Commuting</u>	Bottom-up	Leased vehicle fuel consumption	2021
<u>Cat 14 – Health Services commissioned outside NHS</u>	Top-down	Total £ Spent	2021
<u>Cat 15 – Other</u>	Top-down	Total £ Spent	2021



### 3 Preceding Work

Following on from the NHS' Net Zero declaration, BHT previously commissioned AESG the development of a Net Zero Carbon roadmap and a Heat Decarbonization Plan to address the decarbonization challenges.

The Net Zero Roadmap outlined the trust's strategy for reducing emissions to zero by 2040. To understand the carbon footprint of the trust and set out a roadmap to reduce emissions in line with the targets set out within the NHS' overarching net zero roadmap, the carbon footprint for the 3 main hospitals within the trust (Stoke Mandeville, Amersham & Wycombe) as well as a number of community hospitals was calculated as part of this roadmapping exercise. BHT is a typical trust within the NHS, whereby the majority of the emissions calculated are associated with the supply chain (Scope 3 emissions), as well as significant quantity associated with the running of the estate, shown in Table 2 and Figure 1. The forecasted impact of all the Roadmaps' smart aims upon the total BHT carbon footprint are illustrated on Figure 2.

Subsequently, 2 Heat Decarbonization Plans have been carried out, outlining the condition of the BHT's estate, the amount of energy consumption and the trust's plans for reducing and/or decarbonising its energy use. The plan outlines what the trust has already done, what it is currently doing, and what it plans to do in the future. It explained what actions are going to be taken, over what timescales, and the intended outcomes. The trust has undertaken a number of projects between 2019 and 2021, outlined in further detail on the 'ongoing project' section of this report.



Table 2: Tonnes of Carbon emissions by category of the BHT's carbon footprint in 2019

	Category	Tonnes CO2e	% contribution
Scope 1 Cat 1	Natural Gas	7,767	18.01%
Scope 1 Cat 2	Anaesthetics	374	0.87%
Scope 1 Cat 3*	Staff Business Travel	1,640	3.8%
Scope 1 Cat 4*	Medical Gases	2,809	6.51%
Scope 2	Electricity	5,703	13.22%
Scope 3 Cat 1	Medicines	1,066	2.47%
Scope 3 Cat 2	Food & Catering	79	0.18%
Scope 3 Cat 3	Water Consumption	232	0.54%
Scope 3 Cat 4	Business Services	2,138	4.96%
Scope 3 Cat 5	Non-Medical Equipment	1,822	4.22%
Scope 3 Cat 6	Metered Dose Inhalers	213	0.49%
Scope 3 Cat 7	Medical Devices	4,017	9.32%
Scope 3 Cat 8	ICT Equipment	2,225	5.16%
Scope 3 Cat 9	Construction	122	0.28%
Scope 3 Cat 10	WTT	2,158	5%
Scope 3 Cat 11	Waste	107	0.25%
Scope 3 Cat 12	Patient & Visitor Travel	1,950	4.52%
Scope 3 Cat 13	Employee Commuting	2,220	5.15%
Scope 3 Cat 14	Commissioned Health Services outside NHS	4,983	11.55%
Scope 3 Cat 15	Other	1,501	3.48%
<b>TOTAL</b>		<b>43,126</b>	<b>N/A</b>

Figure 1: Sources of carbon emissions by proportion of the BHT's carbon footprint in 2019

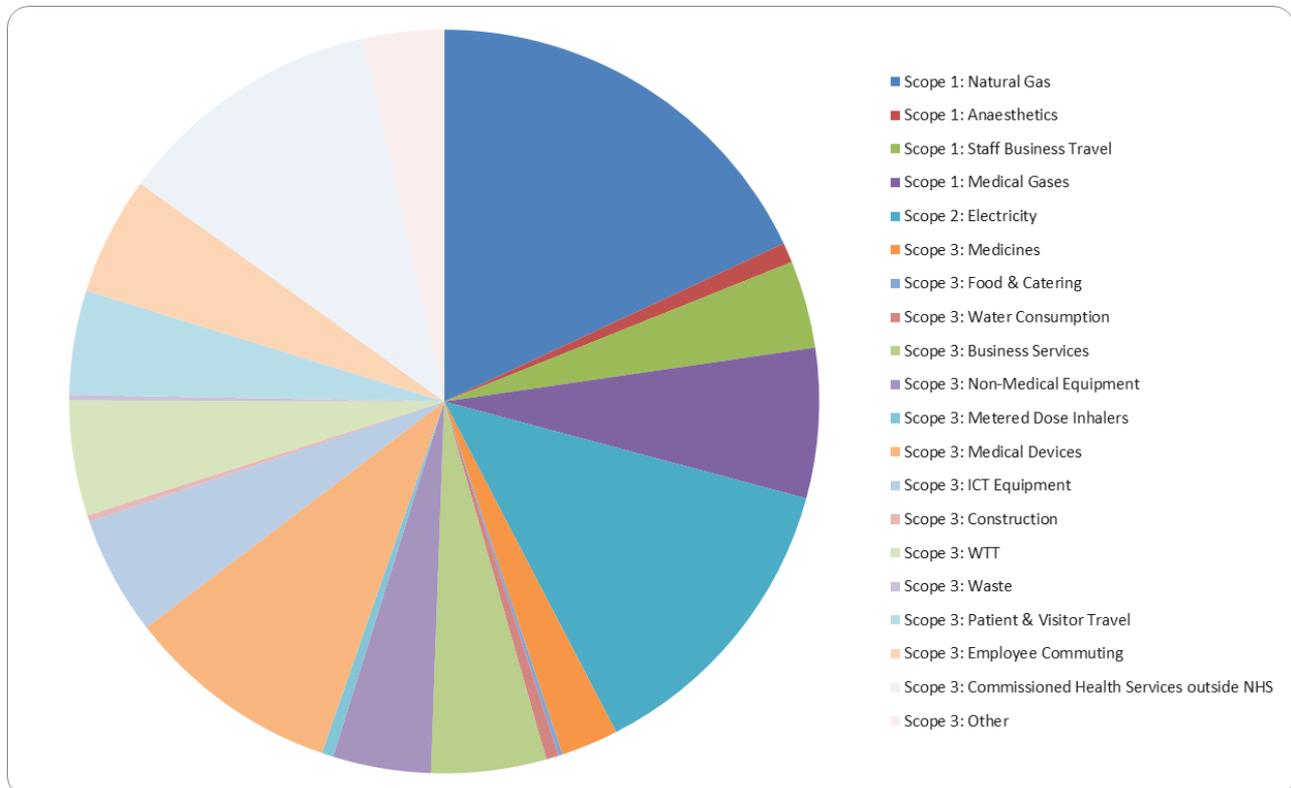
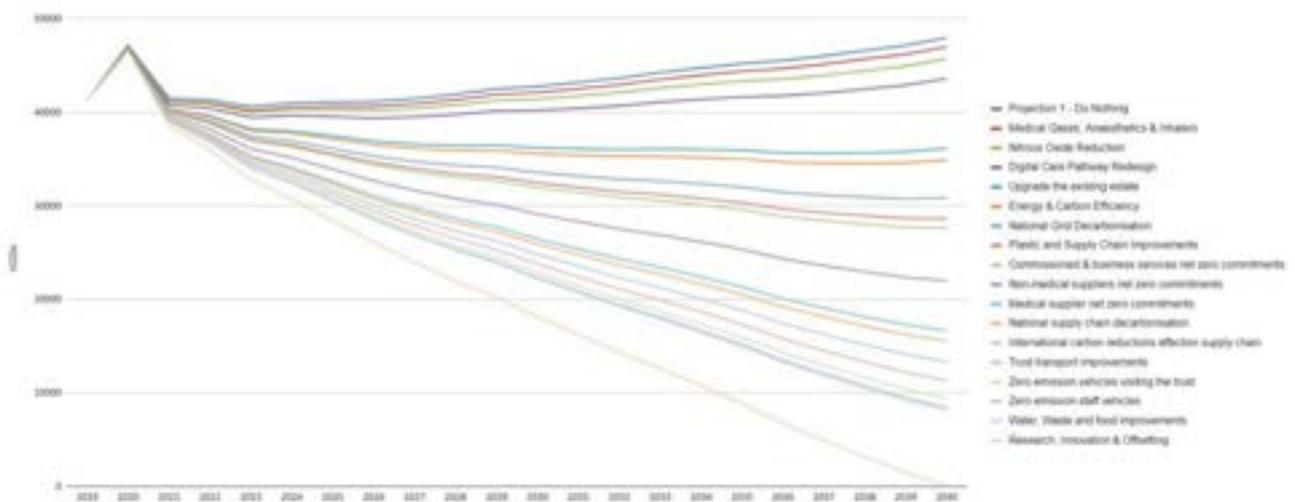




Figure 2: Illustrating the impact of all the smart aims upon the total BHT carbon footprint





## 4 Current data

The tables and figures below detail the results from the 2021 carbon audit process. Table 3 illustrates the proportion of carbon emissions for all of the different categories assessed for the trust. As in 2019, the areas emitting the largest quantities of carbon are in the supply chain, estates and facilities, medical gases and medical devices. These areas therefore also offer the biggest opportunity – or challenge – for change. However, certain categories such as transport and electricity have shown marked reductions in carbon emissions. Figure 3 below provides further illustration of the proportion of carbon emissions for all the different categories assessed for BHT.

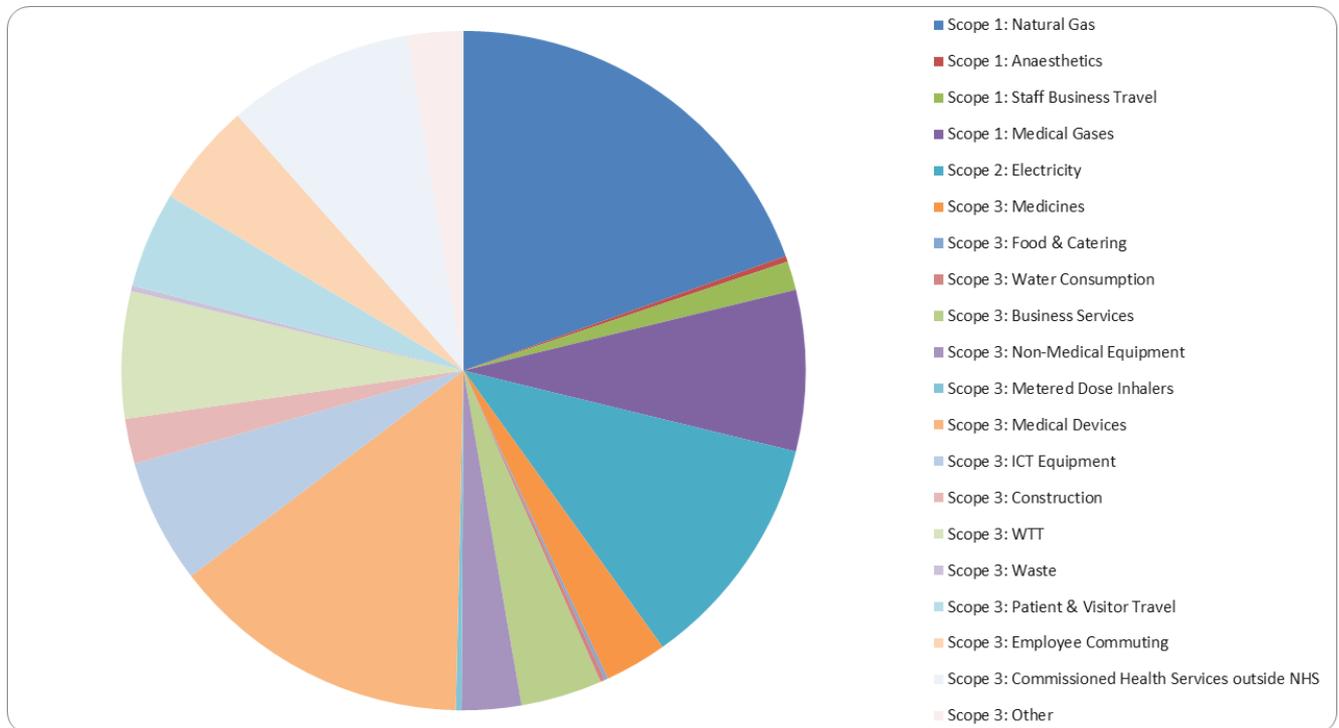
The 2021 carbon footprint of the trust has been calculated at **42,768** tonnes of CO<sub>2</sub> per annum, which is a decrease of **359** tonnes compared to the 2019 data. It is an increase of **1,217** tonnes compared to projected figures for 2021 calculated as part of the previous exercise (without initiatives). Furthermore, it is **1,540** tonnes higher than the figure required to align with the pathway to Net Zero emissions for the trust.

*Table 3: Tonnes of Carbon emissions by category of the BHT's carbon footprint in 2021*

	Category	Tonnes CO <sub>2</sub> e	% contribution
Scope 1 Cat 1	Natural Gas	8,349	19.5%
Scope 1 Cat 2	Anaesthetics	119	0.3%
Scope 1 Cat 3*	Staff Business Travel	586	1.4%
Scope 1 Cat 4*	Medical Gases	3,276	7.7%
Scope 2	Electricity	4,828	11.3%
Scope 3 Cat 1	Medicines	1,262	3%
Scope 3 Cat 2	Food & Catering	63	0.1%
Scope 3 Cat 3	Water Consumption	98	0.2%
Scope 3 Cat 4	Business Services	1,644	3.8%
Scope 3 Cat 5	Non-Medical Equipment	1,198	2.8%
Scope 3 Cat 6	Metered Dose Inhalers	116	0.3%
Scope 3 Cat 7	Medical Devices	6,117	14.3%
Scope 3 Cat 8	ICT Equipment	2,529	5.9%
Scope 3 Cat 9	Construction	919	2.1%
Scope 3 Cat 10	WTT	2,587	6%
Scope 3 Cat 11	Waste	109	0.3%
Scope 3 Cat 12	Patient & Visitor Travel	1,950	4.6%
Scope 3 Cat 13	Employee Commuting	2,111	4.9%
Scope 3 Cat 14	Commissioned Health Services outside NHS	3,773	8.8%
Scope 3 Cat 15	Other	1,136	2.7%
<b>TOTAL</b>		<b>42,768</b>	<b>N/A</b>



Figure 3: Sources of carbon emissions by proportion of the BHT's carbon footprint in 2021



#### 4.1 Review against projections

There have been reductions in several categories across the trust, and overall the emissions have decreased. The key changes are outlined below:

- Emissions from Natural Gas consumption have increased slightly (from 7,767 tonnes to 8,349 tonnes). Increases in gas consumption from the 3 main hospitals has been the driver of this.
- Medical Gas usage has increased which has subsequently increased carbon emissions from this category. 
- An increase in the catalogue and non-catalogue spend on medicines and medical devices has increased carbon emissions from these categories.
- Emissions from electricity have reduced due to a reduction in the carbon factor of electricity.



## 5 Review

### 5.1 Scope 1

#### 5.1.1 Category 1 Natural Gas

In 2019, Natural Gas contributed 18.01% for the overall carbon emissions of the Hospitals and medical facilities under the Buckinghamshire Healthcare NHS Trust, with 7,767,173 kg of CO<sub>2</sub> emissions. This value increased to 8,349,170 kg CO<sub>2</sub> in 2021, contributing to 19.5% of the overall emissions. The change in emissions is shown in figure 4 below. Gas consumption increased across all of the 3 main hospitals, however, the largest increase is from Wycombe Hospital.

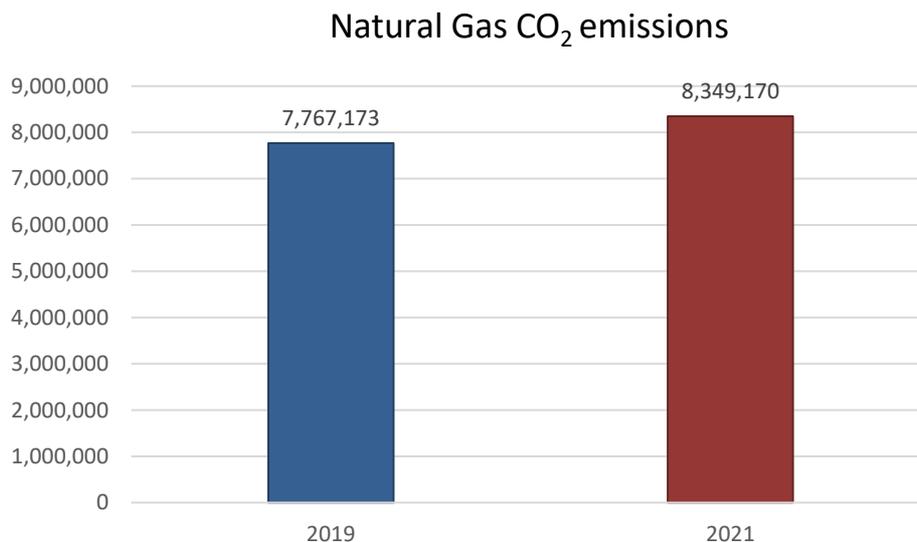


Figure 4: Carbon emissions for Natural Gas in kg, for 2019 and 2021.

- **Amersham Hospital** - The retained natural gas (35%) consumption in 2019 was 1,075,558 kWh, which was estimated to slightly decrease to 1,057,737 kWh in 2021. However, usage increased to 1,189,695 kWh for 2021. The PFI natural gas (65%) consumption in 2019 was 1,997,464 kWh, which was estimated to slightly decrease in 2021 to 1,964,369 kWh. However, usage increased to 2,209,434. The total natural gas used in 2019 was 3,073,022 kWh, which was estimated to decrease to 3,022,106 kWh for 2021. However, usage increased to 3,399,129 kWh.



- **Stoke Mandeville Hospital** - The total natural gas used in 2019 was 21,351,309 kWh, which was estimated to decrease to 21,351,309 kWh for 2021. However, usage increased to 21,522,196 kWh in 2021.  
**Wycombe Hospital**- The retained natural gas (78%) consumption in 2019 was 11,560,288 kWh, estimated to increase to 14,832,618 kWh in 2021 following an increase in gas usage in 2020. Gas consumption increased to 14,136,064 kWh for 2021. The PFI natural gas (22%) consumption in 2019 was 3,260,595 kWh, which was estimated to increase to 4,183,560 kWh in 2021. Gas consumption increased to 3,987,096 kWh for 2021. The total natural gas used in 2019 was 14,820,883 kWh, which was estimated to increase to 19,016,178 kWh for 2021. However, consumption increased less than predicted, to 18,123,160 kWh.
- **Alexandra house** - The total natural gas used in 2019 was 24,114 kWh, estimated to remain the same in 2021.
- **Brookside Clinic** - The total natural gas consumption in 2019 was 490,673 kWh, which decreased to 438,051 kWh.
- **Chalfonts & Gerrards Cross Community Hospital** - The total natural gas consumed in 2019 was 725,542 kWh, which decreased to 593,077 kWh.
- **Chichester House** - The total natural gas used in 2019 was 83,766 kWh, which decreased to 38,338 kWh.
- **Marlow Community Hospital and Health Centre** - The total natural gas consumption in 2019 was 332,019 kWh, which increased to 364,737.54 kWh.
- **Oakridge Centre** - The total natural gas consumed in 2019 was 390,977 kWh, which increased slightly to 391,093 kWh.
- **Rayners Hedge Rehabilitation Unit** - The total natural gas consumed in 2019 was 276,667 kWh, which decreased to 204,092 kWh.
- **Thame Community Hospital and Annex** - The total natural gas consumed in 2019 was 375,623 kWh, which decreased to 314,257 kWh.
- **Thame Annex** - The total natural gas consumed in 2019 was 42,223 kWh, which increased slightly to 44,118 kWh in 2021.



### 5.1.2 Category 2 Anaesthetics

The use of anaesthetics across all hospitals and health facilities under the Buckinghamshire Healthcare NHS Trust contributed to 0.87% of the overall emissions in 2019 with a total carbon footprint of 373,928 kg of CO<sub>2</sub>. This value was forecasted to increase slightly to 381,444 kg of CO<sub>2</sub> in 2021, however, the 2021 data showed that emissions decreased to 118,946 kg of CO<sub>2</sub>, contributing to 0.3% to the overall emissions.

The decrease in emissions is evidence of the trust's efforts to reduce emissions from anaesthetics. The significant reduction in desflurane usage has had a large impact in reducing emissions from this category. Emissions have reduced by ~70% from 2019 to 2021 which is much quicker than expected.

The specific changes in anaesthetic usage and the associated carbon emissions are shown in figure 4 and detailed below:

- Desflurane – 86.2 litres were used in 2019 which equated to 318,222 kg of CO<sub>2</sub>e. However, in 2021, 16.08 litres were used, equating to 59,362 kg of CO<sub>2</sub>e.
- Isoflurane – 2.3 litres were used in 2019 equating to 1,748 kg of CO<sub>2</sub>e. No isoflurane was used in 2021.
- Sevoflurane – 275.3 litres were used in 2019 equating to 53,959 kg of CO<sub>2</sub>e. In 2021, the amount of Sevoflurane used increased to 304 litres equating to 59,584 kg of CO<sub>2</sub>e.

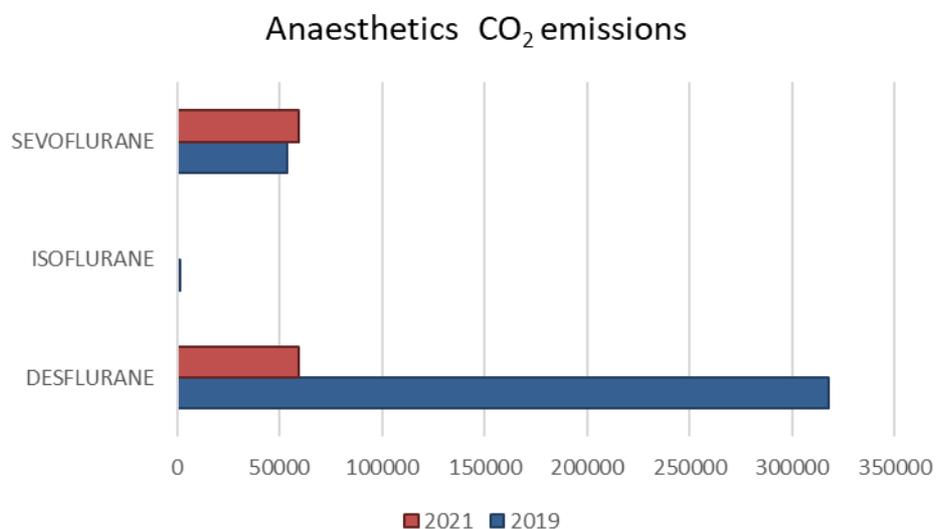


Figure 4: Carbon emissions development of Sevoflurane, Isoflurane and Desflurane, for 2019 and 2021 in kg.



### 5.1.3 Category 3 Staff Business Travel

Due to a lack of data in 2019, a percentage contribution towards the overall carbon footprint was aligned with overall NHS carbon assessment. However, data was obtained for 2021, illustrating that 586 tonnes of carbon were emitted (1.4% contribution).

### 5.1.4 Category 4 Medical Gases

In 2019, a total of 2,809,193 kg of CO<sub>2</sub>e were produced from using medical gases throughout the hospitals and health facilities under the Buckinghamshire Healthcare NHS Trust, contributing to 6.51% of the overall emissions. This value was forecasted to increase slightly due to slight increases in the Buckinghamshire population. Emissions did increase to 3,275,807 kg of CO<sub>2</sub>e in 2021 contributing to 7.7% of the overall emissions. The medical gases and respective CO<sub>2</sub>e emissions development over the years were analysed separately below:

- Entonox - Overall, 3,846 m<sup>3</sup> were used in 2019 equating to 919,656 kg of CO<sub>2</sub>e while in 2021, it decreased slightly to 3,417 m<sup>3</sup> equating to 817,199 kg of CO<sub>2</sub>e.
- Carbon Dioxide - A total of 950 m<sup>3</sup> was used in 2019 equating to 1,744 kg of CO<sub>2</sub>e while in 2021 it increased slightly to 985 m<sup>3</sup> equating to 1812 kg of CO<sub>2</sub>e.
- Nitrous Oxide – Overall, 3,379 m<sup>3</sup> was used in 2019 equating to 1,887,793 kg of CO<sub>2</sub>e, while in 2021 it increased to 4,397 m<sup>3</sup> equating to 2,456,796 kg of CO<sub>2</sub>e.

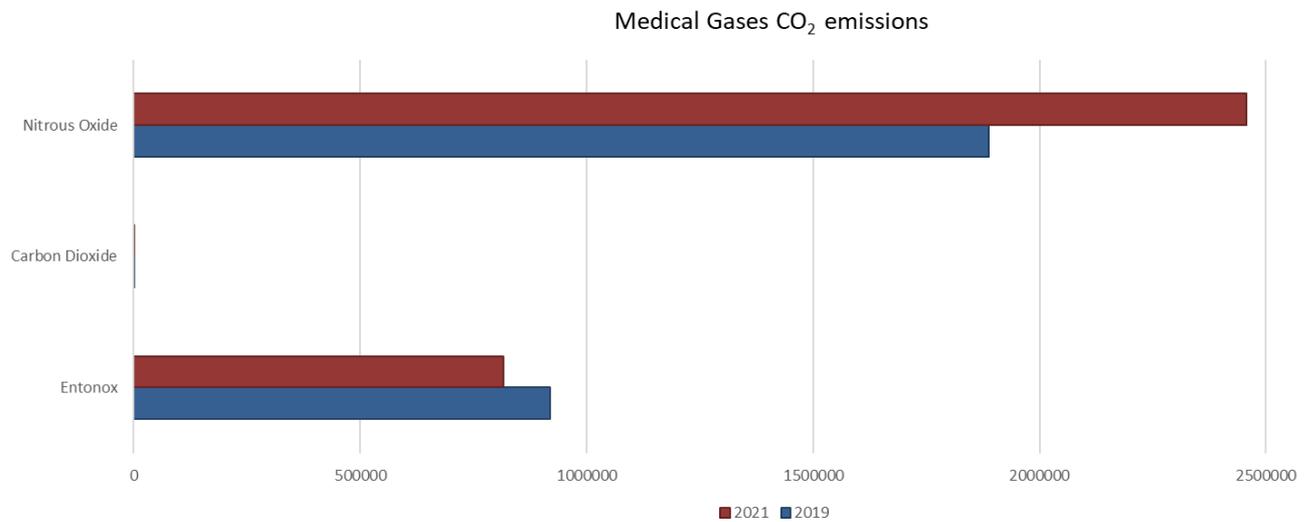


Figure 5: Carbon emissions from Nitrous Oxide, Carbon Dioxide and Entonox in kg, for 2019 and 2021.

## 5.2 Scope 2

### 5.2.1 Electricity

In 2019, the electricity purchased by the Hospitals and medical facilities under the Buckinghamshire Healthcare NHS Trust contributed 13.22% to the overall carbon emissions. In the same year the electricity purchased was 22,313,081 kWh producing 5,703,223.60 kg of CO<sub>2</sub> emissions. Slightly more electricity was purchased in 2021 with 22,741,655 kWh used. Due to a decrease in the carbon factor of the UK electricity grid, a decrease in the emissions from electricity consumption is predicted, down to 4,828,053 kg CO<sub>2</sub>e, contributing 11.3% to the overall emissions.

- Amersham Hospital - The retained electricity (35%) used in 2019 was 438,660 kWh, while in 2021 it increased to 681,887 kWh. The PFI electricity (65%) used in 2019 was 814,655 kWh, which increased to 1,266,361 in 2021. The total electricity used in 2019 was 1,253,315 kWh and it increased to 1,948,248 kWh in 2021.
- Stoke Mandeville Hospital - The retained electricity used in 2019 was 9,093,037 kWh, while in 2021 it increased to 9,249,896 kWh. The PFI electricity used in 2019 was 3,173,788 kWh, which increased to 3,240,704kWh in 2021. The total electricity



used in 2019 was 12,266,825 kWh which saw an increase in use in 2021 to 12,490,600 kWh.

- Wycombe Hospital- The retained electricity (78%) used in 2019 was 6,378,991 kWh, while in 2021 it decreased to 6,051,898 kWh. The PFI electricity (22%) used in 2019 was 1,799,203 kWh, which decreased to 1,706,946 kWh in 2021. The total electricity used in 2019 was 8,178,194 kWh which saw a decrease in use in 2021 to 7,758,844 kWh.
- Alexandra house - The total electricity used in 2019 was 24,947 kWh which saw a decrease to 18,220 kWh in 2021.
- Brookside Clinic - The total electricity used in 2019 was 81,358 kWh which decreased to 58,174 kWh in 2021.
- Chalfonts & Gerrards Cross Community Hospital - The total electricity used in 2019 was 86,682 kWh which increased to 115,822 kWh in 2021.
- Chichester House - The total electricity used in 2019 was 38,592 kWh which increased to 53,140 kWh in 2021.
- Marlow Community Hospital - The total electricity used in 2019 was 104,310 kWh which decreased to 78,169 kWh in 2021.
- Oakridge Centre - The total electricity used in 2019 was 74,425 kWh which decreased to 68,184 kWh in 2021.
- Rayners Hedge Rehabilitation Unit - The total electricity used in 2019 was 34,553 kWh which decreased to 28,154 kWh in 2021.
- Thame Community Hospital - The total electricity used in 2019 was 66,097 kWh which decreased slightly in 2019 to 65,218 kWh.
- Thame Annex - Based on previous years the electricity used was estimated to be 12,418 kWh in 2019 and 2021.

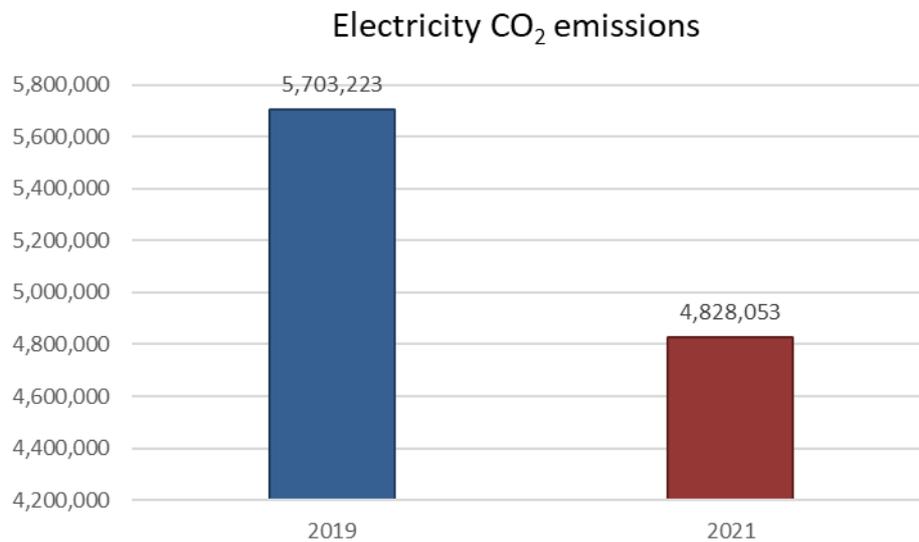


Figure 6: Carbon emissions in kg from purchased electricity, for 2019 and 2021.

## 5.3 Scope 3

### 5.3.1 Category 1 Embodied Carbon Medicines

In 2019, the carbon associated with medicines across the Hospitals and health facilities under the Buckinghamshire Healthcare NHS Trust was 1,065,577 kg of CO<sub>2</sub>e, contributing to 2.47% of the overall emissions. In 2021, there was an increase in the carbon associated with medicines, creating 1,261,844 kg of CO<sub>2</sub>e and contributing to 3% of the overall emissions. Figure 7 below shows this carbon increase. This increase in carbon emissions is due to the increase in catalogue and non-catalogue spend on medicines in the trust.

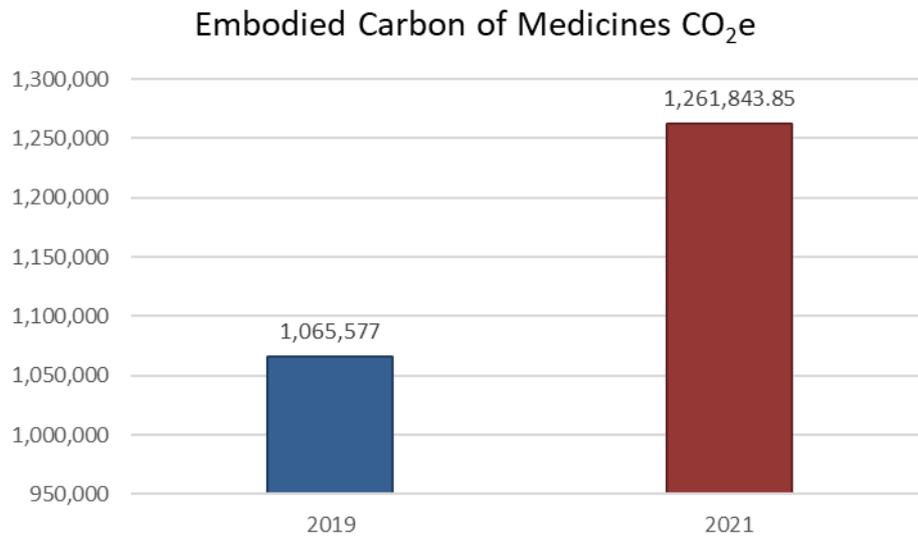


Figure 7: Carbon emissions derived from medicines in kg, for 2019 and 2021.

### 5.3.2 Category 2 Embodied Carbon of Food & Catering

In 2019, the carbon associated with food and catering for the Hospitals and health facilities under the Buckinghamshire Healthcare NHS Trust was 79,452 kg of CO<sub>2</sub>e which contributed to 0.18% of the overall emissions. In 2021, there was a decrease in the carbon associated with food and catering, creating 62,821 kg of CO<sub>2</sub>e, contributing to 0.1% of the overall emissions. The carbon evolution is shown in figure 10 below.

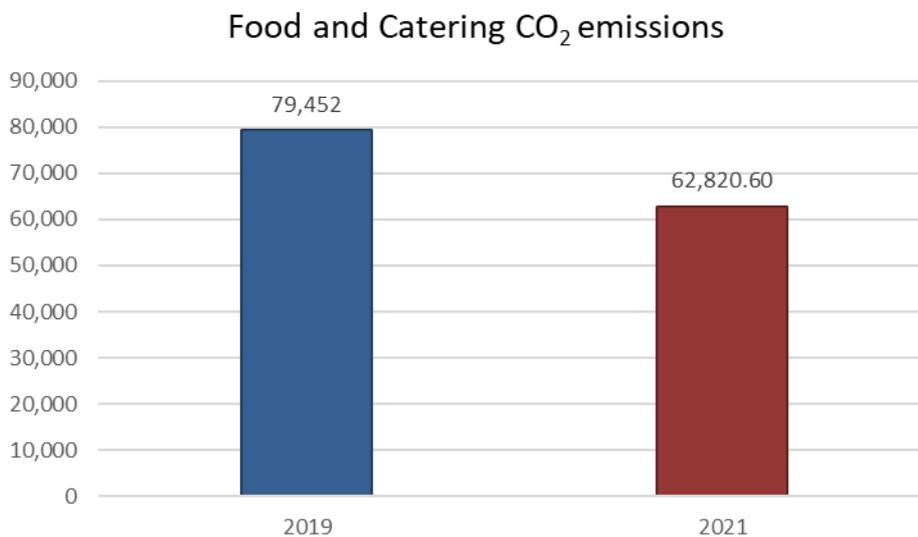




Figure 8: Carbon emissions from food and catering in kg, for 2019 and 2021.

### 5.3.3 Category 3 Water Consumption

The embodied carbon of the water consumption of 2019 accounts for a total of 231,905 kg CO<sub>2</sub>e, contributing to 0.54% of the overall emissions. For 2021, water consumption decreased to 232 m<sup>3</sup> producing 97,917 CO<sub>2</sub>e emissions, contributing to 0.2% of the overall emissions.

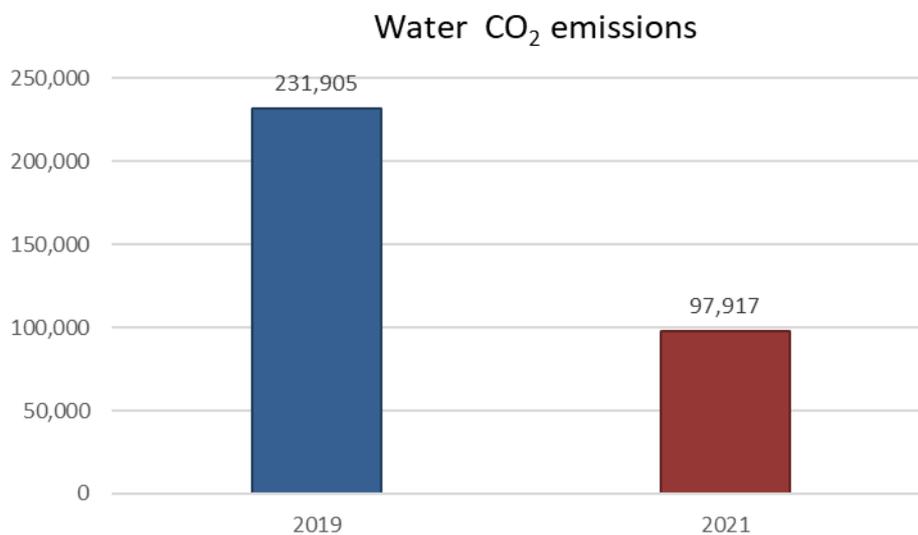


Figure 9: Carbon emissions in kg from water consumption, for 2019 and 2021.

- Amersham Hospital - The retained water (35%) used in 2019 was 4,338.7 m<sup>3</sup>, while it decreased significantly in 2021 to 2,874.4 m<sup>3</sup>. The PFI water (65%) used in 2019 was 8,057.6 m<sup>3</sup>, which decreased to 5,338.2 m<sup>3</sup> in 2021. The total water consumed in 2019 was 12,396.3 m<sup>3</sup>. Created 13,041 kgCO<sub>2</sub> emissions while in 2021 it decreased to 8,212.6 m<sup>3</sup> and producing 3,458 kgCO<sub>2</sub> emissions.
- Stoke Mandeville Hospital - The retained water used in 2019 was 100,963 m<sup>3</sup>, while it decreased slightly in 2021 to 93,512m<sup>3</sup>. The PFI water used in 2019 was 26,742 m<sup>3</sup>, which decreased to 20,109m<sup>3</sup> in 2021. The total water consumed in 2019 was 127,705 m<sup>3</sup> and created 134,346 kgCO<sub>2</sub> emissions while in 2021 it decreased to 113,621m<sup>3</sup> and producing 47,835 kgCO<sub>2</sub> emissions.



- Wycombe Hospital - The retained water used in 2019 was 57,889 m<sup>3</sup>, while it decreased in 2021 to 54,843 m<sup>3</sup>. The PFI water used in 2019 was 16,328 m<sup>3</sup>, which decreased to 15,469 m<sup>3</sup> in 2021. The total water consumed in 2019 was 74,217 m<sup>3</sup> and created 78,076 kgCO<sub>2</sub> emissions while in 2021 it decreased to 70,312 m<sup>3</sup> and producing 29,601 kgCO<sub>2</sub> emissions.
- Alexandra house - The total water consumed in 2019 was 211 m<sup>3</sup> and it remained the same in 2021.
- Brookside Clinic - The total water consumed in 2019 was 894 m<sup>3</sup> and it remained the same in 2021.
- Chalfonts & Gerrards Cross Community Hospital - The total water consumed in 2019 was 517 m<sup>3</sup> and it remained the same in 2021.
- Chichester House - There is no information available, the same quantity as 2021 was used.
- Marlow Community Hospital - The total water consumed in 2019 was 561 m<sup>3</sup> and it remained the same in 2021.
- Marlow Health Centre - There is no information available, the same quantity as 2021 was used.
- Oakridge Centre - The total water consumed in 2019 was 563 m<sup>3</sup> and it remained the same in 2021.
- Rayners Hedge Rehabilitation Unit - The total water consumed in 2019 was 457 m<sup>3</sup> and it remained the same in 2021.
- Thame Community Hospital - The total water consumed in 2019 was 25 m<sup>3</sup> and it remained the same in 2021.
- Thame Annex - There is no information available, the same quantity as 2021 was used.

### 5.3.4 Category 4 Embodied Carbon of Business Services

In 2019, the carbon associated with business services across the Trust was 2,138,228 kg of CO<sub>2</sub>e and contributed to 4.96% of the overall emissions. In 2021, the carbon associated with business services reduced to 1,643,594 kg of CO<sub>2</sub>e, contributing to 3.8% of the overall emissions. The carbon evolution is shown in figure 10 below.

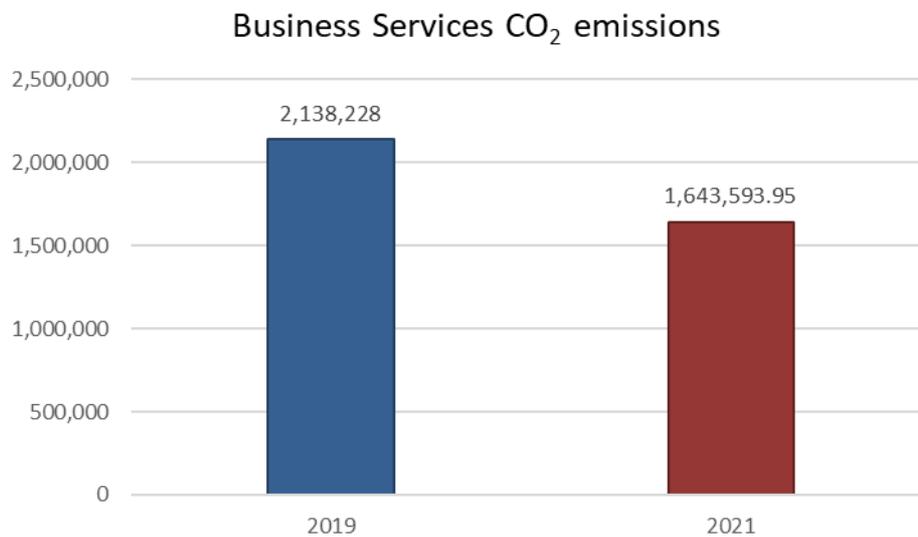


Figure 10: Carbon emissions derived from business services in kg, for 2019 and 2021.

### 5.3.5 Category 5 Embodied Carbon of Non-Medical Equipment

The non-medical equipment includes the manufacturing of staff and patient’s clothing and footwear, patient’s appliances, furniture fittings, hardware crockery, bedding linen and textiles, recreational equipment and souvenirs and hotel services equipment materials and services. In 2019, the carbon associated with non-medical equipment cost across the Trust was 1,821,518 kg of CO<sub>2</sub>e and contributed to 4.22% of the overall emissions. In 2021, there was a decrease in the carbon associated with non-medical equipment with a total of 1,198,479 kg of CO<sub>2</sub>e, contributing to 2.8% of the overall emissions. The carbon evolution is shown in figure 11 below.

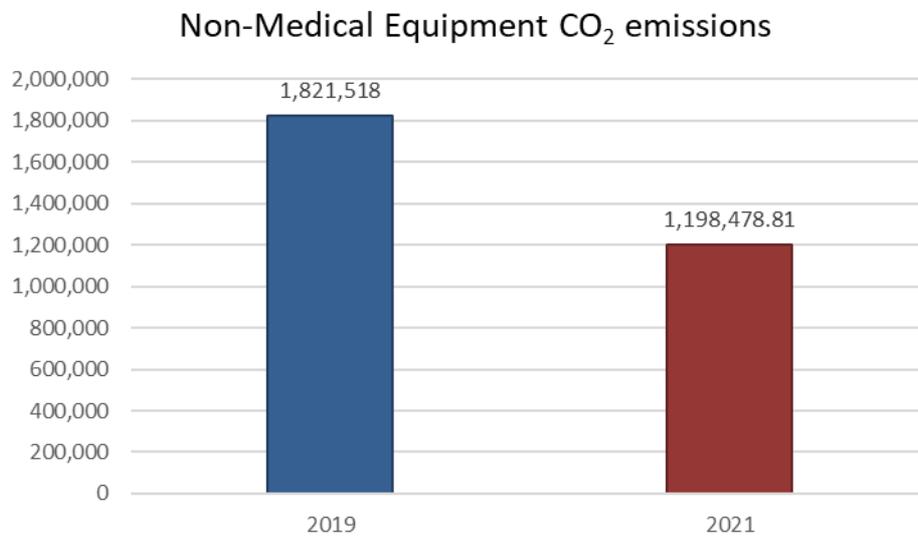


Figure 11: Embodied carbon emissions in kg from non-medical equipment, for 2019 and 2021.

### 5.3.6 Category 6 Embodied Carbon of Metered Dose Inhalers

In 2019, a total of 213,323 kg of CO<sub>2</sub>e were produced from using metered dose inhalers throughout the Hospitals and health facilities under the Buckinghamshire Healthcare NHS Trust which contributed to 0.49% of the overall emissions. This value was estimated to decrease significantly to 75,965 kg of CO<sub>2</sub>e in 2021 and it ended up decreasing to 116,209 kg of CO<sub>2</sub>e while contributing to 0.3% of the overall emissions. This decrease can be observed in figure 12. The metered dose inhalers and respective CO<sub>2</sub> emission development over the years were analysed separately below:

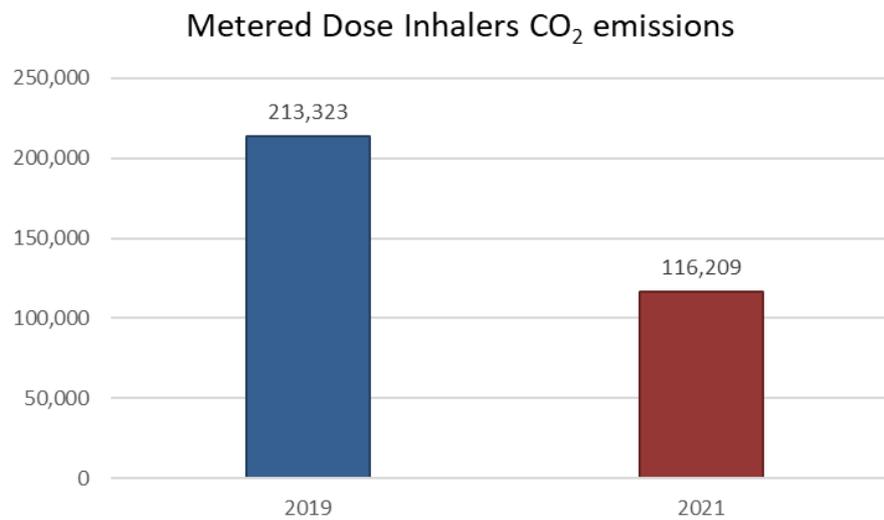


Figure 12: Embodied carbon emissions in g from metered dose inhalers, for 2019 and 2021.

- Acclidinium (BAI) - In 2019, 49 g were used creating 24,500 g of CO<sub>2</sub>e while in 2021 it's use increased significantly to 572,200 g creating 25,039.52 g of CO<sub>2</sub>e.
- Beclomethasone (pMDI) - In 2019, 18,400 g were used creating 9,200,000 g of CO<sub>2</sub>e while in 2021 it's use increased to 25,039.52 g creating 12,519,760 g of CO<sub>2</sub>e.
- Formoterol (DPI) - In 2019, 900 g were used creating 18,000 g of CO<sub>2</sub>e while in 2021 it's use decreased significantly to 2.88 g creating 58 g of CO<sub>2</sub>e.
- Budesonide (DPI) - In 2019, 27,120 g were used creating 542,400 g of CO<sub>2</sub>e while in 2021 it's use decreased to 8,870 g creating 177,400g of CO<sub>2</sub>e.
- Ciclesonide (pMDI) - In 2019, no Ciclesonide inhalers were used while in 2021 it increased 19.2 g generating 9,600 g of CO<sub>2</sub>e.
- Fluticasone (DPI) - In 2019, 30,910 g were used creating 618,200 g of CO<sub>2</sub> while in 2021 it decreased to 7,494.42 g creating 149,888 g of CO<sub>2</sub>e.
- Salbutamol (BAI) - In 2019, 357,628 g were used creating 178,814,000 g of CO<sub>2</sub>e while in 2021 it's use decreased to 191,535.3 g creating 95,767,650 g of CO<sub>2</sub>e.
- Salmeterol (DPI) - In 2019, 5,340 g were used creating 106,800 g of CO<sub>2</sub>e while in 2021 it's use decreased significantly to 126 g creating 2,520 g of CO<sub>2</sub>e.
- Glycopyrronium (DPI) - In 2019, 1,050 g were used creating 21,000 g of CO<sub>2</sub>e while in 2021 it's use decreased significantly to 55.5 g creating 1,110 g of CO<sub>2</sub>e.



- Ipratropium (pMDI) - In 2019, 27,120 g were used creating 542,400 g of CO<sub>2</sub>e while in 2021 it's use decreased to 8,870 g creating 177,400 g of CO<sub>2</sub>e.
- Terbutaline (DPI) - In 2019, 1,460 g were used creating 29,200 g of CO<sub>2</sub>e while in 2021 it's use increased to 2300 g creating 46,000 g of CO<sub>2</sub>e.
- Tiotropium (DPI) - In 2019, 28,952 g were used creating 579,040 g of CO<sub>2</sub>e while in 2021 it's use decreased significantly to 194.2 g creating 3,883 g of CO<sub>2</sub>e.
- Trimbow (pMDI) - In 2019, 9,960 g were used creating 4,980,000 g of CO<sub>2</sub>e while in 2021 it's use decreased to 5,575.2 g creating 2,787,600 g of CO<sub>2</sub>e.

### 5.3.7 Category 7 Embodies Carbon of Medical Devices

The medical devices include medical and surgical equipment, dental and optical equipment, laboratory equipment and services and diagnostic imaging and radiotherapy equipment and services. In 2019, the carbon associated with total medical devices cost across the Trust was 4,017,292 kg of CO<sub>2</sub>e emissions and contributed to 9.32% of the overall emissions. In 2021, there was an increase in the carbon associated with medical devices creating 6,116,520 kg of CO<sub>2</sub>e and contributing to 14.3% of the overall emissions. The total emissions development is shown in figure 13. This increase in carbon emissions is due to the increase in catalogue and non-catalogue spend on medical devices in the trust.

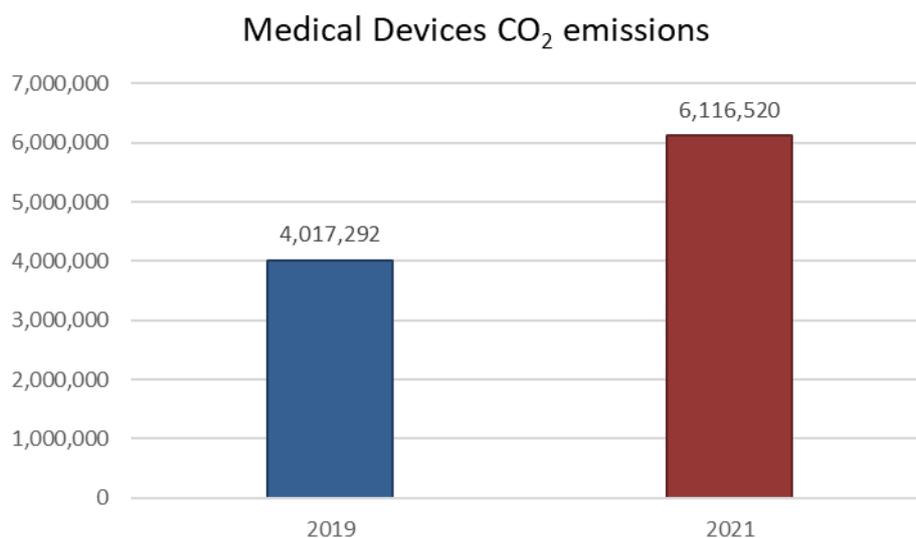


Figure 13: Embodied carbon emissions in kg from medical devices, for 2019 and 2021.



### 5.3.8 Category 8 Embodies Carbon of ICT Equipment

In 2019, the carbon associated with total ICT equipment across the Trust was 2,224,639 kg CO<sub>2</sub>e emissions and contributed to 5.16% of the overall carbon emissions. However, the carbon associated with ICT equipment increased slightly to 2,529,213 kg of CO<sub>2</sub>e, contributing to 5.9% of the overall emissions. This increase can be observed in figure 13.

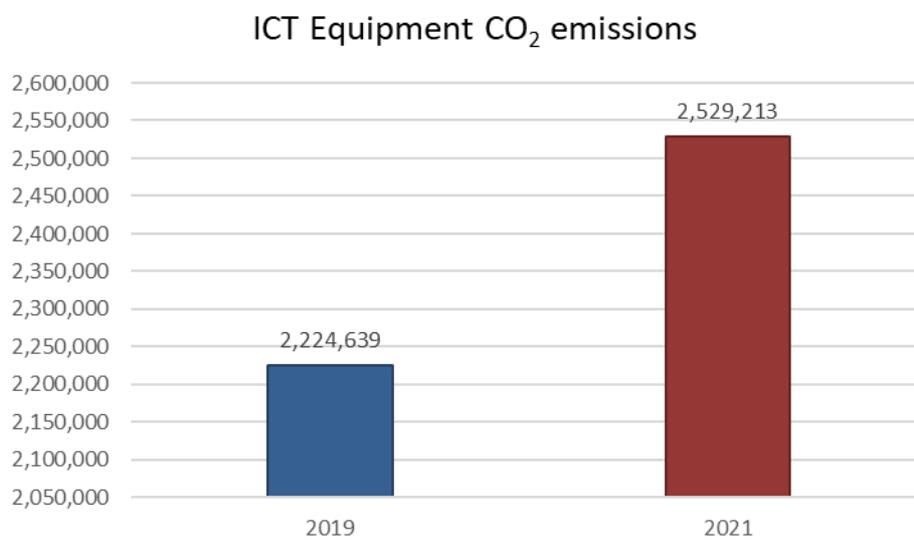


Figure 13: Carbon emissions, associated with ICT equipment, in kg, for 2019 and 2021.

### 5.3.9 Category 9 Embodies Carbon of Construction

The construction includes the manufacturing of building and engineering products and services. In 2019, the carbon associated with total construction across the Trust was 122,351 kg of CO<sub>2</sub>e and contributed 0.28% of the overall emissions. In 2021, the carbon associated with Construction increased significantly to 919,272 kg of CO<sub>2</sub>e and contributing to 2.1% of the overall emissions. The carbon emissions associated with construction have increased due to expansion during the pandemic, which is considered to be a one-off. This increase can be observed in figure 14.

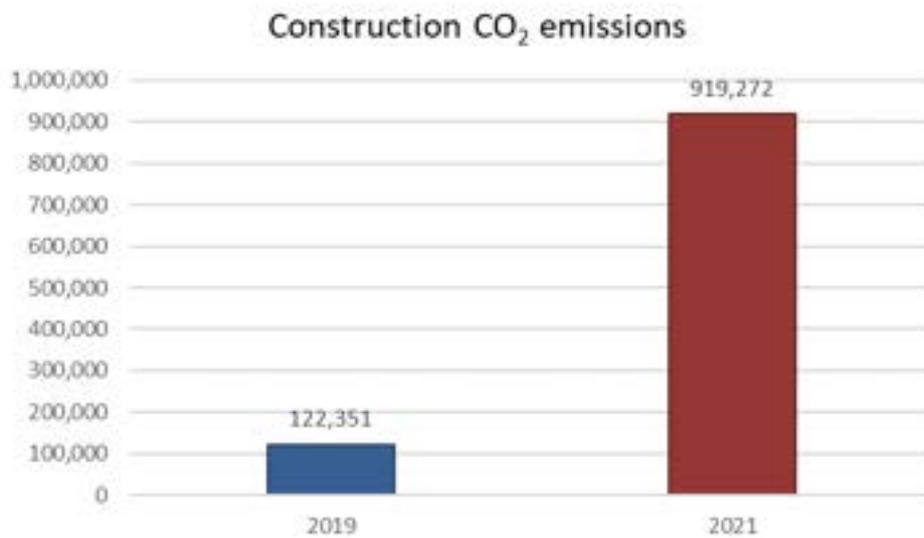


Figure 13: Carbon emissions, associated with construction, in kg, for 2019 and 2021.

### 5.3.10 Category 10 Transmission/distribution and Well to Tank

The embodied carbon of transmission/distribution of the overall purchased electricity and well to tank emissions of the Hospitals and health facilities under the Buckinghamshire Healthcare NHS Trust for 2019 was 2,158,192 kg of CO<sub>2</sub>e. This contributed 5% of the overall emissions. The forecast estimated that this value would increase to 2,213,647 kg of CO<sub>2</sub>e in 2021. The actual data for 2021 illustrated an increase to 2,584,549 kg of CO<sub>2</sub>e in 2021, contributing 6% of emissions. The emission increase can be observed in figure 14.

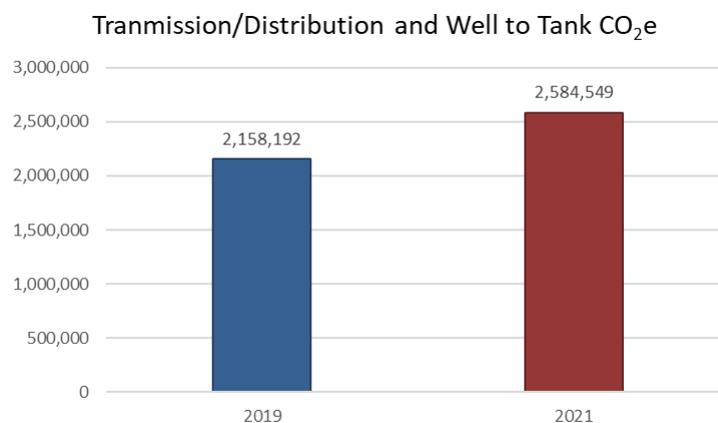


Figure 14: Carbon emissions associated with transmission and distribution of the Trust purchased electricity and well to tank emissions of all fuel, in kg, for 2019 and 2021.



### 5.3.11 Category 11 Waste

The total waste generated in 2019 was 1943.07 m<sup>3</sup> which produced 107,052 kg CO<sub>2</sub>e and contributed to 0.25% of the overall emissions. In 2021, the total waste generated was 2076m<sup>3</sup> which produced 109,204 kg CO<sub>2</sub>e (0.3%). The waste data for the Amersham, Stoke Mandeville and Wycombe Hospitals is detailed below.

#### Amersham Hospital

- In 2019 there were 2.64 m<sup>3</sup> of clinical yellow waste, while in 2021 it decreased to 2.25 m<sup>3</sup>.
- In 2019 there were 1.09 m<sup>3</sup> of alternative orange waste, which increased in 2021 to 8.86 m<sup>3</sup>.
- In 2019, 26.08 m<sup>3</sup> of offensive tiger waste were produced while in 2021 it decreased to 22.70 m<sup>3</sup>.
- Regarding domestic incinerated waste, 58.05 m<sup>3</sup> were produced in 2019, which increased to 69.97 m<sup>3</sup> in 2021.
- In 2019, 15.88 m<sup>3</sup> of waste was recycled, which decreased in 2021 to 7.13 m<sup>3</sup>.
- In 2019 there was no furniture waste while in 2021 there was 7.8 m<sup>3</sup>.
- In 2019 there was 0.33 m<sup>3</sup> of confidential waste while in 2021 it increased to 4.6 m<sup>3</sup>.
- There was no electronic, electrical equipment waste recycling (WEEE) and in 2021 it increased to 3.71 m<sup>3</sup>.

#### Stoke Mandeville Hospital

- In 2019 there were 88.37 m<sup>3</sup> of clinical yellow waste, while in 2021 it increased significantly to 149.01 m<sup>3</sup>.
- In 2019 there were 285.29 m<sup>3</sup> of alternative orange waste, which increased significantly in 2021 to 565.13 m<sup>3</sup>.
- In 2021, 197 m<sup>3</sup> of offensive tiger waste were produced while in 2021 it decreased to 121 m<sup>3</sup>.



- Regarding domestic incinerated waste, 626.64 m<sup>3</sup> were produced in 2019, which decreased to 518.06 m<sup>3</sup> in 2021.
- In 2019, 25.64 m<sup>3</sup> of waste was recycled, which increased significantly in 2021 to 78.23 m<sup>3</sup>.
- In 2019 there was 80.188 m<sup>3</sup> of confidential waste while in 2021 it increased to 102.19 m<sup>3</sup>.
- In 2021 there was 15.14 m<sup>3</sup> of WEEE and in 2021 it decreased to 9.99 m<sup>3</sup>.

### Wycombe Hospital

- In 2019 there were 99.43 m<sup>3</sup> of clinical yellow waste, while in 2021 it decreased to 57.797 m<sup>3</sup>.
- In 2019 there were 39.06 m<sup>3</sup> of alternative orange waste, which increased significantly in 2021 to 93.412 m<sup>3</sup>.
- In 2021, 91.92 m<sup>3</sup> of offensive tiger waste were produced while in 2021 it decreased to 68.509 m<sup>3</sup>.
- Regarding domestic incinerated waste, 212.14 m<sup>3</sup> were produced in 2019, which decreased to 155.82 m<sup>3</sup> in 2021.
- In 2019, 8.12 m<sup>3</sup> of waste was recycled and in 2021 it was higher with 11.14 m<sup>3</sup>.
- There was no furniture waste in 2019 while in 2021 it increased to 13.35 m<sup>3</sup>.
- In 2019 there was no confidential waste while in 2021 it increased to 11.713 m<sup>3</sup>.
- There was no WEEE waste in 2019 and in 2021 it increased to 3.71 m<sup>3</sup>.

### 5.3.12 Category 12 Patient & Visitor Travel

Patient and visitors travel by road, rail and air cost across the Hospitals and health facilities under the Buckinghamshire Healthcare NHS Trust. Due to data not being available for both



2019 and 2021, a percentage contribution towards carbon footprint has been aligned with overall NHS carbon assessment.

### 5.3.13 Category 13 Employee Commuting

The number of staff across the Hospitals and health facilities under the Buckinghamshire Healthcare NHS Trust accounted in 2019 was 6,225 of which travelled a total distance of 7,237,829 km, engaged in an average of 140 annual trips per person, creating a total of 2,220,266 CO<sub>2</sub> emissions. This contributed to 5.15% of the overall carbon emissions. In 2021 the total emissions estimated to decreased to 2,110,641 kg of CO<sub>2</sub>e, contributing to 4.9% of the overall emissions. In this year, staff travelled a total distance of 6,763,890 km. Of the distance travelled, 9,128,915 km were by car, 662,291 km by bus and 501,199 km by train. Due to an increase in the working from home capability of the occupational staff within the trust, the carbon emissions reduced in 2021. This decrease in carbon emissions can be observed in figure 15.

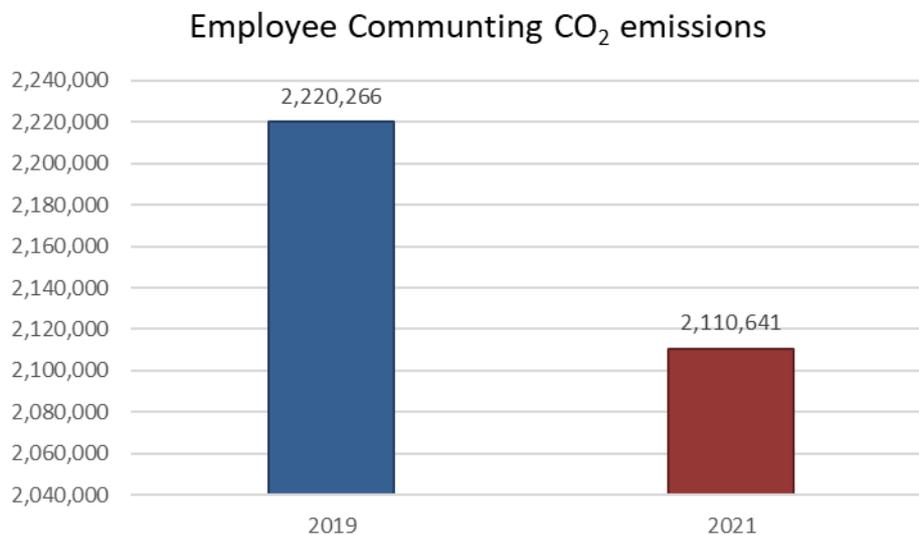


Figure 15: Carbon emissions associated with employee commuting, in kg, for 2019 and 2021.



### 5.3.14 Category 14 Commissioned Health Services outside NHS

The carbon associated with outsourced health services by the Trust in 2019 was 4,982,544 kg of CO<sub>2</sub> emissions, contributing to 11.55% of the overall emissions. In 2021 carbon associated with outsourced health services reduced to 3,773,154 kg of CO<sub>2</sub> emissions and contributed to 8.8% of the overall emissions. The emissions decrease can be observed in figure 16.

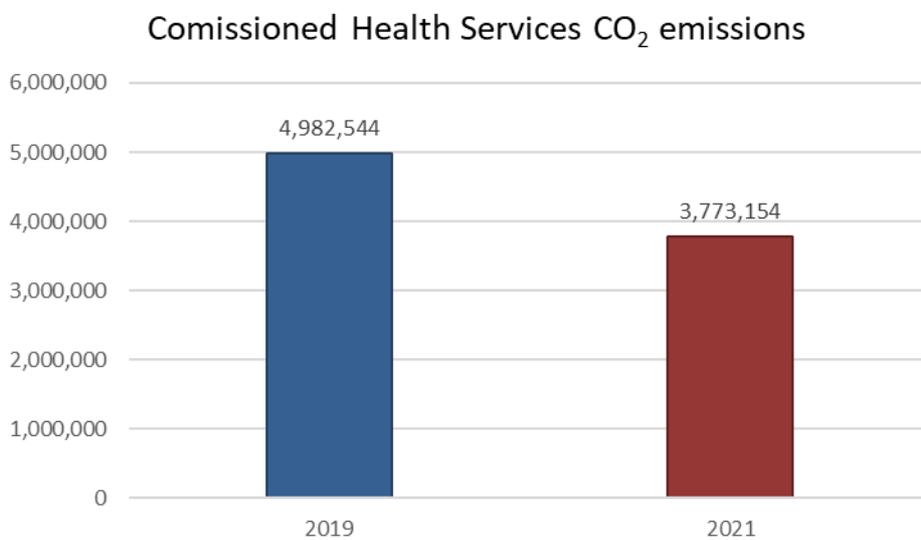


Figure 16: Carbon emissions associated with commissioned health services outside the NHS, in kg, for 2019 and 2021.

### 5.3.15 Category 15 Other

Other carbon emissions incurred by the Trust accounted for 1,500,567 of kg of CO<sub>2</sub>e, contributing to 3.48% of the overall emissions. In 2021 this reduced to 1,136,341 of kg of CO<sub>2</sub> emissions, contributing to 2.7% of the overall emissions. The emission decrease can be observed in figure 17.

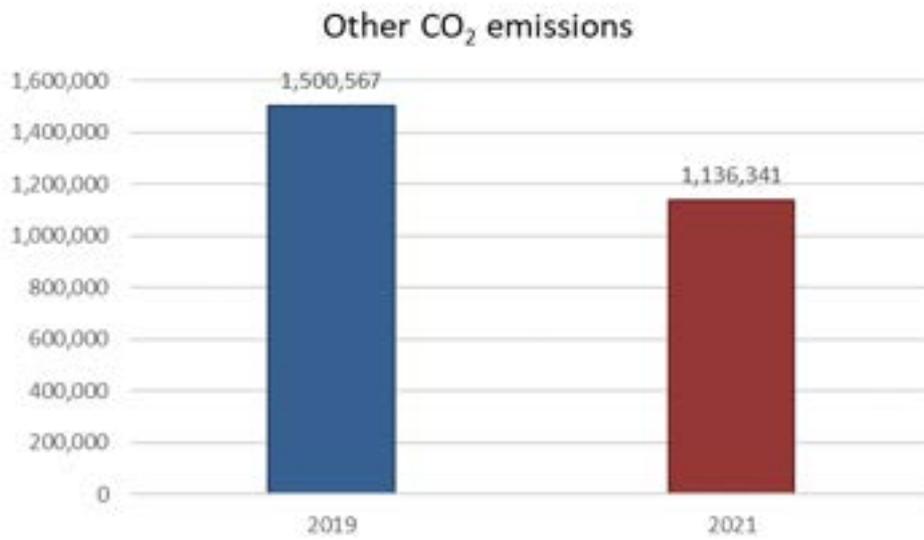


Figure 17: Carbon emissions associated with other activities incurred by the Trust, in kg, for 2019 and 2021.



## 6 Ongoing projects & Initiatives

The following list details the ongoing projects and initiatives at the trust over the next few years that will have a significant impact upon carbon emissions.

- Development of the Wycombe energy centre project – Anticipated to save 954 tonnes of CO2 per annum
  - Jul 23 – Wycombe and Amersham Energy Infrastructure Project replaces 1950 steam boilers and ineffective outdated Boiler Management Systems with latest technology.
  - Builds a standalone Energy Centre and Hydrogen ready Combined Heat and Power plant on site, enabling the decant of services out of the Tower.
  - A 15-year cost neutral operating/maintenance scheme transferring risk to the supplier.
  - Has several levels of carbon reduction:
    - Level 1 is de-steaming the Wycombe site which will reduce the level of carbon emissions by 23% for the site
    - Level 2 - Installation of a combined heating and power unit and the by-product of this unit is any waste heat from the emissions will be converted via a low loss heat pump to usable heat energy
- De-steaming of the Wycombe hospital – Anticipated to go live from June 23 and deliver significant carbon savings
- Development of Building 3 and JHSU at Stoke Mandeville Hospital,
- The demolition of 2 inefficient buildings, Dashwood and Hillview, at Wycombe hospital in 2022 – delivering significant carbon savings
- Further removal of desflurane and other gases and a reduction of others such as nitrous oxide.
- Decommissioning of medical equipment either goes to auction to be reused, or to a company that guarantee no landfill, reducing emissions from waste.
- Aug 21 - BHT have signed up to the **NHS Plastics Pledge**, which is a commitment with the PFI partners to reduce single use plastics where possible. One first step is to work towards delisting all single use plastics from the supply chain
- Aug 21 - BHT swapped all sterile and non-sterile gowns to reusable during Covid, as part of a NHS wide trial, which has been continued owing to its' success.
- Sept 21 - The new Innovation centre at SMH has a heat pump, therefore no fossil fuels are used. The building itself is also 98% recyclable.



- Nov 21 - The first no fossil fuel air source heat pump has been installed at the Floyd auditorium.
- Jan 22 - All business cases and procurement decisions to have a 10% weighting for Carbon Plans/position of supplier.
- Jun 22 - Replacement of all of the available old light fittings to LED and adding movement sensors to carparks, and corridor
- Sept 22 - Onsite anaerobic digester will be installed on SMH to reduce general and recyclable waste by 80%.



## 7 Recommendations

To remain on track with the trust's net zero pathway, carbon emissions are required to be reduced by 10% by 2024. This would require a reduction to **32871 tonnes of CO<sub>2</sub>**. This would require a reduction of **9,897 tonnes** from the 2021 emissions.

As detailed in the previous section, there a number of ongoing projects and initiatives aimed at reducing energy consumption and carbon emissions. These will come into fruition over the next couple of years and carbon savings will be evident from the ongoing work.

The following recommendations have been devised following the carbon audit process:

- Emissions from Natural Gas need to significantly reduce as the trust electrifies its buildings and installs more heat pumps. A number of projects are ongoing within the trust to move from gas to electric heat pumps. It is recommended that these projects continue and extend across all trust buildings. The energy efficiency of the buildings also needs to be improved in line with the targets set out within the net zero carbon roadmap (Clinical Areas to target 150 kWh/m<sup>2</sup>/year & Non-clinical areas to target 70 kWh/m<sup>2</sup>/year).
- Emissions from medical gas usage have the potential to be decreased following changes in practice to reduce the amount of Nitrous Oxide usage, as well as improvements in the efficiency of scavenging and recovery systems.
- It is difficult to target reductions in the emissions from medicines, medical devices and commissioned health services outside of the NHS as these are linked to clinical outcomes that can't be compromised. Although the calculation methodology for these areas has been top-down (based on financial spend), the decision to include a 10% weighting for Carbon Plans/position of supplier onto all business cases and procurement decisions will begin to make an impact upon emissions.

**Meeting:** Trust Board Meeting in Public

**30 November 2022**

<b>Agenda item</b>	BHPL Annual Report 2021 22		
<b>Board Lead</b>	Chief Commercial Officer		
<b>Type name of Author</b>	Commercial Director		
<b>Attachments</b>	Annual Report		
<b>Purpose</b>	Information		
<b>Previously considered</b>	Approved independently by the Directors of BHPL Board F&BPC 22.11.2022		

### Executive Summary

The Trust's wholly owned subsidiary Company, Buckinghamshire Healthcare Projects Ltd (BHPL) has operated as a trading company since 2018 and is now well-established, providing outpatient pharmacy services in the main hospital sites at the Trust and as well as a café and salon in the National Spinal Injuries Unit. The attached reports comprise its end of year annual report.

The key 2021/22 highlights were:

- During the year the Outpatient Pharmacy service delivered almost 100,000 prescriptions to over 53,000 local residents.
- During 2022 It opened its new purpose built premises at Stoke Mandeville within the emergency department.
- Salon OASIS was opened 12 months ago and is demonstrating its value to further support the health and wellbeing of patients, visitors and colleagues at the Trust.
- The company made its first charitable donation of £170,000 to the Trust's charity in 2022 to enable further investments in healthcare.
- BHPL has maintained its Social Enterprise status and continues to adopt the principles of The Blueprint for Better Business.

Regarding the financial accounts contained in the report which have been independently audited, the audit opinion was that the financial accounts gave a true and fair view of the state of the company affairs as at 31 March 2022 and of its profit for the year ended. They have been properly prepared in accordance with the UK GAAP (United Kingdom Generally Accepted Accounting Practice) and the requirements of the Companies Act 2006.

This report was seen and noted by the Finance and Business Performance Committee on 22 November 2022.

<b>Decision</b>	The Board are asked to note this report for information.
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### Relevant Strategic Priority

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

<b>Patient Safety</b>	BHPL follows Trust policies and governance procedures
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Not applicable
<b>Financial</b>	BHPL positively contributes to the financial position of the Group

<b>Compliance</b> <small>Select an item.</small> <b>Good Governance</b>	BHPL as a company is required to submit annual audited accounts to BHT and onto Companies House
<b>Partnership: consultation / communication</b>	BHPL as a wholly owned subsidiary is required to send copies of its statutory accounts to BHT as the shareholder.
<b>Equality</b>	In line with Trust policies, all services provide by BHPL consider equitable access for all, regardless of gender, disability and any other protected characteristic
<b>Quality Impact Assessment [QIA] completion required?</b>	Not Applicable

# Contents

A message from our Managing Director	3
About Us	7
Our Year in Numbers	9
Our Year in Pictures	11
Our Outpatient Pharmacy Service – Pharmacy@Bucks	15
Our Retail Offers - Café OASIS & Salon OASIS	21
Being a Social Enterprise	25
Championing our Colleagues	29
Being a Purpose Driven Business	33
Roadmap for the Future	37
Financial Summary	41



# Annual Report

## 2021/2022

# 1. A message from our Managing Director



Our report looks back at the last 12 months, summarises our achievements and the challenges we faced, and looks forward to what we would like to achieve over the course of the next financial year and beyond.

I became Managing Director of BHPL on the 21st March this year with the responsibility to grow the range and scope of the services offered, and to lead the team through the next phase of expansion.

Whilst I was not in my role for the most part of the 2021 / 22 financial year, I have read this report with great attention, and the information outlined within it has formed an important part of my induction into the company.

I, on behalf of all the Directors, wanted to start with a huge thank you to all our team members for everything they do. The team have emerged from another difficult year of the pandemic, where our team and services have experienced significant pressure.

In a post Brexit world, we have faced further challenges to the business, not least in recruiting the necessary resource to meet our growth expectations. Towards the end of the year, the situation in Ukraine applied further pressures on ours, like so many businesses, with significant inflationary impacts.

I can see that this was an extremely challenging time, though the team should take pride in all that they do, have delivered and know they are doing the very best they can for whoever accesses our services, whether patients currently on site for treatment, those visiting loved ones or the amazing team at Buckinghamshire Healthcare NHS Trust.

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“ I would like to welcome you to the Annual Report and Accounts for 2021/22. ”

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During the year our outpatient pharmacy delivered a dedicated service across multiple locations, across various sites to over **53,000** local residents, an increase of **47%**.

Our team of pharmacists, dispensers and counter assistants are committed to putting the outpatient front and centre to our service, and to offer a familiar face whilst having time for their questions.

Our Oasis retail experience, based at the National Spinal Injuries Centre at Stoke Mandeville hospital grew by over **34%** during the year through our café, and our newly introduced salon.

Overall, this has meant the business has successfully continued to deliver above target results against budget, in both gross revenue and profitability.

The company has grown its annual revenue to over **£6.8M**, up a third against 2020/21, and now employs a team of **26**.

At the end of the 2021/22 financial year, the business reached a stage where profitability meant that the Directors could agree to our first significant charitable donation. A donation of **£170,000** was made to the Trust's Charitable Fund.

I am delighted that the business achieved Social Enterprise UK status during 2021. With this recognition, we further demonstrate our focus on a better way to do business, one that prioritises benefit to people and to our planet and uses the majority of our profit to further that mission.

I am delighted also this year that we continued to follow the five principles of a purpose driven business as developed by Blueprint for Better Business:

- Has a purpose which delivers long-term sustainable performance
- Honest and fair with customers and suppliers
- A responsible and responsive employer
- A good citizen
- A guardian for future generations

As part of this, in 2021/22 all purchase invoices were paid, on average within **25** days of invoice date. The business submits monthly tax returns to HMRC and fully pays all due taxes as soon as they are due. In 2022/23 BHPL plan to work with external experts to develop its own Net Zero Roadmap, having previously supported its parent shareholder in the development of theirs.

At the end of February 2023, we will reach the end of our current contract for outpatient pharmacy services with Buckinghamshire Healthcare NHS Trust. In the final year, we will continue with the growth and will dispense over **100,000** prescription items during the year.

I am confident that not only will we have delivered outstanding quality and safety across the four locations, on three sites in the county, but we will also have delivered across the 5-years over **£3m** of cash releasing value to the Trust that has been used to develop local NHS services.

The coming year will continue to deliver challenges, though significant opportunities are also on the horizon.

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“Our team will grow, and we will face these challenges together, and as such I look forward to working with you all next year.”

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**Eric Lanyon**  
Managing Director

# 2. About Us

“Buckinghamshire Healthcare Project Limited (BHPL) is the well-established, profitable, wholly owned subsidiary of the Trust, that has been trading since 2018.”

Best known for Pharmacy@Bucks, which operates an outpatient pharmacy service across the county. In 2021 / 22 we delivered a dedicated outpatient service to over 53,000 patients in total. A five and a half day service meeting the needs of over 1,000 patients per week from the local community, across the 3 sites:

**Amersham Hospital**

**Stoke Mandeville Hospital**

**Wycombe Hospital**



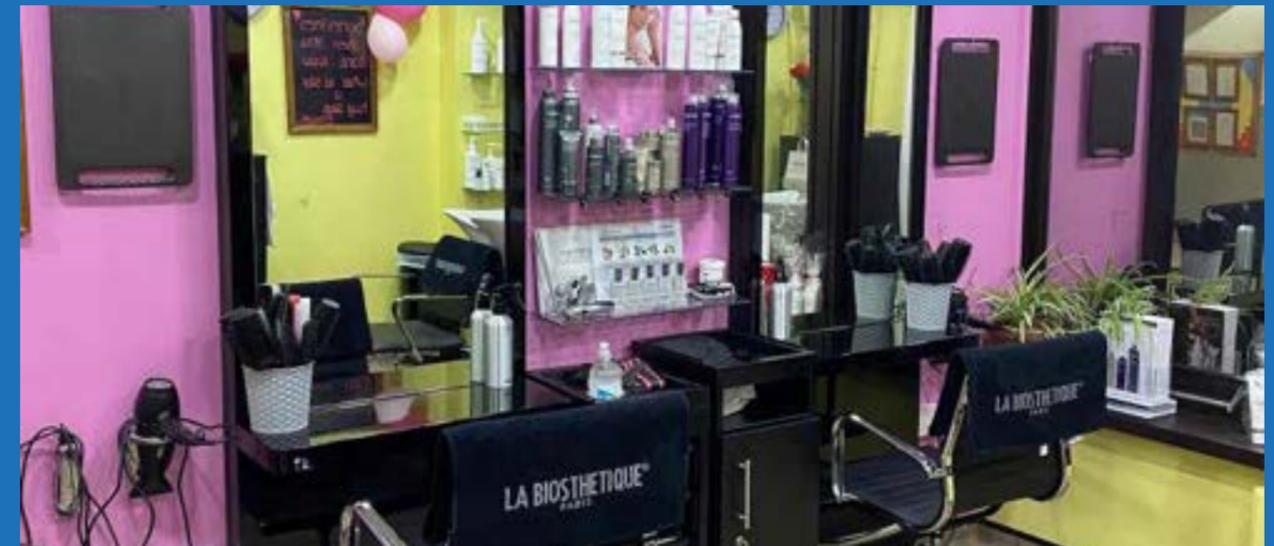
**Café OASIS**, well known to patients, visitors and employees alike, offers a relaxing environment, where they can take a break from their hectic day-to-day, whilst enjoying a refreshing drink and a healthy bite to eat.



It was joined on the Stoke Mandeville site by **salon OASIS** in 2021, where you can experience haircuts and hair treatments in a friendly and welcoming environment, every week day.



The company's primary social objective is to make a material positive impact on society and the environment by providing services and innovations that support the overall health and care objectives of its primary shareholder, Buckinghamshire Healthcare NHS Trust. As a Social Enterprise we have built a team steeped in our values and a drive to be an Equality, Diversity and Inclusion employer



# 3. Our Year in Numbers

“ The numbers demonstrate a tangible step forward in the growth performance of the business. ”



**>53,000**  
**Patients**  
THRU  
PHARMACIES

67% BOARD DIRECTORS  
are women

73%  
of our colleagues  
are from the  
BAME community.



**47%**  
Increase

**53,000**  
Local residents  
across 3 sites

**£6.8M**  
Annual  
Revenue

**26**  
Strong

Committed  
Team

**36,000**  
OASIS customers  
(>700 per week;  
>140 per day)

patients,  
visitors and  
BHT team  
members

Our Team of  
**7 PHARMACISTS**  
completed clinical  
validation and accuracy  
checking of

**94,556**  
PRESCRIPTION  
ITEMS

In **2022/23**

Outpatient pharmacy is  
expected to serve over

**60,000**  
**PATIENTS**

across **4 LOCATIONS**  
at the **3 HOSPITAL SITES**  
covering the county.



**£170K**

CHARITY DONATION

# 4. Our Year in Pictures 2021/2022



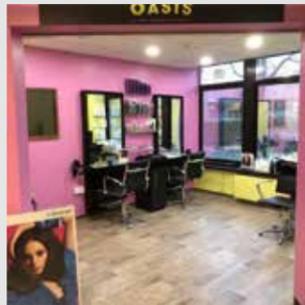
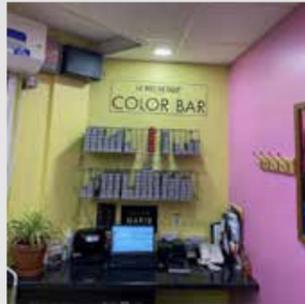
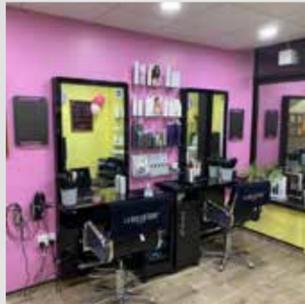
## SPRING

- Delivered an outstanding **Outpatient Pharmacy** service during the ongoing challenges of the pandemic



## SUMMER

- Delivered a welcoming **café experience** for patients on site, visitors and our wonderful BHT colleagues through challenging times



## AUTUMN

- We opened the **Salon OASIS** in November



## WINTER

- We opened the new **Outpatient Pharmacy** located within **A&E**
- Developed an internal **Finance Team** led by Sue our Finance Manager, who was selected to represent **GB** in International **Paragliding Championships**
- Recruited our new MD, **Eric Lanyon**, to lead the next phase of expansion and growth
- Donated our first charitable monies with a donation of **£170,000** to invest in **local NHS services**

# 5. Our Outpatient Pharmacy Service

“ Pharmacy@Bucks, is the Outpatient Pharmacy Service run by Buckinghamshire Healthcare Project Ltd (BHPL), the wholly owned subsidiary of Buckinghamshire Healthcare Trust (BHT). ”



The Pharmacy@Bucks outpatient pharmacy service has been providing outpatient prescription services and advice for 4 years.

It is expected to dispense over 100,000 prescription items dispensed with, at current outstanding quality and safety levels, with quality standards significantly better than the national standards. Waiting times are in line with target at 20 minutes for simple prescriptions, and 25 minutes for complex medications.

Run independently from the internal pharmacy, though working collaboratively and in line with the Trust's Assurance and Governance standards, the service provides clinicians with the confidence of a specific service that is accessible and credible.

The service puts the outpatient front and centre, offering a familiar and reassuring face, one who has time for their questions, and regularly delivers over 85% satisfaction scores for patient experience.

Removing trade-offs between acute hospital priorities and outpatient service provision, the agile and flexible service, through a committed and knowledgeable team, has developed to overcome the challenges of the recent pandemic and the requirements to dispense increasingly complex medicines.

Future innovation will align to the differing needs of homecare provision and virtual hospital models and, together with plans for digital interventions, will enable the service to continue to meet ongoing growth levels of 20%+ increase in activity.



# An Outstanding Outpatient Pharmacy Service...



Delivers a dedicated service across multiple locations across various sites.



A team committed to putting the patient front and centre to the service, from a familiar and reassuring face.



Provides clinicians the confidence of a dedicated service that is accessible and credible.



A future-proofing service that innovates to address the changing needs from healthcare@home and virtual hospital models.



Has a committed team who build and develop the knowledge and skills to deal with the increasing complexity of medicines dispensing e.g. oral oncology.



Offers staff training and development, and a real career opportunity.



Avoids trade-offs between outpatient services and other acute hospital priorities.



Quick turnarounds, reduced waiting times and avoids log-jams in waiting areas.



An agile and flexible service that grows and overcomes challenges, such as Covid.



A business that has grown revenue, controlled costs and delivered a surplus that helps to reinvest in NHS services, through a charitable donation.



Improves the overall patient experience to exceptional satisfaction levels.



An Outpatient Pharmacy service you can be proud of.



# A message from our Superintendent Pharmacist.

“ I am delighted to share that, during the 2021/22 Financial Year, one which was beset with challenges arising from the unique circumstances presented by the then ongoing global pandemic, we still delivered strong operational and financial results.

This in a year when we also project managed the build of the new Outpatient Pharmacy facilities, which we moved into on 22nd March and solved long-standing space and safety issues in the process.

In terms of our providing a safe and efficient service, we certainly delivered against our contractual KPIs for patient satisfaction:

- 87% of patients rated us Good or Excellent
- As patient safety is deeply ingrained in the minds of our pharmacists who, have clinically validated and checked almost 95,000 prescription items with a dispensing error rate which is well below the national average.
- A high staff vacancy rate did mean that there is a slight increase in patient waiting times for patients to collect their medications

For me, our people are very much the reason why we have enjoyed success over the past year and will certainly be at the very heart of all and any of our future successes. In recognition of this, we have continued to place a great deal of emphasis on the wellbeing of

our team, and I personally ensure that I have regular contact with all staff, to ensure any concerns are raised and dealt with as quickly as possible to everyone's satisfaction.

Our small, hard-working Team delivered a very impressive 47% year-on-year growth in workload activities, which smashed the 5% target that we set ourselves at the beginning of the year. This is an exceptional achievement as we also managed to do this with a reduction in what we would describe as our optimal staffing levels.

We are also actively recruiting for a variety of roles to increase our headcount to 26 FTE staff, which will allow us to extend our opening hours and maintain the fourth pharmacy at Stoke Mandeville Hospital.

These are all factors which will help us to drive the targeted activity growth of 10% for 2022/23 and I am also pleased to confirm that we have promoted two of our experienced pharmacists to managers – we wish them both well.

During the coming year, we will continue to look at how we can invest in our people and encourage their personal development, with a particular emphasis on the work life balance. This will include a focus on enhanced training opportunities and professional skills development, together with greater health and wellbeing support wherever it is required.

From a financial performance point-of-view, we delivered double-digit revenue growth and improved profitability, which combined with our operational efficiency and cost controls, has helped drive the investment required for the expansion of the business.

Our commercial focus, built on a bedrock of a safe and efficient service, targets long-term shareholder returns whilst generating the profits required to enable the ambitious expansion plans that we have as a business.

Let us take a look at the numbers:

- 30% Year-on-Year revenue growth
- £435K pre-tax profit against an original forecast of £172K

From a personal point-of-view, I am extremely proud of the ongoing progress that we are making as a business, especially in the face of the unique challenges of the previous few years.

In closing, I would like to sincerely thank all of my colleagues for their commitment, professionalism and sheer hard work which has helped us to achieve great results in 2021/22, and I remain ambitiously excited for the future. ”

*Niranjan Annamalai*

# 6. Our Retail Offer

## Café OASIS & Salon OASIS

“Our OASIS retail experience is based in the National Spinal Injuries Centre at Stoke Mandeville hospital, which is recognised widely as the birthplace of the Paralympic movement.”



Café OASIS, well known to patients, visitors and staff alike, offers a relaxing environment, where they can take a break from their hectic day-to-day, whilst enjoying a refreshing drink and a healthy bite to eat.

Open from 8:30am in the morning until 4pm in the afternoon, Monday to Friday, it offers an environment where customers can relax, take a break and recharge. There is also a grab and go option for those in a hurry.



In November 2021, salon OASIS was opened at Stoke Mandeville, as a salon where ladies, men and children can experience haircuts and hair treatments in a friendly and welcoming environment, every weekday.

Salon OASIS opened part time in November 2021 with a launch day offering goody bags from La Biosmetique, raffle prizes and as a great opportunity for us to get to know our clientele.

Salon OASIS is based on the spinal unit, so the majority of our clients are from the spinal wards. We opened full time in March 2022 and are still in the process of building up our client base as covid has played a big part in this stopping us offering our mobile service to the wards.

We still need to offer these services by advertising on the radio, leaflet drops posters etc. Salon oasis hasn't been advertised to its full potential.

Tracey, our hairdresser and stylist can pamper with a haircut or treatment, along with a coffee from café OASIS. We take bookings Monday to Friday from 10am in the morning through to 6pm in the evening.

Both our retail services have been developed to consider customer wellbeing, and particularly for patients an appreciation that if you feel good, you can get well sooner.

# Our Retail Offer in Summary



## NUMBER CRUNCHING

Our **total income** was over **1/3 UP ON 2020/2021**

Given the trading climate, which continued to be affected by the pandemic, which reduced visitor numbers, the café has done remarkably well to limit losses.



## CUSTOMER FEEDBACK

**93%** Overall service quality, and order accuracy

**91%** Cleanliness and **90%** value for money

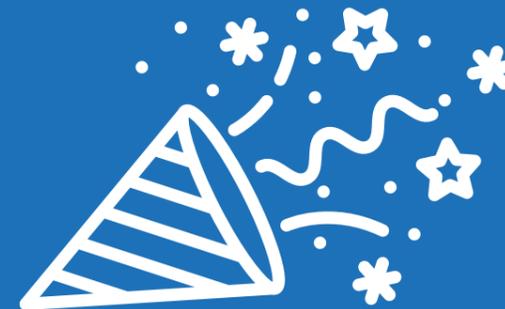
*“Bright & clean, polite staff; keep up the good work!”* 

**84%** Speed of service

Food quality achieved **82%**, where all 20 quantitative feedbacks were **EXCELLENT** or **GOOD**, none were average or dissatisfied.



## CUSTOMER FEEDBACK



We scored **100%**

across the following areas:

- Ambiance/Cleanliness • Variety of Services • Booking Accessibility • Professionalism • Overall Service Quality

“OUR CUSTOMERS TOLD US:”

“Lovely, friendly team that run the salon.”

“My stay on the spinal unit was made so much better by having Tracey as my stylist.”

“The visit was a very pleasant one; what a wonderful job she did to my hair.”

# 7. Being a Social Enterprise

“ In September 2021, BHPL were awarded the Social Enterprise UK accreditation, which enabled us to join the biggest network of social enterprises in the UK. ”



Over 100,000 social enterprises, contributing £60bn to the economy and employing around 2m people. As such we are now able to promote our status, and our services, to demonstrate a better way to do business, one that prioritises benefit to people and our planet, and one that uses the majority of our profit to further our vision.

#### As a Social Enterprise, we:

- Have a clear social mission set out in our governing documents and are controlled in the interests of that mission
- Are independent of government control, and earn more than half of our revenue through trading
- Re-invest or donate at least half of our profits towards our mission
- Are transparent in the way we operate and the impact we have

In doing so, we aim to reduce economic inequality, improve social justice and work towards environmental sustainability.

We're still a business, that aims to succeed commercially and to make a profit. Beyond that we aim to transform lives and communities local to ourselves.

#### Initiatives that we plan to focus on in the coming year and beyond includes:

- Charitable support – to invest in local NHS services
- Carbon reduction – to identify a baseline and then develop a roadmap to Carbon Net zero.
- Career Support – to invest in development and training packages for our colleagues to enable them to develop themselves and build a career.
- Equality, Diversity & Inclusion – to give opportunities to all areas of our local workforce.
- Community Support – to be a good citizen in support of our local communities
- Staff Support – to find ways to support colleagues with the current cost of living crisis



# Our Results as a Social Enterprise

## Delivering Social Value



Charity Donation - **£170K**



Reducing **Carbon**



**Road to Net Zero** – project started to identify baseline/roadmap

## Career Support



**Training & Development**

## Equality, Diversity & Inclusion



Board Directors are **women**



Operational leadership team are **women**



**23% male; 77% female**



**73%** from the **BAME** community



**4%** supporting our **inclusion strategy**

## Community Support



Support art groups projects



Friday food to food banks

## Staff Support



Making BHPL a great place to work



We plan to introduce reckonable sick pay for all staff



Salary sacrifice to help with the cost of living challenges



Learning contracts, with paid study leave, to support career development



# 8. Championing our Colleagues



## TYLER'S STORY

**Tyler Lennard's story is a journey of aspiration and development that took him from his local Special Educational Needs school in Aylesbury to becoming the voice of café and salon OASIS on Radio Mandeville, and always being a hit with customers in the café OASIS.**

He joined the BHPL team as a café assistant in 2019 when the café was transferred across from the Royal Voluntary Service just before the pandemic.

From Furze Down school, highly regarded for supporting children with communication and interaction difficulties, through 6th Form college, where his studies included Hospitality and Food Technology, together with Health & Social Care, to working 4 -5 hours a week for RVS, Tyler has always enjoyed serving customers, chatting about their day and making a real difference.

He has tried different hours in the café, always keen to help out and learn more about the business. Currently you can see him there, during the busy lunchtime period, every day from 11:00 to 15:00 and he will always be interested in your day or will happily share with you his love of football. Chelsea are his team, although he regularly travels with his dad to see Leeds and can even occasionally be seen supporting local Buckinghamshire side, MK Dons.

Tyler is happy to tell you about his family, his mum and his nan, and feels "super proud" to also be part of the NHS family, part of the team that in his own words, "makes a difference."

Tyler would like to continue to build on his retail experience and sees himself extending his hours and supporting his colleagues to grow the café even further. And if the opportunity to build on his hospital radio advertising success, and an opportunity arises to develop his interest in theatre, then he will certainly give it his best.

Like our customers, we are delighted that Tyler is an integral part of the team.



## ANTONIO'S STORY

Antonio Oliveira story is one of passion and overcoming adversity. He was born in Oliveira (Olive Tree) sao Mateus, Portugal in 1988. He did well at school and attended University, where he obtained a degree in Pharmacy in 2010, and became a Pharmacy Technician.

He spent the next 5 years working in such a role in a community pharmacy, in his former country.

With his wife, a nurse, applying for and securing a nursing role in the UK at the National Spinal Injuries Centre at Stoke Mandeville hospital, he left his homeland and dreamt of transferring his pharmacy career to the UK, where they would plan their life together.

He thought it would be straightforward to continue being a pharmacy technician in another EU country. Little did he know, this would be the start of the challenges. His application to the General Pharmaceutical Council indicated his qualification and experience were fine, and his registration would be complete just as soon as he had worked here for 6-months. Oh, and completed a UK Pharmacy Law course. With the help of BHT Chief Pharmacist, Jayne Ballinger, a role within BHT internal pharmacy was found in Summer 2016, and by studying in the evening, both were soon achieved.

Unfortunately, in November 2016 the GPhC regulations were changed, and he was now required to repeat his qualification through English examinations, written and spoken, and not just to the original level he had qualified previously, but to a Pharmacy level (Masters level in Portugal.) He could not see a way forward.

About this time, he met Niranjana, our Superintendent Pharmacist, who would become a boss, mentor and friend over the years. He started by supporting him in the other route to qualification; 2 years' work experience in a pharmacy.

Niranjana, asked him to join the new Outpatient Pharmacy initiative (Pharmacy@Bucks) team in June 2018, which Antonio quickly accepted.

He made Antonio dispensing team leader and supported his further career development through NVQ level 3. Eventually in January 2022 he could finally register as a Pharmacy Technician in the UK.

Not wanting to stop there he has now signed up to complete a 1-year Accuracy Checking Technician role, the highest non-pharmacist role in the UK, which he is already well ahead with, having completed the online part in just 3-months.

2022 has really been a special year for Antonio, accelerating his career together with the recent arrival of his first child, a daughter. He also still finds time to enjoy martial arts, as a black belt in Karate, and keeps a keen eye on motorsport, F1 and MotoGP, "between nappy changes!"

Today, we are proud Antonio is our operational lead for the Outpatient Pharmacy, where the business has grown from one small location to four locations on all three hospital sites. He can be relied upon to offer excellent support to our £7m business and is a hugely valued member of the team by all his colleagues.

It really shows hard work and determination, together with support from people who see your potential, can help you to overcome any obstacle and achieve your dream.

DREAM  
HOPE  
BELIEVE  
DARE  
RISK  
TRY

# 9. Being a Purpose Driven Business

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“ We must breathe to live but breathing is not the purpose of life. The purpose of a corporation is to produce goods and services to meet economic and social needs, to create satisfying and rewarding employment, to earn returns for its shareholders and other investors, and to make a positive contribution to the social and physical environment in which it operates. ”

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**John Kay**  
Economist

BHPL continues to follow the five principles of a purpose driven business developed by Blueprint for Better Business:

The following five principles help guide and inspire our business through a purpose that benefits society and respects people, and challenge ourselves to be “better”:

## 1. Has a purpose which delivers long term sustainable performance

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

This is the second year that BHPL has adopted the responsible business principles. A significant step forward has been the first charitable donation to the NHS Trust’s charity and, by doing so, supporting the NHS to deliver outstanding care. The business also invested in its operational overhead with the recruitment of our first Managing Director, a Finance Manager and a Private Patient Manager, to develop the future strategy and steer the growth course in coming years.

## 2. Honest and fair with customers and suppliers

- Seeks to build lasting relationships with customers and suppliers. Deals honestly with customers, providing good and safe products and services.
- Treats suppliers fairly, pays promptly what it owes and asks that its suppliers do the same. Openly shares its knowledge to enable customers and suppliers to make better informed choices.

In 2021/ 22 all purchase invoices, from suppliers, were paid on average within 25 days of the invoice date. We delivered a great service to approaching 100,000 customers across our outpatient pharmacy and retail businesses and this will continue to increase, with the addition of the salon OASIS in 2022/23.

Informal feedback from customer of the Outpatient Pharmacy service and the OASIS retail experience, café and salon, demonstrate how positive customers are about the services they receive.

## 3. A responsible and responsive employer

- Treats everyone with dignity and provides fair pay for all. Enables and welcomes constructive dialogue about its behaviour in keeping true to its purpose. Fosters innovation, leadership and personal accountability. Protects and nurtures all who work for it to ensure people also learn, contribute and thrive.

Once again, at the start of the financial year we reviewed our colleague's salaries to ensure we were meeting market rates and they were payed fairly by job role. For the second year we paid out a discretionary performance related bonus scheme, linked to our annual business plan, behaviours and values.

We have further planned to introduce a reckonable company sick pay scheme that goes over and above Statutory Sick Pay (SSP), together with a flexible salary sacrifice scheme to help colleagues affordably continue their pension contributions, despite the ongoing cost of living challenges

## 4. A good citizen

- Considers each person affected by its decisions as if he or she were a member of each decision-maker's own community. Seeks and provides access to opportunities for less privileged people.
- Makes a full and fair contribution to society by structuring its business and operations to pay promptly all taxes that are properly due.

BHPL submits monthly tax returns to HMRC and fully pays all due taxes as soon as they become due.

BHPL is committed to a path that ensures equality, diversity and inclusion and this can be seen across our colleagues and teams, recruiting from all areas of the local community and society, as shown in our Social Enterprise performance on page 29.

As we continue to progress through the pandemic, and start to return to normal, our support for volunteering opportunities will restart just as soon as it is safe to do so. Their help to tidy the café Oasis garden has created a relaxing and healthy environment that is appreciated by patients, visitors and Trust colleagues alike.

## 5. A guardian for future generations

- Honours its duty to protect the natural world and conserve finite resources. Contributes knowledge and experience to promote better regulation for the benefit of society as a whole rather than protecting self-interest. Invests in developing skills, knowledge and understanding in wider society to encourage informed citizenship.

BHPL has been an active participant in supporting BHT to develop its Net Zero carbon roadmap and has signed up to the removal of single use plastics pledge. Café Oasis and salon Oasis continue to source their supply of products from as local a supplier as possible to both reduce its carbon impact and add additional value to the local economy.



# 10. Roadmap for the Future



## BHPL Vision

- We believe we can have a positive impact on our Society and the Environment, supporting our local NHS Trust's objectives of:
  - *Outstanding Care*
  - *Creating Healthy Communities*
  - *Being a Great Place to Work*



- The way we support this is as a Social Enterprise

A wholly owned subsidiary of the Trust, where we turn commercial opportunities into profits, and profits into charitable donations that benefit our local NHS today and into the future



- What we deliver - Outstanding Outpatient Pharmacy services and a welcoming on-site retail experience.



### What we Plan to Deliver:

- To explore partnership, collaboration opportunities across the Integrated Care System region, and beyond, to deliver, as a starting point, outpatient pharmacy services.
- To make the retail experience more accessible, across multiple sites, and more broad to meet the changing needs of our valued customers.
- To explore research and innovation opportunities, in conjunction with our Trust colleagues, to enable delivery of healthcare to be more effective and more efficient. This includes working with local Buckinghamshire SME's to drive the local economy.
- To build a range of resources and capabilities within the business to support the future development and growth of the local Trust, and partners across the health and social care eco-system, to deliver services in a more agile, flexible and fast-paced way.

# ● Grow the Core

## RETAIN OUTPATIENT PHARMACY SERVICE

Our No.1 priority is to retain the Outpatient pharmacy service contract with BHT for another 5 years from March 2023.

## INCREASE OUR CAPABILITIES

Increase our capability to dispense more complex, and higher cost, drugs, oral oncology medications.

## EMBRACE INNOVATION AND DIGITAL TECHNOLOGY

Investigate robotic automation and explore electronic prescribing platforms, to improve operating efficiency and increase patient satisfaction.

## NEW OASIS OFFERINGS

New offerings within Oasis – introduce a mobile salon to the wards of Stoke, Amersham and Wycombe hospitals, together with smoking cessation support and Vaping access.

## PRIMARY CARE PARTNERSHIPS

Within our Pharmacy Retail offering we are looking to work with Primary Care partners to support their pharmacy needs.

## IMPROVE OPERATIONAL EFFICIENCY

Reduce waiting times by introducing a more effective EPOS till system and a second coffee machine for the busy lunchtime period.

# ● Extend the Core

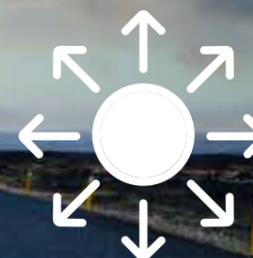
## CAFE OASIS

With the café Oasis we are exploring other sites across the Trust where a full or light café OASIS experience may benefit patients, visitors and staff alike.

Improve accessibility across the Oasis experience - look to increase opening hours, number of sites, with a digital order and collect/ delivery option.

## PHARMACY HOMECARE SERVICE

There is an opportunity to develop a pharmacy homecare service capability to deliver medications at home, thus supporting the Trust's virtual consultation/ ward initiatives that together will help reduce our Carbon footprint.



# Grow Beyond the Core

## REGIONAL COLLABORATION OPPORTUNITIES

To explore with Integrated Care System (ICB, across Buckinghamshire, Oxfordshire and Royal Berkshire) colleagues in areas such as outpatient pharmacy services; private patient healthcare and asset & estates management.

## RESEARCH & INNOVATION

We are at the early stages of understanding how we can drive Research and Innovation further, in conjunction with our Trust colleagues, and what role BHPL can play in that. How we can bring commercial revenues from areas such as clinical trials, and beyond that engage with external partners and innovative SMEs.

# 11. Financial Summary

“ We are delighted with a 30% increase in turnover this year, from £5.26m to £6.84m. This in turn allowed us to donate £170K back to the parent company’s Charity. ”



## Statutory Accounts

Financial Statements for the Year Ended 31 March 2022

For Buckinghamshire Healthcare Projects Limited

Income Statement	43
Balance Sheet	44

**INCOME STATEMENT FOR THE YEAR ENDED 31 MARCH 2022**

	31.3.22 (£)	31.3.21 (£)
<b>TURNOVER</b>	<b>6,842,522</b>	<b>5,258,206</b>
Cost of sales	5,605,152	4,369,969
<b>GROSS PROFIT</b>	<b>1,237,370</b>	<b>888,237</b>
Administrative expenses	1,057,384	744,914
<b>OPERATING PROFIT</b>	<b>179,986</b>	<b>143,323</b>
Interest receivable and similar income	378	66
<b>PROFIT BEFORE TAXATION</b>	<b>180,364</b>	<b>143,389</b>
Tax on profit	21,119	25,371
<b>PROFIT FOR THE FINANCIAL YEAR</b>	<b>159,245</b>	<b>118,018</b>

**BUCKINGHAMSHIRE HEALTHCARE PROJECTS LIMITED  
(REGISTERED NUMBER: 10700085)**

**BALANCE SHEET**

**31 MARCH 2022**

	Notes	31.3.22 (£)	31.3.21 (£)
<b>FIXED ASSETS</b>			
Tangible assets	4	94,950	34,054
<b>CURRENT ASSETS</b>			
Stocks		153,066	239,577
Debtors	5	752,673	617,009
Cash at bank		611,842	521,011
		<b>1,517,581</b>	<b>1,377,597</b>
<b>CREDITORS</b>			
Amounts falling due within one year	6	1,155,296	1,113,661
<b>NET CURRENT ASSETS</b>		362,285	263,936
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>		457,235	297,990
<b>CAPITAL AND RESERVES</b>			
Called up share capital		1	1
Retained earnings	7	457,234	297,989
<b>SHAREHOLDERS' FUNDS</b>		<b>457,235</b>	<b>297,990</b>

The financial statements have been prepared in accordance with the provisions applicable to companies subject to the small companies regime.

The financial statements were approved by the Board of Directors and authorised for issue on ..... and were signed on its behalf by:

.....

Ms A M Williams - Director

## Acronym 'Buster'

### A

- A&E - Accident and Emergency
- AD - Associate Director
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting
- AGS – Annual Governance Statement
- AHP - Allied Health Professional
- AHSN – Academic Health Science Network
- AIS – Accessible Information Standard
- AMR - Antimicrobial Resistance
- AMU – Acute Medical Unit
- ANP - Advanced Nurse Practitioner

### B

- BAF – Board Assurance Framework
- BHT – Buckinghamshire Healthcare Trust
- BMA - British Medical Association
- BME - Black and Minority Ethnic
- BOB – Buckinghamshire, Oxfordshire, Berkshire West

### C

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CCG - Clinical Commissioning Group
- CCO – Chief Commercial Officer
- CCU - Coronary Care Unit
- Cdif / C.Diff - Clostridium Difficile
- CDIO – Chief Digital Information Officer
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CIP - Cost Improvement Plan
- CMO – Chief Medical Officer
- CN – Chief Nurse
- CNST – Clinical negligence scheme for Trusts
- COO – Chief Operating Officer
- CQC - Care Quality Commission
- CQC – Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CRL – Capital Resource Limit
- CRR – Corporate Risk Register
- CYP – Children and Young People

### D

- DBS - Disclosure Barring Service
- DH / DoH - Department of Health and Social Care
- DIPC - Director of Infection Prevention and Control

- DNA - Did Not Attend
- DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
- DNAR - Do Not Attempt Resuscitation
- DNR - Do Not Resuscitate
- DoLS - Deprivation of Liberty Safeguards
- DPA - Data Protection Act
- DSPT – Data Security and Protection Toolkit
- DSU - Day Surgery Unit
- DWP – Department for Work and Pensions

## **E**

- E&D - Equality and Diversity
- EAU – Emergency Assessment Unit
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EIA - Equality Impact Assessment
- EIS – Elective Incentive Scheme
- ENS – Early Notification Scheme
- EPR - Electronic Patient Record
- EPRR - Emergency Preparedness, Resilience and Response
- EPS – Electronic Prescription Service
- ERF – Elective Recovery Fund
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record
- ET – Employment Tribunal

## **F**

- FBC - Full Business Case
- FFT - Friends and Family Test
- FOI - Freedom of Information
- FPPR – Fit and Proper Persons Requirement for Directors
- FTE - Full Time Equivalent

## **G**

- GIRFT – Getting it Right First Time
- GMC - General Medical Council
- GP - General Practitioner
- GPVTS – General Practice Vocational Training Scheme

## **H**

- HAI - Hospital Acquired Infection
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEE – Health Education England
- HETV - Health Education Thames Valley
- HFMA – Healthcare Financial Management Association
- HMRC – Her Majesty’s Revenue and Customs
- HSE - Health and Safety Executive
- HSIB – Healthcare Safety Investigation Branch
- HSJ – Health Service Journal
- HSMR – Hospital-level Standardised Mortality Ratio

- HWB - Health and Wellbeing Board

## I

- I&E - Income and Expenditure
- ICB – Integrated Care Board
- ICP – Integrated Care Partnership
- ICS – Integrated Care System
- ICU - Intensive Care Unit
- IG - Information Governance
- IPC – Infection Prevention Control
- IPR – Integrated Performance Report
- ITU - Intensive Therapy Unit / Critical Care Unit

## J

- JAG - Joint Advisory Group

## K

- KLOE – Key Lines of Enquiry
- KPI - Key Performance Indicator

## L

- LA - Local Authority
- LAC – Looked after Children
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LEP Local Enterprise Partnership
- LMNS – Local Maternity and Neonatal System
- LTP – NHS Long Term Plan

## M

- MDT - Multi-Disciplinary Team
- MIS – Maternity Incentive Scheme
- MIU - Minor Injuries Unit
- MOFD – Medically optimised for discharge
- MRSA - Meticillin-Resistant Staphylococcus Aureus
- MSDS – Maternity Services Data Set
- MSK – Musculoskeletal
- MuDAS – Multi-disciplinary Day Assessment Unit

## N

- NED - Non-Executive Director
- NEWS – National Early Warning Score
- NEWS – National Early Warning Score
- NHS – National Health Service
- NHSBT – NHS Blood and Transplant
- NHSD – NHS Digital
- NHSE – National Health Service England
- NHSE/I – National Health Service England & Improvement
- NHSI – Nation Health Service Improvement
- NHSLA - NHS Litigation Authority
- NHSR – NHS Resolution

- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit

## O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy
- OUH - Oxford University Hospital

## P

- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PBR - Payment by Results
- PBR Excluded – Items not covered under the PBR tariff
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PDP – Personal Development Plan
- PFI - Private Finance Initiative
- PHE - Public Health England
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PMRT – Perinatal Mortality Review Tool
- PP – Private Patients
- PPE - Personal Protective Equipment
- PPI - Patient and Public Involvement
- PQSM – Perinatal Quality Surveillance Model
- PSED - Public Sector Equality Duty
- PTL – Patient Tracking List

## Q

- QA - Quality Assurance
- QI - Quality Indicator
- QIA - Quality Impact Assessment
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QOF - Quality and Outcomes Framework

## R

- R&D – Research & Development
- RAG - Red Amber Green
- RCA - Root Cause Analysis
- RCN - Royal College of Nursing
- RCOG – Royal College of Obstetricians and Gynaecologists
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons

- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

## **S**

- SAU - Surgical Assessment Unit
- SCAS - South Central Ambulance Service
- SDEC – Same Day Emergency Care
- SEN – Special Educational Need
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SID - Senior Independent Director
- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SOC – Strategic Outline Case
- SOP – Standard Operating Procedure
- SoS - Secretary of State

## **T**

- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981
- TVN – Tissue Viability Nurse

## **U**

- UCB – Urgent Care Board
- UEC – Urgent Emergency Care
- UTC – Urgent Treatment Centre

## **V**

- VfM - Value for Money
- VSM - Very Senior Manager
- VTE – Venous Thromboembolism

## **W**

- WDES – Workforce Disability Equality Standard
- WHO - World Health Organization
- WRES – Workforce Race Equality Standard
- WTE - Whole Time Equivalent

## **Y**

- YTD - Year to Date