OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: **Trust Board Meeting in Public**

Date: **Wednesday, 31 May 2023**

Time: **09:30 – 12.00**

Venue: **Via MS Teams and live streamed to the public**

Start Time	Item	Subject	Purpose	Presenter	Encl.
09.30	**1.**	• Chair's Welcome to the Meeting, Meeting Guidance, Who's Who of the Board • Apologies for absence	Information	Chair	Verbal
	2.	Declaration of Interests	Assurance	Chair	Verbal
General Business					
09.35	**3.**	Patient Story	Discussion	Chief Nurse / Chief People Officer	Paper
	4.	Minutes of the last meeting held on: • 26 April 2023	Approval	Chair	Paper
	5.	Actions and Matters Arising	Approval	Chair	Paper
	6.	Chief Executive's Report	Information	Chief Executive Officer	Paper
Board Sub-Committee Chair's Reports					
10.10	**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	Late Paper
	10.	Strategic People Committee • Terms of Reference	Assurance Approval	Committee Chair	Paper Paper
	11.	Charitable Funds Committee Chair Report	Assurance Approval	Committee Chair	Late Paper
Performance					
10.30	**12.**	Integrated Performance Report *Transformation Board 16.05.2023* *Q&CGC 17.05.2023, F&BPC 23.05.2023*	Assurance	Chief Operating Officer	Paper
		QUESTIONS FROM THE PUBLIC			
		COMFORT BREAK – 10 minutes			
Finance					

11.00	**13.**	Monthly Finance Report *EMC & F&BPC 23.05.2023*	Assurance	Chief Finance Officer	Paper
	14.	Financial Plan and Budget *Approved by F&BPC 23.05.2023*	Approval	Chief Finance Officer	Paper
People					
11.25	**15.**	Safe Staffing • Nursing • Medical *Q&CGC 17.05.2023*	Assurance	Chief Nurse Chief Medical Officer	Paper
	16.	Freedom To Speak Up Guardian Annual Report *SPC 15.05.2023*	Assurance	FTSUG	Paper
Risk & Governance					
11.40	**17.**	Organisational Risk Report *EMC 11.04.2023, Audit Committee 04.05.2023*	Assurance	Trust Board Business Manager	Late Paper
	18.	Annual Governance Statement *Audit Committee 04.05.2023*	Approval	Chief Executive Officer	Paper
	19.	Self-Certification *Audit Committee 04.05.2023*	Approval	Chief Executive Officer	Paper
Information					
11.50	**20.**	Private Board Summary Report	Information	Trust Board Business Manager	Paper
AOB					
11.55	**21.**	Risks identified through Board discussion	Discussion	Trust Board Business Manager	Verbal
		ANY OTHER BUSINESS			
		QUESTIONS FROM THE PUBLIC			
		Date of Next Meeting: 28 June 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

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TRUST BOARD MEETINGS

MEETING PROTOCOL

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

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

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

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

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

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

David Highton
Trust Chair

THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

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

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

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

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

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

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

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

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

Board of directors

NHS
Buckinghamshire Healthcare
NHS Trust

David Highton
Chair

Neil Macdonald
Chief executive

Non-executive directors

Dr Dipti Amin

Rajiv Jaitly

John Lisle

Tom Roche

Nicola Gilham

Non-executive director (associate)

Dr Adrian Hayter

Mo Girach

Board affiliate
Dr Sarah Lewis

Board affiliate
Hannah Hornby

Raghuv Bhasin
Chief operating officer

Karen Bonner
Chief nurse

Mr Andrew McLaren
Chief medical officer

Kishamer Sidhu
Chief finance officer (interim)

Bridget O'Kelly
Chief people officer

Duncan Dewhurst
Chief digital information officer

Ali Williams
Chief commercial officer

Meeting: Trust Board Meeting in Public

31 May 2023

Agenda item	Patient Story – Pregnancy Loss
Board Lead	Karen Bonner Chief Nurse
Type name of Author	Heidi Beddall Director of Midwifery
Attachments	Video link to patient story
Purpose	Discussion
Previously considered	Academic half day – Baby Loss Awareness Week 2022

Executive Summary

In 2020, Robyn Yarrow experienced a stillbirth at Buckinghamshire Healthcare NHS Trust Maternity Service which was investigated as a serious incident.

In this patient story, Robyn speaks of her experience from diagnosis of antenatal intra uterine death, the birth of her stillborn daughter Olivia and the subsequent birth of her son Kit.

Decision	The Committee is requested to discuss

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	The care of women and families experiencing baby loss is highlighted in national reports such as Morecambe Bay, Ockenden and East Kent. This patient story reflects the experience of one mother who had a stillbirth, a serious incident investigation and subsequent maternity care at BHT
Risk: link to Board Assurance Framework (BAF)/Risk Register	Strategic Priority - Provide outstanding, high value care (“Outstanding Care”) Principal Risk - Failure to provide care that consistently meets or exceeds performance and quality standards including safety, experience and outcome
Financial	Obstetric litigation costs are the highest claims in the NHS
Compliance CQC Standards Safety	Safety Person centred care Duty of candour Good governance Complaints
Partnership: consultation / communication	Family involved Bereavement midwife
Equality	It is essential to have an increased focus on reducing health inequalities for Black, Asian and minority ethnic women and women who are affected by social deprivation. Maternal mortality is 3.7 times greater for Black women and 2 times

	greater for Asian and mixed ethnicity women than white women (MBRRACE 2022). Perinatal mortality is greater for Black and Asian babies- the highest rates of stillbirth affect Black African and Black Caribbean babies from the most deprived areas; the highest rates of neonatal death affect Pakistani and Black African babies from the most deprived areas (MBRRACE 2022).
Quality Impact Assessment [QIA] completion required?	No

1 Introduction/Position

In 2020, Robyn Yarrow experienced a stillbirth at Buckinghamshire Healthcare NHS Trust Maternity Service which was investigated as a serious incident.

In this patient story, Robyn speaks of her experience from diagnosis of antenatal intra uterine death, the birth of her stillborn daughter Olivia and the subsequent birth of her son Kit.

2 Action required from the Board/Committee

The Board is requested to note and discuss the content of this patient story.

APPENDICES

Patient Experience Video Link

Pregnancy Loss.MOV

OUTSTANDING CARE
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Meeting: Trust Board Meeting in Public

Date: **Wednesday, 26 April 2023**

Time: **09.30 – 11.00**

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

MINUTES

Voting Members:	
Mr D Highton (DH)	Trust Chair
Dr D Amin (DA)	Non-Executive Director
Mr R Bhasin (RB)	Chief Operating Officer
Ms K Bonner (KB)	Chief Nurse
Mrs N Gilham (NG)	Non-Executive Director
Mr R Jaitly (RJ)	Non-Executive Director
Mr J Lisle (JL)	Non-Executive Director
Mr N Macdonald (NM)	Chief Executive Officer
Mr A McLaren (AM)	Chief Medical Officer
Mr T Roche (TR)	Non-Executive Director
Mr K Sidhu (KS)	Interim Chief Finance Officer

Non-Voting Members:	
Mr D Dewhurst (DD)	Chief Digital Information Officer
Mr M Girach (MG)	Associate Non-Executive Director
Mr A Hayter (AH)	Associate Non-Executive Director
Miss H Hornby (HH)	Board Affiliate
Miss S Lewis (SL)	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)

01/04/23 Welcome, Introductions and Apologies

The Chair welcomed everyone to the meeting. No apologies had been received.

02/04/23 Declarations of Interest

There were no additional declarations of interest declared relevant to the agenda items.

03/04/23 Minutes of the last meeting

The minutes of the last meeting held on 29 March 2023 were **APPROVED** as a true and accurate record.

04/04/23 Actions and Matters Arising

Action 1368 – safe staffing report. It was noted the medical staffing report would be aligned with the nursing and Allied Health Professionals report rather than a separate report and would come to the next Board meeting in May.

The Action Matrix was **NOTED**.

05/04/23 Chief Executive's Report

NM recognised the efforts of booking staff, operational managers, clinical teams and management teams on being nearly compliant with the national mandate to reduce the number of patients waiting over 18 months.

NM thanked the Chief Finance Officer and the finance team for their hard work on finalising the annual accounts. RJ added his thanks noting a meeting had taken place of the Audit Committee members to go through the draft accounts.

In response to a query from JL, NM noted it had been highlighted the Trust would require capital support to meet to system objective of the deployment of the electronic patient record (EPR) which was part of the ICB digital strategy.

AH highlighted the achievement of the hospital standardised mortality ratio (HSMR) remaining steady through the winter considering the pressures on urgent and emergency care. AH highlighted by meeting the elective care standards pressure had been relieved in other parts of the system such as general practice.

DH noted the Health and Wellbeing Board would oversee the Place Based Partnership in Buckinghamshire with an Executive Team to deliver across all the partners in the County. NM explained the Place Executive Partnership would be tasked with the delivery of the Place Strategy which was defined by the Health and Wellbeing Board. NM was the Chair of the Executive Partnership and the vice chair of the Health and Wellbeing Board which provided a thread between the two processes. The Strategy which the Board had previously seen contained action plans around cardiovascular health, obesity, children, and older people. It was recognised the Trust was in a much better place than previously ensuring there was core commonality across Council, Health and Wellbeing Board and partner Trust priorities.

The Committee **NOTED** the report.

06/04/23 Quality and Clinical Governance Committee Chair Report

DA took the report as read and highlighted the following key points:

- A review of the content of the IPR metrics the Committee received was required to ensure there was appropriate oversight.
- The team were congratulated on the high level of compliance on the NEWS CQUIN target noting extra focus was required on maintaining up to date clinical guidelines. The Committee were assured from a patient safety perspective, new practices were being actioned, but the guidelines needed to be updated.
- The human tissue authority regulatory inspection had described the mortuary services as being excellent.

The Committee **NOTED** the report and **APPROVED** the Terms of Reference subject to a small amendment around a member of Quality and Clinical Governance Committee attending Audit Committee.

07/04/23 Finance and Business Performance Committee Chair Report

NG highlighted the following key points:

- Improvement and reduction in the 78-week wait and nursing vacancy rates.
- There had been discussion on 'Did not attend' (DNA) rates across all services.
- The introduction of trans nasal endoscopy to support the endoscopy backlog was noted.
- There had been a deep dive into community waiting lists across all services, noting there would be specific metrics added to the IPR to have further oversight of these areas.
- Assurance had been provided on the month 12 finances around meeting the revised deficit plan of £14.3m and annual capital plan for year.
- Assurance had been provided on the efficiency gains, noting however recurrent savings were small compared to non-recurrent savings.
- The plan for a plan for a long-term financial strategy was noted and different initiatives and further development of the Strategy was discussed
- The Annual Financial Plan for 23/24 was discussed and recommended for Board approval with a baseline deficit plan and a further adjustment of £5m.
- The initial draft of Buckinghamshire Healthcare Projects Limited (BHPL) annual business plan was discussed noting this would come back for approval at a later stage.
- The contract for renewal for remote ECG monitoring was recommended for the Board to approve.

The Committee **NOTED** the report and **APPROVED** the Committee's Terms of Reference.

08/04/23	Charitable Funds Committee Chair Report

NG highlighted the following key points:

- Two bids had been approved: a wellbeing therapist and an upgrade of equipment for the children's ward in the national spinal injuries centre.
- Assurance was received on financial statements ending 30 September 2022.
- The investment portfolio was reviewed as of 31 January 2023 which was managed by Cazenove Fund Managers.
- There were two items for recommendation for approval by the Board; an update on the Charitable Funds Policy and Procedures and the recommendation to move to the multi asset fund with Cazenove following a review of the Trust's net zero strategy.

The Board **NOTED** the report and **APPROVED** the Management of Charitable Funds Policy and Procedures and the move to the Responsible Multi-Asset Fund in view of the Trust's social and environmental objectives.

09/04/23	Integrated Performance Report IPR)

RB highlighted the following from the IPR for the month of March:

- Urgent and Emergency Care was in a stable position with significant work underway to implement a new clinical model in April including a revised consultant rota, expanded same day emergency care service and a relocation of the urgent treatment centre to improve the flow for patients.
- The new paediatric emergency department was opening very soon which would provide a significantly improved patient experience including reduced waiting times.
- There had been improvements in the numbers of medically optimised for discharge patients due to collaborative work with the Council.
- There had been improvements in the number of long waiting patients across elective and cancer services. The backlog had reduced and there had been improvements in performance across the 62-day standard and the 28-day faster diagnosis standard which was a primary focus for this year and crucial for positive outcomes. Additional MRI and ultrasound capacity was being provided to assist with reducing the backlog and creating sustainability.
- There had been improvements in the complaint response times, nursing vacancy rates and Statutory and Mandatory training compliance.
- The IPR was being reviewed to reflect the Trust's revised objectives and would come to a future Board meeting.

DH noted the overall staffing plan was down 1% compared to last year and queried if any additional posts in the new operating model would net off the rate. BOK noted they would not net off entirely, there would be a significant adjustment to take into account the investments that had been made. It was noted the turnover rate had decreased significantly to 12.5% which highlighted the investments the Trust was putting into its people.

AH queried how the ambulance handover trajectory would be improved before Winter. RB noted there had been some sustained improvement in ambulance handovers driven by having a consultant senior decision maker in the ambulance receiving area, ambulances coming straight into the receiving area now the new paediatric building had been completed and the use of a liaison officer from the ambulance service which had driven some of the improvement and would be maintained.

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

10/04/23	Transformational Initiatives for the Operating Plan

DD took the plan as read and highlighted the following points:

- The plan contained transformational initiatives for next year and beyond to deliver the strategic priorities over the next three years and the breakthrough objectives for the coming year. The transformational initiatives were the big changes that were needed to deliver the objectives including digital, estates, organisational development, planned care, urgent and emergency care pathway and healthier communities.
- Improving productivity by 5%, reducing corridor care and the percentage of patients waiting over 12 hours and reducing health inequalities were the key initiatives.

- The IPR would include the data for these initiatives as part of the performance review and key milestones would be identified.
- The delivery of the breakthrough objectives was applicable across the Trust and would involve all teams thinking about using quality improvement techniques to allow them to contribute to lots of small changes across the Trust.
- Thanks were expressed to Helen Byrne, Divisional Director for Integrated Medicine, and Jon Berry, Divisional Director for Surgery and Critical Care, for their leading role in developing the programmes.

HH commented on the good communication of these initiatives across the Trust which had enabled colleagues to be engaged with the plan; teams were able to understand what they could do to increase productivity in their areas.

The Non-Executive Directors congratulated the teams on the report, noting its clarity, succinctness, and inclusion of performance metrics. DA queried if the metrics were realistic recognising the industrial action and the possibility of more to come. RB noted these issues were being discussed at BOB level, however the Trust was confident on delivering these metrics noting further industrial action would make them more challenging.

DH commented on the waiting list target of 65-weeks and the target for the following year was 52-weeks and suggested looking at and addressing the 52-week target at the half year point. RB noted this would be the case and productivity ambitions would help to deliver the 52-week target.

The Board **APPROVED** the transformational initiatives.

11/04/23	Monthly Finance Report

KS took the report as read and highlighted the following points:

- The month 12 position showed the Trust had achieved the internal plan of £14.3m slightly below deficit and the NHSE plan which the Trust was being monitored against of £17.6m showed a significant improvement on the bottom line.
- KS noted the Trust had set a plan, bettered it and achieved it which was a lesson to carry forwards in managing the finances.
- The capital plan had been achieved.
- The cash holding was slightly better than expected although less than ideal for an organisation of the Trust's size.

DH congratulated the management and finance teams for meeting the plan.

KS thanked RB and his teams for their positive and collegiate approach in helping to manage the money.

Board were **ASSURED** by the report and the current position.

12/04/23	23-24 Budget Submission

KS noted the report set out the movement between the 2022/23 submission and the 2023/24 plan and highlighted the key points:

- There was a move away from non-recurring to recurring items, with a cultural piece to make recurrent change programmes. This meant instead of delivering £4m in 2022/23 of recurrent saving the Trust was targeting £23.4m in 2023/24.
- There was a significant non-recurrent cost improvement programme with technical movements.
- The financial plan was not yet settled, the local ICB had asked the Trust to stretch the plan by £5m which was being worked through and was incorporated in the £23.9m I&E plan for 23/24.

These three points would be monitored by the Finance and Business Performance Committee to provide assurance on these key areas.

In addition, KS noted the following:

- There was no large growth for people.
- The regulatory compliance which was an element outside of the Trust's control was quite small at £6m and the majority of two thirds was made up of two items; the new building in terms of cleaning and making safe which was £2m and the EPR.
- Underpinning the plan was the achievement of three targets: 65-weeks, 62-days cancer and 76% emergency target. It was a challenging plan and would require strong management.

- Key issues to be considered were internal financial management and a strong degree of collegiate working with partners to land the income positions i.e. to negotiate with commissioners.
- A key risk in the plan which was included across the BOB ICB was to assume ERF from both the ICB and NHSE noting current plans were unlikely to achieve the ERF target. There was likely to be some contractual arrangement emerging later in the year but was a £21m risk.
- The capital plan was currently set at £28.4m and was made up of £20m ICB allocation, £5.7m which was expected externally for the EPR and two technical movements for PFI lifecycle and donated assets.
- The ERF risk was an ICB risk and was a planning assumption the Trust had been asked to make.
- The I&E deficit was currently £23.9m, including the £5m stretch.
- We were being offered an additional £1.3m by the commissioners as a result of moving the plan by £5m; recommending the plan of a deficit of £22.6m and a capital plan of £28.4 for capital.

The Board approved to delegate authority to KS and NM to provide the final submission if there were further improvements before the final submission on 4 May 2023.

RJ noted the detailed discussion at the Finance and Business Performance Committee and highlighted the significant risk if the Trust was unable to achieve the ERF efficiencies.

KS explained the ERF £21m risk was a risk for the Trust but was also part of a larger BOB risk for all providers. KS believed the ERF resource would be provided where the Trust was doing the right thing.

NG noted the ERF income was based on achieving 109% elective activity and requested this was tracked specifically within the IPR and information provided when negotiations were ongoing. NM noted this would become part of the finance report and it was important to create high standards of quality and efficiency across all services noting the focus on activity would drive outcomes.

NM recognised the ask was challenging for the organisation however the Trust would rise to the challenge and ensure appropriate spending of taxpayers' money. The Trust had grown at an exponential rate over the last two years and part of the recovery process would be to adapt and be clear on the activity gap with clearer reporting in the finance report. There should be a continuous source of board challenge on savings and efficiency plans and current long-term deliverables as this would set the organisation on the path to sustainability.

DH requested value weighted activity (WAU) was included in the IPR, noting it was important for the non-executive directors to understand what the risk might be.

DH recognised the need to monitor the value-added number to quantify the risk as the year progressed and to measure productivity, progress toward the 52-weeks wait as well as 65-week waits and suggested the elective surgical metrics would be valuable for the Board to have oversight of and also the number of cases per 4-hour theatre session as the Trust tries to increase the productivity curve.

DH noted the request from the centre was tough and would require coordinated executive action across a whole range of objectives and the non-executives would need regular review and assurance through the IPR with deep dives as necessary.

The Board **APPROVED** the budget of £22.6m deficit and the capital plan of £28.4m and delegated authority to KS and NM to make any final adjustments as long as it improved the position before the submission.

13/04/23	Private Board Summary Report

The Board **NOTED** the report.

14/04/23	Risks identified through Board discussion

JJ noted the following risks:

- External influences outside of organisational control which may impact on our ability to deliver 2023-24 priorities.
- Financial plan for 2023-24:

- Proportion of non-recurrent CIP versus recurrent CIP.
- Ability to achieve ERF target and resultant income.

15/04/23	Any other business

There was no other business.

	QUESTIONS FROM THE PUBLIC

There were no questions from the public.

Date of the next Trust Board Meeting in Public: 31 May 2023 at 09.30

Public Board Action Matrix

4action ID	Agenda Item	Summary	Target Date	Exec Lead	Status	Update
1368	Safe Staffing	Integrated safe staffing reports including medical and AHP colleagues within acute and community sites	~~29/03/2023~~ 31/05/2023	Chief Nurse/ Chief Medical Officer	Propose Close	Medical and nursing staffing reporting aligned; item listed within agenda
1513	Freedom To Speak Up Guardian (FTSUG) - Mid Year Report	Triangulation between FTSUG and Staff Survey results	31/05/2023	Chief People Officer	Propose Close	Incorporated within annual report; item listed within meetring agenda
1489	Integrated Performance Report	Systematic review of critical infrastructure and shortage of skills to ensure no points of failure	28/06/2023	Chief Operating Officer	In Progress	Work underway to present to Board in June 2023
1596	Patient Story	Process to follow up patients post-discharge	25/10/2023	Chief Nurse	In Progress	Considering pilot of discharge follow up scheme in Stroke services. Further details to follow.

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Meeting: Trust Board Meeting in Public

31 May 2023

Agenda item	Chief Executive's Report
Board lead	Neil Macdonald, CEO
Type name of author	Chloe Powell, CEO Business Manager
Attachments	Chief Executive's Report Appendix 1 – CARE value award winners Appendix 2 – Executive Management Committee and Transformation Board Appendix 3 – Place & System Briefing
Purpose	Information
Previously considered	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).

Appended to this report is a list of the winners of our monthly CARE value awards (Appendix 1), a summary of Executive Management Committee and Transformation Board for the last month to provide oversight of the significant discussions of the senior leadership team (Appendix 2), and a Place & System Briefing (Appendix 3).

Decision	The Board is requested to note the CEO report.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	Highlights activities in place to support high quality patient care
Risk: link to Board Assurance Framework (BAF)/Risk Register	Links to all strategic objectives of the BAF and highlights any risks of note to the Board
Financial	Provides an overview of the Trust financial position
Compliance	Updates on any changing or new legislation or regulation of relevance to the Board.
Partnership: consultation / communication	Highlights partnership activities at Place and System
Equality	Highlights activities regarding equalities where relevant, including equality standards and health inequalities
Quality Impact Assessment [QIA] completion required?	Not required for this report

Chief Executive's Report

National and system update

A year ago, in May 2022, the national NHS level 4 incident in response to the COVID-19 pandemic was stepped down to Level 3 in line with transitioning to recovery. Earlier this month on 18 May, we received notification the NHS is now stepping down to Level 2 in response to changes over the past year and recognition of the recent announcement by the World Health Organisation that COVID-19 is no longer a Public Health Emergency of National Concern.

I was interested to attend the Royal Society of Medicine's Stevens Lecture earlier this month during which Matthew Taylor, Chief Executive of NHS Confederation, made his argument for the future of the NHS. He spoke about the need for a 'new social contract' of shared responsibility, building on lessons from the COVID-19 pandemic, and recognising the social determinants of health. A transcript of the speech can be read here.

From July, Dr Nick Broughton, currently Chief Executive at Oxford Health NHS Foundation Trust, will be joining Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB) as interim Chief Executive. Steve McManus, who has led the ICB since September 2022, will be returning to his role of Chief Executive at Royal Berkshire NHS Foundation Trust. We look forward to working with Nick in this new capacity.

The BOB Acute Provider Collaborative is currently developing its draft vision and strategic priorities, and I was pleased to have the opportunity, alongside our Chair David Highton, to discuss these with fellow CEOs and Chairs from neighbouring Trusts earlier this month. These will be presented to respective Boards for consideration once finalised.

Here in Buckinghamshire, I was pleased to Chair the first meeting of the recently established Buckinghamshire Executive Partnership (BEP). The purpose of the BEP is to work with partners, including Buckinghamshire Council, to deliver positive change in areas and ways that cannot be achieved by individual organisations. With this in mind, the priority areas for this year are: transforming special educational needs and disabilities (SEND) services; joining up care; and tackling health inequalities. Further detail on these, and a summary of our first meeting, is enclosed in Appendix 3.

Outstanding care

Key performance data are reported in the Integrated Performance Report with supporting narrative. This report is being developed to ensure that the measures we are focusing on for delivery of our objectives this year are incorporated, and we can clearly monitor progress.

Colleagues will be aware we continue to experience challenges with our urgent and emergency care performance, and this is visible in the data in this report. I have described in previous reports that teams are working extremely hard to make improvements and we are expanding our models of care to ensure that patients receive treatment from the most appropriate service. We now have an Urgent Treatment Centre (UTC) at Stoke Mandeville Hospital in addition to the one at Wycombe Hospital; from July 2023, the UTC at Stoke Mandeville will be open 24 hours a day. We have also appointed a Hospital Ambulance Liaison Officer at Stoke Mandeville to enable patients to be admitted to hospital as quickly as possible to free up the ambulance to help other people in need.

Availability of appropriate ongoing care for patients who no longer need medical care in an acute hospital setting is a significant factor in the flow of patients through hospital and this impacts on the capacity in the ED. Once again this year, Olympic Lodge provided much needed capacity for patients who no longer need inpatient care in the acute setting, but for whom the appropriate onward care is not yet available. Since opening in October 2022, it has supported about 330

patients. Olympic Lodge has now closed and is planned to reopen in the autumn. My thanks to everyone involved in its second year.

Our community teams are also vital to helping prevent patients from needing to attend an acute hospital, or in supporting their discharge to a community setting or their homes. Indeed, there are a total of 37 adult's and children's services provided by community teams from our Trust including our 'Hospital @ Home' (virtual ward) service which is growing week on week.

I am also pleased to report that the Waddesdon Wing has now fully opened at the Stoke Mandeville Hospital site. This is a new building housing our paediatric emergency department on the ground floor, and our obstetrics and gynaecology service on the first. This is a purpose-built building that should significantly improve the quality of experience for patients requiring these services, as well as of course that of colleagues working in these teams.

For 2023/24, our financial plan is £12.1m deficit, with a capital programme of £29.7m. At the end of Month 1, we reported a financial position in line with plan, and spent £0.6m capital.

Healthy communities

Earlier this month, I was pleased to have the opportunity to spend some time with our School Nursing team in Wycombe, who have been rolling out ChatHealth, a new mobile app for pupils to seek support for their physical and mental health.

I also met with our sexual health services team who run their services out of Brookside Clinic in Aylesbury. It was a good opportunity to hear about how they are looking to deliver our Trust priorities for the year ahead.

Great place to work

This month we celebrated International Day of the Nurse and International Day of the Midwife. Our Chief Nurse, Karen Bonner, also led our now annual Nursing and Midwifery Conference, "Courage of Compassion". We were humbled to have some esteemed international speakers join us for this event, which was attended in person and virtually to allow colleagues to participate in between commitments on site.

On 19 May it was International Clinical Trials Day, and our Research & Innovation team held a fantastic celebration of the power and value of research – my particular thanks to the external speakers who brought their expertise and insight to the day.

Time to Talk Week is about encouraging everyone to talk openly about the importance of one's mental health. We are privileged to be the only Trust with acute sites to have a staff network focusing on mental health and our '1:4 network' held various activities across the week to raise the profile of this vitally important aspect of our health as people.

Finally, on behalf of the Trust Board, I would like to extend my warmest gratitude to three of our Non-Executive Directors, for whom this Trust Board in Public is their last at BHT.

Dr Dipti Amin has been a Non-Executive Director (NED) since June 2015 and an important voice on the Board for the patient, bringing her expertise around quality of care, risk, and patient safety, and most recently Chairing our Quality & Clinical Governance Committee.

Mr Rajiv Jaitly also joined BHT in June 2015 as a NED and has brought to the Board significant financial and analytical expertise, holding us to account over our financial and operational performance, Chairing first our Finance & Business Performance Committee and latterly our Audit Committee.

Dr Mo Girach joined BHT as Associate NED in March 2021 and has played a vital role in our Board as Freedom to Speak Up Guardian, as well as being a member of both Quality & Clinical Governance Committee and Strategic People Committee.

Appendices
Appendix 1 – CARE Value awards
Appendix 2 – Executive Management Committee and Transformation Board
Appendix 3 – Place & System Briefing

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.

March 2023

Category	Name	Role	Nomination	Nominated by
Collaborate	Peer Vaccinators	Flu Immunisation programme, Winter '22'-'23	Twenty-six Nurses across all sites in the Trust came together to deliver 826 Flu vaccinations to their colleagues. This is an exceptional response from all our Peer Vaccinators and a very successful year in giving the most vaccinations, given the winter pressures the Trust was experiencing at the time. This award recognises the effort and time that our Peer Vaccinators gave to ensure this vaccine was accessible and an equitable offer to those that wished to have this protection over the winter period. Our plan is to build on this success for the next winter programme but would like to focus and promote those that made the effort - with the most vaccinations given by one vaccinator was 181! An amazing achievement, considering this is done alongside their normal role and responsibilities, and not just about the giving of the vaccine, but the time to take to complete the training and other requirements needed to administer this vaccine safely to all. These twenty-six nurses put their colleague's protection high up their daily workload for no extra remittance or accolade. These colleagues are Alison McKillop, Amy Richards, Amy Gascoyne, Danni Gupta, Julie Tebbutt, Gillian Norris, Katie Greig, Laura O'Connor, Lynda Roche, Michelle Pearsall, Sarah Brown, Samantha Smissen, Sandra Stocks, Sian Brownhill, Sharon Pollmer, Tracey Batt, Tracey Fox-Clinch, Joanna Atkins, Kirsty Morris, Mary Gauchi, Elaine Gilbert, Jackie Stacey, Julie Caunt, Karen Bonner, Roxana Moise & Helen Kenneth.	
Collaborate	School Nursing Team	School Nursing	The whole of the School Nursing Team have exceeded our expectations for their passion and ability to embrace an additional way of working. The introduction of ChatHealth, the web-based text messaging service for teenagers, was never going to ease the workload pressures for the team. Instead, it has required the whole team to come together, to plan collaborative launch events, share resources, set up new duty rotas to manage messages, embark on new training, supporting one another and contributing to the overall service improvement. This is on top of the trebled workload of referrals, staff vacancy and supporting new staff joining the teams. Since July 2022, the cross county team have come together to forge stronger relationships, share knowledge and contribute to the ongoing service improvements. Even though we acknowledge the demand this placed on the whole team, they continue to bring their best every day, always committed to providing outstanding care to the children and young people of Bucks. The team have demonstrated their dogged determination to support the health and well-being needs of our young people in Bucks and have upheld the CARE Values for BHT. This award goes some way to demonstrate our gratitude and appreciation of them. Thank you!	

Respect	Nomalanga 'Noma' Rwodzi	Paediatric Nurse	I feel like we got the best care for our daughter who suffered from prolonged diarrhoea which resulted in dehydration. Doctors got to the bottom of the issue very quickly. But our biggest thanks go to the nurse Noma, who has been exceptional. She goes above and beyond to provide the best care; she is like a ray of sunshine, and I was so grateful we were under her care. People like her erase the worst memories and replace them with happy ones during challenging times. Norma, thank you from the bottom of my heart and we wish you all the best.	Patient Relative
Enable	Liz Anderson	Lead Nurse for Nutrition	Liz has been an active member of the Dietetics team. Recently, she helped facilitate a very complex discharge of a patient who has been a long-standing inpatient on one of the wards at SMH. This meant that nothing could go wrong this time with the discharge. Discharge planning started well in advance with liaising with the nursing home to recognise their training needs and gaps where education was needed. Then she herself did the training for the NH staff. The training pack developed by herself is an exemplar example of how rounded care looks like, what can go wrong and how these situations can be tackled. This pack is a gold standard for training in other NH if something like this is needed in future. The knowledge of NH staff was consolidated by a set of feedback questions to gauge their competencies. Nearer to the discharge there was more liaising and confirming with the NH staff to check their confidence. Two staff were invited to the ward for more practical training just before discharge. All this was done in addition to a heavy clinical load. The final discharge is yet to happen but surely Liz's efforts need to be recognised and applauded.	Staff

Appendix 2

Executive Management Committee and Transformation Board

Executive Management Committee (EMC) 25 April to 23 May 2023

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
Draft Quality Account 2022/23
Infection Prevention & Control Annual Report
Infection Prevention & Control business case
Pre-operative assessment pathway
Health on the High Street pilot
Patient experience of Emergency Department
Safe staffing report
Six-monthly midwifery staffing report
Review of universal wearing of fluid-resistant surgical face mask

People
CARE value awards
Freedom to Speak Up Guardian Annual Report

Digital and Governance
Trust policies update
Organisational Risk: Corporate Risk Register and Board Assurance Framework
Waivers of Standing Financial Instructions
BHT Pol 089 Manual on Corporate Governance
Minutes from EMC sub-committees

Money and Estates
Productivity & Efficiency planning weekly update
Temporary staffing
Monthly capital and finance reports
Commercial strategy review

Transformation Board 16 May 2023

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 (QI). The following provides an overview of the key areas considered in the last two meetings:

QI projects on a page
Transformation portfolio:

- Diagnostics
- Estates
- Organisational Development
- Urgent and emergency care
- Planned care
- Healthy communities
- Digital

M01 finance report
Productivity and efficiency weekly update
Integrated Performance Report

Place and System Briefing

May 2023

Place

Buckinghamshire Executive Partnership (BEP) meeting 9 May 2023

Item	Summary	Impact
Ways of Working	Discussed and finalised terms of reference (ToR) and communications materials. Agreed priorities for BEP and 'Plan on a Page'.	BEP have agreed to focus on three priorities for Buckinghamshire: Transforming SEND, Joining Up Care; and Tackling Health Inequalities. The BEP will ensure its work is transparent and will share 'Plan on a Page' with partners.
SEND	Discussed plans for investing £4.6m SEND transformation funding across three areas of Integrated Therapies, Neurodevelopmental Pathway and Community Paediatrics.	Partners will focus on immediate investment to stabilise waiting lists this year, and will work together across the ICB, Local Authority and providers to develop transformation plans, through existing SEND governance and mechanisms for engaging the voices of families and children.
Joining up Care	Progress update on the Health and Care Integration Programme, which focuses on hospital discharge arrangements for residents, and the work of the Buckinghamshire Urgent and Emergency Care Board.	Agreed that we need to ensure alignment across UEC, discharge and primary care strategies to join up care. Deep dives on UEC and Primary care planned for July meeting.
Health Inequalities	Discussions around £1.1m NHS investment in Health Inequalities, linking to NHS's 'Core20plus5' agenda, Opportunity Bucks and Joint Local Health and Wellbeing Strategy.	Opportunity to align programmes of work on Health Inequalities to turn the dial on health outcomes in the ten most deprived wards of Buckinghamshire.

Buckinghamshire Executive Partnership (BEP) Priorities

	Transforming SEND	Joining up care	Tackling health inequalities
	The aim: Transforming the experience of care and support for young people with SEND and their families	The aim: Bringing partners together across health and care, including primary, mental health, acute and social care to deliver person-centred care, in the community that helps people stay healthy and independent for longer.	The aim: Tackling health inequalities experienced by those from socially deprived areas and ethnic minority groups in: • Early years; • mental health (access to services and experience); • healthy lifestyles (weight losing, smoking cessation and reducing harmful alcohol consumption); • CVD prevention.
By April 2024, we will have:	**Invested up to £6 million funding** to support early intervention for the ”waiting well” enabling quicker diagnostics, a reduction in waiting times and improvements in people’s experience of our SEND pathways.	**Transformed the way we discharge patients from hospital** with the right support where needed in Buckinghamshire, and establishing: • an integrated discharge team working across the NHS and local authority social work teams; • a new interim/complex bedded hub model (June); • A new intermediate care centre (Sept); • A new transfer of care hub to better co-ordinate people’s discharges across multiple agencies (Oct).	**Buckinghamshire Health and Wellbeing Strategy –** Have delivered year 1 of our action plans for the workstreams in the strategy including: • **Invested £1.1m NHS funding and Opportunity Bucks funding in tackling health inequalities and engaging communities in the following ways:** • **Early Years/Start well** - pilot focusing on pre-conception health and service awareness for women of childbearing age. • **Mental Health -** action plan to address inequalities, including defined actions for MH inpatient services and CAMHs. • **Healthy Lifestyles** – increasing referrals into lifestyle services; ensuring all staff are aware of services and how to make referrals. • **CVD prevention** - Ensuring ECGs available for the hypertension pathway to be followed promptly; and implementing a ‘Stop Before the Op’ initiative.
Going further, we aim to:	Transform people’s experience of SEND services in Bucks, moving with partners to an early intervention and needs led approach.	Transform not just discharge services but our wider model of integrated care to ensure that all parts of the health and care system are joining up to support people’s needs in the community, increasingly through integrated teams and preventative models of care.	Embed preventative approaches and proactive work to tackle inequalities into all our work at every level, developing a more sophisticated understanding of the opportunities to improve outcomes for all our populations through outreach and engagement and data.

System

BOB Integrated Care Board (ICB)

The BOB ICB meeting takes place every other month and the agenda and reports for the meeting on 16 May are available here.

I would particularly draw colleagues' attention to the Chief Executive and Directors Report for an update on key system activities.

In addition, the Board were asked to approve the draft BOB ICB Operational Plan for 2023/24, which contains a summary of activity, workforce and financial plans from the respective NHS Trusts.

The Board were also asked to approve the BOB ICB Digital & Data Strategy which sets out the system ambition for the next three years to build collective digital and data maturity across partners and providers in order to improve the lives and experiences of the population served. The Strategy sets out the approach across key areas with some specific milestone dates, as well as outlining the respective organisation's digital maturity.

Report from Chair of Audit Committee
Date of Committee 04 May 2023

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Minutes of the previous meeting	Minutes from the Audit Committee meeting on 02 March 2023	Approved	None	n/a	n/a
Annual Governance Statement	Draft version of the Annual Governance Statement for 2022-23; as required by the Department of Health & Social Care as part of the Trust Annual Report	Approved subject to minor amendments	None	n/a	To approve
Self-certification	Annual self-certification of Trust compliance with the NHS Provider Licence for 2022-23	Approved	None	n/a	To approve

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Organisational Risk	Overview of risk within the Trust including details from the Corporate Risk Register (CRR) and Board Assurance Framework (BAF)	Assured – noting deep dives planned for longstanding risks within the CRR	Details related to specific risks to be highlighted in monthly executive meetings and continued focus on provision of action milestones	Deep dive of CRR 119 ('on-holds') to be considered by Quality & Clinical Governance Committee	To note ongoing development of risk reporting and Committee oversight of key risks; specifically that related to patients 'on hold' (CRR 119)
Governance Manual	Routine review of BHT Pol 089 Manual of Corporate Governance (incorporating Standing Orders and Standing Financial Instructions)	Approved – subject to amendments as raised by the Committee Development of 'bite-size' guides underway	Redefine 'Chairs Action' to ensure collaboration with CEO and at least one NED colleague Ensure appropriate wording re: sensible approach to approval of funds within budget Consideration of audit of compliance with policy	n/a	To approve subject to amendments suggested (noting requirement for ratification by TPSG and EMC prior to Trust Board)
Draft Accounts	Draft accounts for 2022-23, incorporating comments made by Audit Committee members following extraordinary meeting on 24 April 2023	Accounts and initial submission noted	Final submission confirmed as end June 2023	n/a	To note

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
External Audit	Verbal update on current position with potential external auditors for 2022-23 annual audit	Noted – due diligence with potential auditor ongoing; for both Trust and Charity	None	n/a	To note
Internal Audit; Progress Report	Update on progress with annual plan including presentation of one final report (split into two sections): - Serious Incidents (RA)* - Complaints (PA)*	Assured – noting work on mortuary security and DSPT ongoing in draft. 2023-24 work commenced.	None; actions to be undertaken as per Internal Audit recommendations	n/a	To note partial assurance opinion related to management of complaints
Internal Audit; Recommendations Follow Up Report	Update on actions and recommendations followed up since last meeting	Assured – noting significant work at end of year to close down outstanding management actions	Ongoing focus on timely implementation of recommendations	n/a	n/a
Internal Audit; Head of Internal Audit Opinion	Annual report for 2022-23 including Head of Internal Audit Opinion	Assured – noting positive opinion	As above re: focus on management actions	n/a	To note

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Local Counter Fraud Specialist (LCFS); Progress Report	Update on outcomes of Counter Fraud work undertaken March-April 2023 including emerging risk, actions and mitigations and adherence to NHSCFA requirements	Assured	None	n/a	n/a
Local Counter Fraud Specialist (LCFS); Annual Report	Annual summary of fraud prevention, detection and investigation work undertaken by the LCFS in 2022-23	Assured	None	n/a	n/a
Single Tender Waivers (STW)	Overview of STW between March-April 2023 including those considered to be avoidable and retrospective	Partially assured – noting ongoing high numbers of waivers	Ongoing focus on methods of reduction of those STWs considered as avoidable and retrospective	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Losses and Special Payments	Summary of YTD losses including pharmacy and patient property	Partially assured – noting focus required on pharmacy processes and compliance with these to mitigate avoidable losses	None	Planned work by Internal Audit on medicines management and pharmacy Ongoing work overseen by Finance & Business Performance Committee (F&BPC) related to switchover of biosimilar drugs	n/a
Minutes of Quality & Clinical Governance Committee	Minutes from Q&CG Committee Meetings on 15 February 2023	Noted	None		n/a
Minutes of Strategic People Committee	Minutes from SPC Committee Meeting on 13 March 2023 (draft)	Noted	None		n/a
AOB	Internal Audit review of capital management (related to Paediatric ED build)	Publication of finalised report noted	None	Report and accompanying action plan to be considered by F&BPC	n/a

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

Emerging Risks Identified:

- Patients within 'on-hold' follow up waiting lists (as per risk 119).
- Partial assurance opinion related to management of complaints.

Report from Chair of Quality and Clinical Governance Committee (Q&CG)
Date of Committee 17 May 2023

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the Q&CG meeting on 19 April 2023	Minutes approved	None	Refer to Audit Committee for noting	n/a
Integrated Performance Report	Monthly reporting on Trust quality metrics and actions/progress with actions to address negative variance April data considered	Assured Pressure ulcer, maternity and infection prevention and control metrics considered under separate reports in more detail	None	n/a	To note discussion related to Quality metrics when considering full report
Pressure Ulcer Report	Overview of pressure ulcer incidents during 2022-23 including benchmarking data, results of recent thematic analysis and improvement plan from 2023-24	Partially assured – noting data challenges related to being an integrated trust Opportunity for the Trust to take a lead in implementation of the National Wound Care strategy as an integrated Trust noting collaborative working with primary care and system colleagues underway alongside local capacity issues	Further work to source data relevant for integrated trust More creative thinking related to capacity challenges, focusing on working within the local Place	n/a	To note detailed Committee oversight of this subject

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Infection Prevention and Control Committee Quarterly Report	Details of the performance and activities of the Infection Prevention & Control team between January-March 2023	Partially Assured – noting further work required to provide assurance within the IPC Board Assurance Framework Collective working with system colleagues noted with the intention of a health economy approach	Identification of key areas of the BAF for Committee outside with scheduled review of these	Executive Management Committee requested further information on level of risk related to areas of non-compliance within the BAF and next steps to compliance	n/a
Maternity Safety Report	Quarterly report (Jan-Mar 2023) providing an overview of current maternity safety issues and evidence of safety reports/intelligence in line with national, regional and local requirements Full details of maternity serious incidents provided in line with Ockenden recommendations	Assured – noting work to redefine the governance and reporting framework within maternity Noted improvements in Post-natal care	Provision of a short summary of HSIB reports to facilitate understanding	n/a	Revised governance and reporting framework for maternity services scheduled for presentation to the Trust Board
Maternity Staffing Report	Overview of midwifery staffing between October 2022-March 2023 highlighting key concerns	Assured – noting work ongoing within triage	None	n/a	

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Safe Staffing Report	Quarterly report (Jan-Mar 2023) providing an overview of nursing staffing, effective deployment of nursing staff and measures in place to maintain safe staffing	Assured – noting reduction in vacancy rate (6.3%; lowest within 2023-24)	None	n/a	To take assurance from the report
Safe Medical Staffing	Update on the Safe Medical Staffing Programme including breakdown by Division with additional detail on medical staffing within anaesthetics	Assured – noting actions in place to mitigate suboptimal levels of staffing on a daily basis Specialty specific staffing challenges were acknowledged by the Committee	Further clarity to be provided within future reports alongside greater detail on those mitigations in place Evaluation of investment into junior medical colleagues	n/a	To take assurance from the report and work ongoing to refine future reporting
Cancer Report	Update on implementation of the Cancer Improvement Plan and performance against the Cancer Waiting Times standards	Assured – noting ongoing work to promote screening tests, facilitate appropriate referrals from primary care and support adequate diagnostic capacity	None	n/a	n/a
Clinical Harms Update	Update on the clinical harm review including activity in the past 6 months and recorded harm	Assured – noting reduction of long waiters and the absence of any major harm	None – noting final report awaited from NHS England following central review	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Mortality Report	Overview of mortality indicators and summary of activity related to Structured Judgement Reviews	Assured – noting the stability in mortality indicators over challenging winter months and work ongoing to identify any developing themes	Dr Foster and Graphnet being utilised to consider mortality through health inequalities lens; await outcomes Increased focus on appreciative inquiry	n/a	n/a
Never Events	Overview of Never Events which occurred in April 2023	Noted – awaiting completion of detailed Serious Incident (SI) investigation and final report	Consider the use of National Joint Registry (NJR) tools and handheld barcode scanners which can be used intraoperatively within theatres as part of the relevant investigation and subsequent recommendations Recognising the opportunities for learning, consider how best to monitor near-miss incidents	n/a	To note
Research & Innovation Report	Quarterly report (Jan-Mar 2023) highlighting key successes and challenges for the quarter and the ongoing focus for 2023-24	Assured – noting wealth of positive work ongoing	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Diagnostic Radiology Reporting Delays	Deep dive into CRR Risk 92 including a summary of the current position and harm review process and an update on remaining risks and mitigations and the LLP solution	Assured – noting the plans to de-escalate the risk from the Corporate Risk Register (CRR) and the governance processes in place within Radiology	None	n/a	n/a
Patient Experience Report	Quarterly report (Jan-Mar 2023) highlighting compliment and complaint numbers, associated learning and a summary of activity in the PALs and Chaplaincy services, examples of patient engagement and themes for further work to improve patient experience	Assured – noting improvements in complaint response times and patient experience metrics related to the Emergency Department	Consider other methods to triangulate patient experience information including alignment with numbers of patient contacts.	n/a	n/a
Patient Experience; Emergency Department (ED)	Triangulation of data sources related to patient experience within ED with a summary of outputs for the Committee	Assured – noting areas of good performance within Urgent and Emergency Care	None	n/a	n/a
Integrated Safeguarding Report	Quarterly report (Jan-Mar 2023) highlighting activity related to both adult and children safeguarding services	Partially assured – noting capacity issues and ongoing risk related to Deprivation of Liberty Applications (DOLs)	Escalation of increased safeguarding activity to ICB colleagues noting this as a regional issue	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Non-Executive Director (NED) Complaint Review	Summary of quarterly review of complaints undertaken by NED colleagues; theme 'infrastructure'	Assured – noting revised reporting format and reintroduction of action plans relating to complaint responses	Ensure robust framework in place to ensure consistency of lens for review	n/a	n/a
Patient Safety Incident Response Framework (PSIRF)	Briefing paper updating the Committee on PSIRF which replaces the current Serious Incident Framework (SIF) and an overview of the implementation plan	Noted	Work ongoing within the Trust to facilitate implementation of the framework and support relevant culture shift. Full implementation may take 18 months to 2 years and SIF will continue in the interim. Progress to be reported to Q&CG Committee.	Board seminar to be scheduled (Autumn 2023)	n/a
Annual Quality Account (including Quality Priorities)	Draft Quality Account based on requirements of the Department of Health & Social Care detailing the quality of services provided by the Trust and plans for improvement	Noted	Draft to be considered by Committee colleagues; deadline for comments 26 May 2023. Chair of Q&CG comments already included.	For final approval by Quality Committee and Trust Board in June 2023	
Annual Transfusion Report	Annual Report of the Blood Transfusion service for 2022	Assured – noting compliance with MHRA and improvements to service developed during the year	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Mortality Reduction Group Minutes	Minutes of the meeting on 21 March 2023	Noted	None	n/a	n/a
Infection Prevention and Control Committee Minutes	Minutes of the meeting on 20 April 2023	Noted	None	n/a	n/a
AOB	Celebration of recent awards won by the Director of Midwifery for providing outstanding leadership in promoting equality through 'Turning the Tide': - Chief Midwifery Officer's Silver Award - Personal award from Dr Gloria Rowland, Southwest Regional Chief Nurse Thanks provided to Dipti Amin, Committee Chair, ahead of the end of her term as Non-Executive Director for the Trust.				

Emerging Risks noted:

- Occurrence of Never Events; highlight to the Board.
- Lack of capacity related to tissue viability and poor adherence to the National Wound Care strategy noting this is a national issue.
- Capacity within safeguarding team;
    - Increase in children's safeguarding activity.
    - Ongoing risk related to Deprivation of Liberty Applications.
- Rise in MRSA cases.

Report from Chair of Finance and Business Performance (F&BP) Committee
Date of Committee 23 May 2023

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from: - Meeting 28 March 2023 - Extraordinary meeting 20 March 2023 - Meeting 25 April 2023	Approved	None	Refer to Audit Committee for noting	n/a
Trust Biosimilar Drug Usage (Action 1515)	Update on biosimilar usage v originators for key drugs	Assured – noting efforts in place to support clinician engagement and default switching programme	Information for non-biologics to be provided offline	n/a	n/a – action closed
Monthly Integrated Performance Review (IPR)	Monthly reporting on Trust performance metrics and actions/progress with actions to address negative variance. Reporting defined by NHS System Oversight Framework, BHT Strategic Priorities and Operating Plan	Assured – noting positive national feedback on IPR and reduction in cancer 62-day backlog	Revised report by June 2023 to include clear trajectories, estate related theatre utilisation metrics Focus on elective pathway changes to improve patient experience and performance	NHSE Performance Priorities 2023-24 letter; assurance checklist to be considered by the Committee ahead of Board	To note the report and discussions held by the Committee

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Monthly Finance Report	Update on financial position at M01 including year to date, capital and efficiency position against plans and cash flow analysis	Assured – noting on plan at M01 and significant achievements of Integrated Medicine Division in meeting plan	Further consideration of most effective reporting on cost improvement programmes	n/a	To note the report and discussions held by the Committee
Annual Financial Plan & Budget 2023-24	Summary of organisational budget and financial plan for 2023-24 (noting required change in plan from April 2023)	Approved – baseline £12.1m deficit plan for 2023-24 noting justification for movement	Greater transparency on Integrated Care Board (ICB) allocations	n/a	Recommended to approve 2023-24 plan and budget
Property Services Report	Six-monthly reporting (Sept 2022-Mar 2023) on activity including key issues, compliance with legislation, contract performance, Place scores, capital outturn, staff survey and team activity	Partially assured – noting progress made by Property Services during this period alongside risks raised and further work to do	None	EMC to deep dive into areas of non/partial compliance with a focus on HTM	To note any new risks as escalated to Corporate Risk Register

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Internal Audit Report; Paediatric Emergency Department Build	Internal Audit Management Review to support 'lessons learned' following new build which was now open	Partially assured – noting significant discussion undertaken and work underway to implement recommendations alongside risks noted below	None	Audit Committee oversight of delivery of recommendations	To note (post Audit Committee consideration)
Commercial Strategy	Half year review of progress against the 2025 Commercial Strategy	Assured – noting the size and scale of the innovative and complex projects in the strategy that had been achieved	None	n/a	n/a
Wycombe & Camborne Asset Management	Management of assets at both Wycombe Hospital and Community sites	Approved	None	n/a	Recommended to Board for approval
Buckinghamshire Healthcare Projects Limited (BHPL) 3-Year Business Plan & Budget	One year budget and 3-year business plan for the Trust's subsidiary company; BHPL	Approved – noting the 3-year business plan was an evolving strategy	Review of BHPL progress against budget and plan at 3 months Further work on best practice governance including investment framework	n/a	Recommended to Board for approval

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Business Case; Additional Beds	Overview of bid and business case for national funding for additional bed capacity	Approved – noting decision awaited for result of bid	None	n/a	Recommended to Board for approval

Emerging Risks noted:

- Risk of conflicting activity and financial targets noting the upcoming junior doctor industrial action and risk to achieving elective targets.
- Areas of non/partial HTM compliance including ventilation.
- Capability within the organisation to support effective project management and contract management, particularly in large scale cross cutting projects and dependency on such projects to achieve the Trust strategy.

Report from Chair of Strategic People Committee (SPC)
Date of Committee 15 May 2023

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the Strategic Workforce Committee meeting on 13 March 2023	Approved subject to minor amendments	None	Refer to Audit Committee for noting	n/a
Chief People Officer Report	Update on key people developments since the previous Committee meeting (March 2023) Verbal update on position related to industrial action (medical colleagues) and negotiations related to the pay offer (non-medical colleagues)	Assured – noting the significant number of nominations received for the Annual Staff Awards, chaplaincy team support for colleagues during Ramadan and the recent Coronation.	Consider how best to publicise methods for patients/relatives to provide feedback on Trust services, both positive and negative (possibly including the use of QR codes)	n/a	n/a
People Directorate Risk Register	Review of 'People' risks within divisional and corporate risk registers and update on Internal Audit work ongoing	Assured – noting mitigations in place to manage the risk related to the electronic filing system	Update Committee on risks within other registers related to payroll/leavers/ information governance and mitigations in pace	n/a	To note Committee consideration of People risks when reviewing organisational risk report

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Integrated Performance Report (IPR)	Monthly reporting on Trust performance metrics and progress with actions aligned to the Strategic Priorities and the NHS System Oversight Framework March 2023 data presented within formal IPR with verbal update on April 2023	Assured – noting work undertaken and planned to support improved work-life balance for colleagues (noting this as a key reason for colleagues leaving the Trust) Work ongoing to support compliance with stat/mandatory training particularly focussing on information governance Committee noted the rise in vacancy rates from April 2023 due to changes in funded establishments for 2023-24	Committee acknowledged challenges in timing of data; updates to be provided within front sheet where possible going forwards Consider retention with a specific focus on colleagues in Allied Health Professional roles noting work in visibility of People data for specific departments.	n/a	To note Committee consideration of the People metrics within Board discussion of the IPR
Freedom to Speak Up Guardian (FTSUG) Annual Report	Report outlining work of the Freedom To Speak Up team during 2022-23 and next steps for 2023-24	Assured – noting future work being considered to address concerns related to the cohort of people who do not feel that they can speak up	Consider succinctness of future reports	n/a	To note the report and take assurance from the work undertaken by the FTSUG during 2022-23

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Colleague Voice	The voice of Rochelle Breen who explains the role of the Physician Associate and her journey within the Trust	Noted – including the significance of this new profession and the broad benefits for the Trust	None	n/a	Recommended for Board to note and discuss the content of the Colleague Voice
Staff Survey 2022	Presentation of the action plan related to the 2022 Staff Survey and an update on progress with this	Assured – noting the benefits of executive visits to teams to understand any systematic issues and triangulation of the outputs of these conversations with the Team Engagement & Development (TED) programme	Regular updates to Committee on impact of TED programme Consideration of how to understand and address specific medical concerns through use of the Staff Survey; analysis of 2022 results ongoing	n/a	n/a
Committee Terms of Reference	Annual review of the Committee Terms of Reference	Approved – subject to minor amendments made by the Committee	None	n/a	Recommend for approval

FItem	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Flexible Working at BHT	Overview of the proposal and vision for a Flexible and Balanced Working Culture across the Trust alongside the case for change and actions to achieve this	Approved – noting overlap with focus on productivity, culture of QI and intent to facilitate creativity within the Trust and the importance of balancing the need of the employee and the organisation through broad longitudinal conversations Committee noted the differences between agile and flexible working	None	n/a	Recommend endorsement of the approach and approval of associated policy change by the Trust Board
AOB	Thanks given to: - Mo Girach in his role as NED Freedom to Speak Up Champion, noting 31 May 2023 as the end of his term - Rajiv Jaitly for his role as Committee member noting June 2023 as the end of his NED term	Noted	None	n/a	To note

Emerging Risks Identified:

- No new emerging risks noted during the meeting.

Meeting: Trust Board Meeting in Public

31 May 2023

Agenda item	Committee Terms of Reference
Board Lead	Joanna James, Trust Board Business Manager
Type name of Author	Joanna James, Trust Board Business Manager
Attachments	SPC Committee Terms of Reference DRAFT May 2023
Purpose	Approval
Previously considered	SPC 15.05.2023

Executive Summary

The attached document contains the draft terms of reference for the Strategic People Committee including the requirement for these to be reviewed on an annual basis in line with best practice. The Committee and Board last considered these in 2022.

Minor amendments were made to the Terms of Reference after consideration by the Strategic People Committee on 15 May 2023 and these were subsequently approved by the Committee. No material changes have been made to the Terms of Reference.

Decision	The Committee is requested to review and approve the terms of reference.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	A strong link has been established between good governance and patient outcomes and this is recognised widely within research as well as by the CQC well-led domain.
Risk: link to Board Assurance Framework (BAF)/Risk Register	The Committee is required to receive update reports on the principal people risks within the Corporate Risk Register and Board Assurance Framework.
Financial	Good governance is the foundation of strong financial performance and the regular review of Committee Terms of Reference supports this.
Compliance Good Governance	Good governance in healthcare is considered to be a system whereby NHS organisations are accountable for continuous improvement and safeguarding high standards of performance
Partnership: consultation / communication	The terms of reference should be considered by the Committee collectively prior to amendment and/or approval. Membership and attendance is listed to ensure appropriate representation at Committee meetings.

Equality	The terms of reference set out the key functions of the Committee in supporting the Board in the achievement of the Trust strategic objectives including a reduction in health inequalities.
Quality Impact Assessment [QIA] completion required?	No

See attached document.

Strategic People Committee

Terms of Reference

1. Purpose

The purpose of the Strategic People Committee is to take an active role in the development of workforce related strategy and to provide the Board with assurance regarding delivery of the People Strategy.

On behalf of the Trust Board, the Strategic People Committee will oversee all aspects of the workforce and organisational development arrangements of the Trust, including workforce planning as it relates to the Trust and in the context of the Buckinghamshire, Oxfordshire and Berkshire (BOB) Integrated Care System (ICS).

The Committee will regularly review the Trust's workforce performance and delivery against the people programmes of the Trust Corporate Objectives. The Committee will, when required, focus on specific issues where the Trust's performance is deteriorating or there are issues of concern.

2. Constitution

The Board resolves to establish a standing Committee of the Board to be known as the Strategic People Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

These terms of reference shall apply for as long as the Trust is an NHS Trust and can only be amended by the Board of Directors.

3. Membership

The Committee shall be appointed by the Board from amongst the directors of the Trust and shall include at least three independent Non-Executive Directors (this may include associate non-executive directors) and the Chief People Officer.

At least one of the Non-Executive members should also be a member of the Audit Committee.

A Non-Executive Director (NED) shall chair the Committee. In the event the Committee Chair is unable to attend they should make alternative arrangements for a NED member to act as Committee Chair.

Members of the committee shall be appointed by the Board. Members may appoint a deputy to represent them at a committee meeting. Three NEDs shall be appointed as Members for a term of two years, extendable by a further two years at the discretion of the Trust Chair.

The following Executive Directors will be expected to attend or send a deputy:

- Chief People Officer
- Chief Medical Officer

- Chief Nurse
- Chief Operating Officer

Open invitations will be maintained for and papers sent to:

- Deputy Director of Education & OD
- Director of Communications
- Freedom to Speak Up Guardian
- Trust Business Board Manager
- Guardian of Safe Working Hours

Others may be invited to attend depending on relevant of agenda items. These will include:

- Director for Medical Education
- Assistant Director of HR and HR Business Partners

4. Quorum

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

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

5. Meetings

The Committee shall usually meet on a bi-monthly basis with at least 6 meetings per year. Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chair of the Committee

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

6. Authority

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

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

The Strategic People Committee has the authority to require any member of staff to attend its meetings

7. Duties

The Strategic People Committee shall provide strategic oversight of the Trust's people priority of "ensure our people are listened to, safe and supported", in particular the delivery of the people programmes of the Trust Corporate Objectives. This incorporates recruitment, resourcing and retention, culture and leadership, supporting our staff, workforce planning and development and productivity. The Committee shall be responsible for the following duties:

- To be actively involved in the development of any strategy related to workforce and organisational development;
- To monitor, advise on and recommend to the Board matters relating to the Trust's people and organisational development strategy and policies;
- To monitor staff engagement levels and supporting activities including, Talent management and succession planning and leadership & management development;
- To monitor staffing levels to ensure that there are the right number of staff with the right skills and talent working at the Trust through recruitment and retention;
- To monitor, advise and recommend to the Board matters relating to the productivity of the workforce;
- To critically appraise workforce planning activities, in the context of the Buckinghamshire, Oxfordshire and Berkshire (BOB) Integrated Care System (ICS);
- To critically appraise training and education across the organisation including review of effectiveness of training programmes delivered both internally and externally by partner Higher Education Institutes and make recommendations for action;
- Medical staffing: Monitor medical engagement and recommend action as required; scrutinise reports and actions from the Trust Guardian of safe working; monitor the provision of medical education for doctors in training;
- Undertake detailed scrutiny of monthly, quarterly and year to date workforce and organisational development information and determine the quality of assurance that the Board should receive from this information.
- To review the application of the Trust's Raising Concerns Policy and Procedure including the work of the Freedom to Speak Up Guardian (FTSUG);
- Monitor and provide assurance on the delivery of Health and Wellbeing Services.
- Review and maintain an overview of any people related service delivery agreements and key contractual arrangements;
- Deep dives on key people projects;
- To review people related risks;
- To receive assurance on the Health and Safety process and risk management and escalate to Board any significant concerns.

8. Reporting

The minutes of all meetings shall be formally recorded and a summary presented to the Board of Directors by the Committee Chair.

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

9. Review

The Committee shall carry out an annual self-assessment of the Committee's effectiveness including member attendance.

The Committee shall carry out an annual review of these Terms of Reference putting forward any suggested changes to the Trust Board. The Trust Board will review and approve the Terms of Reference annually.

The Board will monitor the effectiveness of the Committee through receipt of the monthly Chair reports.

10. Support

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

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

Document Control

Version	Date	Author	Comments
1.0	18/1/2017	E Hollman	Developed for new Committee, approved by Committee and for Board ratification
2.0	4/1/2018	B O'Kelly	Updated to take account of system changes
3.0	28/5/2019	B O'Kelly	Updated to take account of changes to committee arrangements
4.0	29/06/2022	J James	Periodic review including change of Committee name
5.0	31/05/2022	J James	Periodic review

Buckinghamshire Healthcare NHS Trust

Report from Chair of Charitable Funds Committee (CFC)
Date of Committee 26 May 2023

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Minutes of the previous meeting(s)	Minutes from the meeting on 24 February 2023	Approved	n/a	n/a	n/a
Memorandum of Understanding (MoU); Keyworker accommodation	MoU between the Trust and the Charity setting out the operation of the keyworker housing at the Wycombe site	Approved – noting the asset would be held on trust for the Charity	Separate review and consideration of MoU required by BHT Board.	n/a	Recommended for approval
Charitable Funds Activity & Financial Statements	Overview of financial, operational and governance information related to the Charitable Fund as at 31 March 2023	Assured – noting improved financial position at year end related to significant legacies Committee recognised the significant and proactive achievements of the Charity team	Plans for utilisation of recently received and expected large legacies noting the need to be proactive with such income	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Review of Reserves	Review of the approach to maintaining reserves and proposal for free reserves to cover 3 months estimated commitments	Noted	To support simplification and transparency, review and ensure compliance with Reserves Policy Further paper for approval at next meeting including detail of calculations	n/a	n/a
Cazenove; Portfolio Investment Report	Update on value of the current investment portfolio as of 31 March 2023	Partially assured – noting current returns	Move to multi-asset fund (following approval by Board) Full detailed market test and review of risk appetite; project plan to return to Committee	n/a	n/a
Committee Terms of Reference	Annual review of Terms of Reference for the Charitable Funds Committee	Approved – subject to minor amendments made by the Committee including those related to meeting attendance	Proactive exercise by Local Counter Fraud Specialist (LCFS) in connection with controls over funds approved for spend on bids, particularly those amounts <£5,000	n/a	Recommend for approval

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Risk Management	Charity Risk Register, aligned with guidance from Charities Commission and Trust organisational risk reporting	Assured – noting significant work on the presentation of risk	Quarterly review of risk register by the Committee as a 'living document'	n/a	n/a
Charity Governance Code	An introduction to the Code and proposal on how this could be used by the Charity to gain assurance	Noted	Present to the Committee areas for further development related to governance	n/a	n/a
BHT Charitable Fund and Scannappeal	Overview of approaches to closer working between the BHT Charitable Fund and Scannappeal to generate benefits for both parties	Approved – noting the importance of appropriate communication within and external to both organisations	Further work to understand key issues, risks and benefits; revert to Committee with paper on these matters post meetings with Scannappeal	n/a	n/a
Bids for approval; NSIC Wheelchair Fleet Update	Bid for Charitable Funds to purchase 92 new wheelchairs and 46 new cushions to achieve a number of benefits for patients	Approved – subject to approval by the Chief Operating Officer	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
AOB; Training Approvals	a) Specific request above £500 limit (£915) b) Where funds are available, the £500 limit should apply per member of staff rather than the fund as a whole	a) Approved subject to confirmation the training would benefit the patients of Buckinghamshire b) Approved	Updates to be included in review of BHT Pol 063	n/a	n/a
AOB; Appointment of auditors	Verbal update provided on potential External Auditors for 2022-23 audit (confirmation expected by June 2023)	Noted – expecting completion of the audit in November 2023	None	n/a	To note

Emerging Risks:

- No new risks identified.

Meeting: Trust Board Meeting in Private

31 May 2023

Agenda item	Charity Bids > £100,000
Board Lead	Kishamer Sidhu Interim Chief Finance Officer
Type name of Author	Jane Lucas Interim Head of Charity
Attachments	None
Purpose	Approval
Previously considered	Charitable Funds Committee - 11-14/24.02.2023

Executive Summary

A purchase of medical equipment was noted at Charitable Funds Committee in February 2023. Trust governance procedures have been followed for the purchase of Chemotherapy Plum Pumps, cost £143,500 – fully funded by CCHF.

The Board is asked to approve the purchases as it exceeds £100,000.

Decision	The Board is requested to approve the above expenditure

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	Patient safety considerations were outlined in the original case to the Charity
Risk: link to Board Assurance Framework (BAF)/Risk Register	Principal Risk 1 – Failure to provide care that consistently meets or exceeds performance and quality standards
Financial	No cost to the Trust; seeking Board approval for Charitable Funds use >£100k
Compliance	CQC Standards; Premises & Equipment
Partnership: consultation / communication	Partnership working with the Trust Charity
Equality	Equality considerations were outlined in the original case to the Charity
Quality Impact Assessment [QIA] completion required?	n/a

Meeting: Trust Board Meeting in Public

31 May 2023

Agenda item	Integrated Performance Report (IPR)
Board Lead	Raghuv Bhasin, Chief Operating Officer
Type name of Author	Wendy Joyce, Director of Performance
Attachments	Trust IPR April 2023
Purpose	Assurance
Previously considered	Transformation Board 16.05.2023 Q&CGC 17.05.2023 F&BPC 23.05.2023

Executive Summary

This document provides an Integrated Performance Report for review.

The report was discussed at the Trust's Transformation Board on 16 May 2023. Key points made in the discussion included:

- IPR being revised based on feedback from colleagues with a plan to align the report more closely with breakthrough objectives for 2023-24.
- Ongoing progress with 62-day cancer performance.
- Underlying quality challenges which required greater focus, noting metrics related to pressure ulcers, MRSA and 2 recent Never Events.
- Good progress on 78-week waits with focus to shift to 65-week waits.

The Quality metrics were considered in detail at the Quality & Clinical Governance Committee on 17 May 2023. The Committee discussed timeliness of complaint responses, changes to the maternity governance framework which would be presented to Board later in the month, ongoing maternity staffing challenges. An update was provided to the Committee on the detail of the two recent Never Events along with a deep dive on pressure ulcers. The quarterly Infection and Prevention Control report was provided more detail on the rise in MRSA cases.

On 23 May 2023, the Finance & Business Performance Committee considered the report and focussed on Referral-To-Treatment (RTT) performance noting a refocus on patient pathways to bring down waits and improve patient experience. The impact on the forthcoming Junior doctors strike on elective performance was acknowledged along with the need to balance activity and financial targets. The Committee welcomed a revised IPR in the coming weeks with additional information on estate related theatre challenges and utilisation.

Decision	The Board is requested to consider performance and risk impact.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	Quality and Safety Metrics are a core part of the IPR
Risk: link to Board Assurance Framework (BAF)/Risk Register	Principal Risk 1; Failure to provide care that consistently meets or needs performance and quality standards.

	Principal Risk 4; Failure to provide consistent access to high quality care for CYP Principal Risk 5; Failure to support improvements in local population health and a reduction in health inequalities. Principal Risk 6; Failure to deliver on our people priorities.
Financial	Financial reporting outlined in the outstanding care section of the report
Compliance CQC Standards	Well Led - Operational planning is a statutory requirement of NHS Trusts.
Partnership: consultation / communication	The report is produced in conjunction with divisional and BI colleagues.
Equality	Reducing health inequalities is a core part of our strategy and a core part of the planning requirements for the NHS. Health inequalities metrics included in the health Communities part of the IPR.
Quality Impact Assessment [QIA] completion required?	Not required

NHS
Buckinghamshire Healthcare
NHS Trust

Integrated Performance & Quality Report

April 2023

CQC rating (July 2022) - GOOD

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

Integrated Performance & Quality Report

Buckinghamshire Healthcare NHS Trust

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

Removed
- Employee relations cases closed
- FTSUG outreach contacts

Changed

Integrated Performance & Quality Report

Buckinghamshire Healthcare NHS Trust

Executive Summary

A Great Place to Work:

We continue with our successful nurse recruitment, in particular from overseas. However, as highlighted last month, the vacancy rate increased in April reflecting an uplift in budgeted establishments.

Sickness absence is reducing, in line with season variation. The ongoing focus and investment in colleagues' wellbeing continues with high levels of pro-active referrals into our teams, with the benefits being illustrated in the reducing levels of sickness absence.

The overall compliance with Statutory and Mandatory training has increased incrementally to 89.8%. We expect the Trust target to be met during Q1 as appraisal are completed for non-medical colleagues.

Integrated Performance & Quality Report

Overall Performance Summary

Buckinghamshire Healthcare NHS Trust

April 2023	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Variance: Special Cause - Improvement	★ Open pathway 78 week breaches	★ Open pathway 52 week breaches VTE Assessments Early Warning Score compliance Complaints received Sickness - musculoskeletal Sickness - mental health Sickness - Covid 19 Corporate Induction	★ Complaints response rate Turnover rate Data security awareness training Statutory & Mandatory training
Variance: Common Cause	★ Theatre utilisation Hospital Standardised Mortality Ratio (HSMR)	ED attendances Ambulance arrivals Discharges by 5pm Cancelled operations Cancer treatment levels - 31 day treatments Faster diagnostic standard (28 days) Cancer wait times - 2 Week Waits Incidents that are low/no harm Medication incidents Number of Falls Pressure Ulcers - cat 2, 3, 4 & unstageable SIs confirmed C Difficile infections MSSA bacteraemia infections E.Coli bacteraemia infections Klebsiella spp bacteraemia infections Treatment escalation plan compliance Non critical care inpatient cardiac arrests Friends and Family test - response rate Community average Length Of Stay 21 day LOS - Community Community waiting list size Community urgent 2 hour response Health Visitor appointments - 14 days Average time to replace vacancies Referrals into OH and Wellbeing - stress Occupatient health - management referrals response time	ED 4 Hour performance 12 Hour waits in ED Ambulance handovers within 15, 30 & 60min Medically optimised for discharge patients Medically optimised for discharge bed days lost 21 day LOS - Acute Open pathway performance Elective activity Outpatient DNA rate Outpatient letters to GPs within 14 days Cancer Performance - 62 day pathway Cancer screening Diagnostic activity levels Falls per 1,000 bed days Pseudomonas aeruginosa bacteraemia cases Complaints outstanding at 90 days Friends & Family test - positive responses Sickness
Variance: Special Cause - Concern	Outpatient appointment disruption	Overall size of the waiting list Medication incidents as Sis Never events MRSA bacteraemia infections Nursing and Midwifery vacancy rate Trust vacancy rate	Seen by senior decision maker within 60 min Outpatient activity delivered remotely Cancer wait times - 104 days Diagnostic compliance Endoscopic patients waiting > 6 weeks Non-endoscopic breaches

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

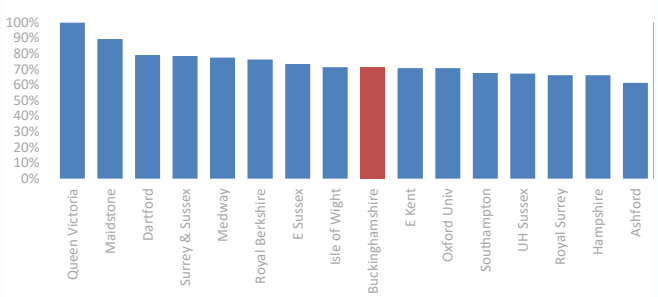
Integrated Performance & Quality Report

Buckinghamshire Healthcare NHS Trust

Benchmarking Summary for South-East Region

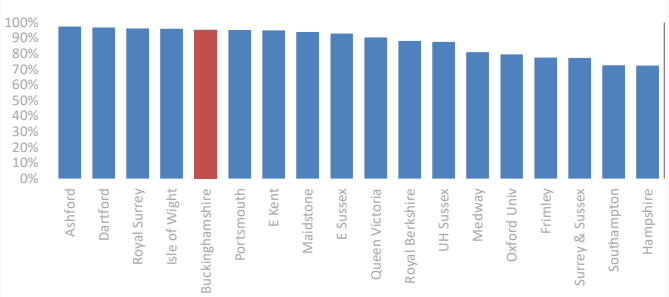
ED 4 hour performance

South East A&E 4 hour performance benchmarking - Apr-23



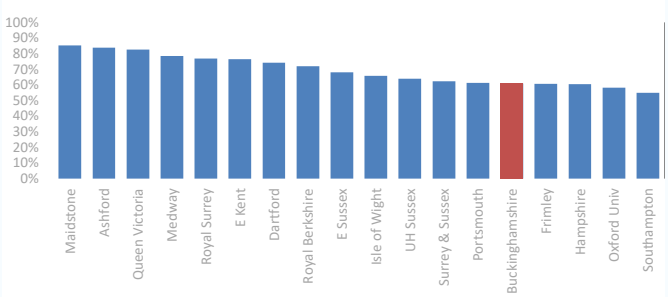
2 week wait cancer

South East region 2 week wait cancer benchmarking - Mar-23



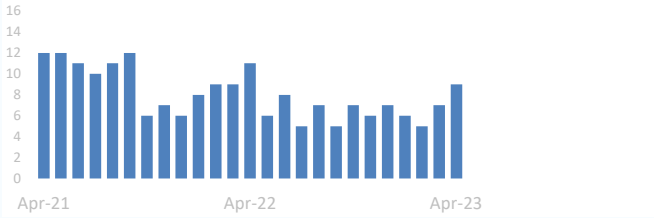
62 day wait cancer

South East region 62 day wait cancer benchmarking - Mar-23



ED 4 hour performance ranking

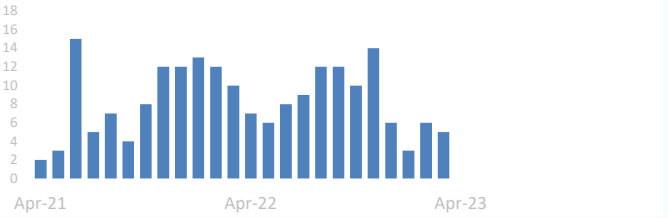
South East A&E 4 hour performance benchmarking - historic rankings out of 16



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

2 week wait cancer ranking

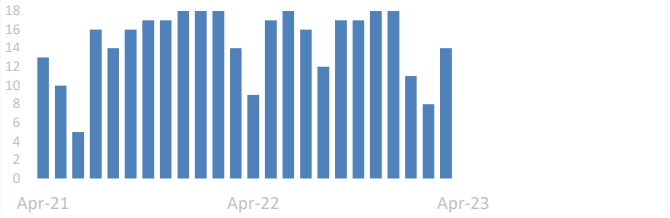
South East region 2 week wait cancer benchmarking - historic rankings out of 18



Hampshire does not report 2 week waits peformance as they are part of the Clinical Services Review.

62 day wait cancer ranking

South East region 62 day wait cancer benchmarking - historic rankings out of 18



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

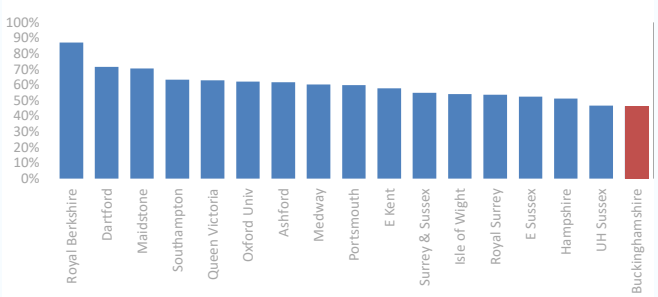
Integrated Performance & Quality Report

Buckinghamshire Healthcare NHS Trust

Benchmarking Summary for South-East Region

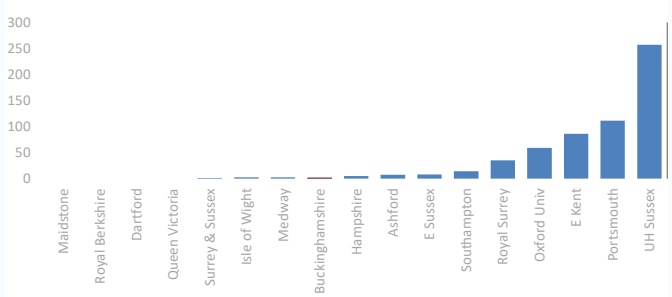
RTT performance

South East RTT performance benchmarking - Mar-23



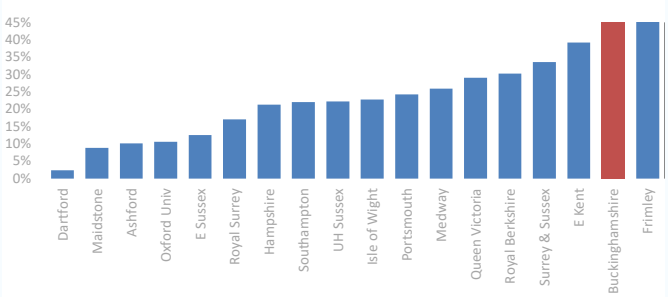
78 week waits

South East over 78 week waits benchmarking - Mar-23



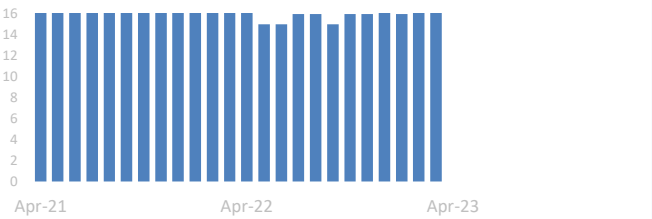
Diagnostic performance

South East diagnostic performance benchmarking - Mar-23



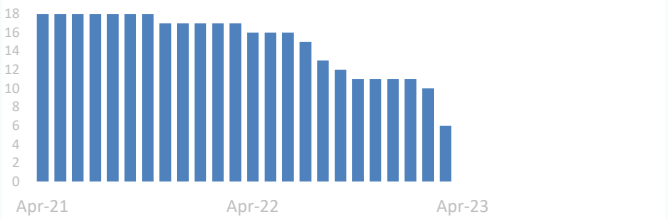
RTT performance ranking

South East RTT performance benchmarking - historic rankings out of 16



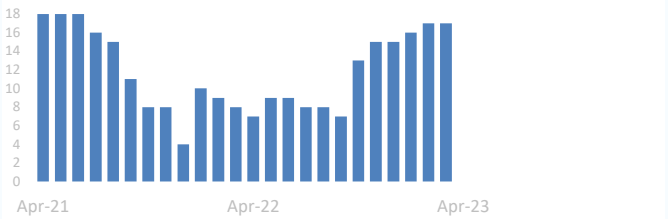
78 week waits ranking

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

Buckinghamshire Healthcare NHS Trust

ED 4 hour performance
The 4-hr performance has seen a sustained improvement in the last reporting period. However, the department continues to experience significant crowding for much part of the 24hr period, reducing the capacity to see, treat, admit / discharge patients timely due to challenges with internal flows and the ability to move patients from specialty areas to more appropriate beds externally for ongoing care.

We continue to embed the improvements / processes specified in the five pillars of work proposed for the front door and informed through the UEC Improvement Board.

12 hour waits in ED
Rising numbers of Emergency Admissions is contributing to the number of persons remaining in the Emergency Department >12hrs.
In the last three reporting periods we have seen a gradual decrease in the number of 12hr stays in ED from 8% to 6.6%.
The contributing factor is limited early flow to specialty wards.

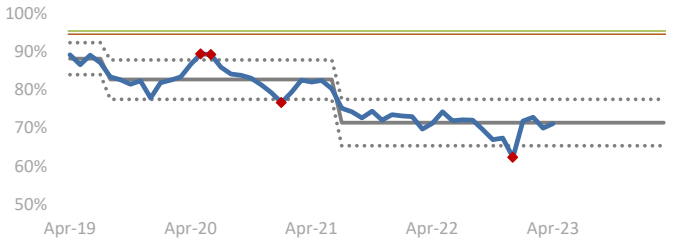
Our ambition is for this to be 2%, which is being supported with our improvement works; improved flows to our assessment areas / SDEC, introduction of the acute medical team attending the ED huddles 3 hourly, introduced specialty in-reach into the Emergency Department, co-located the frailty service to ED and increased communication regarding our virtual ward pathways. Support with discharge processes.

Seen by a Senior decision maker within 60 mins
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 – midnight. This should improve significantly in the coming months with the successful recruitment of 6 Emergency

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

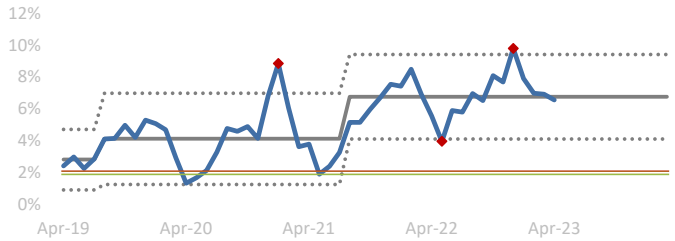
Target 95% Apr-23 **71.2%**



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).

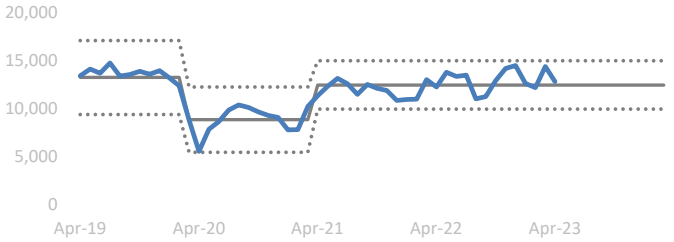
Target 2% Apr-23 **6.6%**



ED attendances

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

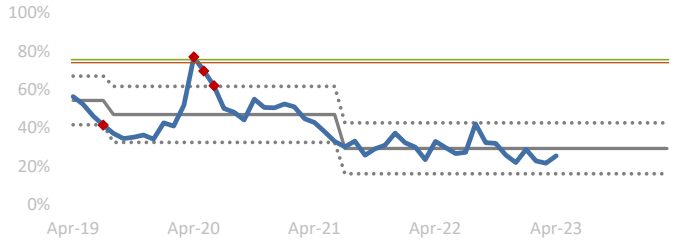
Target N/A Apr-23 **12,876**



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.

Target 75% Apr-23 **25.5%**



Outstanding Care

Operational Standards - Urgent & Emergency Care

Buckinghamshire Healthcare NHS Trust

Ambulance handovers
In this reporting period ambulance conveyances to Stoke Mandeville Hospital have remained static.

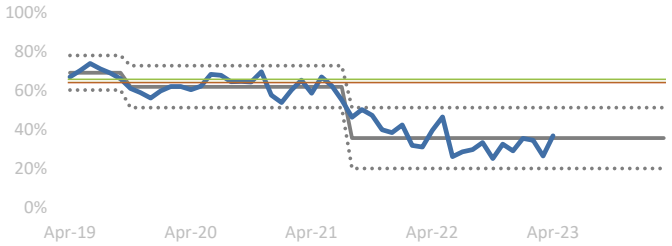
We have seen an improvement in all Ambulance Patient Offload Times, and significantly in the within 60 minute.

We continue to review and modify our processes and pathways and continue to be supported by a Hospital Ambulance Liaison Officer (HALO) supporting timely offloads and advice on pathways.

Ambulance handovers within 15 mins

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

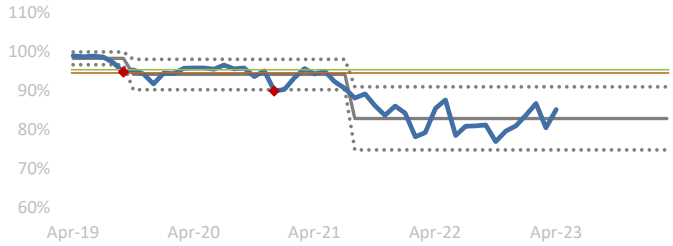
Target 65% Apr-23 **37.0%**



Ambulance handovers within 30 mins

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

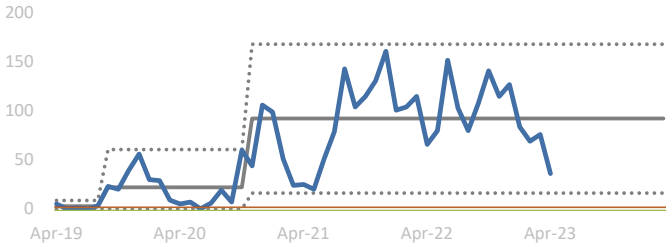
Target 95% Apr-23 **85.2%**



Ambulance handovers over 60 mins

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

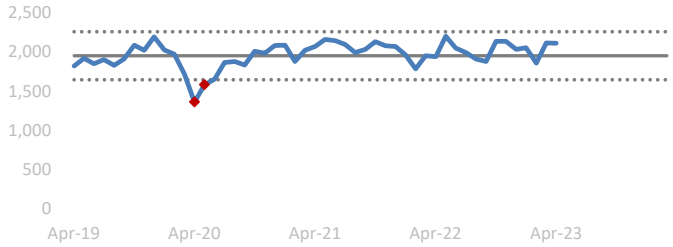
Target 0 Apr-23 **36**



Ambulance arrivals

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

Target N/A Apr-23 **2,114**



Target

Outstanding Care

Operational Standards - Urgent & Emergency Care

Buckinghamshire Healthcare NHS Trust

Medically optimised for discharge
We continue to see c.100 patients who are medically optimised for discharge in our 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. Acute Hospital provider continues to support with the opening of Olympic Lodge.
Dedicated support looking at our discharge processes, regular review of the top 50 patients remaining in an acute bed.

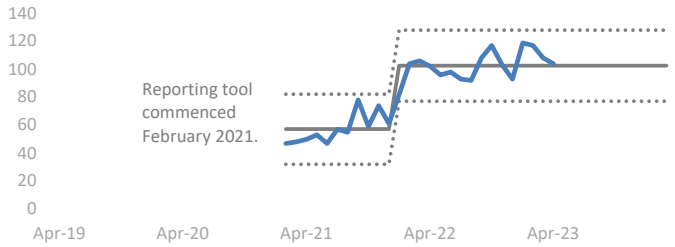
21 day LOS – Acute
We have seen a decrease in patients remaining in hospital >21days on the last reporting period. It does continue to remain high primarily due to lack of capacity in social care and other NHS / Private provider settings.
We continue to maintain this as a focus with the daily MDT meeting reviews and twice weekly over 14 days LoS reviews.
Dedicated support looking at our discharge processes.

Discharges by 5pm
We have seen a slight increase in the number of discharges by 5pm in this reporting period.
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.
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.

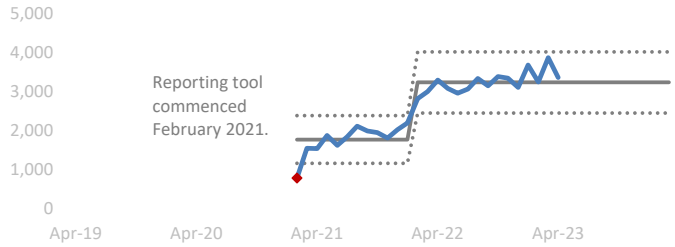
Target N/A Apr-23 **104**



MOFD Bed days lost

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

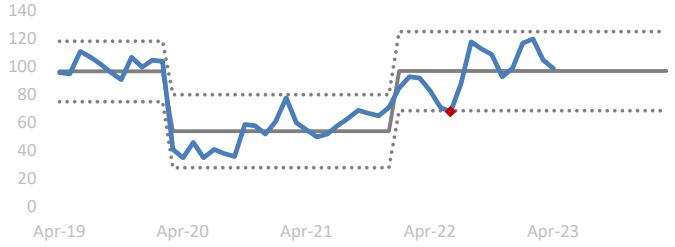
Target N/A Apr-23 **3,364**



21 day LOS - Acute

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

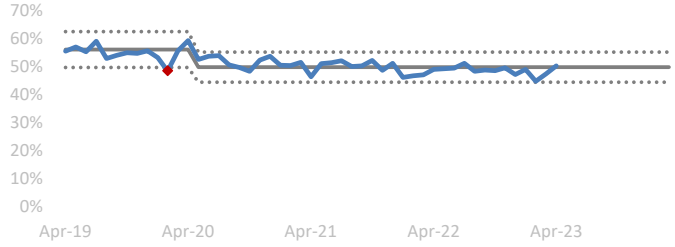
Target N/A Apr-23 **99**



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.

Target N/A Apr-23 **50.4%**



Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

Overall size of the waiting list
Work continues to ensure all referrals are on one waiting list, which enables equal assessment of all patients waiting and capacity planning. This is resulting in an increasing waiting list but ensures no patient is referred on an alternative system without acknowledgement.

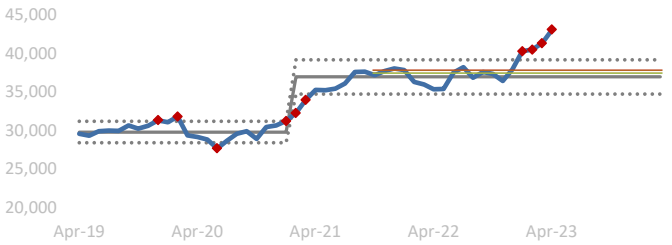
Open pathways
The number of patients treated within 18 weeks remains low and will only start to improve when waiting times reduce and we are able to treat routine patients much earlier in their pathway. This work has started with reductions in patients waiting over 78 weeks.

BHT plan to reduce the longest waiting patient times below 65 weeks by March 24 and below 52 weeks by March 25.

Overall size of the waiting list

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

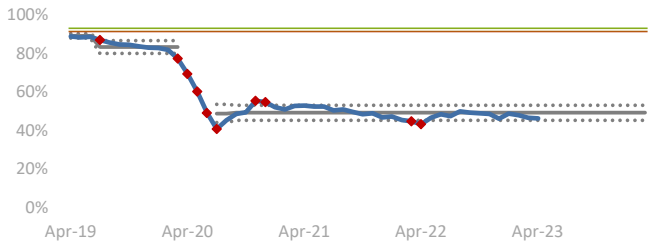
Target 37,590 Apr-23 **43,035**



Open pathway performance

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

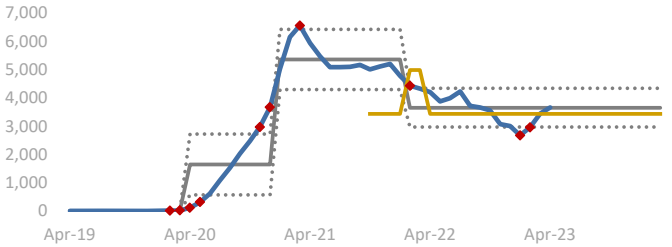
Target 92% Apr-23 **46.2%**



Open pathway 52 week breaches

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

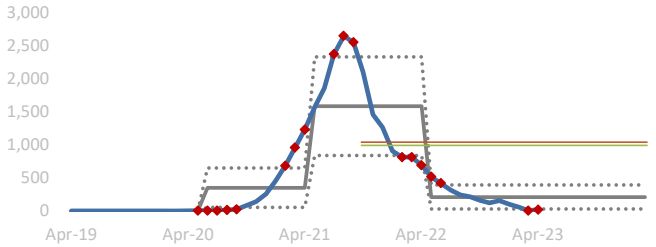
Target 3,437 Apr-23 **3,659**



Open pathway 78 week breaches

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

Target 1,018 Apr-23 **18**



Target

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

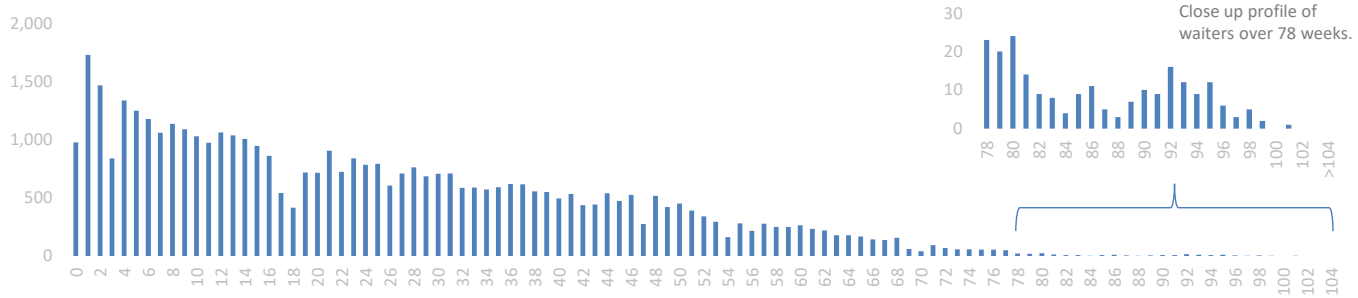
Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

Open pathways by weeks wait

The number of incomplete RTT pathways (patients waiting to start treatment) at the end of the month (Apr-23) by weeks waited from clock start date.



Outstanding Care

Operational Standards - Elective Recovery

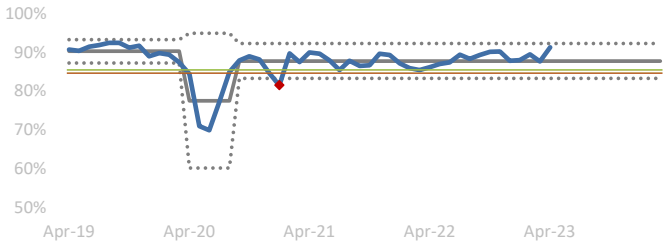
Buckinghamshire Healthcare NHS Trust

Cancelled elective operations

Theatre utilisation

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

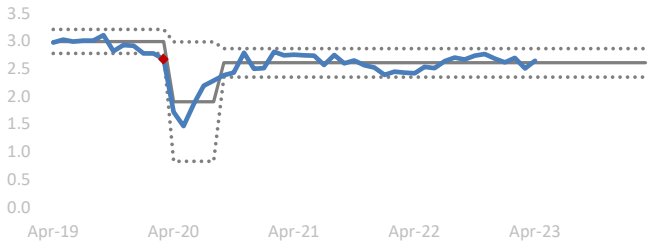
Target 85% Apr-23 **91.3%**



Theatre cases per 4 hours planned time

Number of theatre cases per four hours of planned theatre time during the month.

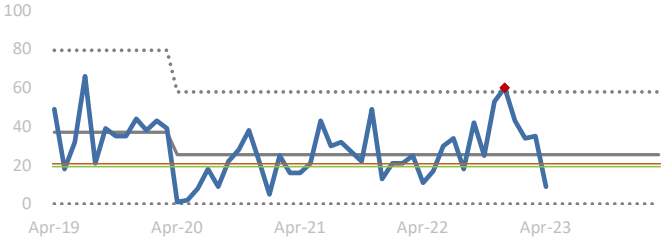
Target N/A Apr-23 **2.6**



Cancelled elective operations

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

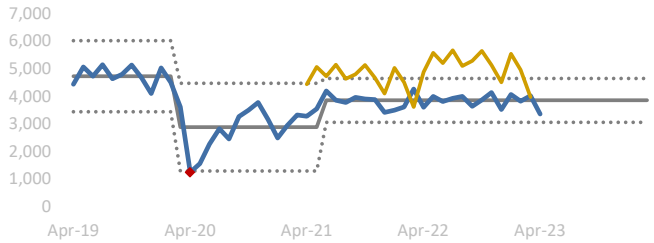
Target 20 Apr-23 **9**



Elective Activity

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

Target N/A Apr-23 **3,358**



Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

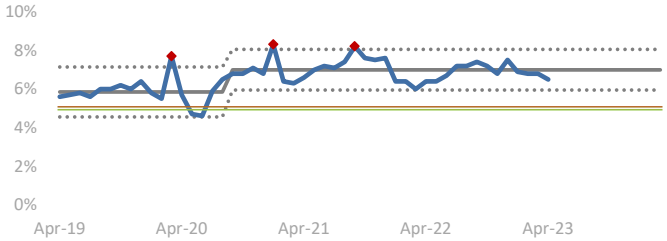
DNA
We continue to see a reduction in the number of patients not attending their appointments with improved communication, and this will continue using electronic reminders and encouraging 2 way communication.

Outpatient activity delivered remotely
Remote consultations remain available in most specialities, however suspected cancer, urgent and long waiting patients who have not been seen for some time often require face to face examinations. We are therefore seeing a reduction in the uptake of remote consultations currently.

Outpatient DNA rate

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

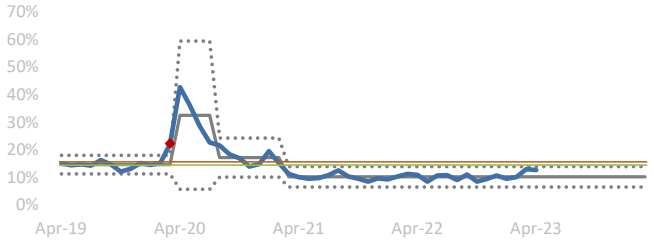
Target 5% Apr-23 **6.5%**



Outpatient appointment disruption

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

Target 15% Apr-23 **12.7%**

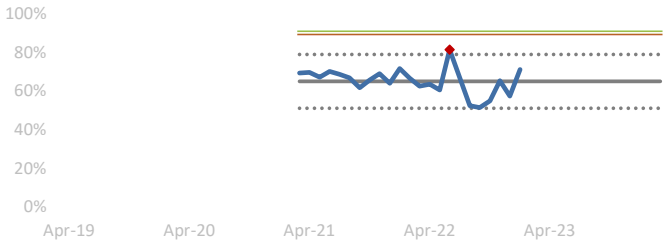


Latest data not available at time of report production

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.

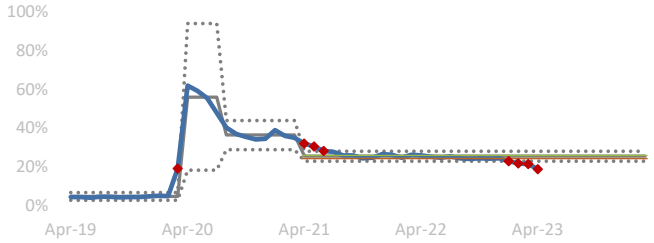
Target 90% Mar-23



Outpatient activity delivered remotely

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

Target 25% Apr-23 **18.6%**



Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

62 day pathway
Performance of 61% has been reported in March (performance reporting month) broadly maintain the sustained increase in performance. Issues impacting performance in month remain were access to timely definitive diagnostics for urology and Head and neck, ongoing delays delivering additional activity in via full skin centre capacity ramp up and elective capacity for patients referred to tertiary centres. These issues also impact the 31 day performance target.
The Trust maintained its backlog position of 166 at the end of April with continued delivery against trajectory.
The Trust backlog position has now decreased to 7.1% of the total patient list compared to average of 9.6% in the BOB ICB.

Delivery of the cancer improvement plan continues with phase 2 implementation having commenced in January 2023. Phase 2 seeks to improvement performance via targeting the FDS standard and early pathway improvement.

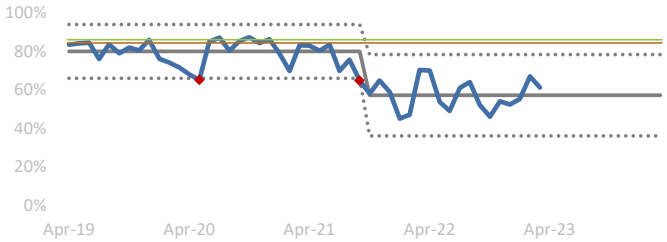
2ww
Work continue to ensure that patient have access within 14 days. The Trust achieved 95.2% compliance against a performance standard of 93% in March 2023.Work continues with TVCA to implement national best practice timed pathways which, while seeking to delivery 28 Fast Diagnosis Standard, will also help deliver 2WW performance (see above). The Trust has been successful in receiving capital funding to improve the diagnostic capacity for patients on a cancer pathway

Cancer Wait times - 104 days
Cancer long waits continue to be discussed and reviewed at fortnightly performance meetings and are subject to increased tracking. The number of patients continues to decrease with only 2.2% of our patients waiting more than 104 days against a national target of 2%. 25% of the current long wait patients have been accepted for treatment at tertiary centres

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.

Target 85% Mar-23 **61.0%**

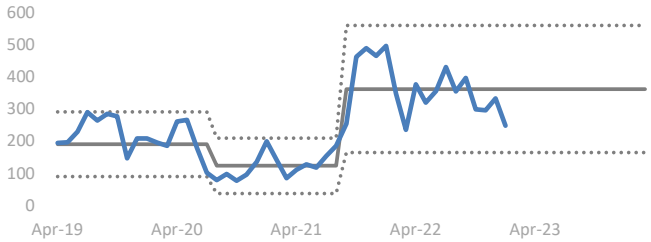


Latest data not available at time of report production

Cancer Wait Times - 62 day waiters

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

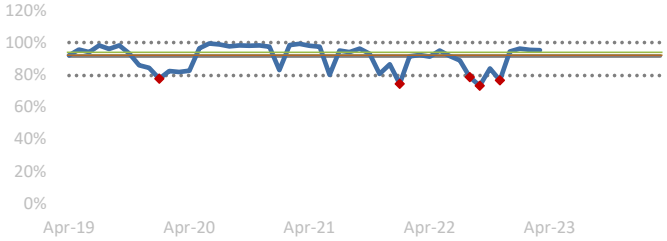
Target N/A Apr-23



Cancer Wait Times - 2WW

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

Target 93% Mar-23 **95.2%**

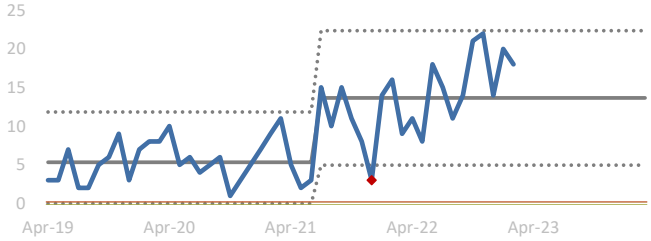


Latest data not available at time of report production

Cancer Wait Times - 104 days

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

Target 0 Mar-23



Target

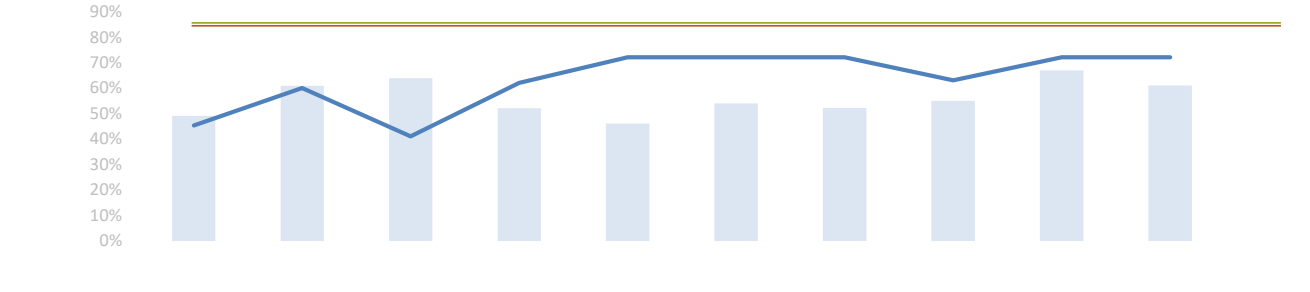
Cancer data runs one month in arrears due to processing and reporting timescales of Open Exeter.

Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

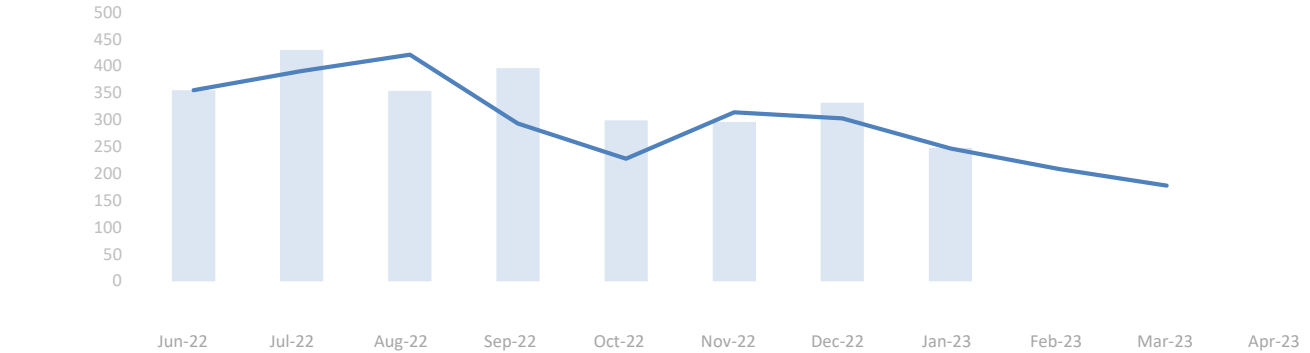
Cancer performance - 62 day trajectory



	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Actual	49.0%	60.9%	63.9%	52.1%	46.0%	53.9%	52.2%	55.0%	66.9%	61.0%	
Trajectory	45.3%	60.0%	41.0%	62.0%	72.0%	72.0%	72.0%	63.0%	72.0%	72.0%	
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Latest data not available at time of report production

Cancer backlog - 62 day waiters trajectory



	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Actual	355	430	354	396	299	296	332	248			
Trajectory	355	391	421	293	228	314	303	247	209	178	

Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

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 Monday between 31st October 2022 and 30th January 2023.

Tumour Site	Snapshot 30 Jan	Sparkline
Brain	1	
Breast	3	
Child	2	
Gynae	15	
Haem	3	
Head and Neck	26	
Lower GI	49	
Lung	11	
Skin	65	
Dermatology	50	
Plastics	15	
Upper GI	21	
Urology	48	
Thyroid	4	
NSS	4	

Latest data not available at time of report production

Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

31 day treatments
Delivery of the 31 day target was impacted by the reasons described for other key cancer performance targets.

Faster diagnostic standard
A FD programme has been developed alongside the TVCA focusing on six pathways: Urology, Gynaecology, Skin Lower GI, Upper GI and Breast.

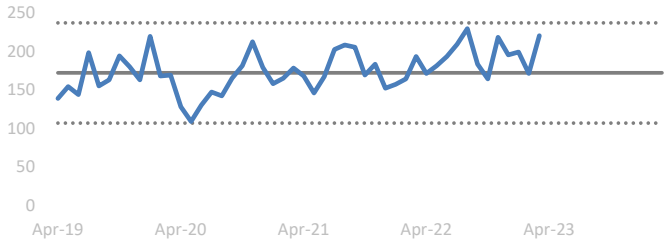
Delivery against trajectory remains in month with a reported performance of 70.4%

Cancer screening
Actions to improve the performance for the specific cohort of patients are incorporated within the overall improvement plan and performance improved to deliver 86.8% against a target of 90%.

Cancer treatment levels - 31 day treatments

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

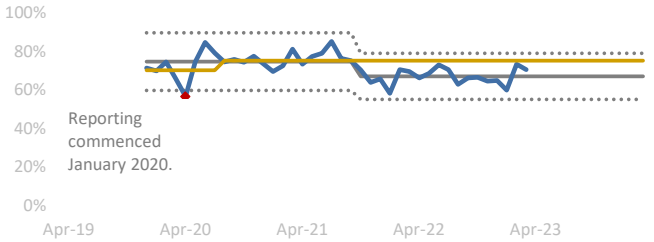
Target N/A Mar-23 **220**



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.

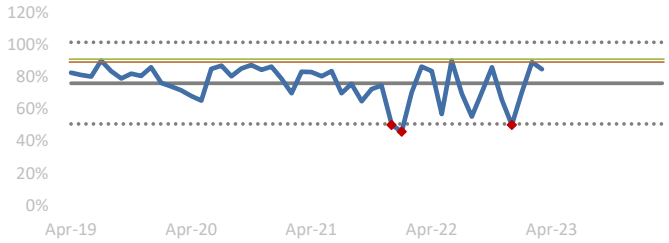
Target 75% Mar-23 **70.4%**



Cancer screening

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

Target 90% Mar-23 **84.6%**



Target

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

Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

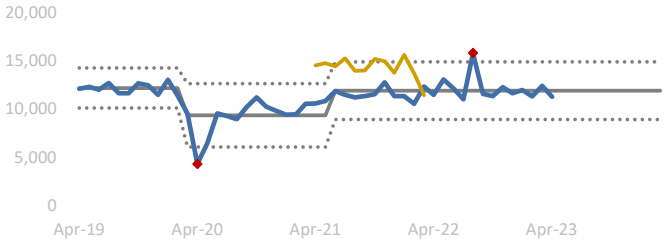
Diagnostic compliance
Improved copliane is dependent on improvement in the 2 main reported areas:
Non-endoscopic breaches
There are 3 main contributors to the non-endoscopric diagnostic backlog:
non-obstetric ultrasound
CT
MRI
There is a plan in place for non-obstetric ultrasound through the use of additional capacity to bring performance back in line by July 2023.
The mobilisation of the new CT PET scanner at Wycombe from Augut 23 will support delivery of the recovery performance trajectory alongside further use of outsourcing opportunities. It is planned for CT to return to compliance in the second half of 23/24. There is a residual risk related to capacity for cardiac CT which is currently being reviewed and a mitigating plan developed.
MRI is the single biggest contributor to the backlog. The Trust has submitted a bid for a mobile MRI scanner to increase capacity and the outcome of the bid is awaited.

Endoscopic Patients waiting >6 weeks (breaches)
Work continues to increase capacity using BHT resource and insourcing aiming to fully utilise available facilities at weekends. This is in progress and recovery trajectories will be shared once agreed.

Diagnostic activity levels

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

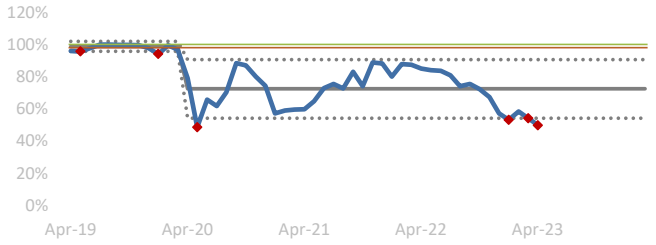
Target Awaiting target Apr-23 **11,248**



Diagnostic compliance

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

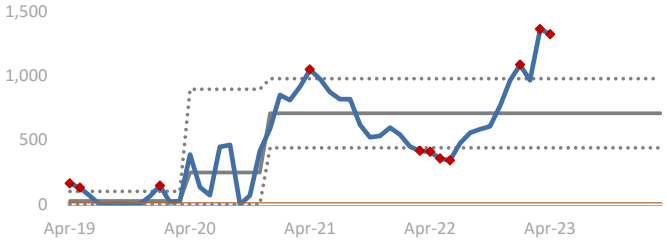
Target 99% Apr-23 **49.8%**



Endoscopic patients waiting > 6 weeks

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

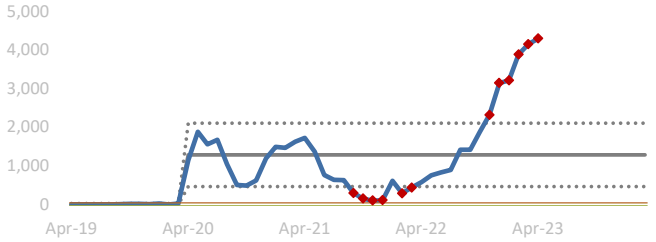
Target 0 Apr-23 **1,320**



Non-endoscopic DM01 breaches

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

Target 0 Apr-23 **4,291**



Target

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

Outstanding Care

Operational Standards - Quality & Safety

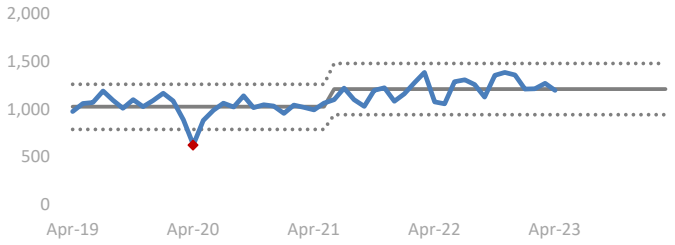
Buckinghamshire Healthcare NHS Trust

Incidents reported
Common cause variation with regards to incidents and excellence reporting.

Incidents reported

Total number of incidents reported on DATIX during the month.

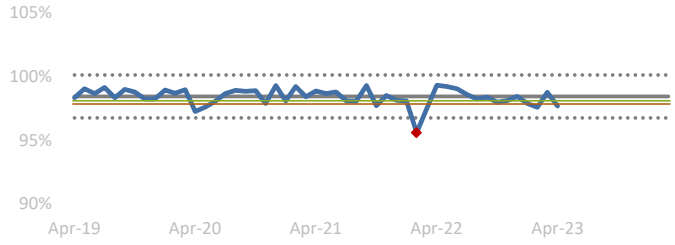
Target N/A Apr-23 **1198**



Incidents that are low/no harm

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

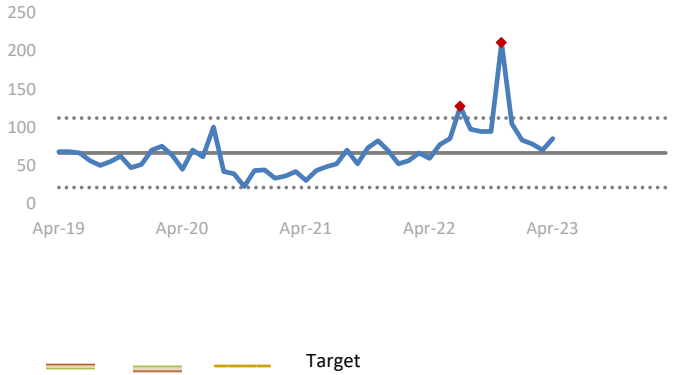
Target 98% Apr-23 **97.7%**



Excellence reporting

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

Target N/A Apr-23 **86**



Outstanding Care

Operational Standards - Quality & Safety

Buckinghamshire Healthcare NHS Trust

Medication Incidents
One serious incident declared related to extravasation injury following intravenous administration of acyclovir resulted to swollen hand. Investigation is ongoing and line management including visual infusion phlebitis (VIP) score completion monitored through quality audit via Tendable App.

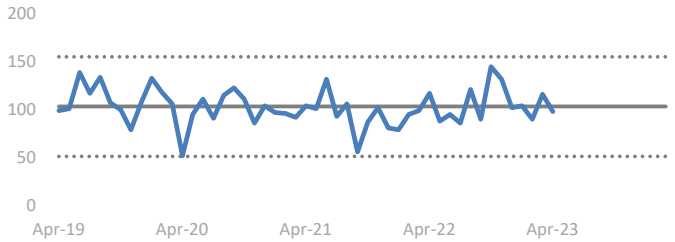
Falls
Medication and falls incidents showing common cause variation. Falls rate per 1,000 occupied bed days remains below national average.

Quarterly falls thematic report including learning identified cascaded to divisions through Harm Free Care Group in support of local improvement. Audit of falls risk assessment compliance has been digitalised and transferred to Tendable App.

Medication incidents

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

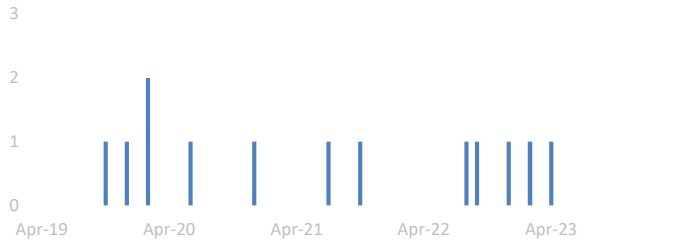
Target N/A Apr-23 **98**



Medication incidents as SIs

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

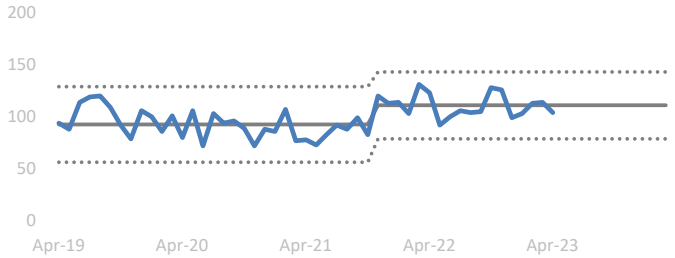
Target 0 Apr-23 **1**

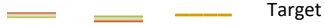


Number of falls

Total number of inpatient falls reported on DATIX.

Target N/A Apr-23 **104**

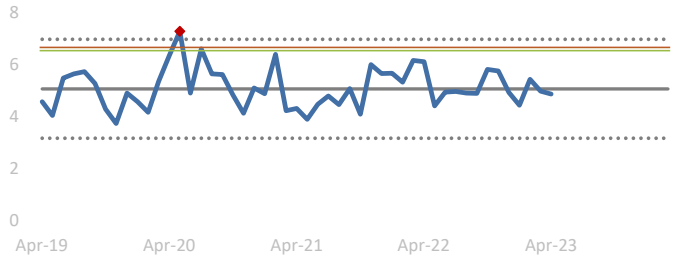




Falls per 1,000 bed days

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

Target 6.6 Apr-23 **4.9**



Outstanding Care

Operational Standards - Quality & Safety

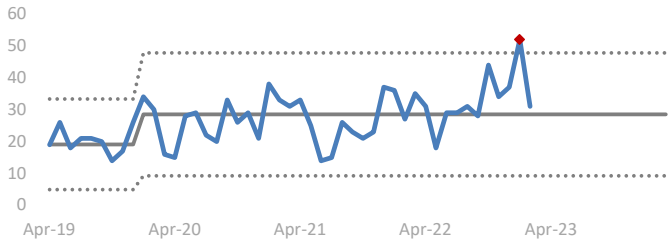
Buckinghamshire Healthcare NHS Trust

Latest data not available at time of report production

Pressure ulcers - category 2

Number of acquired category 2 pressure ulcers.

Target N/A Apr-23

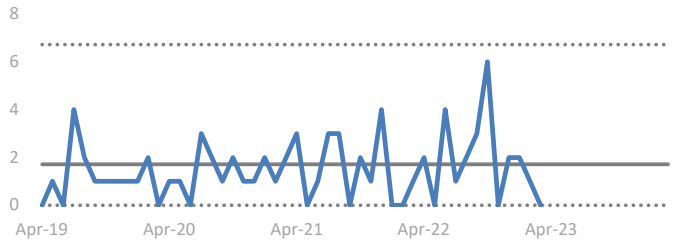


Latest data not available at time of report production

Pressure ulcers - category 3

Number of acquired category 3 pressure ulcers.

Target N/A Apr-23

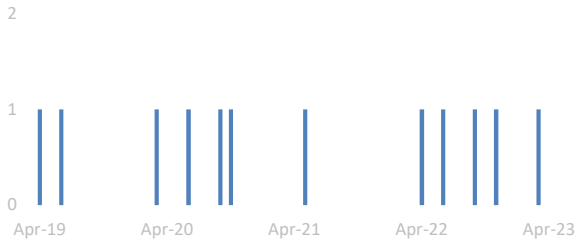


Latest data not available at time of report production

Pressure ulcers - category 4

Number of acquired category 4 pressure ulcers.

Target N/A Apr-23

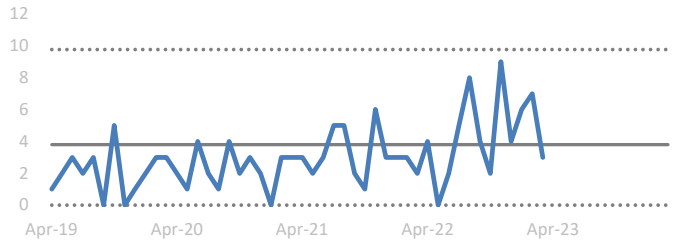


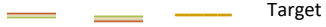
Latest data not available at time of report production

Pressure ulcers - unstageable

Number of acquired unstageable pressure ulcers.

Target N/A Apr-23





Outstanding Care

Operational Standards - Quality & Safety

Buckinghamshire Healthcare NHS Trust

Rolling 12-month HSMR to January 23 is 92.8 - classified as "lower than expected."

Twos serious incident declared in April 2023 meeting the Never Events criteria.

Wrong implant/prosthesis

Mis-matching components were put in for fractured hip repair. The patient was brought back to theatre and correct prosthesis inserted. Duty of candour completed. Patient stable throughout both procedures and been discharged home

Wrong site block

Admitted for surgery on right sided fractured distal radius. Arm marked for theatre and preoperative checklist completed.

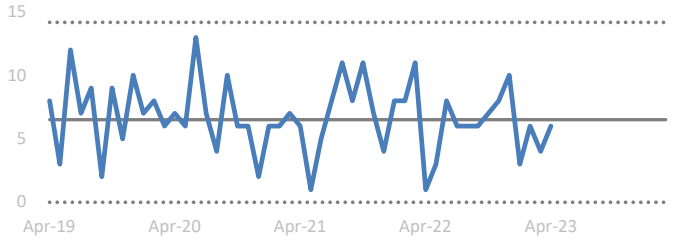
Challenging intravenous access gained on left antecubital fossa under ultrasound guidance by consultant anaesthetist. Proceeded to supraclavicular block the contralateral (uninjured limb, left was blocked instead of right arm.

Immediately apologies and explained to patient and consent gained for surgical procedure under general anaesthesia and no further incident reported. Patient been discharged home following recovery in the ward.

SIs confirmed

The total number of Serious Incidents confirmed during the month.

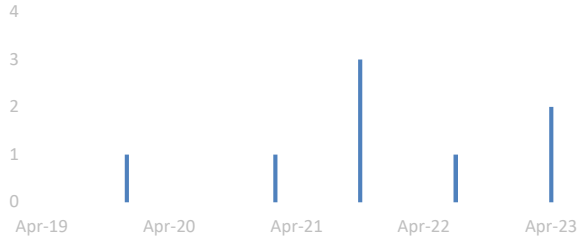
Target N/A Apr-23 **6**



SIs declared as never events

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

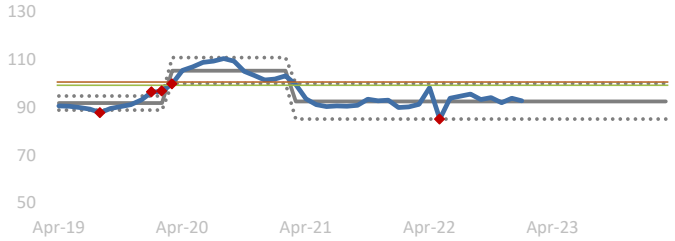
Target 0 Apr-23 **2**



HSMR

Hospital Standardised Mortality Ratio (rolling 12 months).

Target 100 Jan-23 **92.8**



Target

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

Outstanding Care

Operational Standards - Quality & Safety

Buckinghamshire Healthcare NHS Trust

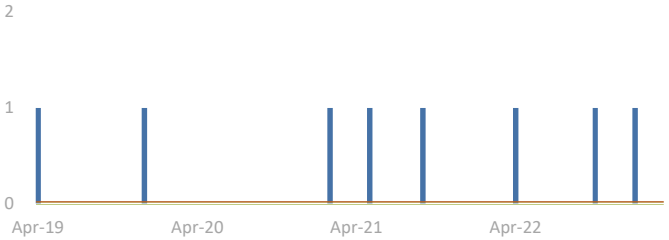
Infection Control

One MRSA bacteraemia reported in April 2023. Post infection review underway together with multidisciplinary team to determine possible source and establish any learning.
Work ongoing with regards to line management and care of devices including blood culture sampling.

MRSA bacteraemia

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

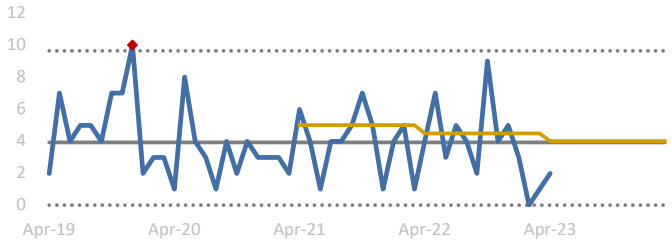
Target 0 Apr-23 **1**



Clostridioides difficile

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

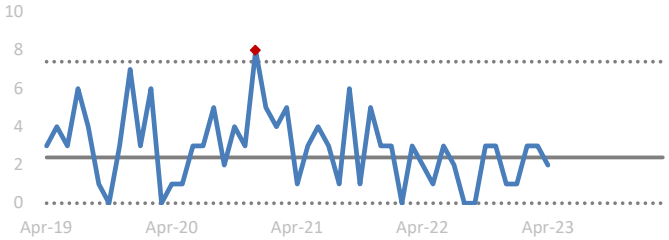
Target 4.0 Apr-23 **2**



MSSA bacteraemia

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

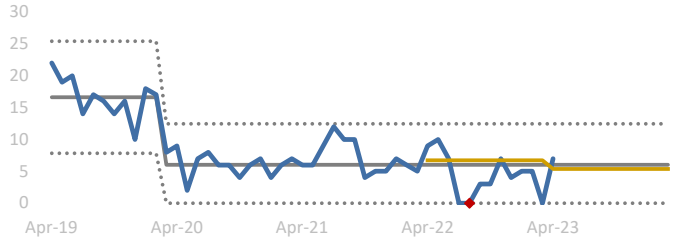
Target N/A Apr-23 **2**

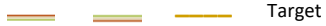


E Coli bacteraemia

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

Target 5.40 Apr-23 **7**





Outstanding Care

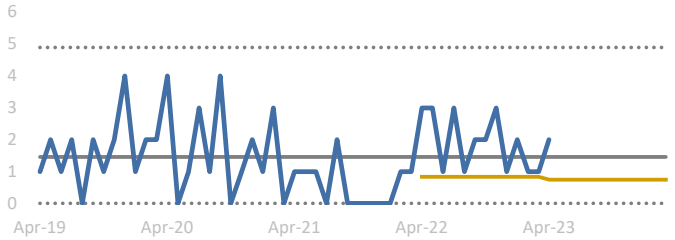
Operational Standards - Quality & Safety

Buckinghamshire Healthcare NHS Trust

Pseudomonas aeruginosa bacteraemia

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

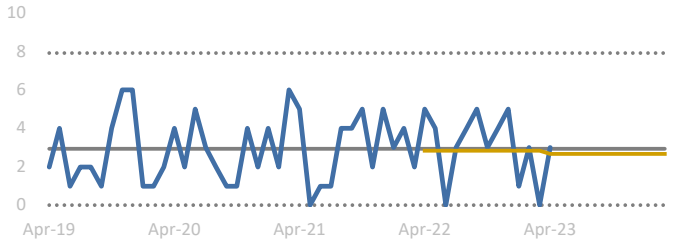
Target 0.8 Apr-23 2

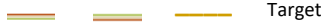


Klebsiella spp bacteraemia

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

Target 2.7 Apr-23 3





Outstanding Care

Operational Standards - Quality & Safety

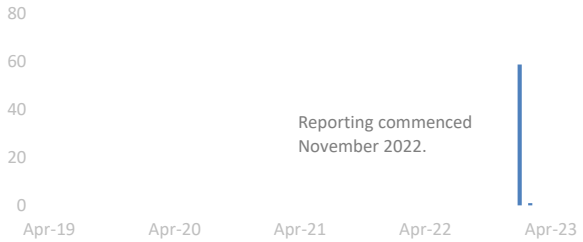
Buckinghamshire Healthcare NHS Trust

Latest data not available at time of report production

Influenza cases

Total number of Flu cases.

Target N/A Apr-23

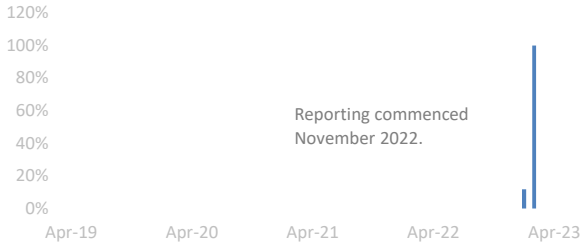


Latest data not available at time of report production

Influenza cases - hospital acquired

Proportion of influenza cases that were hospital acquired (probable and definite) as a total of influenza cases in month.

Target N/A Apr-23



Latest data not available at time of report production

Covid cases

Total number of Covid cases.

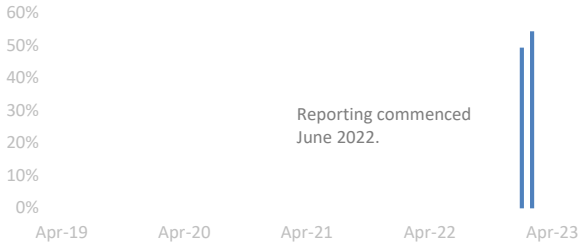
Target N/A Apr-23

Latest data not available at time of report production

Covid cases - hospital acquired

Proportion of Covid cases that were hospital acquired (probable and definite) as a total of Covid cases in month.

Target N/A Apr-23



Outstanding Care

Operational Standards - Quality & Safety

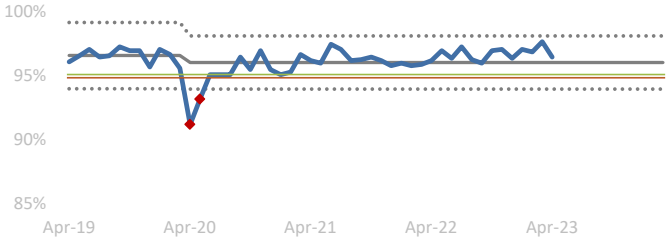
Buckinghamshire Healthcare NHS Trust

VTE assessment
VTE and EWS completion compliance continue to meet the set target.
Work ongoing in collaboration with medical colleagues to support areas identified with low compliance on TEP completion.

VTE assessment

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

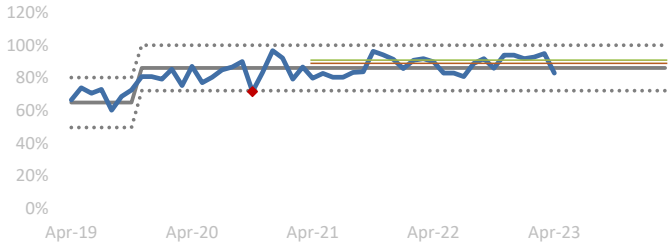
Target 95% Apr-23 **96.5%**



Treatment escalation plan compliance

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

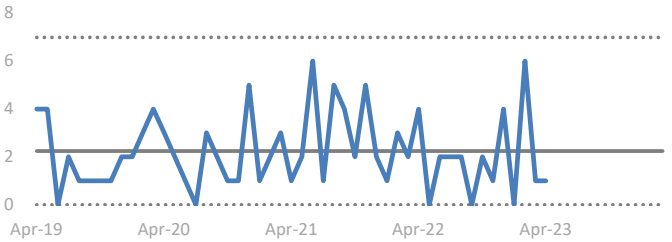
Target 90% Apr-23 **83%**



Non-critical care inpatient cardiac arrests

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

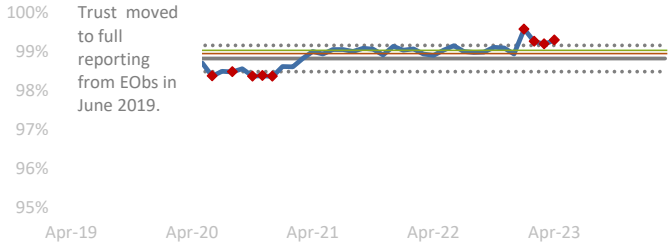
Target N/A Apr-23 **1**



Early warning score

Percentage compliance with early warning score (EWS) completion.

Target 99% Apr-23 **99.3%**



Target

Outstanding Care

Operational Standards - Quality & Safety

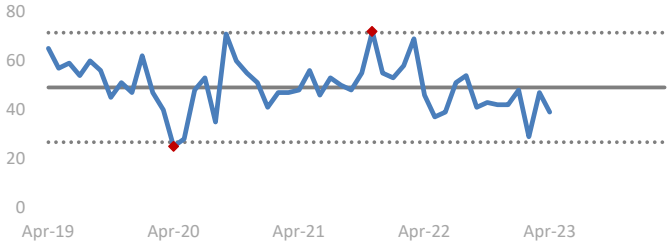
Buckinghamshire Healthcare NHS Trust

Complaints
Reduction in the number of complaints outstanding at 90 days. Continued improvement in complaints 25 days response time compliance since April 2022.
Complaints writing training is scheduled for 28 June and 5 July and offered to governance leads, senior managers and clinical colleagues.

Complaints received

Number of complaints received during the month.

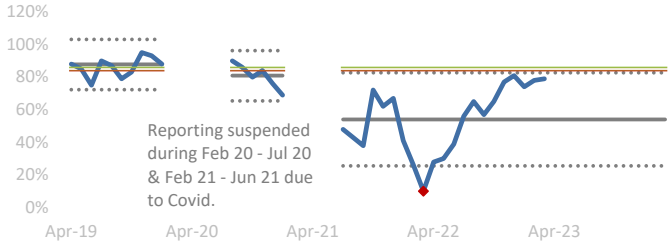
Target N/A Apr-23 **39**



Complaint response rate

Percentage of complaints responded to within 25 days of receipt.

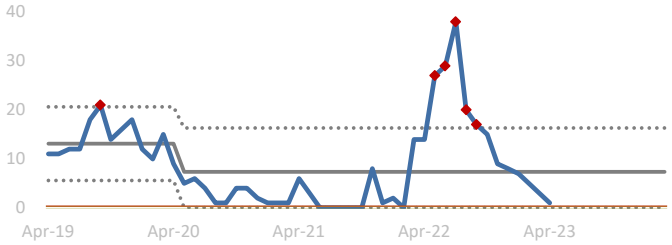
Target 85% Mar-23 **79.0%**



Complaints outstanding at 90 days

Number of complaints still open after 90 days.

Target 0 Apr-23 **1**



Target

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

Outstanding Care

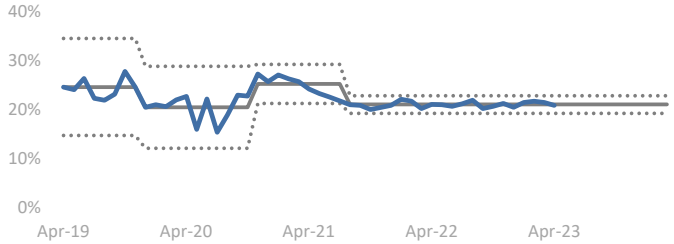
Operational Standards - Quality & Safety

Buckinghamshire Healthcare NHS Trust

Friends and family test - response rate

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

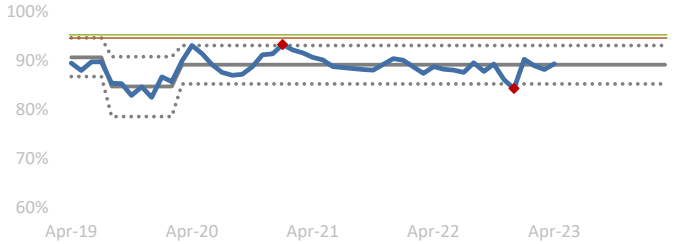
Target Awaiting target Apr-23 **20.9%**



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% Apr-23 **89.4%**



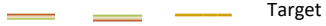
Target

Outstanding Care

Operational Standards - Quality & Safety

Buckinghamshire Healthcare NHS Trust

Maternity metrics currently under review. New metrics will be available for May's report.

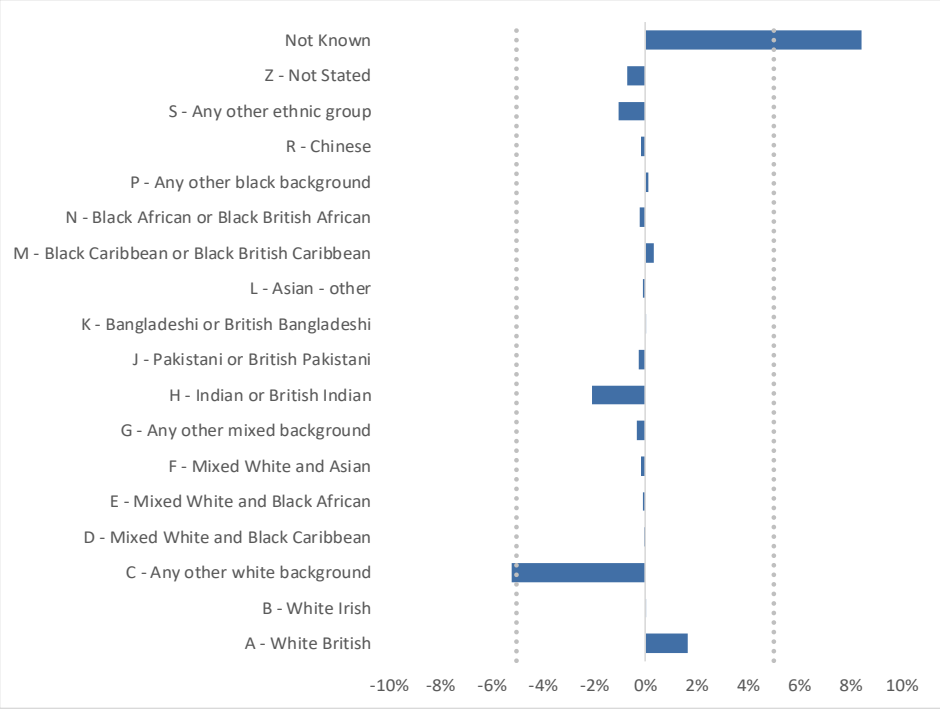


Healthy Communities

Ethnicity and deprivation

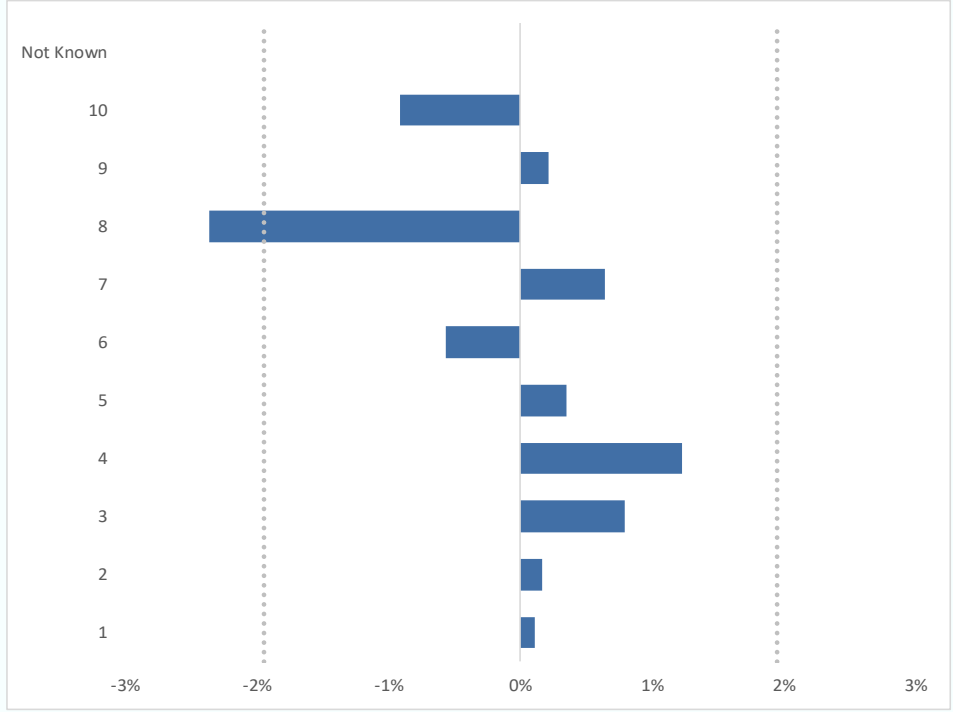
Ethnicity comparison compared to Buckinghamshire Population by waiting list

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 Deprevation (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

Buckinghamshire Healthcare NHS Trust

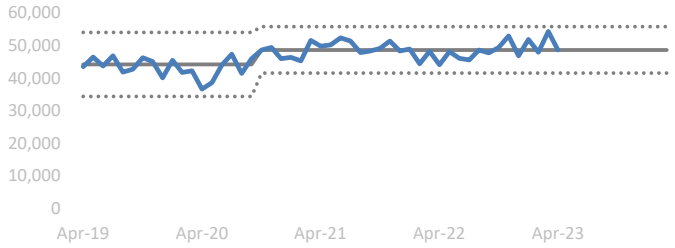
Caseload
A significant number of the total caseload is first[t] appointments (total of 897) which makes up nearly 94% of the total caseload (951), according to the latest NHS benchmarking data (NHSB). NHSB reported the average waiting time for BHT intermediate care is 0.4 days compared to the sample mean of 3.49 days. The teams continue to deliver high performance outcomes despite increase in referrals a significant number of complex patients in the community who require a higher frequency and intensity of visits. There is an increasing trend for Admission Avoidance and community-based referrers for patients needing intermediate care which includes the Urgent Community Response and community physiotherapy.

The District Nursing caseload is showing a slightly downward trend, but this is no cause for concern, as it showcases the impact of the recent drive and effort of validating and improving the quality of the data. OOut of the reported 3,232 on the case load 45% (1454) are new appointments. NHSB reported waiting time for this service has continuously been one day over the last couple of months, this is compared to a mean sample of 5.66 days.

Community contacts

Total number of attended community contacts in the month.

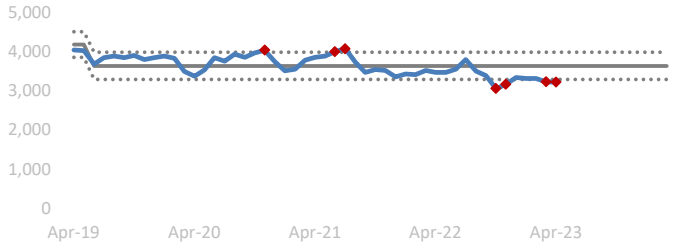
Target N/A Apr-23 **48,701**



Community District Nursing caseload

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

Target N/A Apr-23 **3,229**

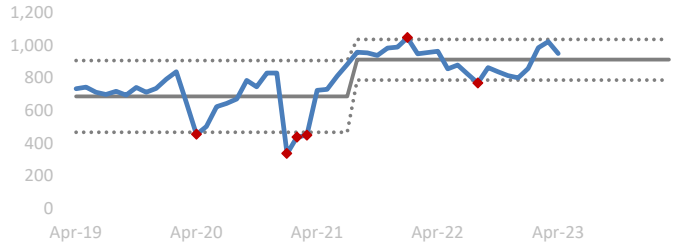


Target

Community RRIC caseload

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

Target N/A Apr-23 **950**



Healthy Communities

Community Hospitals

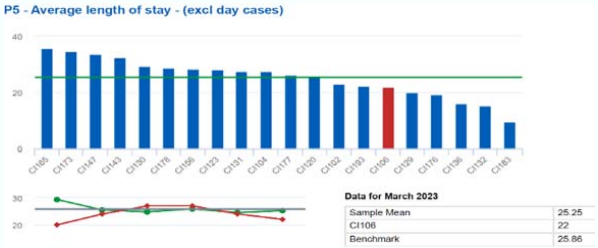
Buckinghamshire Healthcare NHS Trust

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

Community bed occupancy continue to be high above 90% which puts pressure on resources. However, the average length of stay is showing consistent improvement below target (about 20 days) NHSB and peer data is indicating continuously improvement for the last four months.

There are currently 11 Buckinghamshire residents waiting for a BHT Community Hospital bed, with an average wait time of six days. Of the 11 patients, five are non BHT patients waiting in neighbouring organisations for transfer

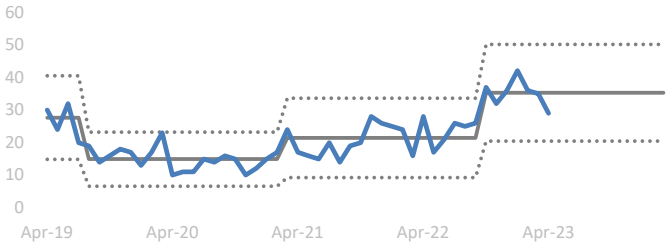
21 day LOS – community hospitals



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.

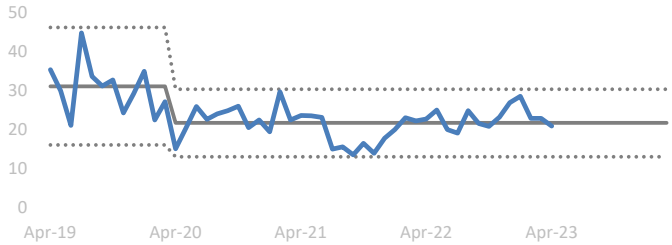
Target N/A Apr-23 **29**



Average LOS - community hospitals

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

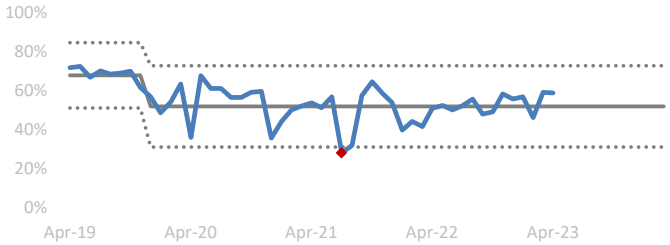
Target N/A Apr-23 **20.9**



Discharges home

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

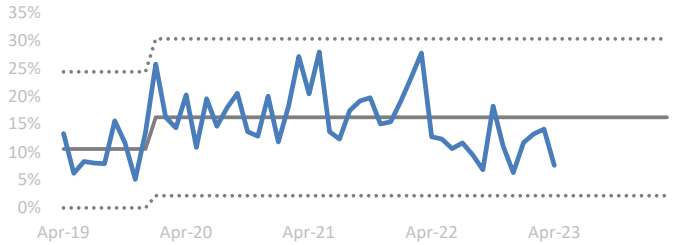
Target N/A Apr-23 **58.7%**



Discharges to residential/care home

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

Target N/A Apr-23 **7.6%**



Healthy Communities

Community Productivity

Buckinghamshire Healthcare NHS Trust

Urgent 2 hour response
For 22/23 there were 10,321 patients referred for an urgent community response of which 9176 were accepted as appropriate (90%).
3719 required a response within 2 hour response (41%)
3515 required a response within 2-24 hours (38%)
1942 required a response within 24-48 hours (21%)
Consistently achieving > 80% for 2-hour responses (national target is 70%).
Working with our single point of access team (CCCT) to review referral pathways, referrer experience and reduce delays
Specialist practitioners from SCAS continue to work in the RRIC team in 23/24 as part of the UCR response
Ongoing collaboration with SCAS to increase referrals from crews, urgent care desk and unblocking barriers / technology to be able to pull from the stack
Continued building relationships and communication with key stakeholders to promote understanding, awareness and increase referrals (SDEC, FSDEC, REACT, ED, Primary Care, Care Homes, NHS111, and other health and social care services)

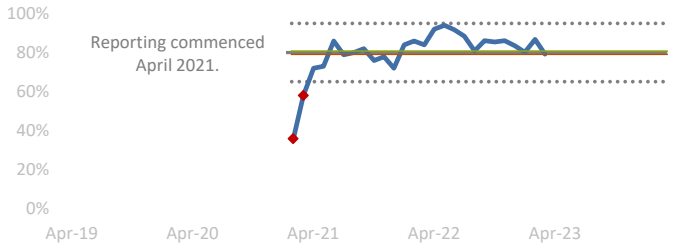
Health Visitor appointments - 14 days
Health Visiting Teams have successfully improved the KPI position for New Birth Visits (NBV) in Q4.
The target of 90% was achieved by day 16 in Q4 which is an improvement from Q3. Assurance is being provided to the Commissioners that the 14-day target is being met for vulnerable families. We continue to closely track and report.
Active recruitment to Health Visiting continues to be a challenge. However, we have had a successful quarter with six health visiting students currently in training (three to qualify in September 2023 and three to qualify in January 2024)
Validated Q4 data reported that 84% of new births were completed by 14 days.

Community waiting list size
Data is showing an increase from 15.082 in March 22 to 15,757 at the end of April 23.
Health Visiting data represents caseload numbers that are 'open to the service', who may never need to access the service and will not receive a first appointment. This represents about >7000 children of the total waiters.
Risk assessments for long waiting patients continue to be undertaken, patients are prioritising alongside the most urgent referrals.

Urgent 2 hour response

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

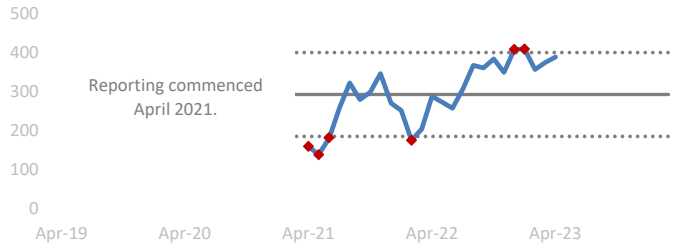
Target 80% Mar-23 **79.3%**



Urgent community response referrals

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

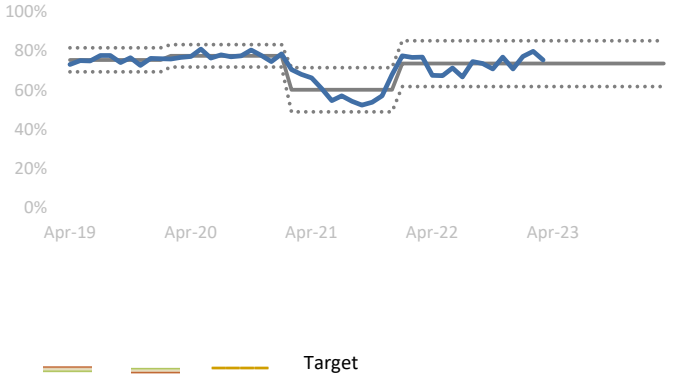
Target N/A Apr-23 **389**



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).

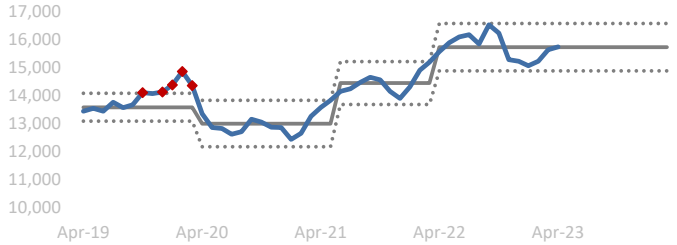
Target Awaiting target Mar-23 **75.6%**



Community waiting list size

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

Baseline 15,211 (Mar 22) Apr-23 **15,757**



Healthy Communities

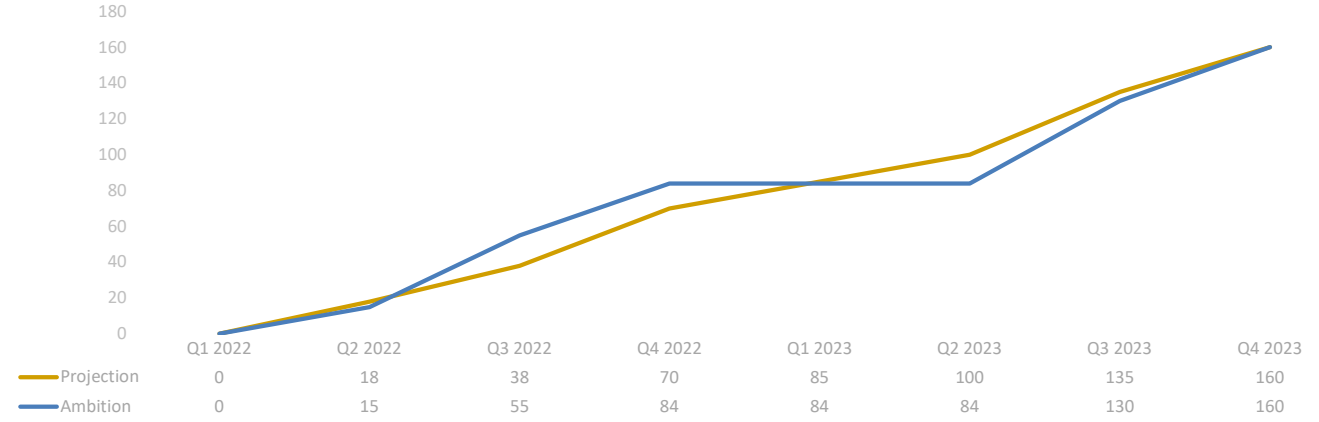
Hospital at Home

Buckinghamshire Healthcare NHS Trust

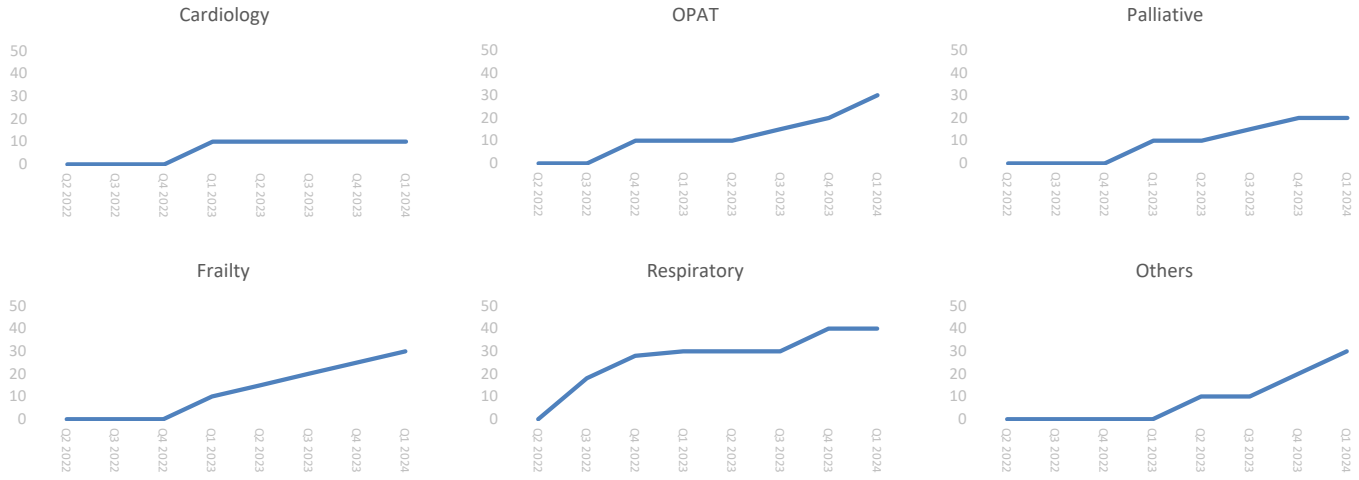
The aim is to provide patients with a safe alternative to hospital care through community-based acute health care using remote monitoring and tele-health where appropriate. Two pathways (Respiratory - BIRS Team) and IV treatment (OPAT) have been operational since June 2022.

The Hospital@Home programme continues to expand, now with four streams providing admission avoidance and early supported discharge these are:
BIRS H@H
OPAT – H@H
Specialist Palliative care @Home
Frailty H@H
The Heart Failure team is developing and adapting their current pathway so for some patient's, diuretic therapy is provided in their own place of residence. The plan is that by the end of June 23 the team will start using this pathway. The plan is for 80 virtual beds to be opened by the end of Q1.
Bed occupancy of BHT's H@H has been variable in March and April 23 with lower than the expected target of 70% (between 49% – 72%) utilisation. This has been due to the time it has taken for new teams to get established, and to ensure that policies and SOPs are robust. PDSA cycles are in place to test the updated SOPs before increasing their referrals within their service.

Bucks Hospital at Home capacity and ambition



Bucks Hospital at Home actuals and projections



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Buckinghamshire Healthcare NHS Trust

Nursing & Midwifery Vacancy rate
The number of registered nurses in post increased in month by 35.5 fte, however, the nurse vacancy rate increased reflecting the establishment increase, following a detailed acuity review of all inpatient areas.
Recruitment from the UK continues, alongside a continued programme of international recruitment. We have been granted funding to recruit an additional 100 internationally trained nurses in f/y 2023/24.

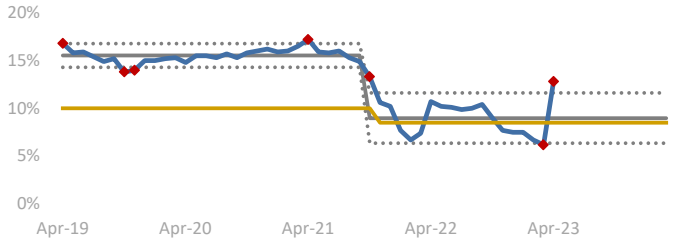
Turnover
Turnover remained stable at 12.5% in April.
In April, a total of 84 colleagues left BHT (excluding end of fixed term contracts, death in service and involuntary reasons for leaving). Of the 84 colleagues that left, 21 were Nursing and Midwifery, 15 Admin & Clerical, 13 Support Staff and 10 HCAs.
The leading cause for resignation was retirement. 30 colleagues retired with 6 returning. Of those that retired, 11 were Nursing and Midwifery (1 returned) and 11 were Admin & Clerical (with 3 returnees). 3 AHPs also retired.
Work life balance was the second most cited reason for leaving, with 19 colleagues selecting this. There is a dedicated workstream in place to improve colleagues' work life balance, including opportunities to work flexibly supported by updated policies and processes.
One of our key people objectives for this f/y is focussing on colleagues who leave within the first year of joining BHT. A programme of work has been developed comprising a number of workstreams.

Recruitment
The recruitment team continue to meet its KPI. In April there was a slight increase in time to hire. The main driver was the in-month implementation of a new process and associated training. The return on investment of this new process in relation to candidate experience is already evident. We expect a further reduction in time to hire in coming months now this is in place.

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.

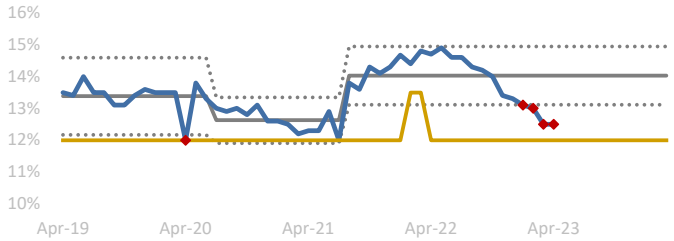
Target 8.5% Apr-23 **12.8%**



Turnover rate

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

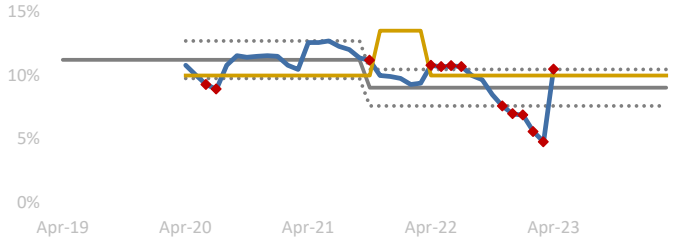
Target 12.0% Apr-23 **12.5%**



Trust overall vacancy rate

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

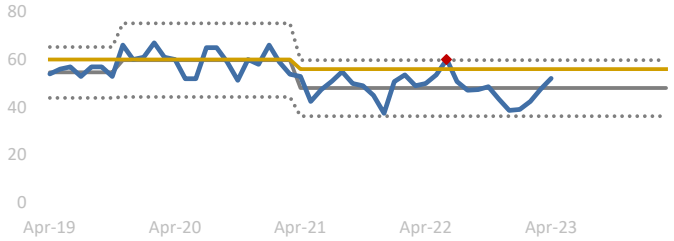
Target 10.0% Apr-23 **10.5%**



Average time to replace vacancies

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

Target 56 Apr-23 **52.1**



Target

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Buckinghamshire Healthcare NHS Trust

Sickness

Sickness absence continues a downward trajectory into Spring. April's absence of 3.2% is within the Trust target of 3.5%

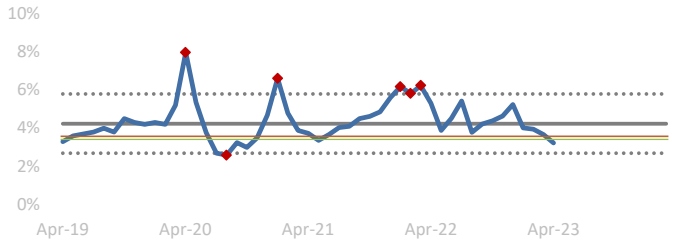
Lateral Flow testing for symptomatic staff has now stopped following updated NHS advice. As a consequence, suspected COVID-19 will now be managed through presenting symptoms.

Management referrals into Occupational Health (OH) remain at over 100 per month. April's KPI of 10 days for an appointment with OH was 91% which is below the target of 95%. This was due to absence within OH and has been mitigated for May.

Sickness

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

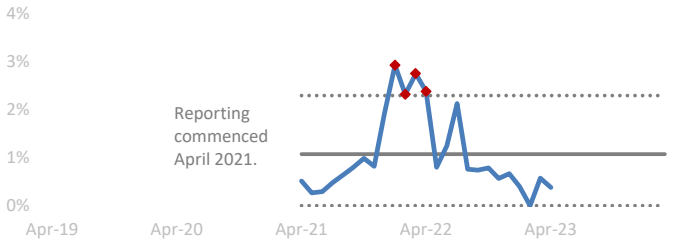
Target 3.5% Apr-23 **3.2%**



Sickness - Covid 19

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

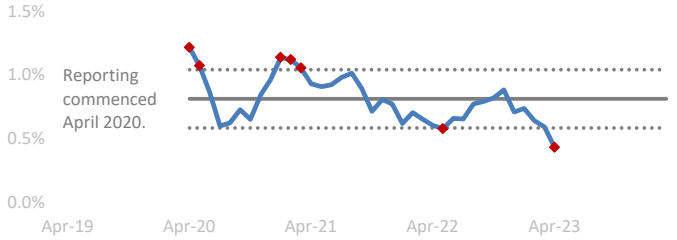
Target N/A Apr-23 **0.4%**



Sickness - mental health

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

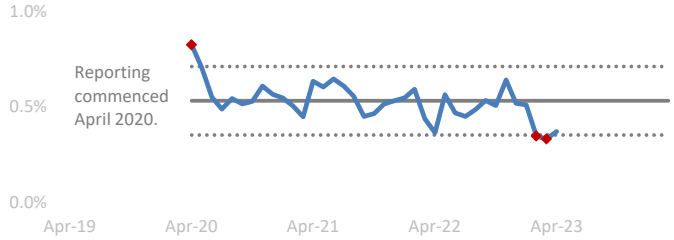
Target N/A Apr-23 **0.4%**

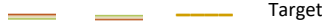


Sickness - musculoskeletal

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

Target N/A Apr-23 **0.4%**





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Buckinghamshire Healthcare NHS Trust

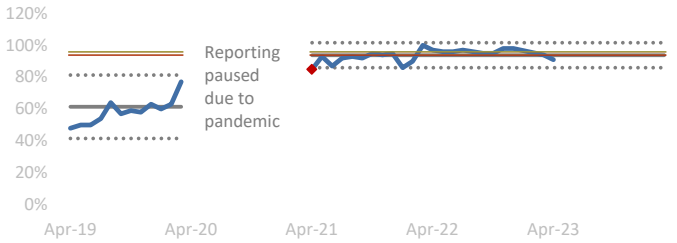
Wellbeing and stress referrals

Absence due to Mental Health reasons reduced in April to 0.43%, which is the lowest it's been in the last 2 years. However, the total number of stress referrals remains relatively stable at 119, averaging 117 per month in the last 6 months. It will be important that we continue to support the long-term impact of the pandemic, together with support for the impact of ongoing operational and personal pressures.

Occupational Health Management referrals

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

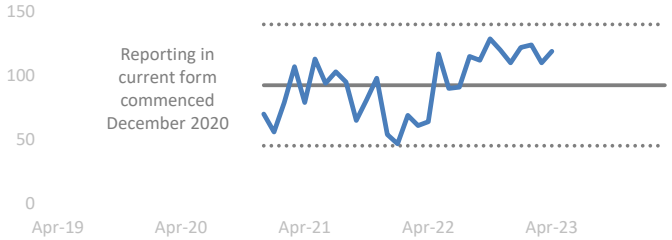
Target 95% Apr-23 **91.0%**



Referrals into OH and Wellbeing - stress

Referrals into Occupational Health and Wellbeing for stress per month.

Target N/A Apr-23 **119**



Target

A Great Place to Work

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Buckinghamshire Healthcare NHS Trust

Data Security awareness training
As at the end of April Trust-wide compliance is at 88%. The Information Governance Team continue to follow-up non-compliance and send comms bulletins and newsletter reminders. On direction from the SIRO the Information Governance team will be running an audit of staff who have been consistently non-compliant, for escalation. This was provided to the SIRO who delegated to DPO to progress. DPO is on unexpected leave and therefore this has been delayed.

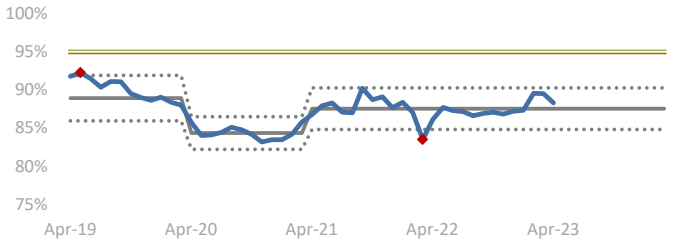
Statutory & Mandatory training
There was a small improvement in Statutory and Mandatory compliance in April with compliance now at 89.8%. The Education team follows up with Divisions and individual teams where compliance is not meeting the 90% level. We expect compliance to increase as individuals participate in Appraisals during April to June.

Corporate induction
A 99% attendance record has been achieved at the BHT Welcome & Induction event. Positive feedback continues to be received following the event, with continuous improvement utilised to further improve how the event is delivered and the content covered. The next face to face quarterly connection event for new starters is scheduled for 27 June.

Data security awareness training

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

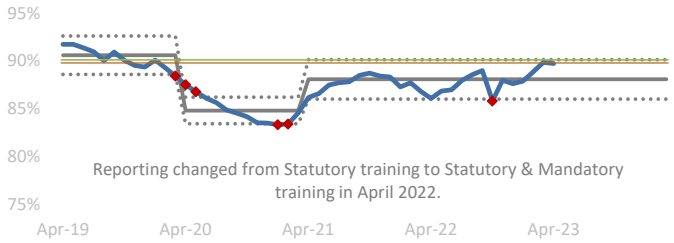
Target 95% Apr-23 **88.3%**



Statutory & Mandatory training

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

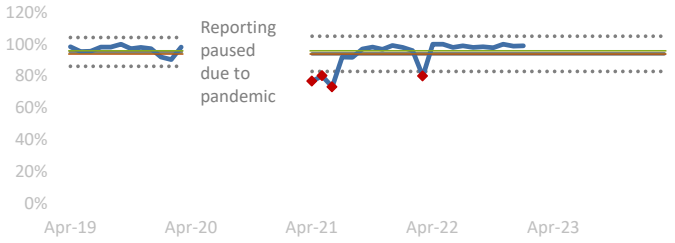
Target 90% Apr-23 **89.8%**



Corporate induction

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

Target 95% Jan-23 **99%**



Target

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

Integrated Performance & Quality Report

Buckinghamshire Healthcare NHS Trust

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.

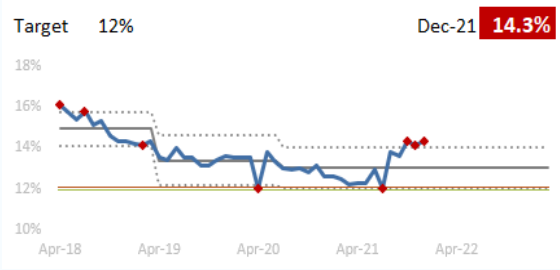
In these charts, where it looks like there has been some kind of change in the variability or average result in the reported data, the limits and the central line have been adjusted to indicate when it appears - statistically - that the change happened. This should be a prompt for users of the chart 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

Integrated Performance & Quality Report

Buckinghamshire Healthcare NHS Trust

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

31 May 2023

Agenda item	Month 1 2023/24 Finance Report
Board Lead	Chief Finance Officer
Type name of Author	Kish Sidhu
Attachments	Month 1 2023/24 Finance Report
Purpose	Assurance
Previously considered	EMC 23.05.2023 F&BPC 25.05.2023

Executive Summary

As at Month 1, the Trust is reporting a 2023/24 Month 1 deficit of £(4.2)m, this is in line with the 2023/24 Month 1 Planned £(4.2)m deficit. As at Month 1 there are no adjustments to funding in relation to level of Elective Recovery Activity undertaken.

As at Month 1 the Trust has delivered Efficiencies of £0.71m against a Month 1 Plan of £0.84m.

As at Month 1 2023/24 the Trust has delivered £0.63m of the £28.37m 2023/24 Capital Plan.

The closing Cash Balance at the end of Month 1 2023/24 was £19.58m, with the forecast Cash Balance at the end of 2023/24 being £1.92m.

The report was considered by the Finance and Business Performance Committee on 23 May 2023 who take assurance from the report noting the Trust was on plan. The work of the Integrated Medicine division was noted. There would be further consideration of the most effective method of efficiency and transformation reporting going forwards.

Decision	The Board is requested to note the report

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	Maintaining patient safety whilst living within our financial means
Risk: link to Board Assurance Framework (BAF)/Risk Register	Principal Risk 2; Failure to deliver our financial plan. CRR 234 – Delivery of Financial Plan CRR 224 – Capital resourcing
Financial	Achieving our financial targets for 2023/24
Compliance	Achieving the NHSE/I approved 2023/24 financial plan
Partnership: consultation / communication	Achieving our part of the BOB ICB 2023/24 Financial Plan
Equality	N/A
Quality Impact Assessment [QIA] completion required?	N/A

1 Summary financial position

1.1 The Trust Reports a 2023/24 Month 1 deficit of £(4.2)m, this is in line with the Month 1 year-to-date £(4.2)m deficit plan.

1.2 Income is £0.3m favourable to plan at Month 1. Other income is £0.2m favourable to plan (at £2.9m year-to-date), primarily relating to income for MRI activity undertaken. Contract Income is £0.1m favourable to plan at Month 1, with BOB ICB income and NHSE Specialised Commissioning Activity Income reflected in line with 2023/24 agreements and offers.

1.3 Pay expenditure is in line with plan at Month 1, at £(30.53)m. Substantive vacancies resulting in a £4.41m underspend at Month 1 are offset by a £(4.40)m pressure on bank, agency and overtime staff costs. Agency costs of £(1.02)m are 3.3% of total staff costs in Month 1, which is below the 4.7% 2023/24 Cap.

1.4 Non Pay expenditure is £(0.3)m adverse to plan in Month 1 2023/24, primarily due to a £(0.2)m overspend in Pbr included Drugs, and ISTC costs in Surgery. Clinical Supplies expenditure was £0.2m underspent in Month 1 due to Elective Activity being adversely affected by Bank Holidays and Industrial Action.

1.5 As at Month 1, the Trust has delivered Efficiencies of £0.71m against the Month 1 Plan of £0.84m.

2 Capital

2.1 The Trust has reported £0.63m Capital expenditure in Month 1, of its £28.37m Capital Plan. The Trust is forecasting to deliver its full year 2023/24 Capital Plan of £28.37m.

3 Balance Sheet

3.1 The value of the Trust's balance sheet is £1.3m better than plan at Month 1 2023/24, due to the cash position being £6.0m better than plan, partially offset by Non-current assets being £(2.6)m adverse to plan due to the Capital Plan delivery being low in Month 1 and Trade and Other Current Assets being £(3.1)m adverse to Plan, largely due to a reduction in debtors. Non-current borrowing is £0.6m better than plan at Month 1.

3.2 The Trust continues to closely monitor its cash position forecasts to ensure liquidity.

4 Action required from the Trust Board

4.1 The Board is requested to:

a) The Board is asked to note the report

APPENDICES
Appendix 1: Month 1 2023/24 Finance Report

Buckinghamshire Healthcare NHS Trust

Finance Report Month 1 - 30th April, 2023

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

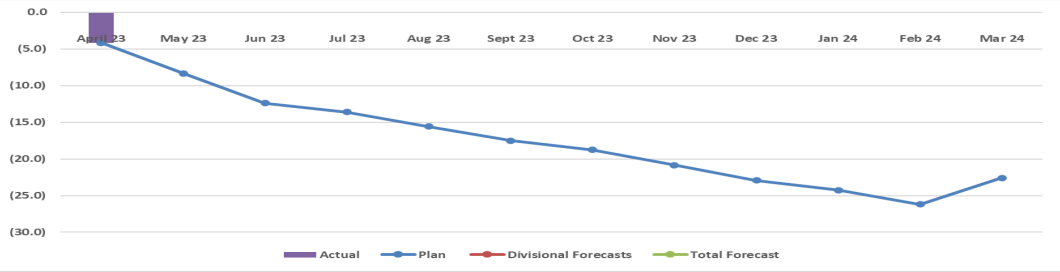
Contents

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	44.2	44.3	0.1	44.2	44.3	0.1	530.6
Other income	2.7	2.9	0.2	2.7	2.9	0.2	32.4
Total income	**46.9**	**47.2**	**0.3**	**46.9**	**47.2**	**0.3**	**563.1**
Pay	(30.5)	(30.5)	0.0	(30.5)	(30.5)	0.0	(350.2)
Non-pay	(17.1)	(17.4)	(0.3)	(17.1)	(17.4)	(0.3)	(194.6)
Total operating expenditure	**(47.7)**	**(48.0)**	**(0.3)**	**(47.7)**	**(48.0)**	**(0.3)**	**(544.8)**
EBITDA	**(0.8)**	**(0.8)**	**(0.0)**	**(0.8)**	**(0.8)**	**(0.0)**	**18.3**
Non Operating Expenditure	(3.4)	(3.5)	(0.1)	(3.4)	(3.5)	(0.1)	(40.9)
Retained Surplus / (Deficit)	**(4.2)**	**(4.3)**	**(0.1)**	**(4.2)**	**(4.3)**	**(0.1)**	**(22.6)**
Adjusted financial performance excluding profit on disposal of assets and excluding impairment	**(4.2)**	**(4.2)**	**(0.0)**	**(4.2)**	**(4.2)**	**(0.0)**	**(22.6)**

Graph 1 - Income & Expenditure YTD position & Forecast



Executive Summary

• The Trust reports a breakeven position for April 2023/24, in line with the annual plan (£(22.6)m deficit .

• The month 1 capital spend is £0.6m. Total Capital Resource Limit (CRL) funding of £28.4m includes BOB/ICS £20.3m, PFI Lifecycle £1.7m, and PDC allocations of £6.2m (£5.7m for ERF and £0.6m for Digital Diagnostic Capability programme). As at M1, a breakeven position is forecast against the CRL.

• Contract Income includes BHT agreements for 2023/24 funding with BOB ICB as part of the 2023/24 annual plans submitted to NHSE/I and the NHSE Specialised Commissioning 2023/24 offer. 2023/24 Income from Associate Commissioners is reflected at expected levels, where agreement is yet to be reached.

• Other income totals £2.9m for April 2023/24, £0.2m favourable to plan, primarily driven by Income released to cover additional MRI costs.

• Pay costs for Month 1 2023/24 total £(30.5)m, a breakeven position with 2023/24 Month 1 plan. Within this overall postion clincal areas experinced unplanned temporary staff spend, particularly within the medcial workforce. This being in part driven by cover for industrial action. Women, Children is £(0.16)m adverse to budget largely due to underachievement of the pay savings target. These overspends are offset by central provisions for 2023/24.

• Non-pay operating expenditure totalled £(17.4)m in Month 1 2023/24, £(0.3)m adverse to Plan. Drugs costs (within PBr) are £(0.2)m overspent in Month 1, primarily in Integrated Medicine. Other non pay is £(0.3)m overspent in Month 1 2023/24, partially resulting from ISTC costs in Surgery . This was partially offset by a £0.2m underspend in Clinical Supplies as Elective activity was affected by Bank Holidays and Industrial Action.

• Non operating expenditure reports a £(0.1)m adverse variance to Plan in Month 1 2023/24, this is excluded from NHSE/I financial performance metrics against which the Trust is measured.

Key Highlights: Income

NHS Income and Activity

• The Contract Income position totalled £44.3m for Month 1 2023/24 which is £0.1m favourable to plan, with the 2023/24 plan being based upon contract offers where available and expected contract values where not yet agreed.

• Other Income is £0.2m favourable to Plan as at Month 1.

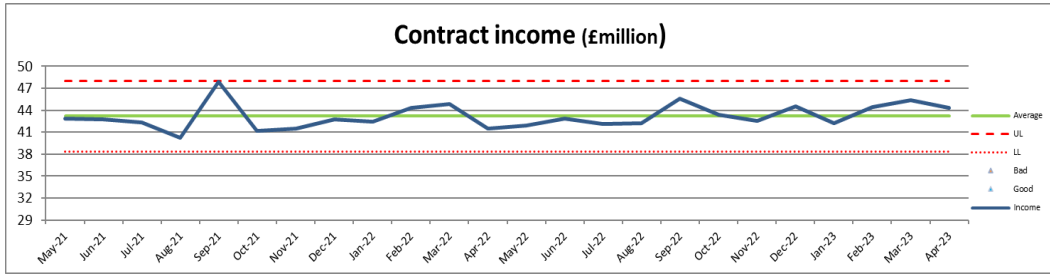
• As at Month 1 no adjustments have been made for actual levels of activity undertaken for the Elective Recovery Funding (ERF) received by the Trust as part of our contract baseline values for 2023/24.

• The Statistical Process Control Chart (Graph 2) for Contract Income shows income is close to the mean with a few exceptions. 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 increase in income in September 2022 reflects the pay award funding for the previous 6 months. The increase in December 2022 relates to the additional Specialist Commissioner income for Elective and Non Elective ERF totalling £2.8m for 2022/23.

Table 2 - Breakdown of Contract Income

Commissioner (£m)	Annual Budget Total 2022-23	YTD Budget	YTD Actuals	YTD Variance
BOB ICS (Block)	372.5	31.1	31.1	0.0
BOB ICS (Additional Inc)	23.6	2.0	2.0	0.0
Bob Block Sub Total	**396.2**	**33.0**	**33.0**	**0.0**
Associates	37.3	3.1	3.1	0.0
Specialist Commissioners	76.7	6.4	6.4	0.0
Regional Specialist	4.7	0.4	0.4	0.0
Other NHS	3.4	0.3	0.4	0.1
Bucks Council	11.3	1.0	1.0	0.0
Other Income	0.9	0.1	0.1	0.1
Total	**530.6**	**44.2**	**44.3**	**0.1**

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



Other Income

Table 3 - Breakdown of other income

Category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Research	1.6	0.1	0.1	(0.0)
Education And Training	11.9	1.0	1.1	0.1
Non-NHS PPS & Overseas Visitors	3.5	0.3	0.3	(0.0)
Injury cost recovery scheme	1.2	0.1	0.1	(0.0)
Donated Asset Income	1.0	0.1	0.1	0.0
Other Income	13.2	1.1	1.3	0.2
Total	**32.4**	**2.7**	**2.9**	**0.2**

• Other Income (Table 3) is £0.2m favourable to plan for April 2023/24 which is mainly related to income for MRI activity.

Key Highlights: Expenditure (Pay & Workforce)

Table 4 - YTD pay position (excl. employers pension top up of £13.52m)

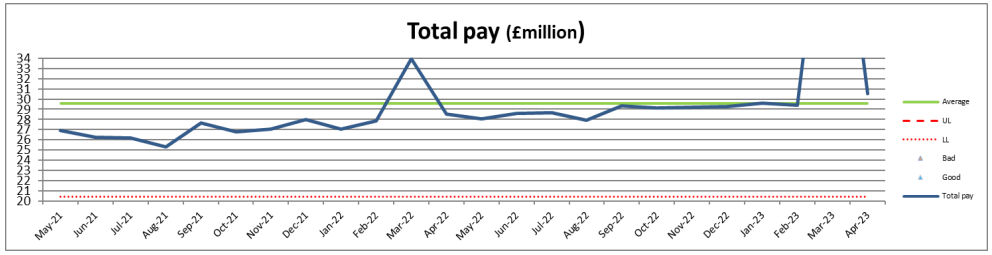
Pay category (£m)	YTD Budget	YTD Spend *	YTD Variance	% of Total Pay Bill	Last Year YTD Spend	Last Year % of Total Pay Bill
Substantive	30.38	25.98	4.41	85.1%	305.5	84.3%
Overtime	0.00	0.12	(0.12)	0.4%	1.7	0.5%
Bank	0.07	2.26	(2.19)	7.4%	26.7	7.4%
Locum	0.04	1.15	(1.11)	3.8%	9.3	2.6%
Agency	0.03	1.02	(0.98)	3.3%	19.1	5.3%
Total	**30.52**	**30.53**	**(0.00)**	**100.0%**	**362.3**	**100.0%**

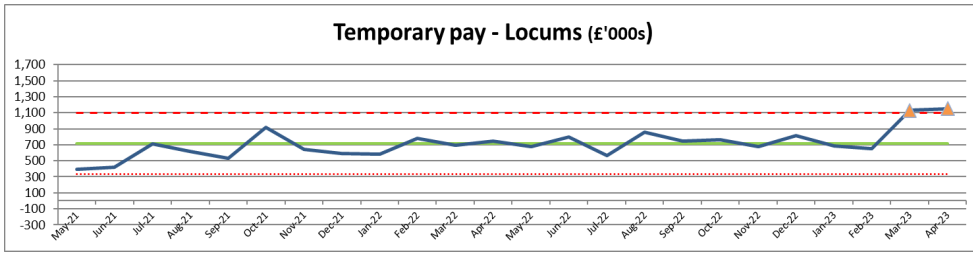
• Pay expenditure totals £(30.53)m for April 2023/24 which is to plan. The expenditure includes £(0.63)m for the 2023/24 Pay Award, £(0.1)m for CEA awards. The estimated costs for the pay award and for CEA awards have been matched with budget. Key pressure areas in pay include Integrated Elderly and Community Care Division, £(0.21)m adverse to budget mainly related to temporary medical staffing costs in the Medicine for Older People directorate. Surgery & Critical Care Division reports a £(0.24)m adverse to budget relating to temporary medical staff costs mainly driven by cover for the in month industrial action. Women, Children and Sexual Health Services' pay position is £(0.16)m adverse to budget largely due to underachievement of the pay savings target. These overspends are offset by central provisions for 2023/24.

• Temporary staffing expenditure (Bank, Agency & Locum) totals £(4.43)m for April. A large proportion of these temporary costs are offset by vacancy related underspends within substantive budgets. Agency expenditure totals £(1.02)m for the month, equating to 3.3% of total pay costs for April, this is below the 4.7% cap for 2023/24.

• The Pay Statistical Process Control Charts are detailed below (Graph 3 & 4). Key highlights include the increase in total pay costs in March 2022 and 2023 includes year end pay related adjustments as detailed last month, which included a £(13.52)m employers pension top up in March 2023. This is reflected in the subsequent drop in April 2022 and April 2023.The increase in total pay costs in September 2022 relates to payment of the 2022/23 pay awards to staff including backdated pay awards for April 2022 through to August 2022.

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





Key Highlights: Expenditure (Non Pay)

Table 5 - YTD non-pay position

Non-Pay category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Drugs	51.3	4.3	4.5	(0.2)
Clinical supplies	36.2	3.3	3.1	0.2
Other non-pay	107.1	9.5	9.9	(0.3)
Total Expenditure	**194.6**	**17.1**	**17.4**	**(0.3)**

Table 6 - YTD drugs position

Drug Categories (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
PBR Drugs	12.4	1.0	1.2	(0.2)
PBR excluded Drugs	37.0	3.1	3.1	0.0
Other Drug Items	1.9	0.2	0.2	(0.0)
Total expenditure	**51.3**	**4.3**	**4.5**	**(0.2)**

Non pay expenditure totals £(17.4)m for April 2023/24, £(0.3)m adverse to plan.

Key drivers of the non pay position include:

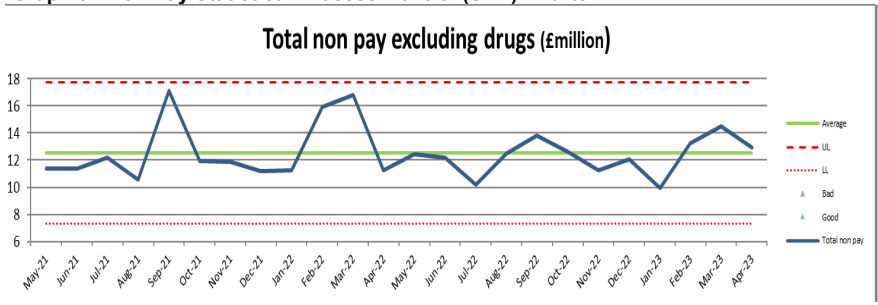
•Drugs expenditure which is £(0.2)m overspent in Month 1 2023/24; this is driven by an overspend in Integrated Medicine.

•Other non pay is £(0.3)m overspent in Month 1 2023/24, partially resulting from Independent Sector (IS) costs in Surgery.

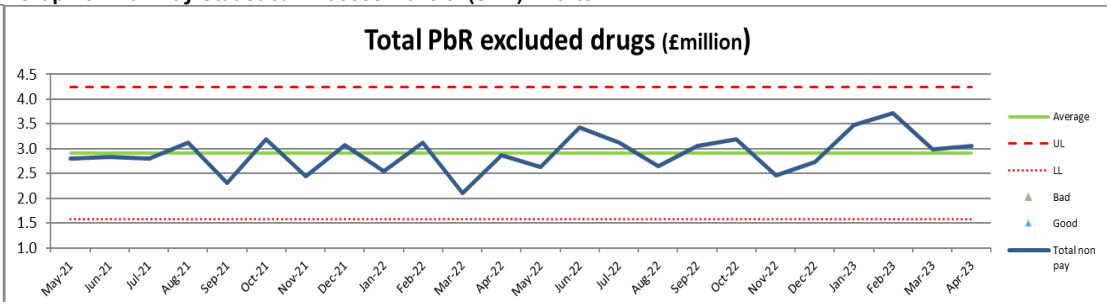
•Clinical Supplies costs are £0.2m underspent in Month 1 2023/24, largely resulting from Elective Activity being adversely impacted in April 2023 by bank holidays and industrial action.

•Statistical Process Control charts (SPC) for non pay and PBR Excluded drugs expenditure are detailed below (Graph 4). Key highlights show:
- The increase in non pay expenditure in February & March 2022 related 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 including IS use, training & consultancy.
- March 2022 and March 2023 costs included 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



Key Highlights: Expenditure (Efficiencies)

Division	Exec Lead	Total Plan Target (£'000)	M01 In Month Plan (£'000)	M01 In Month Actual (£'000)	In Month Variance from Plan (£'000)	YTD Plan (£'000)	YTD Actual (£'000)	YTD Variance from Plan (£'000).	YTD RAG	YTD Reccurent Value (actual)	Total Plan (£'000)	Total Forecast (£'000)	Total Forecast Variance (£'000)
Integrated Medicine	HB	3,875	-	-	-	-	-	-	G	-	3,875	-	-3,875
Integrated Elderly and Community Care	JR	1,998	167	131	-35	167	131	-35	A	-	1,998	1,592	-406
Specialist Services	TA	3,618	-	110	110	-	110	110	G	8	3,618	110	-3,508
Surgery & Critical Care	JB	4,626	-	59	59	-	59	59	G	-	4,626	59	-4,567
Women's and Children's	Emc	2,600	217	77	-140	217	77	-140	R	-	2,600	77	-2,523
Clinical Divisions		-		-			-				-		-
Clinical Total		**16,717**	**383**	**377**	**-6**	**383**	**377**	-6		**8**	**16,717**	**1,838**	**-14,879**
Chief Executive	NM	156	13	6	-7	13	6	-7	R	6	156	190	34
Chief Operating Off-Management	RB	199	17	5	-11	17	5	-11	R	5	199	201	2
Information Technology	DD	1,009	84	26	-58	84	26	-58	R	5	1,009	725	-284
Finance Dept	KS	395	33	33	0	33	33	0	G	33	395	395	0
Property Services	AW	2,450	204	17	-187	204	17	-187	R	17	2,450	1,279	-1,171
People Directorate	BoK	421	35	14	-22	35	14	-22	R	13	421	371	-50
Medical Director	AM	14	1	-	-1	1	-	-1	R	-	14	-	-14
Nursing Director	KB	779	65	9	-56	65	9	-56	R	5	779	141	-638
Corporate	KS	1,183	-	-	-	-	-	-	G	-	1,183	1,183	-
Total Corporate		**6,606**	**452**	**109**	**-343**	**452**	**109**	**-343**		**83**	**6,606**	**4,486**	**-2,120**
Commercial	AW	2,000	-	76	76	-	76	76	G	76	2,000	401	**-1,599**
Trustwide		-	-	-	-	-	-	-	G		-	-	-
Unallocated		2,921	-	-	-	-	-	-	G		2,921	-	**-2,921**
Total (excl. NR £9.9m)		**28,244**	**835**	**562**	-273	**835**	**562**	**-273**		**167**	**28,244**	**6,725**	**-21,519**
Finance Controls (Non-Rec)	KS	9,900	-	146	146	-	146	146	G	-	9,900	146	-9,754
Grand Total		**38,144**	**835**	**708**	**-127**	**835**	**708**	**-127**		**167**	**38,144**	**6,871**	**-31,273**

Divisional Positions

Breakdown of financial position by division

Table 7 - Divisional income and expenditure

Division / (£m)	YTD Budget	YTD Actuals	YTD Variance against Plan	Annual Plan	Current Month Run Rate M01
Integrated Medicine	(8.5)	(8.6)	(0.1)	(93.3)	(8.6)
Integrated Elderly Care	(4.6)	(4.8)	(0.1)	(48.9)	(4.8)
Surgery And Critical Care	(9.6)	(9.5)	0.1	(108.4)	(9.5)
Women and Children	(4.1)	(4.2)	(0.1)	(49.3)	(4.2)
Specialist Services	(7.5)	(7.7)	(0.1)	(86.9)	(7.7)
Total Clinical Divisions	**(34.3)**	**(34.7)**	**(0.3)**	**(386.9)**	**(34.7)**
Chief Executive	(0.3)	(0.3)	0.0	(3.8)	(0.3)
Chief Operating Officer	(0.3)	(0.3)	(0.1)	(3.3)	(0.3)
Commercial Director Mgmt	(5.1)	(5.1)	0.0	(59.7)	(5.0)
Finance Dept.	(0.5)	(0.5)	0.0	(5.9)	(0.8)
Information Technology	(1.6)	(1.6)	(0.1)	(17.2)	(1.6)
Human Resources	(0.2)	(0.1)	0.0	(2.0)	(0.1)
Medical Director	(0.0)	(0.0)	(0.0)	(0.6)	(0.0)
Nursing Director	(1.6)	(1.6)	(0.0)	(19.3)	(1.6)
PDC And Depreciation	(2.4)	(2.6)	(0.2)	(28.5)	(2.6)
Total Corporate	**(12.0)**	**(12.2)**	**(0.3)**	**(140.3)**	**(12.5)**
Contract Income	44.2	44.3	0.1	530.6	44.3
Corporate Services / Provisions	(2.1)	(1.8)	0.3	(26.1)	(1.5)
Retained Surplus / (Deficit)	**(4.2)**	**(4.4)**	**(0.2)**	**(22.6)**	**(4.3)**
Adjusted Financial Performance excl. Profit on disposal of Assets	**(4.2)**	**(4.2)**	**0.0**	**(22.6)**	

Key reasons for the April 2023/24 divisional variances are:

Integrated Medicine £(0.1)m overspend
The main pressure relates to pay costs in the Emergency Department, Neurology and Respiratory directorates.

Integrated Elderly Care £(0.1)m overspend
The overspend is mainly on temporary medical staffing costs in the Medicine for Older People directorate due to Ward 9 and sickness cover. Month 1 Spend on Olympic Lodge is covered by ICB Income in Month 1 in the Trust position.

Surgery & Critical Care £0.1m underspend
Key reasons: £0.2m underspend on theatre clinical supplies due to industrial action impact on elective activity and bank holidays; £0.1m underspend on Ophthalmology drugs; offset by £(0.2)m overspend on temporary medical staff mainly driven by cover for the in month industrial action.

Women & Children £(0.1)m overspend
The overspend is related to under-achievement of pay savings target in month £(0.1)m.

Specialist Services £(0.1)m overpend
This overspend relates to outsourced radiology diagnostic costs supporting elective recovery activity in Month 1 2023/24. Staff are being recruited to, to provide this in-house in line with the agreed 2023/24 Trust budget.

Information Technology £(0.1)m overspend
This is mainly due to a catch up in ethernet extension costs.

Chief Operating Officer £(0.1)m overspend
This overspend mainly relates to pay costs across admin & clerical and nursing in site management.

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	362.8	360.2	2.6	1.4
Cash and cash equivalents	13.6	19.6	(6.0)	(2.7)
Trade and other current assets	46.3	43.2	3.1	1.9
Total Assets	**422.7**	**423.0**	**(0.4)**	**0.6**
Current Borrowing	(5.3)	(5.2)	(0.0)	(0.4)
Other Current liabilities	(81.6)	(81.3)	(0.3)	4.2
Non Current Borrowing	(39.1)	(38.5)	(0.6)	0.0
Other Non-current liabilities	(1.4)	(1.4)	0.0	0.0
Total Liabilities	**(127.4)**	**(126.4)**	**(1.0)**	**3.8**
TOTAL NET ASSETS	**295.2**	**296.6**	**(1.4)**	**4.4**
PDC and Revaluation reserve	422.6	424.4	(1.8)	0.0
Income and Expenditure Reserve	(127.3)	(127.8)	0.5	4.4
TOTAL EQUITY	**295.2**	**296.6**	**(1.3)**	**4.4**

• Non Current assets have decreased by £1.4m from the prior month. This is due to in month capital expenditure of £0.6m being more than offset by in month depreciation of £2m. Non current assets are £2.6m behind plan due to capital spend being behind projections.
• The closing cash balance has increased by £2.7m in month and is £6m higher than plan. This is due to higher advance clinical receipts £3.7m and VAT of £4m. The planned PFI lifecycle payment of £1.7m was also paid in early May instead of April.
• Trade and other current assets are lower by £1.9m compared to prior month. This mostly due to the reduction in debtors analysed in the table 10 below £1m.
• Other current liabilities have increased by £4.2m from the prior month. Expenditure accruals have increased which is associated with the earlier sub-ledger closure to support day one reporting. This is not done for financial year end.
• The PDC and revaluation reserve is £1.8m higher than plan as the Trust has not yet accessed PDC draws but is also assuming that the revaluation reserve will be corrected for the £2.7m stranded reserve identified through audit.
• The change in Income and Expenditure reserve of £4.4m from the prior month is consistent with the planned position for M1.

Accounts Receivable
Table 10 - Accounts Receivable

Month 1

(£m)	Current	31-60 days	61-180 days	6 mths - 1 year	1 year - 2 years	More than 2 years	Total
NHS	0.2	0.8	1.5	0.3	0.1	0.1	3.0
Non-NHS	1.6	1.0	1.2	0.3	0.3	0.8	5.2
Total	**1.9**	**1.8**	**2.7**	**0.6**	**0.4**	**0.9**	**8.2**
% of total	23%	22%	33%	7%	5%	10%	100%

Month 12

(£m)	Current	31-60 days	61-180 days	6 mths - 1 year	1 year - 2 years	More than 2 years	Total
NHS	1.7	0.2	1.7	0.3	0.2	0.7	4.7
Non-NHS	1.4	0.7	1.7	0.4	0.1	0.1	4.4
Total	**3.1**	**0.9**	**3.4**	**0.7**	**0.3**	**0.8**	**9.2**
% of total	34%	10%	37%	7%	4%	9%	100%

• Debtors have decreased by £1.0m from £9.2m in month 12 to £8.2m in month 1.
• The majority of this decrease is due to collections during April from NHS England £0.47m and Oxford Health NHS FT £0.54m .
• Overdue has increased by £0.2m from £6.1m in month 12 to £6.3m in month 1.
• Top 5 overdue debts at month 1 are:
1 - Oxford University Hospitals NHS FT £1.3m
2 - Buckinghamshire Council £0.9m
3 - University of Buckingham £0.3m
4 - Florence Nightingale Hospice Charity £0.2m
5 - The Shelbourne Hospital £0.2m
• Post AR sub ledger close Oxford University Hospitals have settled £0.7m and University of Buckingham have settled £0.3m overdue debt as of month 1.
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.

* values have been taken from detailed reports to enable a clear audit trail to underlying subsidiary reports and therefore some arithmetic rounding errors will occur when the information is presented in millions.

Balance Sheet

Accounts Payable

Table 11 - Accounts Payable

Creditors

(£m)	Current	30-60 days	60-90 days	90-120 days	>120 days	Total
NHS	2.26	-0.04	0.03	0.00	-0.02	2.2
Non-NHS	0.44	-0.10	0.20	0.05	-0.02	0.6

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	
NHS	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty
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
Month 8	3.2	433	1.1	56	0.4	67	0.8	111	0.5	84	0.2	62	0.2	53
Month 9	2.7	488	0.4	62	0.5	51	0.8	128	0.6	96	0.2	93	0.1	58
Month 10	2.9	482	1.1	84	0.0	73	0.6	131	0.9	108	0.2	49	0.1	37
Month 11	2.3	425	0.2	82	0.9	51	0.6	123	0.3	77	0.2	56	0.1	36
Month 12	2.8	432	1.6	107	0.1	38	0.7	118	0.2	60	0.2	73	0.1	36
Month 1	2.2	471	0.4	96	0.8	81	0.4	110	0.3	84	0.2	64	0.1	36

Non NHS	Total Value (£m)	Total Count	0-30 days		31-60 days		61-180 days		6 months to 1 year		1 year to 2 years		More than 2 years	
	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty	£	Qty
Month 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
Month 8	12.1	2,884	4.7	599	4.3	457	1.7	794	1.0	450	0.4	353	0.2	231
Month 9	7.5	3,035	2.3	671	1.6	455	2.2	844	0.8	470	0.4	354	0.2	241
Month 10	8.3	3,341	3.3	868	1.5	428	2.0	973	0.8	539	0.5	354	0.1	179
Month 11	10.9	2,789	6.4	697	1.3	343	1.8	711	0.7	526	0.5	334	0.1	178
Month 12	11.2	3,006	5.7	937	2.0	381	1.6	621	0.7	524	0.5	338	0.2	206
Month 1	11.3	2,910	4.3	799	3.7	422	1.9	630	0.7	510	0.5	333	0.2	216
Total M12	13.5	3,381	4.7	895	4.5	503	2.3	740	1.0	594	0.7	397	0.3	252

Non NHS - lack of PO's in place for 27 invoices for Fedbucks, Abbott Labs, Buckinghamshire CC, Access Uk and Next generation scaffolding totalling 2.6m is the main reason for the movement of 2.5m from 0-30 days to 31-60 days. We are working to get PO's in place but due to the invoice value involved, most are having to be authorised at Board level before being raised. AP/Supplies and the systems teams are running courses around the P2P process to reaffirm the need to receipt and AP are working with those teams lagging to see what improvements can be made in the time taken to receipt. Progress will be reviewed between May - Jun23.
NHS - NHS Supply Chain is the main driver for the increase in 31-61 days. This is due to reports being received late which is delaying authorisation and processing. These invoices will clear in May23. Overall there is still more work to be done to improve the speed in raising PO's for NHS suppliers which in turn will reduce the volume of unprocesed invoices on the register.

Better Payment Practice Code

Table 12 - Better Payment Practice Code

	Count Total	Count Pass	% Pass	Total (£m)	Pass (£m)	% Pass
NHS	170	129	76%	3.5	3.0	85%
Non-NHS	2,794	2,501	90%	20.5	18.4	90%
Total	**2,964**	**2,630**	**89%**	**24.0**	**21.3**	**89%**

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.

There were two significant invoices that were paid late in M1 which deteriorated the BPPC performance (by value). This is due to lack of receipted POs in place for Western Buildings Systems Ltd and Access UK Ltd. Removing the values of the two suppliers the BPPC performance for Non-NHS would be 95%.

Cash Position

Cash

Table 13 - Cash summary position

£'000	Actual Mar-23	Actual Apr-23	forecast May-23	forecast Jun-23	forecast Jul-23	forecast Aug-23	forecast Sep-23	forecast Oct-23	forecast Nov-23	forecast Dec-23	forecast Jan-24	forecast Feb-24	forecast Mar-24	22/23
INCOME														
Clinical Income	44,424	43,508	44,194	44,194	44,194	44,194	44,194	44,194	44,194	44,194	44,194	44,194	44,172	**529,620**
Clinical Income top up / Covid / Growth	0	3,719	0	0	0	0	0	0	0	0	0	0	0	**3,719**
Education and Training	0	0	3,713	0	0	3,713	0	0	3,713	0	0	3,713	0	**14,852**
Other Income	3,330	2,387	603	603	603	603	603	603	603	603	603	603	590	**9,007**
HMRC vat reclaim	0	4,006	0	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,601	**20,007**
Payroll Support	552	0	0	11,200	0	0	0	0	0	0	0	0	0	**11,200**
PDC capital	4,200	0	0	0	0	0	0	0	0	0	5,714	0	580	**6,294**
Revenue PDC	5,302	0	0	0	0	0	1,014	2,825	0	4,435	0	0	7,009	**15,281**
External Cash Support ICB	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other Receipts	2,099	607	635	635	635	635	635	635	635	635	635	635	635	**7,592**
TOTAL RECEIPTS	**59,907**	**54,227**	**49,145**	**58,232**	**47,032**	**50,745**	**48,046**	**49,857**	**50,745**	**51,467**	**52,746**	**50,745**	**54,587**	**617,573**
PAYMENTS														
Pay Costs - Substantive	(26,217)	(25,682)	(25,277)	(28,689)	(26,414)	(27,666)	(27,432)	(26,414)	(26,414)	(26,414)	(26,414)	(26,414)	(26,441)	**(319,671)**
Back dated Payroll	0	0	0	(11,500)	0	0	0	0	0	0	0	0	0	**(11,500)**
Pay Costs - Temporary Staffing	(7,012)	(4,202)	(1,430)	(1,430)	(1,430)	(1,430)	(1,430)	(1,430)	(1,430)	(1,430)	(1,430)	(1,430)	(1,430)	**(19,932)**
Creditors	(17,762)	(12,969)	(14,500)	(14,500)	(14,500)	(14,500)	(14,500)	(14,500)	(14,500)	(14,500)	(14,500)	(14,500)	(14,500)	**(172,469)**
Creditors - Capital Spend	(3,632)	(4,043)	(1,500)	(1,500)	(1,500)	(1,500)	(1,500)	(1,500)	(1,500)	(4,000)	(4,000)	(4,000)	(4,000)	**(30,543)**
NHSLA	280	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	0		**(15,620)**
PDC Dividends	(3,728)	0	0	0	0	0	(4,819)	0	0	0	0	0	(4,106)	**(8,925)**
PFI CHARGE	(1,858)	(3,099)	(6,300)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	(4,450)	**(53,899)**
TOTAL PAYMENTS	**(59,930)**	**(51,557)**	**(50,569)**	**(63,631)**	**(49,856)**	**(51,108)**	**(55,693)**	**(49,856)**	**(49,856)**	**(52,356)**	**(52,356)**	**(50,794)**	**(54,927)**	**(632,560)**
NET CASH FLOW IN PERIOD	(23)	2,670	(1,424)	(5,399)	(2,824)	(363)	(7,647)	0	889	(890)	390	(49)	(340)	(14,986)
OPENING CASH BALANCE	16,930	16,907	19,577	18,153	12,754	9,930	9,567	1,920	1,920	2,809	1,920	2,310	2,260	**16,907**
CLOSING CASH BALANCE	**16,907**	**19,577**	**18,153**	**12,754**	**9,930**	**9,567**	**1,920**	**1,920**	**2,809**	**1,920**	**2,310**	**2,260**	**1,920**	**1,920**

• Clinical Income receipts forecast has been aligned to the Income and expenditure assumptions as per the operating plan.
• Total receipts in month1 decreased from £59.9m in March to £54.2m. This is mainly due to relatively less income from non-clinical sources. The "Other Income" receipt of £2.38m is made up of £550k Oxford Health, Bucks Univ £670K, ICB £900K . "Other Receipts" for £578k is made up of miscellaneous receipts including RTA/ICR, bank interest, childcare/nursery, etc.
•We received VAT reclaim in Apr23 for £4m relating to Feb23 & Mar23's VAT returns and KPMG VAT review in Feb23.
• No material movements in substantive pay costs between Mar23 and Apr23.
• Temporary staffing pay costs were lower in month 1 compared to previous month due to month 12 including a catch up of month 11. Also the temporary staffings pay costs have been alligned to the opartional plan forecasting reduced costs in future months.

Capital Position

Table 14: Capital Overview - M1 2023-24 YTD

Capital Expenditure (£M)	YTD Actual (£m)	Prior Month YTD Actual (£m)	Movement In Spend
Medical Equipment	-	-	-
Property Services	0.2	-	0.2
Information Technology	0.3	-	0.3
General	0.1	-	0.1
Flow	-	-	-
Total Capital Expenditure	**0.6**	**0.0**	**0.6**

Table 15: Capital Overview - M1 2023-24 Full Year

Capital (£m)	Full Year
Funding Streams	
Funded By Trust	20.3
Funded By PDC	6.3
PFI	1.7
ERF	0.0
Funded by Donations / Grants	0.0
Total Capital Funding	**28.4**
Expenditure	
Medical Equipment	4.6
Property Services	7.4
Information Technology	12.3
General	2.1
Flow	2.0
Total Capital Expenditure	**28.4**
Total	**0.0**

Table 16: Capital Detail

	£000's					£000's	
Capital Expenditure Plan	BOB/ICS	Lifecycle	PDC Plan	Donated	2023/24 Total	YTD Expend	Full Year Variance
Medical Equipment	**4,611**				**4,611**	**0**	**0**
Property Services	**7,358**				**7,358**	**219**	**(0)**
Information Technology	**6,030**		**6,294**		**12,324**	**345**	**(0)**
General	**348**	**1,728**			**2,076**	**64**	**0**
Flow	**2,000**				**2,000**	**0**	**0**
Total	**20,347**	**1,728**	**6,294**	**0**	**28,369**	**628**	**(0)**

The month 1 capital spend is £0.6m. Property Services spend of £0.2m relates to £0.1m on the MRI scheme and £0.1m on the Paediatric build. IT spent £0.2m on EPR and £0,1m on integrated voice and data networks in M1. General includes spend on PFI lifecycle of £0.05m.

As at month 1 the Trust is not forecasting an overspend against it's capital resource limit.

Total CRL Funding of £28.4m includes BOB/ICS £20m, PFI Lifecycle £1.7m, and PDC allocations of £6.2m (£5.7m for ERF and £0.6m for Digital Diagnostic Capability programme)

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

31 May 2023

Agenda item	BHT 2023-24 Operating Plan
Board Lead	Kishamer Sidhu, Interim Chief Finance Officer
Type Name of Author	Kishamer Sidhu, Interim Chief Finance Officer
Attachments	BHT 2023/24 Budget and financial plan revision
Purpose	Approval
Previously considered	F&BPC 23.05.2023

Executive Summary

The NHS 2023/24 Operational Planning Guidance was published on 23/12/2022.

This paper sets out revised financial plan and budget for approval, following receipt of additional income, contract settlements and an additional CIP target.

The Finance and Business Performance Committee considered this on the 23 May 2023 and recommended approval by the Board.

Decision	The Committee is requested to approve the BHT 2023/24 Financial Plan and Budget

Relevant Strategic Priority

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

Implications / Impact

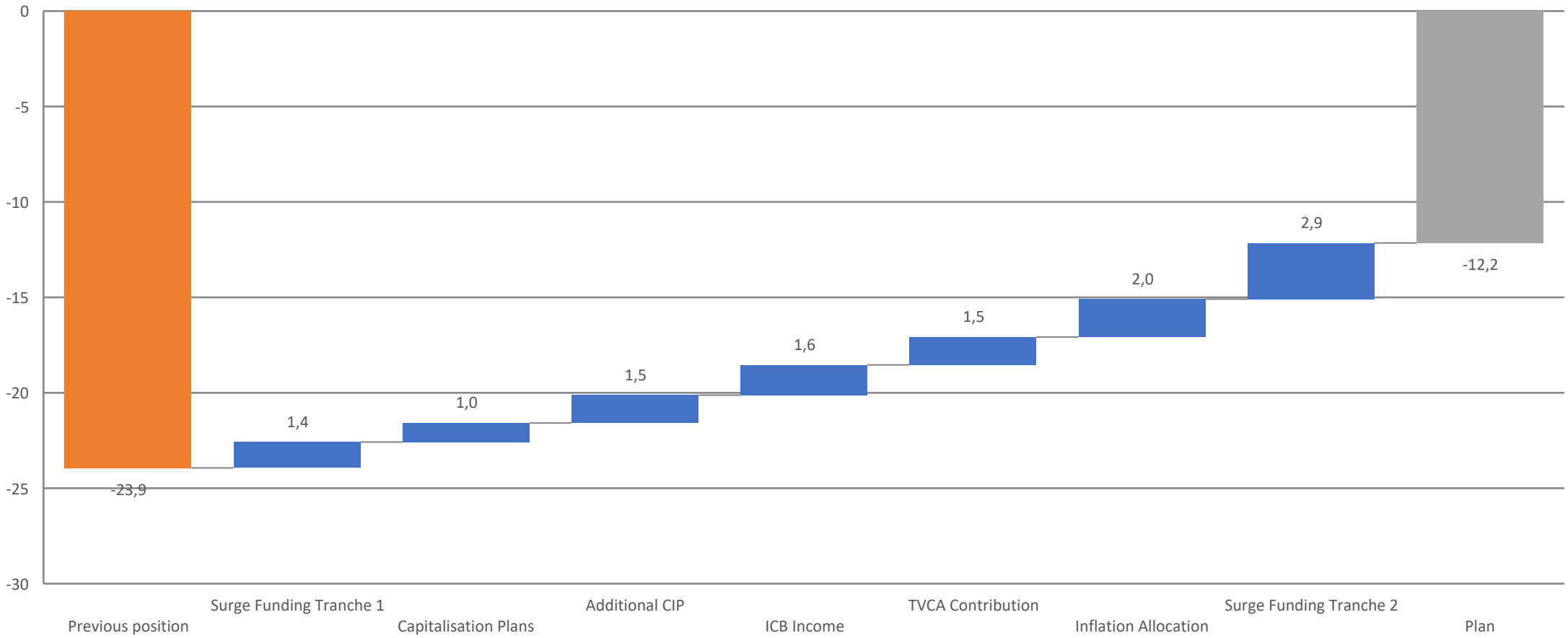
Patient Safety	As financial plan are developed, any impacts on patient safety will be identified and addressed as part of the QIA process.
Risk: link to Board Assurance Framework (BAF)/Risk Register	1. Failure to provide care that consistently meets or exceeds performance and quality standards including safety, experience and outcome. 2. Failure to deliver our annual financial and activity plans. 3. Failure to work effectively and collaboratively with external partners 4. Failure to support improvements in local population health and a reduction in health inequalities 5. Failure to deliver on our people priorities related to recruitment & resourcing, culture & leadership, supporting our staff, workforce planning & development and productivity. 6. Failure to provide adequate buildings and facilities.

	7. Failure to learn, share good practice and continuously improve.
Financial	This report sets out the Trust's Financial Plan and budget for 2023/24.
Compliance CQC Standards Good Governance	This report provides assurance on the development of the Trust's annual business planning process.
Partnership: consultation / communication	Business planning is being undertaken collaboratively by corporate and divisional teams.
Equality	As plans are developed, any equality impacts of plans will be identified and addressed as part of the EQIA process.
Quality Impact Assessment [QIA] completion required?	Not required for this report. As business plans are developed, QIAs will be completed for specific plans in line with the Trust's QIA process.

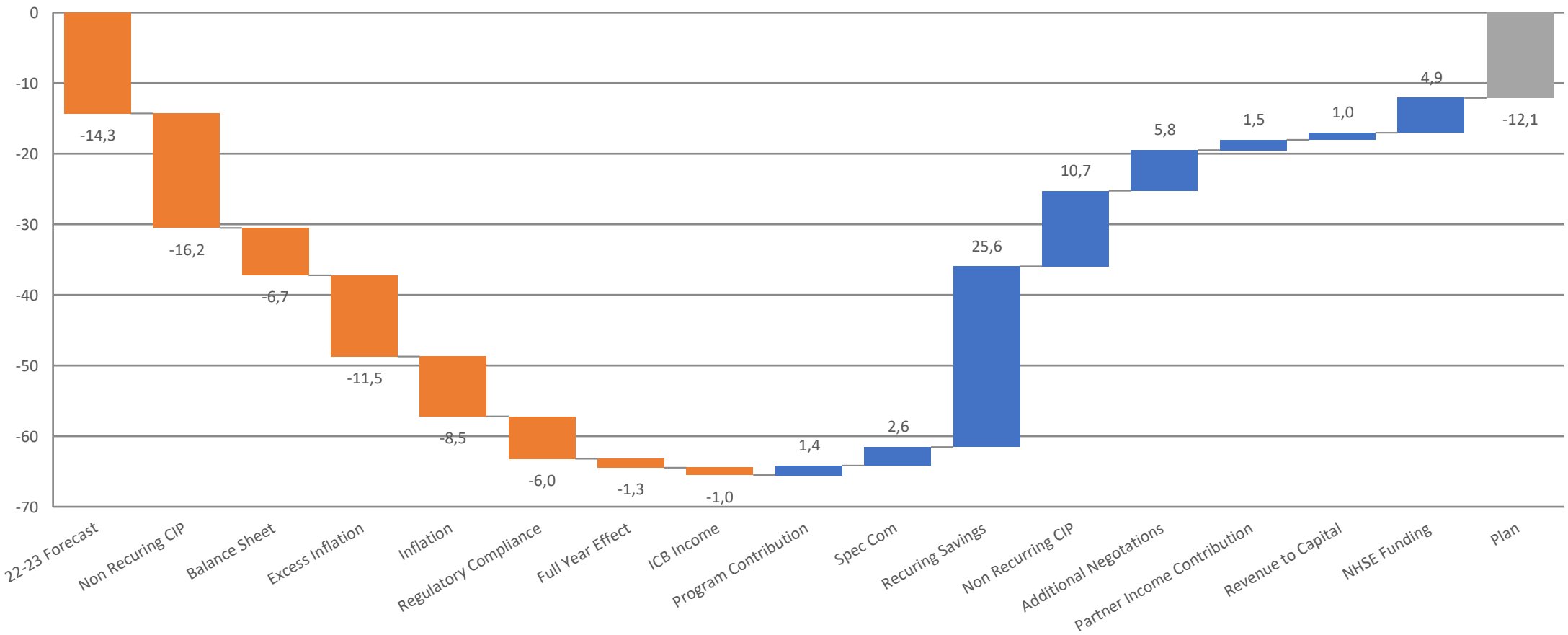
Budget 23-24

May Submission

Movements since last submission



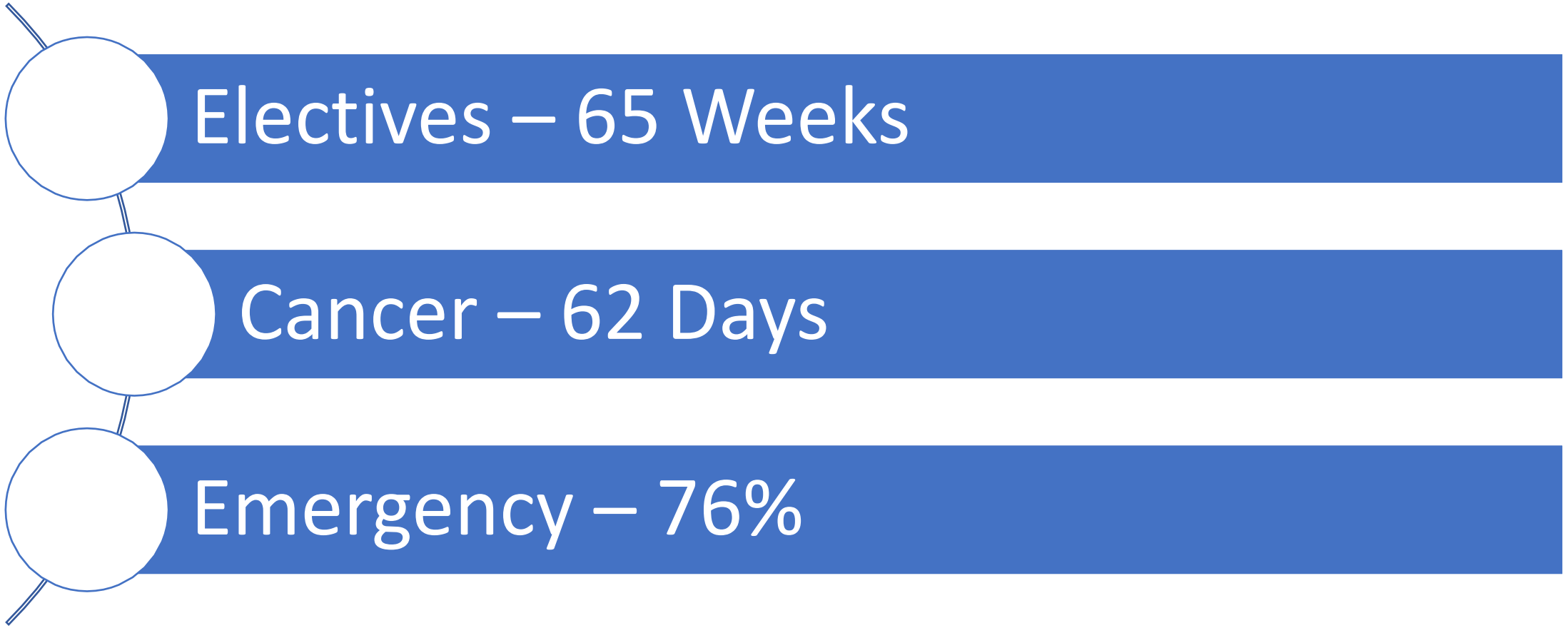
22-23 to final Plan



Contextual Position

	30-Mar			04-May	Within system control - ICS Proposed Adjustments				10-May	Subject to NHSE		
BOB ICS	**(Deficit) Plan 2023/24**	**Stretch Target Adj**	**Balance 50% surge**	**Revised Plan 2023/24 submitted**	**Deferred Income release/IT capitalisation**	**TVCA Income**	**Strict Financial Controls**	**Additional in year income/ICB controls**	**Revised Plan 2023/24**	**Inflation allocation**	**further 50% surge**	**Revised Plan 2023/24**
	£k	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
BHT	**-28,938**	**5,000**	**1,358**	**-22,580**	**1,000**	**1,458**	**1,458**	**1,585**	**-17,079**	**1,986**	**2,943**	**-12,149**
OUH	**-29,766**	**5,000**	**3,057**	**-21,709**		**2,099**	**2,099**	**3,566**	**-13,946**	**4,469**	**6,623**	**-2,854**
OHFT	**-2,859**	**2,859**	**226**	**226**	**2,000**			**264**	**2,491**	**331**	**491**	**3,312**
RBFT	**-23,000**	**3,500**	**1,132**	**-18,368**		**1,443**	**1,443**	**1,321**	**-14,161**	**1,655**	**2,453**	**-10,052**
BHFT	**-2,051**	**2,051**	**226**	**226**				**264**	**491**	**331**	**491**	**1,312**
Total Providers	**-86,614**	**18,410**	**6,000**	**-62,204**	**3,000**	**5,000**	**5,000**	**7,000**	**-42,204**	**8,773**	**13,000**	**-20,431**
ICB	**-**	**-**	**-**	**-**					**-**			**-**
ICS Plan Total	**-86,614**	**18,410**	**6,000**	**-62,204**	**3,000**	**5,000**	**5,000**	**7,000**	**-42,204**	**8,773**	**13,000**	**-20,431**

Key activity assumptions



Key Budget Assumptions 23- 24

Patient Care Income	Based on agreed income numbers for the ICB and contracts where available. Specific issues are highlighted in the income part of the papers.
ERF Income	This is assumed in the baseline and it is highly likely negotiation will be required to retain this income.
COVID 19 funding	This is non recurring income which is included in contracts
Pay Costs	Recurrent full year pay budgets based on 22-23 funded establishment (i.e. no establishment drift funded), and staff in post, adjusted for historical incremental drift and full year effects and other smaller changes. Pay inflation based on national assumptions held centrally, along with the medical CEA award.
Non Pay	Recurrent full year budgets based on 22-23 adjusted for national non pay inflation assumptions and specific cost areas such as PFI and CNST. The energy excess inflation number will be held centrally.
PDC and depreciation	Based on recurrent 22-23 budget plus the impact of the capital program.
Efficiency Target	This is based on a target of £25.6m recurrent and £10.7m non recurrent savings
Budget Requests	Budget have been requested for specific projects, that will be held centrally, and released when spend occurs only for those specific projects. Slippage will be used to cover contingency requirements.

Pay / Non Pay and Income Budgets Split 23- 24

Area	Place	Income	Pay	Non pay	Total
Contract Income	Contract Income	(542,077)			(542,077)
Contract Income Total		**(542,077)**			**(542,077)**
Chief Operating Officer	Integrated Elderly Care	(1,605)	47,440	3,040	48,874
	Integrated Medicine	(2,874)	66,105	30,112	93,342
	Specialist Services	(1,728)	54,977	33,654	86,903
	Surgery And Critical Care	(2,891)	78,294	33,015	108,418
	Women & Children	(498)	43,933	5,892	49,326
Chief Operating Officer Total		**(9,597)**	**290,749**	**105,712**	**386,864**
Corporate	Chief Executive	(2)	2,399	1,401	3,798
	Chief Operating Off-Management	(4)	3,195	137	3,328
	Commercial Director Division	(3,792)	5,245	58,229	59,682
	Corporate Services	(3,296)	11,074	10,773	18,552
	Division Of Information Technology	(87)	9,946	7,384	17,242
	Finance Directorate	(99)	4,299	1,671	5,872
	Human Resources	(12,835)	12,163	2,669	1,997
	Medical Director	(1,713)	2,164	120	571
	Nursing Director	0	3,125	16,131	19,256
	Pdc And Depreciation	(2,865)		31,339	28,475
Corporate Total		**(24,693)**	**53,610**	**129,855**	**158,773**
Provisions	Provisions		8,590	0	8,590
Provisions Total			**8,590**	**0**	**8,590**
Total		**(576,366)**	**352,949**	**235,567**	**12,149**

Key Issues

- Associates need to be managed to block same as 22-23
- ERF Assumed in ICB (£12.5m), associates (£3m) and specialist (£4m)
- Minimal CQUIN included in baseline (opportunity / performance risk)

Capital Plan 23-24

- This is largely for regulatory / legislative spend
- Should expect more latter in year but not yet known
- Does not include potential asset sales
- Does not include benefits from MES

	Projects	ICB allocation	Known Other	Total
Property Services	CEF	3.0		
	Lifts & Spinal Water	1.0		
	Other	2.5		
IT	Cyber	2.0		2.0
	EPR	2.25	5.7	7.95
	Contingency	0.75		0.75
Equipment		2.0		2.0
Urgent Patient related		2.0		2.0
Anesthetic machines		2.7		2.7
Pre-committed 22-23		4.1		4.1
PFI Lifecycle			1.7	1.7
Donated Assets			1.0	1.0
Capitalisation		1.0		1.0
Total		21.3	8.4	29.7

Summary

- The organizational financial position for 22-23 was £14.3m, an improvement on the original NHSE plan of £17.6m. The plan for 23-24 is a deficit of £12.1m.
- The financial plan and resulting budgets entail a savings program of £25.6m and £10.7m of non recurring savings.
- The are risks arising from the income positions which will need managing.
- The expenditure budgets will need to be managed to remain within allocated resources., which are aimed at achieving the 3 key activity targets.
- It is proposed the Board approves the revised budget of £12.1m deficit and the capital plan at £29.7m.

Meeting: Trust Board Meeting in Public

31 May 2023

Agenda item	Safe Medical Staffing 2023
Board Lead	Andrew McLaren
Type name of Author	Stephen Gardner
Attachments	Medical Safe Medical Staffing May 2023
Purpose	Assurance
Previously considered	Q&CGC 17.05.2023

Executive Summary

- Between August 2020 and March 2021 medical staffing levels for junior doctors on the Medicine Speciality wards were identified as unsafe within wards/departments up to 26% of the time (average11%). This resulted in a business case which was approved in August 2021.
- Consequently Medicine has improved the staffing on the wards with Acute Medicine, Respiratory, Gastroenterology, Rheumatology and Cardiology all 100% safe in Q4. Stroke was only short for 8 hours and BNRU for 32 hours. BNRU is low acuity so can manage without a doctor for an odd day.
- The Medicine on-call rotas are more difficult as they provide out of hours and therefore are effected more by last minute sickness. However there were no F1 gaps, 118 hours of F2 in January but none in Feb or March and IMT about 40 hours a month. Registrar gaps were minimal except in February when a doctor was sick for a set of nights.
- Having staffing numbers below the safe level does not immediately make patient care unsafe but requires mitigation which can vary depending on the area, acuity levels, activity levels on the day and some jobs may be delayed. Junior doctor training activity may be cancelled.
- The Emergency Department is currently going through a consultation on rotas etc for consultants and will then move onto the middle grade rota to ensure safety and remove excess temporary staff. The new rotas are expected in July. Minimum safe staffing levels have been revised for April as they are currently set too high.
- Surgery are revisiting the Anaesthetic and Surgery Consultant rotas as they are the cause of high locum spend to ensure safety and cost effectiveness. Anaesthetics have a robust SOP for safety and reduce theatre activity if staffing levels are insufficient. Junior doctor rotas are a cause for concern with no minimum standards set and no data.
- Surgery and W&C currently use Medirota software which is unable to provide safe staffing data. This is being replaced by Healthrota which is already used in Medicine and has this functionality.
- W&C have a high locum spend at middle grade level. The rotas are being redone for the new building. This is a cost concern but not a safety concern as it is covered by familiar staff on Bank.
- IECC junior doctors are included in the medicine on-call data but not their ward activity. The rota co-ordinator had left and has only just been replaced so this has not progressed recently.

The Quality & Clinical Governance Committee considered this report on 17 May 2023. The Committee acknowledged the iterative work on reporting and actions underway to mitigate staffing

risks. Further actions requested included clarity on mitigations and evaluation fo junior doctor investments in 2022.

Decision	The Board are requested to take assurance from the report

Relevant Strategic Priority			
Outstanding Care ☒	**Healthy Communities ☐**	**Great Place to Work ☒**	**Net Zero ☐**

Implications / Impact	
Patient Safety	This report reviews safe and effective staffing of the medical support to ward at Stoke Mandeville, Wycombe and Amersham Hospitals
Risk: link to Board Assurance Framework (BAF)/Risk Register	Corporate risk CRR 85 – shortage of junior doctors. Links to Strategic Objective: Ensure staff are safe, supported and listened to. Multiple associated Divisional risks to staffing, redundancy and high temporary staffing spend.
Financial	High temporary staffing cost which is being managed separately.
Compliance Select an item. **Staffing**	Safe medical staffing | RCP London ACSA-STDSFULL-2022.pdf (rcoa.ac.uk)
Partnership: consultation / communication	Rota Co-ordinators for Medicine and Surgery, Director of Medical Education, Guardian of Safe Working
Equality	No protected characteristic is disadvantaged by the proposal in this document.
Quality Impact Assessment [QIA] completion required?	Not required

1 Introduction/Position

1.1 This is an update on the Safe Medical Staffing Programme started after the Royal College of Physicians report “Guidance on Safe Medical Staffing” July 2018 and the Medicine Division business case in October 2021. This became possible due to the introduction of the HealthRota eRostering system in Medicine during the Covid pandemic. Surgery and W&C use the Medirota eRostering system but are changing to Healthrota except for Anaethetics who use CLW. At present this is planned for 2024/5 but expediting this will be looked at.

1.2 Anesthetic have their own guidance set as part of Anaesthesia Clinical Services Accreditation based on Royal College of Anesthesia guidelines. The Guidelines for the Provision of Anaesthetic Services (GPAS) support anaesthetists with responsibilities for service delivery and healthcare managers to design and deliver high quality anaesthetic services. It is developed using a rigorous, evidence-based process, which was accredited by the National Institute for Health and Care Excellence (NICE) in 2016.

2 Problems

2.1 Limited data available from Medirota
2.2 Limited data outside Medicine and Anaesthetics
2.3 High Temporary Staffing spend to maintain safety in some areas

2.4 Engagement from some areas

3 Proposal, conclusions recommendations and next steps.

- Continue work on Safe Staffing in Medicine and expand work in ED after consultations complete
- Define surgical safe staffing levels and data analysis for areas of risk
- Extend work to include Paediatrics, O&G and NSIC
- Expedite roll out of Healthrota to Surgery\W&C
- Report back in 6 months

4 Action required from the Board/Committee

4.1 The Board is requested to:

a) Take assurance from the current Safe Medical Staffing Programme and proposed next steps

APPENDICES

Medical Safe Medical Staffing May 2023

Medical Safe Staffing May 2023

Introduction

The Division of Medicine completed a report into safe medical staffing on the wards based on the Royal College of Physician's 'Guidance on Safe Medical Staffing" report from July 2018. This became possible in 2020/21 due to the introduction of the electronic HealthRota system. This culminated in a business case that was approved at the Executive Management Committee in October 2021 which was implemented over the subsequent year, particularly for the August 2022 junior doctor change over.

The consequences of unsafe medical staffing are:

- Impacts on patient safety identified through increased DATIX & SI reports
- Impacts on patient safety, through reduced response times to Sepsis-alerts, NEWS escalations and nursing concerns
- Reduced patient flow, late TTOs and delayed discharges; which lead to an increase in the average length of patient stay, along with increased 'long-stays'.
- Reduced elective activity, which is cancelled to prioritise inpatient care; or cannot be provided due to staff already being rostered on wards.
- Impacts on Junior Doctor morale, through increased exception reports, poor trainee feedback and GMC survey outcomes.
- Impacts on Junior Doctor training, by reduced time available for teaching and learning opportunities.
- Significantly reduced ability to recruit and retain the best staff, by providing a poor work environment where staffing concerns are ever present. Results in trainees not returning to BHT and therefore high Consultant vacancy rates.

The Royal College of Anaesthetists have also produced safety standards which are incorporated into the Accreditation Standards 2022 (ACSA-STDSFULL-2022.pdf (rcoa.ac.uk)).

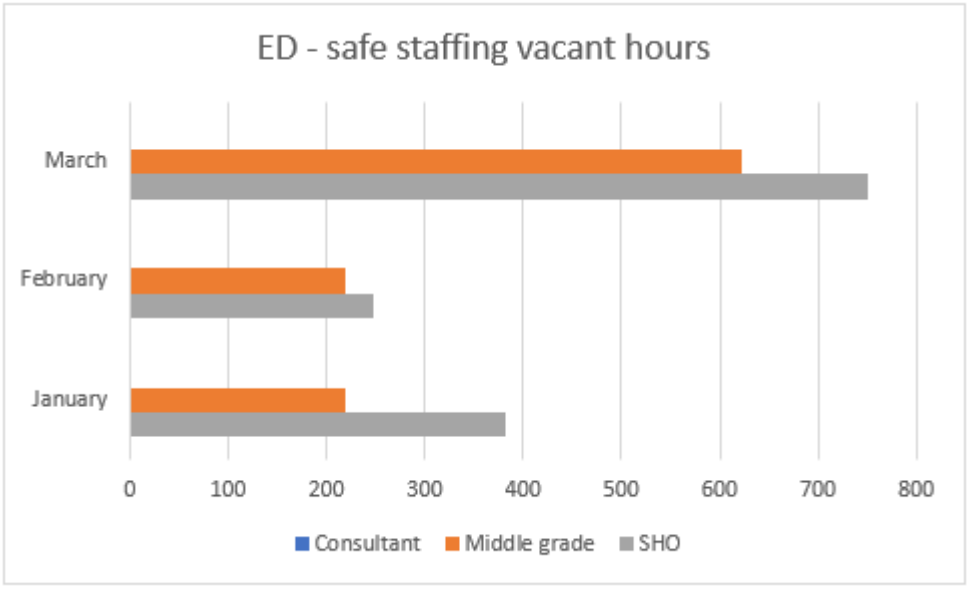
This paper follows on from the Safe Medical Staffing Report 2022 presented at EMC October 2022.

Safe Medical Staffing has been incorporated into the Temporary Staffing Programme as minimum levels have to be defined to ensure that Temporary staffing cost is minimised but is used if required to provide a safe service. This is Chaired by the Chief People Officer and has a medical workstream with a Deputy Chief Medical Officer as Senior Responsible Officer.

Divisional Breakdowns

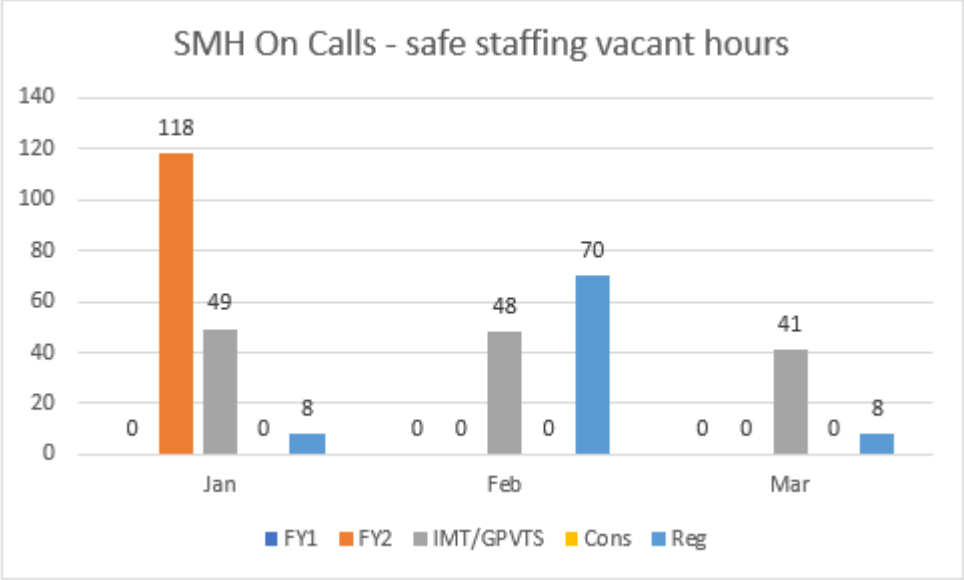
Division of Medicine

The original Medicine business case covered the medical specialities but did not cover the Emergency Department. The department has now moved onto the Healthrota software and minimum safe staffing levels have been defined. In March all agency doctors were given notice as part of the Temporary Staffing Project so there was a big increase in the number of unsafe hours. However, the minimum levels have been set too high and this has been adjusted for April. The rotas have also been changed and there is a consultation going on with the Consultants and Middle grades which will improve the situation again from both the safety and financial perspective.



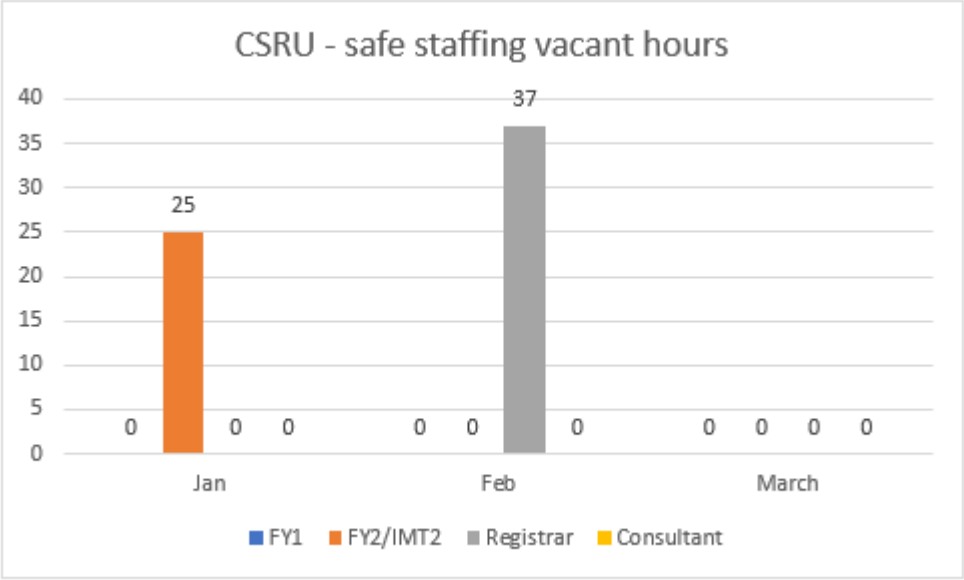
Number of unsafe hours in the Emergency Department for Q4 2022/3

Within the Medical Specialities the ward cover, Acute Medicine, Respiratory, Gastroenterology, Rheumatology and Cardiology were all 100% safe in Q4. Stroke was only short for 8 hours and BNRU for 32 hours. BNRU is low acuity so can manage without a doctor for an odd day. The on-call is more prone to last minute sickness However there were no F1 gaps, 118 hours of F2 in January but none in Feb or March and IMT about 40 hours a month. Registrar gaps were minimal except in February when a doctor was sick for a set of nights.



SMH on-call vacant hours for Q4 2022/3

At CSRU Medicine on-call unsafe hours were mainly caused by high sickness in F2 in January and Registrar sickness for nights in February. A rota gap caused recurrent issues at IMT level. Although the staffing levels were below minimum safe levels, mitigations on the day were able to maintain patient safety and short gaps can be managed.



Division of Surgery

The anaesthetics SDU maintains accreditation from the Royal College of Anaesthesia. As part of this they have produced SOP for general anaesthetics and the Obstetric service. Both of these are on CAKE and are included in the appendices. Further information and data are in the Anaesthetic Safe Staffing Report May 2023 in the appendices. The tables below show data for the whole of 2022-23 with only 11 ICU gaps which includes 3 days of the junior doctor

industrial action. In theatres there were only three gaps all year and no unfilled shifts for the Resident Obstetric Anaesthetist SMH, Resident ICU Doctor WGH, or Consultant O/C shifts.

SMH ICU: April 2022-2023

Date	Shift	No of Doctors	Airway Doctor?	Notes
3/4/2022	18:00-20:00 weekday	1 / 2	Yes	Covid leave
11/4/2022	18:00-20:00 weekday	1/2	yes	Covid isolation leave
6/6/2022	20:00-08:00	1/2	yes	Covid isolation leave
19/6/2022	08:00-20:00	1/2	yes	Sick leave
13/8/2022	20:00-08:00	1/2	yes	WGH rota gap – SMH TR moved to cover
14/9/2022	20:00-08:00	1/2	yes	Obs sick leave – ICU ST moved to cover
18/9/2022	08:00-20:00	1/2	yes	SAS night rota gap – ST LD moved to cover night shift
3/12/2022	08:00-20:00	1/2	yes	OH advice unable to do oncall
13/3/2022	18:00-20:00 weekday	1/2	yes	Doctors Strike
14/3/2022	18:00-20:00 weekday	1/2	yes	Doctors Strike
15/3/2022	18:00-20:00 weekday	1/2	yes	Doctors Strike

SMH Theatres: April 2022 -2023

Date	Shift	No Theatre O/C Junior	ICU 2 Docs	Notes
14/10/2022	08:00-20:00	No	Yes	Covid Isolation Leave
29/7/2022	18:00-20:00	No	Yes	Covid Isolation Leave
16/4/22	08:00-20:00	No	Yes	Sick Leave

The situation in the rest of the Division is less well developed and safe staffing levels have not been defined. Surgery use Medirota for rostering rather than Healthrota although they do

have to use Healthrota for exception reporting. Medirota is unable to provide safe staffing data and plans are being developed to replace it.

Division of Integrated Elderly and Community Care

On-call for IECC are included with the Medicine data. Ward minimal staffing levels have not been defined. The rota co-ordinator had left and has only just been replaced so this has not progressed recently.

Division of Women and Children

W&C have a high locum spend at middle grade level. The rotas are being redone for the new building. This is a cost concern but not a safety concern as it is covered by familiar staff on Bank. Further information will become available for the next quarter, but minimum safe staffing levels have not been defined.

Division of Specialist Medicine

This Division provides limited inpatient or on-call cover with the inpatient care covered by Medicine out of hours. There are on-call consultants for Haematology and Microbiology who provide telephone advise out of hours and a limited weekend service. This is not a concern and data has not been collated for this report. The Spinal unit has cover from a RMO overnight and minimum safe staffing levels have not yet been defined.

Problems

The main problems in progressing safe staffing are the balancing the requirements for safe staffing with the temporary staffing cost reductions. Defining minimum safe staffing for each rota is an essential first step and requires engagement from the relevant services. To adequately provide data will require a change to Healthrota software in Surgery and W&C and there are concerns that the surgical rota co-ordination is inadequately resourced to implement the required changes. Further work needs to be done on this. Data for O&G and Paediatrics is limited due to change in rotas due to the new building but better information should be available next quarter. Again minimum safe staffing numbers will need to be defined.

Proposal, conclusions recommendations and next steps.

- Continue work on Safe Staffing in Medicine and expand work in ED after consultations complete
- Define surgical safe staffing levels and data analysis for areas of risk
- Extend work to include Paediatrics, O&G and NSIC
- Expedite roll out of Healthrota to Surgery\W&C
- Report back in 6 months

APPENDICES

Rota April 2023 report

Anaesthesia-safe-staffing-Version2-AA.pdf

Guideline533 Obstetric anaesthetics.pdf

Anaesthetic Safe Staffing Report May 2023

Meeting: Trust Board Meeting in Public

31 May 2023

Agenda item	FTSUG Annual Report
Board Lead	Bridget O'Kelly – Chief People Officer
Type name of Author	Tracey Underhill – Lead Freedom to Speak Up Guardian
Attachments	None
Purpose	Assurance
Previously considered	EMC 09.05.2023 SPC 15.05.2023

Executive Summary

Attached is the FTSUG Annual Report for the year 01 April 2022 to 31 March 2023, an Executive Summary is included within the attached report.

Included is an account of work achieved during this period to progress our journey towards building a positive Speaking Up Culture across the Trust. The report sets out how we are making a positive contribution to our overall aim of wanting to achieve results in the National Staff Survey that put us in the "Best in Class" group for Freedom to Speak Up. However, we are not there yet and there is more targeted hard work in this area required and planned this year across the Trust.

This report was reviewed by The Executive Management Committee (EMC) and The Strategic People Committee (SPC) before being submitted to Trust Board. Both Committees have enabled further discussion and provided feedback.

Decision	Assurance.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	A positive speaking up culture underpins patient safety and good quality care
Risk: link to Board Assurance Framework (BAF)/Risk Register	Patient Safety and the quality of patient care – if staff don't feel able to speak up.
Financial	Unnecessary costs are incurred if barriers prevent people speaking up to minimise risk of errors occurring, incidents, poor practice or declarations of fraudulent behaviours, or poor behaviour. There are also human and financial costs associated with cultures where staff are not supported to speak up.
Compliance	NHS Contract, CQC, the NHS Constitution and NGO Trust Board and FTSU Guidance
Partnership: consultation / communication	The sharing of good practice through regional and national FTSUG Networks.
Equality	Concerns raised can highlight inequalities or matters related to fairness.
Quality Impact Assessment [QIA] completion required?	N/A

Buckinghamshire Healthcare NHS Trust

Freedom to Speak Up Annual Report

01 April 2022 to 31 March 2023

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

Buckinghamshire Healthcare NHS Trust

A message from our Chief Executive

"Our Freedom To Speak Up service is fundamental to our organisation and plays a critical role in the safety of our colleagues and the care we provide to patients. The success of our FTSU service relies on colleagues feeling safe to speak up, and I am particularly pleased to see the diversity of individuals in our growing FTSU network of champions – my thanks to everyone who has put themselves forward to contribute to this vital team and support their colleagues at BHT."

Neil MacDonald
Chief Executive Officer

A message from our Chief People Officer

""It is important that colleagues across the Trust feel safe and supported to be able to raise concerns in the interest of patient safety and staff experience. This report demonstrates our progress in continuing to strengthen our positive speaking up culture across the Trust, supports the People Promise, "We each have a voice that counts" and our engagement with our colleagues Trust-wide. Learning locally and across the Trust from concerns raised through the Freedom to Speak Up team plays a key part in the improvement cycle".

Bridget O'Kelly
Chief People Officer

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Our priority: people are listened to, safe and supported.

Making sure colleagues feel safe and supported to speak up and heard is just one of the ways we demonstrate this at BHT…… it underpins patient and staff safety, quality of care and improvement.

Freedom to Speak Up

Buckinghamshire Healthcare NHS Trust

To build a great place to work, we have and will continue our focus on building a positive Speaking Up culture which underpins patient and colleague safety across the Trust.

Freedom to Speak Up feeds into:

- Our Priority:
  People are listened to, safe and supported.
- Our Strategic Goals:
  1) People feel engaged, 2) Caring and skilled people in high performing teams.
- The People Promises:
  We each have a voice that counts,
  We are always learning,
  We are safe and healthy
- Our Strategic People Objectives e.g retention

Throughout the year we have and will:

- Continue to maintain and raise awareness of the importance of Speaking Up, the national FTSU training and access to our FTSU service.
- Continue to strengthen our FTSU outreach, improving engagement and reducing barriers to speaking up.
- Continue to build a representative network of Speaking Up Champions, increasing numbers across the Trust.

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

Executive Summary

The Freedom to Speak Up Guardian (FTSUG) is a designated role which provides a safe place for colleagues to raise concerns safely, without fear of detriment or blame, helping to improve the safety of our patients and colleagues. The Freedom to Speak Up Guardian is a mandatory post for all NHS Trusts in England which also reports to the National Guardian Office thereby offering a level of independence. The National Guardian visited BHT last July and also presented to over 80 leaders whilst with us, sharing some key messages.

Our bespoke Outreach Freedom to Speak Up Guardian model at BHT continues to develop and offers extensive accessibility to colleagues of an increasingly diverse background, with a total of just under 3,500 outreach contacts across the Trust. The service has managed an additional 80 cases of concerns which represented 93 of our colleagues raising a concern safely. The outreach has been maintained despite team capacity being affected in year, as a result of the transition to permanent posts which is positive progression and provides the opportunity to build an established team going forward. The model means well over a 100 further opportunities for learning and improvement have been shared this year for patient and staff safety which we might otherwise not have heard about. Service satisfaction is also included in this report. Main themes reported to the service this year include violence and aggression towards colleagues from relatives, carers, patients, and visitors, which was also reflected nationally. Further work continues in addressing individual behaviours between colleagues and their managers. Patient safety related themes evolved pertaining to process, governance and pathway. Between colleagues and within teams there is more to do to improve early engagement of colleagues in service or organisational change. Improved communication is also raised in a number of different contexts.

Our plans to further increase awareness and embed the importance of “Speaking Up” at a local level across BHT have also advanced. We now have an established network of champions; having launched this programme just last year with 58 applications made in total. Ongoing promotion means we have more interested colleagues scheduled for training in May. Our numbers of volunteer champions show good engagement in comparison to other Trusts across our region. This report highlights the strong representation and over representation evident for disability, LGBTQ Plus and ethnicity. The exception is our male champions who are just slightly under-represented but we continue to give this focus going forward.

The Trust has remained committed to supporting individuals to complete the national modules of online ‘Speak Up , Listen Up and Follow Up’ Training and this year over 5,500 colleagues from a total of 6,500 have done so.

Our new champions also made a valuable contribution to our October Speaking Up month last year “Speaking Up is for Everyone” resulting in good engagement and a varied programme of events and activities across the Trust. Feedback on the month was positive.

These initiatives have increased visibility and accessibility of the FTSUG role and service. We believe this is one of the reasons why BHT has demonstrated a set of improved scores in the National Staff Survey results against the national context of decreasing scores for Speak Up relevant questions in the National Staff Survey. BHT also achieved a score of significant improvement against health sector averages for similar Trusts. However, we remain on a journey and there is still much work to do to achieve best in class which is our mission. We remain focused on targeting work this year to those colleagues responding to the questions showing less confidence in speaking up. We do not underestimate the importance of reaching out to colleagues to further understand and clarify the barriers and contributing factors, also enabling us to check if we differ in any way from the national research. Work is already underway to look into this and gather colleague feedback and will be a major workstream for the forthcoming year.

People Promises – How did we do overall?

Buckinghamshire Healthcare NHS Trust

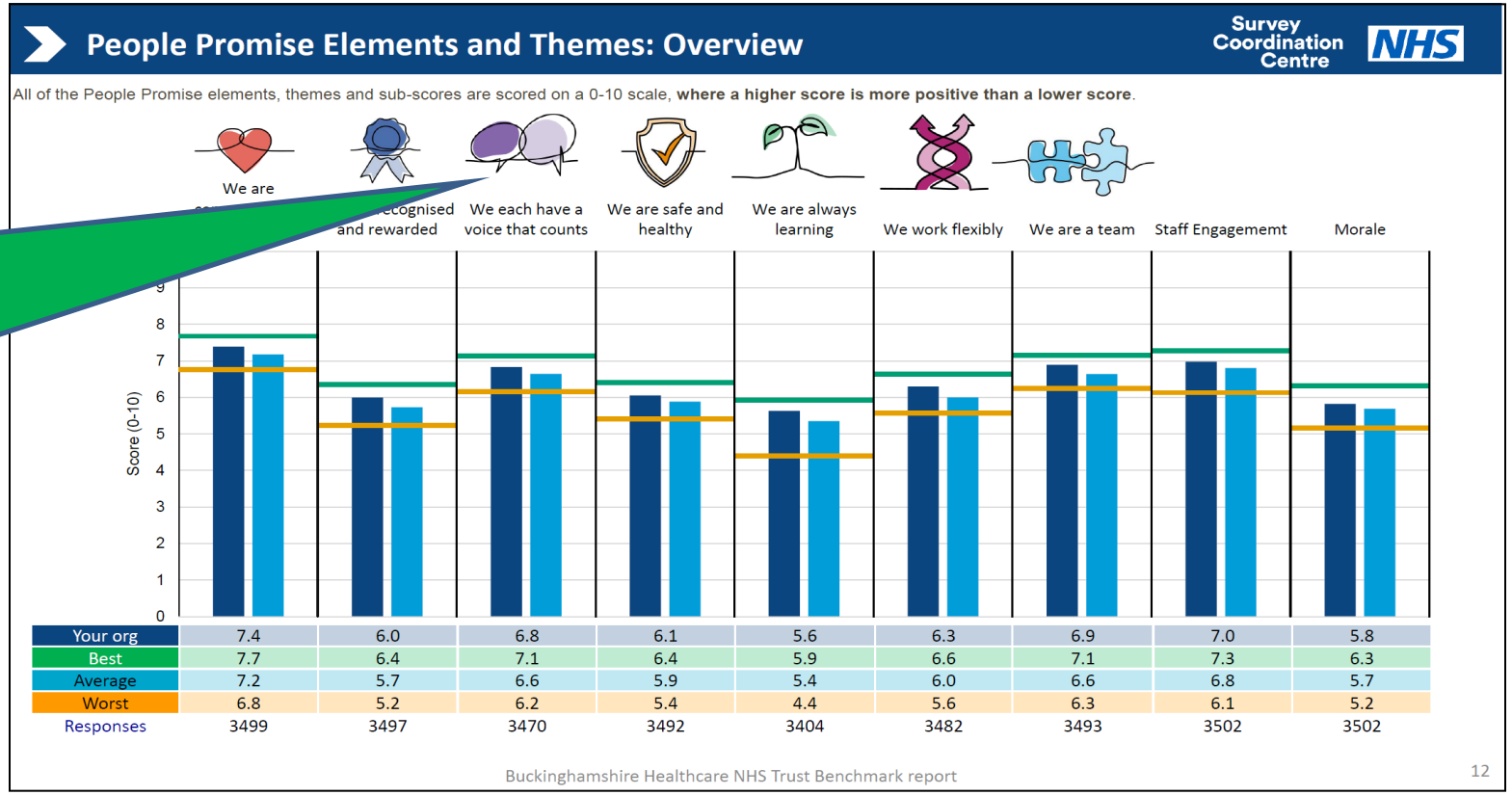
People Promise

"We each have a Voice that Counts"

BHT achieved 6.8

This is only 0.3 below the best in class!

BHT was named as one of the 5 most improved Trusts overall.



OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

Most Recent National Staff Survey Results 2022 – Benchmarked Report

People Promise – We each have a voice that counts

Buckinghamshire Healthcare NHS Trust

People Promise - Divisions

- Our Corporate and Integrated Elderly Care divisions achieved the two highest scores against the People Promise “We have a voice that counts”, with a very positive 7 and 7.2 respectively.
- Divisions with the two lower scores for this promise are Specialist Services and Integrated Medicine which both scored 6.6.

People Promise - Staff Groups

- The two staff groups scoring highest against this same People promise “We each have a Voice that counts” were Students with a very positive 7.8 and our Allied Health Professionals who collectively gave a score of 7.1
- Estates and Ancillary staff groups scored 6.6 the same as Medical and Dental which was just slightly higher than Healthcare scientists who scored 6.3.
- These results serve to triangulate and help to confirm what we know locally. In areas where scores are low there is already a wide range of work already underway to help make improvements to the specifics that are likely to be feeding into these
- scores. However, it will take time to see these improvements reflected in future NSS surveys which are retrospective and reported in the Spring of the following year.

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

Section 1: The national picture 2022/2023

The National Guardian Office (NGO) has been progressing with the “Freedom to Speak Up” agenda for those working in healthcare across the country and this section contains a few key messages.

National Guardian Office (NGO) Some key messages 22/23

Buckinghamshire Healthcare NHS Trust

Jayne Chidgey-Clarke, our National Guardian now in her second year, with over 30 years of experience in the NHS started life as a nurse. She has also worked in higher education, with NHSE, voluntary and private sectors and just prior to taking up her post with the NGO was a NED for a Clinical Commissioning Group in the South West.

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

*"It is a privilege to lead the vibrant network of Freedom to Speak Up Guardians who do so much to support workers. Over **20,000** cases were brought to them in 2021 – 2022 (ref March 2022) and Freedom to Speak Up Guardians have handled over **75,000** cases since the National Guardian's office first started in 2017"*

Dr Jayne Chidgey-Clarke

National Staff Survey Results 2022

On reading the results for the speaking up questions in the staff survey, Dr Jayne Chidgey-Clark said:

"It is disappointing that the staff survey results reflect a decrease in workers' confidence to speak up, and especially concerning that this includes about clinical matters.

"However, fostering a culture where speaking up is supported, and actions taken as a result is the responsibility of each and every one of us. Whether you are a government minister, a regulator, a board member or senior leader; whether you work in a department, in a team, on a ward, or in a GP practice.

"No one should feel they cannot speak up to protect their patients or their colleagues. These survey results must be a wake up call to leaders at all levels that Freedom to Speak Up is not just a 'nice to have' – it is essential for safe services."

New appointment to the NGO Accountability and Liaison Board

Suzanne McCarthy, a lawyer by background has recently been announced as the new Independent Chair of the Accountability and Liaison Board with the role of providing leadership of the Board, and to bring together the views of each of the individual members who are representatives of the funding bodies for the NGO. As the work of the National Guardian has developed, the Board wished to appoint an Independent Chair in line with good corporate governance. Sir Andrew Morris OBE Hon FRCP, Deputy Chair of NHS England is the outgoing Chair and has welcomed Suzanne's appointment.

Section 2:
Key areas of progress for FTSU at BHT 2022/2023

This section provides a snapshot of some of the FTSU work undertaken this year in support of continuing to build and progress a positive speaking up culture at BHT.
The background context includes the impact of the COVID pandemic on both clinical services as well as our people, periods of extreme demand pressures and more recently the impact of strike action by those across a number of different healthcare professional groups.

In our Annual Report 21/22 we said that in 22/23 we would…….

Buckinghamshire Healthcare NHS Trust

Based on the success of FTSU expansion plan one (one year fixed term trial to develop and establish a FTSUG team based on a bespoke Outreach model), this was approved for moving to a permanent model. This model provides Trustwide outreach, engagement and is is proactive rather than reactive model.. It improves accessibility, diversity and sustainability and removes the risk of a single point of failure.

We would invite and host a visit from the new National Guardian Jayne Chidgey-Clarke to include a presentation to our leaders across the Trust

Stage two of our expansion plan .

Build and develop a network of Trustwide Freedom to Speak Up Champions who have a clear role, be supported and who will receive FTSU training locally. Working towards 50 in 22/23. (Voluntary role)

The Trust has remained committed to supporting individuals to complete the national modules of online Speak Up , Listen Up and Follow Up Training

October Speaking Up month was outr first with our freedom to Speak Up Champions. They provided great input and were invaluable to supporting the team in promoting the month, campaign key messages and activities.

Continuing to engage and being proactive. Despite the FTSU team not being at capacity in year 22/23 the team have achieved virtually the same extensive trustwide outreach and engagement with colleagues as last year when it was.

All Fully Met

Freedom to Speak Up is an agenda that supports and feeds directly into the delivery of our…

Trust People Priority

&

People Promise

"We have a voice that counts"

FTSU Team

The model was adjusted reducing posts and increasing PT hours slightly. A full recruitment process has been undtertaken following funding approval which was delayed.

Jayne Chidgey-Clarke

visited BHT on the 28th July, Meetings were held with the CEO, Chair, Chief Nurse and Chief People Officer. Jayne also presented at our leadership briefing to just under 100 leaders across the Trust.

FTSU Champions

We now have over 50 champions. The network has developed well and is over represented in all groups including disability, with the exception of males, who represent 20% of our workforce.

The Champions are a varied group of colleagues across a range of bands and areas

National FTSU Training

5,500 colleagues have undertaken at least one of these modules which is a very positive achievement

(Workforce circa 6,500)

October Speaking Up Month

From webinars to green food options in the restaurants on Wednesdays, a wear something green day, speaking about the importance of civility our patient safety and clinical accreditation programme and stands etc it was as action packed as usual.

Outreach

Just under **3,500** outreach contacts across acute community services have been achieved

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Local Activity Concerns Raised 22/23

Buckinghamshire Healthcare NHS Trust

Quarter	2017/2018 Inaugural Year Cases	2018 / 2019 Cases	2019/2020 Cases	2020/2021 Cases (Covid)	2021/2022 Cases (Covid)	2022/2023 Current year Cases	Current Individuals
Q1 Cases	3 (Start-up quarter)	20	26	32	25	17	21
Q2 Cases	10	16	19	23	27	21	22
Q3 Cases	20	22	35	35	28	25	27
Q4 Cases	13	16	17	15	27	21	25
Year Totals	46	74	97	105	107	84	95

FTSU and SAFETY

2017 to 2023 provides six years of BHT FTSU information. Across this period the concerns raised, equates to **513** opportunities to make improvement, reduce risk and keep our patients and staff safe which might otherwise have been lost if people had not spoken up.

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N.B Numbers of cases 2022 / 2023 are reflecting case numbers more aligned to pre the Covid period,

Changing the mindset

Buckinghamshire Healthcare NHS Trust

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Representation by ethnicity of those accessing the FTSU service 2022 - 2023

Buckinghamshire Healthcare NHS Trust

	Those who define their ethnicity as Black, Asian or from a Minority Ethnic group (BAME) and have accessed the FTSU service	Those who define their ethnicity as white British and have accessed the FTSU service	Representation of Diversity increasing in those accessing the service
Previous FTSU Annual Report 2021-2022. (For comparison - as of 31stMarch 2022)	25%	61%	BAME groups of colleagues less represented by 40% year ending 2021 - 20222
2022-2023 shows a significant improvement in representation			
Quarter 1 (April - June 2022)	50%	50%	Equal
Quarter 2 (July - Sept 2022)	53%	47%	BAME Groups greater representation
Quarter 3 (Oct -Dec 2022)	48%	51%	BAME groups of colleagues less represented by 3%
Quarter 4 (Jan – March 2023)	44%	52%	BAME groups of colleagues less represented by 8%

BHT demographic information shows an overall split of 69% White British colleague population with 26% representing Black, Asian, and Minority Ethnic groups.

2022 – 2023 concluded in a much improved position from the end of 2021 -2022 . Many more colleagues of diverse backgrounds are accessing the service than the previous year. The ethnicity of those raising concerns and accessing the FTSU service at BHT continues to show strong and increasing diversity. In our second quarter we saw more colleagues from Black, Asian, and Minority Ethnic groups than White British access the service.

We will continue to monitor this.

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Some examples of a range of outcomes ….

Buckinghamshire Healthcare NHS Trust

A few examples to demonstrate the range of types and outcomes resulting from Concerns raised 2022/2023	
A concern was raised to the Freedom to Speak Up Guardian (FTSG) about the management of referrals in a specific pathway and potential safety issues, the process they were managed through and a single point of failure, the FTSUG raised this with the senior manager who investigated the concern. These issues were addressed resulting in discussions with the responsible team member with regards to their working practices and behaviours, collaborative working to implement a new system which eliminates the single point of failure and provides shared access and ownership. A different and new pathway for those referrals has been implemented. This has also resulted in time efficiencies, improved patient safety, better access to wait information and improved governance. No patient safety associated issues were found as a result of the investigation.	Following a number of concerns arising from a similar area about related matters, team dynamics and team culture a patient safety concern was raised. Having established some factual information to support the concerns, the FTSUG immediately escalated this matter through to Divisional senior management level and the CEO notified. An SI was requested and relevant investigations undertaken. Due to other information triangulating that additional support was identified as being needed for this team, the Trust has committed to providing additional support to the team to assist with addressing internal team dynamics and ways of working. This work is currently underway and has included a widespread engagement exercise and diagnostic tools alongside the expertise required to support our colleagues through the process of positive change. There was also an escalation to the Strategic People Committee (SPC) of the increased numbers of colleagues who were experiencing unusually high levels of violence and aggression from patients, carers and public whilst at work last year. This was reflected nationally. Actions to address included some prior work to review the Trust policy on dealing with this, a leadership briefing and our Executive Committee continue to give this overview. The FTSUG will periodically update the SPC.
A team felt uncomfortable with how a move of office location was being progressed. They felt there was a lack of information about the move and how processes relevant to their work would function once moved, they did not feel involved or informed. Following raising this with the FTSUG and encouragement to ask for a team meeting / communication opportunity with the managers, the issues were addressed and the move went ahead with a positive outcome.	
A lot of the outcomes of this year are about the need for improved behaviours and the need to act in alignment with our CARE values. There have been a variety of conversations with different colleagues of a wide variety of professional groups in different services and areas regarding the need to address behavioural matters that have been brought as concerns to the service. It is difficult to select one example but the following also reminds us that bullying can and does also occur upwards. One of our service users raising a concern about bullying reported back that they felt more confident about standing up to bullying behaviour from junior colleagues knowing they had the support of her senior manager which resulted from a supportive conversation with one of our FTSUGs and the manager.	Managers listening to suggestions from concerns raised within their team and implementing actions to allow better communication. A stronger link has been developed between colleague and their grandparent manager so they feel supported and can go to them in future if needed. Resulting actions have left colleagues feeling listened to and their views important. Behaviours that are not satisfactory are also being addressed, colleagues are feeling empowered after conversations with the FTSUG to take action themselves once given contact details of who to go to and ideas about how to approach the situation.
Training given to colleague regarding the importance of confidentiality and not sharing person staff information	An individual raising the concern was able to speak with senior managers and resolve issues and discuss how improvements to system could be made
General – Numerous individuals have received coaching, development opportunities or wellbeing support, cost of living help and even crisis support as a result of approaching the FTSUG service as an additional result of raising their concern. We are also able to report another year of achieving retention for a few individuals who would otherwise have left the Trust.	Improved communication between 2 professional groups both of whom had been using a site but one had been moved out. Issues had arisen about patient notes, for removal, and appropriate storage and clarity around responsibilities as a result of a move. This was raised and quickly resolved with a joint understanding of how to prevent reoccurrence in the future.

Satisfaction Survey

Buckinghamshire Healthcare NHS Trust

Whilst a small sample, the number of responses this year has more than doubled and we have given this some focus over recent months to try to boost numbers of responses. Despite this, it provides a sense of satisfaction by recent service users.

- Of the 26% of colleagues who responded to our request for feedback on satisfaction with the service they had received:
- 100% said they felt listened to by the Freedom to Speak Up Guardian
- 96% said they found the Freedom to Speak Up Guardian (FTSSUG) helpful and the one respondent that responded differently opted for, “to some degree”. There were no negative responses.
- 96% and one response of “to some degree” said they felt supported by the FTSUG and safe in the way the FTSUG handled their concern, feeling the concern was handled appropriately and there were no negative responses.
- 96% said yes - given their experience, they would speak up again, the feedback of one individual was unsure but went onto say they would definitely recommend the service
- 96% of service users who responded said they would recommend a colleague to the service if appropriate. Only one person said they were unsure which from the narrative of the response suggests their feedback was not based on experience of the process or service but rather their experience of management in that situation.

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A few quotes from users of the BHT Freedom to Speak Up Service

Buckinghamshire Healthcare NHS Trust

I was happy with the service and the support provided

I was very happy with the way my situation was handled as in a small team like mine it is not easy to speak out.

Valuable service by the FTSUG

It is a very good service and I would recommend the service to other colleagues

A couple of comments raised to me is the fear of anonymity. This is especially predominant in the male sector of our Trust. I'm not sure how we can tackle this issue but I am trying to alleviate fears so they may approach with concerns. However, thank you for your support.

I really appreciated the support from the FTSUG Service but I just feel that not enough was done by higher management after the issues were raised with them.

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Network of FTSU Champions

Buckinghamshire Healthcare NHS Trust

		NHS workforce	BHT Workforce	Champions trained or awaiting training As of End March 2023	Bucks Population
Gender	Male	23.0%	19.3%	10.3%	49.0%
	Female	77.0%	80.7%	86.2%	51.0%
	Non binary	unknown	-	0.0%	-
	not declared	-	-	3.4%	-
Sexual orientation	LGBTQ+	2-3%	1.2%	6.9%	no data
	Heterosexual		68.5%	82.8%	no data
	not declared		22.6%	5.2%	no data
Ethnicity	White	77.9%	69.0%	65.5%	86.4%
	BAME	19.7%	26.0%	31.0%	13.6%
	not declared		5.0%	3.4%	-
Disability/ Long term condition	Disability/LTC	3.7%	2.8%	20.7%	13.0%
	none		87.1%	75.9%	-
	not declared		10.0%	1.7%	-

We are committed to building a strong diverse network of Freedom to Speak Up Champions from a broad range of roles, bands and staff groups across the Trust. We launched our recruitment campaign a little over a year ago. This is a voluntary role that we ask colleagues to take on. Our Champions played a really invaluable role in their first October Speaking Up Month as is highlighted later in this report.

Despite the impact of service pressures and the impact of COVID on both our colleagues and increased demands we have seen strong steady growth over the year. As of March 31st 2023 we had 58 applications with only 11 awaiting training with the next session scheduled in May.

Having a representative network is important to us, the table shows that against our own workforce and wider NHS statistics, our network of FTSU champions has representation and over representation of some groups such as those with a disability, at 20.7%, those who declare themselves to be LGBTQ+ and sexual orientation and those who declare themselves to be from a Black, Asian or Minority background. However, males are under represented and this has been an area of focus for us and will continue going forward. In April this rose to 11.5%.

Having defined the role of the FTSU champion at BHT and mindful of national guidance which is important for governance and good practice, role descriptions have been developed, we have created a bespoke training package which all FTSUG champions have to undertake to become a Champion. All training sessions have been evaluated to date and a summary of results are shown in the next slide.

Evaluations of FTSU Champion Training 22/23

Buckinghamshire Healthcare NHS Trust

Question asked of the participant to rate	Strongly Agree	Agree	Neutral	Disagree
The aims of the training were clearly defined	26	4		
The content was well structured and easy to follow	27	2	1	
Participation and interaction were encouraged	24	2	1	
I feel more confident for colleagues to approach me with their concerns	24	6		
I am happy that I have a better understanding of the role of the FTSU champion	27	3		
I feel happy that I understand what this role is and what it is not	28	2		
I have a clear understanding of the importance of Confidentiality and Consent	29	1		
I know how and where to signpost my colleagues	27	2	1	
I would recommend my colleagues to consider becoming champions	27	3		
It was good to meet members of the FTSU team	27	3		
I felt able to speak up and ask questions	27	3		

Overall participants rated their learning experience as follows:

Excellent = 26

Good = 1

Average = 0

Poor = 0

Some quotes from participants

- Thank you. Really enjoyed it and feeling inspired and empowered
- I found it useful as it gave me confidence to contribute to my service to make the NHS a safe environment to work
- I felt that as champions we would be well supported, thank you, I have really enjoyed the training session
- Provoked useful and interesting conversations and discussions
- Thoughtful – fabulous as always,

When someone speaks up, it is important we listen up.

National Guardian

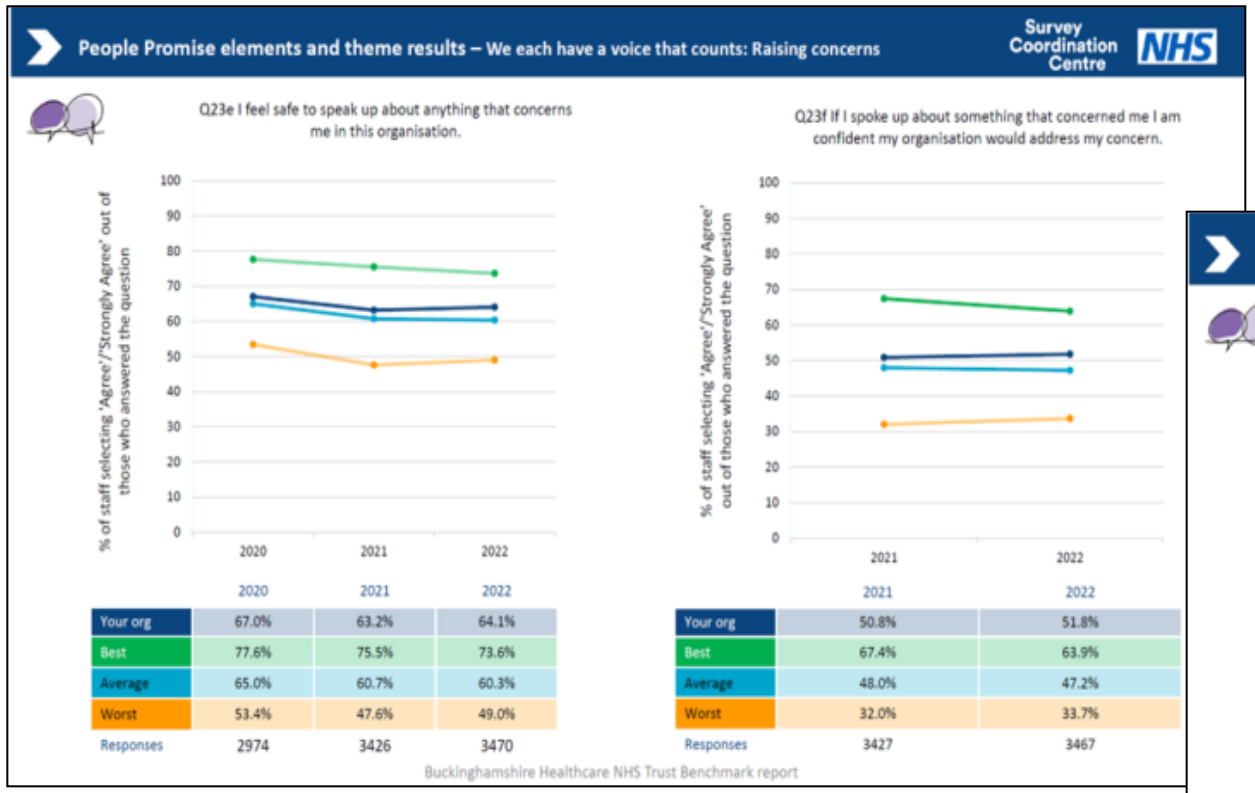
www.nationalguardian.org.uk

SPEAK UP LISTEN UP FOLLOW UP

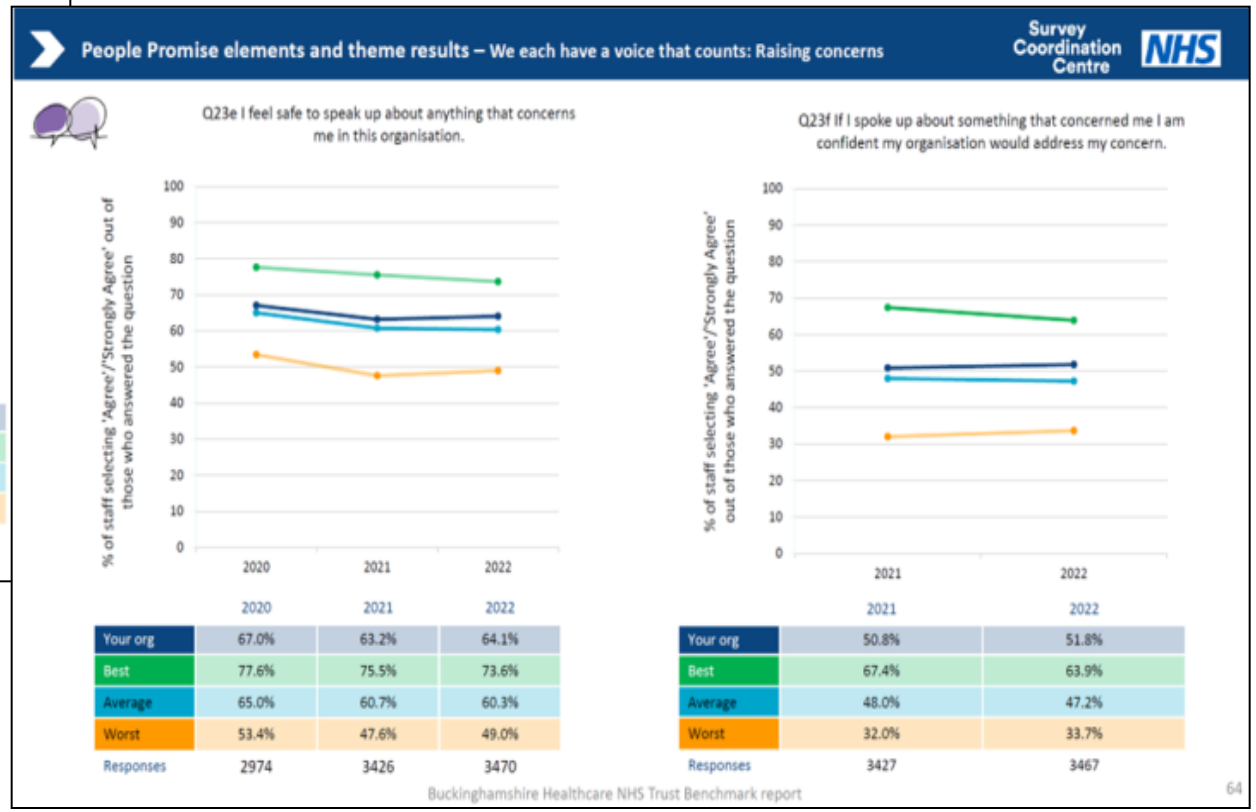
MAKE YOUR #SPEAKUPPLEDGE

National Staff Survey 2022 – Trust results

Buckinghamshire Healthcare NHS Trust



1) BHT scores continue to show improvement when the National picture reflects two years of deterioration across the relevant "Speaking Up" questions. However ……there is more work to do.



2)……..Whilst we are closing the gap between ourselves and the best in class, we cannot ignore those colleagues in their numbers who are responding less positively to these questions and gaining a deeper understanding of this will be a key focus for this year.

OUTSTANDING CARE

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National Staff Survey 2022 – Trust results continued

Buckinghamshire Healthcare NHS Trust

These results show BHT achieved a “significantly better” result for the “Speaking Up” related questions in the latest results of the National Staff Survey when compared with the score across the healthcare Trusts similar to ours. This reflects the previous information showing local improvement against the context of the wider downward trend.

However, this also shows that there is less improvement in BHT scores 2021 / 2022. We do know that for all four of these questions the negative scores improved, meaning fewer people responding negatively to these questions than before, but …… this means more work to do as this still leaves a number of people who are responding less positively.

We each have a voice that counts (continued)

People Promise/Theme/Question	2021 Score	Significance	2022 Score	Significance	Sector Score
People Promise 3, Subscore 2 - Raising concerns	6.56	Not Significant	6.58	Significantly Better	6.37
19a. I would feel secure raising concerns about unsafe clinical practice.	74.8%	Not Significant	73.1%	Significantly Better	71.1%
19b. I am confident that my organisation would address my concern.	59.2%	Not Significant	60.8%	Significantly Better	55.5%
23e. I feel safe to speak up about anything that concerns me in this organisation.	63.1%	Not Significant	64.0%	Significantly Better	60.1%
23f. If I spoke up about something that concerned me I am confident my organisation would address my concern.	50.8%	Not Significant	51.8%	Significantly Better	47.1%

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

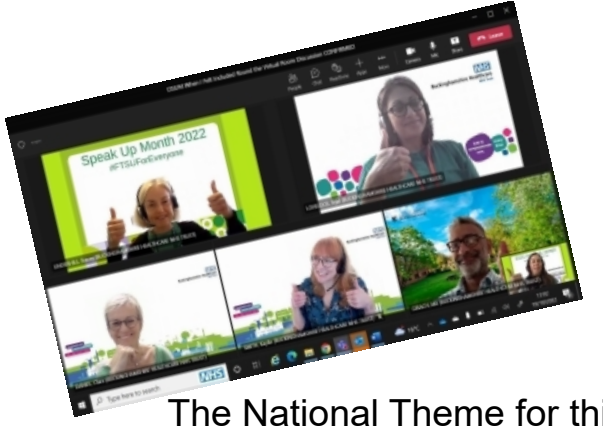
When leadership follow up this promotes a culture where everyone has a voice.

National Guardian

www.nationalguardian.org.uk

SPEAK UP LISTEN UP FOLLOW UP

MAKE YOUR #SPEAKUPPLEDGE



Buckinghamshire Healthcare NHS Trust

October Speaking Up Month 2022

The National Theme for this year was “Speaking Up is for Everyone”.

It was another busy October Speaking Up Month with a varied Programme developed by the team to include weekly “Lunch and Learn Webinars” led by Executives or specialists in their areas covered a range of topics including “Speaking Up For Safety introducing our clinical accreditation programme, Civility and a follow up discussion on can we respond to incivility well? Other key topics included “Speaking Up for a Warm Welcome” and with our designated NED Mo Girach, “Speaking Up for Inclusion” with some personal and powerful stories about how feeling included can make such a positive difference to individuals and finally Building a positive Speaking Up Culture, how are we doing?

New this year we were able to implement a Green Food menu every Wednesday at our main restaurant at SMH thanks to our partner providers, our Wear Green Day (***national colour for Speaking Up)*** achieved more green attire across the hospital than in previous years and we also held multiple stands, boards, asked for pledges and we ran “Tops and Pants”, collecting views in regards to Speaking Up across the Trust in a variety of different areas across acute and community services and we supported Mental Health Day.

However, the Stars of the show have to be our wonderful Speaking Up Champions for whom this was their first October Speaking Up month.

They made such a valuable contribution taking part in a real variety of novel and interesting ways gaining even more social media coverage than usual. A big thank to everyone who is a Speaking Up Champion. From taking Speaking Up to outdoor activities on days off to green team lunches and a quick green lunchtime picnic!

Next steps for the FTSU team 2023 to 2024

Our ongoing aim is to: Achieve a set of results for Freedom to Speak Up in the National Staff Survey, that puts BHT in the "Best In Class" group.

This year:

- We will deliver Training to the Trust Board. *May 2023*
- We will give focus to further understanding the contributing factors for our colleagues where they are feeling less able to speak up at BHT*. Pulse Survey April 2023.*
- We will deliver a programme using mixed formats for staff feedback informed by results from the above and recent national staff survey results. Engagement directly with colleagues and information gathered through complaint reviews and incidents will also inform this programme. *July – December 2023*
- We will continue to build a strong and representative Speaking Up Champion network and celebrate the work they do. *September 2023*
- We will participate in October Speaking Up Month 2023 and support the national campaign.
- We will continue with our ongoing journey to build a consistent positive Speak Up culture across the Trust and support our colleagues to feel safe to speak up at BHT in the interests of patient and staff safety and quality of care. *(Ongoing)*

Meeting: Trust Board Meeting in Public

31 May 2023

Agenda item	Organisational Risk Report
Board Lead	Joanna James, Trust Board Business Manager
Type name of Author	Joanna James, Trust Board Business Manager
Attachments	Corporate Risk Register Report (CRR) CRR Heatmap Board Assurance Framework Report (BAF)
Purpose	Assurance
Previously considered	EMC 11.04.2023 Audit Committee 04.05.2023

Executive Summary

This report provides an overview of current risk within the organisation, considering both strategic and operational risks as well as the Trust's risk appetite for each of the strategic objectives. An update is also provided on work within the Trust to improve overall management of risk.

Current Position

At the time of writing the report, the Trust was carrying a high level of risk related to finance, people, quality and performance and estates and facilities, significantly above the Board's appetite for such risk.

Key Changes

Since the previous report was presented to the Board, the residual risk score related to industrial action has increased. Residual risk scores related to cancer service provision, HVLV, radiology reporting and the interventional radiology service have been reduced.

On 11 April 2023 the Executive Management Committee (EMC) approved the removal of Risk 92 from the CRR (radiology reporting).

On 4 May 2023, the Audit Committee considered this paper and discussed CRR risk 119 in detail. A further deep dive is planned by the Quality and Clinical Governance Committee. The Audit Committee also requested ongoing focus on the continued provision of milestones and timely action updates.

On 17 May 2023, a deep dive on CRR Risk 92 (radiology reporting) was provided to the Quality and Clinical Governance Committee. The Committee were assured by the governance processes in place and noted the plan to de-escalate this risk from the CRR.

Additional information was provided to both EMC and Audit Committee on the length of time that specific risks had been held within a Trust risk register. This information is currently undergoing further validation. Deep dives on the oldest of the CRR risks will be provided to EMC and the relevant Board Committee.

All strategic actions have been reviewed since the last report to Board and there has been a reduction in overdue actions related to risks on the corporate risk register.

The detail of changes related to strategic risk profiles are listed within the summary page of the Board Assurance Framework (appendix 3, page 2) and within the Corporate Risk Register report (appendices 1 and 2).

Organisational Risk Management

Theoretical risk management training is ongoing, facilitated by an external provider, with complementary internal training sessions to support colleagues in the practical use of Datix 14.

Standardised Terms of Reference for Divisional Governance meetings have been written to support Trust wide processes for managing risk registers alongside a wider review and re-design of the Trust governance and performance framework. A new Associate Chief Nurse started in the Trust on 3 April 2023 (fixed term maternity leave cover) and will be supporting the monthly risk review process going forwards.

Decision	The Committee is requested to: a) Note the contents of the report and use this information to support risk-based discussions and decision making. b) Take assurance from the actions to support improvements in the management of risk Trust wide. c) Consider and approve the de-escalation of CRR 92 as per the CRR report appendix.

Relevant Strategic Priority			
Outstanding Care ☒	**Healthy Communities ☒**	**Great Place to Work ☒**	**Net Zero ☒**

Implications / Impact	
Patient Safety	There are a significant number of operational mapped to the Trust ambition to 'meet/exceed quality and performance standards'.
Risk: link to Board Assurance Framework (BAF)/Risk Register	This paper attempts to highlight and map risks from the Corporate Risk Register (CRR) aligned to the Trust's strategic objectives and principal risks.
Financial	Two risks from the CRR are mapped against the objective to 'deliver a financially sustainable plan'.
Compliance CQC Standards Good Governance	An effective, comprehensive process is required to be in place to identify, understand, monitor and address current and future risks to the organisation
Partnership: consultation / communication	No CRR risks have been mapped against the objective to 'work with partners and engage people'.
Equality	Specific attention to issues related to equality are considered in relation to the Trust ambition to 'reduce health inequalities' and 'deliver people priorities'.
Quality Impact Assessment [QIA] completion required?	n/a

1 **Introduction**

The purpose of this report is to provide a summary of current risk within the organisation considering the detail of both those risks within the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF).

The report maps operational risks against the strategic objectives and provides a risk management KPI dashboard. Further iterations of the report will also provide a clear overview of risk movement as additional months of data are added.

2 **Risks mapped to Strategic Objectives**

The table below lists the nine Strategic Objectives of the Trust as documented in the BHT Strategy 2025. For each objective, the risk appetite of the Board is noted, the number of high scoring operational risks within the CRR and the risk rating of the relevant Principal and CRR risks (maximum, minimum and average for the latter). This is intended to provide a more global overview of the risk portfolio in each area.

No.	Strategic Objective	Risk Appetite (max. 5)	Principal Risk RR*	No. of Corporate Risks mapped to Objective	Maximum RRR** (Corporate Risks)	Minimum RRR (Corporate Risks)	Average RRR - Mean (Corporate Risks)
1	Consistently meet or exceed quality and performance standards	2.5	12	5	16	9	14 Decreased
2	Deliver a financially sustainable plan	2.5	12	2	20	12	16 No change
3	Work with partners and engage people	4	9	0	-	-	- No change
4	Ensure children get the best start in life	2.5	12	0	-	-	- Decreased
5 6	Use population health analytics to reduce health inequalities and improve outcomes Improve the wellbeing of communities	4	9	0	-	-	- No change
7	Deliver People priorities	2	12	2	20	15	18 Increased
8	For buildings and facilities to be great places to work	3	16	6	20	5	15 Decreased
9	Maximise opportunities for improving, sharing good practice and learning	4	9	0	-	-	- No change

**RR – Risk Rating; **RRR – Residual Risk Rating*
No change in any Principal Risk Ratings.

The amber and red colouring is intended to highlight those areas of most significant risk.

As per the table:

- Objectives 1 (quality and performance) and 8 (buildings and facilities) carry the highest number of CRR risks with risk ratings of 12 (strategic) and 14 (average corporate) and 16 (strategic) and 15 (average corporate) respectively.
- Objectives 2 (finance) and 7 (people) have 2 corporate risks attached but with a strategic risk rating of 12 and average corporate risk ratings of 16 and 18 respectively.
- Objectives 3 (partners), 4 (children), 5&6 (health communities) and 9 (learning and improving) carry a moderate strategic risk rating with no corporate risks.

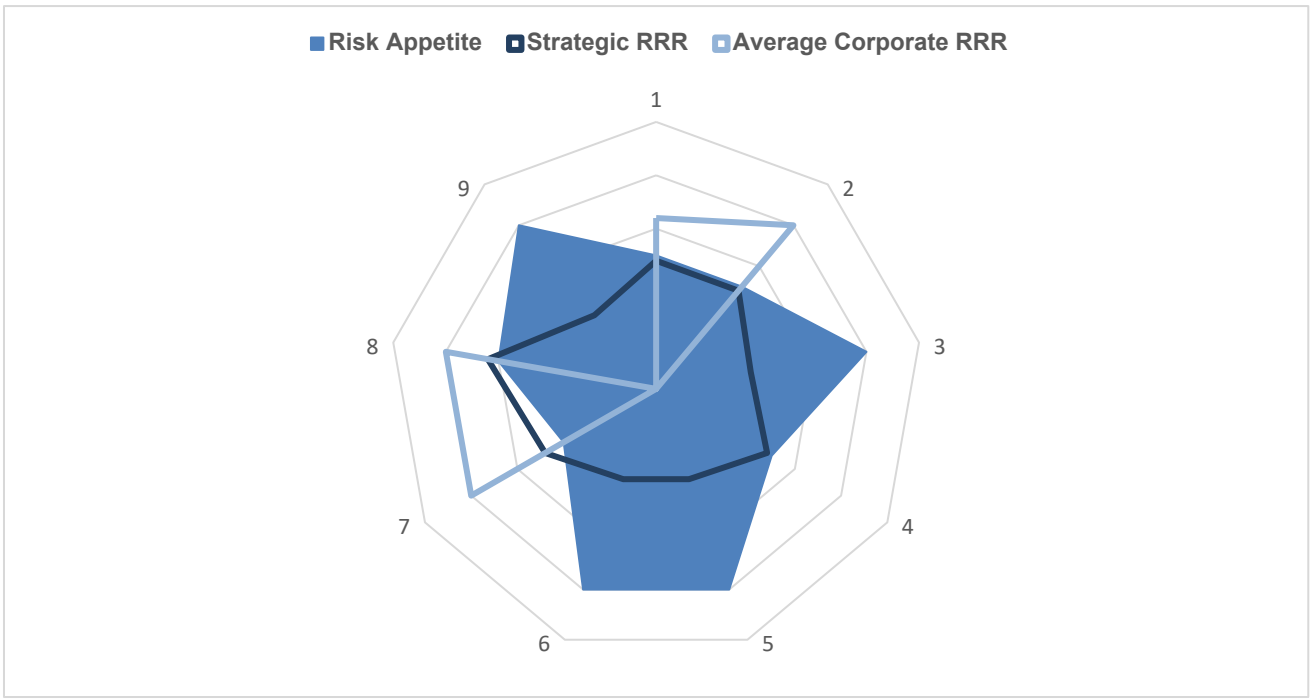
Key changes since the last report to Board include:
- CRR 54 (shortage of chemotherapy nurses) has been moved from Principal Risk 7 to Principal Risk 1 in view of the potential impact on patient safety. in line with risks related to shortage of nursing and midwifery colleagues more broadly.
- Reduction in risk rating for CRR 118 (HVLV), CRR 92 (radiology reporting), CRR 36 (IR service) and CRR 93 (cancer services).
- Increase in risk rating for CRR 189 (industrial action).

2.1 Operational Risks

Risks currently within the CRR have been identified within a Trust risk register (most commonly entered initially at SDU level) for varying periods of time. Information was provided to both EMC and the Audit Committee on length of time these had been within a Trust risk register to support a greater understanding of the profile of organisational risk over time and this information is currently undergoing validation. A programme of deep dives has been scheduled for Committee oversight.

3 Risk Appetite

The diagram below displays the residual ratings for each strategic risk and the average risk ratings of corporate risks against the Trust risk appetite, demonstrating where these are aligned.



The diagram indicates the Trust is carrying higher risk than set out in the risk appetite in relation to quality and performance, finance, people and buildings and facilities. The Trust is open to more risk in relation to working with partners, healthy communities and innovation and learning.

4 Risk and Compliance Monitoring Group (RCMG)

Since the previous report to Board, RCMG met on 17 April 2023 and proposed the following to EMC:

- CRR risks 226 (bleep system) and 118 (HVLV) to de-escalate subject to the receipt of required evidence. Evidence remains awaited to de-escalate these risks.
- De-escalation of risk 92 (radiology reporting) which was approved.

The RCMG met again on 15 May 2023 and propose the following to EMC (to be considered June 2023):

- Escalation to CRR of risk 76 (electrical failure in theatres).
- De-escalation of CRR risk 82 (poor flow in ED).
- Closure of risks 50 (midwifery staffing) and 43 (PDU capacity) in view of the removal of continuity of carer requirements and the opening of the Waddesdon Wing respectively.

5 Organisational Risk Management

A number of activities are underway to support improvements in the management of risk Trust wide.

a) Training

Risk Management Training continues to be delivered by an external provider, focussing on the theory of risk management. As of 24 May 2023, 126 colleagues have attended these session with a further two workshops yet to be held. These workshops are fully booked with ongoing expressions of interest. Divisional are ensuring triumvirate members and clinical governance leads attend one of the sessions. Drop-in sessions have been run alongside these to complement the theoretical training, however these have been put on hold whilst we redesign and relaunch Datix 14 training which will encompass all aspects of the system covering Incidents and Risk. A bespoke risk management workshop for the Board is under development for end June 2023.

b) Divisional Governance

Draft Terms of Reference have been written and due to be trialled to standardise and strengthen discussions in these meeting. Along with other governance items, the governance meeting agendas will incorporate the moderation of divisional risk registers. The Trust wide performance and governance framework is under review with risk reporting aligned with the new model.

c) Other

To note, there has been a change of oversight in the monthly risk review activity. To cover maternity leave, a fixed term appointment has been made for a new Associate Chief Nurse who started on 3 April 2023. The new ACN will continue to be supported by the Interim Governance Lead.

6 Risk Management KPI Dashboard

The table overleaf provides high level information on how risk is being managed each month. For more detail on each specific risk, the CRR and BAF papers are included as an appendix.

Month	% Strategic Risks reviewed*	% Operational Risks reviewed*	% Actions Overdue	Balance of assurance Internal v External	Number of new risks	Number of closed risks	% risks with increased scores Strategic	% risks with reduced scores Strategic	% risks with static scores Strategic	% risks with increased scores Operational	% risks with reduced scores Operational	% risks with static scores Operational
Feb 2023	100%	100%	12%	Med	0	0	0%	0%	100%	0%	22%	78%
Mar 2023	62.5%	82%	45%	Med	0	0	0%	0%	100%	6%	22%	72%
Apr 2023	67%	100%	35%	Med	0	0	0%	0%	100%	0%	0%	100%

**Since last report to Committee*

At the end of the month of April:

- Not all strategic risks had been reviewed in month; 6/9 had. All operational risks were reviewed either through individual meetings with risk owners/executive leads or via RCMG.
- 35% of actions were overdue related to operational risks. This applied to 9/23 operational actions. All strategic actions were reviewed and updated.
- The balance of assurances across both registers continues to be considered as medium.
- No new risks were escalated for inclusion in the CRR, one was de-escalated (delay in radiology reporting). A number of other risks are proposed for escalation/de-escalation/closure and will be considered in June.

5 Action required from the Board/Committee

The Committee is requested to:

a) Note the contents of the report and use this information to support risk-based discussions and decision making.
b) Take assurance from the actions to support improvements in the management of risk Trust wide.

APPENDICES

Appendix 1: Board Assurance Framework (BAF) Report
Appendix 2: Corporate Risk Register (CRR) Report

Appendix 1

Corporate Risk Register Report

1. Purpose

This report provides an update on risks on the Corporate Risk Register (CRR).

2. Background

The CRR is reviewed monthly with the risk owner or relevant representative to consider the score, mitigations, gaps in control, actions update and progress update. Additionally, monthly reviews are completed with executive directors for risks within their portfolios.

The process for the CRR is that all new and current risks scored at 15 or above on the Divisional and Corporate Service risk registers are reviewed and reported on at the Risk and Compliance Monitoring Group (RCMG) every month. The RCMG review guides the Executive Management Committee (EMC) in moderating risks for escalation or de-escalation onto and from the CRR.

3. Updates

There are currently 15 risks on the CRR as transferred onto the Datix system. Quality assurance work (including updates) is carried out monthly through RCMG as per the policy. The table overleaf details updates to individual risks.

4. New Risks for approval from EMC to add to the CRR

EMC will be asked to consider the escalation of risk 76 (electrical failures in theatres) at the next meeting in June 2023.

5. Risks requiring EMC approval to remove from the CRR

CRR 92 was recommended to be de-escalated from the CRR due to the significant improvement on the backlog**.** This was approved by EMC on 11 April 2023.

In June 2023, EMC will be asked to consider the de-escalation of risk 82 (poor flow in ED) due to the progress with actions to address this risk. Two risks have been closed due to continuity of carer requirements being removed from the Trust (risk 50; midwifery staffing) and the opening of the Waddesdon Wing which includes a new Paediatric Emergency Department (risk 43, PDU capacity).

6. Risk actions

Risk actions are monitored monthly during RCMG meetings. Risks where actions are not articulated continue to be reviewed as a part of the risk quality assurance work.

7. Action required from the Committee

The Committee are required to note and take assurance from the updates to the CRR.

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
36	There is currently no Interventional Radiology (IR) Service at BHT	The Interventional Radiology equipment has been condemned due to equipment failure impacting the IR service delivery across BHT. Consequently, patients requiring IR procedures have to be seen in other Trusts.	16/05/2022 Discussed at RCMG to increase risk back to 15 as still no solution for WH site - HoN has been provided with feedback from Urology Consultants and Radiologists.	20	15	↔↓
82	This is a risk of poor flow through ED leading to crowding in the department and patient's being treated in ED overflow areas.	Daily, ED has seen an increase in attendance and a lack of flow out of the department. On occasion, there are up to 100 patients in the department. This results in long waits to be seen, ambulance delays in off-loads, delays in assessments and treatment of critically ill patients (which may result in patient harm) and poor patient experience.	10/05/2023 - Discussed with COO and risk is not yet resolved to a level it can be de-escalated but moving in the right direction	25	12	↔↓
~~92~~	~~There is a risk of delays in diagnostic and treatment planning due to delays in the reporting of scans~~	~~There is a significant backlog of unreported scans (CT and MRI scan dating back to 10th March 2022).~~ ~~Contributing factors:~~ ~~The national shortage of radiologists, changes to HMRC rules on pension contributions and consultants not taking additional work outside their job plans due to incurring higher tax charges~~	Approved for de-escalation by EMC 11 April 2023	~~20~~	~~12~~	~~↔↓~~
93	There is a risk that the Trust will become non-compliant with cancer performance standards.	"For 12 consecutive months, the trust has been non-compliant with the 62-day standard due to various contributing factors such as the number of referrals above baseline, the backlog created by Covid, delay in diagnostics, Theatre capacity, and not having enough trackers in the team.	10/05/2023 Planning for full review by Cancer Board to assess level of risk	20	16	↔↓
184	The ageing WH tower Block is showing signs of interior deterioration, which is challenging to maintain.	"The ageing WH tower Block is showing signs of interior deterioration which is challenging to maintain in a condition suitable for modern healthcare provision.	Risk reviewed by PS senior management team 27/02/2023. Decant planning underway.	25	20	↔↔
190	The Ward 2a environment remains non-compliant with CQC Regulation 15 - premises and equipment	The premises (building fabric) and equipment (CD cupboard; medication mixing facilities) are non-compliant with CQC regulation 15 which stipulates that premises where care and treatment are delivered are clean, maintained and suitable for the intended purpose. This risk has been highlighted by the CQC (as an environment not fit for purpose) and documented in their reports following last two inspections.	04/01/2023 Decant plan review to begin in Q4 2023.	20	20	↔↔
224	There is a risk that Trust Capital Resourcing is insufficient to support operational objectives for 2023-24.	For 2022/23, the Trust has a total capital requirement of £128.8m split between property services £104.4m, IT £18.2m and Medical Equipment £6.4m. BOB ICS has allocated a notional £20m capital envelope for BHT, which is only a sixth of the total requirement, leaving a funding shortfall of £108.8m. As in previous years, further funding streams may become available later in the year, but it would not be prudent to factor this in at this stage.	31/03/2023 – Risk rewritten to reflect 2023-24 capital pressures	25	20	↔↔
225	There is a risk of disruption to Trust technology systems and services caused by cyberattacks.	There is a risk that the aged applications running on out of date Microsoft servers, network and telephony systems upon which the Trust relies are vulnerable to cyber-attack as they are no longer receive vendor security updates.	13/4/2023 – Cyber standards and accountabilities in place, hardware, and software patching now routine for operating systems (where supported) but gaps remain in application patching due to the age of applications in use. 95% of Trust servers are now hosted in the Private Cloud at Rackspace. NHSE Cyber recovery plan agreed with NHS CISO and annual checks	20	20	↔↔

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
			underway, expect to achieve at least 85% compliance in June '23.			
54	There is a risk to chemotherapy service provision due to the lack of chemotherapy-trained nurses.	There is a significant vacancy in chemotherapy-trained nurses within CCHU and Sunrise, resulting in a risk to patient safety due to capacity issues, delay in chemotherapy administration and chemotherapy booking delays. The service is currently running at a 25-50% deficit in capacity.	15/05/2023 - On advice of Chief People Officer risk category has been changed to patient centred and Lead Exec Director changed to Chief Nurse to ensure appropriate patient safety focus.	25	9	↓
119	There is a risk that patients are not being followed up appropriately due to being on the 'on hold' list	A review of data (captured in June 2022) demonstrates 116,575 "on-hold" records dating back to 2013 affecting a total of 108,458 patients, many of which have multiple simultaneous "on-hold" episodes. These include: >6,600 records with no recorded clinical outcome >11,000 records awaiting a clinical action or decision following an investigation >39,000 records awaiting a clinic appointment (including >13,000 cases who have been waiting >12 months). In total, of these 116,575 records, >75,000 records should be considered as inappropriate and require further action.	10/05/2023 – Reviewed by COO and CG Leads and ACN for Governance - risk owner should be changed to delivery Director	20	16	↔↔
~~43~~	~~Insufficient PDU Capacity.~~	~~Insufficient capacity within the PDU footprint for ongoing treatment of children and young people leading to periods of overcrowding; assessment and treatment of children in non-clinical environments; increasing clinical risk and adversely affecting patient experience.~~	Closed (Waddesdon Wing now open)	~~20~~	~~16~~	~~↔↔~~
56	Deterioration of the concrete panel metal clips on the WH tower block leading to risk of concrete panels falling.	The concrete panels installed on the exterior of the WH tower block are at risk of falling away from the main building due to deterioration of the cast iron clips installed when the tower was constructed. Metal clips may fail resulting in concrete panels falling to the ground. Patients, visitors, contractors and staff may be struck by falling concrete panels while walking around the base of the tower block.	04/01/2023 Decant plan review to begin on Q4 2023.	25	20	↔↔
51	Workforce - nursing	A 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.	20/03/2023 International recruitment to realise additional staff in March 23.	15	15	↔↔
118	The SMH main HV/LV electrical supply is insufficient for the current needs of the Estate and is not resilient.	Expansion of services and additional buildings/equipment at the SMH site is placing a demand for power greater than the supply cable is capable of delivering. Additionally, due to corrosion on the existing equipment, the installation of new transformers, 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.	Awaiting evidence to de-escalate (delay in receiving Test Certificate; sign off from Electricity Board awaited)	25	5 (Pending review of evidence)	↓↓
234	There is a risk to the delivery of the Financial Plan due to insufficient financial envelop.	Trust is unable to define / live within its financial envelope impacting on its ability to resource / deliver clinical, operational and strategic priorities.	21/04/2023 – Trust delivered 2022-23 financial plan. Risk re-articulated to reflect 2023-24 plan.	20	12	↔↔

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
226	There is a risk of loss of 2222 emergency bleeps, key bleep groups and non-emergency bleeps at WH and Amersham hospitals.	There is a risk that the emergency bleep system at Wycombe and Amersham will fail due to its significant age before we cut over to the newly installed systems.	Awaiting evidence to close.	12	12	↔↔
189	Risk of industrial action in relation to national pay award	Risk of industrial action in relation to national pay awards affecting multiple professional groups	10/05/2023 – Reviewed and actions updated.	12	20	↑
~~50~~	~~Workforce - midwifery~~	~~Target set to reduce midwifery 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 lead to increased turnover in these areas.~~	Closed (continuity of carer no longer applicable)	~~15~~	~~12~~	~~↔↔~~

Risk Heat Map – Corporate Risk Register – May 2023

Buckinghamshire Healthcare NHS Trust

Key: ↑ = risk score has increased; ↓ = risk score has decreased; ⇔ = no change.
The CRR changes on a monthly basis and the arrows indicate the change since the previous version (up to 3 changes)

Likelihood \ Consequence	1	2	3	4	5
5				190- Ward 2a environment non-compliant with CQC Regulation 15- premises and equipment⇔⇔⇔ 189 - Risk of industrial action in relation to national pay award. ↑	
4			82- This is a Risk of Poor Flow out of ED leading to Crowding in the department and patient's being treated in ED overflow areas ⇔↓	119- There is a risk that patients are not being followed up appropriately due to being on the 'on hold' list ⇔⇔⇔ ~~43- Insufficient PDU Capacity.⇔⇔⇔~~ 93- There is a risk that the trust will be non-compliant with cancer performance standards⇔⇔↓	224- There is a risk that Trust Capital Resourcing is insufficient to support operational objectives for 2022/23.⇔⇔⇔ 225- There is a risk of disruption to Trust technology systems and services caused by cyber incidents. ⇔⇔⇔ 184- The ageing WH tower Block is showing signs of interior deterioration which is challenging to maintain. ⇔⇔⇔ 56- Deterioration of the concrete panel metal clips on the WH tower block leading to risk of concrete panels falling. ⇔⇔⇔
3			118- The SMH main HV/LV electrical supply is insufficient for the current needs of the Estate and is not resilient. ⇔↓↓ (To be put forward for removal once evidence of mitigation reviewed.) 54 - There is a risk to chemotherapy service provision due to the lack of chemotherapy-trained nurses ⇔↓↓ 36- There is currently no IR Service at BHT ↑⇔↓	226- There is a risk of loss of 2222 emergency bleeps, key bleep groups and non-emergency bleeps at Wycombe and Amersham hospitals.⇔⇔ ⇔ ~~50- Workforce – midwifery ⇔⇔⇔~~ 234- There is a risk to the delivery of the 2022-23 Financial Plan due to insufficient financial envelop. ⇔↓⇔	51- Workforce – nursing ⇔⇔⇔
2					
1					

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Board Assurance Framework

Contents

1.0 Introduction & Summary of Changes

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 risk that this creates to support strategic decision making.

Since the previous report to the Trust Board on 29 March 2023, a review of the Board Assurance Framework has been undertaken by the Chief Finance Officer, the Chief People Officer and the Chief Medical Officer; updates are reflected in the report under the relevant risks.

- Principal Risk 1a; Review of all areas by COO including review of deep dive areas for Finance & Business Performance Committee.
- Principal Risk 1c: **Action update:** Clinical accreditation expansion.
- Principal Risk 2; **Action update:** Examples provided of mechanisms to explore related to capital deficit.
- Principal Risk 3; **Action update:** update of all actions.
- Principal Risk 5; **Action update:** Breakthrough objectives for 2023-24 agreed (action closed).
- Principal Risk 6; Additional **assurance gap** highlighted related to industrial action.

The strategic priorities for 2023-24 ('what we want to achieve by 2025') have been included within this document as per the overview below.

Vision	Outstanding Care	Healthy Communities	Great Place to Work
What we want to ACHIEVE by 2025	We will **see people as early as possible** when they need our services, to improve outcomes. We will continuously improve our services and use of resources to **deliver value for our residents.**	We will **prevent people dying earlier than they should**, with a particular focus on addressing inequalities in access and outcomes.	Our people will feel **motivated, able to make a difference and be proud** to work at BHT. We will attract and retain talented people to build **high performing teams with caring and skilled people.**
How we'll MEASURE progress	Eliminate corridor care. Improve productivity to be in the top quartile nationally.	Play our part in ensuring that more children in the most deprived communities are ready for school Increase proportion of people over the age of 65 years who spend more years in good health. Improve outcomes in cardiovascular disease.	Improve staff engagement score to be in the top quartile in the National NHS Staff Survey. Improve overall Trust vacancy rate to be no more than 8%.
Our FOCUS for next year 2023/24	**Improve waiting times**, with less than 4% of patients waiting more than 12 hours in the Emergency Department (ED). **Improve safety**, with 80% of acute and community services having a clinical accreditation assessment by 1 April 2024, and 40% of those assessed achieving silver accreditation. **Improve productivity** in every service, with overall Trust improvement of at least 5%.	**Improve access** and effectiveness of our services **for communities experiencing the poorest outcomes**, with priorities to: • **Reduce smoking in pregnancy**, with less than 5% of women smoking at the time of delivery. • Increase % of people being referred to **cardiology services** from the most deprived areas. • Improve the **early identification of frailty**, with more than 30% of patients in ED having a documented frailty score.	**Improve the experience of our new starters**, with the number of people who leave in the first year less than 12% (improvement also measured through quarterly pulse surveys). **Develop operational and clinical management and leadership skills in key roles**, so 300 managers are equipped with enhanced technical, management and leadership skills (impact measured by quarterly pulse surveys and national staff survey).

Each strategic objective is detailed on the following pages.

1. To consistently meet or exceed quality and performance standards.
2. To deliver a financially sustainable plan and improve our benchmarking in model hospital.
3. To work with our partners and engage people.
4. To ensure children get the best start in life.
5. To use population health analytics to reduce health in equalities and improve outcomes in major diseases.
6. To improve the wellbeing of communities.
7. To deliver our 5 people priorities.
8. For our buildings and facilities to be great places to work and contribute to the health and wellbeing of our staff.
9. To maximise opportunities for improving, sharing good practice and learning.

2.1 Strategic Objective 1 Principal Risk; Failure to provide care that consistently meets or exceeds performance and quality standards

Strategic Objective 1	**To consistently meet or exceed quality and performance standards**				
Achieve by 2025…	**We will see people as early as possible when they need our services, to improve outcomes**				
Strategic Priority	Provide outstanding, high value care ("Outstanding Care")				
Principal Risk	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. d) Maternity & Neonatal care.				
Executive Lead	Chief Operating Officer (1a, 1b) Chief Nurse (1c, 1d)		**Oversight Committee**	Finance & Business Performance Committee* Quality & Clinical Governance Committee*	
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**		
Impact 4 Likelihood 5 **Total Score 20**	Impact 3 Likelihood 4 **Total Score 12**	**Minimal-Cautious (2-3)**	CRR 119	Follow up 'on hold' waiting lists	
			CRR 82	Overcrowding of ED and poor flow	
			CRR 93	Non-compliance with cancer performance standards	
Last Review	Chief Nurse 23 February 2023 Chief Operating Officer 10 May 2023 Director of Midwifery 16 February 2023 Associate Chief Nurse 20 February 2023		CRR 36	Interventional radiology service	
			~~CRR 92~~	~~Backlog of radiology reporting~~	
			CRR 54	Shortage of chemotherapy trained nurses	
Movement in Risk	None				

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
1a. Reducing long waits				
Limitations in capacity and growing capacity due to estate 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 - Unable to replace/restore faulty estate and equipment - 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. - Poor patient experience.	- - Optimisation of available capital investment; prioritisation of business cases for maintenance. - PFI investment. - Planned care transformation programme including focus on elective productivity Structured harm review process across elective care and cancer - GIRFT reviews. - Productivity metrics. - Flag function on Datix. - - Prioritisation of waiting lists by clinical risk and long wait status. - - ICS wide working on cancer and elective performance - External audits/reviews. - Suite of dashboards to monitor performance.	- Outputs from relevant meetings (level 1) - Monthly reporting on performance metrics through IPR (1). - Records of deep dives/escalation calls (1). - - 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).	**Action**: Endoscopy Improvement Programme – oversight through the IPR **Action:** Additional F&BPC deep dives to be agreed as part of the 2023/24 work programme (May 2023)

			- Mortality report/learning from deaths (1). - Litigation report (1). - National inpatient survey results (3). - Safeguarding reports (1). - External reviews (3).	
1b. Providing safe emergency care				
Inability to control demand for services or primary/social care capacity Inability to reform the urgent care pathway Inadequate infection, prevention and control due to estates infrastructure	- Overcrowding and extended length of stay within ED. - Ambulance handover delays - Staff resilience. - Clinical, operational, financial and regulatory consequences - Challenging/costly to clean clinical areas effectively. - Potential for hospital acquired infections. - Harm caused by delayed treatment - Political mistrust/lack of confidence in management. - Poor patient experience.	- Incident response structure; Gold/Silver/Bronze. - Site management processes including regular ED huddles - Place-based delivery board. - Place-based escalation protocol, admission avoidance and discharge action plans. - Long stay deep dives - Discharge escalation calls with partners. - Place UEC Board. - Paeds ED development - 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 work. - PFI investment. - Divisional performance reviews. - External audits and reviews. - Dashboards for performance monitoring.	- Outputs from relevant meetings (level 1) - Outputs from ED huddles (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). - CQC insights report (3). - Dr Foster report (3). - IQVIA report (3). - Mortality report/learning from deaths (1). - Litigation report (1). - National inpatient survey results (3). - Safeguarding reports (1). - External reviews (3). - Safe (safest) staffing; daily huddles and regular reporting to Board/Board Committee (1)	**Action:** UEC Improvement Plan (COO) – oversight by F&BPC through deep dive programme **Action**: Winter Plan (COO) – oversight by F&BPC through deep dive programme **Action:** MOfD Improvement Plan (COO) – oversight by F&BPC through deep dive programme *NB – F&BPC Deep Dive Programme to be considered by the Committee March/April 2023*
1c. Management of risk and clinical governance				
Variation in clinical service lines Organisational governance not always being easy to navigate and enabling of change	- Inadequate ward-board assurance.	- Clinical accreditation programme. - Quality audits via Tendable.	- Data reported through Tendable app; reported to Q&PSG/Q&CGC (level 2).	**Action:** Questions sets for maternity (assessment, birthing and community area), paediatric ward, outpatients complete. ITU and assessment areas (A&E, AMU, SAU and UTC) question set tailoring have commenced (Associate Chief Nurse) – July 2023

1d. Maternity and Neonatal Care				
Maternity and neonatal staffing levels Data quality Digital immaturity Antenatal pathway capacity Size of bed base within neonatal unit and transitional care Health inequalities	- Staff resilience. - Potential for clinical harm - Clinical, operational, financial and regulatory consequences. - Political mistrust/lack of confidence in management. - Ability to plan sustainable services and manage demand and capacity. - Patient experience. - Paper based systems including additional administrative burden.	- Daily safety huddles (departmental and LMNS level). - Regular workforce reviews. - Dashboards for performance monitoring including KPIs. - Perinatal quality surveillance model (PQSM) in place. - External governance reporting. - Regional and national SitReps for capacity reporting. - Maternity safety champions meetings/walkarounds. - Maternity governance meetings. - Training programme of learning in place including following incidents.. - Clinical audit. - Centralised governance function. - Resilient team to support national compliance and assurance. - Divisional performance reviews. - Clear policies and procedures in place. - Midwifery and paediatric manager on call (in addition to site rota). - Quality Improvement (QI) plans. - Support offer for workforce from NHSE. - LMNS co-production strategy. - LMNS equity strategy. - Business continuity plans, escalation framework and LMNS guidance (management of bed base). - Workarounds for lack of EPR. - Birthrate plus acuity app.	- Maternity safety reports (1). - Outputs of relevant meetings (1). - Feedback from HSIB (3). - External quality assurance visits (3). - Annual Picker survey (3). - Maternity services dataset scorecard (3). - Outputs from QI projects (1). - Claims/litigation scorecard (1). - Annual MBRRACE reports (3). - Maternity CNST (1). - Ockenden compliance reports (1). - 'Saving babies lives' quarterly survey (3). - Quarterly patient feedback survey via Maternity Voices Partnership (MVP) (3). - PQSM quarterly report incl. detail of Serious Incidents for Board oversight (3). - Maternity staffing reports (1). ASSURANCE LEVEL **MEDIUM**	**Actions:** Action plans for: - CNST compliance - Ockenden requirements - Saving Babies Lives - MBRRACE - Picker - External reviews - Serious Incidents (Director of Midwifery; DoM) – oversight by Q&CGC **Action:** Modify content of Exec Summary of maternity reporting; highlight reporting of perinatal quality surveillance metrics (DoM) – May 2023 (Q4 report). **Assurance Gap:** EPR with interoperability between maternity and neonates, aligned with national data reporting requirements and with patient access functionality **Action:** Delivery of maternity digital strategy (CDIO) – oversight by F&BPC **Assurance Gap:** Staffing levels **Action:** Recruitment workstreams (see CRR) **Action:** Implement single delivery plan (DoM) – awaited; early 2023)

**See Committee framework for clarity in individual metrics*

2.2 Strategic Objective 2 Principal Risk; Failure to deliver our annual financial plan

Strategic Objective 2	**To deliver a financially sustainable plan and improve our benchmarking in model hospital**			
Achieve by 2025…	**We will continuously improve our services and use of resources to deliver value of our residents**			
Strategic Priority	Provide outstanding, high value care ("Outstanding Care")			
Principal Risk	2. Failure to deliver our annual financial plan.			
Executive Lead	Chief Finance Officer	**Oversight Committee**	Finance & Business Performance Committee	

Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 3 Likelihood 5 **Total Score 15**	Impact 3 Likelihood 4 **Total Score 12**	**Minimal-Cautious (2-3)**	CRR 234	Delivery of the 2023-24 Financial Plan
			CRR 224	Trust capital resourcing insufficient to support objectives
Last Review	Interim Chief Finance Officer 30 May 2023			

Movement in Risk	None

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls? What level is this assurance?*	**Action Required** *Where are our gaps in assurance? What actions are required?*
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). - 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 quarterly SLR data. - Commercial initiatives to increase income and reduce Trust costs.	- 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) - Oversight of Commercial Strategy through F&BPC (1) ASSURANCE LEVEL **MEDIUM**	**Assurance Gap:** Historic issues underpinning organisational deficit to be addressed as part of joint external review with ICB. **Action:** Plan to address the underlying expenditure as part of the Long Term Financial Strategy. (CFO). **Assurance Gap:** Historic issues underpinning organisational capital deficit. **Action:** Need to pursue external capital provision (eg. PFI bullet payments, MES and Asset Sales) – to complete by March 2024. **Assurance Gap:** Finalisation of longer-term financial plan (LTFS) to support medium term financial sustainability **Action:** LTFS (CFO) – monitored through F&BPC action matrix. **Action:** Refresh of financial governance framework (linked to refreshed performance framework) (COO/CFO) – May 2023

2.3 Strategic Objective 3 Principal Risk; Failure to work effectively and collaboratively with external partners

Strategic Objective 3	**Work with our partners and engage people**			
Strategic Priority	Take a leading role in our community ("Healthy Communities")			
Principal Risk	3. Failure to work effectively and collaboratively with external partners			
Executive Lead	Chief Commercial Officer	**Oversight Committee**	Trust Board Finance & Business Performance Committee	
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 4 Likelihood 5 **Total Score 20**	Impact 3 Likelihood 3 **Total Score 9**	**Open (4)**	n/a	n/a
Last Review	Director of Clinical Partnerships 11 October 2022 Chief Commercial Officer 26 January 2023			
Movement in Risk	None			

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
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). ASSURANCE LEVEL **HIGH**	**Assurance Gap:** Collaborative development of S106 policy with Bucks Council. **Action:** ~~Proforma due for consideration at EMC (Deputy Commercial Director) – end February 2023~~ **Assurance Gap:** Awaiting local plans **Action:** ICB strategy and strategic plan (being considered by Board May 2023) **Action:** Implementation of Health on the High Street pilot (Deputy Director of Strategy) – approved by EMC May 2023, pilot due to commence July 2023 (refurbishment work underway)

2.4 Strategic Objective 4 Principal Risk; Failure to provide consistent access to high quality care for Children and Young People

Strategic Objective 4	**Ensure children get the best start in life**			
Strategic Priority	Take a leading role in our community ("Healthy Communities")			
Principal Risk	4. Failure to provide consistent access to high quality care for Children and Young People (CYP)			
Executive Lead	Chief Nurse		**Oversight Committee**	Quality & Clinical Governance Committee

Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 5 Likelihood 5 **Total Score 25**	Impact 4 Likelihood 3 **Total Score 12**	**Minimal-Cautious (2-3)**	~~CRR 43~~	~~Insufficient PDU capacity~~
Last Review	Director of Clinical Partnerships 23 February 2023 Chief Commercial Officer 26 January 2023			
Movement in Risk	None			

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
Inability to reform paediatric urgent care pathway No urgent care pathway in community paeds 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). ASSURANCE LEVEL **MEDIUM**	**Action:** Review of acceptance and triage criteria, clinics, admin and JDs (Director of Clinical Partnerships) – update end April 2023; 12-month plan. **Assurance Gap:** Estates plan for relocation of therapies at SMH **Action:** Centre of Excellence; development of Commercial Strategy, Stakeholder and Engagement Plan considered by Transformation Board & Finance & Business Performance Committee February 2023 – stakeholder engagement and funding opportunities being explored (CCIO) - update August 2023

2.5 Strategic Objectives 5 & 6 Principal Risk; Failure to support improvements in local population health and a reduction in health inequalities

Strategic Objective 5	**Use population health analytics to reduce health inequalities and improve outcomes in major disease**			
Strategic Objective 6	**Improve the wellbeing of communities**			
Achieve by 2025…	**We will prevent people dying earlier than they should, with a particular focus on addressing inequalities in access and outcomes**			
Strategic Priority	Take a leading role in our community ("Healthy Communities")			
Principal Risk	5. Failure to support improvements in local population health and a reduction in health inequalities			
Executive Lead	Chief Digital Information Officer 09 March 2023	**Oversight Committee**	Finance & Business Performance Committee	
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 3 Likelihood 4 **Total Score 12**	Impact 3 Likelihood 3 **Total Score 9**	**Open (4)**	n/a	n/a
Last Review	Chief Digital Information Officer 11 May 2023			
Movement in Risk	None			

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
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. - Health and Wellbeing (HWB) Strategy agreed with dedicated Trust leads for each element. - Appointment of substantive Director of Strategic Programmes.	- 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). ASSURANCE LEVEL **MEDIUM**	**Action:** Board Seminar confirmed (CDIO) – July 2023 **Assurance Gaps:** - Consistency in EQIA completion. - 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 **Action:** Recruitment of substantive Director of Strategic Programme Delivery (starting 6 June) *Completion of above actions plus further analysis required prior to further actions being set.*

2.6 Strategic Objective 7 Principal Risk; Failure to deliver our People priorities

Strategic Objective 7	**Deliver our people priorities**				
Achieve by 2025…	**Our people will feel motivated, able to make a difference and be proud to work at BHT We will attract and retain talented people to build high performing teams with caring and skilled people**				
Strategic Priority	Ensure our workforce are listened to, safe and supported ("A Great Place to Work)				
Principal Risk	6. Failure to deliver on our people priorities related to recruitment & resourcing, culture & leadership, supporting our staff, workforce planning & development and productivity.				
Executive Lead	Chief People Officer		**Oversight Committee**	Strategic People Committee	
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**		
Impact 4 Likelihood 4 **Total Score 16**	Impact 4 Likelihood 3 **Total Score 12**	**Minimal (2)**	CRR 51	Shortage of nursing staff; registered and unregistered	
			~~CRR 50~~	~~Shortage of registered midwives~~	
			CRR 189	Risk of Industrial Action	
Last Review	Chief People Officer 15 May 2023				
Movement in Risk	None				

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls? What level is this assurance?*	**Action Required** *Where are our gaps in assurance? What actions are required?*
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 Significant and sustained operational demand Industrial action	- 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. - Comprehensive cost of living support package. - Comprehensive in house OH & Wellbeing offer with external referral as appropriate - Staff reporting of sickness through GoodShape, monitored by OH. - Trust sickness absence management policy. - Comprehensive vaccination programme. - Regular JMSC & JCNC meetings. - Staff networks (SNs) in place. - Monthly ED&I committee including SN 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. - Involvement of unions in policy development.	- Monthly reporting on vacancy rates, sickness rates and OH referrals 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). - GoodShape reporting (level 2). - FTSUG reporting (level 2). - GSWH reporting (level 2). - Uptake of Thrive reports (SPC) (level 1). - Annual staff survey (level 3). - Quarterly Pulse survey (level 3). - Monthly reporting through Transformation Board (level 1). - Outputs of relevant meetings (level 1). - Risk registers (level 2). - WRES/WDES action plans (level 3). - PSED annual reports (level 3). - EQIAs (level 2). - Papers to SPC and Board (level 1). - Gender Pay Gap reporting (level 2). - ICS People Strategy (level 2). - Safe staffing reports; (level 1). ASSURANCE LEVEL **MEDIUM**	**Assurance Gap:** National shortage of registered nurses **Action:** Recruitment workstreams (see CRR) **Assurance Gap:** Inequal experience for BME colleagues **Action**: As per WRES action plans; monitored through SPC **Assurance Gap:** Difference in experience across Trust - Identified through Staff Survey; feeds into Divisional Risk Registers where appropriate. **Action**: As per risk registers. **Assurance Gap:** No resolution to Junior Doctors dispute and uncertainty in relation to AfC pay negotiations.

2.7 Strategic Objective 8 Principal Risk; Failure to provide adequate buildings and facilities

Strategic Objective 8	**Our buildings and facilities will be great places to work and contribute to the health and wellbeing of staff**			
Strategic Priority	Ensure our workforce are listened to, safe and supported ("A Great Place to Work)			
Principal Risk	7. Failure to provide adequate buildings and facilities. a) Estates b) Digital			
Executive Lead	Chief Commercial Officer (Estates) Chief Digital Information Officer (Digital)		**Oversight Committee**	Finance & Business Performance Committee* Strategic Workforce Committee*
Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 4 Likelihood 4 **Total Score 16**	Impact 4 Likelihood 4 **Total Score 16**	**Cautious (3)**	CRR 225	Risk of disruption to Trust technology through cyber incidents *(risk under revision)*
			CRR 118	SMH main HV/LV electrical supply
			CRR 56	Wycombe Tower concrete panels
Last Review	Chief Digital Information Officer 09 March 2023 Chief Commercial Officer 26 January 2023		CRR 184	Wycombe Tower interior; suitability for provision of healthcare
			CRR 190	Interior condition of ward 2a; CQC regulation compliance
			CRR 226	Failure of critical bleeps at Wycombe & Amersham Hospitals
Movement in Risk	None			

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
7a. Estates				
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)	**Assurance Gap:** Significant backlog maintenance within the estate
7b. Digital				
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 - Potential clinical harm (lack of EPMA)	- 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).	**Assurance Gap:** Gaps in infrastructure and unsupported systems. **Action:** Updating systems to comply with cyber standards (monitored through DSPT) **Assurance Gap**: Funding for key elements of digital strategy, particularly EPR, to be identified.

			ASSURANCE LEVEL **MEDIUM**	**Action:** EPR Business Case (CDIO) – TBC Funding identified; plan under discussion (Summer 2023) **Assurance Gap:** Stabilisation of IT infrastructure and modernisation of apps to be completed. **Action:** (CDIO) – as per CRR Risk 225

2.8 Strategic Objective 9 Principal Risk; Failure to learn, share good practice and continuously improve

Strategic Objective 9	**Maximise opportunities for improving, sharing good practice and learning**			
Strategic Priority	Ensure our workforce are listened to, safe and supported ("A Great Place to Work)			
Principal Risk	8. Failure to learn, share good practice and continuously improve.			
Executive Lead	Chief Medical Officer		**Oversight Committee**	Quality & Clinical Governance Committee

Inherent Risk	**Residual Risk**	**Risk Appetite**	**Related Corporate Risk Register Entries**	
Impact 3 Likelihood 4 **Total Score 12**	Impact 3 Likelihood 3 **Total Score 9**	**Open** **4**	n/a	n/a
Last Review	Head of Quality – 15 May 2023			
Movement in Risk	None			

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
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	- Missed opportunities to improve patient outcomes/experience. - Non-systematic approach to learning. - Inefficiencies, processes not completed in a timely manner, erosion of desire to innovate and improve. - Inadequate foresight of organisational risk. - Inability to transform care and clinical models in a way that is fit for the future.	- Reflect and Review learning forum (monthly) - Monthly reporting on Serious Incidents - Nursing Learning forum - Patient safety meeting (monthly) - Upgraded Datix risk management platform - Analysis of Datix reports (weekly, monthly) - Weekly review panel for Serious Incidents - Board and Committee workplan. - Benchmarking. - Board and Committee structures. - Review of governance framework. - Innovation centre; hub for R&I teams and space for teams to come together and share good practice. - Digital infrastructure upgrades. - Roll out of QI programme.	- SI reports, meeting minutes and actions (level 1). - Meeting notes/actions from patient safety meeting (level 1). - Outputs of relevant meetings (level 1). - Outcomes of external reviews (level 3). - External governance report (level 3). - R&I Strategy (level 1). - QI plans (level 1). - Quality Strategy (level 1). - R&I Annual Report (level 1). ASSURANCE LEVEL **MEDIUM**	**Assurance Gap:** Clarity of organisational and governance structures **Action:** Review of governance structures (Deputy Chief Nurse) – May 2023 **Assurance Gap:** Inability for Datix to identify trends within reporting (not possible on upgraded version) **Action:** Executive dashboards being set up (Deputy Chief Nurse) ~~– March 2023~~ in progress; to be completed May 2023

3.0 Emerging Risks; Board & Board Committees

Month	Meeting	Risks Noted
March 2023	Audit	- Inability to appoint External Auditors. - Head of Internal Audit Opinion 2022-23.
	F&BP	- Current financial position; ongoing risk to income and energy costs. - Capital 2023-24. - Pending medical strike action and potential impact to service delivery. - Lack of contracts in place for Healthy Child Programme alongside other adult/child place-based contracts following pandemic; process of catching up in place.
	Q&CG	- Impact on quality metrics of increased hospital attendances with greater acuity and frailty of patients. - Delay in processing Deprivation of Liberty (DoLs) applications.
	SPC	- Staff Survey results and further work to understand potential number of leavers, individuals reporting feeling unable to speak up and how to increase response rates.
	Public Board	- Risks to 2023-24 financial plan including inflation, energy and PFI costs and a need for recurring efficiencies. Further work required on proposed deficit position for next year. - Availability of capital and impact on 2023-24 Capital Plan for the Trust; particular focus on decanting the Wycombe Tower and the need for timely capital to allay ongoing risks to safety at the site. - Medically Optimised for Discharge (MOfD) patient numbers; impact on colleague workload and resultant wellbeing.
	Private Board	- None raised
April 2023	Q&CG	- Lapsed clinical guidelines, noting overall progress.
	F&BP	- Annual financial deficit plan for 2023-24; organisation and ICS position. - Proportion of non-recurrent CIP versus recurrent CIP and impact on 2023-24 - Length of waits for community services particularly those affecting looked after children.

	Public Board	- External influences outside of organisational control which may impact on our ability to deliver 2023-24 priorities.
		- Financial plan for 2023-24:
		  ○ Proportion of non-recurrent CIP versus recurrent CIP.
		  ○ Ability to achieve ERF target and resultant income.

	Private Board	- None raised.

For those risks highlighted in the above table (not reflected in the BAF or CRR), the table overleaf pulls together actions held by the Board and Committees where these have been set to address these risks.

Risk(s)	Action Details	Committee Matrix	Action Owner	Due Date
Inability to appoint External Auditors	Ongoing work to explore options and communicate position with NHSE colleagues. Update to Board.	n/a	Chief Finance Officer	29 March 2023 (complete)
Head of Internal Audit Opinion 2022-23	Comprehensive and pragmatic approach to the management of long dated actions	Audit	Trust Board Business Manager	Regular review: - EMC (monthly) - Audit Comm (alternate months)
Impact on quality metrics of increased hospital attendances with greater acuity and frailty of patients	Report on increasing number of falls and mitigating actions to be presented to the Committee	Q&CGC	Chief Nurse	17 May 2023 (complete)
	Provision of harms review report; focussing on ED during winter months			
Lapsed clinical guidelines	Through Clinical Effectiveness Group	Q&CGC	Chief Medical Officer	Quarterly review by Q&CGC

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.

5.0 Heatmap – Residual Risk

Catastrophic (5)					
Major (4)			4. Failure to provide consistent access to high quality care for Children and Young People (CYP) 6. Failure to deliver on our people priorities	7. Failure to provide adequate buildings and facilities.	
Moderate (3)			3. Failure to work effectively and collaboratively with external partners 5. Failure to support improvements in local population health and a reduction in health inequalities 8. Failure to learn, share good practice and continuously improve	1. Failure to provide care that consistently meets or exceeds performance and quality standards. 2. Failure to deliver annual financial and activity plans	
Minor (2)					
Negligible (1)					
	Rare (1)	**Unlikely (2)**	**Possible (3)**	**Likely (4)**	**Almost Certain (5)**

6.0 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.

7.0 Risk Matrix

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/ audit	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
Human resources/ organisational development/staffing/ competence	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

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	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
Business objectives/ projects	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
Finance including claims	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
Service/business interruption Environmental impact	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

31 May 2023

Agenda item	Annual Governance Statement
Board Lead	Neil Macdonald, Chief Executive Officer
Type name of Author	Joanna James, Trust Board Business Manager
Attachments	Annual Governance Statement_May 2023
Purpose	Approval
Previously considered	n/a

Executive Summary

The Department of Health & Social Care (DHSC) Group Accounting Manual (GAM) requires NHS Trusts to include an Annual Governance Statement within their annual report. Guidance is issued by NHS Improvement (NHSI) on the format of this and the requirements for submission are set out within NHSI's accounts and reporting timetable.

Attached is the draft Annual Governance Statement (AGS) for the financial year 2022-23. This was considered by the Audit Committee on 4 May 2023 and recommended to Board subject to minor amendments which have been included in this current iteration.

Decision	The Board is requested to consider and approve the draft AGS for inclusion in the Annual Report.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	Governance arrangements related to patient safety are considered within the report.
Risk: link to Board Assurance Framework (BAF)/Risk Register	The role of the BAF and the key risks faced by the organisation in achieving the strategic objectives are summarised within the report.
Financial	Financial governance arrangements are considered in the report.
Compliance NHS Regulation Good Governance	As per the above, an Annual Governance Statement is a requirement of the DHSC.
Partnership: consultation / communication	The Annual Report and Annual Governance Statement have been produced through collaborative working with internal teams, the Audit Committee and Internal Auditors.
Equality	Governance related to equality matters is considered within the report.
Quality Impact Assessment [QIA] completion required?	n/a

Corporate Governance Report

Directors Report

Trust Board
The Trust Board provides strategic leadership to the organisation. It sets the strategic direction, fosters the appropriate culture, monitors performance and ensures management capacity and capability. It outlines the vision of the organisation, championing and safeguarding its values, keeping the safety of patients at the centre of its work and ensuring obligations to all key stakeholders are met. By ensuring the effective and efficient use of resources it safeguards public funds.

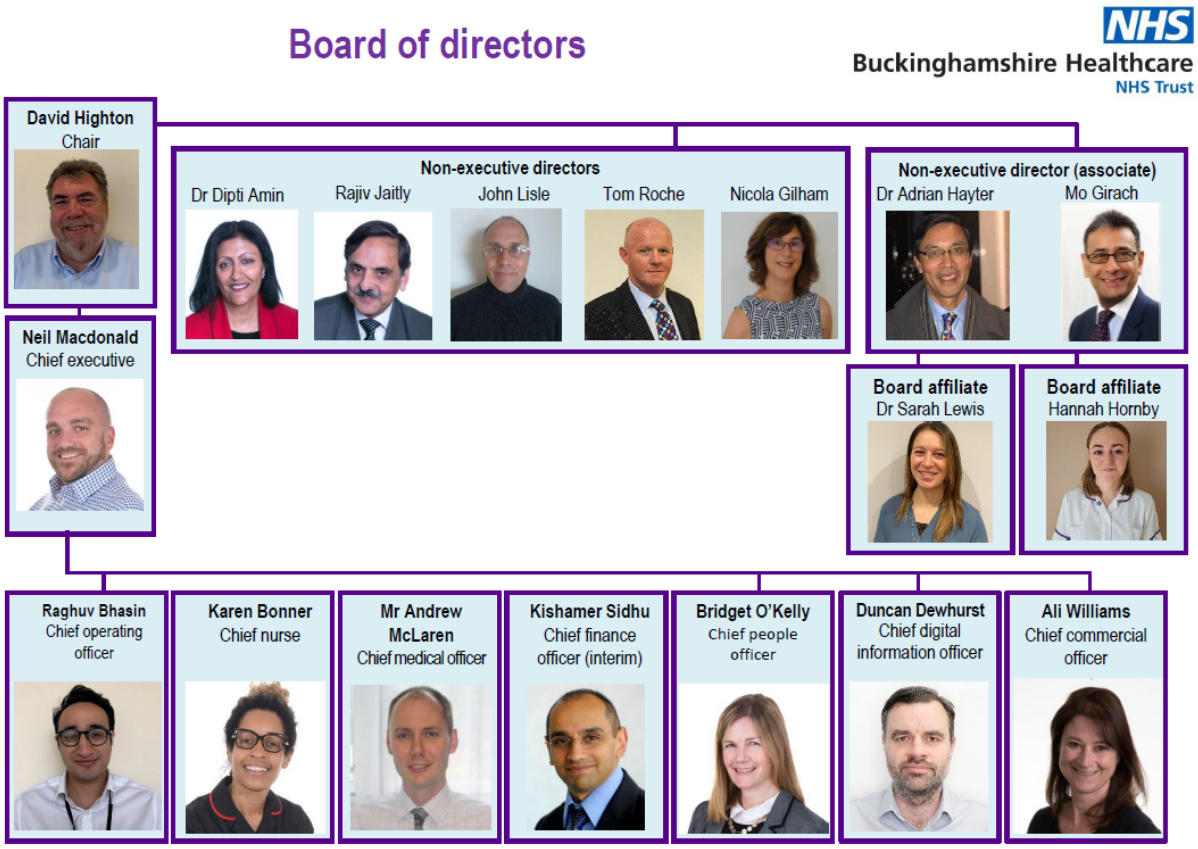
Non-Executive and Executive Directors both have responsibility to constructively challenge the decisions of the Board. Non-Executive Directors have a particular duty to hold the Executive Directors to account, ensuring appropriate challenges are made. As well as bringing their own expertise to the Board,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

The Trust Board meets 10 times per year in public, details of which are available in advance on the Trust's public website which also contains agendas, minutes and reports. Our Trust Board - Buckinghamshire Healthcare NHS Trust (buckshealthcare.nhs.uk)

The Trust Board formally operates within its Terms of Reference, the Trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions.

The maintenance of an effective Board is supported by the Trust Board development programme with seminars on key themes held on a monthly basis. During 2022-23 these included effective chairing of meetings, safe maternity services, cyber security, major service change and reconfiguration, countering fraud and bribery, workshops related to the electronic patient record plan and estates and the work of our Trainee Leadership Board on the carbon net zero agenda.

Our Board members in 2022-23 and their roles are shown below:

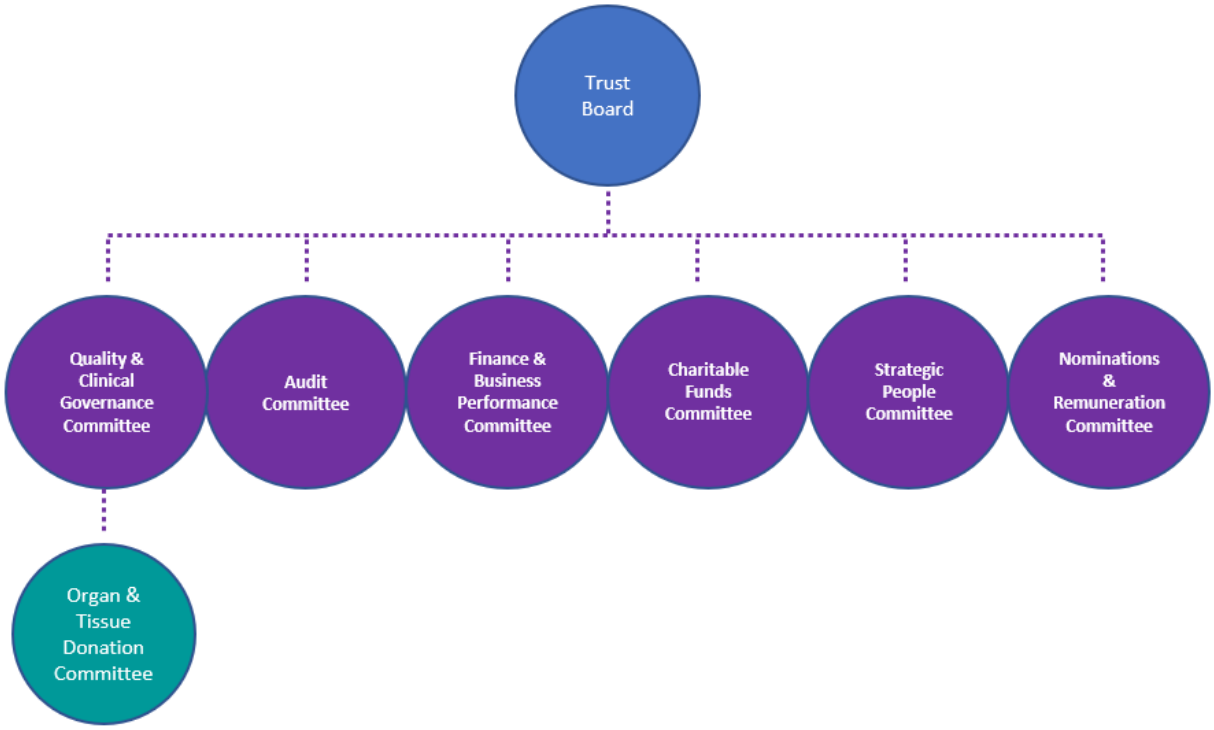


The following changes took place during 2022-23:

- Duncan Dewhurst joined the Board on 11 July 2022 as Chief Digital Information Officer in place of Ian Roddis, Interim Chief Digital Information Officer.
- Barry Jenkins left his role as Chief Finance Officer on 27 November 2022. Kishamer Sidhu joined the Board on 28 November 2022 as Interim Chief Finance Officer in his place.
- Hannah Hornby joined the Board on 1 September 2022 as Board Affiliate (non-medical) to replace Sandra Silva.
- Dr Sarah Lewis joined the Board on 1 February 2023 as Board Affiliate (medical) to replace Dr Mark Johnson.

Trust Board Committees

The figure below illustrates the structure of the Board and its Committees



A governance framework and associated processes are in place across the organisation to ensure that information flows clearly to the Board, providing assurance where possible and highlighting risks identified through gaps in control or gaps in assurance. The structures around governance and performance are currently undergoing a review.

The Board has delegated scrutiny of assurance process relating to workforce, quality and finance to four Committees:

- Audit Committee
- Finance & Business Performance Committee
- Quality & Clinical Governance Committee
- Strategic People Committee.

The Committees work together to provide an integrated approach to governance which is supported by common membership of Board members across the committees. Each has a Non-Executive Director as Chair and Non-Executive Directors form part of the membership. Each of the Committees has Terms of Reference and a plan of work which are reviewed annually and used as the basis of an annual assessment of Committee effectiveness.

There are two other Board Committees which are also described below:

- Nominations and Remuneration Committee
- Charitable Funds Committee.

Audit Committee

This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing governance, risk management and internal control (plus the Board Assurance Framework); oversight of the Internal and External Audit and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014.

In 2022-23 the Committee was chaired by Rajiv Jaitly, Non-Executive Director and Senior Independent Director and met bimonthly (plus a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). Four other Non-Executive Directors were also members: Dr Dipti Amin, Nicola Gilham, John Lisle and Tom Roche.

Finance & Business Performance Committee

The purpose of the Finance & Business Performance Committee is to provide the Board with assurance concerning all aspects of financial, commercial and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. It provides the Trust Board with assurance that the financial issues of the Trust are being appropriately addressed, and with information and recommendations on key issues. The Committee also has oversight of the Trust's performance management framework and, as required, focuses on specific issues where the Trust is experiencing challenges with its operational performance.

During 2022-23, the Committee met monthly and was chaired by Nicola Gilham, Non-Executive Director.

Quality & Clinical Governance Committee

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

During 2022-23 the Committee met monthly and was chaired by Dr Dipti Amin, Non-Executive Director.

Strategic People Committee

The Strategic People Committee aims to provide assurance to the Board in the areas of workforce development, planning, performance, engagement, equality, diversity and inclusion and assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high-performing and motivated workforce that is supporting business success. The Committee also receives assurance around health and safety processes and compliance. Reports from the Trust's Freedom to Speak up Guardian (FTSUG) set out activity, learning and resulting actions.

The Committee was chaired by Tom Roche, Non-Executive Director, in 2022-23 and met on a bi-monthly basis.

Nominations & Remuneration Committee

On behalf of the Trust Board this Committee reviews the appointment of Executive Directors and other staff appointed on Very Senior Manager (VSM) contracts, to ensure such appointments have been undertaken in accordance with Trust policies. It also reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive) the performance of Executive Directors and other staff appointed on VSM contracts; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves proposals on issues which represent significant change.

The Committee meets as required and, during 2022-23, was chaired by David Highton, Trust Chair.

Charitable Funds Committee

This aims to ensure that the Buckinghamshire Healthcare NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors. This includes reviewing and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board.

In 2022-23 the Committee was chaired by Nicola Gilham, Non-Executive Director.

Further information on the Charitable Funds Committee and related activities can be found in the Charitable Funds Annual Report which is available via the Trust website. Velindre NHS Trust (charitycommission.gov.uk)

Executive Management Committee

Also important to the governance process is the Executive Management Committee (EMC) and its sub-committees. EMC is the key decision-making and risk committee. It is chaired by the Chief Executive and attended by the Executive team, Associate Director of Communications and a representative from the Divisional Triumvirates (Divisional Chair, Divisional Director or Head of Nursing).

Meetings of EMC enable key clinical and managerial issues to be discussed, debated, developed, scrutinised, monitored and agreed and/or approved. Other senior leaders in the organisation attend as required. EMC is authorised to make decisions on any matter that is not reserved for the Trust Board or its Board Committees in line with the Trust Standing Financial Instructions; key issues are reported to the Trust Board as part of the monthly report from the Chief Executive.

In addition to EMC, there are a range of other forums, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance.

Transformation Board

The Transformation Board was established to provide assurance that the Trust's transformation plans are delivered successfully and that associated benefits related to quality, people and finance are realised. The Transformation Board supports EMC in providing a dedicated forum for Executive Directors and Divisional Triumvirates to discuss and debate such programmes alongside senior clinical and corporate colleagues and provides support and direction for escalated issues and risks to support delivery of plans.

Declarations of Interest

The Trust Board and Board Committees routinely ask that any interests relevant to the agenda items be declared at each meeting. In addition, a Register of Directors' Interests is maintained by the Trust Board Business Manager, presented to Board on an annual basis and published on the Trust website.

Reports to the Information Commissioner's Office

Information on personal data-related incidents where these have been formally reported to the Information Commissioner's Office can be found in the Annual Governance Statement later in the Corporate Governance Report.

Statement of Directors' Responsibilities

Each Director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken all steps that he or she ought to have taken to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Annual Governance Statement

Scope of responsibility
As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Buckinghamshire Healthcare NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that Buckinghamshire Healthcare NHS Trust ('the Trust') is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Buckinghamshire Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Buckinghamshire Healthcare NHS Trust for the year ending 31 March 2023 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk
The Trust has a Risk Management Policy and a Risk Management Strategy, both of which are endorsed by the Board. The Risk Management Policy was last reviewed in 2022 and the Risk Management Strategy is currently under review.

The way in which leadership is given to the risk management process
Risk management is recognised as everyone's responsibility and all staff are expected to cooperate in the management of risk to maintain their own safety and the safety of all others in the organisation. The Risk Management Strategy sets out the corporate and individual accountability for risk management through the Trust Board and Board Committees as follows:

- The role of the Trust Board in reviewing the management of extreme risks; the Board receive details of these through regular reporting including that related to organisational risk, performance (through the integrated performance report) and finance.
- The role of the Audit Committee in monitoring the effectiveness of the system for managing risk; the Committee receive organisational risk reports including details of the Corporate Risk Register and Board Assurance Framework at every meeting and, through these reports, is able to provide assurance to the Board on the Trust's application of risk management processes.
- The role of the Finance, Quality and People Board Committees in monitoring risks pertaining to their purpose; these Committees regularly receive and consider the strength of assurance reflected within the risk management system and the actions being taken to manage risks.
- The role of the Executive Management Committee in moderating scores of those risks included on the Corporate Risk Register; the Committee reviews the Corporate Risk Register and the Board Assurance Framework and is responsible for challenging the effectiveness of operational risk management, moderating risks to ensure consistency and ensuring adequate controls are in place.

- The Risk & Compliance Monitoring Group in reviewing risk registers and making recommendations to the Executive Management Committee.

Board Committees are chaired by Non-Executive Directors and the Audit Committee, which has a pivotal role in providing assurance over risk management processes within the Trust, has a membership of only Non-Executive Directors. Through their position as Chairs and Audit Committee members, the Non-Executive Directors all have a responsibility to provide robust challenge to the executive management of risk and to seek reasonable assurance of adequate control.

The Chief Executive, as the Accountable Officer for the Trust, has overall responsibility for effective risk management in the organisation. The Trust Risk Management Policy sets out in detail the roles and responsibilities of the Chief Executive and other Executive Directors. These include the following:

- The Chief Nurse leads on the process for the strategic development and implementation of organisational risk management, is accountable for the development of strategic clinical risk and for ensuring there is a robust system in place for monitoring compliance with the Care Quality Commission (CQC) standards.
- The Chief Nurse is also the Director of Infection Prevention and Control for the Trust and, together with the Patient Safety Officer, is responsible for managing patient safety, complaints, patient information and medical legal matters.
- The Chief Finance Officer has delegated responsibility for maintaining financial controls including overseeing the adoption and implementation of the Standing Financial Instructions and is the lead for counter fraud. The Chief Finance Officer also liaises with Internal and External Audit services who undertake programmes of audit with a risk-based approach.
- The Chief Medical Officer is the Responsible Officer for Medical Revalidation.
- The Chief Operating Officer is the Accountable Planning Officer for Emergency Preparedness, Resilience and Response (EPRR)
- The Chief Digital Information Officer is the Senior Information Risk Owner (SIRO). The SIRO is accountable to the Chief Executive with specialist support from the Information Governance team and Caldicott Guardian to ensure the management of confidentiality and security risks to Trust information and records.
- The Chief People Officer is accountable for the strategic management of the Trust's People strategy and equality and diversity compliance and employment processes.
- The Chief Commercial Officer has delegated responsibility for the management of Health & Safety risks and compliance with relevant legislation/regulation.

Collectively, the Executive Directors share responsibility for identifying and implementing control of strategic risks as well having individual accountability for risks within their specific portfolios. Each Executive Director will have governance mechanisms in place for the delivery and risk management of relevant services.

In addition, specific responsibilities are allocated to senior individuals within the organisation including:

- The Divisional Triumvirate (Divisional Chair, Divisional Director and Head of Nursing) share accountability to the Chief Operating Officer for identifying, managing and communicating risk within their respective divisions.
- The Trust Board Business Manager is the lead for the Board Assurance Framework on behalf of the Chief Executive.
- The Counter Fraud team are accountable to the Chief Finance Officer. The Local Counter Fraud Specialist (LCFS) undertakes the operational management and recording of fraud, bribery and corruption risks in the Trust.

The way in which staff are trained or equipped to manage risk in a way appropriate to their authority and duty

The Trust has a range of systems in place to prevent, manage and mitigate risks and measure associated outcomes. In addition to the Risk Management Policy, a comprehensive range of risk management policies and guidance are made available to staff including those related to incident reporting and investigation, risk assessment and health and safety. Other measures in place to support colleagues in their ability to manage risks include:

- Risk-related training in specific areas as part of the corporate induction and mandatory training programme.
- Availability of advice related to the management of risk in specific areas from a range of in-house professional and specialist staff. In addition, certain types of risk are addressed by the engagement of external expertise. For example, the risk of fraud is managed and deterred by the appointment of an external Local Counter Fraud Specialist (LCFS).
- Clinical and corporate teams are encouraged to consider learning related to risk management from both internal and external sources. There are processes in place to share learning following reported incidents and best practice. A proportion of these will relate to how services predict and manage the elements of clinical and business risk that are a factor in the day-to-day delivery of healthcare services.
- The Trust has an embedded learning culture supported by excellence reporting which highlights key episodes of excellent work achieved by colleagues and is part of monthly reporting to the Trust Board. Such a culture is also supported by the implementation of national clinical standards, the delivery of improvements from local and national clinical audits, the Medical Examiner review of deaths process, and the focus on learning from all untoward incidents.
- An annual compliance with legislation activity is undertaken.

The risk and control framework

The key elements of the risk management policy

Risk management is described as the systematic identification, description, assessment and management of risk in a given context and all colleagues are expected to follow the processes outlined in the Risk Management Policy and utilise the incident reporting system.

Following identification, risks are scored using a standardised risk scoring matrix. Risks scoring 8 or above and new/emerging risks are reported at monthly Service Delivery Unit (SDU) governance meetings for inclusion in local risk registers. Risks scoring at 12 or above will be reported to divisional governance meetings for inclusion in divisional risk registers. Risks scoring 15 or above will be reported monthly to the Risk and Compliance Monitoring Group. A similar process is followed for those corporate services sat outside of clinical divisions.

The Risk and Compliance Monitoring Group meets on a monthly basis and will make recommendations to the Executive Management Committee regarding risks to be escalated/de-escalated from the Corporate Risk Register. Urgent review of emerging or escalating risks are brought to the attention of the Associate Chief Nurse outside of these meetings by the Divisional Triumvirate.

On a bi-monthly basis, the Corporate Risk Register is presented to the Executive Management Committee and then onto Audit Committee and the Trust Board. Discussion at the Executive Management Committee will consider risks across the broader system and strategic risks, along with other known or emerging risks that may not yet be recorded.

Where an operational risk has significant implications for delivering a Trust objective, this will be reflected in the Board Assurance Framework.

The Quality & Clinical Governance, Finance & Business Performance and Strategic People Committees are presented with their profile risks on a regular basis throughout the year. These meetings have a significant role in gaining assurance in relation to risk management within the Trust, ensuring challenges at service level are discussed, supported and managed.

At the end of each Board and Board Committee meeting, the Trust Board Business Manager summarises the emerging risks; those that have been highlighted through reports received and discussions during the meeting. These triangulated with those risks within the Corporate Risk Register and Board Assurance Framework and presented to the Trust Board through the Committee Chair reports. Any risks not already reflected are presented to Audit Committee alongside meeting minutes with associated actions to ensure oversight of these.

The Risk Management Policy and Risk Management Strategy both describe the Trust Board's risk appetite statement which was considered last by the Board in June 2022 and is scheduled for review in June 2023. The previous review was facilitated through an externally-led workshop and also involved setting an individual appetite for such risk to each of the strategic objectives and this information is displayed in the Board Assurance Framework report.

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.

Trust Board Risk Appetite Statement, June 2022

The Trust has an established Board Assurance Framework (BAF) through which the Board is provided with a mechanism for satisfying itself that its responsibilities are being discharged effectively and informs the Board where the delivery of strategic objectives are at risk due to gaps in control/assurance. During 2022, Board Assurance Framework reporting was reconfigured to align with the BHT Strategy 2025 strategic objectives and to reflect the relationship with the Corporate Risk Register and the oversight of principal risks by specific Board Committees.

Documented within the Board Assurance Framework for each of the principal risks are the strategic threats, potential effects should the risk materialise, controls and assurance records in place and any gaps in assurances with actions to address these. Inherent and residual

risk ratings are presented alongside the Board's appetite for risk in that area. The Board Assurance Framework ensures that appropriate internal and external assurances are put in place in relation to the management of all high-risk areas and a level of assurance is provided for each of the risks.

Key elements of the quality governance arrangements

The Trust's quality governance arrangements are managed by the Quality & Clinical Governance Committee, it's sub-groups and committees and via a number of associated systems and processes.

Clinical audit is supported by a central team and the Quality & Clinical Governance Committee receives assurance on the design and the delivery of the clinical audit programme through a range of reporting including a quarterly update from the Clinical Effectiveness Group.

The investigation of incidents, and learning from these, is predominantly managed within Divisions and is discussed at divisional and specific governance meetings. Serious Incidents (SIs) are discussed and monitored through the executive-led Serious Incident Executive and Divisional Management (SIEDM) Panel. The Trust Board has monthly oversight of SIs through performance reporting and via the Quality & Patient Safety Group. Full details of maternity SIs are received by Board quarterly. A wide range of mechanisms are in place to support learning from both incidents and the results of quality audits and these include:

- Chief Nurse- and Chief Medical Officer-led monthly newsletters and weekly bulletins highlighting the top quality and safety messages.
- A 'Reflect and Review' monthly forum for clinical and non-clinical colleagues to share examples of excellent patient care and examine areas for improvement.
- Academic half days.
- Formal and informal training and simulation sessions and experiential learning.

Complaints are managed by the central complaints team in partnership with Divisional colleagues. The number of new complaints and percentage of complaints responded to within the required timeframe is considered monthly by the Trust Board. In 2022-23 the Trust compliance with responding to complaints from the public within 25 days of receipt improved from 28% in April 2022 to 78% in February 2023, supported by a revision of the Trust's complaints policy and procedures and focussed recruitment. In early 2023, Internal Audit undertook a review of compliance with such internal complaints processes for which a partial assurance opinion was received. Further changes to systems and processes are subsequently being made in line with recommendations.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). Compliance with these requirements is ultimately assessed via CQC inspections and the Trust was subject to such an inspection in February 2022. This was an unannounced inspection of medical and surgical services at Stoke Mandeville and Wycombe Hospital. The final report was published in July 2022 and the Trust retained it's overall rating of Good. The Trust was rated as 'good' in the effective, responsive and well-led domains, as 'requires improvement' in the safe domain and maintained an 'outstanding' rating for the caring domain. The Trust Board maintains oversight of the subsequent 'Must Do' and 'Should Do' CQC action plan.

Quarterly engagement meetings with CQC continued throughout 2022-23. Outside of formal inspections, the Trust monitors compliance with CQC registration requirements independently, primarily through a programme of regular in-house assurance visits/inspections. In 2022, the Clinical Accreditation Programme was launched and rolled out which measures and provides assurance on quality, safety, patient and colleague

experience and leadership across the organisation. In addition, the Trust introduced daily temperature checks and weekly and monthly quality audits through a digital application (Tendable).

On an annual basis the Trust conducts a comprehensive review of compliance with all regulation and legislation, including CQC requirements. This process includes identifying any gaps in compliance, setting actions to address these and monitoring progress with achieving such actions and is led by the Executive team. The process also allows the Trust to understand and assure the robustness of its compliance with regulatory and legislative duties. A new compliance dashboard was introduced in 2022 specific to Health & Safety legislation to improve Board oversight in this area.

The quality of performance information is primarily assessed by the Internal Audit programme. In 2022-23 this included review of CQC oversight controls, clinical audit, complaints and serious incidents. Changes to systems and processes were made in line with subsequent recommendations.

On a monthly basis, the Trust Board consider the Integrated Performance Report which encompasses key metrics regarding quality, people and finances aligned with the NHS System Oversight Framework and the Trust strategic priorities. Board Committees are responsible for oversight of metrics within the remit of the Committee and the use of statistical process control charts and accompanying narrative facilitate this. The Quality & Clinical Governance Committee consider the quality metrics on a monthly basis and request deep dives into any areas of concern. People metrics are considered by the Strategic People Committee with the Finance & Business Performance Committee considering key performance metrics.

How risks to data security are managed and controlled

Risks to data security are managed in accordance with the NHS Information Governance classification framework and the Data Security and Protection Toolkit (DSPT) requirements. Any gaps in controls are identified as risks and recorded, scored and reviewed in line with the Trust risk management policy. Additional oversight of cyber related risks is provided by the Cyber Information Security Officer (CISO).

Following an independent audit of Trust compliance with the Data Security and Protection Toolkit (DSPT) commissioned by NHS Digital, the Trust demonstrated low compliance to these standards. Subsequently an action plan to address areas of non-compliance was produced and reviewed regularly by the Board throughout 2022-23. In June 2022, a partially compliant submission was made and in December 2022, the Trust was awarded ‘Approaching Standards’ status by NHS England. Investment continues to be made to ensure further gains will be delivered in this area throughout 2023-24.

Major organisational risks

In 2021, the Trust published BHT Strategy 2025 which set out three strategic priorities; outstanding care, healthy communities and great place to work and nine strategic objectives. The risks to achieving these objectives are set out within the Board Assurance Framework which was revised in 2022. The principal risks facing the organisation, those with the potential to prevent the achievement of key objectives during the year 2022-23, were as follows:

Failure to provide care that consistently meets or exceeds performance and quality standards

This incorporates risk related to long elective waits, the provision of safe emergency, maternity and neonatal care and overall management of risk and clinical governance within the organisation. Key contributors include inadequate infection prevention and control due to

estates infrastructure, data quality and digital immaturity, demand and capacity for services (including primary/social care capacity), variation in productivity of clinical service lines and a lack of understanding and consistency in clinical governance and risk management across the organisation.

Failure to deliver our annual financial plan
This reflects the underlying Trust organisational financial deficit, structural financial challenges, inflationary pressures and a mismatch in the demand and availability of capital funds.

Failure to work effectively and collaboratively with external partners
This risk reflects the Trust's ambitions as an anchor institution alongside some local uncertainty as structures and relationships within the local Integrated Care System develop and mature.

Failure to provide consistent access to high quality care for Children and Young People
This reflects long waits for some community services alongside a significant increase in demand for such services, particularly related to educational needs, insufficient funding and an inability to recruit specialist staff.

Failure to support improvements in local population health and a reduction in health inequalities
This risk reflects inequalities in access to care and the potential for continued growth in the health inequality gap. Digital immaturity and a failure to effectively utilise data to manage local population health is a key contributor.

Failure to deliver our People priorities
The five people priorities relate to recruitment and resourcing, culture and leadership, supporting our staff, workforce planning and development and productivity. Key contributors to this risk are identified as insufficient levels of appropriately skilled staff, national cost of living and resultant recent industrial action. Following the pandemic and subsequent sustained operational pressures, low morale is recognised as impacting negatively on colleague wellbeing and retention levels.

Failure to provide adequate buildings and facilities
This incorporates risk related to both estates and digital for which a lack of available capital is a significant contributor to both. The age of the estate and the lack of digital maturity are recognised as a standalone risk and also a key contributing factor in a number of other risks faced by the organisation.

Failure to learn, share good practice and continuously improve
This reflects some gaps in learning following incidents and the organisation not consistently being a place where new innovation and new ideas can be easily implemented.

The Board Assurance Framework, alongside the Corporate Risk Register, is considered by Trust Board and Board Committees as part of a regular report on overall organisational risk which was newly introduced in 2022-23. The Board Assurance Framework provides details on strategic threats for each of the risks, potential effects should the risk materialise, existing controls and assurance records and subsequent gaps in assurance with mitigating actions. Overall review and moderation of risks as well as progress with mitigating actions are monitored by Board and Board Committees as well as through monthly meetings with Executive leads in line with the Trust Risk Management Policy.

CQC well-led framework

Following the inspection of medical and surgical services in February 2022, CQC conducted an inspection against the well-led framework in March 2022. The Trust was rated as 'good' for well-led which was an improvement on the previous rating (requires improvement).

Risks to compliance with the NHS provider licence

In May 2022 the Trust Board completed the required self-certification for 2021-22 that the Trust could meet relevant obligations set out in the NHS provider licence. These include;

- Effective systems to ensure compliance with considerations of the licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6)
- Compliance with governance arrangements (condition FT4)

The required self-certification has been undertaken for 2022-23 and will be presented to Board with full compliance.

The Trust has yet to appoint external auditors for 2022-23 due to national challenges and this has been escalated to NHS England. A potential auditor has been identified and due diligence is underway prior to any formal appointment.

The Directors Report provides further information on Board and Board Committee structures, roles and responsibilities.

The Trust remains in Segment 3 of the Single Oversight Framework with an action plan in place to support movement to Segment 2.

The key ways in which risk management is embedded in the activity of the organisation

As identified, the Trust Risk Management Policy sets out the processes by which risk is managed in the organisation. Alongside this, a range of supporting systems and processes are in place to embed risk management activity into the day-to-day activity of the Trust. These include:

- Through the Trust induction and mandatory training programme which includes information governance, safeguarding, fire safety, infection prevention and control, health and safety and manual handling.
- Incident reporting is openly encouraged across the Trust with promotion of just culture and appreciative inquiry. Lessons learned from incidents and investigations are shared and disseminated. More information on this can be found in the Annual Report.
- The patient safety team has robust lines of communication with the Executive Directors, Director for Medical Education and the Freedom To Speak Up Guardian (FTSUG) to ensure that conditions where colleagues feel safe to report incidents are fostered and maintained.
- Risk is regularly discussed at a wide range of forums including the Trust Board and Committees and divisional and service delivery unit (SDU) level governance meetings.
- Emergency preparedness systems are in place to ensure the Trust is able to respond, take action to control and mitigate risks at SDU, divisional and organisational levels.
- Risk management is incorporated into the Trust planning and Cost Improvement Programme (CIP) through the Quality Impact Assessment (QIA) process.

The way in which the Trust ensures that workforce strategies and staffing systems are in place

The Trust complies with the NHS Developing Workforce Safeguards through a number of methods:

- A review of safe staffing levels is led by the Chief Nurse and this is presented to the Board on a quarterly basis. These reviews follow the National Quality Board 2016 guidance and cover three components; evidence-based tools, professional judgement and quality outcomes. In addition, supplementary papers are considered which focus on maternity and medical staffing.
- The Trust Board reviews all people metrics on a monthly basis as part of a wider review of quality, safety, performance and finance metrics to ensure that challenges and risks are understood as part of the wider context of service delivery. This is supported by daily staffing reviews, key governance meetings within the people directorate and the Strategic People Committee.
- The Trust has as annual workforce plan that is submitted centrally along with the annual financial and activity plans. The Trust Board discusses all of these plans prior to their submission.
- Where there are critical service risks related to staffing and the safe delivery of care, these are escalated to the Trust Board, and external regulators as required, along with associated mitigations. Information from relevant risk registers are utilised as part of this process.
- A workforce representative is present at all Silver Command meetings when the Trust command and control structure is stood up.
- Recognising the continued impact of COVID-19 on the physical health, mental health and wellbeing of our colleagues, the Trust continues the significant focus on its health and wellbeing offering. The Trust has enhanced the counselling resources available in the wellbeing service to support demand and enable more 'outreach' across the Trust to provide quick and easy access to all. The dedicated physiotherapy resource to support musculoskeletal health conditions has also been expanded.
- The NHS People Plan, including the People Promise, remains a key thread through the work of the Trust in supporting the strategic priority to be a 'Great Place to Work'. In 2022, the Trust was selected as one of 23 exemplar sites for the NHS England People Promise Exemplar Programme.

The Trust has a range of mechanisms in place for staff to raise concerns which includes accessing the Freedom To Speak Up Guardian. During 2022, the freedom to speak up service was expanded through the implementation of an outreach model and the introduction of a number of part time guardians. Initial results of the expansion demonstrate increased contacts with the service and better representation at staff networks (see below). The Trust also has a Guardian of Safe Working Hours in post dedicated for medical staff to raise concerns. At Board level, dedicated Speaking Up Champion and Wellbeing Guardian roles are filled by Non-Executive Directors.

Care Quality Commission (CQC) registration

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

Register of interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

In August 2022 a proactive exercise was undertaken jointly by Internal Audit and the Local Counter Fraud Specialist into Declarations of Interest and Private Practice and changes to Trust policies and processes were implemented as recommended.

NHS Pension Scheme

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

Obligations under equality, diversity and human rights legislation

A number of control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

- Cover sheets for all papers that are presented to the Executive Management Committee, all Board Committees and Trust Board include a section for the author to make Committee and Board members aware of any specific equality impact or implication.
- Executive and Non-Executive Directors have undertaken Allyship training and have become a sponsor for one of our staff networks.
- The Trust currently supports eight staff networks, more information on which can be found in the Annual Report.
    - BHT EMBRACE (BME colleagues).
    - BHT Disability (colleagues with long-term health conditions or disability).
    - BHT Belonging (LGBTQ+ colleagues).
    - BHT VIBES (a multi-faith and spiritual network for all colleagues).
    - BHT Carers (colleagues actively caring for other family members).
    - BHT One in Four (supporting colleagues to talk about mental health).
    - BHT Women's Network
    - KALINGA (Filipino Healthcare Professional Organisation Bucks)
- Equality, diversity and inclusion training has been provided to every new joiner to the Trust via the induction programme. Additional inclusion training is available via the internal 'Peaks' management and leadership development programme.
- All Trust policies and relevant business cases include an equality impact assessment.

The Trust's Public Sector Equality Duty (PSED) report has been published and is available on the Trust website.

A number of control measures are in place to ensure the Trust meets and complies with all relevant obligations including:

- All Trust policies have an integral compliance and monitoring section with annual monitoring requirements.
- Monthly review of workforce related data by the HR and Workforce Group.
- Employee Relations Tracker for ongoing monitoring of cases with annual overview of this through PSED, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reporting.
- Annual review of the Trust equality, diversity and inclusion objectives.
- At least an annual review of WRES and WDES reports by Trust Board and at a Divisional level.
- Completion of equality impact assessments as per above.

The Trust is planning to publish its 'Diversity and Inclusion Manifesto' as part of the Trust People Strategy in 2023-24.

Obligations under the Climate Change Act and the Adaption Reporting requirements

The Trust has undertaken risk assessments, has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme and ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. To progress towards the NHS ambition to become carbon net zero by 2024, the Trust published its Net Zero Roadmap in 2021 and the first audit of progress against this plan in November 2022.

During 2022-23 our Trainee Leadership Board undertook a project focussed on understanding the current performance of the Trust in relation to net zero targets and where further gains could be made. Subsequent recommendations were presented to the Board and an implementation plan put in place. These related to the use of medical gases and single use items and a reduction in patient travel; areas considered to have the most significant potential impact on carbon reduction.

Review of economy, efficiency and effectiveness of the use of resources

The Trust is required to demonstrate that it achieves value for money for taxpayers by demonstrating economy, efficiency and effectiveness in the use of resources available. The Trust's governance processes provide assurance regarding use of resources with regular scrutiny by the Capital Management Group, Executive Management Committee, Finance & Business Performance Committee, Audit Committee and Trust Board. The executive-level Transformation Board provides assurance that transformation plans are delivered successfully and associate benefits relating to quality, people and money are realised. Governance for divisional performance is through monthly review meetings.

In 2022-23 the Group delivered a £14.158m deficit against its statutory reporting position which is consistent with the revised £14.3m deficit plan agreed with NHS England. Related to capital, the Group reported a £28.5m expenditure against its revised allocation of £28.8m for 2022-23.

The 2023-24 budget has been agreed with a full year deficit plan of £22.6m and a capital plan of £28.4m. The budget includes significant efficiencies of £35.1m. The efficiency plan remains challenging given the need to deliver increased activity to support continued recovery from the pandemic and meet ongoing significant operational pressures.

External auditors are required to provide an opinion on whether they are satisfied that, in all significant respects, the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness for its use of resources for the year ending 31 March 2023. At the time of publication the Trust had yet to appoint an external auditor due to a shortage of capacity reflecting the national picture in this industry. The Trust position was promptly escalated to NHS England and work is ongoing to secure an external auditor to undertake the 2022-23 audit within an agreed but deferred timetable.

The draft Head of Internal Audit Opinion for 2022-23 is that the organisation has an adequate and effective framework for risk management, governance and internal control. However, further enhancements to the framework have been identified to ensure that it remains adequate and effective. During the year no reports were presented with minimal assurance. Six reports were issued with a partial assurance opinion (negative) and five with a reasonable assurance opinion (positive). The details of all reports are considered by the Audit Committee who also monitor the implementation of actions to address identified weaknesses. The Executive Management Committee collectively considered all reports with a negative opinion and maintained a strong focus on supporting the implementation of management actions throughout the year.

The Trust also commissioned an internal audit review into the management of its capital spend in relation to the building of the new paediatric emergency department at Stoke Mandeville Hospital. This highlighted some issues with respect to our capital programmes and as such, the Executive Management Committee and Finance & Business Performance Committee took on greater scrutiny of capital programmes. Recommendations from the review continue to be worked through.

In view of the need to regain and retain financial grip and control following the pandemic whilst also deliver significant operational and workforce targets, in 2022 the Healthcare Financial Management Association (HFMA) published a Financial Sustainability self-assessment for Trusts to complete to consider whether appropriate processes were both in place and working effectively. Following completion of the self-assessment and an independent review of associated evidence by Internal Audit, the Trust demonstrated good compliance across all domains. Where areas for improvement were identified, relevant actions were articulated and implemented. This tool will be used on an ongoing basis to consider financial sustainability in the organisation, overseen by the Audit Committee.

Information governance
Any serious incidents that meet the required threshold are reported to the Information Commissioner's Office via the Data Security and Protection Toolkit. For the period 2022-23 there were two serious incidents which were notified to the Information Commissioner's Office (ICO). These related to a phishing email and data being disclosed in error. In both cases, the ICO confirmed no further action was required.

Data quality and governance
A number of measures are in place to assure the quality and accuracy of data including that which relates to elective waiting lists:

- The Trust has an Elective Care Access Policy which encompasses a number of Standard Operating Procedures for waiting list management at all stages of a referral to treatment pathway. The policy outlines the responsibilities of key colleagues including those related to the auditing of data quality.
- The Trust also has a Data Quality Policy which supports the principles of the information governance agenda in the element of quality assurance and as produced to achieve and maintain high quality data throughout the Trust. The policy describes the approach to data quality and outlines the role and responsibilities of the Data Quality Group.
- A weekly validation process is in place involving operational, management and information leads to assure the quality of local and national waiting times including the Referral to Treatment (RTT) pathway and ensure this information is both up to date and correct.
- A regular checking process is in place for RTT patients who have been removed from the waiting list following a non-patient interaction/validation. This is to assure data quality but also identify opportunities for improvement and/or training that support continued implementation and alignment with the Elective Care Access Policy.
- Within cancer services, patient level information is reviewed daily as part of multidisciplinary team meetings and tracing processes to support patient pathway management.
- Following the pandemic, additional clinical harm reviews were conducted across multiple services and patients were prioritised accordingly. Due to the volume of patients affected, clinical and non-clinical teams work closely together to ensure patients continue to be prioritised appropriately and risk of clinical harm minimised. More information can be found in the Performance Overview section of the Annual Report.

Data quality is also assessed through the Internal Audit programme. In 2022-23, specific audits were undertaken related to waiting list management policies and data (records) management. Changes to systems and processes were made in line with subsequent recommendations.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive managers and clinical leads within Buckinghamshire Healthcare NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, Finance & Business Performance Committee, Quality & Clinical Governance Committee and Strategic People Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The draft Head of Internal Audit Opinion for 2022-23 states that “the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective”. The last sentence of the opinion reflects that six reports received a partial assurance opinion (waiting list management, CQC, clinical audit, data management, major contract management and complaints) and five received a reasonable assurance opinion (serious incidents, business cases, payroll, financial systems and risk management and assurance framework). The Audit Committee approves in the Internal Audit annual plan and receives details from each of the reviews undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Executive Management Committee during the year.

Significant internal control issues

One Never Event was reported by the Trust in 2022-23; a retained foreign object post procedure. This incident was investigated and cross referenced to a similar event which occurred in 2021 in order to review the robustness of existing safety recommendations. The investigation has been completed, approved by Commissioners (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board) and the report shared with the patient concerned. Assurance has been provided by the Division of Surgery and Critical Care that all identified actions have been implemented.

During 2022-23 the Trust saw an increase in cancer referrals. Across the Trust, an average of 56.6% cancer patients received their first treatment within 62-days of diagnosis compared to a target of 85%. This has improved from 47% in 2021-22 and, supported by a programme of work, the number of patients waiting over 62 days continues to reduce.

The Trust remains in Segment 3 of the Single Oversight Framework with an action plan in place to support movement to Segment 2.

Conclusion

The significant internal control issues which have been identified in 2022-23 are described above, namely operational performance and one Never Event.

Signed……..

Chief Executive Date: XX

Modern Slavery Act 2015

The Modern Slavery Act 2015 establishes a duty for commercial organisations with an annual turnover in excess of £36 million to prepare an annual slavery and human trafficking statement. This is a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.

We published a statement regarding slavery and human trafficking on our website in July 2022. Modern slavery declaration - Buckinghamshire Healthcare NHS Trust (buckshealthcare.nhs.uk)

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

31 May 2023

Agenda item	Self-certification
Board Lead	Neil Macdonald, Chief Executive
Type name of author	Joanna James, Trust Board Business Manager
Attachments	Self-certification template & evidence FT4_2022-23 Self-certification template & evidence G6_2022-23
Purpose	Approval
Previously considered	Audit Committee 04.05.2023

Executive Summary

NHS trusts must self-certify that they can meet the obligations set out in the NHS Provider licence. This includes requirements to comply with NHS acts and constitution and with governance requirements.

The attached paper provides further information on those conditions that the Trust is required to comply with. Completed templates are attached to confirm compliance.

The Audit Committee considered all of the self-certification documents on 4 May 2023 and recommended these to Board for consideration and support.

Decision	The Board is requested to note the contents of the attached papers and support the proposal that the Trust is compliant with Conditions FT4 and G6.

Relevant strategic priority

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

Implications / Impact

Patient Safety	Governance regarding clinical and patient safety is described in the Annual Governance Statement.
Risk: link to Board Assurance Framework (BAF)/Risk Register	The Trust risk management process is referred to in the attached document
Financial	The Trust financial processes are referred to in the attached document
Compliance CQC Standards Good Governance	The attached document confirms that the Trust meets relevant statutory requirements
Partnership: consultation / communication	Internal Auditors are asked to comment on the attached document
Equality	Equality issues are highlighted in the report
Quality Impact Assessment [QIA] completion required?	Not required

1 Introduction

The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefits of patients.

As set out in 'Self-certification: guidance for NHS foundation trusts and NHS trusts', "the annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

a) effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
b) complied with governance arrangements (condition FT4); and
c) for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7)."

Although historically NHS trusts have not needed to hold a provider licence, they are required to demonstrate compliance with conditions equivalent to those within the licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (G6 and FT4) and must self-certify under these licence conditions. CoS7 does not apply to NHS trusts.

2 Condition G6

- Condition G6(2) requires NHS providers to have processes and systems that:
  - identify risks to compliance with the licence, NHS acts and the NHS Constitution
  - guard against those risks occurring.
- Providers must complete a self-certification after reviewing whether their processes and systems were implemented in the previous financial year and were effective (condition G6(3)).
- Providers must publish their self-certification by 30 June (condition G6(4)).

3 Condition FT4

- Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4.
- Before making the statement, providers should review whether their governance systems and processes enable them to achieve compliance with condition FT4. There is no set approach, but we expect any compliant approach to involve a review of the effectiveness of board and committee structures, reporting lines and performance and risk management systems.

4 Requirements and timelines

NHS Providers need to self-certify the following conditions after the financial year end:

Condition G6(3)	The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution.	By 31 May
Condition G6(4)	Publication of condition G6(3) self-certification.	By 30 June
Condition FT4(8)	The provider has complied with required governance arrangements.	By 30 June

Templates are provided to assist with our self-certification process, and the recommendation is to supplement with a process for supporting the declarations contained within. We are not required to return the templates to NHS England & Improvement unless specifically asked to do so; however, we publish our self-certification on our Trust website annually.

5 New Provider Licence

From April 2023, a new provider licence has been introduced with the intention of supporting effective system working, enhance oversight of key services provided by the independent sector, address climate change and make a number of necessary technical amendments.

The Trust received its provider licence on 29 March 2023 and will be required to self-assess against this new licence going forwards.

6. Recommendation

The Board is asked to support the proposed:

- Condition G6 is formally signed-off as “Confirmed”.
- Condition FT4 is formally signed off as “Confirmed”.

APPENDICES

Self-certification Condition G6 completed template and evidence pack
Self-certification FT4 completed template and evidence pack

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | **2022-23** | Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Not required

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Not required

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Not required

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust has taken all precautions to comply with the conditions of the licence, there have been no additional requirements imposed on the Trust under the NHS Acts during 2022-23 and the Trust continued to have regard to the NHS Constitution through the Trust strategy, policies and procedures and governance structures.

The Trust has yet to appoint external auditors for 2022-23 due to national challenges and this has been escalated this to NHS England.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	David Highton	**Name**	Neil Macdonald
Capacity	Trust Chair	**Capacity**	Chief Executive Officer
Date	TBC	**Date**	TBC

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Not applicable

PROVIDER LICENCE – EVIDENCE OF COMPLIANCE

The provider has taken all precautions necessary to comply with the licence, NHS Acts and the NHS Constitution (Condition G6 (3))

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
GENERAL CONDITIONS					
G1	This condition requires licensees to provide NHSE with any information they may require for licensing functions.	Compliant	BHT has strong data collection and validation processes and has a good track record of producing and submitting large amounts of accurate, complete and timely information to regulators and other third parties to meet specific requirements. Compliance confirmed as part of external CQC inspection in February 2022.	N/A	N/A
G2	This condition contains an obligation for all licensees to publish such information as NHSE may require, in a manner that is made accessible to the public.	Compliant	The Trust is committed to operating in an open and transparent manner and has robust governance arrangements to ensure that required information is made accessible to the public. The Board meets in public and will continue to undertake the majority of Trust business in public meetings; agendas, minutes and associated papers are published on our website. Our website contains a variety of information providing advice to the public and referrers who may require further information about services. Copies of the Trust's Annual Report and Accounts and Quality Account are published on the website and the Trust operates a publication scheme for Freedom of Information requests.	N/A	N/A
G3	Payment of fees to NHSE	N/A	**The Health & Social Care Act 2012 ("The Act") gives NHSE the ability to charge fees and this condition obliges licence holders to pay fees to NHSE if requested.**	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
			No requirements have been made by NHSE to charge fees. However, the obligation to pay fees is a condition and will be accounted for if necessary within the Trust's financial planning. The Trust pays fees annual to other parties such as the Care Quality Commission and NHS Resolution.		
G4	Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)	Compliant	All employment contracts contain a clause concerning possible termination in the event of gross misconduct. The Trust disciplinary policy defines misconduct. The Trust operates a rolling programme of Disclosure & Barring Service (DBS) checks for front line staff and for staff with access to sensitive information. The Board of Directors are subject to DBS checks on appointment and every 3 years thereafter. The Board of Directors adhere to a Code of Conduct that identifies expected standards of behaviour which includes clear references to the new FPP regulation. The constitution contains relevant clauses for governors and directors about eligibility, disqualification and removal. Non-Executive and Executive Directors are required to sign an annual declaration that they remain a Fit and Proper Person (FPP). This was presented to the Trust Board in March 2023. Compliance with the FPP Regulations confirmed as part of CQC inspection in March 2022.	N/A	N/A
G5	Having regard to NHSE guidance	Compliant	**This condition requires licensees to have regard to any guidance that NHSE issues.** The Trust has had regard to NHSE guidance.		
G6	Systems for compliance with licence conditions and related obligations	Compliant	**This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.**	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
			The Trust has an approved Risk Management Policy and a clear approach to identifying, managing, escalating and mitigating risk. The Board, Board Committees, and Executive management Committee monitors risk across the organisation. This is described in the Annual Governance Statement. Internal and External Audit report on regulatory compliance.		
G7	Registration with the Care Quality Commission	Compliant	**This licence condition requires providers to be registered with the Care Quality Commission and to notify NHSE if registration is cancelled.** The Trust has full registration of all services with the CQC. The Trust was rated Good following a CQC inspection in March 2022.	N/A	N/A
G8	Patient eligibility and selection criteria	Compliant	**This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner.** The Trust publishes descriptions of the services it provides and who the services are for on the Trust website. Eligibility is defined through commissioners' contracts. Assurance is gained through the assessment stages to ensure that the appropriate services are provided.	N/A	N/A
G9	Application of Section 5 (Continuity of Services)	Compliant	**This condition applies to all licensees. It sets out the conditions under which a service will be designated as a Commissioner Requested Service.** Licensees are required to notify NHSE at least 28 days prior to the expiry of a contractual obligation if no renewal or extension has been agreed. Licensees are required to continue to provide the service on expiry of the contract until NHSE issues a direction to continue service provision for a specified period or is advised otherwise.	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
			Services shall cease to be Commissioner Requested Services (CRS) if: • commissioners agree in writing that there is no longer a service need and the regulator has issued a determination in writing that the service is no longer a CRS; • three years have elapsed since the 1 April 2013 or one year has elapsed since the commencement of the license, whichever is the latter; or • the contract to provide a service has expired and the direction notice issued by NHSI specifying a further period of provision has expired. Licensees are required under this Condition, to notify NHSI of any changes in the description and quantity of services which they are under contractual or legal obligation to provide. Similar to the previous Mandatory Services, Commissioner Requested Services continue to be set within the contracts agreed with commissioners. The Trust has strong working relationships with its commissioning partners within the local health and social care system. The Board has a director responsible for leading on contract negotiations.		
PRICING CONDITIONS					
P1	Recording of information	Compliant	**Under this condition, NHSE may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by NHSE.** The Trust records all of its information about costs in line with current guidance and will comply fully with any new guidance.	N/A	N/A
P2	Provision of information	Compliant	**Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to NHSE.** The Trust will comply fully with any new requirements to submit information to NHSE.	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
P3	Assurance report on submissions to NHSE	Compliant	**When collecting information for price setting, it will be important that the submitted information is accurate. This condition allows NHSE to oblige licensees to submit an assurance report confirming that the information that they have provided is accurate.** The Audit Committee receives and monitors all Internal Audit reports including any specific reports on pricing.	N/A	N/A
P4	Compliance with the National Tariff	Compliant	**The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.** The Trust follows national guidance which is consistent with the NHS payment system, with a value-based commissioning contract where variable payments are related to outcomes or activities.	N/A	N/A
P5	Constructive engagement concerning local tariff modifications	Compliant	**The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to NHSE for a modification.** The Trust will follow national guidance which is consistent with the NHS payment system, with a value based commissioning contract where variable payments are related to outcomes or activities.	N/A	N/A
CHOICE AND COMPETITION CONDITIONS					
C1	The right of patients to make choices	Compliant	**This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice under the NHS Constitution, or where a choice has been conferred locally by commissioners.** The Trust complies fully with all guidance in relation to patient choice.	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
C2	Competition oversight	Compliant	**This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct that has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.** All licensed provider organisations will be treated as 'undertakings' under the terms of the Competition Act 1998. This means that all licensed providers will be deemed to be organisations engaging in an 'economic activity' for which the provisions of the Competition Act will apply. Licensed providers therefore need to comply with the Competition Act. The Trust Board and Executive Management Committee have access to expert advice to ensure compliance with this condition.	N/A	N/A
INTEGRATED CARE CONDITION					
IC1	Provision of integrated care	Compliant	**The licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care.** The Trust is an active participant and leader in the local health and social care economy across the Buckinghamshire Integrated Care Partnership, and the Buckinghamshire, Oxfordshire & Berkshire West Integrated Care System, and is working with partners to take forward models of integrated care. The Trust has a strong track record of working on integrated care pathways with other health and social care providers.	N/A	N/A
CONTINUITY OF SERVICES CONDITIONS					
CoS1	Continuing provision of Commissioner Requested Services	Compliant	**This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provides Commissioner Requested Services, without the agreement of relevant commissioners.**	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
			The Trust has strong working relationships with its commissioning partners within the local health and social care economy. The Board has a director responsible for leading on contract negotiations. The Trust has a strong track record of delivering service transformation, efficiency, productivity and quality improvement to meet the needs of the local population.		
CoS2	Restriction on the disposal of assets	Compliant	**This licence condition ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain NHSE consent before disposing of these assets when NHSE is concerned about the ability of the licensee to carry on as a going concern.** The Finance Department maintains a capital asset register for all depreciable assets valued at over £5,000 on purchase, or group assets valued individually over £1,000, and when grouped together functionally, valued at more than £5,000. The Estates Department maintains a property and property leases register and the Contracts team a register of contracts (including non-estates leases).	N/A	N/A
CoS3	Standards of corporate governance and financial management	Compliant	**This condition requires licensees to have due regard to adequate standards of corporate governance and financial management.** The Single Oversight Framework will be used by NHSE to determine compliance. In October 2021, the Trust was moved from Segment 2 to Segmnet 3 under the Single Oversight Framework and remained in Segment 3 throughout 2022-23. The Trust has a suite of governance documents including:	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
			• Standing Financial Instructions; and • Reservation of Powers to the Board and Delegation of Powers. Governance and financial reports to Board meetings and Board Committees confirming details of the Trust's governance and financial management and information which supports the Governance and Continuity of Services declarations.		
CoS4	Undertaking from the ultimate controller	N/A	**This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the license conditions. This is best described as a 'parent/subsidiary company' arrangement. If no such controlling arrangements exist then this condition would not apply.** Should a controlling arrangement come into being, the ultimate controller will be required to put in place arrangements to protect the assets and services within 7 days. Directors and Trustees of Charities are not regarded by NHSI as 'Ultimate Controllers'. *This licence condition would not apply as the Trust is not an NHS Foundation Trust.*	N/A	N/A
CoS5	Risk pool levy	N/A	**This licence condition obliges licensees to contribute, if required, towards the funding of the 'risk pool' – this is like an assurance mechanism to pay for vital services if a provider fails.** The Trust currently contributes to the NHS Resolution risk pool for clinical negligence, property expenses and public and employment liability schemes.	N/A	N/A
CoS6	Cooperation in the event of financial stress	Compliant	**This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSE/I and any of its appointed persons in these circumstances in order to protect services for patients.**	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
			The Trust has maintained a Continuity of Service/Financial Sustainability rating of 3 for the last 12 months. The Trust has a positive and compliant track record of co-operating with external bodies and regulators.		
CoS7	Availability of Resources	Compliant	**This licence condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.** As with the provision of Mandatory Services, the Trust has well-established services in place and currently provides all of the Commissioner Requested Services to a high standard. The Trust has forward plans and agreements in place with commissioners that meet this condition.	N/A	N/A
NHS FOUNDATION TRUST CONDITIONS					
FT1	Information to update the register of NHS Foundation Trusts.	N/A	This licence condition ensures that NHS Foundation Trusts provide required documentation to NHS.. *This licence condition would not apply as the Trust is not an NHS Foundation Trust.*	N/A	N/A
FT2	Payment to NHSI in respect of registration and related costs.	N/A	If NHSE moves to funding by collecting fees, we may need this licence condition to charge additional fees to NHS Foundation Trusts to recover the costs of registration. NHSE would consult stakeholders before introducing such a fee. *This licence condition would not apply as the Trust is not an NHS Foundation Trust.*	N/A	N/A
FT3	Provision of information to advisory panel.	N/A	The Act gives NHSE the ability to establish an advisory panel that will consider questions brought by governors. It is NHSE's current intention to establish this panel. This licence condition requires NHS Foundation Trusts to provide the information requested by an advisory panel.	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
			This licence condition would not apply as the Trust is not an NHS Foundation Trust.		
FT4	NHS Foundation Trust Governance arrangements *Although BHT is not an NHS Foundation Trust it must comply with the governance framework.*	Compliant	This condition will enable NHSE to continue oversight of governance of NHS Foundation Trusts and NHS Trusts. In summary, licensees are required to: • have systems and processes and standards of good corporate governance; • have regard for the guidance published by NHSI; • have effective Board Committee Structures • have clear accountabilities and reporting lines throughout the organisation and maintain appropriate capacity and capability of the Board; • comply with healthcare standards; • have effective financial management, control and decision making; and • maintain accurate information The Board undertakes an annual review of: Board effectiveness; Strategic objectives and risks to delivery through the Board Assurance Framework, Strategic Risk Register and Annual Plan • Board committee and assurance framework; their terms of reference and performance against these; • Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers. • Rules of Procedure Other forms of assurance include; • Overall Good with Outstanding for caring rating by CQC following inspection in February 2022 • Managerial and professional lines of accountability and clinical leadership; • Annual Governance Statement; • Audit Committee scrutiny; • Internal Controls Framework	N/A	N/A

Licence condition		Level of compliance	Evidence / Board assurance	Comment where non-compliant or at risk of non-compliance and required action	Completion date
			• Internal and External Audit reports (external audit for 2021-22); • Integrated Performance reports received by the Board each month • Annual appraisals and development plans; • Performance Management Framework; • Annual Report and Quality Account; • Monthly reports to the Board from Committee Chairs • Strategies and policies kept under regular review.		

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | 2022-23 | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust currently has no conditions imposed upon it preventing it from discharging its statutory responsibilities. Following a well-led inspection by the CQC in March 2022, the Trust was rated as 'good'.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	All new guidance is considered by the Trust Board and taken account of. Where required, Board development time will be committed to ensure understanding in support of implementation.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board has a clear Committee structure underpinned by up to date Standing Orders and Committee terms of reference. A review of performance and governance frameworks in the organisation is underway.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Trust achieved its financial plan for 2022-23. The Trust has yet to appoint external auditors for 2022-23 due to national challenges and this has been escalated to NHS England. A potential auditor has been identified and due diligence is underway prior to any formal appointment.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Trust Board is considered to have sufficient capability to ensure effective leadership related to quality of care. Following a CQC inspection in February 2022, the Trust maintained its 'outstanding' rating in the caring domain. The Trust continues to implement the subsequent action plan for all 'must do' and 'should do' actions, of all which are on track for completion.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	All Board directors have complied with and meet the requirements of the Fit and Proper Persons Test.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name David Highton, Trust Chair **Name** Neil Macdonald, Chief Executive Officer

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A Not applicable — OK

PROVIDER LICENCE – EVIDENCE OF COMPLIANCE

The provider has taken all precautions necessary to comply with the licence, NHS Acts and the NHS Constitution (Condition FT4)

Corporate Governance Statement		Response	Evidence / Board assurance
1.	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	• The Chief Finance Officer and the Trust Board Business Manager provide expertise on standards of governance as they apply to the NHS and advise the Board and organisation accordingly • Reviews of elements of governance are carried out by the CQC, NHS Improvement, External Audit, and Internal Audit • The Trust has a Declaration of Interests policy and process • The Trust Board of Directors comply with the requirements of the Fit and Proper Persons test
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board and relevant Committees are briefed on guidance issued by NHS Improvement in relation to governance.
3.	The Board is satisfied that the Licensee has established and implements: a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	• The Board and Committees are set up in line with the Code of Governance for Foundation Trusts as far as it applies to NHS Trusts • The Trust has Standing Orders, Standing Financial Instructions and Committee Terms of Reference reviewed annually by the Board • Board and Committee Self-reflection on effectiveness is evident in minutes of Board meetings and Committees • Review of effectiveness of Audit Committee and performance in each committee • Chair's observation of each Committee and feedback to each Committee Chair • Organisational structure charts showing lines of accountability • Performance Management Framework and processes
4.	a) The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	Confirmed	• Board and committee forward plans • Board agendas and minutes • Annual Governance Statement • Internal and External Audit • Local Counter Fraud Specialist Annual report • Auditor review of going concern declaration • Risk Management Strategy and Policy

Corporate Governance Statement		Response	Evidence / Board assurance
	b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.		• Board Assurance Framework • Corporate Risk Register • Comprehensive business planning process involved Board and Committee sign off • Emergency Planning, Resilience and Response compliance reported to Finance and Business Performance Committee • Data Security and Protection Toolkit submission • Compliance with legislation paper to the Board
5.	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	Confirmed	• Board development programme including Board self-review • Quality Impact Assessment process • Leadership programme • Quality report to Board • Range of internal and external assurances to Quality and Clinical Governance Committee including clinical audit and other reviews • Monthly mortality reporting

Corporate Governance Statement		Response	Evidence / Board assurance
	b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate		• Patient Experience Group • Programme of patient and public involvement reported to the Board • Feedback processes such as Friends and Family Test and complaints process • Range of patient stories to Board • Engagement with Healthwatch and the Health and Adult Health and Social Care Select Committee
6.	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence	Confirmed	• Strategic People Committee forward plan and meeting minutes • Staff performance reports and links to operational/quality performance. • Staff survey • CQC reports • Business cases for additional/new staff brought to Board/Committees for approval.

Meeting: Trust Board Meeting in Public

31 May 2023

Agenda item	Private Board Summary Report 26 April 2023
Board Lead	Trust Board Business Manager
Type name of Author	Senior Trust Board Administrator
Attachments	None
Purpose	Information
Previously considered	N/A

Executive Summary

The purpose of this report is to provide a summary of matters discussed at the Board in private on 26 April 2023.

The matters considered at this session of the Board were as follows:

- Contract for Approval: CardioScans
- Lease for a building in Wycombe for Children's Services
- Board Development Programme 2023-24

Decision	The Board is requested to note the contents of the report.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	Aspects of patient safety were considered at relevant points in the meeting
Risk: link to Board Assurance Framework (BAF)/Risk Register	Any relevant risk was highlighted within the reports and during the discussion
Financial	Where finance had an impact, it was highlighted and discussed as appropriate
Compliance	Compliance with legislation and CQC standards were highlighted when required or relevant
Partnership: consultation / communication	N/A
Equality	Any equality issues were highlighted and discussed as required.
Quality Impact Assessment [QIA] completion required?	N/A

Acronym 'Buster'

- A&E - Accident and Emergency
- AD - Associate Director
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting
- AHP - Allied Health Professional
- AIS – Accessible Information Standard
- AKI - Acute Kidney Injury
- AMR - Antimicrobial Resistance
- ANP - Advanced Nurse Practitioner

B

- BBE - Bare Below Elbow
- BHT – Buckinghamshire Healthcare Trust
- BME - Black and Minority Ethnic
- BMA - British Medical Association
- BMI - Body Mass Index
- BOB – Buckinghamshire, Oxfordshire, Berkshire West
- BPPC – Better Payment Practice Code

C

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CCG - Clinical Commissioning Group
- CCU - Coronary Care Unit
- Cdif / C.Diff - Clostridium Difficile
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CHD - Coronary Heart Disease
- CIO - Chief Information Officer
- CIP - Cost Improvement Plan
- CQC - Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CRL – Capital Resource Limit
- CSU - Commissioning Support Unit
- CT - Computerised Tomography
- CTG - Cardiotocography

D

- DBS - Disclosure Barring Service
- DGH - District General Hospital
- DH / DoH - Department of Health
- 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
- DOH – Department of Health
- DoLS - Deprivation of Liberty Safeguards
- DPA - Data Protection Act
- DSU - Day Surgery Unit
- DVT - Deep Vein Thrombosis

E

- E&D - Equality and Diversity
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ECG - Electrocardiogram
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EIA - Equality Impact Assessment
- EIS – Elective Incentive Scheme
- ENT - Ear, Nose and Throat
- EOLC - End of Life Care
- EPR - Electronic Patient Record
- EPRR - Emergency Preparedness, Resilience and Response
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record

F

- FBC - Full Business Case
- FFT - Friends and Family Test
- FOI - Freedom of Information
- FTE - Full Time Equivalent

G

- GI - Gastrointestinal
- GMC - General Medical Council
- GP - General Practitioner
- GRE – Glycopeptide Resistant Enterococci

H

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEE – Health Education England
- HETV - Health Education Thames Valley
- HMRC – Her Majesty's Revenue and Customs

- HSE - Health and Safety Executive
- HSLI – Health System Led Investment
- HSMR – Hospital-level Standardised Mortality Ratio
- HWB - Health and Wellbeing Board

I

- ICS – Integrated Care System

M

- I&E - Income and Expenditure
- IC - Information Commissioner
- ICP - Integrated Care Pathway
- ICU - Intensive Care Unit
- IG - Information Governance
- IGT / IGTK - Information Governance Toolkit
- IM&T - Information Management and Technology
- IPR - Individual Performance Review
- ITU - Intensive Therapy Unit / Critical Care Unit
- IV - Intravenous

J

- JAG - Joint Advisory Group

K

- KPI - Key Performance Indicator

L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LHRP - Local Health Resilience Partnership
- LiA - Listening into Action
- LOS / LoS - Length of Stay
- LUCADA - Lung Cancer Audit Data

M

- M&M - Morbidity and Mortality
- MDT - Multi-Disciplinary Team
- MIU - Minor Injuries Unit
- MRI - Magnetic Resonance Imaging
- MRSA - Meticillin-Resistant Staphylococcus Aureus

N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director

- NHS – National Health Service
- NHSE – National Health Service England
- NHSE/I – National Health Service England & Improvement
- NHSI – Nation Health Service Improvement
- NHSLA - NHS Litigation Authority
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

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

- PACS - Picture Archiving and Communications System / Primary and Acute Care System
- 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
- PE - Pulmonary Embolism
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PPE - Personal Protective Equipment
- PP – Private Patients
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty

Q

- QA - Quality Assurance
- QI - Quality Indicator
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework

R

- RAG - Red Amber Green
- RCA - Root Cause Analysis

- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

S

- SAU - Surgical Assessment Unit
- SCAS / SCAmb - South Central Ambulance Service
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SSI(S) - Surgical Site Infections (Surveillance)
- SNAP - Sentinel Stroke National Audit Programme
- STF – Strategic Transformation Fund
- STP - Sustainability and Transformation Plan
- SUI - Serious Untoward Incident

T

- TIA - Transient Ischaemic Attack
- TNA - Training Needs Analysis
- TPN - Total Parenteral Nutrition
- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

U

- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

V

- VfM - Value for Money
- VSM - Very Senior Manager
- VTE - Venous Thromboembolism

W

- WHO - World Health Organization
- WTE - Whole Time Equivalent

Y

- YTD - Year to Date