Meeting: **Trust Board Meeting in Public**

Date: **Wednesday, 26 July 2023**

Time: **09:30 – 12.00**

Venue: **R & I Centre, Stoke Mandeville Hospital & 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
	3.	Colleague Voice	Discussion	Chief People Officer	Verbal
General Business					
10.00	**4.**	Minutes of the last meeting held on: • 28 June 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					
10.15	**7.**	Audit Committee Chair Report • Audit Committee Terms of Reference • Audit Committee Annual Report 2022-23	Assurance Approval	Committee Chair	Paper Paper Paper
	8.	Finance and Business Performance Committee Chair Report	Assurance	Committee Chair	Verbal
	9.	Quality and Clinical Governance Committee Chair Report	Assurance	Committee Chair	Paper
	10.	Strategic People Committee Chair Report	Assurance	Committee Chair	Paper
Performance					
10.30	**11.**	Integrated Performance Report	Assurance	Chief Operating Officer	Late Paper
	12.	Breakthrough Objectives; Quarterly Update	Assurance	Chief Digital Information Officer	Paper
11.00		QUESTIONS FROM THE PUBLIC			
	COMFORT BREAK – 10 minutes				
Finance					

Time	Item	Title	Purpose	Lead	Format
11.10	**13.**	Finance Report	Assurance	Chief Finance Officer	Paper
People					
11.20	**14.**	Medical Appraisal and Revalidation Report	Approval	Chief Medical Officer	Paper
	15.	Health & Safety Executive (HSE) Letter and Trust Actions	Assurance	Chief People Officer	Paper
Quality					
11.30	**16.**	External Reviews	Assurance	Chief Nurse	Paper
Risk & Governance					
11.35	**17.**	Organisational Risk Report	Assurance	Chief Executive Officer	Paper
	18.	Nomination & Remuneration Committee Terms of Reference	Approval	Chief Executive Officer	Paper
	19.	Modern Slavery Act; Annual Statement	Approval	Chief Executive Officer	Paper
Information					
11.50	**20.**	Private Board Summary Report	Information	Chief Executive Officer	Paper
	21.	Health & Safety Annual Report	Information	Chief Commercial Officer	Paper
	22.	Integrated Safeguarding Annual Report	Information	Chief Nurse	Paper
AOB					
	23.	Risks identified through Board discussion	Discussion	All	Verbal
		ANY OTHER BUSINESS			
		QUESTIONS FROM THE PUBLIC			
		Date of Next Meeting: 27 September 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

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

David Highton
Chair

Non-executive directors
Dr Lise Llewellyn
John Lisle
Tom Roche
Nicola Gilham
Nicola Frayne

Non-exec directors (associate)
Dr Adrian Hayter
Elaine Siew

Neil Macdonald
Chief executive

Board affiliate
Dr Sarah Lewis

Board affiliate
Hannah Hornby

Raghuv Bhasin
Chief operating officer

Karen Bonner
Chief nurse

Mr Andrew McLaren
Chief medical officer

Jon Evans
Chief finance officer

Bridget O'Kelly
Chief people officer

Duncan Dewhurst
Chief digital information officer

Ali Williams
Chief commercial officer

Meeting: Trust Board Meeting in Public

Date: 26 July 2023

Agenda item	Colleague Voice – The Trust Senior Physician Associate
Board Lead	Bridget O'Kelly
Author	Bridget O'Kelly
Appendices	None
Purpose	Information
Previously considered	SPC 15.05.2023

Executive summary

Rochelle Breen, Lead Physician Associate at the Trust will share with the Board:

- Information about the Physician Associate role
- How the role fits in at the Trust and beyond
- Personal Journey of a Physician associate
- Future ambitions and opportunities

More information about Physician Associates can be found
https://www.healthcareers.nhs.uk/explore-roles/medical-associated-professions/roles-medical-associate-professionals/physician-associate

The Strategic People Committee considered Rochelle's presentation on 15 May 2023 and noted the significance of this new profession and the broad benefits to the organisation.

Decision	The Board are requested to note and discuss the role of the Physician Associate.

Relevant strategic priority

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

Implications / Impact

Patient Safety	Physician Associates are key roles in providing safe care to patients and service users
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 6: Failure to deliver our People priorities
Financial	The Trust pay bill comprises c70% of costs
Compliance CQC Standards Staffing	Ensure we continue to deliver the right staff, in the right place, with the right skills. Staff are safe, supported and listened to Developing and supporting newer roles such as Physicians Associates will be

	key in delivering the NHS Workforce Plan.
Partnership: **consultation / communication**	Trade unions/professional bodies
Equality	Hearing directly from Colleagues we aim to bring a diverse group of colleagues to share their experience and journeys with the Board, improving understanding of their experience at BHT
Quality Impact Assessment [QIA] completion required?	No

Meeting: Trust Board Meeting in Public

Date: Wednesday, 28 June 2023

Time: 09.30 – 11.00

Venue: R&I Building, Stoke Mandeville Hospital & live streamed to the public

MINUTES

Voting Members:	
Mr D Highton (DH)	Trust Chair
Mr R Bhasin (RB)	Chief Operating Officer
Ms K Bonner (KB)	Chief Nurse
Mrs N Gilham (NG)	Non-Executive Director
Mr J Lisle (JL)	Non-Executive Director
Dr L Llewellyn (LL)	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 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)

01/06/23 Welcome, Introductions and Apologies

The Chair welcomed everyone to the meeting in particular, Lise Llewellyn who was attending her first meeting as newly appointed Non-Executive Director. No apologies had been received.

02/06/23 Declarations of Interest

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

03/06/23 Minutes of the last meeting

The minutes of the last meeting held on 31 May 2023 were **APPROVED** as a true and accurate record.

04/06/23 Actions and Matters Arising

The Action Matrix was **NOTED**.

05/06/23 Chief Executive's Report

NM presented the CEO report which was taken as read and highlighted the Trust had received two visits from the CCQ since the last meeting; an unannounced paediatric emergency pathway inspection related to a particular case and a planned visit to maternity services. The formal reports had not yet been received however the verbal feedback had been complementary on culture, people, capability, and enthusiasm. NM thanked the teams involved in the visits.

DH noted the NHS Workforce plan was expected for publication and further industrial action had been announced; junior doctors followed two days later by consultants. DH recognised this would create pressure on performance both clinically and financially. NM noted there would be disruption with 'Christmas Day' cover in place. This would be first time for a strike over the weekend and there would be costs for providing cover. The teams were doing well however each time there was industrial action, it became less easy and more exasperating.

TR commended the work with the Bucks Skills Hub and attracting people into the Trust. NM highlighted the strong programme of engagement the Trust has with local schools and engaging with students.

In response to a query from JL, NM noted a strategy to look at technology and improvements for the future with innovative ideas would be a good topic for further discussion.

The Committee **NOTED** the report.

06/06/23	Finance and Business Performance Committee Chair Report

NG highlighted the following key points:

- The Committee had reviewed the IPR for May noting work to standardise Board rounds and digitising bed management noting Artificial Intelligence would assist these journeys. There were some barriers noted with respect to recruitment in the Hospital at Home Service and Dermatology capacity.
- There was a risk to financial performance due to Industrial action and a report would come back to the Committee on the impact.
- The work on improvements to contract management was noted.
- The increased number of litigation claims was noted however this was in line with the national position. A forecast had been requested on how any future claims would affect the premium.
- Three business cases had been recommended for Board approval.

AH queried if the Trust was cited on the long-term risk around clinical negligence due to COVID 19 hospital acquired infections. KB noted this was being looked at nationally.

The Committee **NOTED** the report.

07/06/23	Integrated Performance Report IPR)

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

- Progress on emergency care had been static and there had been progress on reducing the longest waiters with improvements in discharge which reflected the changes in pathway working alongside the Council and ICB and would support further improvements ahead of the Winter months.
- There were challenges around diagnostics in the elective pathway specifically around endoscopy and MRI capacity and an update would come to Board next month on the recommended approach for bridging the demand and capacity gaps.
- There were ongoing delays with response to complaints noting these were being considered in more detail.
- The statutory and mandatory training rate had increased and there had been a reduction in turnover.

JL queried how quality was assessed in the community metrics, RB explained this was examined in the divisional performance reviews however this would be brought out more clearly in the IPR going forward including a focus on healthy communities including support for cardiovascular disease and reducing smoking in pregnancy.

HH highlighted the resilience of the workforce noting the reduction in sickness and recognising the work of the Health and Wellbeing team.

In response to a query from AH, RB explained work was ongoing around discharge with the Council and discharge to assess beds and integrated teams. A transfer of care hub would be set up by October to manage all the complex discharge capacity. Work was also being carried out to review the Trust's processes regarding long waiters and identifying themes. KB added the teams were learning and sharing practices with other teams such as Berkshire. RB noted there would be

standardised processes on wards for discharges and managing discharges with the Council and reflected in an electronic control centre by the beginning of December.

LL queried the barriers to discharge by 17.00, RB explained there was a lack of standardisation and processes which was hindered by the lack of a discharge lounge which could take patients on trolleys. There was a focus on improving this which included a change of culture around discharge. KB added there was an analysis underway on improving UEC and discharge.

DH queried the establishment of more posts year on year. RB explained there was a difference between the head count level and vacancy level, noting some of the bank and agency roles were now substantive. The overall headcount cost had reduced.

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

08/06/23 Finance Report

KS took the Month 2 Finance report as read and highlighted the following points:

- The Trust was on plan and £300k better off at month 2 and was expected to achieve the forecast by year end which was a positive position however it was important to continue to have a grip on the position.
- There had been no adjustments to the Elective Recovery Fund (ERF).
- There was an underlying risk related to industrial action.
- The Cost Improvement Plan (CIP) included recurring change in Q1 and Q2 to be implemented by Q4 which would need to be monitored.
- Inflation financed on a national formula would have an acceleration impact going into next year if the Trust did not deliver its CIP.
- The Trust had spent £1m so far of the Capital budget of £29.4m.
- The following business cases would require appropriate monitoring; Bed business case which would provide £10m, the Ophthalmology and building changes which would add a further £10m and Diagnostics which would add another £3-5m.
- The Cash position was relatively healthy and would need to be monitored through the year to ensure debtors and creditors hit the correct time scales.

NG queried if the Trust had the right resources to manage these capital projects. KS noted he had confidence the base programme and controls were in place and additional project managers would be brought in to manage the additional cases which would allow a high level of scrutiny to maintain quality. NM added pre-work had already been undertaken with the cases and would be closely monitored by the Board through the capital report.

Thanks were given to Kish Sidhu for his time at the Trust as the Interim Chief Finance Officer noting this was his last Board meeting.

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

09/06/23 Annual Quality Account

KB presented the Quality Accounts for 22/23 which outlined the performance data against patient safety experience and clinical effectiveness and was due for publication by 30 June 2023.

The Board acknowledged the strong overall performance related to quality metrics noting the significant challenges faced by the Trust during the year and welcomed an excellent annual account.

The Board discussed Parkinsons' tools, dementia training for non-clinical colleagues, patient initiated follow up (PIFU) and performance related to total knee replacement surgery. The Board recognised a more ambitious approach was required for the roll out of Appreciative Inquiry (AI).

The Board **APPROVED** the Quality Accounts for publication.

10/06/23 Charitable Funds Committee Terms of Reference

The Board **APPROVED** the updated Terms of Reference.

11/06/23 Future Delegation of Statutory Functions

AW informed the Board the report had been written alongside NHS England's 'Updated Guidance on Joint Working and Delegation' noting strategic opportunities would be explored by the Board during specific strategic workshops.

The Board noted the Integrated Care Board (ICB) was not able to delegate the commissioning of services but collaboration between provider organisations was encouraged and work programmes were being built locally to support this. LL stressed the importance of early patient and resident involvement.

DH noted he and NM were involved in meetings with acute provider collaborative and executives were involved from across all the Trusts. It was likely that non-executive directors would be involved to have oversight at a future point.

The Board **NOTED** the report.

12/06/23	Private Board Summary Report
	The Board **NOTED** the report.

13/06/23	Risks identified through Board discussion

JJ noted the following risks:

- Planned industrial action by medical colleagues and impact of this on both strategic and financial performance.
- Potential for clinical negligence claims related to COVID-19 noting national work underway related to this.
- Size and complexity of the 2023/24 Capital Programme

14/06/23	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: 26 July 2023 at 09.30

Public Board Action Matrix

4action ID	Agenda Item	Summary	Target Date	Exec Lead	Status	Update
1628	ICB Strategy	Following review and endorsement by the Trust Board in May 2023, subject to consideration of comments, to circulate final strategy	26/07/2023	Chief Commercial Officer	Propose close	The Joint Forward Plan is now available via **https://www.bucksoxonberksw.icb.nhs.uk/integrated-care-strategy-joint-forward-plan/joint-forward-plan/**
1489	Integrated Performance Report	Systematic review of critical infrastructure and shortage of skills to ensure no points of failure	~~28/06/2023~~ ~~26/07/2023~~ 27/09/2023	Chief Operating Officer	In Progress (deferred)	Work underway to present to Board in September 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.

Meeting: Trust Board Meeting in Public

Date: 26 July 2023

Agenda item	Chief Executive's Report
Board Lead	Neil Macdonald, Chief Executive
Author	Chloe Powell, CEO Business Manager
Appendices	Chief Executive's Report Appendix 1 – Letter from Anne Eden Appendix 2 – BHT response Appendix 3 – CARE value award winners Appendix 4 – Executive Management Committee and Transformation Board Appendix 5 – 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 letter from Anne Eden, South East Regional Director (NHS England) to the BOB Integrated Care Board regarding the system financial plan (Appendix 1). Our response to this will be published in the coming days ahead of the Board meeting (Appendix 2).

Also appended are a list of the winners of our monthly CARE value awards (Appendix 3), 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 4), and a Place & System Briefing (Appendix 5).

Decision	The Board is requested to note this 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) and local or Corporate 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

NHS England has now published its long-term workforce plan; this is available here. The report outlines measures designed to address well-publicised workforce shortages through three priority areas: train, retain and reform. We are pleased to see this long-term commitment and meanwhile continue our local efforts to ensure we have the right numbers of people with the right skills to deliver outstanding care, and to make BHT an attractive place to work and train.

At the time of writing this report, we are experiencing our fourth period of industrial action by junior doctors. Once again, significant planning and preparation has gone into ensuring patients remain safe during this period, and urgent and emergency care remains in place. My thanks again to colleagues for their hard work, to those medical colleagues who are undertaking additional shifts, and to the public for their patience and understanding if their care has had to be rescheduled.

We are also preparing for the first consultant industrial action in the coming days, and similarly this involves significant hard work across clinical and support services. These periods continue to be managed through our command-and-control structures to ensure robust governance and oversight of critical decision-making.

Following the submission of the Operational Plan from the Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care Board (ICB), which included a deficit financial plan, the CEO has received a letter (Appendix 1) from the South East Regional Director of NHS England, Anne Eden, setting out a series of financial controls required to be in place this financial year. We will also append our response to this ahead of the Trust Board meeting on 26 July (Appendix 2).

NHS75

On 5 July, seven of our colleagues and volunteers joined their Royal Highnesses the Duke and Duchess of Edinburgh, other NHS staff, senior government and political leaders, health leaders and celebrities at a service at Westminster Abbey in celebration of NHS75.

Nurses Anne Hutton and Ann Clairmonte-Rajab, occupational therapist Claire Farrant, consultant Ralph Robertson and volunteer Trevor Hudson were all chosen to represent the Trust due to their outstanding contributions to healthcare and consistently going above and beyond to look after people both in their own homes as well as in our hospitals.

In addition, we were delighted that May Parsons, one of our senior nurses who delivered the world's first COVID-19 vaccine outside of a clinical trial in December 2020, carried the George Cross into the Abbey in a procession. May received the medal from Queen Elizabeth II, along with NHS England Chief Executive Amanda Pritchard and representatives from the other UK health services at Windsor Castle in July 2022.

Our Chief Nurse, Karen Bonner, also attended the service and we are very proud that both Karen and May have recently been recognised by the Nursing Times as two of 75 nurses and midwives nationally who have positively shaped the NHS over the past 75 years or are doing so right now.

Outstanding care

Key performance data are reported in the Integrated Performance Report with supporting narrative. The data this month are presented slightly differently in an effort to align with our objectives and to help focus the reader's attention to where there are statistically significant changes (through the statistical process chart analysis). I would draw the Board's attention to our current urgent and emergency care performance, which we acknowledge is not where we want it to be both in terms of Type 1 performance and total time in the emergency department.

A key element of delivering outstanding care is seeking and hearing feedback from patients and service users. We were pleased to attend the launch of the Healthwatch Bucks Annual Report and join their 10-year celebrations. The report is available here. Of note in 2022/23, Healthwatch Bucks produced reports on social prescribing and the experience of young people with dementia. In the year ahead, their focus will turn to primary care, social care (with a focus on hospital discharge) and children and young people's experience of health and social care. I was particularly interested to see their ambition to consider health inequalities as part of all future work rather than a standalone issue.

We were pleased to welcome Rob Butler MP to Stoke Mandeville Hospital earlier this month to take a look around our new paediatric emergency and obstetrics and gynaecology departments in the Waddesdon Wing, as well as visit some of the older parts of our estate.

Healthy communities

I described last month some new initiatives by our schools engagement team, inspiring the next generation to consider careers in healthcare and the NHS. This month a new series of evening talks called 'Discover careers in...' launched with a focus on medicine. These are aimed at young people in Years 11 and 12 in local schools and colleges, and future months will focus on other career possibilities and opportunities.

It was a delight to see our garden volunteers at Amersham Hospital organise a celebration of NHS75 earlier this month. The green spaces for colleagues and patients at this hospital are a testament to the generous time and effort local residents choose to give, and we are extremely lucky and grateful for it.

On 29 July we will be delighted to host our Trust Open Day at Stoke Mandeville Hospital – the first in a few years following the COVID-19 pandemic, and an opportunity to celebrate NHS75. There will be tours and behind the scenes visits of various parts of the hospital, including our simulation suite, mortuary and theatres. Horatio's Garden, part of the National Spinal Injuries Centre, will also be open to the public. We hope the day will also inspire local people to consider joining the organisation or volunteering.

Great place to work

Our NHS75 celebrations continued through a series of events and celebrations for colleagues this month, and I would particularly like to thank Mike Wozniak who performed his solo show 'Zusa' (currently touring the UK) exclusively for BHT colleagues and their guests at Waterside Theatre in Aylesbury for free. Thanks also to the Bucks Free Press for bringing free copies of their special edition (plus cakes!) to our Wellbeing Garden at Stoke Mandeville Hospital.

We held our Annual Awards a few weeks ago, and I am sure the Board will join me in celebrating all colleagues and teams who were nominated by peers, patients or their loved ones, with of course particular commendation to those who won. It was wonderful to hold this celebration together in person after reduced activities over recent years.

In celebration of South Asian Heritage Month, colleagues once again organised a fantastic Cricket Match, this year challenging NHS colleagues at Milton Keynes University Hospital. On 22 July the now annual Sportsfest organised by the Kalinga Filipino network will take place at Stoke Mandeville stadium, a fantastic opportunity to have fun and spend time with colleagues we might not usually get to. We also celebrated the Women's World Cup with teams competing to decorate their areas for one of the countries.

I was pleased to join fellow senior leaders from across the organisation at the first of our Leadership Away Days this year focusing on our organisational development plan and taking the time to workshop together ways to increase our productivity and efficiency. I look forward to continuing to work with this group throughout the year to deliver these changes.

Finally, I would like to formally welcome Jon Evans, Chief Financial Officer (CFO), who joined the Trust on 17 July 2023, bringing with him a wealth of experience of both district general and large teaching hospital NHS organisations. I would also like to formally thank Kishamer Sidhu, our interim CFO since autumn 2022. It has been a pleasure to work with Kish and have him as part of the Board and the Executive team, and we wish him well in his future endeavours.

Appendices
Appendix 1 – Letter from Anne Eden
Appendix 2 – BHT response
Appendix 3 – CARE Value awards
Appendix 4 – Executive Management Committee and Transformation Board
Appendix 5 – Place & System Briefing

Sent by e mail:
Steve.mcmanus4@nhs.net

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

30 June 2023

Dear Steve

I am writing to acknowledge receipt of Buckinghamshire, Oxfordshire and Berkshire West ICBs final system operating plan for 2023/24 and set out next steps.

The objectives set out in 2023/24 priorities and operational planning guidance are framed around three tasks for the coming year. Our immediate priority is to recover our core services and productivity. Second, as we recover, we need to make progress in delivering the key ambitions in the NHS Long Term Plan. Third, we need to continue transforming the NHS for the future.

You have developed your plan during a period of intense pressure on services and in the context of industrial action and uncertainties around pay and inflation. Systems will receive additional funding for the cost impact of the recently announced 2023/24 pay award. The finance and contracting actions that ICBs and NHS providers should take have been set out in the recently published guidance on the 2023/24 pay award.

We have reviewed your submission in this context, and I have set out below some of the key elements of your plan that you are committed to deliver on as a system. Where appropriate, I have also highlighted issues for you to keep under review and / or that require specific action. Please could you share this letter with your full Board for consideration.

Emergency care and system resilience

- Bed occupancy remains high across the ICB >95% throughout the entire year.
- 76% of 4-hour performance is predicted to be met by the system.
- Demand assumptions seem realistic with an increase in capacity in virtual wards and admission avoidance.
- The system identifies promoting alternatives to ED via 111.

Please refer to the letter from the national ambulance team regarding the SCAS allocation.

Elective and Outpatients

- The system is committed to reducing the of long waits and plans to work with other partners to achieve the target of eliminating 65weeks+ waits by April 2024. Guidance

states March 2024 and to include 52weeks waits, this is dependent on staffing levels although robust workforce plan in place.

- The system does not plan to meet the OPFU activity target. OPFU reduction recalculated with corrected baseline, now 102% (27% above target).
- The system plans to meet 104.4% of the Value Weighted activity.
- The system plans do not meet the 25% OPFU reduction targets and planned delivery for BHT would make the system an outlier nationally.
- The System does not plan to meet 85% Theatre utilisation and 85% Day Case targets.

Cancer

- The system does not meet national requirements to recover Cancer 62d backlog by March 24 driven by RBFT (200 vs 161). Plans are in place with Thames Valley Cancer Alliance to support.
- The system plan does not aim to meet the 80% FIT target, however, plans have been made to increase FIT uptake.
- The system is planning to meet the 75% FDS target by end of March 2024, noting that BHT is not currently meeting FDS target but is meeting interim milestones to support end of March 24 ambition with clear plans.

Diagnostics

- The system recognises that it needs to increase activity in 2024/25 and believes it can be delivered through increased CDC capacity.
- System diagnostic plans include a reduction in WL size and number of >6ww, but with comparatively small positive performance impact. Only £2m capital expenditure earmarked for imaging equipment replacement compared to a requirement of c.£46.7m.

Mental health and Learning Disability and Autism

- System activity plans are below LTP objective for perinatal mental health access (69% of the LTP objective) and Talking Therapies access (87% of objective). Dementia diagnostic standard revised to meet target. However, prevalence has not been amended so delivery of DDR not expected to be recovered.
- Ambitious plan identified on reducing OAPs from 750 to 120.
- We look forward to seeing the implementation of work to reduce health inequalities in relation to cancer care with specific focus screening for our citizens with learning disabilities.
- We are mindful that the submission doesn't explicitly reference Autism or SEND however, we are aware of workstreams within the recovery plan shared with the LDA Programme.

Workforce

- The system plans for a small workforce increase overall, with increases in the substantive workforce offset by a significant decrease in agency usage.

All ICBs are expected to monitor delivery against their workforce plans and work with colleagues at all levels to consider whether actions to improve substantive recruitment, retention and staff health and wellbeing are sufficient to meet workforce demand.

Finance

Delivering system-level financial balance remains a key requirement for all ICBs. We note that you have submitted a deficit plan, and that this deficit is in line with the level discussed in the recent meeting with Amanda Pritchard, Julian Kelly and Sir David Sloman/Sarah-Jane Marsh. Given that the level of deficit is in-line with expectations the additional inflationary funding we communicated has been added to your allocation.

Although the level of deficit in your plan is in line with our expectations at this stage, we still expect you to work to mitigate this in-year and strive to deliver a break-even out-turn position. Regional teams will continue to monitor progress.

We expect all systems and providers to continue to apply the following conditions stipulated in 2022/23:

- Commit to recurrent delivery of efficiency schemes from quarter 3 to achieve a full year effect in 2024/25 to compensate for any non-recurrent measures required to achieve 23/24 plans. Within this we expect all systems to be able to describe how this will be achieved by the end of quarter 1.
- Fully engage in national pay and non-pay savings initiatives, in particular around national agreements for medicines and other non-pay purchasing.
- Monitoring of agency usage by providers, and compliance with usage and rate limits.
- Any revenue consultancy spend above £50,000 and non-clinical agency usage continue to require prior approval from the NHS England regional team based on agreed regional process.

We also expect that by the end of quarter 2 every system will prepare a medium-term financial plan, demonstrating how recurrent financial sustainability will be delivered. These plans should provide a clear demonstration how the recurrent exit run-rate from 2023/24 will be consistent with this, and how this run-rate will be improved through 2023/24.

In addition, because your system did not submit a balanced plan, you will also be required to comply with the following conditions (all of which should be shared with Regional teams for oversight and sign-off, with agreed process for assuring implementation):

- Review your current processes and arrangements around the pay controls described in the appendix to this letter.
- Ensure that you have a vacancy control panel in place for all recruitment.
- That you apply the agency staffing and additional payment controls stipulated in the appendix to this letter.
- Ensure you have an investment oversight panel in place to oversee all non-pay expenditure, with papers shared with NHSE. Within this process we would not expect approval of any non-funded revenue or capital business cases.
- Where revenue or capital cash support is required, the additional conditions described in the appendix to this letter will apply.

Next Steps

Where this has not been done already, ICBs must ensure that all contracts are agreed and completed in line with final plans, and signed as soon as possible.

We will continue to work with you to address the issues highlighted above and ensure you are able to access the necessary development support to strengthen the system's capability and capacity for delivery.

We will review progress through our [regular monitoring meetings].

If you wish to discuss the above or any related issues further, please let me know.

Yours sincerely,

Anne Eden
Regional Director – South East

Cc Neil Macdonald, CEO Buckinghamshire Healthcare Trust
Meghana Pandit, CEO Oxford University Hospital NHS Foundation Trust
Nick Broughton, CEO Oxford Health NHS Foundation Trust
Janet Lippett, CEO Royal Berkshire Hospitals NHS Foundation Trust
Julian Emms, CEO Bekshire Healthcare NHS Foundation Trust
David Eltringham, CEO South Central Ambulance Service NHS Trust

Appendix – Standard Financial Controls

Where the system has not submitted a balanced plan the follow standard reviews and controls should be applied across organisations in the system.

1. Pay Controls
Review of Recruitment and Processes
1.1 Produce and review a complete reconciliation of staff increases since 19/20 with full justification for post increases based on outcomes/safety/quality/new service models. A review of the value for money of the outcomes of these new posts should be included. Where value for money is not demonstrated a plan for the removal of the post needs to be in place. The overall plan to be signed off by the Board and the ICB.
1.2 Review all current open vacancies to consider where the removal or freezing of posts is appropriate. This should initially focus on posts which have been vacant for over 6 months with a starting assumption that these should be removed or re-engineered.
1.3 Review the establishment to remove partial posts not required and identify unfunded/unapproved posts which should be removed.
1.4 Review current governance arrangements for recruitment and temporary staffing (panels and sign off at all levels of the organisation including groups, terms of reference, SFIs and sign off rights).
1.5 Ensure workforce plans are in place and that these are in a granular level of detail (e.g. by service, workforce type and substantive / temporary) and align to approved establishment levels and budget.
1.6 Ensure that rigorous illness policy and procedure is in place and consistently applied.
1.7 Ensure that retention processes are reviewed – including exit interviews, flexible working options and retentions schemes.
1.8 Ensure that rota processes are reviewed to provide assurance to the Board that they are embedded and operate as anticipated across the organisation.
General Vacancy Controls
1.9 Ensure that a regular vacancy control panel or equivalent is in place to check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits.
1.10 Ensure Vacancy Control Panel terms of reference enable flexibility to avoid operationally delaying opportunities for savings and considering clinical need.
Non Clinical Posts

1.11 No use of non-clinical agency staff, with exceptions authorised by an executive director and then requiring onward approval by ICB and NHSE regional director.
Nursing
1.12 Review one to one nursing policies, approvals, and tracking process to ensure standardised approach linked to patient need/acuity.
Medical
1.13 Review consultant job planning compliance and policies.
1.14 Benchmark waiting list initiative and other additional payments against local organisations. An enhanced authorisation process for these payments should be in place, ensuring that such payments deliver value for money or are operationally critical before approving.
Agency Controls and Additional Payment Controls
1.15 Established governance process to oversee agency staffing with clear terms of reference (either at overall level or by key staffing group e.g. nursing, medical, corporate) to be chaired by an executive director.
1.16 Limit the authorisation of agency staff to Executives or named senior managers. Executive level sign-off of locum spend and off-framework spend.
1.17 Agree an implementation date for the removal of all non-framework agency staffing with an associated organisation-wide temporary staffing policy.
1.18 Clear Board accountability and reporting of plans and actual spend.
2. Non-pay
2.1 Commitment of additional expenditure over £10,000 which will add to the expenditure run-rate, excluding categories out of scope, to be approved at an executive chaired group.
Non-pay categories of spend out of scope of non-pay controls: Supplies and services - clinical (excl. drugs) Drug costs Clinical negligence fees Audit fees Depreciation and Amortisation

3. Cash
3.1 Where a trust is seeking cash support for their revenue or capital position, they will need to continue to provide all of the documentation required as part of this process.

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.

May 2023

Category	Name	Role	Nomination	Nominated by
Collaborate	Caroline Coomber	Community Nursery Nurse Marlow Health Visiting Team	I would like to nominate Caroline for a CARE award due to her outstanding willingness to help others. Whether it is a child who needs extra support, the office in need of clearing in preparation for new flooring or a service improvement to be made, Caroline is always happy to lend a helping hand. Caroline has for example been instrumental in setting up continence webinars for parents/carers, which can now be accessed through the Trust website. She has helped create an evidence-based PowerPoint presentation and recently successfully delivered the first live webinar. Caroline has a real 'can do' attitude and creates solutions for the team whilst always putting the needs of others first, which is truly inspiring and make her an invaluable member of our team. Thank you, Caroline, for all that you do and for the positive impact that you have on the families we work with and the team.	Colleague
Aspire	Liz Ritson	Health Visitor Wycombe West Health Visiting Team, Chichester House	I would like to nominate Liz for a CARE award due to the outstanding care she has provided to a baby with biliary atresia, the support she offered the family and her commitment to raising awareness about this rare disease. In her role as Health Visitor for the family, Liz has demonstrated compassion and expertise in her role. Biliary atresia is a rare and serious liver disease that affects infants. While Liz and the multi-disciplinary team supported baby (and family), Liz ensured seamless communication from all members of the team to ensure optimal care for baby. Liz has become an advocate for raising awareness about biliary atresia and the challenges families face when caring for a child with this condition. She has delivered teaching sessions for her Health Visiting colleagues and provided a presentation about biliary atresia to specialist community public health students at Buckinghamshire New University, which was highly received. Her efforts have helped to raise awareness about biliary atresia and to promote understanding and support for families affected by this rare disease.	Colleague
Respect	Stuart Berry	Ophthalmology technician/HCA	My 5-year-old daughter came to her ophthalmology appointment and had her first ""eye pictures"" done. Stuart spoke to my daughter in such an age-appropriate manner. Taking his time to explain everything, even down to why he was having to turn the light off and for her to tell him if it was too dark and she was worried. He talked through everything he was going to do whilst kneeling to her eye level to engage with her. He showed her the images afterwards and praised her for being so brave. We have had lots of eye tests, but Stuart showed so much compassion and empathy towards my daughter. My daughter has regular checks, and he has made it less worrying for her to come back.	Patient relative

Respect	Alice Rigby, Sophie Adams and Lorna Peace	Aylesbury District Nurse Team	I must praise 3 community district nurses who have made a massive impact on my life, my family and in particular my mother. Sadly, Mum is now on end-of-life care since coming out of hospital and me and my sisters are caring for Mum 24 hours a day with the help of Carers, the District Nurses and Marie Curie nurses. These 3 District Nurses have been outstanding, the care, compassion and knowledge is phenomenal as mum is quite complex with advanced dementia she has a syringe driver, catheter, cannula, is no longer eating and only having a few droplets of water via a syringe. The District Nurses come every day to change the medication in the driver. We have also called them on numerous occasions, all hours of the day/night to come and give more pain relief. Nothing is too much bother for them. Even when I ring and I'm in tears and struggling to get my words out the admin ladies on the other end are so kind and compassionate.	Patient relative

June 2023

Category	**Name**	**Role**	**Nomination**	**Nominated by**
Collaborate	Jayne Rode & Kathryn Frechter	Administration Community Head Injury Service	Jayne and Catherine were instrumental in supporting their clinical colleagues to take on supportive administrative duties from them to create more capacity to complete clinical duties. The whole team came together to work through tasks they frequently did to see if these tasks could be done by others within the team. The admin team were open to supporting the team and took on multiple extra tasks to free up time for their colleagues. They were willing to test if this worked and although not everything was suitable most of the tasks trialled, they were able to complete. This helped the OT clinical staff to free up between 2 & 4 hrs per week to complete more clinical tasks. This was a fantastic team effort from the administrative team to support their colleagues.	Colleague
Aspire	Quasim Zaman, Filipe Ussene, Natasha Hamilton-Tanner	ICU Pharmacy Team	Natasha as the former pharmacy lead for the ICU and now the wider divisional lead has been instrumental in striving to staff the ICU pharmacy team properly in the face of increasing pressure on the pharmacy service, both before, during and since the Covid 19 pandemic. Natasha always went above and beyond her role working long hours and had significant input into establishing the ICCA electronic records including prescribing which went live in summer 2022. Philipe was recruited as a pharmacy technician and his role has been invaluable. Thanks to his diligence and commitment the ICU have saved a 5-figure sum on drug spend alone due to careful stock take and control. He provides regular updates on stock shortages and anticipates and sources alternative products to ensure there are no gaps. To provide an optimum service with limited resource Quasim has adjusted his hours and supports the ICU on both Saturday and Sunday mornings which makes a huge difference to the service we deliver. He joins the ward round, having already reviewed many of the patient's drug charts. He advises on switches to improve efficacy, reduce interactions, and make cost savings. My ward rounds function so much more efficiently with the presence of the pharmacy team, Quasim is a first point of call for advice on medicines and always does this with good humour and patience. The ICU pharmacy team are always trying to improve the excellent service they deliver and aspiring to be the best and I	Colleague

			would like this to be formally recognised through the CARE awards, as would my consultant colleagues on the ICU.	
Respect	Aleksandra Drewnowska	Physiotherapy Assistant Southern RRIC Team	Aleks demonstrated incredible compassion, patience and care during the initial assessment and aftercare of a non-English speaking patient approaching the end of life. She agreed to act as a translator and accompany the initial assessment to ensure that the patient's wishes and husbands wishes could be conveyed and to reassure the patients relatives who spoke English as a second language. Aleks was able to gain the confidence of the patient and family through her manner and use of humour which meant that all options for transfers and care could be explored. This included multiple complex moving and handling transfers during the provision of a hospital bed. Aleks then supported other staff during care visits meaning that the patients and family needs were supported during a difficult time.	Colleague
Enable	Various	Medical Photography Team	The medical photography team agreed to take photos of all shortlisted nominations for this year's Annual BHT Awards to enable us to include images on the event presentation. They created a timetable for us to send out to the nominees, providing drop-in sessions across the 3 main sites for individuals and smaller teams, but also offered to meet with teams to get larger group shots that could not be done in the studio, but to also maximise the number of people in the photo, especially in clinical settings where they are unable to leave their department for too long. There were a few images that had to be sent in by the nominees as they could not make it to one of the sites, and a few teams that sent in multiple images of their team as they could not get everyone together. Deniz worked his magic on the images, putting them all together to make it look like they were all in one photo! Having the photos in the presentation gave it an extra special touch and it was nice for the attendees and those watching the live stream to be able to put faces to names. Thank you for enabling us to create the perfect presentation.	Colleague

Appendix 4

Executive Management Committee and Transformation Board

Executive Management Committee 27 June to 11 July 2023

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

Summary of Internal Audit Work/Outstanding Actions
Approval to change use of area that was previously paediatric decision unit
Pharmacy Homecare Service
Quality Account
Diagnostic backlogs
Integrated Performance Report (Quality section)
National inpatient survey 2022
Getting it Right First Time Annual Report
Clinical Effectiveness Annual Report
Clinical Audit Plan 2023/24
Emergency Department observations report
Enteral feeding contract
Homelink Healthcare

Money and Estates

Productivity and efficiency weekly update
Wycombe Tower Report June 2023
Utilities Purchase Order Uplift
Waivers of Standing Financial Instructions
Future Delegation of Statutory Functions
Contract Management update

People

Safe Staffing Report
Medical Appraisal & Revalidation Annual Report
International recruitment
Divisional structure review
CARE Value awards

Digital and Governance

Minutes from EMC sub-committees
Data and Security Protection Toolkit: Internal Audit report

Transformation Board 19 July 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 meeting:

QI projects on a page
Corporate objectives progress update
Transformation portfolio overview

- Metrics and milestones
- Planned care

Transformation portfolio updates:

- Urgent and emergency care
- Healthy communities
- Digital
- Diagnostics

Project lifecycle management
Productivity and efficiency weekly update
Temporary staffing programme
Patient flow projects

Appendix 5

Place and System Briefing

July 2023

Place

Buckinghamshire Executive Partnership (BEP) meeting 11 July 2023

Item	Summary	Impact
Priorities update	Detailed scope of three agreed priorities: • Transforming Special Educational Needs & Disabilities • Joining up care • Tackling health inequalities	Report summarises key measures, milestones and activities, alongside progress and emerging risks/issues for each priority
Buckinghamshire Health & Social Care Academy	Overview of BHSCA aims, purpose, objectives, milestones and future aspirations	Paper also focuses on how the BHSCA workforce and training focus can support the three BEP priorities
Primary care deep dive	Report from The United Front for General Practice in Buckinghamshire (GPPA; an alliance) to inform a discussion on Primary care strategy	This detailed report identifies links to the BEP priorities as well as offering potential solutions for local issues including demand in urgent care, planned care, and estates and digital issues
Winter planning	Outline of the proposed approach to planning for winter 2023/24	Four key challenges identified, with proposed approach as a system described: • Primary Care Access • High Admission levels • Low Bed Capacity • High Delayed Discharges

Buckinghamshire Health & Wellbeing Board 22 June 2023
Papers are available here

Item	Summary	Impact
Joint Strategic Needs Assessment Update	The JSNA is a joint statutory obligation of Local Authorities and NHS Integrated Care Boards. The purpose is to improve the health and wellbeing outcomes of the local community and reduce inequalities for all ages.	The Buckinghamshire JSNA aligns with the Health & Wellbeing Board Strategy and three priority areas of Start Well, Live Well, Age Well. The full directory can be found here.
Joint Local Health & Wellbeing Strategy	Review of delivery of two of Joint Local Health and Wellbeing Strategy areas: • Improving outcomes during maternity and early years • Improving mental health support for Children & Young People, Adults & Older People	Of particular note are two projects under the Start Well priority: • Pre-conception health and service access/awareness pilot project • Improving the educational/parenting support available to families in deprived areas
Healthwatch Bucks Quarterly Overview	A review of the work undertaken by Healthwatch Bucks over the previous quarter	Two recent projects: • Young onset dementia • Early intervention for eating disorders: youth engagement in

		• Buckinghamshire
Buckinghamshire Executive Partnership	Summary of first meeting in May 2023, plus Health & Care Integration programme plan for 2023/24	Key developments of the Health & Care Integration programme include: • New bed-base • Integrated discharge team • Transfer of care hub • Trusted assessor model
Better Care Fund	Out-turn for 2022/23 and plan for 2023/25	This includes the majority of Trust adult community service provision and overseas implementation of additional discharge funding.
Integrated Care Partnership	Joint Forward Plans from the two Integrated Care Partnerships within the Buckinghamshire geography	Approved BOB Joint Forward Plan previously been to Board for comment.

System

BOB Integrated Care Board (ICB) 18 July 2023
The BOB ICB meeting takes place every other month and this month was the first with Nick Broughton as Interim CEO of the ICB, having taken over from Steve McManus at the start of July.

Papers are available here, and I would draw the Board's attention to the Performance report. Alongside other standing items on Finance and Risk, the Board considered the following for Approval:

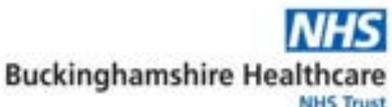
- Joint Forward Plan (final version)
- Interim People Plan – this is a short-term plan for 2023/24, to be followed by a longer term plan in light of the NHS England Long Term Workforce Plan publication
- Communications and Engagement Strategy

I would also highlight the report on progress against findings of a Peer Review by the Leading Integration Peer Support Programme.

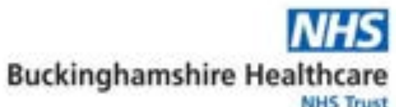
This meeting was my last as Provider Representative, with Steve McManus resuming this role on the BOB ICB having resumed his position as CEO of Royal Berkshire NHS Foundation Trust.

Report from Chair of Audit Committee
Date of Committee 13 July 2023

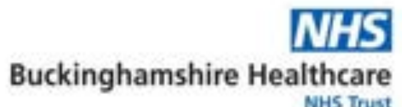
Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Minutes of the previous meeting	Minutes from the Audit Committee meeting on 04 May 2023	Approved	None	n/a	n/a
Action Matrix	Consideration of actions ongoing and proposed to close Focussed conversation on Trust Policies	Partially assured – noting controls in place including access via Trust intranet, statutory/mandatory training and clarity on professional responsibilities	Consideration of how best to assess and ensure broad compliance with Trust policies and focus on providing summary pages for all policies of significant length to support ease of reading	n/a	n/a
Committee Terms of Reference	Amendment of Committee Terms of Reference to reflect oversight of the Data Security and Protection Toolkit compliance	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 robust monthly processes in place for updating actions and regularly scheduled review of relevant risks by Quality, Finance and People Committees (visible to Audit Committee through review of minutes)	Committee review of risks to be reflected within BAF	Executive review of Principal Risk 4 and provision of further detail on actions related to reduction in community paediatric waiting lists	To note report and Committee discussions
Audit Committee Annual Report	Annual report for 2022/23 outlining how the Committee has discharged its responsibilities and met its terms of reference	Approved	None	n/a	To note
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



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Internal Audit; Progress Report	Update on progress with annual plan including presentation of four final reports: - Mortuary Security (RA)* - Mandatory Training (SA)* - Chaperoning Policy (PA)* - Data Security & Protection Toolkit (Unsatisfactory)	Assured – noting levels of assurance	Greater consideration of chaperoning within Community services	n/a	n/a
Internal Audit; Recommendations Follow Up Report	Update on actions and recommendations followed up since last meeting	Partially assured – Committee raised concerns re: culture around management actions	In view of late updates, further paper to be circulated to the Committee by end July From next meeting, lead Executive Director to attend meeting for any overdue actions	n/a	n/a
Local Counter Fraud Specialist (LCFS); Annual Report	Final Annual Report for 2022/23 including extract of the NHSCFA Functional Standard Return	Noted	None	n/a	n/a



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
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 – noting proactive working to raise awareness within the Trust, improve referral activity and share risks between organisations	None	n/a	n/a
LCFS Benchmarking Report	Details of reactive fraud referrals across the internal audit client base	Noted	None	n/a	n/a
LCFS Fraud Spotlight Document	Focus on Dual Working	Noted	None	To be considered by the Strategic People Committee at next meeting (September 2023)	n/a
Single Tender Waivers (STW)	Overview of STW between March-April 2023 including those considered to be avoidable and retrospective	Assured – including simplicity of reporting and reduction in numbers	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Non-Waiver Notifiable Payments	Overview of payments made outside of the Standing Financial Instructions (not included within the STW report)	Assured – including rationale for payments	Review of relevant limits to be included in review of Governance Manual (BHT Pol 089)	n/a	To note report
Losses and Special Payments	Summary of YTD losses including pharmacy and patient property	Noted – including significant reduction; to for ongoing trend	None	n/a	n/a
Data Security and Protection Toolkit (DSPT)	Update on Trust self-assessment, internal audit report and overall compliance	Partially assured – noting variation in self-assessment and internal audit findings but overall significant progress	None	n/a	To note
Minutes of Finance & Business Performance Committee	Minutes from F&BP Committee Meeting on 23 May	Noted	None		n/a
Minutes of Strategic People Committee	Minutes from SPC Committee Meeting on 15 May 2023	Noted	None		n/a

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

Emerging Risks Identified:

- Culture related to management actions; need to strengthen local ownership and commitment to timely completion of actions mandated by Board Committees.
- DSPT action timetable fitted to NHSE requirements may be unrealistic.
- Partial assurance opinion on Chaperoning Policy demonstrates unknown/incomplete awareness/compliance with Trust policies.

Meeting: Trust Board Meeting in Public

26 July 2023

Agenda item	Committee Terms of Reference
Board Lead	Trust Board Business Manager
Type name of Author	Joanna James, Trust Board Business Manager
Attachments	Audit Committee Terms of Reference APPROVED_March 2023_Amended_July 2023
Purpose	Approval
Previously considered	n/a

Executive Summary

The attached document contains the terms of reference for the Audit Committee which were considered and approved by the Committee and Trust Board in March 2023.

Following:

a) Transfer of responsibility of oversight of the Data Security & Protection Toolkit (DSPT) from the Finance & Business Performance Committee to the Audit Committee and;
b) Recommendation by Internal Audit to ensure this was reflected within Committee Terms of Reference ahead of the annual review to ensure all Committee members were aware of this change;

an additional sentence has been added to Page 5 ('Other Assurance Functions') to reflect this and is highlighted in red for ease.

The Terms of Reference were considered by the Audit Committee on 13 July 2023. These were recommended for approval by the Trust Board.

Decision	The Board 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	A key duty of the Audit Committee is to monitor the effectiveness of risk management, integrated governance and internal control across the whole of the Trust's activities. The CRR and BAF are considered at every meeting and the Committee are instrumental in driving improvement and integration in the reporting of these.
Financial	As per the terms of reference, the Committee is required to review the Annual Report and Financial Statements prior to submission to the Board as well as

	ensuring the systems of financial reporting are subject to review.
Compliance Select an item. **Good Governance**	The UK Corporate Governance Code requires the Board to establish formal and transparent procedures to ensure the independence and effectiveness of internal and external audit functions. The Code clearly sets these out as functions of an Audit Committee making clear terms of reference essential. Internally, the Committee is responsible for the review of processes in use by the other Board Committee to gain assurance.
Partnership: consultation / communication	The Committee works collaboratively with members of the Internal and External audit teams. The terms of reference should be considered by the Committee collectively prior to amendment and/or approval.
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. The Trust Strategy references the 5 People Priorities acknowledging the importance of ED&I within the leadership of the organisation.
Quality Impact Assessment [QIA] completion required?	No

See attached document.

Audit Committee
Terms of Reference

1. Purpose

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

- Review the establishment and maintenance of an effective internal control and risk management process across the whole of the Trust's activities that supports the achievement of the Trust's objectives;
- Monitor the integrity of the financial statements of the Trust;
- Monitor the independent auditors' qualifications, independence and performance;
- Monitor the performance of the Trust's Internal Audit function and Local Counter Fraud provision;
- Make recommendations to the Board on the appointment of external and internal auditors; and
- Monitor compliance by the Trust with legal and regulatory requirements.

2. Constitution

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

3. Membership

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

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

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

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

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

- Chief Finance Officer
- Trust Board Business Manager
- Committee Secretary
- Clinical representative
- Local Counter Fraud Specialist (LCFS).

- Representative from External Audit
- Representative from Internal Audit

Others may be invited to attend according to the agenda

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

4. Quorum

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

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

5. Meetings

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

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.

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

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

6. Authority

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

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

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

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

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

7. Duties

The Audit Committee shall be responsible for the following duties:

7.1 Governance, Risk Management and Internal Control

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

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

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

the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

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

7.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

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

7.3 Local Counter Fraud Service

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

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

7.4 External Audit

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

- Consideration of the appointment and performance of the external auditor;
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan, and ensure coordination, as appropriate, with other external auditors in the local health economy;
- Discussion with the External Auditor of their local evaluation of audit risks, their assessment of the Trust and the associated impact on the audit fee;
- Review of all External Audit reports together with the management responses;
- Agreement of the annual audit letter before submission to the Board and agreement to any work falling outside the annual audit plan; and
- The Committee will monitor the implementation of the policy on the engagement of the external auditor to supply any non-audit services to ensure the external auditor retains a high degree of independence from the Trust.

7.5 Other Assurance Functions

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

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

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

The Committee will also monitor the use of Single Tender Waivers (STW) and losses and special payments and have oversight of the Data Security Protection Toolkit (DPST).

7.6 Management

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

7.7 Financial Reporting

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

- The wording in the Annual Governance Statement and other disclosures within the terms of reference of the Committee;

- Changes in, and compliance with, accounting policies and practices;
- Unadjusted misstatements in the financial statements;
- Significant judgements in the preparation of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

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

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

8. Reporting

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

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

9. Review

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

10. Support

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

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

Appendix 1

Annual Objectives

Recognising the assurance function of the Committee, the Committee objectives for the financial year 2023-2024 are as follows:

a) External Audit
   i. Appointment of External Auditors
   ii. Achievement of unmodified external opinion and clean value for money (VfM) opinion
b) Internal Audit
   i. Effective identification of areas of risk for internal audit focus through horizon scanning and triangulation with emerging risks
   ii. Support for improved management of resultant actions
   iii. Improvement in ratings when compared to previous audit opinions
c) Compliance with Legislation
   i. Trust compliance with all legislative/regulatory requirements OR assurance provided by the implementation of an action plan to address any gaps in compliance
d) Risk Management
   i. Committee workplans inclusive of CRR and BAF items

The appropriateness of these objectives will be considered as part of the annual review of the Terms of Reference.

Document Control

Version	Date	Author	Comments
1.0	1 Dec 2013	E Hollman	Revised Draft for Committee Chair
1.1	17 March 2014	B Courtney	Revised draft following Audit Committee
1.2	26 March 2014	B Courtney	Board approved.
1.3	27 August 2015	N.McKechnie	Periodic review for Committee
1.4	22 December 2016	E Hollman	Periodic review for Committee
1.5	24 January 2018	E Hollman	Periodic review for Committee
1.6	4 January 2019	E Hollman	Periodic review for Committee
1.7	24 January 2022	J James	Periodic review for Committee
1.8	20 February 2023	J James	Periodic review for Committee Approved by Audit Committee March 2023 Approved by Board March 2023
1.9	6 July 2023	J James	Amendment to include oversight of the Data Security & Protection Toolkit (DSPT) *Responsibility transferred from F&BPC*

Meeting: Trust Board Meeting in Public

26 July 2023

Agenda item	Audit Committee Annual Report 2021-22
Board Lead	Audit Committee Chair
Type name of Author	Joanna James, Trust Board Business Manager
Attachments	Audit Committee Annual Report 2022-23
Purpose	Assurance
Previously considered	Audit Committee 13.07.2023

Executive Summary

In line with best practice, the Audit Committee should prepare an annual report for the Trust Board that sets out how the Committee has discharged its responsibilities and met its terms of reference. The attached report considers the purpose of the Audit Committee, its key duties and how these have been fulfilled during the financial year 2022-23.

The Audit Committee approved this report at the meeting on 13 July 2023.

Decision	The Board is requested to note the contents of this work, suggest any amendments and approve for onward presentation to the Trust Board.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	A sound and effective framework of governance supports an environment within which high quality safe healthcare can be delivered.
Risk: Link to Board Assurance Framework (BAF)	The Audit Committee has a pivotal role in reviewing the establishment and maintenance of an effective internal control and risk management process across all Trust activities that support Trust objectives.
Financial	The terms of reference describe 'Financial Reporting' as a key duty of the Committee. This includes a review of the annual report and financial statements before submission, monitoring compliance with the Standing Orders and Standing Financial Instructions and review of the systems of financial reporting and budgetary control.
Compliance CQC Standards 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	This report considers the joint work of the Committee with both internal and external

	auditors and the Local Counter Fraud Specialist (LCFS).
Equality	In order to embed ED&I within the organisational culture, this should be considered at Board level. Whilst the report does not reference equality directly, Audit Committee members are committed to the Trust's inclusive culture and focus on ED&I and consider this during discussions.
Quality Impact Assessment [QIA] completion required?	n/a

APPENDICES
Appendix 1: Audit Committee Annual Report 2022/23

Audit Committee
Annual Report 2022/2023

1.0 Introduction

The purpose of this report is to set out how the Audit Committee has discharged its responsibilities and met its terms of reference during the financial year; 2022/2023.

2.0 Overview of the Committee

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

- Review the establishment and maintenance of an effective internal control and risk management process across the whole of the Trust's activities that supports the achievement of the Trust's objectives;
- Monitor the integrity of the financial statements of the Trust;
- Monitor the independent auditors' qualifications, independence and performance;
- Monitor the performance of the Trust's Internal Audit function and Local Counter Fraud provision;
- Make recommendations to the Board on the appointment of external and internal auditors; and
- Monitor compliance by the Trust with legal and regulatory requirements.

The Audit Committee is an advisory body and a non-executive Committee of the Board with no executive powers, only those delegated within the terms of reference.

3.0 Committee Meetings

During 2022/2023, the Audit Committee met 8 times. This was in line with the requirement from the terms of reference to meet on at least four occasions.

The dates of the meetings were as follows.

- 22 April 2022 (extraordinary meeting)
- 6 May 2022
- 20 June 2022 (extraordinary meeting)
- 7 July 2022
- 1 September 2022
- 4 November 2022
- 12 January 2023
- 2 March 2023

As per the terms of reference, each meeting was minuted and an action log formulated. A summary of each meeting was provided to the next Trust Board meeting in public.

4.0 Committee Membership

The Audit Committee membership consists of four non-executive directors, plus the Committee Chair. This is above the recommendation within the Committee terms of reference which required up to four non-executive who were financially literate and had the personal and professional characteristics necessary to be effective.

For the financial year 2022/23, members were:

- Mr Rajiv Jaitly (Chair)
- Dr Dipti Amin
- Mrs Nicola Gilham
- Mr John Lisle
- Mr Tom Roche

The terms of reference note the expectation that Committee members attend each meeting. Attendance at Audit Committee meeting is documented within the meeting minutes and summarised within the Trust Annual Report. The below table demonstrates member attendance across all eight Committee meetings.

All meetings were quorate; two members were required for quoracy.

	R. Jaitly	N. Gilham	J. Lisle	T. Roche	D. Amin
22 April 2022 (EM)	√	√	√	x	√
6 May 2022	√	√	√	√	√
20 June 2022 (EM)	√	√	x	√	√
7 July 2022	√	√	x	√	X
1 September 2022	√	√	√	√	x
4 November 2022	√	√	√	√	√
12 January 2023	√	√	√	√	√
2 March 2023	√	√	√	√	x

EM – Extraordinary Meeting

Apologies were received in advance for all members who were unable to attend.

The table below demonstrates attendance of Committee attendees:

	CFO	Clinical Rep.	Other EDs	TBBM	LCFS	External Audit	Internal Audit
22 April 2022 (EM)	√*	x	x	√	x	x	X
6 May 2022	√	√*	√	√	√	√	√
20 June 2022 (EM)	√	X	x	√	x	√	√
7 July 2022	√	x	√	X	√	√	√
1 September 2022	√	√	√	√	√	√	√
4 November 2022	X	√*	√	√	√	x	√
12 January 2023	√*	√	√	√	√	x	√
2 March 2023	√	√	√	√	√	x	√

CFO – Chief Finance Officer, Clinical Rep. – Clinical Representation from Executive Team; CN/CMO, EDs – Executive Directors, TBBM – Trust Board Business Manager, LCFS – Local Counter Fraud Specialist
**Denotes attendance by a Deputy.*

5.0 Committee Terms of Reference

The Committee terms of reference were reviewed in March 2022 and subsequently approved by Trust Board. These terms of reference outline a number of key duties of the Committee. Activities during the financial year 2022/23 will be summarised under each of these headings.

5.1 Governance, Risk Management and Internal Control

During the financial year 2022/23, further work was undertaken to integrate the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) reporting. During 2022, the CRR migrated to the updated Datix© system to provide greater visibility and reporting functionality and a more robust audit trail. In June 2022, the Board participated in a risk workshop which resulted in a revised set of Principal Strategic Risks and a review of the risk appetite for each.

Reporting was revised in line with these. Reporting on the BAF also evolved to link emerging risks with Committee action matrices to ensure there was adequate oversight of these. In March 2023, the first iteration of an ‘Organisational Risk’ report was presented to the Committee to provide a global view of current risk across the organisation, considering both strategic and operational risks against the risk appetite for such. This report continues to develop with input from Committee members.

At the extraordinary meeting on 20 June 2022, the Committee reviewed the draft Trust Annual Report including the Annual Governance Statement (AGS) for 2021/22. This was recommended to Board for final approval, concluding that the content of the AGS was consistent with the view of the Committee on the organisation’s system of internal control.

In October 2022, the Audit Committee recommended the Trust Risk Management Policy to Board following a thorough review and suggested amendments. This was subsequently approved. The Committee noted a programme of theoretical risk training was rolled out across the organisation during 2022/23 alongside Datix© support sessions, primarily focused on those within divisional triumvirate and governance lead roles.

5.2 Internal Audit

The Trust internal audit function continued to be provided by RSM. The annual plan of internal audit work for 2022/23 had been considered and adopted during the previous financial year. At each meeting, the Committee considered the findings from internal audit reports issued and progress made with implementing agreed management actions and with the overall plan of work. The planning was approached by considering organisational risks and a three-year cycle of reviews of key control areas (both completed and planned) and the results of those completed reviews.

Concern had been raised by internal audit and the Committee during the previous financial year on the lack of pace and progress with management actions. Following a change in processes during the previous year, the Committee had seen an improvement although there remained concern during 2022/23. During the year, executive directors attended the Committee where any internal audit reports gained a partial or minimal assurance opinion and to address any actions for which no update had been provided. The Committee noted that all reports with partial or minimal assurance opinions were also reviewed in detail by the Executive Management Committee.

The Head of Internal Audit Opinion (HOIA) summarises the work undertaken by the team during the year and provides assurance on the effectiveness of the organisation’s system of control. The HOIA for 2022/23 stated “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”. This reflected the six reports presented to the Committee issued with partial assurance.

Areas considered by internal audit during 2022/23 were as follows:

- Waiting list management policies (partial assurance).
- CQC (partial assurance).
- Clinical audit (partial assurance).
- Data management (partial assurance).
- Contract management – major contracts (partial assurance).
- Complaints (partial assurance).
- Business cases (reasonable assurance).
- Payroll (reasonable assurance).
- Financial systems – general ledger & treasury management (reasonable assurance).
- Risk management and assurance framework (reasonable assurance).
- Serious incidents (reasonable assurance).
- Security arrangements including mortuary – work ongoing.
- Data security & protection toolkit – independent assessment against standards.
- Financial sustainability – advisory review; performance above average.

The annual plan of internal audit work for 2023/24 was approved by the Committee in March 2023.

5.3 Local Counter Fraud Service

The Trust has a nominated Local Counter Fraud Specialist (LCFS), fully accredited which has continued to be provided by RSM. The annual counter fraud plan had been previously approved for the financial year 2022/23 and the LCFS was invited to all Committee meetings to present reports on progress with the programme of work. In May 2022, the annual return to the NHS Counter Fraud Authority was discussed and following which, submitted and subsequently signed off by the Chair of the Audit Committee and the Chief Finance Officer.

The annual programme of work for 2023-24 was approved by the Committee in March 2023.

5.4 External Audit

During 2021/22, the external audit function was provided by Grant Thornton. At the extraordinary meeting on 20 June 2022, the Committee reviewed the audit report findings, annual report and accounts and the letter of representation.

The Trust remains without external auditors for the 2022/23 audit and due diligence is underway with a potential provider to complete the audit in December 2023. The Committee note this is reflective of national challenges with NHS Trusts being unable to secure external auditors. Regular briefings were provided to Committee members during 2022/23 to update on this.

No work was conducted for the Trust by Grant Thornton between April 2021-March 2023 that fell outside of the scope for independence on the audit of the financial systems. In March 2023, the Committee approved a Standard Operating Procedure (SOP) setting out the role of the Audit Committee in the appointment of external auditors for non-audit work with a plan to revisit this in line with the annual review of the Committee terms of reference.

5.5 Assurance Function

Both Single Tender Waivers (STW) and Losses and Special Payments were standing agenda items for the Committee during the year with significant work undertaken to the development of STW reporting in line with best practice and an reduction in the number of retrospective and avoidable waivers seen (breaches to the Trust Standing Financial Instructions). In addition, the Committee were presented with updates on the progress with the Clinical Audit plan, being mindful of the scope of the detailed work conducted by the Quality & Clinical Governance Committee.

The Committee is required to keep under review its own working arrangement and is mindful of the need to ensure that it's remit fits with that of other Board Committees. The annual Committee self-assessment was conducted during the summer of 2022 with recommendations presented to the Committee at the September meeting. Where appropriate, these were included within the terms of reference approved in March 2023.

Meeting minutes from the Finance and Business Performance, Quality and Clinical Governance and Strategic People Committees were received by the Audit Committee at each meeting to provide assurance on their oversight function. Items were referred between Committees for greater scrutiny where appropriate.

Reports of the Freedom to Speak up Guardian are received by the Strategic People Committee (SPC) ahead of Trust Board. These are monitored by the Audit Committee through receipt of SPC minutes. Reports on External Reviews were received by the Quality & Clinical Governance Committee (QCGC) during 2022/23 and these were monitored by the Audit Committee through receipt of QCGC minutes. The External Reviews policy is currently under review.

5.6 Financial Reporting

The Committee meeting on 22 April 2022 received and considered the annual financial statements for 2021/22 along with papers setting out the judgements on going concern and the management judgments identified for the preparation of the accounts. Following a detailed review, the Committee recommended the accounts be adopted by the Trust Board which they subsequently were.

Training was provided for the Committee in May 2022 which provided an overview of the function of the audit committee, the relationship with internal and external audit functions and an understanding of NHS accounts and the audit process. The Committee are currently considering the most effective training topics for 2023/24.

Opportunities were provided throughout the year for meetings between the Committee members with both internal and external auditors in the absence of the executive team and the Chair of the Audit Committee met regularly with internal auditors during the course of the year and external auditors early in the year in relation to the 2021/22 audit.

Conflicts of interest of the Committee continue to be monitored.

6.0 Conclusion

This report sets out the manner in which the committee has discharged its functions during the year, the material areas it has focussed on and sought assurance on. There are no other material concerns within the scope of its functions that need reporting.

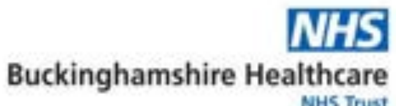
Members of the Committee look forward to continuing on the journey toward good governance and financial sustainability for the Trust.

7.0 Action Required

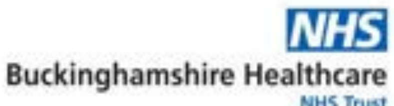
The Committee are requested to note the contents of this report, reflecting the work of the Audit Committee during the financial year 2022-23 and consider any amendments.

Report from Chair of Quality and Clinical Governance Committee (Q&CG)
Date of Committee 19 July 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 17 May 2023	Minutes approved	None	Refer to Audit Committee for noting	n/a
Integrated Performance Report (IPR)	Monthly reporting on Trust quality metrics and actions/progress with actions to address negative variance Report presented in a revised format with inclusion of additional metrics	Assured – noting improvements in complaint response times and MRSA incidence as per emerging risks	Following improvement in pressure ulcer metrics, replicate lessons learned for falls Committee to agree targets/ambitions related to new quality metrics Consider how best to ensure visibility of letters of concern received following receipt of concern regarding maternity triage	n/a	To note the quality metrics for June 2023 and Committee discussions
Patient Safety Incident Response Framework (PSIRF)	Update on progress with implementation of PSIRF following introduction in April 2023	Noted – including significant organisational cultural shift required and change in focus to quality of 72-hour reports and referral to full investigation only where additional learning is anticipated	Maintain golden thread of key goals of framework throughout Committee reporting	Board seminar planned for October 2023 to support engagement in setting priorities and quality requirements	n/a



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Emergency Department (ED) Observation	Proposal for undertaking observations within the ED including use of e-Obs (electronic observations) and in line with the National Early Warning Score (NEWS) model	Assured – noting workstreams underway to improve ED flow more broadly	Build in a robust mechanism through clinical audit for providing Board oversight of timely observations within the ED Share full SI report with the Committee once finalised	n/a	n/a
Dementia Rapid Review Cabinet Recommendation Response	Proposal for the Trust to use the 'This is Me' campaign to capture information about individuals with dementia and embed the principles of 'John's Campaign', enabling family to remain with the person during an acute hospital admission	Approved – noting this was evidence based best practice for patients with dementia but there would be benefits in using across other long-term conditions	Ongoing work to streamline the use of one document across the patient's home and ambulance hospital services	n/a	n/a
Quality Priority Report	Overview of progress to date against the Quality Priorities set out in the Quality Strategy	Assured – noting the positive reporting and learning culture of the organisation Committee noted the national drive for Patient Initiated Follow Up (PIFU) and were supportive of Trust approach to support key specialties with PIFU as well as increasing new appointments across all specialties	Consider global measures of patient safety, patient experience and clinical effectiveness	n/a	n/a

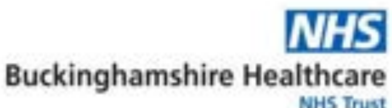


Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Patient Story	Stories of Peter and Laurel, who share their experiences of living with Parkinson's Disease patients at BHT	Noted – including the importance of considering the use of Trust services through the patient lens Committee acknowledged the benefit of patient support, targeted colleague education and a bid for funding to support an innovative in-reach service	Consider revisiting all patient stories one year on to review changes in services	n/a	To note the stories of Peter and Laurel and feedback
Nursing Safe Staffing Report	Overview of nursing staffing metrics for May 2023 in line with the National Quality Board (NQB) Standards	Assured – noting robust processes in place for overseeing nursing staffing and the reduction in agency usage alongside a rise in colleagues joining the bank	None	n/a	n/a
Emergency Department (ED) Deep Dive	Overview of the Urgent & Emergency Care (UEC) Programme and deep diver into ED quality metrics	Noted	Greater focus on integration of acute and community services		
Integrated Safeguarding Annual Report	Summary of safeguarding activities Trust strategic objectives for 2022/23	Noted – including a significant increase in training compliance and the risks as outlined below	Committee to be kept informed of progress in system workstreams to support safeguarding capacity more broadly	n/a	To note

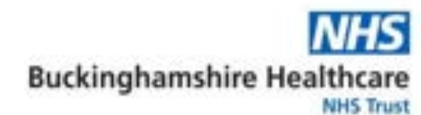
Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Medicines Management Report	Summary of Pharmacy activities through 2022/23 in line with the Trust strategic objectives	Assured – noting proactive antimicrobial stewardship, oversight by the Medical Gases Committee of nitrous oxide and early-stage development of outpatient pharmacy delivery service by BHPL	Results of the room-by-room review related to nitrous oxide use and ventilation to be presented to the Committee on completion Greater Committee oversight of NICE guidance compliance related to medicines	n/a	n/a
Quality & Patient Safety Group Minutes	Minutes of the meeting on 29 June 2023	Noted	Revised Governance and Performance Framework to be shared with the Committee	n/a	n/a
Mortality Reduction Group Minutes	Minutes of the meeting on 15 May 2023	Noted – including improvements in timeliness of completion of Medical Cause of Death Certificates	None	n/a	n/a

Emerging Risks noted:

- Further incidence of MRSA against annual trajectory of zero cases, noting this as a national issue.
- Pharmacy staffing levels and associated impact on capacity affecting a number of programmes including Homecare and Cancer.
- Safeguarding:
    - Ongoing risk related to delayed Deprivation of Liberty applications (DoLs).
    - Organisational capacity to apply the Mental Capacity Act (MCA).

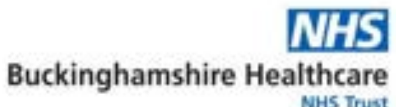


- Violence and aggression toward colleagues from patients and relatives, particularly toward international nursing colleagues and ahead of Winter months noting a recent revision of the Violence and Aggression Policy.

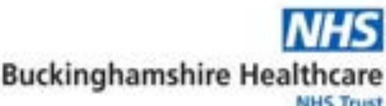


Report from Chair of Strategic People Committee (SPC)
Date of Committee 10 July 2023

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 15 May 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 (May 2023)	Assured – Committee welcomed the publication of the NHS Workforce Plan	None	n/a	n/a
Health & Safety Annual Reports	Annual reports for 2022/23 across the following areas: - Health & Safety - Fire Safety - Security	Assured – including further improvement work planned	Further consideration on appropriate use of alerts for violent and aggressive individuals	n/a	To take assurance from the suite of reports and Committee discussion
National Health & Safety Executive (HSE) investigation; letter to NHS Trust Boards	HSE findings on the management of risks from workplace violence and aggression and musculoskeletal disorders in the NHS including Trust response	Assured – noting actions in place at BHT to protect staff from both violence and aggression and MSK injury	As per actions outlined	n/a	To note HSE letter and take assurance from the actions in place to protect staff



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Medical Appraisal & Revalidation Report	Annual submission for medical appraisal activity during 2022/23	Assured – noting robust and supportive processes in place to facilitate compliance	Update to the Committee to provide assurance of follow up in all outstanding areas and number of outstanding appraisals ahead of approval and sign off (see paper for details)	n/a	To approve and delegate sign-off of the statement of compliance by the Chief Executive Officer
Guardian of Safe Working Hours; Annual Report	Annual report for 2022/23 including annual comparative data for exception reports and immediate safety concerns	Assured – noting focused work in the Cardiac & Stroke Receiving Unit (CSRU) and Trauma & Orthopaedics (T&O)	Addition of benchmarking data from other similar NHS trusts and further information on closure of immediate safety concerns	n/a	To take assurance from the report
Corporate Performance Review	Quarterly review (Q1; April-June 2023) of performance within the People Directorate Included update on staff survey, People Promise Programme, temporary staffing programme, financial management and breakthrough objectives	Assured	None	n/a	n/a



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Transformation Objectives	Update on Trust Breakthrough Objectives related to People	Assured – particularly impact of eRostering roll out on Trust productivity	None	n/a	n/a
Integrated Performance Report	Monthly reporting on Trust performance metrics and progress with actions aligned to the Trust Strategic Priorities and the NHS System Oversight Framework May 2023 data presented within formal IPR with verbal update for June 2023	Assured – noting improved turnover rates and focussed tracking on individuals within first 12 months and reduction in recruitment timescales	Consider adding data on first year leavers to the IPR noting information is available in other reports and there may be a need to remove an existing IPR metric	n/a	To note updated People metrics and Committee conversation related to these

Emerging Risks Identified:

- No new emerging risks noted during the meeting.

Meeting: Trust Board Meeting in Public

26 July 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 June 2023	
Purpose	Assurance	
Previously considered	Transformation Board 19.07.2023 F&BPC 25.07.2023	

Executive Summary

June's IPR has updated content which reflects the Trust's key objectives for 2023/24. The new presentation reflects best practice using Statistical Process Control (SPC) charts to better highlight areas of success and challenge. The report highlights:

- Progress against cancer care.
- A challenging month in UEC.
- Improvement in recruitment.

The IPR was considered by Transformation Board on 19 July 2023 and noted the Trust were currently at OPEL 2, there had been an improvement in statutory and mandatory training compliance and complaint response times and a reduction in Medically Optimised for Discharge (MOfD) numbers. The group welcomed the new format of the IPR. Further detail on community waiting lists including a breakdown of these were requested as well as a focus on improving diagnostic performance where there were not significant structural issues and associated actions already in place. The group discussed the increase in the overall acute waiting list and asked for further assurance that the growth would be contained in line with the annual plan submitted.

A verbal update on the discussions held at the Finance and Business Performance Committee on 25 July will be provided to Board.

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 Good Governance	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

Integrated Performance & Quality Report

June 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 Trust's three strategic objectives and the Trust Improvement Programme.

Outstanding Care

Provide outstanding cost effective care

Operational Standards

- Urgent Emergency Care Recovery
  - ED Performance
  - Ambulance Handovers
  - Emergency Admissions
  - Length of stay
  - Urgent 2 hour response
- Elective Recovery
  - Waiting List
  - Activity
  - Theatres
  - Outpatients
  - Community waiting list
  - Cancer
  - Diagnostics

Quality and Safety

- Incidents
- Infection Control
- Patient Safety
- Patient Experience

Healthy Communities

Taking a lead role in our community

- Community Contacts
- Cardiology referrals from deprived wards
- Maternity smoking & breastfeeding
- New Birth Visits Within 14 Days
- Child health reviews

A Great Place to Work

Ensuring our people are listened to, safe and supported

People

- Vacancies
- Turnover
- Occupational Health
- Sickness
- Training

Report changes this month

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

Added

Removed

Changed

Integrated Performance & Quality Report

Buckinghamshire Healthcare NHS Trust

Executive Summary

June's IPR has an updated content that reflects the Trust's key objectives for 2023/24 as set out in its Operating Plan. In addition, the presentation has changed to follow best practice for Statistical Process Control charts to better highlight areas of success and improvement and where those changes can be deemed as sustainable. This should better guide understanding of the various metrics in the IPR and where focus is needed on learning from successes and challenges that need to be addressed. This is a draft of a new format with feedback requested as it continues to evolve the transparency of the Trust's Performance.

Operationally June continued to be a challenging month for the Trust with limited progress made on Urgent and Emergency Care as part of the Urgent and Emergency Care Improvement Programme in the Trust and integration work in the council continue to be implemented. An improvement in performance is expected in July with further improvements due in August as a result of the bedding in of key changes to the opening hours of the Urgent Treatment Centre at Stoke Mandeville Hospital and the Same Day Emergency Care Unit and reductions in the numbers of Medically Optimised for Discharge Patients and the bed days they spend in hospital. Unvalidated data in July shows this improvement is starting to be achieved in the first half of the month. There is further progress also expected and planned on our virtual wards to significantly increase capacity and return to trajectory by September with expansions due across frailty, cardiology and other services.

With regards to elective care, the Trust continues to make good progress in cancer care improvement although key tumour sites remain challenged in delivering sustainably due to rapidly increasing referrals and workforce challenges. Recruitment plans are in train to address this. The elective waiting list size has risen over recent months and this is a reflection of moving patients quicker from the referral stage to a single waiting list. Progress on 65 week wait reduction has been hampered by continued industrial action which is removing large amounts of elective activity and making it challenging to consistently drive through high volumes of patients needed to rapidly reduce the waiting lists. This is a position mirrored across the NHS. Actions have been taken to increase booking capacity and convert theatre capacity to outpatients which will aid seeing patients earlier in the pathway. The elective waiting list size has risen over recent months and this is a reflection of moving patients quicker from the referral stage to a single waiting list. Additional funding received for community children's services will also enable a reduction in long waiters and waiting lists in these areas. Diagnostic capacity remains challenged and the Committee and Board are receiving a detailed paper on backlog reduction plans through additional external investment that will significantly improve the position.

Our overall vacancy rate is reducing month on month (having increased from April due to the uplifted budgeted establishment) and is now 10.4%. We continue with our successful nurse recruitment, in particular from overseas. Alongside this we have a focus on the recruitment of temporary staff into our substantive workforce vacancies, as part of our temporary staffing usage reduction programme of work. Our turnover rate has consistently fallen for over 12 months and is now at to 11.6% (June 23). We are part of the National People Promise exemplar programme (now in its second year), which is a key driver of these improvements. The Programme focuses on improving retention at BHT and incorporating national best practice.
Sickness absence is reducing, although there has been a small increase in-month of absence due to Stress & Anxiety. The numbers of colleagues accessing support from our Occupational Health and Wellbeing team remains high.
The overall compliance with Statutory and Mandatory training has increased to over 90% (the Trust target), as the annual appraisal process is underway across the organisation during Q1.

With regards to Quality and Safety, key areas to draw out include:
Complaints compliance rate of 94% for 25 days response time with set target achieved for the first time since 85% target restarted post COVID-19 pandemic. No complaints outstanding for 90 days in June 2023 and this metric is demonstrating special cause variation of an improving nature with a downward trend of the last eight data points.
One MRSA bacteraemia case has been reported in June 2023. The Post Infection Review (PIR) has taken place and learning identified. A multi-disciplinary team action plan has been developed which will be reviewed in the divisional governance meeting and reported to Infection Prevention and Control Committee (IPCC) in July 2023 meeting.
Clostridium difficile infection (CDI) showing special cause variation of an improving nature with the last six data points falling below the central line
Inclusion of clinical accreditation programme and PALS performance metrics in the newly revised Trust IPR. Both metrics achieving the set target during June 2023 performance
HSMR for March 2023 is 89.8 and classified as "lower than expected".
Continue to achieve set target on VTE risk assessment completion compliance. EWS compliance experiencing special cause variation of an improving nature with the last six data points falling above the central line.

Healthy Communities is making progress against this year's priority areas, with maternity tobacco dependency service initiated, trajectory and target agreed and plans being developed to increase referrals to cardiology from the most deprived areas, and early identification of frailty of those attending ED.

Integrated Performance & Quality Report

NHS 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 two years' worth of data to show the post Covid period (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.

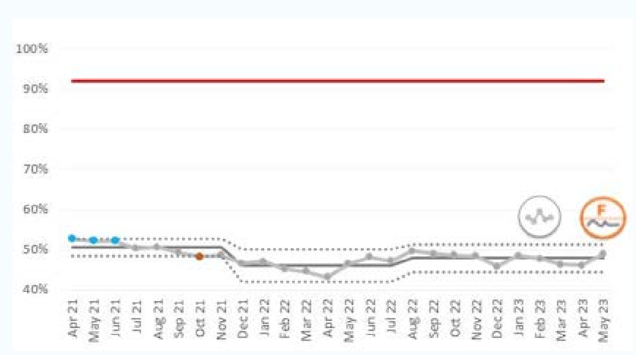
In these charts, where it looks like there has been some kind of change in the variability or average result in the reported data, the limits and the central line have been adjusted to indicate when it appears - statistically - that the change happened. This should be a prompt for users of the chart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

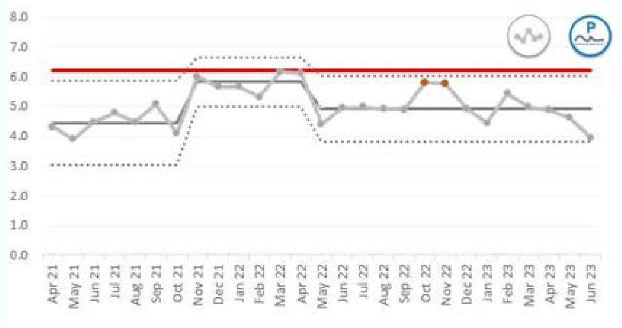
Either way, users of the charts should take care not to directly attribute causal factors to changes in the charts without further investigation.

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.

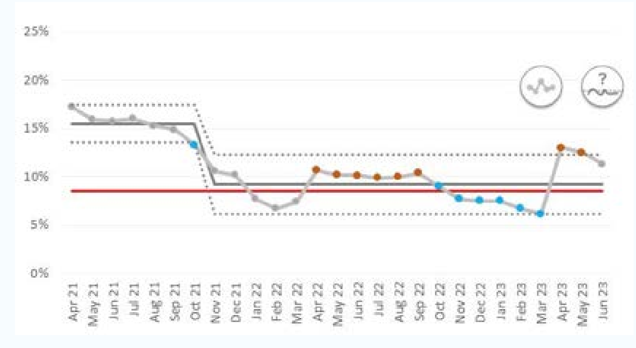
Target line is above the upper limit for this indicator (higher is better) showing that it will not be achieved consistently



Target line is above the upper limit for this indicator (lower is better) showing that it will be achieved consistently without a



Target line is between the control limits for this indicator (lower is better) showing that the process will hit or miss the



Integrated Performance & Quality Report

Key to Variation and Assurance icons

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable.** If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement.** Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Integrated Performance & Quality Report

Key to Matrix

Buckinghamshire Healthcare NHS Trust

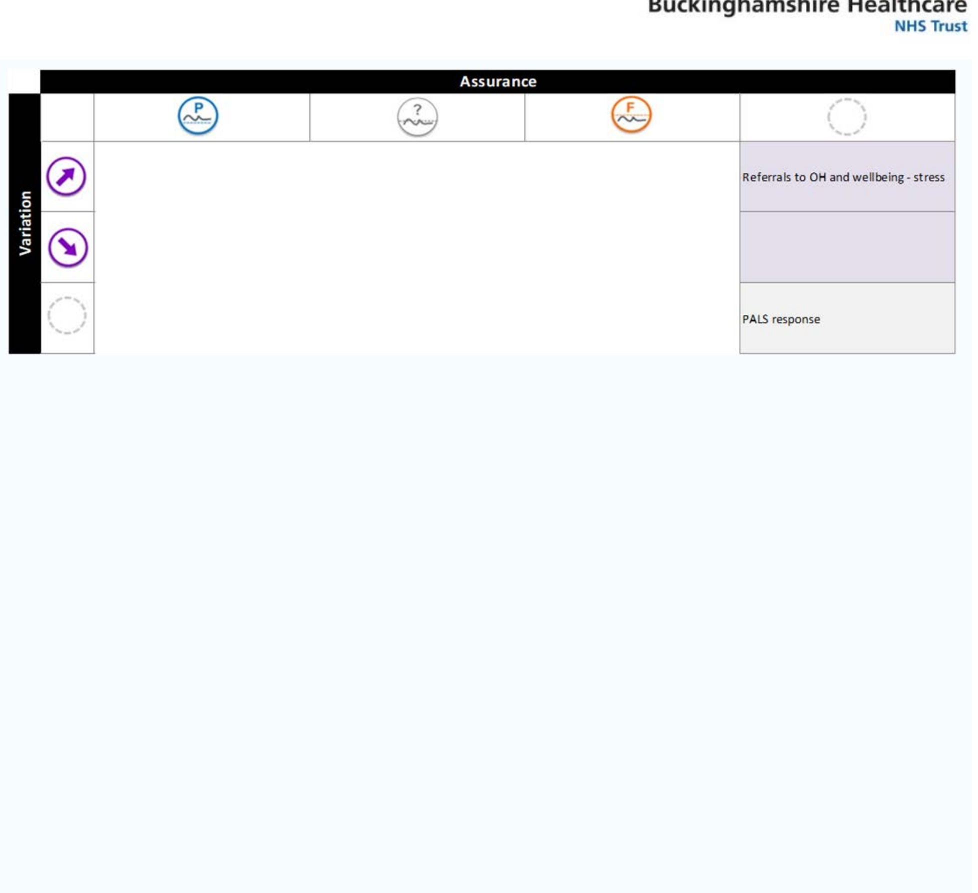
Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (no target)
H (improving)	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L (improving)	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
Common cause	**Good** — **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H (deteriorating)	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L (deteriorating)	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
Upward arrow				**Unsure** — **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
Downward arrow				**Unsure** — **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
Insufficient data				**Unknown** — **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

Integrated Performance & Quality Report

Buckinghamshire Healthcare NHS Trust

Overall Performance Summary

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (no icon letter)
H		Early Warning Score	Statutory and mandatory training	Cardiology referrals from deprived wards Breastfeeding at discharge
L	Pre term birth < 24 weeks	Clostridiodes difficile Turnover rate Sickness	Ambulance handovers over 60mins Complaints outstanding at 90 days	Acute open pathway 65 week breaches Sickness - mental health
(no icon letter)	Falls per 1,000 bed days HSMR VTE assessment PALS Term birth <10th centile Corporate induction	Reduce OP follow up Cancer wait times - 2ww Cancer screening Incidents that are low/no hard Medication incidents as SIs SIs declared as never events MRSA bacteraemia MSSA bacteraemia E Coli bacteraemia Pseudomonas aeruginosa bacteraemia Klebsiella spp bacteraemia Treatment escalation plan compliance Complaints response rate Stillbirths - total cases Neonatal deaths Term admissions to neonatal unit Pre term birth Pre term birth >24 weeks Maternity smoking at time of delivery Trust overall vacancy rate Nursing and midwifery vacancy rate Average time to replace vacancies	12 hour waits in ED Ambulance handovers 15mins & 30 mins Acute open pathway performance Outpatient DNA rate Cancer performance 62 day pathway Endoscopic patients waiting > 6 weeks Data security awareness training	ED attendances Ambulance arrivals Medically optimised for discharge patients Medically optimised for discharge bed days lost 21 day LOS - acute Discharges by 5pm 14 day LOS Community hospitals avg LOS Urgent 2 hour response Urgent 2 hour response referrals Theatre utilisation Theatre cases per planned time Cancelled elective operations Elective activity Mean waiting time for first OP appointment Community waiting list size Diagnostic activity levels Incidents reported Medication incidents Inpatient falls SIs confirmed Pressure ulcers - all categories Excellence reporting Complaints received PALS contacts Community contacts Maternity smoking at time of booking Breastfeeding at birth Health Visitor appointment - 14 days
H			Acute open pathway 52 week breaches Community waiting list 52 week breaches Community waiting list 65 week breaches Non endoscopic DM01 breaches	Acute waiting list size
L			ED 4 hour performance Senior decision maker seen within 60 mins Diagnostic compliance	



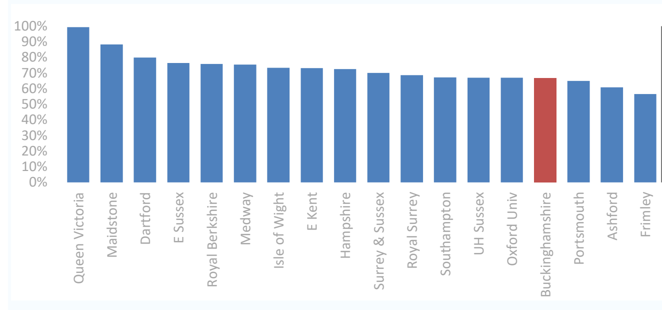
Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (no icon letter)
(up arrow)				Referrals to OH and wellbeing - stress
(down arrow)				
(no icon)				PALS response

Integrated Performance & Quality Report

Benchmarking Summary for South-East Region

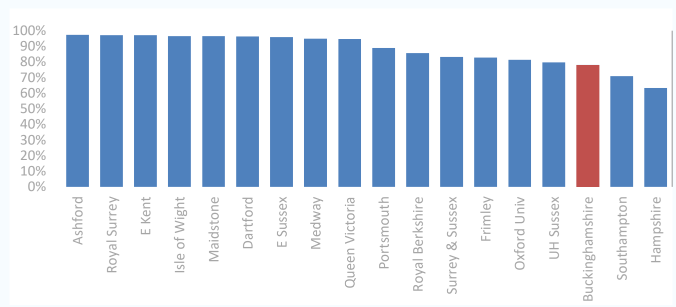
ED 4 hour performance

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



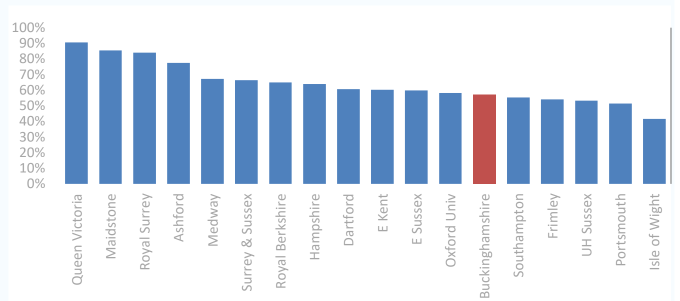
2 week wait cancer

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



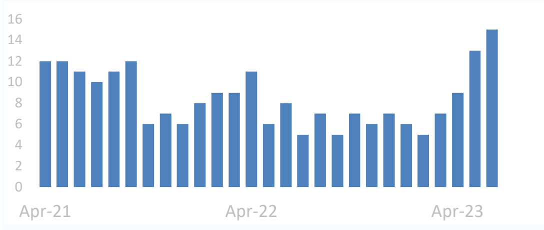
62 day wait cancer

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



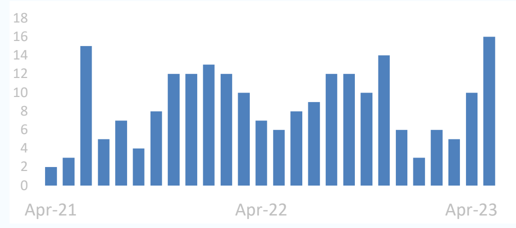
ED 4 hour performance ranking

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



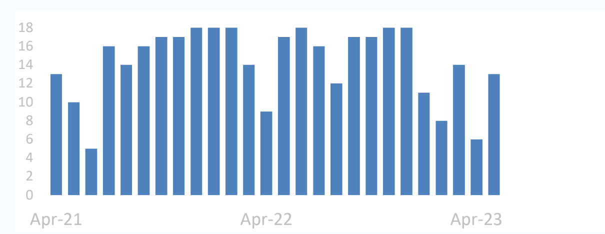
2 week wait cancer ranking

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



62 day wait cancer ranking

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



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

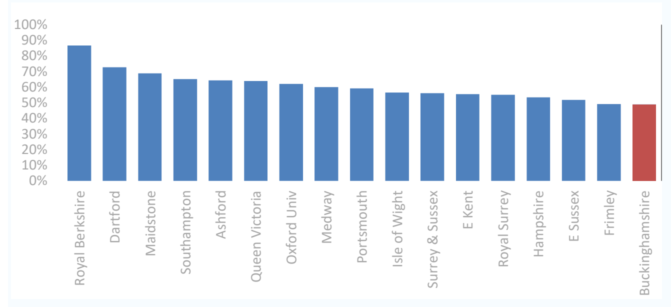
Hampshire does not report 2 week waits peformance as they are part of the Clinical Services Review.

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

Integrated Performance & Quality Report

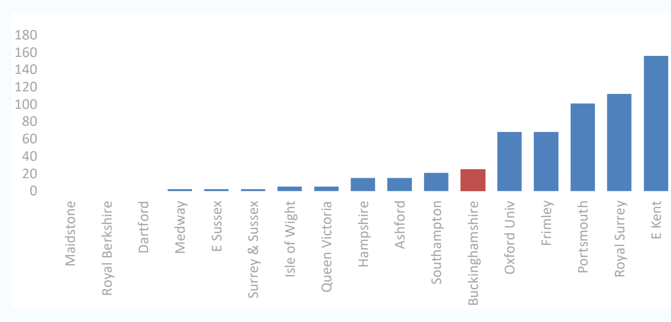
RTT performance

South East RTT performance benchmarking - May-23



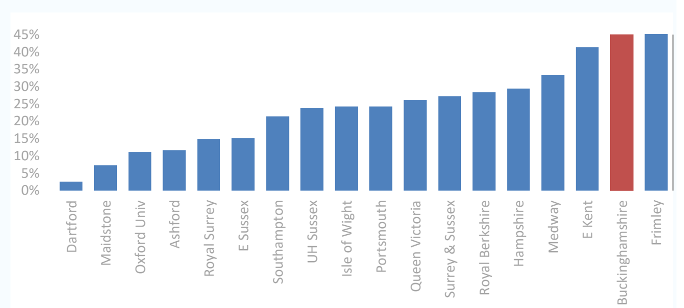
78 week waits

South East over 78 week waits benchmarking - May-23



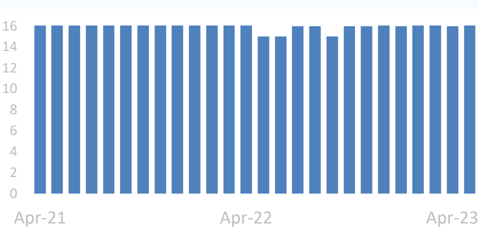
Diagnostic performance

South East diagnostic performance benchmarking - May-23



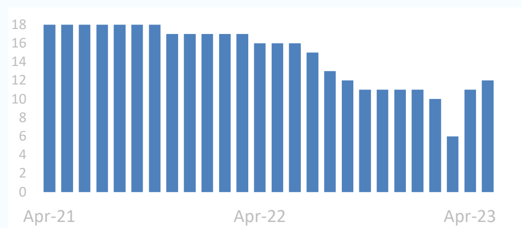
RTT performance ranking

South East RTT performance benchmarking - historic rankings out of 16



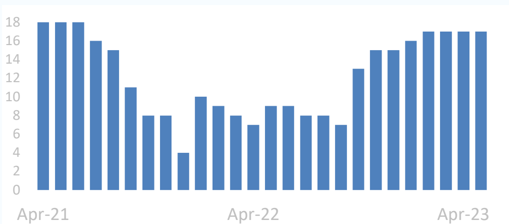
78 week waits ranking

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

Buckinghamshire Healthcare NHS Trust

Operational Standards - Urgent Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
ED 4 hour performance	Jun 23	66.5%	95.0%			72.3%	66.6%	78.1%
12 hour waits in ED	Jun 23	7.0%	2.0%			7.0%	4.5%	9.5%
ED attendances	Jun 23	14118	-			12629	10124	15135
Senior decision-maker seen within 60 minutes	Jun 23	25.1%	75.0%			29.8%	17.2%	42.5%
Number of patients seen in SDEC			-					
Number of admissions - conversions from attendance			-					
Ambulance handovers within 15 mins	Jun 23	37.2%	65.0%			34.3%	19.4%	49.2%
Ambulance handovers within 30 mins	Jun 23	85.9%	95.0%			82.6%	74.5%	90.6%
Ambulance handovers over 60 mins	Jun 23	52	0			92	18	166
Ambulance arrivals	Jun 23	2082	-			2046	1793	2298
Medically optimised for discharge patients	Jun 23	100	-			103	78	127
Medically optimised for discharge bed days lost	Jun 23	3122	-			3224	2477	3971
21 day LOS - acute	Jun 23	101	-			97	63	131
14 day LOS - acute	Jun 23	141	-			149	110	188
Occupancy			-					
Discharges by 5pm	Jun 23	51.4%	-			49.3%	44.6%	54.1%
Average LOS - community hospitals	Jun 23	21.9	-			21.1	14.6	27.5
Urgent 2 hour response - community	May 23	85.7%	-			85.9%	75.3%	96.5%
Urgent community response referrals	Jun 23	386	-			377	313	442

What the charts show us

ED 4 hour performance: This metric is experiencing special cause variation of a concerning nature with the latest data point falling below the lower control limit. The target lies above the current control limits and so cannot be achieved unless something changes in the process.

12 hour waits in ED: This metric is experiencing common cause variation i.e. no significant change. However the target lies below the current control limits and so cannot be achieved unless something changes in the process.

Senior decision maker seen within 15 minutes: This metric is experiencing special cause variation of a concerning nature with the last nine data points falling below the central line. The target lies above the current control limits and so cannot be achieved unless something changes in the process.

Ambulance handovers within 15 minutes: This metric is experiencing common cause variation i.e. no significant change. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

Ambulance handovers within 30 minutes: This metric is experiencing common cause variation i.e. no significant change. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

Ambulance handovers over 60 minutes: This metric is experiencing special cause variation of an improving nature with the last six data points falling below the central line. However the target lies below the current control limits and so cannot be achieved unless this improvement continues.

All other metrics are showing common cause variation i.e. no significant change.

Outstanding Care

Operational Standards - Urgent Emergency Care

Buckinghamshire Healthcare NHS Trust

ED 4 hour performance

The 4-hr performance has seen a slight decrease in the last reporting period. The department continues to experience significant crowding particularly in the evening when the UTC pathway closes to new patents at 8pm, 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.

The UTC pathway is expected to go 24/7 from the 24th of July 2023 so should support flow.

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 reporting period, we have seen a sustained increase in the number of 12hr stays in ED continuing to sit at 7.0%.

The contributing factor is limited early flow to specialty wards.

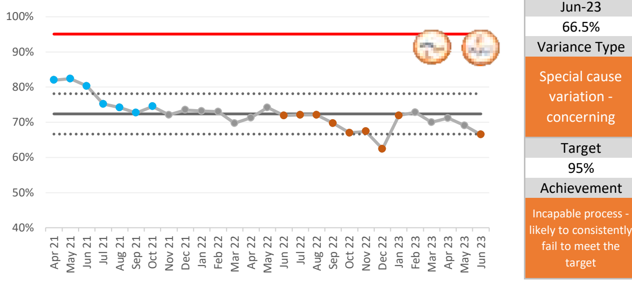
Our ambition is for this to be 2%, which is being supported with our improvement works; improved flows to our assessment areas / SDEC, the opening of a 24/7 UTC pathway, introduction of the acute medical team attending the ED huddles 3 hourly, introduced specialty in-reach into the Emergency Department, co-located the frailty service to ED, expanding the number of Acute Medical Beds and increased communication regarding our virtual ward pathways. Support with discharge processes.

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 Consultants.

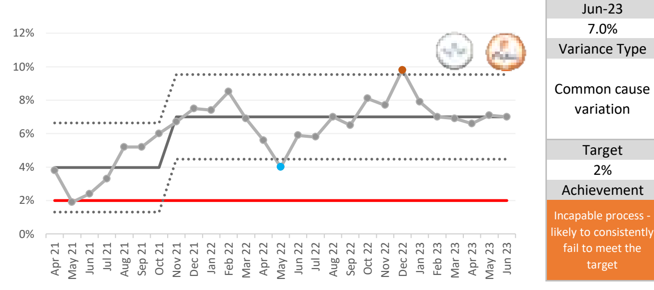
ED 4 hour performance

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



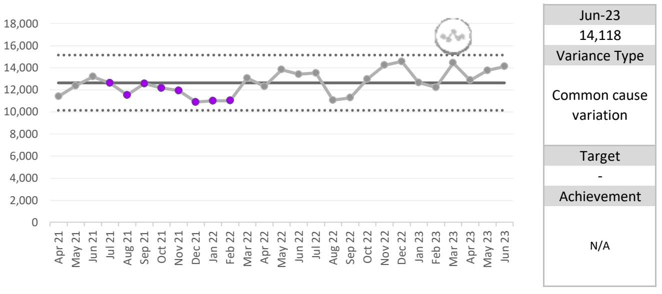
12 hour waits in ED

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



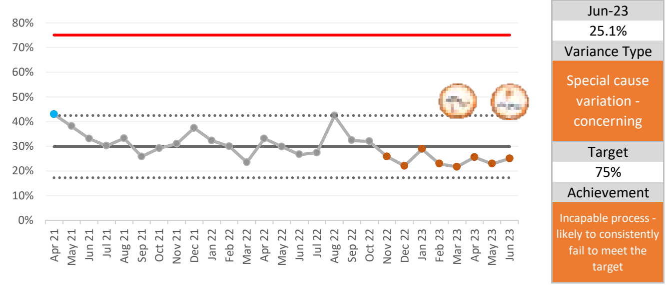
ED attendances

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



Senior decision-maker seen within 60 minutes

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



Number of patients seen in SDEC

Awaiting definition

Number of admissions - conversions from attendance

Awaiting definition

Outstanding Care

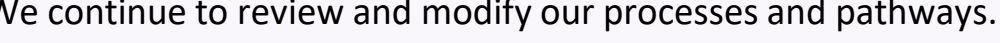
Operational Standards - Urgent Emergency Care

Ambulance handovers

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

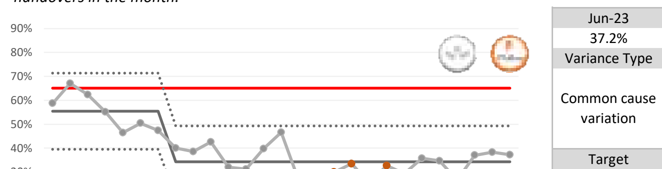
The within 15mins performance has seen some variation but fairly consistent between 20% -40% achievement despite investment in additional staff and support from a Hospital Ambulance Liaison officer (HALO), however, there has been a consistent improvement in the 30mins and 60 mins handover performance.

We continue to review and modify our processes and pathways.



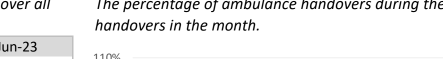
Ambulance handovers within 15 mins

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

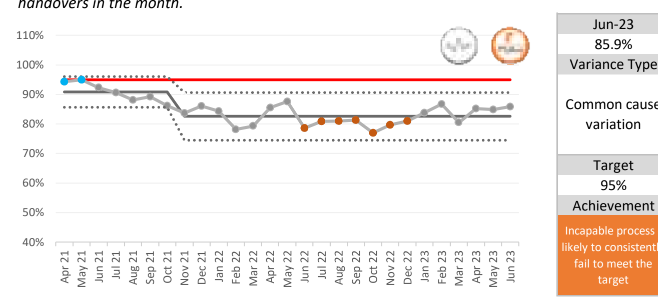


Jun-23
37.2%
Variance Type
Common cause variation
Target
65%
Achievement
Incapable process - likely to consistently fail to meet the target

Ambulance handovers within 30 mins



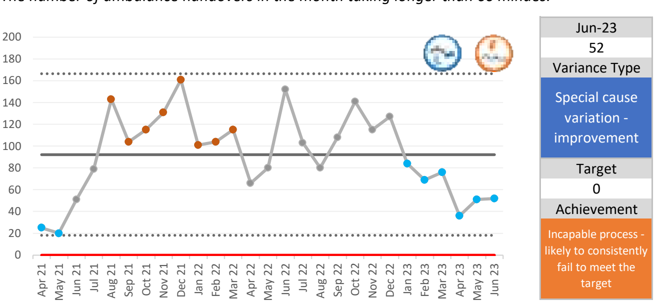
The percentage of ambulance handovers during the month taking 30 minutes or less, over all handovers in the month.



Jun-23
85.9%
Variance Type
Common cause variation
Target
95%
Achievement
Incapable process - likely to consistently fail to meet the target

Ambulance handovers over 60 mins

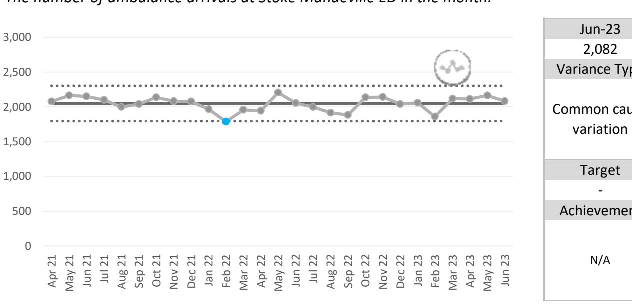
The number of ambulance handovers in the month taking longer than 60 minues.



Jun-23
52
Variance Type
Special cause variation - improvement
Target
0
Achievement
Incapable process - likely to consistently fail to meet the target

Ambulance arrivals

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



Jun-23
2,082
Variance Type
Common cause variation
Target
-
Achievement
N/A

Outstanding Care

Operational Standards - Urgent Emergency Care

Buckinghamshire Healthcare NHS Trust

Medically fit 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 supported by executive colleagues of all in-patients and 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.

Dedicated support looking at our discharge processes, regular review of the top 50 patients remaining in an acute bed.

21 day LOS
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 sustained increase in the number of discharges by 5pm in this reporting period.

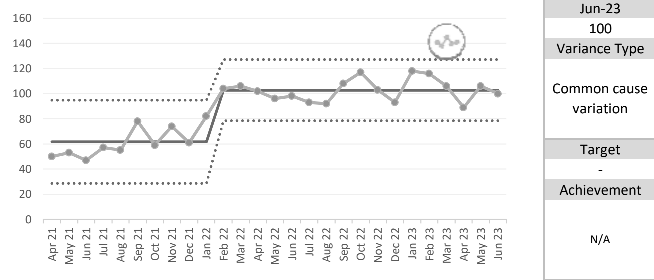
We continue our improvement work across our in-patient areas on board round and ward round processes.

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.

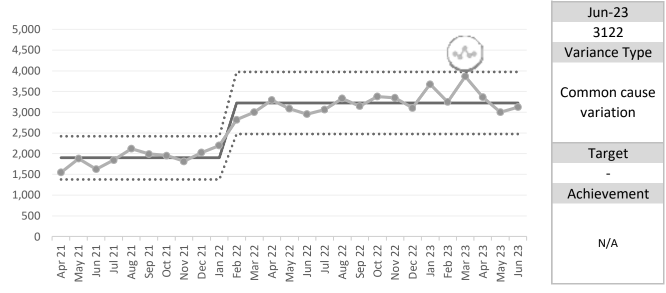
Medically optimised for discharge patients

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



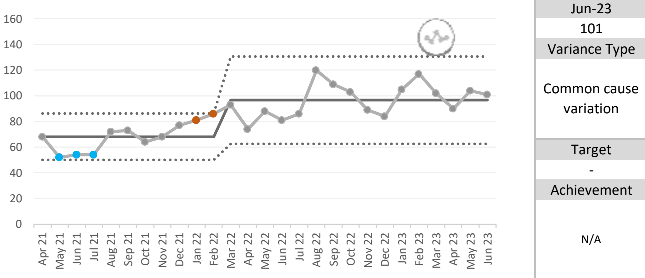
Medically optimised for discharge bed days lost

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



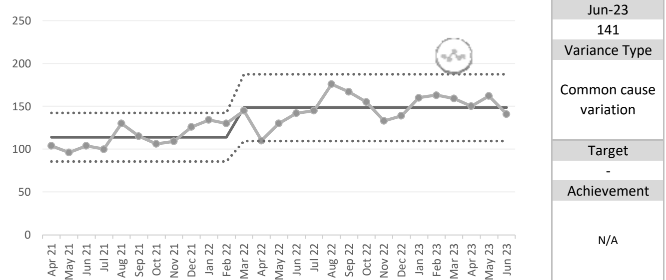
21 day LOS - acute

Count of patients in an acute bed (Stoke and Wycombe only) at the end of the month who have a total length of stay of more than 21 days. Based wards included in the daily Sitrep.



14 day LOS - acute

Count of patients in an acute bed (Stoke and Wycombe only) at the end of the month who have a total length of stay of more than 14 days. Based wards included in the daily Sitrep.

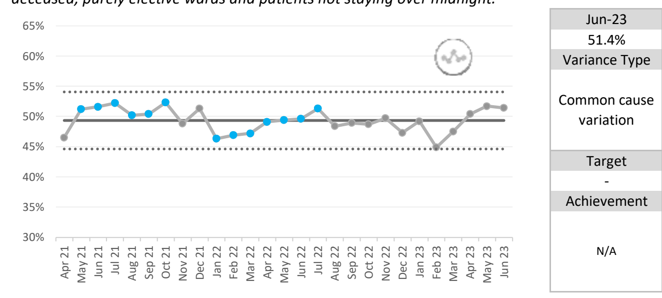


Occupancy

Awaiting definition

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.



Outstanding Care

Operational Standards - Urgent Emergency Care

Urgent 2 hour response
BHT's 2-hour UCR response rate continues to be well above the national expectation.

Rapid Response & Intermediate Care (RRIC) completed the staff consultation on introducing two UCR squads to respond to most RRIC UCR referrals, instead of seven teams. Plan to go live in September five days a week. Weekend responses will continue from the seven teams, switching to using two UCR squads at weekends after more recruitment.

Benefits: strengthen response as a key part of avoiding hospital admissions and reducing ambulance conveyances; increase the skills of staff and cohort of patients who can be kept at home; handle the peaks of referrals to improve the consistency, quality, speed of triage; balance the competing priorities of RRIC better and enables better quality of care for all

The team are developing closer working with Frailty Hospital@Home team for medical support and interventions to enable patients to stay at home.

Hosptal at Home
At present on Hospital at Home there are four pathways providing admission avoidance and early supported discharge with bed capacity of 51 beds

To increase capacity by August 23 (to the expected level of capacity of 89 beds) there are three key areas of focus:

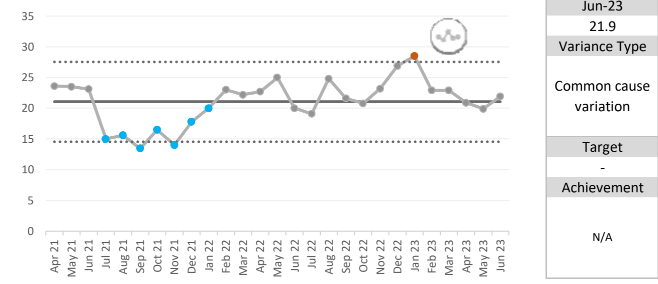
- Expansion of Frailty H@H and further alignment with UCR (18 beds)
- Heart Failure H@H services to come online (10 beds)
- Expansion of Palliative SPH@H (Neuro) planned to come online (10 beds)

An application has been submitted for additional funding to increase capacity within our Single Point Of Access team. This will fund senior clinical triage for **all** ambulatory pathways (including H@H) ahead of winter – pending outcome from the ICB.

Bed capacity utilisation of BHT's H@H has been consistent above the required >80% for the June 23.

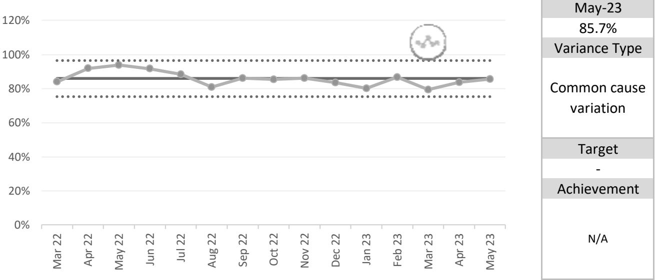
Average LOS - community hospitals

Mean length of stay in days in a community bed for patients discharged from a community hospital (Buckingham hospital, Chartridge ward and Waterside ward) during the month.



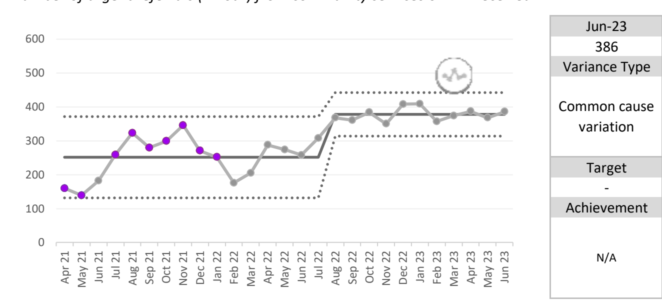
Urgent 2 hour response - community

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



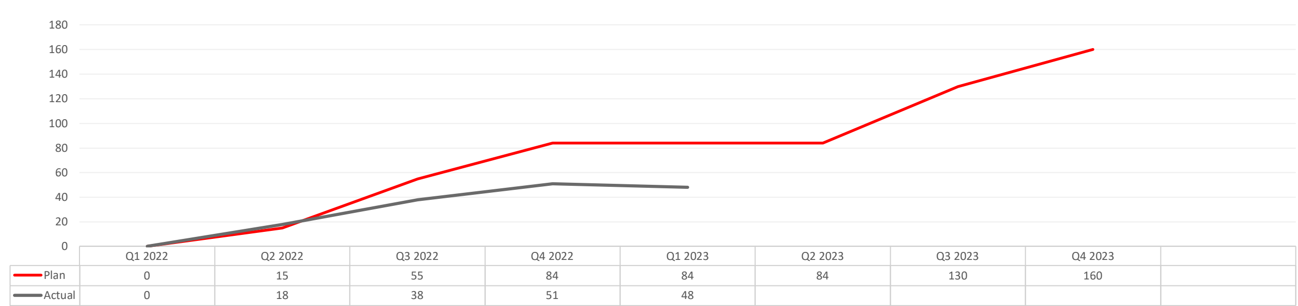
Urgent community response referrals

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



Hospital at home

Bucks Hospital at Home current open beds against plan.



	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Plan	0	15	55	84	84	84	130	160
Actual	0	18	38	51	48			

Outstanding Care

Operational Standards - Elective Recovery

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Acute waiting list size	May 23	45341	-			37769	35459	40079
Acute open pathway performance	May 23	49.0%	92.0%			48.0%	44.5%	51.4%
Acute open pathway 52 week breaches	May 23	4239	0			3395	2623	4167
Acute open pathway 65 week breaches	May 23	1017	0			1090	828	1353
Theatre utilisation	Jun 23	89.4%	-			88.1%	84.3%	92.0%
Theatre cases per 4 hours planned time	Jun 23	2.7	-			2.6	2.4	2.8
Cancelled elective operations	Jun 23	37	-			30	-5	64
Elective activity	Jun 23	4288	-			3820	2958	4681
Outpatient DNA rate	Jun 23	7%	5%			7%	6%	8%
Reduce OP follow up	Jun 23	26607	-			25486	18938	32034
Mean waiting time for first outpatient appointment	Jun 23	60.1	-			56.4	44.8	68.0
Community waiting list size	Jun 23	15683	-			15663	14910	16416
Community waiting list 52 week breaches	Jun 23	5020	-			4788	4585	4990
Community waiting list 65 week breaches	Jun 23	4098	-			3883	3670	4097

What the charts show us

Acute waiting list size: This metric is experiencing special cause variation of a concerning nature with the last five data points falling above the upper control limit.

Acute open pathway performance: This metric is experiencing common cause variation i.e. no significant change. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

Acute open pathway 52 week breaches: This metric is experiencing special cause variation of a concerning nature with the latest data point falling above the upper control limit. The target lies below the current control limits and so cannot be achieved unless something changes in the process.

Acute open pathway 65 week breaches: This metric is experiencing special cause variation of an improving nature with the last seven data points falling below the central line. The target lies within the current control limits and so the metric will consistently hit or miss the target.

Outpatient DNA rate: This metric is experiencing common cause variation i.e. no significant change. However the target lies below the current control limits and so cannot be achieved unless something changes in the process.

Community waiting list 52 week breaches: This metric is experiencing special cause variation of a concerning nature with the last four data points falling above the upper control limit.

Community waiting list 65 week breaches: This metric is experiencing special cause variation of a concerning nature with the last four data points falling above the upper control limit.

All other metrics are showing common cause variation i.e. no significant change.

Outstanding Care

Operational Standards - Elective Recovery

Acute waiting list size
The number of patients on the acute waiting list has steadily increased since January 23. BHT are committed to ensuring all patients are on one central waiting list, ensuring they are considered equally and fairly when offered appointments. The rise in the number of patients waiting is a result of speeding up the process of moving patients from the referral system to a single waiting list using robotic services.

Growth is expected to stabilise. These are not additional referrals but clearing backlog and reducing the time referrals spend on a separate system.

Acute Open pathway performance
Open pathway performance measured against Referral to Treatment targets remains poor. There is a large number of patients waiting over 18 weeks compared to those below. Waiting times do continue to improve however this will not make a significant impact on open pathway performance until the number of patients waiting longer starts to reduce. This is in line with 65 week reductions.

Acute open pathway 52 and 65 week breaches
We are prioritising long waiting patients after cancer referrals, and aim to treat all those waiting 65 weeks and over by March 24. This is a work in progress, ensuring all waiting for their first appointment are booked as soon as possible. This does mean we are seeing a rise in patients waiting over 52 weeks but this will start to reduce as we recover the very longest waiters.

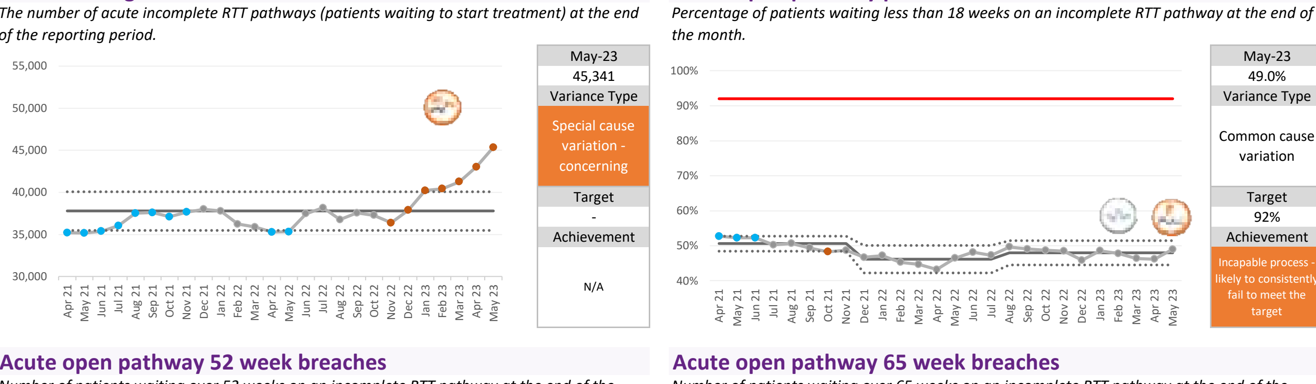
We expect to see improvement in October 23.

Acute waiting list size

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

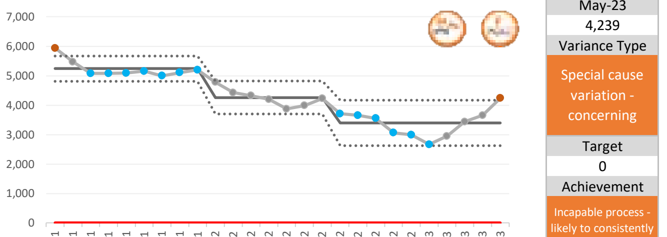
Acute open pathway performance

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



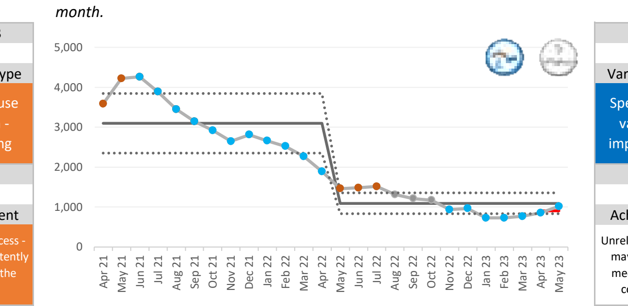
Acute open pathway 52 week breaches

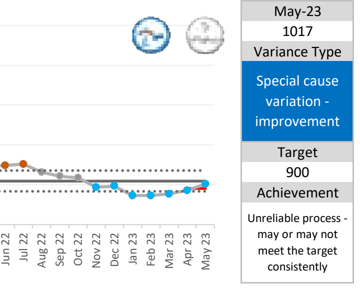
Number of patients waiting over 52 weeks on an incomplete RTT pathway at the end of the month.



Acute open pathway 65 week breaches

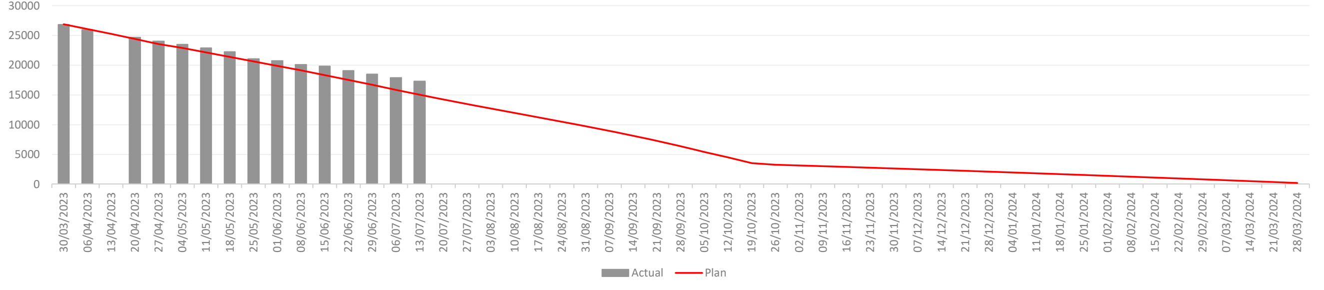
Number of patients waiting over 65 weeks on an incomplete RTT pathway at the end of the month.



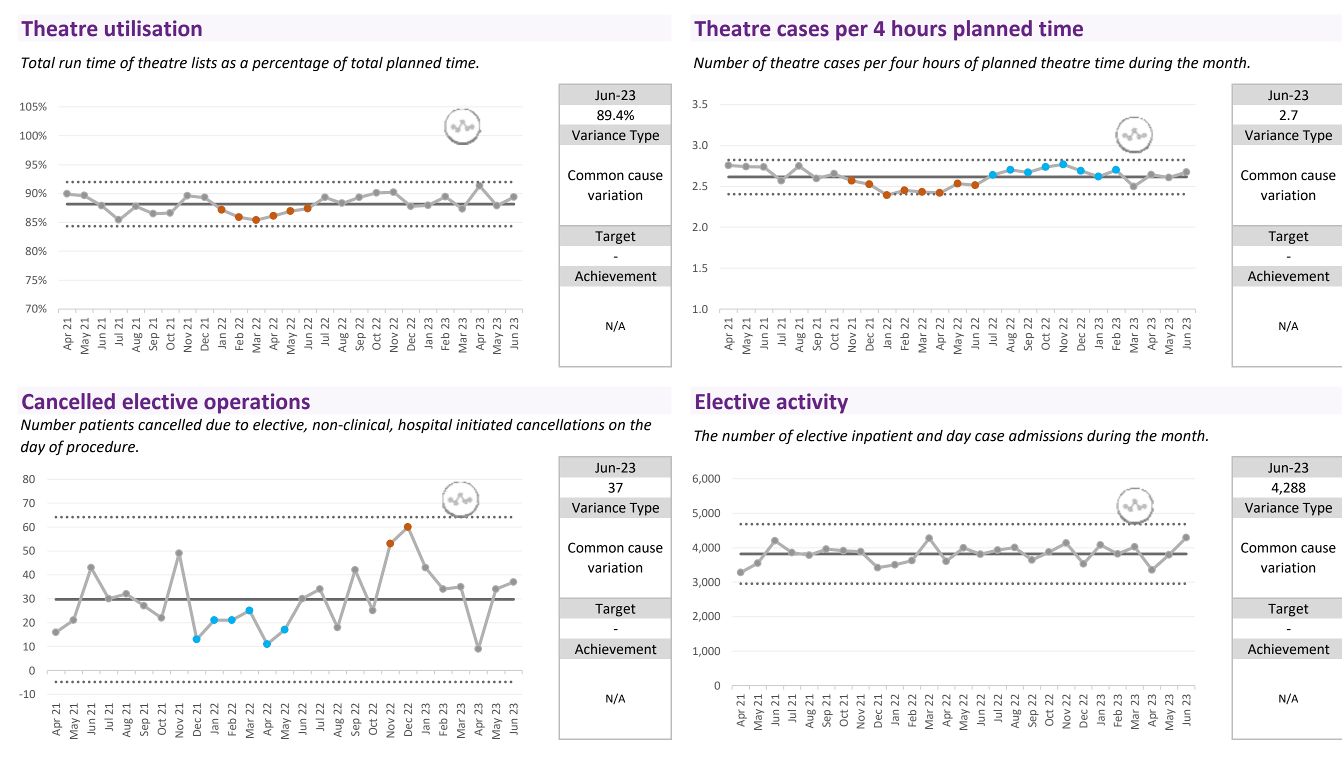


Acute open pathway 65 week risks

The total number of patients on an incomplete RTT pathway who will breach 65 weeks waiting time by March 24.



NHS
Buckinghamshire Healthcare
NHS Trust



Theatre utilisation
Total run time of theatre lists as a percentage of total planned time.
Jun-23
89.4%
Variance Type
Common cause variation
Target
-
Achievement
N/A
Theatre cases per 4 hours planned time
Number of theatre cases per four hours of planned theatre time during the month.
Jun-23
2.7
Variance Type
Common cause variation
Target
-
Achievement
N/A
Cancelled elective operations
Number patients cancelled due to elective, non-clinical, hospital initiated cancellations on the day of procedure.
Jun-23
37
Variance Type
Common cause variation
Target
-
Achievement
N/A
Elective activity
The number of elective inpatient and day case admissions during the month.
Jun-23
4,288
Variance Type
Common cause variation
Target
-
Achievement
N/A

Outstanding Care

Operational Standards - Elective Recovery

Outpatient DNA rate
We continue to improve communication with patients to reduce this further.

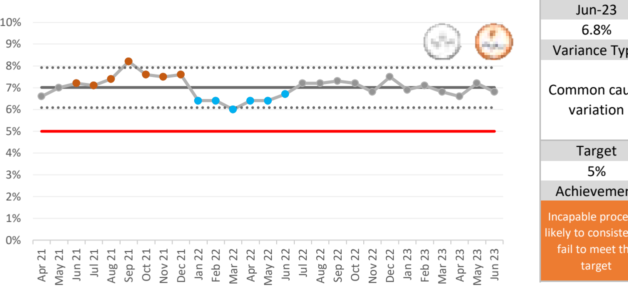
Community Waiting List Size
The community waiting list size has remained relatively static for the last four months. However, a deep dive at individual service level shows some positive movement within open referrals. Nearly 1000 waits have been risk assessed and validated during this period. Data also indicates a steady increase of new urgent referrals in some areas like Podiatry, which get prioritised over the non-urgent waits

There are 4896 community 52 week breaches, split between Podiatry (654) and Health Visiting (4232) . A deep dive at the end of July 23 will provide further feedback.

There are 4100 community 65-week breaches of which 355 are in Podiatry services (up from 20 in May) and 3745 open referrals in Health Visiting teams. The majority of these are universal referrals to children services, kept on the list for between three – five years.

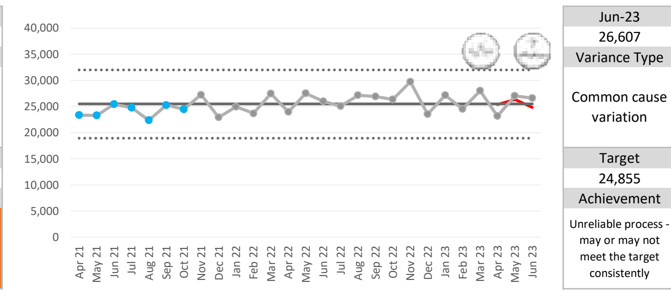
Outpatient DNA rate

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



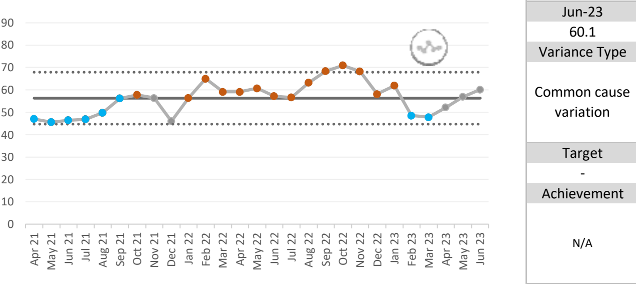
Reduce OP follow up

Total number of follow up attendances during the month.



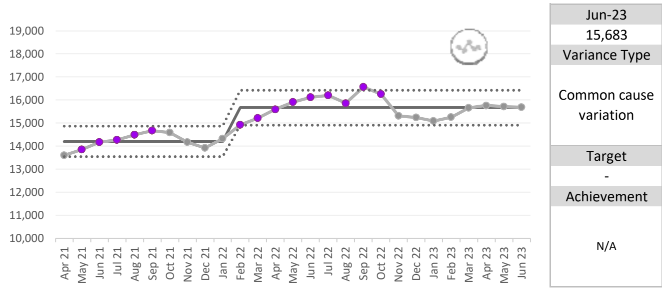
Mean waiting time for first outpatient appointment

Mean waiting time in days between referral date and first outpatient appointment date for appointment dates in month. Includes attendances and did not attends.



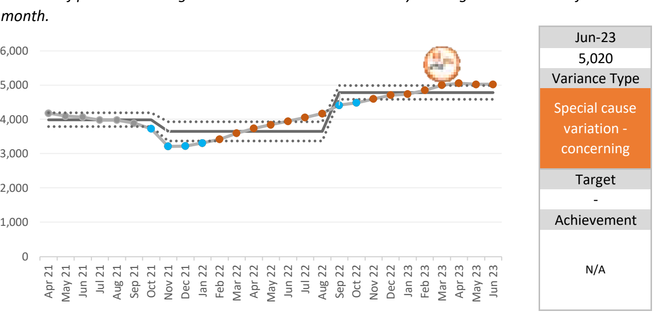
Community waiting list size

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



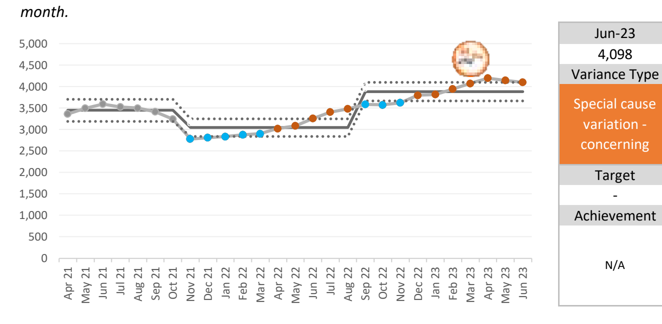
Community waiting list 52 week breaches

Number of patients waiting over 52 weeks on the community waiting list at the end of the month.



Community waiting list 65 week breaches

Number of patients waiting over 65 weeks on the community waiting list at the end of the month.



Outstanding Care

Operational Standards - Cancer

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer Performance 62 day pathway	May 23	57.5%	85.0%			62.0%	40.4%	83.7%
Cancer Wait Times 62 day waiters	Jan 23	248	-			369	194	544

62 day performance by modality

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active Monitoring (excluding Non-Specialist Palliative Care)	*Latest data not available at the time of report production.*							
Anti-Cancer Drug Regimen (Cytotoxic Chemotherapy)								
Anti-Cancer Drug Regimen (Hormone Therapy)								
Anti-Cancer Drug Regimen (Immunotherapy)								
Chemoradiotherapy								
Other Treatment								
Surgery (excluding enabling treatment)								
Teletherapy (Beam Radiation excluding Proton Therapy)			-					

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer Wait Times - 2WW	May 23	78.0%	93.0%			88.6%	70.4%	106.8%
Cancer Wait Times - 104 days	Feb 23	18	0			12	-1	25
Cancer screening	May 23	84.6%	90.0%			72.3%	35.0%	109.5%

Faster diagnostic standard by tumour site

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Faster diagnostic standard (28 days)	May 23	64.1%	75.0%			69.4%	57.8%	80.9%
Breast	*Latest data not provided at the time of report production.*							
Skin								
Head & Neck								
Lung								
Urology								
Gynaecology								
Upper GI								
Lower GI								

What the charts show us

Cancer performance 62 day pathway: This metric is experiencing common cause variation i.e. no significant change. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

All other metrics are showing common cause variation i.e. no significant change or do not show the latest data.

Outstanding Care

Operational Standards - Cancer

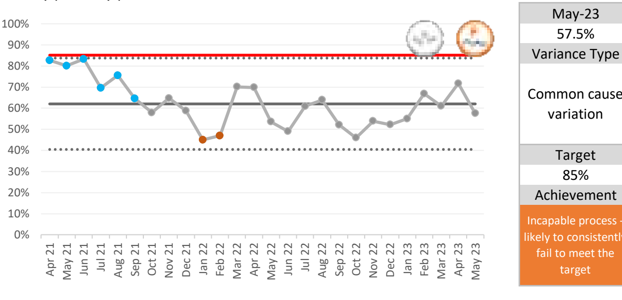
Performance of 57.5% has been reported in May (performance reporting month) this is a decrease in performance from the previous month. Issues impacting performance in month are industrial action, access to timely definitive diagnostics for Urology and Head and Neck, ongoing delays delivering additional 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 improved its backlog position of below 150 at the end of June with continued delivery against trajectory. The Trust backlog position has now decreased to below 5% 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 Faster Diagnosis standard and early pathway improvement.

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.

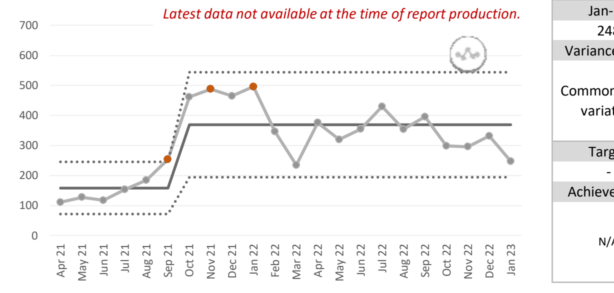


May-23
57.5%
Variance Type
Common cause variation
Target
85%
Achievement
Incapable process - likely to consistently fail to meet the target

Cancer Wait Times 62 day waiters

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

Latest data not available at the time of report production.



Jan-23
248
Variance Type
Common cause variation
Target
-
Achievement
N/A

Cancer performance 62 day pathway by modality

The percentage of patients treated in month within 62 days over all patients treated in month. For 62 day pathway patients. By modality (treatment).

Latest data not available at the time of report production.

Outstanding Care

Operational Standards - Cancer

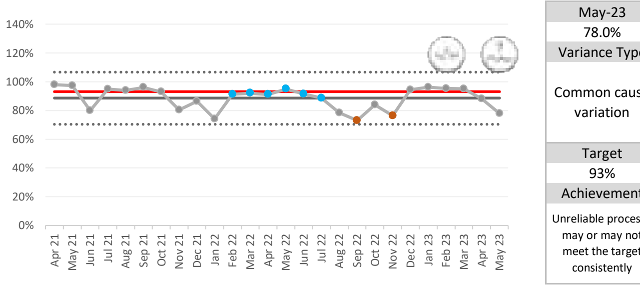
2ww
Work continues to ensure that patients have access within 14 days. The Trust performance decreased slightly in month compared to the previous performance. This was due to increases in skin referrals and reduced capacity within gynaecology. Work continues with TVCA to implement national best practice timed pathways which, while seeking to delivery 28 Fast Diagnosis Standard, will also help deliver 2WW performance (see above).

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 less than 2% of our patients waiting more than 104 days against a national target of 2%.

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 84.6% against a target of 90%.

Cancer Wait Times - 2WW

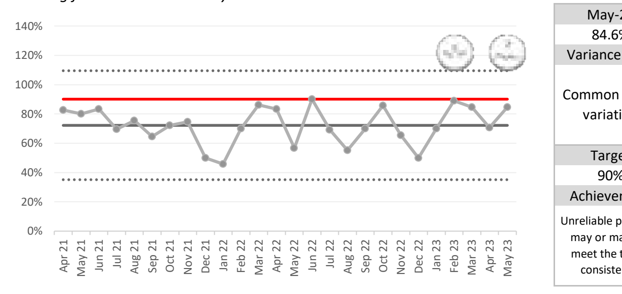
Percentage of urgent referrals for suspected cancer to first outpatient attendances within 2 weeks.



May-23
78.0%
Variance Type
Common cause variation
Target
93%
Achievement
Unreliable process - may or may not meet the target consistently

Cancer screening

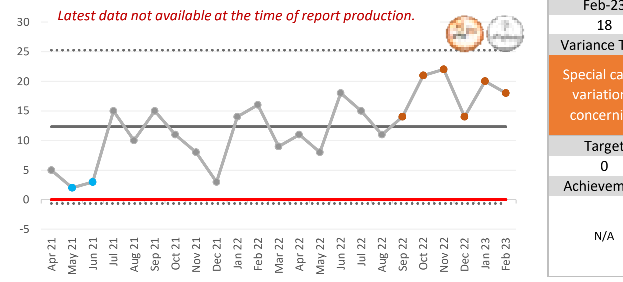
Percentage of the NHS Cancer Screening Programmes' urgent referrals for suspected cancer starting first treatment <62 days.



May-23
84.6%
Variance Type
Common cause variation
Target
90%
Achievement
Unreliable process - may or may not meet the target consistently

Cancer Wait Times - 104 days

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



Feb-23
18
Variance Type
Special cause variation - concerning
Target
0
Achievement
N/A

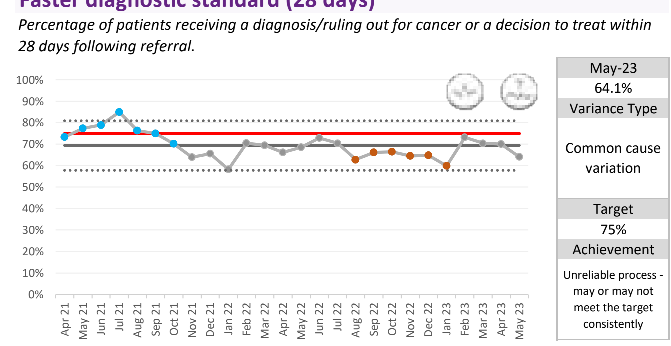
Outstanding Care

Operational Standards - Cancer

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

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.



Faster diagnosis standard by tumour site

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

Latest data not available at the time of report production.

Outstanding Care

Operational Standards - Diagnostics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic activity levels	May 23	12804	-			11791	8853	14729
Diagnostic compliance	May 23	55.0%	99.0%			58.4%	44.0%	72.8%
Endoscopic patients waiting > 6 weeks	May 23	1280	0			1105	700	1510
Non-endoscopic DM01 breaches	May 23	3879	0			2957	1986	3928

By modality

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Magnetic resonance imaging	May 23	2153	-			1827	1245	2409
Computed tomography	May 23	223	-			206	102	311
Non-obstetric ultrasound	May 23	1340	-			424	-22	870
DEXA scan	May 23	8	-			9	-23	41
Audiology - audiology assessments	May 23	83	-			42	-42	126
Cardiology - echocardiography	May 23	59	-			218	-24	460
Respiratory physiology - sleep studies	May 23	0	-			0	0	0
Urodynamics - pressures & flows	May 23	13	-			21	-2	44
Colonoscopy	May 23	444	-			379	274	484
Flexi sigmoidoscopy	May 23	213	-			181	116	245
Cystoscopy	May 23	162	-			142	73	210
Gastroscopy	May 23	461	-			413	228	598

What the charts show us

Diagnostic compliance: This metric is experiencing special cause variation of a concerning nature with the last six data points falling below the central line. The target lies above the current control limits and so cannot be achieved unless something changes in the process.

Endoscopic patients waiting >6 weeks: This metric is experiencing common cause variation i.e. no significant change. The target lies below the current control limits and so cannot be achieved unless something changes in the process.

Diagnostic compliance: This metric is experiencing special cause variation of a concerning nature with the last six data points falling above the central line. The target lies below the current control limits and so cannot be achieved unless something changes in the process.

For patients waiting > 6 weeks for a diagnostic test both **Magnetic Resonance Imaging** and **Non-obstetric ultrasound** are showing special cause variation of a concerning nature with the last six data points for each falling above the central line. **DEXA scans** are showing special cause variation of an improving nature with the last six data points falling below the central line.

All other metrics are showing common cause variation i.e. no significant change.

Outstanding Care

Operational Standards - Diagnostics

Diagnostics activity

Diagnostic activity in month was above plan through a combination of insourcing and outsourcing to create additional capacity

Diagnostic compliance

A diagnostic improvement board has been established chaired by the COO. The diagnostic phase of the reasons for non compliance has been completed and the drivers identified as:

- 6% year on year increase in demand across all modalities
- Insufficient capacity to meet demand specifically for MRI
- Staff shortages to maximise activity

An improvement plan is in place which focuses on:

- Demand management
- Increasing capacity
- Delivering productivity gains
- Delivering agreed performance improvement trajectories

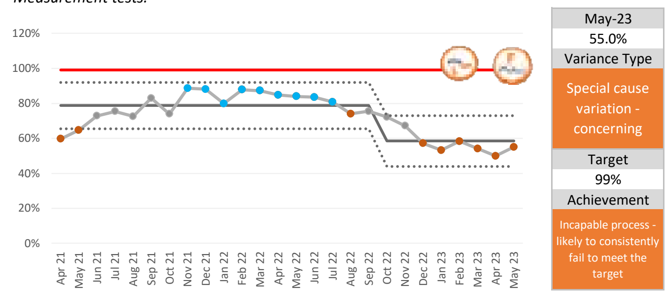
Diagnostic activity levels

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

May-23
12,804
Variance Type
Common cause variation
Target
-
Achievement
N/A

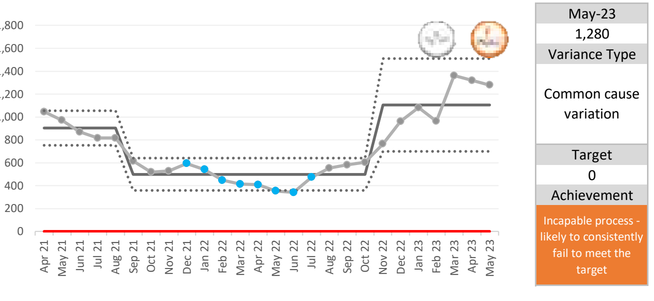
Diagnostic compliance

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



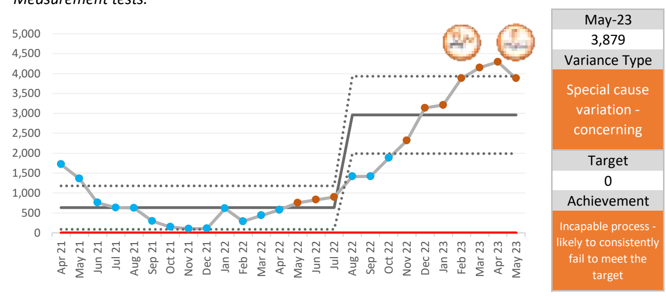
Endoscopic patients waiting > 6 weeks

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



Non-endoscopic DM01 breaches

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



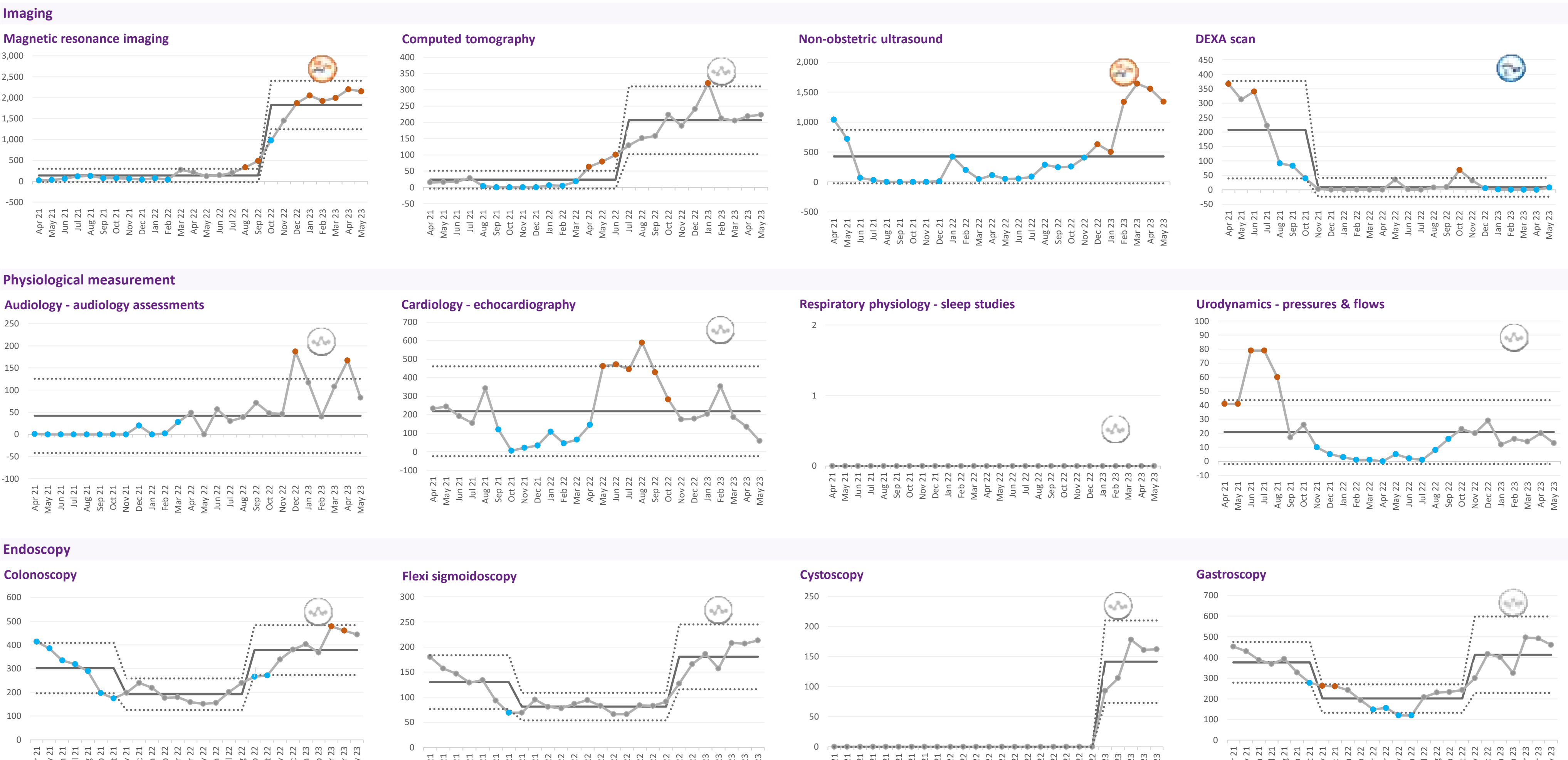
Outstanding Care

Buckinghamshire Healthcare NHS Trust

Operational Standards - Diagnostics

Diagnostic waiters > 6 weeks by modality

The number of patients waiting more than 6 weeks at month end by modality (test).



Outstanding Care

Buckinghamshire Healthcare NHS Trust

Operational Standards - Quality & Safety

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Incidents reported	Jun 23	1309	-			1202	945	1459
Incidents that are low/no harm	Jun 23	97.9%	98.0%			98.3%	96.5%	100.0%
Medication incidents	Jun 23	98	-			101	48	153
Medication incidents as Sis	Jun 23	0	0			0	-1	2
Inpatient falls	Jun 23	82	-			109	81	137
Falls per 1,000 bed days	Jun 23	4.0	6.2			4.9	3.8	6.0
SIs confirmed	Jun 23	7	-			7	-1	14
SIs declared as never events	Jun 23	0	0			0	-1	1
Pressure ulcers - category 2	Jun 23	41	-			34	12	56
Pressure ulcers - category 3	Jun 23	4	-			2	-4	7
Pressure ulcers - category 4	Jun 23	0	-			0	-1	1
Pressure ulcers - unstageable	Jun 23	8	-			4	-2	10
MRSA bacteraemia	Jun 23	1	0			0	-1	2
Clostridioides difficile	Jun 23	3	4			4	-3	10
MSSA bacteraemia	Jun 23	1	0			2	-2	7
E Coli bacteraemia	Jun 23	3	5			6	-1	13
Pseudomonas aeruginosa bacteraemia	Jun 23	1	1			1	-1	4
Klebsiella spp bacteraemia	Jun 23	3	3			3	-3	8
HSMR	Mar 23	89.8	100.0			92.2	85.6	98.7
VTE assessment	May 23	96.9%	95.0%			96.6%	95.1%	98.0%
Treatment escalation plan compliance	Jun 23	87.0%	90.0%			87.7%	78.0%	97.4%
Early warning score	Jun 23	99.4%	99.0%			99.1%	98.8%	99.4%
Excellence reporting	Jun 23	108	-			105	18	192
Clinical Accreditation Programme			4					

What the charts show us

Falls per 1,000 bed days: This metric is experiencing common cause variation i.e. no significant change. The target lies above the current control limits and will be consistently achieved unless something changes in the process.

Clostridiodes difficile: This metric is experiencing special cause variation of an improving nature with the last six data points points falling below the central line. The target lies within the current control limits and so the metric will consistently hit or miss the target.

HSMR: This metric is experiencing common cause variation i.e. no significant change. The target lies above the current control limits and will be consistently achieved unless something changes in the process.

VTE assessment: This metric is experiencing common cause variation i.e. no significant change. The target lies below the current control limits and will be consistently achieved unless something changes in the process.

Early warning score: This metric is experiencing special cause variation of an improving nature with the last six data points points falling above the central line. The target lies within the current control limits and so the metric will consistently hit or miss the target.

All other metrics are showing common cause variation i.e. no significant change.

Outstanding Care

Operational Standards - Quality & Safety

Incidents reported
Increased in incidents reporting since October 2022 with majority of incidents were of low harm or no harm. No medication related incidents declared as serious incident in June 2023.

Falls
Consistently achieved falls rate per 1,000 bed days with performance which is lower than the set target and better in comparison to national median.

Incidents reported

Total number of incidents reported on DATIX during the month.

Jun-23
1,309
Variance Type
Common cause variation
Target
-
Achievement
N/A

Incidents that are low/no harm

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

Jun-23
97.9%
Variance Type
Common cause variation
Target
98%
Achievement
Unreliable process - may or may not meet the target consistently

Medication incidents

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

Jun-23
98
Variance Type
Common cause variation
Target
-
Achievement
N/A

Medication incidents as SIs

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

Jun-23
0
Variance Type
Common cause variation
Target
0
Achievement
Unreliable process - may or may not meet the target consistently

Inpatient falls

Total number of inpatient falls reported on DATIX.

Jun-23
82
Variance Type
Common cause variation
Target
-
Achievement
N/A

Falls per 1,000 bed days

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

Jun-23
4.0
Variance Type
Common cause variation
Target
6.2
Achievement
Capable process - likely to always meet the target

Outstanding Care

Operational Standards - Elective Recovery

SIs
No serious incidents declared as Never Event in June 2023.

Pressure Ulcers
Pressure ulcer incidents showing common cause variation.
PU themes and quality improvement continued to be monitored by the Harm Free Care Group.

SIs confirmed

The total number of Serious Incidents confirmed during the month.

Jun-23
7
Variance Type
Common cause variation
Target
-
Achievement
N/A

SIs declared as never events

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

Jun-23
0
Variance Type
Common cause variation
Target
0
Achievement
Unreliable process - may or may not meet the target consistently

Pressure ulcers - category 2

Number of acquired category 2 pressure ulcers.

Jun-23
41
Variance Type
Common cause variation
Target
-
Achievement
N/A

Pressure ulcers - category 3

Number of acquired category 3 pressure ulcers.

Jun-23
4
Variance Type
Common cause variation
Target
-
Achievement
N/A

Pressure ulcers - category 4

Number of acquired category 4 pressure ulcers.

Jun-23
0
Variance Type
Common cause variation
Target
-
Achievement
N/A

Pressure ulcers - unstageable

Number of acquired unstageable pressure ulcers.

Jun-23
8
Variance Type
Common cause variation
Target
-
Achievement
N/A

Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

MRSA
One MRSA bacteraemia case has been reported in June 2023. This is the second case for the financial year against an annual trajectory of zero. The Post Infection Review (PIR) has taken place and learning identified.
A multi-disciplinary team action plan has been developed which will be reviewed in the divisional governance meeting and reported to Infection Prevention and Control Committee (IPCC) in July 2023 meeting.

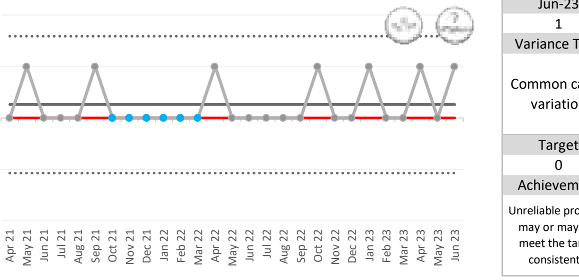
Clostridioides difficile
Clostridium difficile infection (CDI) showing special cause variation of an improving nature with the last six data points falling below the central line.

Three CDI cases were reported in June 2023. Seven cases have been reported since April 2023 against the Trust threshold for this year of 49 CDI cases.

Infections
In June 2023, 7 Gram-negative bloodstream infection (GNBSI) cases were reported: of those 3 E. coli, YTD 20 against the 65 of the national thresholds given to BHT. 3x Pseudomonas aeruginosa cases, YTD 6 against 9 of the national thresholds given to BHT. There was a case of Klebsiella, YTD 6 against 32 of the BHT national threshold. All GNBSI are reviewed to identify any lapses in care and to look for the sources of infections. Detailed information of this findings will be reported in the IPC quarterly report.

MRSA bacteraemia

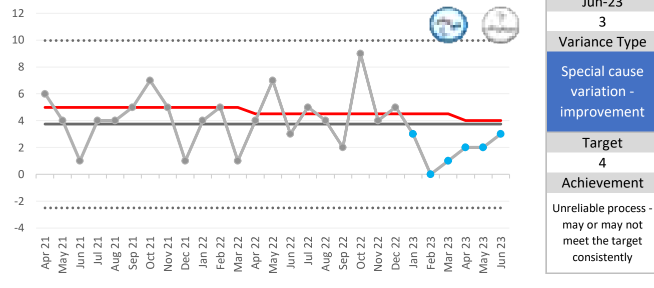
Number of MRSA cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



Jun-23
1
Variance Type
Common cause variation
Target
0
Achievement
Unreliable process - may or may not meet the target consistently

Clostridioides difficile

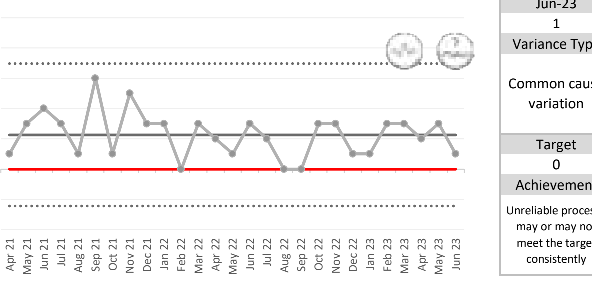
Number of C-diff cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



Jun-23
3
Variance Type
Special cause variation - improvement
Target
4
Achievement
Unreliable process - may or may not meet the target consistently

MSSA bacteraemia

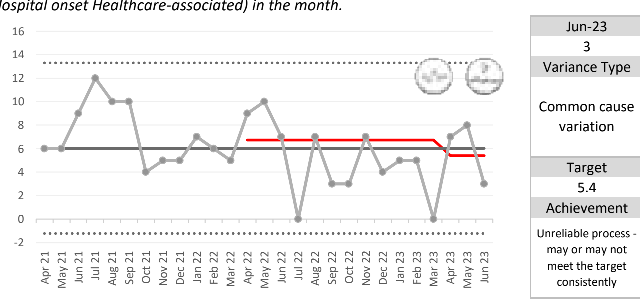
Number of MSSA cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



Jun-23
1
Variance Type
Common cause variation
Target
0
Achievement
Unreliable process - may or may not meet the target consistently

E Coli bacteraemia

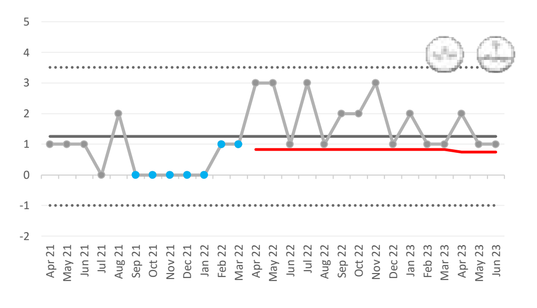
Number of E-Coli cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.

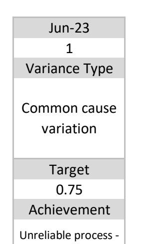


Jun-23
3
Variance Type
Common cause variation
Target
5.4
Achievement
Unreliable process - may or may not meet the target consistently

Pseudomonas aeruginosa bacteraemia

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

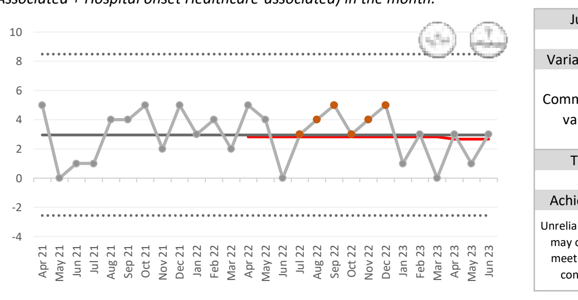




Jun-23
1
Variance Type
Common cause variation
Target
0.75
Achievement
Unreliable process - may or may not meet the target consistently

Klebsiella spp bacteraemia

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



Jun-23
3
Variance Type
Common cause variation
Target
2.67
Achievement
Unreliable process - may or may not meet the target consistently

Outstanding Care

Operational Standards - Elective Recovery

HSMR
HSMR for March 2023 is 89.8 and classified as "lower than expected".

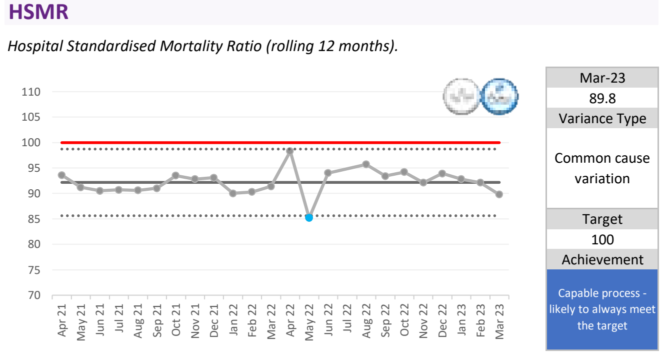
VTE assessments
Continue to achieve set target on VTE risk assessment completion compliance. EWS compliance experiencing special cause variation of an improving nature with the last six data points falling above the central line. TEP compliance showing common cause variation and areas with compliance below the set target identified and quality improvement monitored through the Harm Free Care Group and Clinical Effectiveness Committee.

Clinical Accreditation Programme
Soon to be reported, progress so far:

- Six clinical accreditation assessments completed in June 2023 against the target of four assessments per month.
- A total of 28 inpatient wards and outpatient department had accreditation award since January 2023 with 14 achieving silver status and the other 14 were bronze.

HSMR

Hospital Standardised Mortality Ratio (rolling 12 months).



Mar-23
89.8
Variance Type
Common cause variation
Target
100
Achievement
Capable process - likely to always meet the target

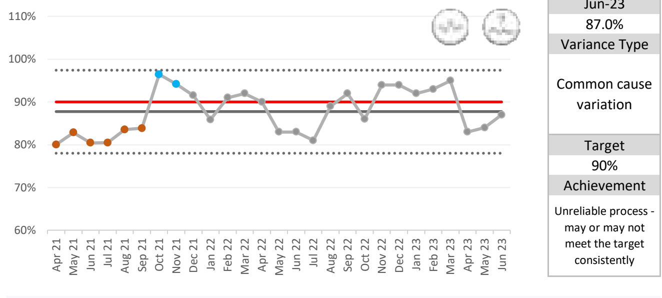
VTE assessment

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

May-23
96.9%
Variance Type
Common cause variation
Target
95%
Achievement
Capable process - likely to always meet the target

Treatment escalation plan compliance

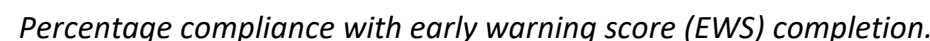
Treatment Escalation Plan completion rate based on documentation audit conducted via Tendable app.

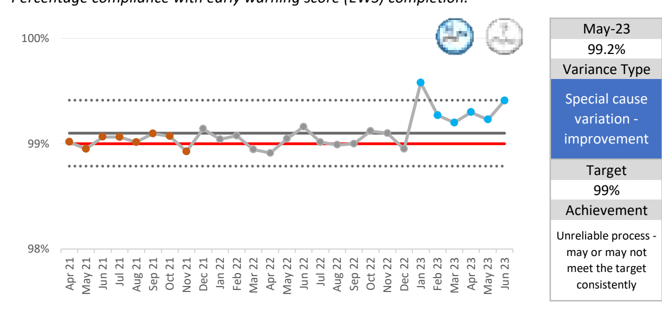


Jun-23
87.0%
Variance Type
Common cause variation
Target
90%
Achievement
Unreliable process - may or may not meet the target consistently

Early warning score

Percentage compliance with early warning score (EWS) completion.

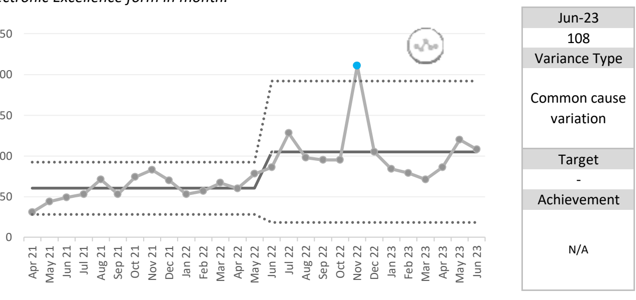




May-23
99.2%
Variance Type
Special cause variation - improvement
Target
99%
Achievement
Unreliable process - may or may not meet the target consistently

Excellence reporting

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



Jun-23
108
Variance Type
Common cause variation
Target
-
Achievement
N/A

Clinical Accreditation Programme

The total number of accreditation assessments completed in month.

Latest data not provided at the time of report production.

Outstanding Care

Operational Standards - Patient Experience

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Complaints received	Jun 23	48	-			43	23	64
Complaints response rate	May 23	94.0%	85.0%			70.9%	39.5%	102.3%
Complaints outstanding at 90 days	Jun 23	0	0			4	1	8
PALS contacts	Jun 23	484	-			396	290	502
PALS response	Jun 23	99.5%	85.0%	Not enough data points for an SPC chart				

What the charts show us

Complaints outstanding at 90 days: This metric is experiencing special cause variation of an improving nature with a downward trend of the last eight data points. However the target lies below the current control limits and so cannot be achieved unless something changes in the process.

All other metrics are showing common cause variation i.e. no significant change.

Outstanding Care

Operational Standards - Patient Experience

Complaints response rate
Complaints compliance rate of 94% for 25 days response time achieved for the first time since target of 85% restarted post COVID-19 pandemic.

Complaints outstanding at 90 days
No complaints outstanding for 90 days in June 2023 and this metric is demonstrating special cause variation of an improving nature with a downward trend of the last eight data points.

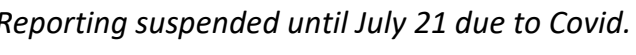
PALS contacts
PALS response for contacts and queries within three working days achieving 99.5% for emails and phone calls. The team continues to accommodate and offer walk in contacts and queries.

Complaints received

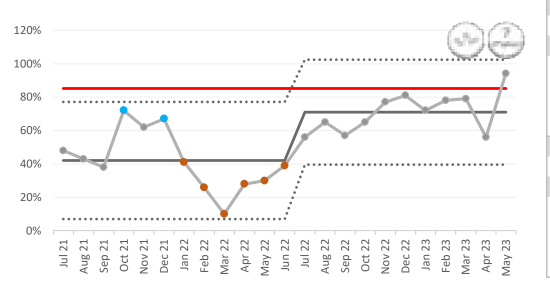
Number of complaints received during the month.

Jun-23
48
Variance Type
Common cause variation
Target
-
Achievement
N/A

Complaints response rate



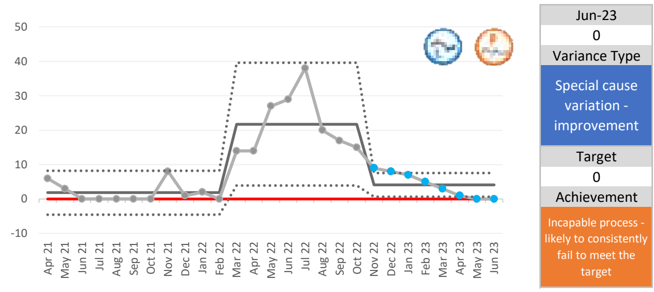
Percentage of complaints responded to within 25 days of receipt.
Reporting suspended until July 21 due to Covid.



May-23
94.0%
Variance Type
Common cause variation
Target
85%
Achievement
Unreliable process - may or may not meet the target consistently

Complaints outstanding at 90 days

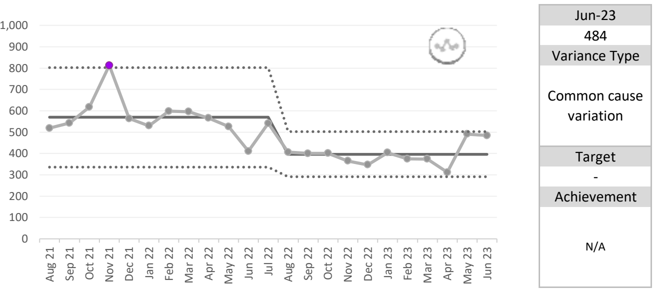
Number of complaints still open after 90 days.



Jun-23
0
Variance Type
Special cause variation - improvement
Target
0
Achievement
Incapable process - likely to consistently fail to meet the target

PALS contacts

Total number of contacts and queries received by PALS during the reporting month.



Jun-23
484
Variance Type
Common cause variation
Target
-
Achievement
N/A

PALS responses

The proportion of PALS emails answered within 3 working days of receipt.

Currently not enough data for an SPC chart.

May = 97%
June = 99.5%

Outstanding Care

Buckinghamshire Healthcare NHS Trust

Operational Standards - Maternity

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Stillbirths - total cases	Jun 23	3	0			1	-2	4
Neonatal deaths	Jun 23	0	0			0	-1	1
Term birth <10th centile	Jun 23	2.3%	7.0%			3.5%	0.7%	6.2%
Term admissions to neonatal unit	Jun 23	3.7%	5.0%			4.2%	1.5%	6.9%
Preterm birth	Jun 23	7.3%	6.0%			5.6%	1.9%	9.4%
Preterm birth < 24 weeks	Jun 23	0.0%	6.0%			0.1%	-0.3%	0.5%
Preterm birth > 24 weeks	Jun 23	7.3%	6.0%			5.6%	2.0%	9.1%

Pre term birth optimisation

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Place of birth achieved	Jun 23	100%	80%			97%	86%	108%
Magnesium sulphate achieved	May 23	75%	80%			90%	53%	128%
Antibiotics achieved	May 23	75%	80%			59%	-13%	131%
Steroids achieved	May 23	25%	80%			50%	-43%	143%
Optimal cord management achieved	May 23	75%	80%			55%	-33%	144%
Thermoregulation achieved	Jun 23	100%	80%			83%	6%	159%
Expressed breatmilk achieved	Jun 23	100%	80%			81%	25%	136%

What the charts show us

Term birth < 10th centile: This metric is experiencing common cause variation i.e. no significant change. However the target lies above the current control limits and will be consistently achieved unless something changes in the process.

Pre term birth < 24 weeks: This metric is experiencing special cause variation of an improving nature with the last six data points falling below the central line. The target lies above the current control limits and will be consistently achieved unless something changes in the process.

Pre term birth optimisation - place of birth achieved: This metric is experiencing common cause variation i.e. no significant change. However the target lies below the current control limits and will be consistently achieved unless something changes in the process.

Pre term birth optimisation - antibiotics achieved: This metric is experiencing special cause variation of an improving nature with the last eight data points falling above the central line. The target lies within the current control limits and so the metric will consistently hit or miss the target.

All other metrics are showing common cause variation i.e. no significant change.

Outstanding Care

Operational Standards - Maternity

Stillbirths
There were 3 stillbirths in June:
One was a 35-week infant where there was a previous pregnancy complication but no antenatal concerns this pregnancy. The woman experienced a spontaneous intrauterine death, the umbilical cord was found to be around the baby's neck at birth but as yet the cause of death is unknown.
The second was a 39-week infant born to a woman that booked with a carbon monoxide level of 23 (target is <4) and declined smoking cessation. There was a history of alcohol use. Appropriate clinical care was provided during pregnancy in relation to the mother's risk factors, however a spontaneous intrauterine death occurred.
The third was a 36-week intrauterine death that occurred on 30th June. A review is currently underway (owing to the weekend).
Unless immediate concerns are identified with the final case, all cases will be reviewed through the PMRT process.

Neonatal deaths
No neonatal deaths occurred in June.

Births less than the 3rd centile have remained below 2% for the past 3 consecutive months. New processes for identification of babies at risk are now stable but will continue to be monitored through collection of SBL data.

Term admissions were less than 4% in June, this is an improvement on previous months. The Avoiding Term Admissions to Neonatal Unit (ATAIN) action plan 23/24 has been approved.

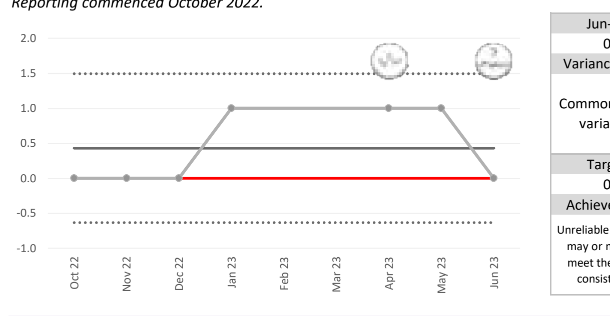
Stillbirths - total cases

Number of cases of stillbirths at 24 weeks or later in month.

Jun-23
3
Variance Type
Common cause variation
Target
0
Achievement
Unreliable process - may or may not meet the target consistently

Neonatal deaths

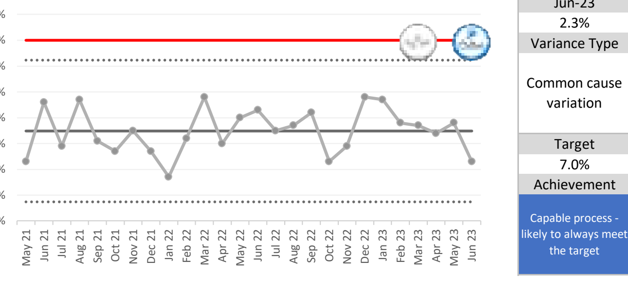
Actual number of neonatal deaths in month.
Reporting commenced October 2022.



Jun-23
0
Variance Type
Common cause variation
Target
0
Achievement
Unreliable process - may or may not meet the target consistently

Term birth <10th centile

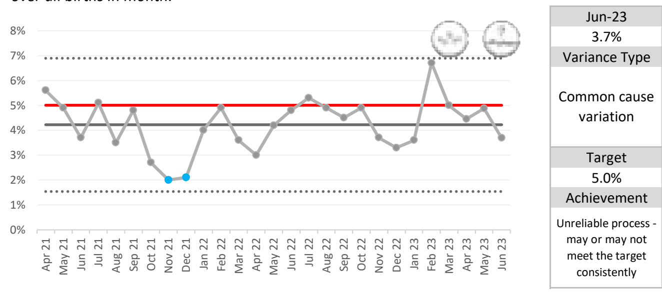
The number of babies born after 37 week gestation with a weight below the 10th centile over all births in month.



Jun-23
2.3%
Variance Type
Common cause variation
Target
7.0%
Achievement
Capable process - likely to always meet the target

Term admissions to neonatal unit

The number of babies born after 37 week gestation who were admitted to the neonatal unit over all births in month.



Jun-23
3.7%
Variance Type
Common cause variation
Target
5.0%
Achievement
Unreliable process - may or may not meet the target consistently

Outstanding Care

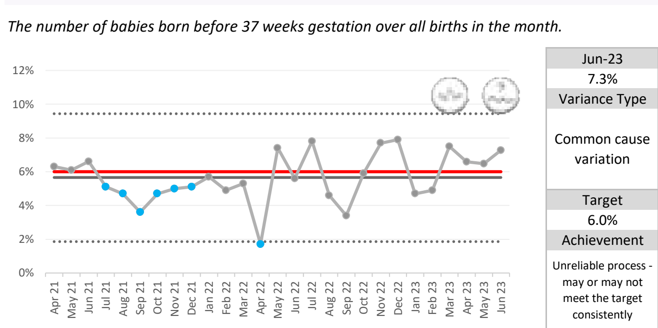
Operational Standards - Maternity

Preterm birth
Preterm birth data is presented one month in arrears owing to a lack of electronic patient record. The following elements were either stable or improved: place of birth, antibiotics, optimal cord management, thermoregulation and early breastmilk. Individual case reviews will commence in September to review more detail regarding missed elements of the bundle. Two new additions to the preterm birth optimisation care bundle will be added from August 2023. These are probiotics and caffeine.

Preterm birth less than 24 weeks has remained at 0% since November 2022

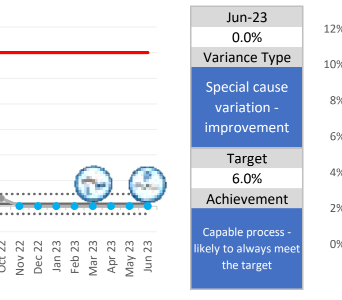
Preterm birth

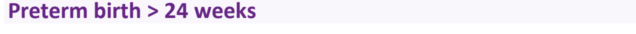
The number of babies born before 37 weeks gestation over all births in the month.



Preterm birth < 24 weeks

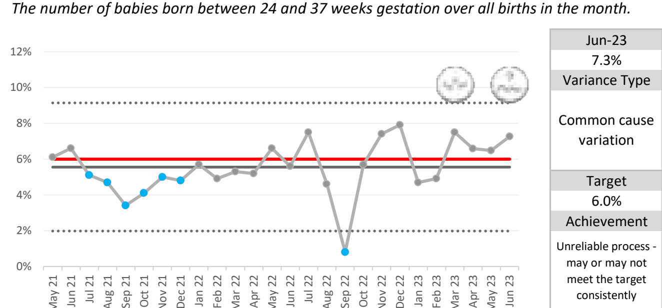
The number of babies born before 24 weeks gestation over all births in the month.





Preterm birth > 24 weeks

The number of babies born between 24 and 37 weeks gestation over all births in the month.



Outstanding Care

Operational Standards - Maternity

Pre term birth optimisation

Percentage of pre term birth optimisation elements achieved.

Place of birth achieved

Magnesium sulphate achieved

Antibiotics achieved

Steroids achieved

Optimal cord management achieved

Thermoregulation achieved

Expressed breatmilk achieved

Healthy Communities

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Community Contacts	Jun 23	55438	-			49414	41668	57159
Cardiology referrals from deprived wards	Jun 23	22.5%	-			20.4%	17.0%	23.7%
Maternity smoking at time of booking	Jun 23	6.0%	-			6.7%	2.2%	11.1%
Maternity smoking at time of delivery	Jun 23	6.0%	5.0%			6.2%	2.5%	10.0%
Breastfeeding at birth	Jun 23	74.0%	-			72.7%	62.1%	83.2%
Breastfeeding at discharge	Jun 23	83.0%	-			65.6%	46.6%	84.6%
Health visitor appointments - 14 days	May 23	80.6%	-			72.4%	59.2%	85.7%
Breastfeeding at 6-8weeks			-					
Children having 1 year health review			-					
Children having 2 year health review			-					
Frailty			-					

What the charts show us

Cardiology referrals from deprived wards: This metric is experiencing special cause variation of an improving nature with the last six data points falling above the central line.

Breastfeeding at discharge: This metric is experiencing special cause variation of an improving nature with the last three data points close to the upper control limit.

All other metrics are showing common cause variation i.e. no significant change.

Healthy Communities

In June, the Healthy Communities data is being reported for the first time.

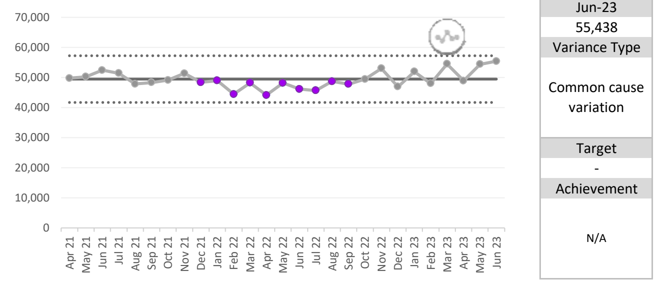
Good progress has been made for smoking at time of delivery, with the maternity tobacco dependency service starting in June and 100% of women smoking at booking being referred, with 44% of those referred accepting this support. It is expected to see a demonstrable impact from this from December - January when women booking from June onwards give birth.

A plan is being developed to increase referrals to cardiology from the most deprived areas, including engagement with GPs from Opportunity Bucks wards and attendance at Community Action Days, a trajectory and target of an increase of 7.5% at the end of the year has been set and an impact should start to be seen by the end of quarter 2.

In quarter one, 30% of patients in the Emergency Department have had a Clinical Frailty Score. Data will be included in the August IPR. The team continue to work towards achieving this throughout the year with the Clinical Frailty Score app and e-learning modules now available to support staff

Community Contacts

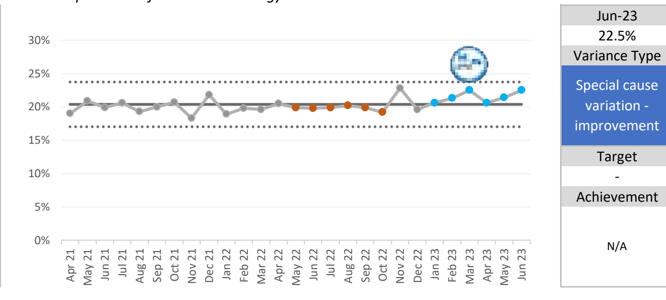
Total number of attended community contacts in the month.



Jun-23
55,438
Variance Type
Common cause variation
Target
-
Achievement
N/A

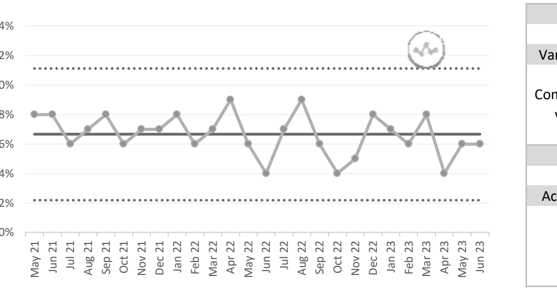
Cardiology referrals from deprived wards

The percentage of patients being referred to cardiology services from the most deprived areas over all patients referred to cardiology services in the month.



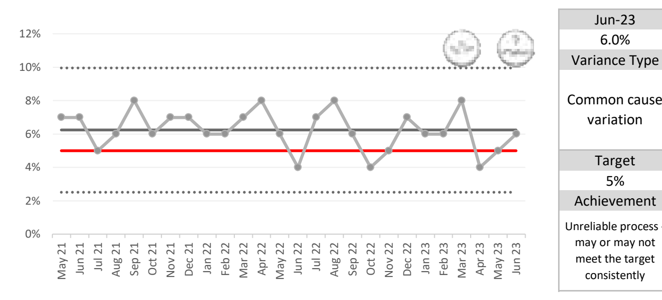
Jun-23
22.5%
Variance Type
Special cause variation - improvement
Target
-
Achievement
N/A

Maternity smoking at time of booking



Jun-23
6.0%
Variance Type
Common cause variation
Target
-
Achievement
N/A

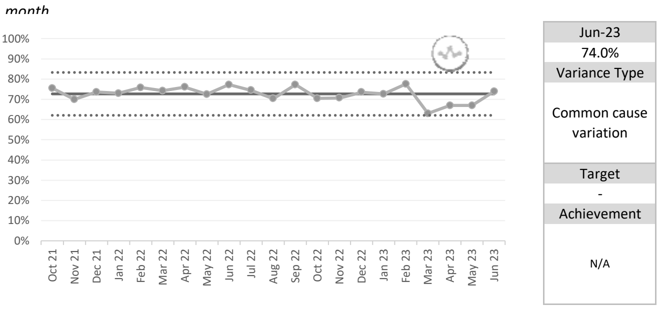
Maternity smoking at time of delivery



Jun-23
6.0%
Variance Type
Common cause variation
Target
5%
Achievement
Unreliable process - may or may not meet the target consistently

Breastfeeding at birth

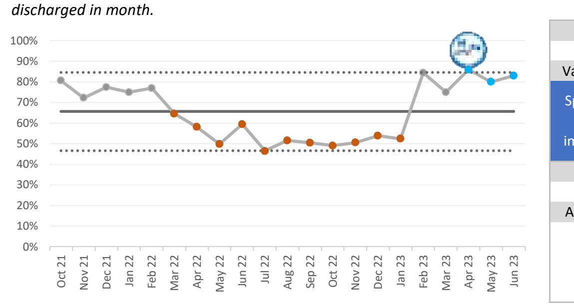
The percentage of babies receiving maternal breastmilk for first feed over all babies born in month



Jun-23
74.0%
Variance Type
Common cause variation
Target
-
Achievement
N/A

Breastfeeding at discharge

The percentage of babies having breastmilk at the point of discharge over all babies discharged in month.



Jun-23
83.0%
Variance Type
Special cause variation - improvement
Target
-
Achievement
N/A

Healthy Communities

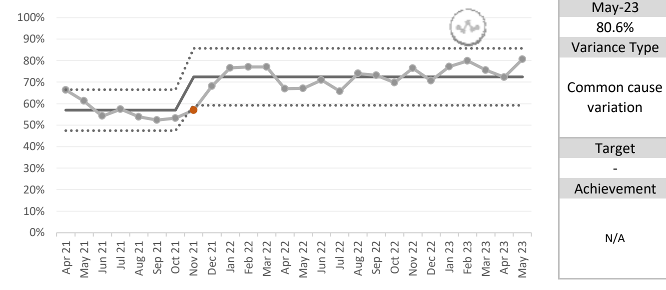
Health Visitor appointments - 14 days
Q1 23/24 to date, May 23 demonstrates a sustained improvement. Assurance is provided to the Commissioners against the 14 day target for vulnerable families.

Success: Recruited three Student Health Visitors (HVs) starting in Sept 2023, two of these were community staff nurses in the HV team. Additionally, three student HV are on target to qualify in September. Additional recruitment of three externally appointed HV to be in post by September

Challenge: Currently writing the tender bid for renewal of the Healthy Child contract with planned workforce transformation. The new service specification will require additional targeted and specialist contacts and an improved digital offer.

Health visitor appointments - 14 days

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



Breastfeeding at 6-8weeks

The percentages of full term babies (>37 weeks) fully breastfed at 6-8 weeks over all full term babies having a 6-8 weeks check up in month.

Children having 1 year health review

Children having 2 year health review

Frailty

A Great Place to Work

Ensuring our people are listened to, safe and supported

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Trust overall vacancy rate	Jun 23	10.4%	10.0%			8.1%	4.5%	11.6%
Nursing and midwifery vacancy rate	Jun 23	11.3%	8.5%			9.3%	6.2%	12.3%
Turnover rate	Jun 23	11.6%	12.5%			12.7%	12.0%	13.3%
Average time to replace vacancies	Jun 23	45.6	56.0			48.2	36.4	60.1
Leavers < 1 year service			-					
Sickness	Jun 23	2.9%	3.5%			4.4%	3.0%	5.8%
Sickness - mental health	Jun 23	0.46%	-			0.73%	0.55%	0.92%
Occupational health management referrals	Apr 23	91%	95%			94%	86%	102%
Referrals into OH and Wellbeing - stress	Apr 23	119	-			95	51	139
Data security awareness training	Jun 23	90.1%	95.0%			87.7%	85.0%	90.4%
Statutory and Mandatory training	Jun 23	91.2%	90.0%			88.0%	86.1%	89.9%
Corporate induction	Mar 23	97.8%	95.0%			98.8%	96.4%	101.2%
Peaks programmes			-					

What the charts show us

Turnover rate: This metric is experiencing special cause variation of an improving nature with the last two data points falling below the lower control limit. The target lies within the current control limits and so the metric will consistently hit or miss the target.

Sickness: This metric is experiencing special cause variation of an improving nature with a run of seven decreasing data points. The target lies within the current control limits and so the metric will consistently hit or miss the target.

Sickness - mental health: This metric is experiencing special cause variation of an improving nature with the last three data points falling below the lower control limit.

Referrlas into OH and Wellbeing - Stress: This metric is experiencing special cause variation of an increasing nature where up is neither improvement nor concern, with the last nine data points falling above the central line. However the latest data was not available at the time of report production.

Data security awareness training: This metric is experiencing common cause variation i.e. no significant change. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

Statutory and Mandatory trainings: This metric is experiencing special cause variation of an improving nature with the last four data points falling above the upper control limit. However the target lies above the current control limits and so cannot be achieved unless this improvement continues.

Corporate induction: This metric is experiencing common cause variation i.e. no significant change. The target lies below the current control limits and will be consistently achieved unless something changes in the process.

All other metrics are showing common cause variation i.e. no significant change.

A Great Place to Work

Ensuring our people are listened to, safe and supported

Overall vacancy rate
The overall vacancy rate has further reduced by 0.7%. We anticipate further reductions in the vacancy rate during July and August as a result of recruitment from both within and outside of the UK for a number of roles.

Nursing and Midwifery vacancy rate
This month saw a further reduction of 1.2% in the Nursing & Midwifery vacancy rate. The number of registered nurses in post increased in month by 24.5fte. Recruitment plans include international recruitment and UK recruitment (including graduate students). We continue to focus on recruitment of existing temporary staff into our substantive workforce.

Turnover
Turnover fell again in June by 0.3% and remains below our Trust target of 12%.

In June, a total of 41 colleagues left BHT (excluding end of fixed term contracts). Of these, 12 were Nursing and Midwifery, 10 Admin and Estates, 5 AHP's and 5 HCA's.

The leading cause of resignation was relocation, with 11 colleagues selecting this reason. Work life balance (8 colleagues) was the second highest reason for leaving.

Our People Promise programme is now in its second year and is focused on improving retention at BHT and incorporating national best practice. The multiple workstreams in this programme are key contributing factors to our reduced turnover.

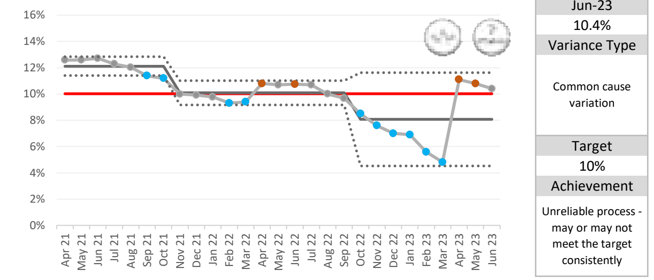
Average time to recruit
The average time to recruit saw a further reduction of 5.7 days since May following improvements to internal processes. The recruitment team continue to receive positive feedback from applicants/colleagues and appointing managers.

No. of leavers < 1 year
In June, 9 colleagues left BHT with under a year's service. A number of different reasons for leaving were cited, with no particular trend. Of the total number of these leavers, 3 were HCSW's, 3 Support Staff, 2 Admin and Estates and 1 N&M.
The majority of these leavers were Band 2 (55.6%).

As part of the work to reduce the number of leavers with under a year's service, we have a dedicated workstream focused on improving the onboarding journey from the moment someone reads a BHT job advert throughout their first year. We also have a separate HCSW retention programme, focused on improving the retention of this population.

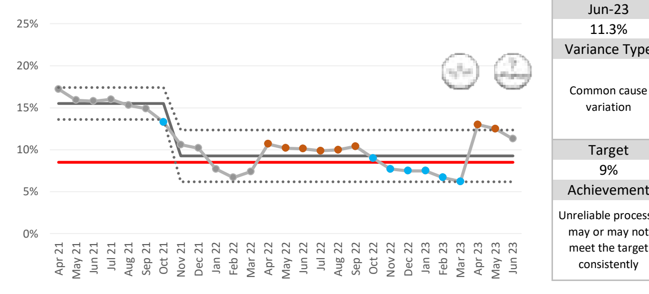
Trust overall vacancy rate

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



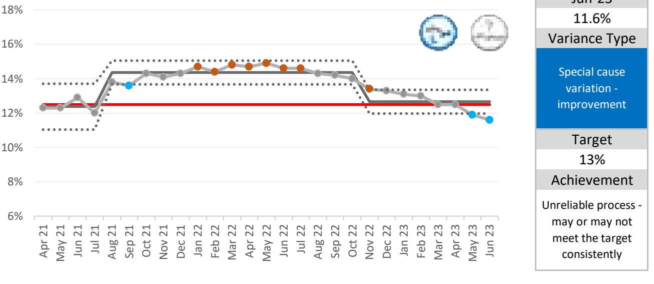
Nursing and midwifery vacancy rate

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



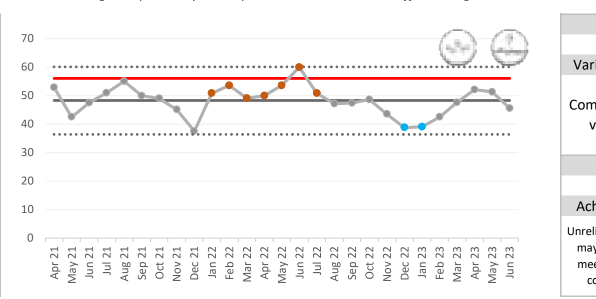
Turnover rate

% number of FTE staff that have left the employment of the Trust compared to the total FTE staff employed by the Trust. Rolling 12 months.



Average time to replace vacancies

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



Leavers < 1 year service

Number of leavers with <1 year service with BHT

Latest data not available at the time of report production.

A Great Place to Work

Ensuring our people are listened to, safe and supported

Sickness
June saw a further reduction in the sickness absence rate from 3.1% to 2.9% (remaining within the Trust 3.5% threshold).

Work has begun on reviewing Sickness Absence Policy.

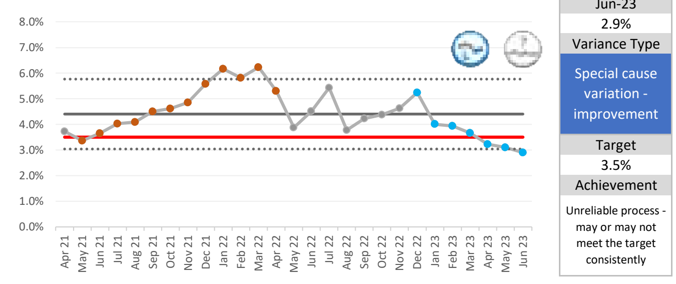
Occupational Health
MSK clinics in OH are very busy due to an increase in colleagues requesting advice on MSK issues alongside formal referrals from managers. OH are staying within its performance targets for management referrals, however demand remains high and requires triage.

OH and Wellbeing
Mental Health sickness absence has increased slightly from last month from 0.42% to 0.46%.

Although mental health sickness has increased, encouragingly wellbeing referrals have also increased from 109 to 111 which highlights a further proactive trend in colleagues seeking support, which therefore helps the individual in the long term.

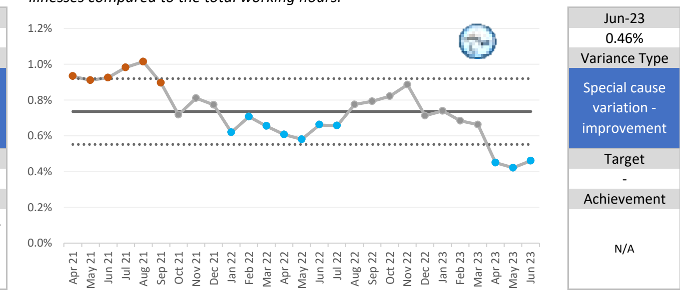
Sickness

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



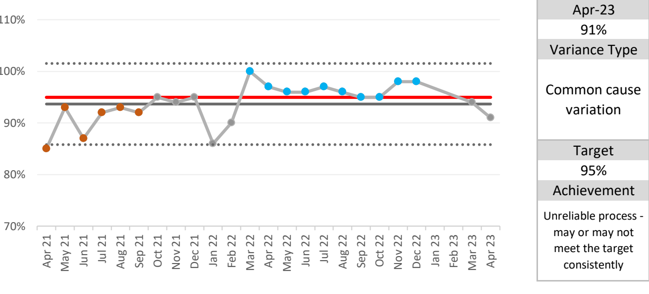
Sickness - mental health

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



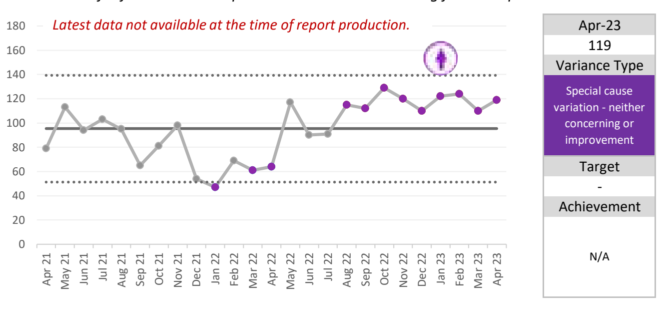
Occupational health management referrals

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



Referrals into OH and Wellbeing - stress

The number of referrals into Occupational Health and Wellbeing for stress per month.



A Great Place to Work

Ensuring our people are listened to, safe and supported

NHS Buckinghamshire Healthcare NHS Trust

Data Security awareness training
On 30th June Trust wide compliance was at 90%. The Information Governance Team continue to follow-up non-compliance and send comms bulletins, newsletter reminders and provide Pay Day training.

Statutory and Mandatory training
Compliance has increased in month and now reports at 91.24%.

Compliance is highlighted at the monthly Trust-wide steering group and are working with the Subject Matter Experts to improve compliance for their specific subjects.

Corporate Induction
A 100% attendance record has been achieved at the BHT Welcome & Induction event. The second BHT Connecting event was held on 27th June. This was attended by 116 new starters with 26 stands from teams across the Trust. Attendees expressed how beneficial the event had been for their onboarding experience. The next quarterly event is scheduled for September 2023.

Peaks Programme
Peak 1 – virtual
3 modules were scheduled and delivered:
90 managers had enrolled of which
61 attended

Peak 1 – face-to-face
Cohort 2 – Day 1
55 managers were enrolled of which
32 attended

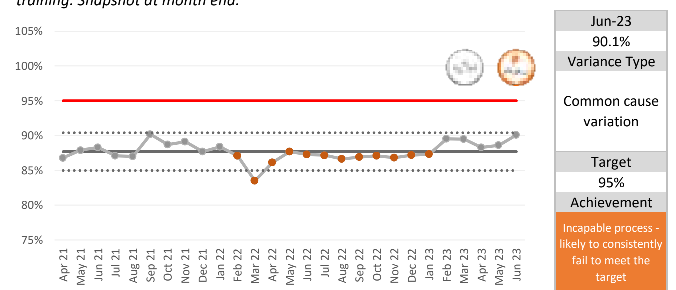
Peak 2 – virtual
4 modules were scheduled and delivered:
79 managers were enrolled of which
53 attended

Peak 2 – face-to-face
There was no face-to-face cohort scheduled in June.

Peak 3
Cohort 1 is currently running with 28 colleagues in the cohort, which is due to graduate in September. Including the 22 colleagues already graduated, we are currently on track to achieve our target to have 300 senior managers having been through at least one of Peaks programmes.

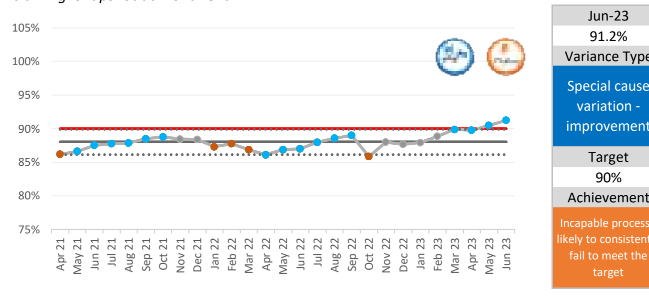
Data security awareness training

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



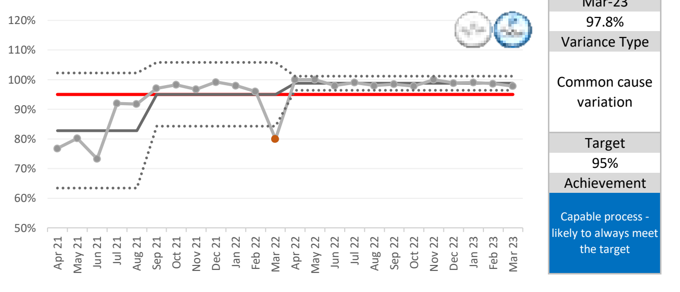
Statutory and Mandatory training

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



Corporate induction

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



Peaks programmes

Number of managers participating in Peaks programmes.

Latest data not available at the time of report production.

Outstanding Care

Operational Standards - Productivity

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
NHSE productivity model for improvement	Metrics to be agreed							
VWA activity monthly								
Temporary staffing								
Theatre downtime measure								

What the charts show us

Outstanding Care

Operational Standards - Productivity

NHSE productivity model for improvement

Metrics to be agreed.

VWA activity monthly

Metrics to be agreed.

Temporary staffing

Metrics to be agreed.

Theatre downtime measure

Metrics to be agreed.

Meeting: Trust Board Meeting in Public

26 July 2023

Agenda item	BHT 2023-24 Breakthrough Objectives
Board Lead	Duncan Dewhurst, Chief Digital Information Officer
Type name of Author	Debbie Hawkins, Head of QI &Transformation
Attachments	BHT Breakthrough Objectives Q1 2023/24
Purpose	Assurance
Previously considered	Transformation Board 19.07.2023

Executive Summary

The 2023/24 Operating Plan set out the Trust's medium-term strategic goals, and the Trustwide areas of focus for 2023/24, our 'breakthrough objectives'.

These breakthrough objectives provide a small set of organisation-wide priorities which are understood and owned by everyone.

Achievement of these objectives will enable a step change towards delivering our medium-term goals.

This report provides the Q1 update on progress against the breakthrough objectives.

Decision	The Board is requested to • Take assurance from the progress, current status and risks regarding delivery of the breakthrough objectives.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	As breakthrough objectives are progressed, 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 provide consistent access to high quality care for Children and Young People (CYP) 5. Failure to support improvements in local population health and a reduction in health inequalities 6. Failure to deliver on our people priorities related to recruitment & resourcing, culture &

	leadership, supporting our staff, workforce planning & development and productivity. 7. Failure to provide adequate buildings and facilities. 8. Failure to learn, share good practice and continuously improve.
Financial	None related to this report. Financial implications/requirements for specific breakthrough objectives addressed through normal process.
Compliance Select an item. **Good Governance**	This report provides assurance on the delivery of the Trust's breakthrough objectives.
Partnership: consultation / communication	Each breakthrough objective is owned by named individuals. This report has been produced based on input from these leads.
Equality	As breakthrough objectives are developed and implemented, 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 plans are developed, QIAs will be completed for specific plans in line with the Trust's QIA process.

BHT 2023-24 Breakthrough Objectives

Q1 Update Jul 23 Trust Board

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

Outstanding Care, Healthy Communities, Great Place to Work

Personalised, compassionate care every time

	Outstanding Care	Healthy Communities	Great Place to Work
Vision	Outstanding Care, Healthy Communities, Great Place to Work		
Mission	Personalised, compassionate care every time		
Strategic Goals 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**
Outcome Measures 2025	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%
Focus for 2023/24	Improve waiting times in our emergency department, with <4% of patients waiting more than 12 hours Improve safety, with 80% of acute and community services having a clinical accreditation assessment by Apr ’24, 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, with the aim of 300 managers in key roles equipped with enhanced technical, management and leadership skills (impact measured by quarterly pulse surveys and national staff survey)

Outstanding Care - Improving waiting times in our emergency department

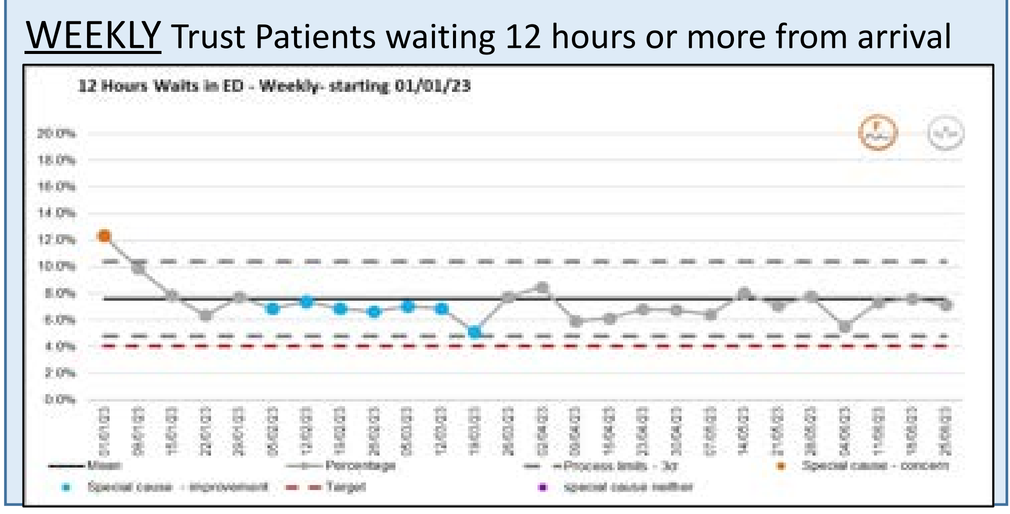
Aim: Improve waiting times in our emergency department, with <4% of patients waiting more than 12 hours

Current Status

- In this reporting period, inconsistent performance due to rising numbers of Emergency Admissions impacting the number of persons remaining in the Emergency Department >12hrs. Contributing factor is limited early flow to specialty wards. In Jun, achieved target of 4% or less on 1 day with best performance day of 3.63% and worst 14.15%.
- UEC programme is well developed, with five workstreams supporting achievement of this breakthrough objective, focusing on: attendance avoidance and redirection; admissions avoidance; improving quality of care and flow through ED; optimal use of SDEC and assessment areas; and improved patient flow and discharge.
- Key interventions already in place include
    - New Emergency Department (ED) footprint in place
    - Extended hours in Urgent Treatment Centre (UTC) and Same Day Emergency Care (SDEC)
- The further planned interventions will support delivery of the 4% target, however there are key risks below, for some of which we have limited control.

Key risks

- Limited control over patient attendances, however work continues with ICB on alternative pathways and redirection pathways through the UEC programme.
- Winter pressure (as above).
- Patient flow and Medically Optimised - Workstream 5 of UEC Programme along with Transfer of Care Hub working to address these issues.



Planned Interventions

Right patient, right place, first time.

- 24/7 UTC
- Full staffing model in SDEC
- Hot lab (diagnostics) in ED footprint
- Full ED consultant staffing by end Sept
- Redirection pathways (pharmacy etc.)
- Avoidable admissions (Urgent Community Response, MUDAS, etc).
- Hospital @ Home capacity expansion
- Learning from AMU & Ward 10 discharges
- Medical Decision Unit (MDU) pilot on ward 18
- Discharge Rapid Improvement Event
- New ward

Outstanding Care – Improving safety through clinical accreditation

Aim: Improve safety, with 80% of acute and community services having a clinical accreditation assessment by Apr '24, and 40% of those assessed achieving silver accreditation

Overview

The Accreditation Programme is an internal quality and safety assessment of the care delivered within the department. A structured Trust-developed framework is used to undertake the evaluation of a department by a team of peer assessors. During the accreditation visit, the department is assessed against 14 standards, good practice is observed and advice given on areas that need to be improved.

To achieve the breakthrough objective, this requires 81 areas, of the total of 102, to have a completed clinical accreditation assessment by Mar '24, with 32 achieving Sliver accreditation.

Progress to date (Jun '23)

- Accreditation process completed for 31 areas (30%) of which 29 are wards, 1 ICU and 1 outpatient area
- 16 Silvers and 15 Bronze awards have been achieved
- Currently working at a maximum of 8 areas to accredit every month
- Remaining: 48 areas to complete by end Mar '24 to achieve the target of 80%; 16 additional areas to achieve aim of 40% Sliver

Risks

- Availability of administrative support to complete data reporting
- Timely return of question sets tailored for each individual area
- Availability of the multidisciplinary team to complete peer reviews
- Risk for scheduled accreditation to be cancelled due to unforeseen circumstances including but not limited to workforce issues and or IPC concerns.

Risks are being mitigated through a range of actions to support achievement of the breakthrough objective. The programme trajectory has also built-in small allowance for cancellations of scheduled inspections.

Celebration

As well as improving quality and safety, clinical accreditation provides an opportunity to showcase teams and their achievements, enhance collaborative work amongst groups and individuals, and find commonality in day-to-day challenges.

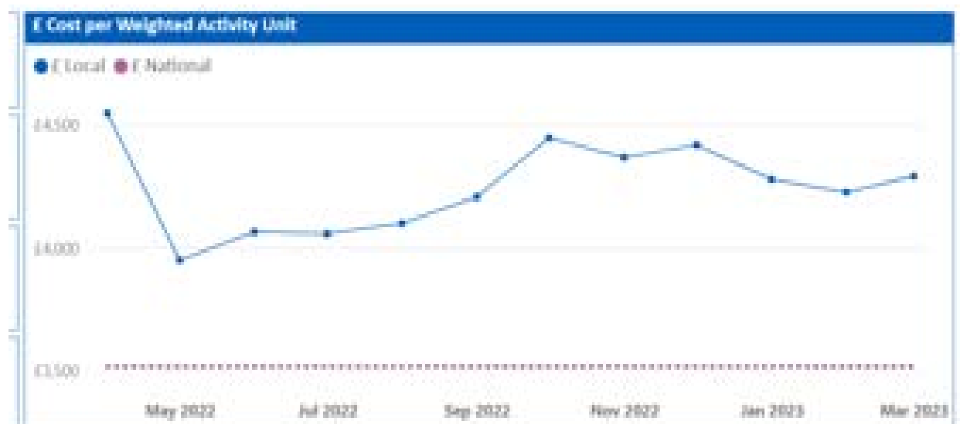
Outstanding Care – Improving productivity

Aim: Improve productivity in every service, with overall Trust improvement of at least 5%

Current Status

- Trust productivity measured by national NHS productivity report and the WAU (Weighted Activity Unit). National report shows BHT as 10.6% less productive than 19/20, however BHT compares favourably to national figure of 14.7%; BHT positive improvement from 16.1% in M02 of 22/23.
- Using the WAU however, our Trust WAU is materially higher than the national WAU in Model Health.
- Cross-cutting programmes are underway to improve productivity:
    - Theatres – increased utilisation, reducing cancellations, increasing average cases per list, reducing LoS, increasing day case rate.
    - Outpatients – conversion of New to Follow-Up appointments; reduction in cancellations and DNAs; improvement in coding.
    - Diagnostics demand management - reducing unnecessary tests.
    - Urgent & Emergency – reducing length of stay; reducing avoidable attendances and admissions; improving flow; improving discharge.
    - Admin & Clerical review - reviewing use of digital and service models.
- Extensive work has been undertaken to develop a productivity dashboard, now ready for release.
- In addition to the national productivity measure and WAU, a suite of productivity measures has been defined – the majority will be reported in the IPR; they will be reviewed at monthly divisional Quality, Performance, Finance Reviews; and managed via Transformation Programme Boards.
- Trustwide 'Team brief' and communication focus for April on productivity, incl. video from CeO; presentation at leadership briefing; cascade of Team Brief. Clear definition for productivity set out as a combination of increasing activity / reducing cost. Ongoing communications required.

BHT WAU compared to national



Upcoming plans

- Three SDU pilot workshops on productivity & efficiency.
- Implementation of divisional/departmental productivity ideas developed at recent leadership away day.
- New IPR will provide visibility re productivity measures.
- Plan to be developed to build data capabilities.

Risks

- Improving productivity requires an increase in activity above the Trust's 23/24 Activity Plan. Impact of strike action currently being quantified; depending on materiality this may impact on the Trust's ability to deliver increased activity and therefore productivity.

Org Name	M1	M2*	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
ENGLAND		**(19.5%)**	**(18.4%)**	**(19.0%)**	**(19.2%)**	**(18.6%)**	**(17.3%)**	**(17.0%)**	**(16.6%)**	**(16.7%)**	**(16.3%)**	**(14.7%)**
Buckinghamshire Healthcare NHS Trust		(16.1%)	(16.6%)	(14.5%)	(14.1%)	(12.8%)	(12.3%)	(12.2%)	(12.2%)	(12.1%)	(11.6%)	(10.6%)

Healthy Communities – Improving access and effectiveness for communities experiencing the poorest outcomes

Reduce smoking in pregnancy, with less than 5% of women smoking at the time of delivery

- Data reported for first time – in Jun '23, 6% of women were smoking at time of delivery; expect impact of plans to start to be seen in in early Q3.
- Maternity Tobacco Dependency Advisor in post, one being recruited to.
- In June 100% of women smoking at booking were referred to smoking cessation.
- 44% accepted smoking cessation support.
- 32% of women smoking at booking have set a quit date.
- Carbon monoxide monitoring at booking and at 36 weeks is now reportable.

Increase % of people being referred to cardiology services from the most deprived areas

- Focus so far on establishing baseline data and developing plans to increase referrals.
- Improvement target now agreed – baseline 6126 referrals, aim to increase by 460 by Mar '24 = 7.5% increase overall, with trajectory of 2.5% increase in Sept; 5% increase in Dec.
- Data shows those from this most deprived areas have a 6% lower probability of being referred to Cardiology; however people from deprived areas make up 26% of cardiac attendances in the Emergency Department despite representing 22% of the total population. In addition, those from the most deprived areas are more likely to have risk factors i.e. smoking, highlighting the increased prevalence in these areas.
- Plans to increase referrals include communication to GPs in Opportunity Bucks areas and supporting community action days.
- Capacity for those in the most deprived areas agreed within Cardiology to support increase in referrals.

Improving the early identification of frailty, with more than 30% of patients in ED having a documented frailty score

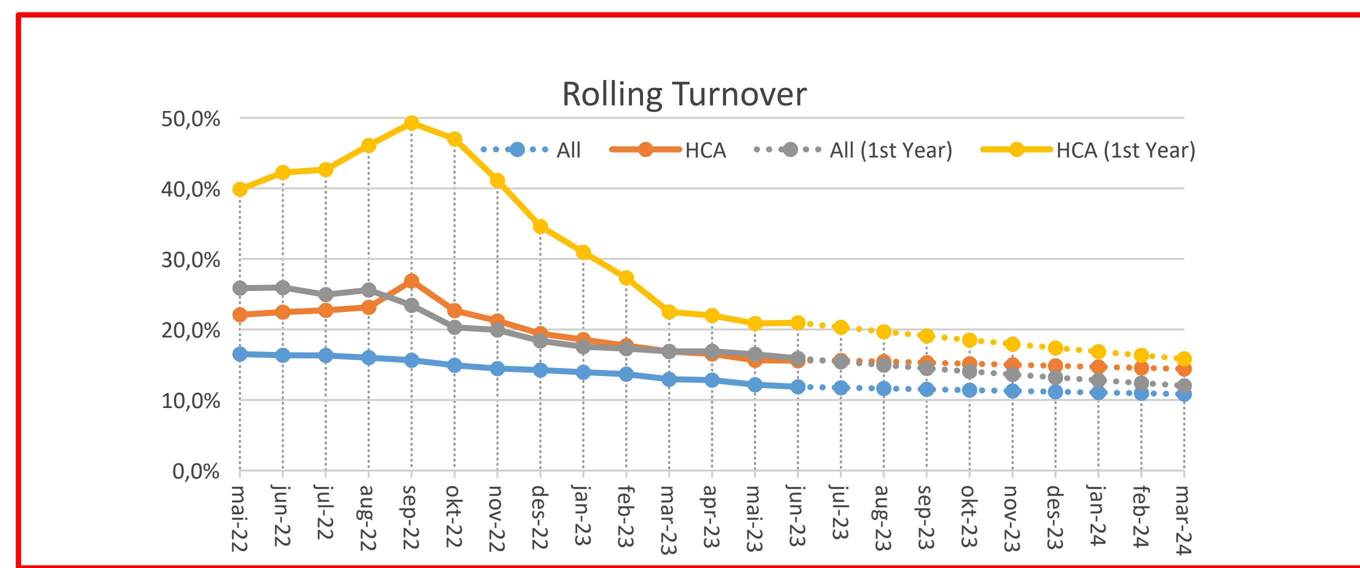
- 30% of Emergency Department (ED) patients were over 65 in Q1; of these 93% had a clinical frailty score (CFS) recorded – exceeding the original target of 30%. This has been the first opportunity to record scores to inform decisions based on acuity.
- Workshop on 'Frailty at Front door' delivered for ED staff. Quarterly workshops planned so staff are fully aware of the relevant pathways and pertinent conversations both in and out of ED, depending on the CFS.
- CFS app now available in BHT app store to improve staff confidence in calculating a score.
- Frailty webpage to include links to eLearning module and information on CFS app.
- Validation of CFS score has been undertaken to establish accuracy of scores.
- Key focus is now the development of patient pathways for patients with higher CFS.

Great Place to Work – Improving the experience of colleagues in the first year

Aim: 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)

Current Status

- Rolling turnover in first 12 months – 15.9% Jun ‘23, improvement from 16.5% May ‘23, reflecting sustained downward trend.
- Cross-cutting plan in place with actions to improve onboarding experience from moment people read job advert through first 12 months.
- Analysed reasons cited for leaving - leading reason ‘work life balance’ (as is the case for all leavers) - related programme in place focused on improving our ‘working flexibly’ culture.
- HCA assessment day group recruitment process has enabled changes to selection and onboarding (via dedicated assessment days) – seen significant improvement in turnover.



Plans

Improving our pre-employment journey

- Improving job adverts/other attraction communications
- Flexible Working at interview stage
- Improving our accessibility as an employer of choice for protected characteristics support
- Improving IT access
- Measuring experience through recruitment survey
- Preparing for first day e.g. rosters, contact points

Improving the first few weeks experience at BHT

- Local Induction to support onboarding
- Measuring experience through onboarding survey

Improving the first year experience at BHT

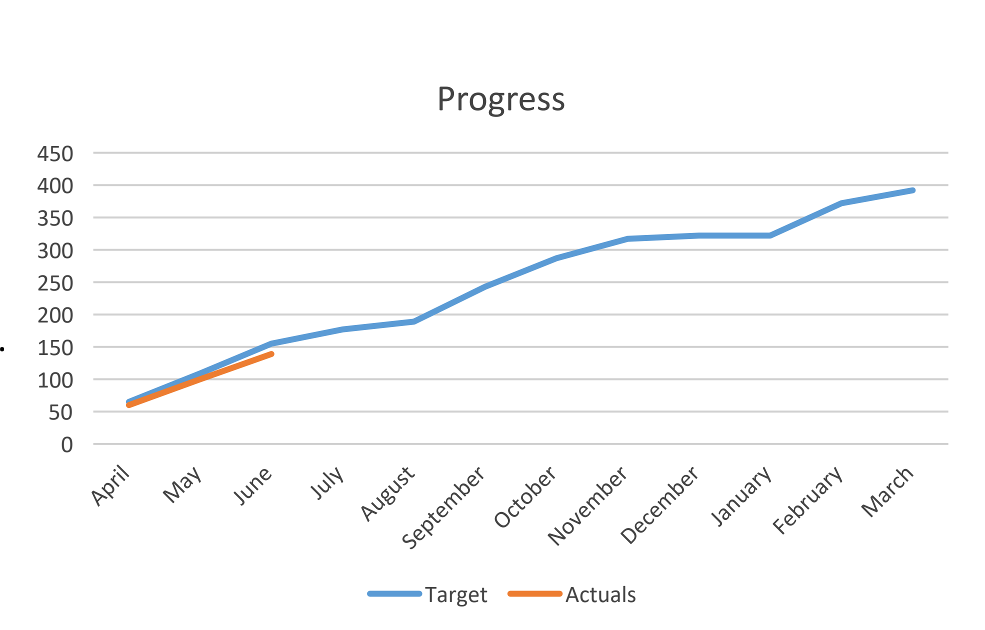
- Opportunities to keep in touch e.g. 6 monthly welcome events; regular check in sessions
- Communication with our colleagues e.g. ‘New to BHT’ newsletter
- Developing a career at BHT, focusing on appraisal conversations, talent management, secondment opportunities

Great Place to Work – Developing operational, clinical management and leadership skills

Aim: Develop operational and clinical management and leadership skills in key roles, with the aim of 300 managers in key roles equipped with enhanced technical, management and leadership skills (impact measured by quarterly pulse surveys and national staff survey)

Current Status

- Development offer includes: Peaks Leadership Programme (Peak 1, Peak 2, Peak 3); Operational Excellence; team development; external development.
- Progress to date includes
  - Programmes reviewed for currency, accuracy and relevance
  - Programmes socialised widely
  - Buy-in from all divisional colleagues
  - Face-to-face and virtual offerings facilitated
- Currently on track to deliver trajectory required to meet breakthrough objective.



Upcoming Plans

- A calendar of all leadership development activities across the trust to enable overall visibility and facilitate linking of events.
- Linking this programme to the Trust OD plan.
- Managing non-attendance in a more systematic way.

Risks

- Our leaders ability to attend due to increases in workload (demand) and decrease in resources (capacity).
- Capacity of Education and OD team to deliver.

Meeting: Trust Board Meeting in Public

26 July 2023

Agenda item	Month 3 2023/24 Finance Report
Board Lead	Jon Evans, Chief Finance Officer
Type name of Author	Jon Evans, Chief Finance Officer
Attachments	Month 3 2023/24 Finance Report
Purpose	Assurance
Previously considered	EMC 25.07.2023 F&BPC 25.07.2023

Executive Summary

As at Month 3 2023/24, the Trust is reporting a Month 3 YTD deficit of £(8.3)m, £0.4m better than the Month 3 YTD Planned Deficit of £(8.7)m. As at Month 3 there are no adjustments to funding in relation to level of Elective Recovery Activity undertaken.

Month 3 2023/24 YTD the Trust has delivered Efficiencies of £3.11m, £(0.06)m behind the Month 3 YTD Plan of £3.17m, the Trust is forecasting to deliver its £36.22m 2023/24 Efficiency Plan.

As at Month 3 20223/24 the Trust has delivered £1.69m of the £40.0m 2023/24 Capital Plan, the Trust is forecasting to deliver its Capital Plan for 2023/24.

The closing Cash Balance at the end of Month 2 2023/24 was £17.64m (£4.9m better than plan), with the forecast Cash Balance at the end of 2023/24 being £1.92m.

Decision	The Board is requested to take assurance from 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 annual financial plan
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 3 deficit of £(8.3)m, this is £0.4m better than the Month 3 2023/24 YTD Plan of £(8.7)m deficit.

1.2 Income is £0.5m favourable to plan YTD Month 3. Other income is £0.4m favourable to plan (at £9.9m year-to-date), relating to income for MRI activity, Private Patients and Overseas Visitors Income and Home First Project Income. Contract Income is £0.1m ahead of Plan Month 3 YTD at £137.5m, with BOB ICB income and NHSE Specialised Commissioning Activity Income reflected in line with 2023/24 agreements and offers and includes income for the 2023/24 Agenda for Change Pay Award.

1.3 Pay expenditure is £0.3m underspent YTD Month 3, at £(94.0)m against YTD Month 3 Plan of £(94.3)m. This includes the YTD cost of the 2023/24 Agenda for Change Pay Award. Substantive vacancies resulting in a £13.1m underspend YTD Month 3 are offset by a £(12.9)m pressure on bank, locum, agency and overtime staff costs. Agency costs of £(3.4)m YTD Month 3 are 3.6% of total staff costs YTD Month 3, which is below the 3.7% 2023/24 Cap.

1.4 Non Pay expenditure is £(1.2)m adverse to plan YTD Month 3, primarily due to outsourcing costs in Radiology and Pathology supporting Trust activity, Property Services Wycombe Tower costs £(0.18)m and PFI Cost pressures £(0.26)m.

1.5 As at Month 3 YTD, the Trust has delivered Efficiencies of £3.11m against the YTD Plan of £3.17m.

2 Capital

2.1 The Trust has reported £1.69m Capital expenditure YTD Month 3, of its £40.0m Capital Plan. The Trust is forecasting to deliver its full year 2023/24 Capital Plan of £40.0m.

3 2023/24 Year End Forecast

3.1 As at Month 3 2023/24 the Trust is forecasting to achieve its £(12.15)m Deficit Plan, in line with the 2023/24 Annual Plan submitted to NHSE/I.

3.2 As at Month 3 2023/24 the Trust is forecasting to deliver the £36.22m CIP Plan for 2023/24.

3.3 As at Month 3 the Trust is forecasting to deliver its £40.0m Capital Plan.

4 Balance Sheet

4.1 The value of the Trust's balance sheet is £(0.5)m lower than plan at Month 3 2023/24, the cash position is £4.9m better than plan, offset by Non-current assets being £(6.4)m worse than plan with Capital expenditure being behind plan YTD. Non-current borrowing is £0.9m better than plan at Month 3.

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

5 Action required from the Trust Board

5.1 The Board is requested to:

a) The Board is asked to take assurance from the report

APPENDICES
Appendix 1: Month 3 2023/24 Finance Report

Finance Report Month 3 - 30th June, 2023

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Page 5 Key Highlights: Expenditure (Pay & Workforce)

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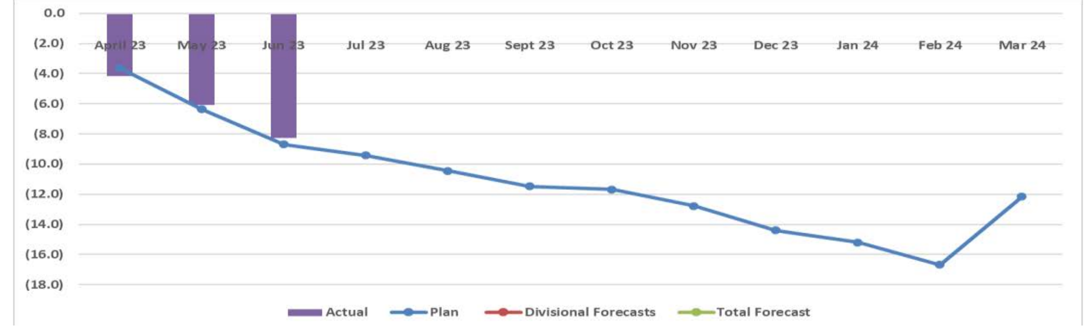
Financial performance

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	47.1	47.2	0.0	137.4	137.5	0.1	549.3
Other income	3.4	3.3	(0.1)	9.5	9.9	0.4	39.5
Total income	**50.6**	**50.5**	**(0.1)**	**146.9**	**147.4**	**0.5**	**588.8**
Pay	(32.7)	(31.8)	0.9	(94.3)	(94.0)	0.3	(363.1)
Non-pay	(16.7)	(17.7)	(1.0)	(50.7)	(51.9)	(1.2)	(196.4)
Total operating expenditure	**(49.4)**	**(49.5)**	**(0.1)**	**(145.0)**	**(145.9)**	**(0.9)**	**(559.6)**
EBITDA	**1.2**	**1.0**	**(0.2)**	**1.9**	**1.5**	**(0.4)**	**29.2**
Non Operating Expenditure	(3.5)	(3.4)	0.2	(10.6)	(10.2)	0.4	(41.4)
Retained Surplus / (Deficit)	**(2.3)**	**(2.3)**	**(0.0)**	**(8.7)**	**(8.7)**	**0.0**	**(12.1)**
Adjusted financial performance excluding profit on disposal of assets and excluding impairment	**(2.3)**	**(2.2)**	**0.1**	**(8.7)**	**(8.3)**	**0.4**	**(12.1)**

Graph 1 - Income & Expenditure YTD position & Forecast



Executive Summary

• The Trust reports a year-to-date (YTD) £0.4m favourable variance to plan as at June 2023/24 of £(8.3)m M3 YTD deficit, against the £(8.7)m Month 3 YTD deficit plan and revised £(12.15)m deficit annual plan as submitted to NHSE/I. The Trust is forecasting to achieve the £(12.15)m deficit plan for 2022/23, with mitigating actions.

• The Month 3 YTD capital spend is £1.5m against £5.1m Month 3 YTD plan of £21.3m 2023/24 Capital Allocation. Total CRL Funding of £29.4m includes BOB/ICS £21.3m Capital Allocation. PFI Lifecycle £1.7m, and PDC allocations of £6.2m (£5.7m for ERF and £0.6m for Digital Diagnostic Capability programme). As at Month 3 2023/24, 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. The Month 3 YTD Contract Income includes expected levels of funding from Commissioners for 2023/24 Agenda for Change Pay Award.

• Other income totals £9.9m YTD Month 3 2023/24, £0.4m favourable to plan, Specialised Services being £0.5m favourable to plan due to Income released to cover additional MRI costs and £0.13m non recurrent income from supporting another provider,. IECC income is £0.6m favourable to plan M3 YTD predominantly due to Home First Income.

• Pay costs for Month 3 YTD 2023/24 total £(94.0)m, including reflection of the cost of the 2023/24 Agenda for Change Pay Award YTD Month 3, resulting in a £0.2m surplus to plan Month 3 YTD. Within this overall position clincal areas continue to experience unplanned temporary staff spend, Trust total Agency, Bank & Locum spend is £13.3m Month 3 YTD, These overspends are offset by vacancies and central provisions for 2023/24.

• Non-pay operating expenditure totalled £(51.9)m M3 YTD 2023/24, £(1.2)m adverse variance against M3 YTD plan. Drugs costs are £(0.5)m adverse to Plan Month 3 YTD, a £(0.5)m overspend on PbR Excluded drugs, Other Drug expenditure including PBr Included Drugs is on plan M3 YTD. Clinical Supplies is £(0.5)m overspent Month 3 YTD at £(10.2)m, PFI costs are £(0.5)m overspent against Plan M3 YTD at £(7.2)m.

• Non operating expenditure reports a £0.5m favourable variance to plan in YTD Month 3 2023/24.

Key Highlights: Income

NHS Income and Activity

• The Contract Income position totalled £137.5m for Month 3 YTD 2023/24 which is £0.1m ahead of Month 3 YTD plan, with the 2023/24 plan being based upon contract offers where available and expected contract values where not yet agreed.

• Other Income is £0.4m favourable to plan Month 3 YTD at £9.9m, Specialised Services being £0.5m favourable to plan due to Income released to cover additional MRI costs and £0.1m non recurrent income from supporting another provider. IECC income is £0.6m favourable to plan M3 YTD predominantly due to Home First Income. Overseas Visitors and Private Patients Income is £0.2m above plan M3 YTD .

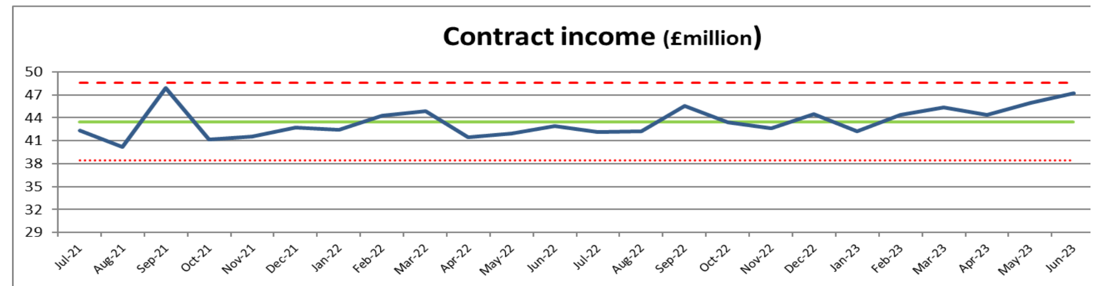
• As at Month 3 YTD no adjustments have been made for actual levels of activity undertaken for the Elective Recovery Funding (ERF) received by the Trust as part of our contract baseline values for 2023/24.

• 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)	410.0	102.5	102.5	0.0
BOB ICS (Additional Inc)	0.0	0.0	0.0	0.0
Bob Block Sub Total	**410.0**	**102.5**	**102.5**	**0.0**
Associates	37.7	9.4	9.4	0.0
Specialist Commissioners	77.4	19.3	19.3	0.0
Regional Specialist	4.8	1.2	1.2	0.0
Other NHS	3.5	0.9	0.9	0.1
Bucks Council	14.9	3.8	3.8	0.0
Other Income	1.0	0.2	0.2	0.0
Total	**549.3**	**137.4**	**137.5**	**0.1**

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



Other Income

Table 3 - Breakdown of other income

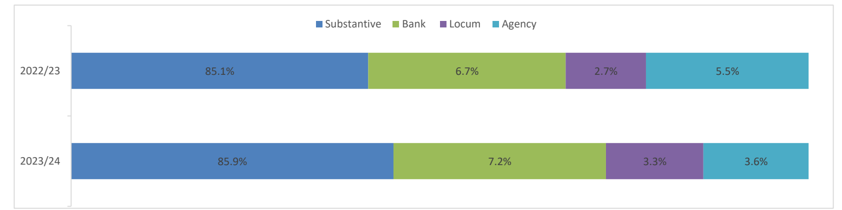
Category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Research	1.6	0.4	0.5	0.1
Education And Training	12.0	3.0	3.2	0.2
Non-NHS PPS & Overseas Visitors	3.5	0.9	1.1	0.2
Injury cost recovery scheme	1.2	0.3	0.3	(0.0)
Donated Asset Income	1.7	0.4	0.1	(0.3)
Other Income	19.5	4.5	4.7	0.2
Total	**39.5**	**9.5**	**9.9**	**0.4**

• Other Income (Table 3) is £0.4m favourable to plan for M3 YTD 2023/24 which is mainly related to income for Private Patients and Overseas Visitors and Income for MRI activity.

Key Highlights: Expenditure (Pay & Workforce)

Table 4 - YTD pay position

Pay category (£m)	YTD Budget	YTD Spend *	YTD Variance	% of Total Pay Bill	Last Year YTD Spend	Last Year % of Total Pay Bill
Substantive	93.8	80.7	13.1	85.9%	72.8	85.1%
Bank	0.2	6.8	(6.6)	7.2%	5.7	6.7%
Locum	0.1	3.1	(3.0)	3.3%	2.3	2.7%
Agency	0.1	3.4	(3.3)	3.6%	4.7	5.5%
Total	**94.3**	**94.0**	**0.3**	**100.0%**	**85.6**	**100.0%**

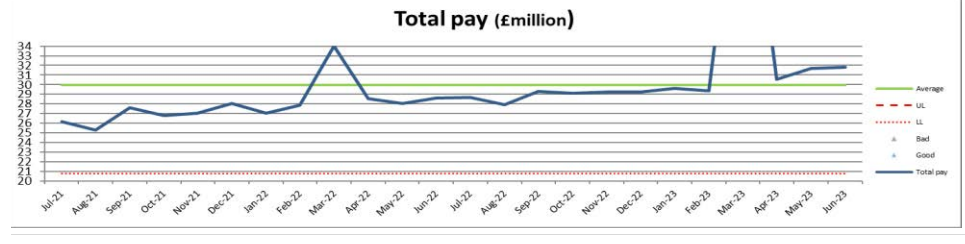


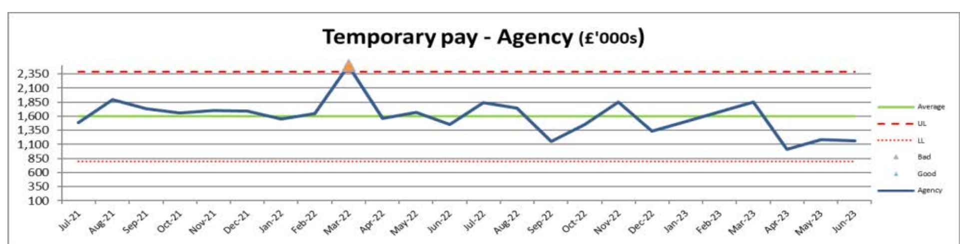
• Pay expenditure totals £(94.0)m for Month 3 YTD 2023/24 which is £0.2m favourable to M3 YTD Plan. The expenditure includes 2023/24 Pay Award costs Month 3 YTD and £(0.3)m for CEA awards. Key pressure areas in pay include Integrated Elderly and Community Care Division, £(0.6)m adverse to budget M3 YTD, £(0.3)m due to Medical Staffing rotas, actions are being undertaken to reduce this going forward (i.e combining ward medical staff rotas), alongside actions to achieve the 5% A&C savings target. There are also budget pressures in IECC nursing that will be reviewed. The Surgery & Critical Care division reports a £(0.7)m adverse variance to budget M3 YTD position, this is relating to temporary medical staff costs, partially due to the impact of the industrial action in Months 1 and 3, there are temporary Locum staffing costs covering Maternity Leave and gaps in Junior Doctors rotas and Industrial Action, together with WLI costs (£(0.2)m of the budget pressure), medical staffing accelerated recruitment is being worked on to fill vacant posts and reviews of current backfilling and locum oncall arrangements are being undertaken. Integrated Medicine is £(0.4)m adverse to budget M3 YTD, partially due to Admin & Clerical £(0.2)m overspent due to substantive roles, and Medical Staffing £(0.1)m in Neurology & Cardiology temporary staffing that is being reviewed, Nursing £(0.1)m due to high temporary staffing driven by double running with overseas nurses overspent due to temporary staffing pressures in Cardiology & Neurology.

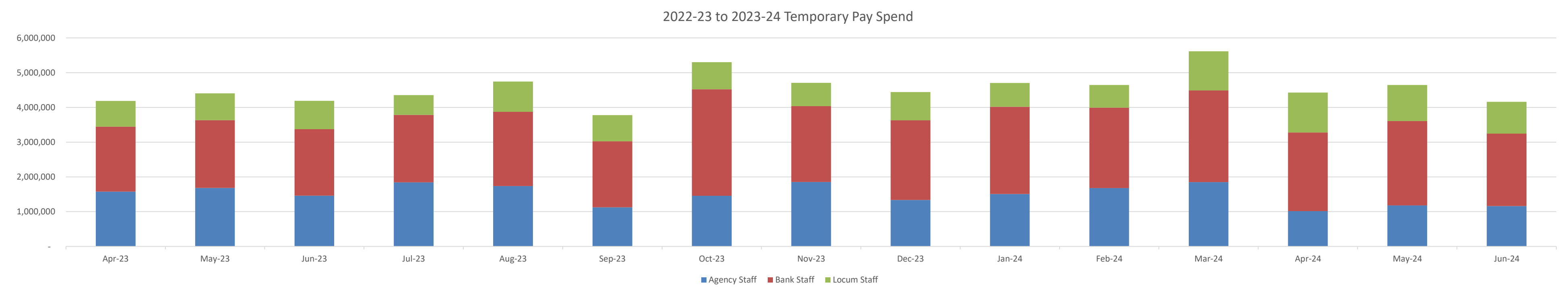
• Temporary staffing expenditure (Bank, Agency & Locum) totals £(13.3)m Month 3 YTD. These temporary costs are offset by vacancy related underspends within substantive budgets. Agency expenditure totals £(3.4)m Month 3 YTD, equating to 3.6% of total Pay costs YTD, this is below the 3.7% cap for 2023/24.

• 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	12.8	13.3	(0.5)
Clinical supplies	35.6	9.7	10.2	(0.5)
Other non-pay	109.6	28.2	28.4	(0.2)
Total Expenditure	**196.4**	**50.7**	**51.9**	**(1.2)**

Table 6 - YTD drugs position

Drug Categories (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
PBR Drugs	12.4	3.1	3.0	0.1
PBR excluded Drugs	37.0	9.3	9.8	(0.6)
Other Drug Items	1.9	0.5	0.4	0.1
Total expenditure	**51.3**	**12.8**	**13.3**	**(0.5)**

Non pay expenditure totals £(51.8)m for Month 3 2023/24 YTD, an overspend of £(1.1)m against the Month 3 YTD plan.

Key drivers of the non pay position include:

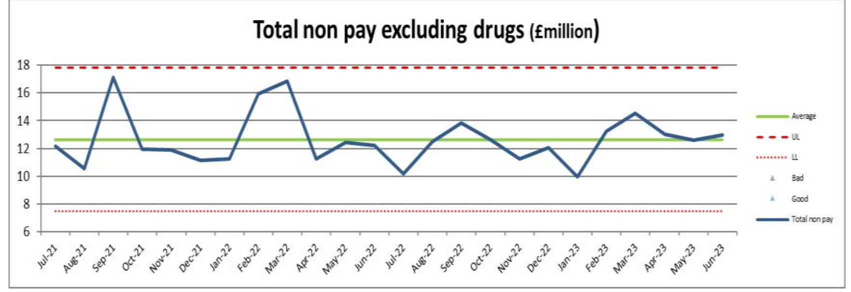
• Drugs expenditure is £(0.5)m adverse to M3 YTD Plan at £(13.29)m , however PbR Excluded Drugs are £(0.5)m overspent Month 3 YTD offset by an underspend in PbR included Drugs.

• Non Pay expenditure in Integrated Elderly is overspent by £(0.4)m Month 3 YTD, this is driven by Non Pay Project costs, where the projects are ahead of plan and initial set up costs that will not recur, together with Healthlink costs of £(0.2)m M3 YTD. Integrated Medicine Non Pay is £(0.2)m adverse to plan M3 YTD, driven by drugs pressures in Gastro, Neurology & Dermatology and the Division is reviewing current protocols. Surgery & Critical Care is £0.2m underspent Month 3 YTD, this driven by theatre closures affecting year-to-date capacity reducing Clinical Supplies costs.

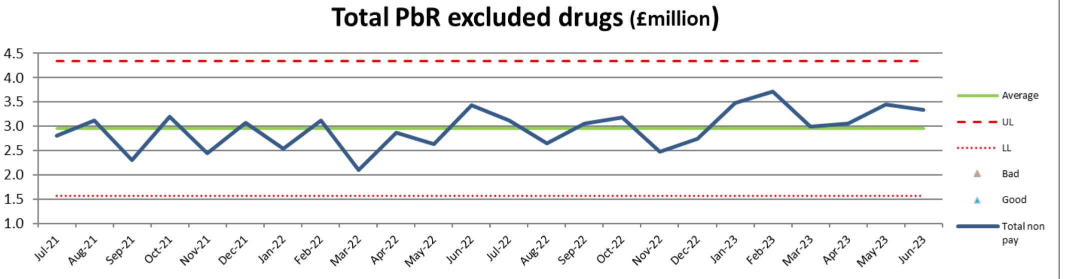
• Non Pay expenditure in Specialist Services is overspent by £(1.4)m Month 3 YTD, this is primarily driven by outsourcing costs in Radiology and Pathology, supporting Trust act+I22ivity levels. Outsourcing costs are now prioritised to Cancer pathway patients and Long Wait patients.

•Statistical Process Control charts (SPC) for non pay and PBR Excluded drugs expenditure are detailed below (Graphs 5 & 6). 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 there assessment 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 independent sector 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



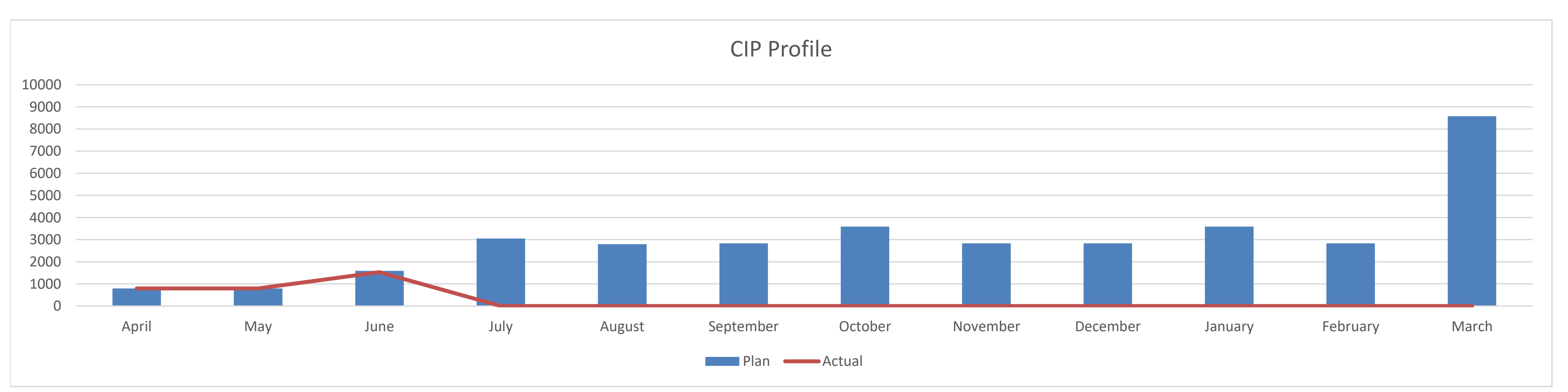
Graph 6 - Non Pay Statistical Process Control (SPC) Charts



2023/24 Efficiencies

2023/24 Summary Efficiency Plans by Division (£'000)

Division	YTD Plan	YTD Achieved	YTD Variance	Annual Target	Forecast	Forecast Variance
Integrated Elderly	500	284	(216)	1,998	1,998	-
Integrated Medicine	-	37	37	3,875	3,875	-
Surgery & Critical Care	-	291	291	4,626	4,626	-
Specialist Services	-	735	735	3,618	3,618	-
Women & Childrens	650	27	(623)	2,600	2,600	-
CEO	39	50	11	156	156	-
Commercial Director	613	263	(349)	2,450	2,450	-
COO	50	32	(18)	199	199	-
Finance	77	94	18	306	306	-
IT	252	347	95	1,009	1,009	-
Medical Director	3	10	6	14	14	-
Nursing Director	82	45	(37)	779	779	-
PDC & Depreciation	-	-	-	1,183	1,183	-
Corporate Services	-	-	-	2,291	2,291	-
Human Resources	104	93	(11)	417	417	-
Central Savings	800	800	-	10,700	10,700	-
Trust Total 2023/24 CIPs	**3,170**	**3,109**	**(61)**	**36,222**	**36,222**	**-**



Divisional Positions

Breakdown of financial position by division

Table 7 - Divisional income and expenditure

Division / (£m)	YTD Budget	YTD Actuals	YTD Variance against Plan	Forecast Annual Plan	Forecast Outturn	Variance Plan to Forecast	Position Signed Off by Divisions	Current Month Run Rate		
								M01	M02	M03
Integrated Medicine	(25.8)	(26.3)	(0.5)	(99.2)	(99.2)	0.0	Yes	(8.4)	(8.6)	(9.3)
Integrated Elderly Care	(14.5)	(15.0)	(0.5)	(56.8)	(56.9)	(0.1)	Yes	(4.9)	(4.7)	(5.3)
Surgery And Critical Care	(29.6)	(30.1)	(0.4)	(114.6)	(114.6)	0.0	Yes	(9.5)	(10.0)	(10.6)
Women and Children	(13.4)	(13.3)	0.1	(50.8)	(50.8)	0.0	Yes	(4.2)	(4.4)	(4.7)
Specialist Services	(22.4)	(23.3)	(0.9)	(88.7)	(88.7)	0.0	Yes	(7.7)	(7.4)	(8.2)
Total Clinical Divisions	**(105.6)**	**(107.8)**	**(2.2)**	**(410.1)**	**(410.2)**	**(0.1)**		**(34.7)**	**(35.1)**	**(38.1)**
Chief Executive	(1.0)	(0.9)	0.0	(3.8)	(3.8)	0.0	Yes	(0.3)	(0.2)	(0.4)
Chief Operating Officer	(0.9)	(1.0)	(0.2)	(3.5)	(3.8)	(0.3)	Yes	(0.3)	(0.3)	(0.4)
Commercial Director Mgmt	0.0	0.0	0.0	0.0	0.0	(0.0)	Yes	0.1	(0.0)	(0.0)
Finance Dept.	(1.6)	(1.5)	0.0	(6.2)	(6.2)	0.0	Yes	(0.5)	(0.5)	(0.6)
Information Technology	(4.8)	(4.7)	0.1	(17.9)	(17.9)	0.0	Yes	(1.6)	(1.3)	(1.8)
Property Services	(16.8)	(17.4)	(0.6)	(62.0)	(62.0)	0.0	Yes	(5.1)	(6.6)	(5.7)
Human Resources	(0.6)	(0.6)	0.1	(2.5)	(2.5)	0.0	Yes	(0.2)	(0.1)	(0.3)
Medical Director	(0.2)	(0.1)	0.0	(0.7)	(0.7)	0.0	Yes	(0.0)	(0.0)	(0.0)
Nursing Director	(5.2)	(4.9)	0.3	(19.5)	(19.6)	(0.1)	Yes	(1.6)	(1.7)	(1.6)
PDC And Depreciation	(7.4)	(7.3)	0.1	(28.3)	(27.8)	0.5	Yes	(2.6)	(2.3)	(2.4)
Total Corporate	**(38.3)**	**(38.5)**	**(0.2)**	**(144.3)**	**(144.3)**	**0.0**		**(12.2)**	**(13.1)**	**(13.2)**
Contract Income	137.4	137.5	0.1	549.3	549.3	0.0		44.3	46.0	47.2
Corporate Services / Provisions	(2.2)	0.2	2.4	(7.0)	(6.9)	0.1		(1.8)	0.2	1.8
Retained Surplus / (Deficit)	**(8.7)**	**(8.7)**	**0.0**	**(12.1)**	**(12.1)**	**0.0**		**(4.3)**	**(2.1)**	**(2.3)**
Adjusted Financial Performance excl. Profit on disposal of Assets	**(8.7)**	**(8.3)**	**0.4**	**(12.1)**	**(12.1)**	**0.0**		**(4.2)**	**(1.9)**	**(2.2)**

The Trust is forecasting a Year End 2023/24 Deficit of £(12.15)m in line with the 2023/24 Annual Plan as submitted to NHSE/I. This forecast includes mitigating actions on run rate and to ensure 2023/24 CIPs are delivered in line with £33.2m 2023/24 CIP Plan, these mitigating actions are being finalised and signed off by Divisions.
Key reasons for the Month 3 YTD 2023/24 divisional variances are:

Integrated Medicine £(0.52)m overspend M3 YTD
Integrated Medicine Pay is £(0.42)m adverse to budget M3 YTD, partially due to Admin & Clerical £(0.22)m overspent due to substantive roles, and Medical Staffing £(0.12)m in Neurology & Cardiology temporary staffing that is being reviewed, Nursing £(0.12)m due to high temporary staffing driven by double running with overseas nurses overspent due to temporary staffing pressures in Cardiology & Neurology. Intergrated Medicine Non Pay is £(0.23)m adverse to plan M3 YTD, driven by drugs pressures in Gastro, Neurology & Dermatology and the Division is reviewing current protocols.

Integrated Elderly Care £(0.45)m overspend M3 YTD
Integrated Elderly and Community Care Division, £(0.58)m adverse to budget M3 YTD, £(0.25)m due to Medical Staffing rotas, actions are being undertaken to reduce this going forward (i.e combining ward medical staff rotas), alongside actions to achieve the 5% A&C savings target. There are also budget pressures in IECC Nursing that will be reviewed. Non Pay is overspent by £(0.43)m Month 3 YTD, this is driven by projects that are ahead of plan and initial set up costs that will not recur, together with Healthlink costs of £(0.18)m M3 YTD. This is partially offset by income being ahead of plan in relation to the Home First project.

Surgery & Critical Care £(0.45)m overspend M3 YTD
Pay is £(0.72)m adverse to budget M3 YTD, this is relating to temporary medical Y7staff costs, partially due to the impact of the industrial action in Months 1 and 3, there are also temporary Locum staffing costs covering Maternity Leave and gaps in Junior Doctors rotas, together with WLI costs (£(0.19)m of the budget pressure), medical staffing accelerated recruitment is being worked on to fill vacant posts and reviews of current backfilling and locum oncall arrangements are being undertaken. Non Pay is £0.16m underspent Month 3 YTD, this driven by theatre closures affecting year-to-date capacity reducing Clinical Supplies costs.

Women & Children £0.09m underspend M3 YTD
The Month 3 YTD underspend is due to £37k underspend on Pay due to Nursing vacancies, A&C and Medical pressures are being reviewed to reduce run rate. Non Pay is £(0.02)m over budget M3 YTD, due to Drugs pressures. Income is £65k over-achieved against plan M3 year to date due to non recurrent support to OUH.

Specialist Services £(0.86)m overpend M3 YTD
Non Pay expenditure in Specialist Services is overspent by £(1.39)m Month 3 YTD, this is primarily driven by outsourcing costs in Radiology and Pathology, supporting Trust activity levels. Outsourcing costs are now prioritised to Cancer pathway patients and Long Wait patients. This is partially offset by Income being £0.52m above plan M3 YTD, relating to TVCA and non recurrent income providing support to OUH.

Property Services £(0.61)m overspend M3 YTD
Driving factors in the Property Services M3 YTD overspend are the Wycombe Tower scaffolding cost pressure of £(0.19)m, PFI costs of £(0.26)m, Prework activities of £(0.08)m and North Bucks Warden Call System costs of £(0.05)m.

Chief Operating Officer £(0.16)m overspend M3 YTD
This overspend mainly relates to Bed Management Service Delivery cost pressures of £(0.05)m M3 YTD, HIPP System costs of £(0.02)m and Other Staffing cost pressures of £(0.04)m in COO Managment.

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	363.8	357.3	(6.4)	(1.3)
Cash and cash equivalents	12.8	17.6	4.9	2.7
Trade and other current assets	46.3	42.5	(3.8)	(9.5)
Total Assets	**422.8**	**417.5**	**(5.3)**	**(8.2)**
Current Borrowing	(4.4)	(4.4)	0.1	0.5
Other Current liabilities	(82.2)	(81.1)	1.2	5.4
Non Current Borrowing	(39.4)	(38.5)	0.9	0.0
Other Non-current liabilities	(1.4)	(1.4)	(0.0)	0.0
Total Liabilities	**(127.4)**	**(125.3)**	**2.1**	**5.8**
TOTAL NET ASSETS	**295.4**	**292.2**	**(3.2)**	**(2.3)**
PDC and Revaluation reserve	424.4	424.4	0.0	0.0
Income and Expenditure Reserve	(131.7)	(132.2)	(0.5)	(2.3)
TOTAL EQUITY	**292.7**	**292.2**	**(0.5)**	**(2.3)**

- Non Current assets have decreased by £1.3m from the prior month. This is due to in month capital expenditure of £0.6m being more than offset by in month depreciation of £1.8m. Non current assets are £6.4m behind plan due to capital spend being behind projections.
- The closing cash balance has increased by £2.7m in month and is £4.9m higher than plan. This is mostly due to the full pay award funding being received in June. Tax and NI payments on the arrears will take place in July.
- Trade and other current assets are lower by £9.5m compared to prior month. This is mainly due to releasing the accrued income of £11.2m for non-consolidated pay offer. The prepayment dropped by £3.2m in M3 compared to M2. The unallocated receipts increased in M3 by £0.4m increasing the overall balance. All these have been offset by the increase in debtors of £0.9m as detailed below in table 10 and the recoverable VAT increase of £3.4m following the COS review.
- Other current liabilities are lower than previous month by £5.4m which is due to a reduction in accruals of £14.1m mainly relating to releasing the pay award accrual of £14.5m.
- The change in Income and Expenditure reserve of £2.3m from the prior month is consistent with the planned position for M3.

Accounts Receivable

Table 10 - Accounts Receivable

Month 3

(£m)	Current	31-60 days	61-180 days	6 mths - 1 year	1 year - 2 years	More than 2 years	Total
NHS	1.5	0.4	0.8	0.1	0.2	0.1	3.1
Non-NHS	1.5	0.3	0.4	0.4	0.3	0.8	3.7
Total	**3.0**	**0.7**	**1.2**	**0.5**	**0.5**	**0.9**	**6.8**
% of total	44%	10%	18%	7%	7%	13%	100%

Month 2

(£m)	Current	31-60 days	61-180 days	6 mths - 1 year	1 year - 2 years	More than 2 years	Total
NHS	0.4	0.1	0.9	0.2	0.2	0.2	2.0
Non-NHS	0.7	0.3	1.5	0.3	0.3	0.8	3.9
Total	**1.1**	**0.4**	**2.4**	**0.5**	**0.5**	**1.0**	**5.9**
% of total	19%	7%	41%	9%	9%	16%	100%

- Debtors have increased by £0.9m from £5.9m in M2 to £6.8m in M3.
- Although overall the level of outstanding debt has increased, the major increase has been in the current debt of £1.9m (£1.1m to £3.0m) due to invoicing cycles. Outstanding debt outside payment terms has reduced by £1m, with the most significant reduction in the 61-180 days bracket. The AR team are continuing their focus on the recovery of aged debt.
- **Top 5 overdue debts at month 3 are:**
  1 - Oxford University Hospitals NHS FT £1.03m
  2 - Buckinghamshire Council £0.77m
  3 - Nhs Bucks, Oxfordshire And Berks West Icb £0.53m
  4 - Imperial College Hospital NHS Trust £0.43m
  5 - The Shelburne Hospital £0.34m
- £0.8m invoice from Buckinghamshire Council which was overdue since M11 / 2023 has now been paid (16th June 2023).

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	1.5	0.0	0.0	-0.0	0.0	1.5
Non-NHS	4.4	0.0	0.1	0.0	-0.2	4.4

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 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
Month 2	3.3	480	1.8	78	0.2	72	0.9	133	0.3	95	0.1	64	0.1	38
Month 3	1.9	482	0.3	86	0.2	45	0.8	152	0.3	92	0.1	66	0.1	41

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 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
Month 2	13.1	2,953	5.1	790	4.1	482	2.4	629	0.8	463	0.6	370	0.2	219
Month 3	14.6	2,659	4.5	586	3.6	421	5.0	678	0.7	407	0.5	345	0.2	222
Total M3	16.4	3,141	4.8	672	3.8	466	5.8	830	1.0	499	0.7	411	0.3	263

Non NHS - 33 invoices(>£100K each) account for £8.7m of the total £16.4m value in M3. The top six (all non-NHS) are Fedbucks (£2.4m), Practice Plus Group (£1.2m), Western Building Systems Ltd (£1.1m), Abbott Labs (£0.9m), Next Generation Scaffolding Ltd (£0.7m), Buckinghamshire Council (£0.6m) totalling £7.0m. The number of invoices held on the register awaiting processing has reduced this month and work is being undertaken around those invoices below £100.00 to clear them proactively from the register. On Value - the total Value has not moved. This is due to 50% of the total value being held in 28 invoices which do not have a Purchase order in place to enable timely payment. Due to the values most Contracts or schemes have to be approved by the Board, leading to a further delay. 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 with specific issues with complying with process to see what improvements can be made in the time taken to receipt. As at M3, AP are reporting that 80% of all supplier invoices are now showing a matching PO as opposed to 50% previously.

NHS - Still very little progress on the majority of NHS invoices due to lack of Purchase orders. The decrease in value between month 2 and 3 is due to NHS Profesional invoices being approved. NHS Prof invoices fall outside the Purchase order process. Overall there is still more work to be done to improve the speed in raising PO's for NHS suppliers and AP will continue to work with departments to achieve compliance targets.

Better Payment Practice Code

Table 12 - Better Payment Practice Code

	Count Total	Count Pass	% Pass	Total (£m)	Pass (£m)	% Pass
NHS	560	430	77%	16.4	14.9	91%
Non-NHS	12,487	11,249	90%	67.3	62.2	92%
Total	**13,047**	**11,679**	**90%**	**83.7**	**77.1**	**92%**

Adherence to the BPPC requires 95% of suppliers to be paid within 30 days of receipt of a valic reported agaist invoice date, which is a more stringent measure. Our reporting process is now r ensuring consistency of approach.
NHS invoices remain a challenge, with 77% of the number of invoices (M02 75%) being paid wi value (91% M02). The performance of non-NHS invoices is better at 90% by number (88% M02 As the invoice register (made up of some high-value non-NHS items) gets cleared down, we m BPPC targets for a short period.

Cash Position

Cash

Table 13 - Cash summary position

£'000	Actual Mar-23	Actual Apr-23	Actual May-23	Actual 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	23/24
INCOME														
Clinical Income	44,424	43,508	44,038	52,192	45,000	45,000	45,000	45,000	45,000	45,000	46,400	46,400	46,400	**548,938**
Clinical Income top up / Covid / Growth	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Education and Training	0	3,719	0	0	3,719	0	0	3,719	0	0	3,719	0	0	**14,876**
Other Income	3,330	2,387	1,830	738	800	800	800	1,000	1,000	1,000	1,000	1,000	1,000	**13,355**
HMRC vat reclaim	0	4,006	546	0	5,000	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	**21,553**
Payroll Support	552	0	0	11,324	537	537	537	537	537	537	537	537	537	**16,157**
PDC capital	4,200	0	0	0	0	0	0	0	0	2,500	8,214	2,500	3,660	**16,874**
Revenue PDC	5,302	0	0	0	0	0	0	0	4,089	4,088	0		6,403	**14,580**
External Cash Support ICB	0	0	0	0	0	1,000	0	0	0	0	0	0	0	**1,000**
Other Receipts	2,099	607	521	578	600	600	600	600	600	600	600	600	600	**7,107**
TOTAL RECEIPTS	**59,907**	**54,227**	**46,935**	**64,832**	**55,656**	**49,437**	**48,437**	**52,356**	**52,726**	**55,225**	**61,970**	**52,537**	**60,100**	**654,439**
PAYMENTS														
Pay Costs - Substantive	(26,217)	(25,682)	(26,297)	(27,264)	(27,103)	(26,463)	(26,463)	(26,463)	(26,463)	(26,463)	(26,463)	(26,463)	(26,463)	**(318,054)**
Back dated Payroll	0	0	0	(7,715)	(5,399)	0	0	0	0	0	0	0	0	**(13,114)**
Pay Costs - Temporary Staffing	(7,012)	(4,202)	(3,884)	(3,906)	(3,900)	(3,900)	(3,900)	(3,900)	(3,900)	(3,900)	(3,900)	(3,900)	(3,900)	**(47,092)**
Creditors	(17,762)	(12,969)	(12,840)	(16,054)	(14,500)	(14,500)	(14,500)	(14,488)	(14,500)	(14,500)	(14,500)	(14,500)	(14,500)	**(172,351)**
Creditors - Capital Spend	(3,632)	(4,043)	(496)	(1,082)	(1,500)	(1,500)	(1,500)	(1,500)	(1,500)	(4,000)	(6,500)	(6,500)	(7,080)	**(37,201)**
NHSLA	280	(1,562)	(1,562)	(1,432)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	-	-	**(15,490)**
PDC Dividends	(3,728)	0	0	0	-	-	(4,679)	-	-	-	-	-	(3,975)	**(8,654)**
PFI CHARGE	(1,858)	(3,099)	(6,511)	(4,661)	(4,800)	(4,800)	(4,800)	(4,800)	(4,800)	(4,800)	(4,800)	(4,800)	(4,800)	**(57,470)**
TOTAL PAYMENTS	**(59,930)**	**(51,557)**	**(51,589)**	**(62,113)**	**(58,764)**	**(52,725)**	**(57,404)**	**(52,713)**	**(52,725)**	**(55,225)**	**(57,725)**	**(56,163)**	**(60,718)**	**(669,426)**
NET CASH FLOW IN PERIOD	(23)	2,670	(4,654)	2,719	(3,108)	(3,288)	(8,967)	(357)	1	(0)	4,245	(3,626)	(618)	(14,987)
OPENING CASH BALANCE	16,930	16,907	19,577	14,923	17,642	14,533	11,245	2,277	1,920	1,920	1,920	6,165	2,538	**16,907**
CLOSING CASH BALANCE	**16,907**	**19,577**	**14,923**	**17,642**	**14,533**	**11,245**	**2,277**	**1,920**	**1,920**	**1,920**	**6,165**	**2,538**	**1,920**	**1,920**

- Clinical Income receipts forecast has been aligned to the Income and expenditure assumptions as per the operating plan.
- Total receipts - Total receipts in M3 rose by £18m from M2, with 'Clinical Income' (+£8m) and 'Payroll Support' (£11.3m) accounting for the increase. The £8m from Clinical Income is made up of payments from Nhs Bucks, Oxfordshire And Berks West ICB.
- The M3 VAT Claim forecast receipt for £3.2m was not received before period cut off but was paid by HMRC (4th July).
- Pay Cost - Substantive pay cost for M3 increased by £9m in line with the expected backdated pay increase. Temporary pay cost was not materially different from M1 & M2 and in line with £3.9m Jun23 forecast.
- Capital Creditors assumes that £10.6m PDC for the additional beds will be spent and drawn down over the last 4 months of the year.
- Cash forecast in M3 assumes a shortfall of £15m by the end of the Financial Year which will require support from the External Cash Support ICB and Revenue PDC in order to maintain minimum cash balance of £1,920m.

Capital Position

Table 14: Capital Overview - M3 2023-24 YTD

Capital Expenditure (£M)	YTD Actual (£m)	Prior Month YTD Actual (£m)	Movement In Spend
Medical Equipment	0.1	-0.0	0.1
Property Services	0.7	0.3	0.5
Information Technology	0.9	0.6	0.4
General	-0.1	0.1	-0.2
Flow	-	-	-
Total Capital Expenditure	**1.7**	**0.9**	**0.8**

Table 15: Capital Overview - M3 2023-24 Full Year

Capital (£m)	Full Year
Funding Streams	
Funded By Trust	21.3
PDC	16.9
PFI Lifecycle	1.7
Donated/Grant	0.0
Total Capital Funding	**40.0**
Expenditure	
Medical Equipment	4.8
Property Services	18.0
Information Technology	12.3
General	2.9
Flow	2.0
Total Capital Expenditure	**40.0**
Total	**(0.0)**

Table 16: Capital Detail

	£000's				
Capital Expenditure Plan	**BOB/ICS**	**Lifecycle**	**PDC Plan**	**Donated**	**2023/24 Total**
Medical Equipment	4,811				4,811
Property Services	18,010				18,010
Information Technology	6,031		6,294		12,325
General	1,148	1,728			2,876
Flow	2,000				2,000
Total	32,000	1,728	6,294	0	40,022

£000's	
YTD Expend	**Full Year Variance**
143	
726	
907	
(89)	
0	
1,688	0

The month 3 capital spend is £1.7m. This is 4.2% of the total capital plan at the end of the first quarter.

As at month 3 the Trust is not forecasting an overspend against it's capital resource limit.

Total CRL Funding of £29.4m includes BOB/ICS £21m, PFI Lifecycle £1.7m, and PDC allocations of £26.9m, £5.7m for ERF, £0.6m for Digital Diagnostic Capability programme and £10.6m for additional beds. £10m has been allocated to the Trust for Mandeville Wing and the visual outpatient clinics this will be added into the programme once the memorandum of understanding has been received and returned.

The forecast position is being continually reviewed with the project leads and managers.

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
CIP	

Meeting: Trust Board Meeting in Public

26 July 2023

Agenda item	Medical Appraisal & Revalidation Annual Board Report 2022/2023
Board Lead	Mr Andrew McLaren, Chief Medical Officer
Type name of Author	Sarah Klamut, Medical Appraisal & Revalidation Team
Attachments	Appendix 1 – Medical Appraisal and Revalidation Board Report Appendix 2 – Annex-d-annual-board-report-and-statement-of-compliance
Purpose	Assurance
Previously considered	EMC 04.07.2023 SPC 10.07.2023

Executive Summary

Medical Appraisal and Revalidation is regulated through the General Medical Council and the Responsible Officer is required to report to the Trust Board in public on an annual basis in regard to compliance of connected doctors with the process.

The report is to provide assurance to the Trust Board that internal processes for Medical Appraisal and Revalidation are robust, and to report on the 22/23 activity.

Since the report was written, out of the 11 outstanding, 5 have now completed an appraisal. The remaining 6 will be completed by 30 September.

The board are asked to delegate approval for the CEO to sign the Annex-d-annual-board-report-and-statement-of-compliance confirming that the organisation, as a designated body, is in compliance with the regulations.

On 4 July 2023, the Executive Management Committee considered this report and noted the plan to train more peer appraisers and the ability for individuals to feedback about their appraisal experience as good practice.

The Strategic People Committee considered the report on 10 July and, subsequently, the paper was updated to reflect the number of appraisals outstanding. The Committee were informed regarding the process for individuals that did not engage in the process and noted this to be clear and transparent. Those that did not engage were not eligible for clinical excellence awards.

Decision	The Board is requested to approve the report and seek clarification if required.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise.
Risk: link to Board Assurance Framework (BAF)/Risk Register	Principal Risk 6 – Failure to deliver on our People Priorities
Financial	There is no financial implication in the report

Compliance NHS Regulation Good Governance	The NHS England Annex-d-annual-board-report-and-statement-of-compliance confirms that the organisation, as a designated body, is in compliance with the regulations. The purpose of the statement-of-compliance is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time.
Partnership: consultation / communication	The report is not required to consult with any partnership
Equality	The Trust provide data in the Employee Relations PSED report (public sector equality duty). A quarterly report is provided to the Trust board. This report has not Identified any equality or diversity issues.
Quality Impact Assessment [QIA] completion required?	The report does not require a QIA

1 Introduction/Position

1.1 It is a requirement that the Trust Board receives an annual report on Medical Appraisal and Revalidation.

1.2 The purpose of the report is to update the Trust Board as part of the Responsible Officer (RO) regulations on arrangements within the Trust and performance in achieving compliance with the process and advise on future developments.

2 Problem

The Trust does not have the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners. There has been a significant rise in GMC prescribed connections to the Trust, particularly with fixed term contracts and the return of the medical Locum bank in house. Whilst this is testament to the successful recruitment of medical staff it does impact on the existing Trust approved medical appraisers.

3 Possibilities

To ensure the Trust can continue to support doctors with medical appraisal, additional investment is required to train more appraisers.

4 Proposal, conclusions recommendations and next steps.

Medical appraisal team to undertake an audit and analyse current appraiser activity and explore financial support.

5 Action required from the Board/Committee

5.1 The Board is requested to:

a) Agree to the report.

b) The Chief Executive Officer is asked to sign a Statement of Compliance Appendix 1 – NHS England and NHS Improvement Annex D – The Annual Board Report and Statement of Compliance. This is to confirm the Trust has reviewed the content of the report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

APPENDICES

Appendix 1: Medical Appraisal and Revalidation Board Report

Appendix 2: Annex-d-annual-board-report-and-statement-of-compliance

Annual Board Report

Medical Appraisal and Revalidation

Summary of 2022-2023 Appraisal Year

Author	**Sarah Klamut, Medical Quality & Development Manager**
Lead executive	**Mr Andrew McLaren, Chief Medical Officer**

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Appendix 1 – Annex D Statement of compliance (Separately Attached)

1.0 Executive Summary

The Medical Appraisal and Revalidation report is part of the Trust's annual reporting to NHS England. The report is presented to the Trust Board for assurance that the statutory functions of the Responsible Officer (RO) are being appropriately and adequately discharged. The Trust has a statutory duty to support its RO in discharging their duties under the Responsible Officer Regulations.

1.1 This report covers the 2022/2023 Medical Appraisal activity from 01 April 2022 – 31 March 2023.

1.2 By the 31 March 2023 **480** Doctors had a GMC prescribed connection to the Trust for Medical Appraisal and Revalidation. This includes doctors with a Trust contract, Consultants, SAS doctors, Locally Employed doctors and Locum bank doctors.

1.3 Arrangements are in place to ensure doctors are appraised and revalidated to a standard that meets the requirements of the RO regulations and are working effectively.

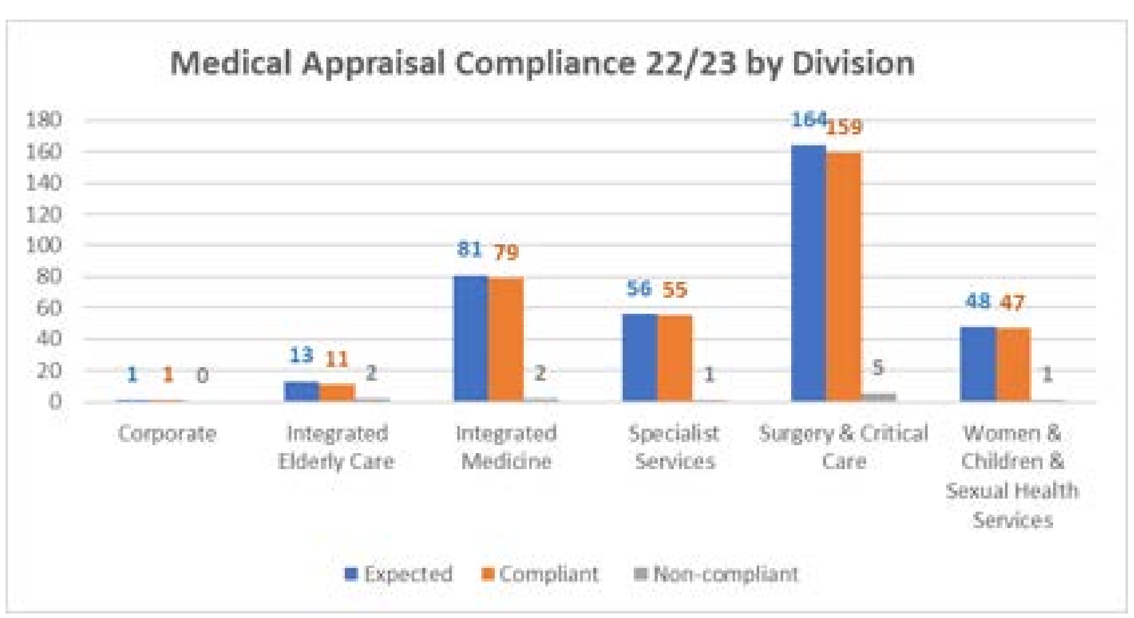
1.4 In the 2022/2023 appraisal year, **363** out of **480** GMC prescribed doctors were required to undertake a Medical Appraisal and **97% (352) of 363** doctors had a completed appraisal.

1.5 There are 11 doctors who have not had an appraisal as expected in 2022/2023. These doctors have been contacted individually and are being monitored to reach compliance by 30 September 2023.

22/23 Outstanding appraisals		
Status	**Number of doctors**	
Dates booked	2	Meeting to be completed
Appraiser assigned but no date booked	3	Meeting to be completed
No appraiser assigned	6	Not accepted x 3 Accepted reasons x 3

1.6 A further 117 doctors were not expected to undertake an appraisal in the 2022/2023 appraisal year which the RO accepts reasons for these. This includes new starters joining the organisation and therefore not appropriately due an appraisal in this period and doctors on maternity leave/career break/sick leave.

1.7 The Trust are required to complete NHS England and NHS Improvement Annex D – The Annual Board Report and Statement of Compliance (Appendix 1 – separately attached). This is a Framework of Quality Assurance for Responsible Officers and Revalidation. The date for submission of this report to NHS England is 30th September 2023



Division	No doctors expected to have an appraisal	No of doctors compliant	No of doctors Non-compliant
Corporate	1	1	0
Integrated Elderly Care	13	11	2
Integrated Medicine	81	79	2
Specialist Services	56	55	1
Surgery & Critical Care	164	159	5
Women & Children & S H	48	47	1
Grand Total	**363**	**352**	**11**

2.0 Purpose of the Paper

2.1 The Trust has a statutory duty to support its RO in discharging their duties under the Responsible Officer Regulations and it is expected that the Board will oversee compliance by:

- Monitoring the frequency and quality of Medical Appraisals in the organisation.
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors.

- Confirming the feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.
- Ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 It is a requirement that the Trust Board receives an annual report on Medical Appraisal and Revalidation.

2.3 The purpose of this report is to update the Trust Board as part of the RO regulations on arrangements within the Trust and performance in achieving compliance with the process.

2.4 The Board is asked to **Note** the report.

3.0 Governance Arrangements

3.1 The management of Medical Appraisal and Revalidation is supported by the Medical Appraisal and Revalidation team. The team has access to GMC Connect to ensure that the list of doctors for whom the designated body (Buckinghamshire Healthcare NHS Trust) is responsible for is up to date. The GMC sends e-mail notifications when a doctor is added to the Trust's Designated Body list. These notifications are checked and any unexpected additions to the list are rejected or accepted as appropriate. The GMC has developed an online help tool, to assist doctors in identifying who they should have a prescribed connection with. For the majority of doctors the prescribed connection is with the designated body where they undertake the majority of work.

Doctors on the GP Performers List for England connect to NHS England, and Junior doctors in Deanery training programmes connect to a post-graduate dean. Doctors registered with the General Dental Council (GDC) follow the GDC Annual Renewal process.

3.2 All complaints and concerns involving medical staff are notified to the RO.

3.3 Doctors must declare and reflect on all significant events or complaints relating to them in the previous 12 months as part of the annual appraisal process. The Medical Appraisal and Revalidation team provide data on complaints and Datix reports.

3.4 A Medical Appraisal and Revalidation Policy is in place and was reviewed and agreed in January 2022 through the Trust's policy approval processes. The Policy is due to be reviewed in January 2025.

3.5 Regular meetings are held with a GMC Employer Liaison Adviser to discuss local concerns/investigations concerning doctors, GMC cases, deferrals, and non-engagement recommendations.

4.0 Medical Appraisal

4.1 The Medical Appraisal and Revalidation database is audited monthly against GMC Connect and ESR to record new starters and leavers and to ensure there is an accurate record of doctors requiring an annual appraisal.

4.2 All doctors with a prescribed GMC connection are allocated an appraisal month in which to have an appraisal. This is usually within 12 months of the last appraisal and in line with revalidation dates.

4.3 Medical Appraisal can be postponed or deferred if a doctor is off sick, on maternity leave, or is agreed in advance with the Medical Appraisal Lead.

4.4 Annual Medical Appraisal compliance is monitored by an online Medical Appraisal management system, L2P. Any compliancy concerns will be escalated to the Medical Appraisal Lead, SDU leads and divisional chairs if necessary. Non-engagement concerns are discussed with the GMC, Medical Appraisal Lead and the RO and appropriate action taken.

4.5 All doctors connected to the RO are provided with access to the online Medical Appraisal management system. The system allows a doctor to assign an appraiser, book an appraisal meeting, complete the appraisal paperwork and add supporting information. All new starters are sent a welcome email from the Medical Appraisal and Revalidation team. This includes information on the appraisal platform, links to the L2P quick guide videos and the Trust's Medical Appraisal and Revalidation leaflet.

4.6 Doctors undertake a patient and colleague feedback exercise (required once in 5 years for revalidation). This is completed on the L2P system and includes an online patient feedback function. L2P collate the data and provide the doctor with a report for discussion/reflection at their appraisal.

4.7 The quality and consistency of Medical Appraisal relies heavily on the skills and the professionalism of Medical Appraisers. There is 60 Trust approved Medical Appraisers. Annual appraiser network meetings are held to provide training and updates. 2 network meetings were held in 22/23.

4.8 Medical Appraisal and Revalidation workshops are held for new starters particularly for doctors who are out of training and those that have joined BHT as their first UK job. 3 workshops were held in 22/23.

5.0 Quality Assurance

5.1 Quality assurance is undertaken in a two-step process. All Medical Appraisals are reviewed briefly by the Medical Appraisal and Revalidation team for completeness of required information. Any concerning appraisals are then flagged to the Medical Appraisal Lead for further review using the Medical Appraisal Quality Assurance Assessment Tool (MAQAAT). Following a MAQAAT, feedback is sent to both the appraiser and the appraisee. There are plans to collate more data on quality assurance to report to the board in future.

This will be supported by 2 existing appraisers who will assist the medical appraisal lead in completing the quality assurance feedback tool.

Medical Appraisal Quality Assurance Assessment 22/23

Medical Appraisal Quality Assurance Assessment Tool (MAQAAT)			No of appraisals assessed							
		0=Unsatisfactory 1=Satisfactory 2=Good	1	2	3	4	5	6	7	8
Overview	1	Appraiser summarises doctor's whole scope of work and documents any changes or achievements over the past year.	1	1	2	2	2	2	2	1
	2	Specific Supporting Information is documented with a description of what it demonstrates and objective statements about its quality.	2	2	2	2	2	2	1	2
	3	All statements made by the appraiser are supported by appropriate evidence.	2	2	1	1	1	2	1	2
Reflection	4	Reference is made to Speciality specific guidance for appraisal e.g. National Audit data, CPD, etc. and completion of Statutory/Mandatory training.	2	2	2	2	2	2	2	2
	5	learning has been appropriately shared, or the appraiser has discussed how the doctor could do so.	2	2	2	1	1	2	2	2
	6	There is documentation that learning has improved patient care/practice or appraiser has discussed with the doctor how this could be taken further.	2	1	2	2	2	2	2	2
PDP	7	The completion (or not) of last year's PDP is documented.	2	2	2	2	2	2	2	2
	8	Reasons why any objectives have not been met have been discussed with objectives carried forward or next steps included in new PDP	2	1	2	2	2	2	2	2
	9	There are clear links between the appraisal discussion and the new PDP with evidence of appropriate challenge by the appraiser.	1	1	1	2	2	2	1	2
	10	The new PDP covers the whole scope of work, contains 3-6 objectives and is SMART.	2	2	1	2	2	2	0	2
General	11	The Appraisal is typed and uploaded in clear and fluent English	2	2	2	2	2	2	2	2
	12	The stage of the Revalidation cycle is commented on (Score 0 or 1)	1	1	1	1	0	1	0	0
	13	There is documentation about revalidation readiness including plans to address any outstanding requirements e.g. colleague and patient feedback. (Score 0 or 1)	1	1	1	1	0	1	0	1
	14	The Appraisal statements, including health and probity, are signed or an explanation given. (Score 0 or 1)	1	1	1	1	1	1	1	1
		Total score	23	21	22	23	21	25	18	23

Medical Appraisal Quality Assurance Assessment Tool (MAQAAT) max total score 25	**Average score**
Overview Q1-3	5
Reflection Q4-6	5.63
PDP Q7-10	7
General Q11-14	4.38
Average overall score	**22**

5.2 All doctors are encouraged to provide feedback on their appraisal meeting via an electronic survey provided by L2P. The results are provided to the appraiser annually and contribute towards the appraiser's own appraisal discussion. 354 responses were received in 22/23.

5.3 The Medical Appraisal and Revalidation team attend NHS England RO & Medical Appraisal Leads Network Meetings to keep up to date with NHS England and GMC activity.

5.4 Maintaining health and wellbeing is a professional responsibility described in the Good Medical Practice. It is essential to providing safe and effective patient care. Since the Covid pandemic, a new section "personal and professional wellbeing" was added to the medical appraisal. This section gives doctors the opportunity to reflect and discuss with an appraiser on how they maintain their personal and professional wellbeing to practice safely and effectively.

6.0 Access, security and confidentiality

6.1 Whilst the detail of an appraisal meeting is confidential to the appraiser and appraisee, the RO, Appraisal Lead and revalidation team do have access to the documentation through the e system. All doctors are required to comply with Trust policies for confidentiality and data security and must ensure that all patient and staff identifiers are removed prior to uploading any information into their appraisal.

6.2 Each doctor has their own electronic login for the appraisal platform.

6.3 When a doctor leaves the Trust, access to their records is removed from the online platform.

7.0 Revalidation Recommendations

7.1 All revalidation recommendations are reviewed by the Revalidation Referral Group (RRG). The group members include the Chief Medical Officer/Responsible Officer, Deputy Chief Medical Officer, Divisional Chairs, Director of Medical Education, Medical Appraisal Lead, Speciality Doctor Tutor and Locally Employed Doctors Tutor.

7.2 The purpose of the Revalidation Referral Group (RRG) is to provide assurance to the board that there is a robust mechanism in place supporting the Responsible Officer with revalidation recommendations to the GMC. The RRG ensures that proposed doctors have met the criteria set out by the GMC prior to a recommendation being made.

7.3 The number of revalidations deferred between 01 April 2022 and 31 March 2023 and agreed by the Responsible Officer was 5 doctors. 1 x maternity leave, 1 x sickness and 3 x insufficient appraisals and/or feedback evidence.

8.0 Recruitment and Engagement, Background Checks

8.1 The Trust follows the NHS Employment Check Standards produced by NHS Employers for all recruitment of permanent and fixed term staff with a Trust contract.

8.2 In addition to a Trust Standard Employment reference, a transfer of information between designated bodies can be obtained for new appointments and doctors who have moved to another organisation. This is requested through the RO to RO teams and supports revalidation decisions.

Doctors working in another NHS organisation or private practice must declare such work in their appraisal scope of work. An external practice form must be completed and signed by the doctor where other work is undertaken and to confirm if there are any fitness to practice concerns.

8.3 GMC connect provides designated bodies with a connection history and establishes a doctor's movement within the medical field.

9.0 Monitoring Performance

9.1 All doctors are professionally accountable to the Chief Medical Officer.

9.2 Monitoring performance is undertaken by Job planning, management of complaints via Datix and a medical HR casework tracker.

9.3 Significant events are recorded as part of the annual Medical Appraisal. Discussions are about how events have led to a specific change in practice or demonstrate learning.

10.0 Responding to Concerns and Remediation

10.1 All medical Conduct, Capability, Ill health is managed by the medical HR team. The Appeals Policies and Procedures for Practitioners – Maintaining High Professional Standards (MHPS) outlines the process for dealing with serious concerns about a doctor's performance including Conduct, Capability and Health issues. A case tracker is held by the Medical HR team.

11.0 Future Developments

11.1 The Trust continues to see a rise in GMC prescribed connections for medical appraisal and revalidation particularly with fixed term contracts and the return of the medical Locum bank in house. Whilst this is testament to the successful recruitment of medical staff it does impact on the existing Trust approved medical appraisers. To ensure the Trust can continue to support doctors with medical appraisal, additional investment is required to train more appraisers.

11.2 The key to standardising the quality of appraisal is to develop and quality assure the work of appraisers. This work is usually led solely by the appraisal lead, however with the increase in GMC prescribed connections more support is needed. The team are working with 2 trained appraisers to support the appraisal lead with quality assurance.

12.0 Recommendations

12.1 The board are asked to agree to this report.

12.2 The Chief Executive Officer is asked to sign a Statement of Compliance **Appendix 1** – (separately attached) NHS England and NHS Improvement Annex D – The Annual Board Report and Statement of Compliance. This is to confirm the Trust has reviewed the content of the report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Buckinghamshire Healthcare NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes Action from last year: **None** Comments: **Mr Andrew McLaren GMC No. 3277294 is the Responsible Officer /Chief Medical Officer** Action for next year: **None**

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: **None** Comments: **There has been a rise in GMC prescribed connections** Action for next year: **Strengthen funds for new appraiser training and updates for existing appraisers**

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes Action from last year: **Continue to monitor medical appraisal & revalidation GMC connect activity.** Comments: **Monthly audits undertaken against GMC Connect and the Trust Electronic staff record** Action for next year: **None**

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes
Action from last year:
None
Comments:
There is a current Medical Appraisal & Revalidation Policy which is subject to review in January 2025
The job planning policy provides an opportunity for objectives agreed at appraisal to be incorporated into the job plan. The job planning policy will be reviewed in November 2025
The Conduct, capability, ill health and appeals policies and procedures for practitioners (MHPS Maintaining High Professional Standards) for raising concerns about a practitioner is due a review in November 2024 by Medical HR
Action for next year:
None

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

No
Actions from last year
None
Comments:
There is no requirement to have a peer review.
Action for next year:
None

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes
Action from last year:
None
Comments:
All short term / locum doctors are supported to take part in the Trust clinical governance processes and have access to training and library facilities to support their continuing professional development. The Appraisal team also ensure that they are aware of their need to undertake appraisal & revalidation and have an appropriate connection to a Responsible Officer and have a booked appraisal date.
Action for next year:
None

Section 2a – Effective Appraisal

7. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Yes
Action from last year:
None
Comments:
Doctors are provided with information on complaints and DATIX for discussion at appraisal. Doctors must declare work outside of BHT by completing an external practice form
Action for next year:
None

8. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Yes Action from last year: **N/A** Comments: **N/A** Action for next year: **None**

9. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes Action from last year: **Medical Appraisal & Revalidation Policy was reviewed and approved in January 22.** Comments: **Next review due in January 2025** Action for next year: **None**

10. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

No Action from last year: **None** Comments: **There has been a rise in GMC prescribed connections which has increased the number of appraisals each appraiser has to complete. This will increase more due to the Locum bank coming back in house. Time restraints in job plans doesn't allow appraisers to undertake more.** Action for next year: **To source funding to recruit/Train more appraisers**

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Yes Action from last year: **None** Comments: **Annual appraiser network meetings are held to provide training and updates. Formal appraiser training for existing appraisers has not been held since before Covid.** Action for next year: **Source funding to provide a formal training session to existing appraisers to support & maintain appraisal skills and competence. Increase pool of appraisers to quality assure appraisals.**

12. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Yes
Action from last year:
None
Comments:
Quality assurance is undertaken in a two-step process. All Medical Appraisals are reviewed briefly by the Medical Appraisal and Revalidation team for completeness of required information. Any concerning appraisals are then flagged to the Medical Appraisal Lead for further review using the Medical Appraisal Quality Assurance Assessment Tool (MAQAAT). Following a MAQAAT, feedback is sent to both the appraiser and the appraisee.
With the increase in GMC prescribed connections more support is needed. 2 trained appraisers will support the appraisal lead with quality assurance.
Action for next year:
To collate quality assurance data to report to Board

Section 2b – Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	480
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	352
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	128
Total number of agreed exceptions	123

Section 3 – Recommendations to the GMC

13. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes Action from last year: **None** Comments: **All recommendations are submitted in a timely manner** Action for next year: **None**

14. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes
Action from last year:
None
Comments:
Doctors are supported to achieve revalidation readiness and discuss options to defer if required. All revalidation recommendations are reviewed by the Revalidation Referral Group (RRG). The RRG ensures that proposed doctors have met the criteria set out by the GMC prior to a recommendation being made. All doctors with a prescribed connection for revalidation are contacted to confirm when a revalidation decision has or has not been made. Non engagement concerns are discussed with the RO and GMC ELA
Action for next year:
None

Section 4 – Medical governance

15. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes
Action from last year:
None
Comments:
There are effective clinical governance processes in place for doctors. The clinical governance processes within Divisions and associated reporting structures have recently been revised with new Terms of Reference responding to recommendations made by an external quality review
Action for next year:
None

16. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes
Action from last year:
None
Comments:
Doctors are provided with information on complaints and DATIX for discussion at appraisal.
The appraisal management system allows the RO to request a discussion at an appraisal where necessary.
Action for next year:
None

17. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes
Action from last year:
None
Comments:
Any concerns regarding fitness to practise are dealt with under the Conduct, capability, ill health and appeals policies and procedures for practitioners (MHPS Maintaining High Professional Standards) and managed by the Medical HR Team. The policy **is due to be a reviewed in November 2024**
Action for next year:
None

18. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Yes Action from last year: **None** Comments: **The Trust provide data in the Employee Relations PSED report (public sector equality duty). A quarterly report is provided to the Trust board.** Action for next year: **None**

19. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Yes Action from last year: **None** Comments: **Transfer of information - RO to RO is completed when a doctor connects to the Trust through GMC connect. There is a dedicated email address for all transferring information.** Action for next year: **None**

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

20. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes Action from last year: **None** Comments: **There are robust safeguard processes in place for responding to concerns about a doctor's practice. A Decision Management Group was introduced to review decisions around process in an anonymised manner to reduce bias and expand the number of individuals involved in such decisions. This group has been selected to improve diversity of decision making** Action for next year: **None**

Section 5 – Employment Checks

21. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes Action from last year: **None** Comments: **Employment checks are undertaken by the medical HR team for all medical staff appointments.** Action for next year: **None**

Section 6 – Summary of comments, and overall conclusion

Please use the comments box to detail the following:

General review of actions since last Board report – **Following the RCOP publication, Medical Appraisal 2022, a decision was made to introduce the new format from 01 April 2023. This will be reviewed through appraiser networks.**

Actions still outstanding – **None**

Current issues –**Increase in GMC connections and availability of appraisers to undertake appraisals will need to be addressed as well as recruitment and training appraisers.**

New actions –

- **Strengthen funds to recruit new appraisers and update training for existing appraisers**
- **To collate quality assurance data to report to Board**
- **To Increase support for quality assurance of appraisals**

Overall conclusion:
Arrangements are in place to ensure doctors are appraised and revalidated to a standard that meets the requirements of the RO regulations. To support quality of appraisals, appraisers need to have regular training to maintain skills and competence.

Section 7 – Statement of Compliance:

The Board of Buckinghamshire Healthcare NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Mr Neil Macdonald

Official name of designated body: **Buckinghamshire Healthcare NHS Trust**

Name: **Mr Neil Macdonald** Signed:

Role: **Chief Executive Office**

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This publication can be made available in a number of other formats on request.

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Meeting: Trust Board Meeting in Public

Date: 26 July 2023

Agenda item	HSE letter on violence and aggression and MSK actions
Board Lead	Bridget O'Kelly - CPO
Author	Karon Hart - Deputy Director Workforce and Wellbeing
Appendices	Letter to NHS Chief Executives from Health & Safety Executive (HSE) BHT Audit of Actions – HSE Letter to Trust
Purpose	Assurance
Previously considered	Health & Safety Committee Strategic People Committee

Executive summary

The Health & Safety Executive (HSE) has written to all NHS Chief Executives setting out their findings on the management of risks from workplace violence and aggression (V&A) and musculoskeletal (MSK) conditions in the NHS following an inspection programme carried out between 2018 and 2022.

The HSE did not inspect BHT as part of this programme.

The HSE recommends that Trusts consider the areas where they identified failings and ensure that they are compliant with health and safety law. The letter also sets out that they will be making appointments with several NHS Chief Executives and carrying out more inspections.

These are 2 areas where we already have programmes of work underway and have been making significant improvements. We have carried out a detailed audit against the recommendations made by the HSE – the summary of which is attached.

Musculoskeletal conditions: We have enhanced our proactive Occupational Health support, with dedicated in-house physiotherapists. Our moving and handling team play a key role in the prevention of MSK conditions, through their mandatory training provision, as well as more specific support as required.

Violence and aggression: Support and initiatives have been a priority area of work through last year – specifically in relation to the revision and implementation of the Managing Violence and Aggression policy through collaborative work with security, wellbeing, and nursing management teams.

Internally, we have established a multi-disciplinary security group (chaired by the Chief Commercial Officer)

We have more work in progress this year and are working with system partners including Thames Valley Police to continue to take this work forwards.

Strategic People Committee reviewed the audit of actions at its meeting in July and has taken assurance from the actions in place.

Decision	The Board is requested to take assurance from the report.

Relevant strategic priority

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

Implications / Impact

Patient Safety	Ensuring safest staffing levels supports patient safety and high-quality patient care
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 6: Failure to deliver our People priorities
Financial	Alignment with Trust Improvement plan and associated financial efficiencies.
Compliance CQC Standards Staffing	Ensure we continue to deliver the right staff, in the right place, with the right skills. Staff are safe, supported and listened to
Partnership: consultation / communication	Staff network groups – specifically including EMBRACE and our disability network, as well as staff side colleagues
Equality	Maintain workforce race equality standards. Support inclusion, with fair and equitable processes and policies. Our workforce should reflect the diversity of our population.
Quality Impact Assessment [QIA] completion required?	No

Health and Safety Executive

John Crookes

Health and Safety Executive
10 South Colonnade
Canary Wharf
London
E14 4PU

http://www.hse.gov.uk/

By email

28th March 2023

To: all NHS Trust and Board Chief Executives

Health and Safety Executive (HSE) - Recommendations for Managing Violence and Aggression and Musculoskeletal Disorders in the NHS

Please find attached HSE's summary findings on the management of risks from workplace violence and aggression (V&A) and musculoskeletal disorders (MSDs) in the NHS, following an inspection programme carried out between 2018 and 2022.

HSE is recommending that you consider the four main categories where management failings have been identified (Risk Assessment, Training, Roles and Responsibilities, and Monitoring and Review) and satisfy yourself that your Trust / Board is managing these areas in such a way as to comply with health and safety law.

This document is being circulated to all NHS Trusts and Boards in Great Britain via internal NHS EPRR channels. Copies of the recommendations are also being shared with relevant NHS employer and employee groups, employee representative groups and trade unions.

For HSE to be assured that suitable action has been taken, we will be undertaking further interventions with the NHS over the next 12 months. These interventions will follow a two-step approach as follows:

Step One: Several high-level interventions by appointment between NHS Trust Chief Executives and HSE Field Operations Division (FOD) Operational managers, to discuss what is being done at senior management level to address the risks from V&A and MSDs.

These interventions will focus on the findings from the 2018-22 inspections as detailed in the attached summary report. In addition, they will explore the following areas:

- steps taken by your organisation over recent years at senior level to address the risks from V&A and MSDs;
- leadership in ensuring that sufficient organisational attention, resources and priority are given to the reduction of V&A and MSD risks.

Step Two: Inspectors will carry out several site inspections to seek assurance that what was described to us, in the high-level interventions, is being delivered on the ground.

Inspectors will engage with a cross-section of management and the workforce to assess the measures taken. Feedback on findings, including details of any action required, will be given at the end of the visits, at senior level where possible.

If you have any queries on the above, please do not hesitate to contact us at public.services-sector@hse.gov.uk

Yours faithfully,

John Crookes HM Principal Inspector of Health and Safety

Head of Health and Social Care Services Sector
Transport and Public Services Unit, Operational Strategy Branch
Health and Safety Executive

Enc: Summary Report

MANAGING VIOLENCE AND AGGRESSION AND MUSCULOSKELETAL DISORDERS IN THE NHS

A Summary of findings from April 2018 – March 2022 inspections of NHS Trusts / Boards focusing on workplace violence and aggression and musculoskeletal disorders.

- Between 2018 and 2022, HSE carried out a series of inspections to assess the management and control of risk from musculoskeletal disorders (MSDs) and violence and aggression (V&A) in the NHS.

- HSE selected these two areas for proactive inspection because they aligned with HSE's strategic priority of reducing work-related ill health. Violence and aggression is a stressor and therefore a contributory factor to work-related stress, which along with MSDs are the two most common causes of new and long-standing, work-related ill health Statistics - Work-related ill health and occupational disease (hse.gov.uk)

- A total of 60 NHS trusts and boards (hereby referred to as NHS Employers for ease of reference) were visited across Great Britain (England, Scotland and Wales). This included acute, mental health and community trusts, but not specialist trusts such as ambulance services and represents approximately one in four of these NHS employers. Twenty organisations were inspected in each of three work years (2018-19, 2019-20, and 2021-22).

- In 38 (63%) of the NHS employers inspected over the course of the three work years at least one contravention of health and safety law in respect of management of risk from MSDs or V&A was identified. In 26 (43%) of the organisations inspected they were found to have contraventions across both areas.

- The level of contraventions of the law for V&A (60%) was slightly higher than that of MSDs (47%).

- The rate of contraventions of health and safety law that were found across each of the inspection years was as follows:

Contravention Rate		
	MSDs	V&A
2018-19	**10 (50%)**	**11(55%)**
2019-20	**11 (55%)**	**14 (70%)**
2021-22	**7(35%)**	**11 (55%)**
TOTAL	**28 (47%)**	**36 (60%)**

- Whilst this summary necessarily focuses on the issues identified during the inspections, it is important to note that nearly 40% of NHS employers were compliant or only needed some verbal advice (37%).

- The common feature where contraventions were identified were management failings. These are failings of the management systems and relate to the following four categories:

  - Risk assessment

    - This refers to the steps taken by NHS employers to conduct suitable and sufficient risk assessments to control the risk to employees from MSDs and V&A.

    - Issues identified during the visits included:

      - assessments being too generic, with high-risk areas not being identified;
      - assessments not including non-clinical workers who were exposed to the risk;
      - inconsistencies in the approach to risk assessment across the same organisation.

  - Training

    - This refers to the training on controlling risk from MSDs and V&A provided to employees.

    - Issues identified during the visits included:

      - training was too generic and lacked evidence it was based on a training needs analysis;
      - where training was identified as being mandatory, in practice it was optional for relevant workers to attend;
      - non-clinical workers who were exposed to the risk were not included in training;
      - no suitable assessment of the competency of the trainers.

  - Roles and Responsibilities

    - This refers to the allocation of specific roles and responsibilities within the organisation to effectively supervise and manage the risk to employees from MSDs and V&A.

- Issues identified during the visits included:

    - a lack of clarity over roles and responsibilities;
    - a lack of wider organisational awareness of who does what;
    - inadequate provision of time and resource given to those with roles and responsibilities;
    - no suitable assessment of the competence of those with specific roles and responsibilities to carry out that work.

- Monitoring and Review

    - This refers to conducting effective monitoring and review of existing risk control measures to ensure they are effective and that the risks to employees from MSDs and V&A are being effectively managed.

    - Issues identified during the visits included:

        - failure to actively monitor and review control measures to ensure they are effective;
        - insufficient time and resource being allocated to monitoring and review;
        - failure to use available data sources (eg absence data, incident reporting) in the review process;
        - a lack of clarity over what should be reported and how, leading to non-reporting.

- **In particular, the inspections found that, whilst NHS employers generally do have policies and procedures for MSDs and V&A in place, these are often not monitored or reviewed to ensure that they work in practice or remain effective.**

- These findings have been shared with a number of NHS stakeholder groups at national level and NHS unions. It is expected that all NHS employers will review their management systems for these common failings and take any remedial action identified by that review process.

END

Ref - HSE Letter re MSK and Violence and Aggression

This document summarises the audit of the work we have in place, against the issues highlighted by the HSE in a letter sent to all CEO's in May 23. The audit provides assurance that appropriate proactive and reactive work is in place, with further initiatives in development

1. Management of Violence and aggression – summary of actions

Risk Assessment: ***Refers to steps taken by NHS employers to conduct suitable and sufficient risk assessments to control the risk to employees from V&A***
Steps taken by your organisation in recent years at Senior level to address the risks from V&A
The Trust has a Managing Violence, Aggression and Unacceptable Behaviour (MVAUB) policy. This is an important tool to help us reduce and address the instances of these behaviours. The policy was reviewed and updated at the end of 2021 following extensive engagement with key clinical and non-clinical colleagues across the Trust. Following the approval and publication of the revised MVAUB policy, the Trust launched a campaign to ensure awareness and compliance with the expectations of the policy across the Trust. We continue to hold Trust-wide webinars and secure time at a range of meetings across the Trust e.g. Chief Nurse and Matrons forums. The policy, presentation and accompanying FAQ document (containing answers to questions captured throughout the socialisation campaign) were included in this campaign and subsequently placed on the Trust intranet site, along with a one-page summary of the policy. This campaign was actively supported by the leaders across the Trust. An external communications campaign during 22/23, led by our chief nurse, to support reduction of violence and aggression, including in the Nursing Times and local radio.
Training: ***Refers to the training on controlling risk from V&A provided to employees***
Steps taken by your organisation in recent years at Senior level to address the risks from V&A
We offer practical hands-on training in two stages: 1. The **Enhanced Conflict Resolution e-learning** course covers many of the potential risks which might be faced by colleagues and what to do in each case. 2. This is followed by **Face-to-Face Conflict Resolution training** which will help colleagues to better manage a situation using physical intervention skills and de-escalate a situation through verbal/body language to reduce the risk of harm to patients or the colleagues involved. We have 7 of our own specialist clinical colleagues, including security, who deliver the face-to-face Conflict Resolution course in-house. These colleagues also provide ad-hoc in the moment training when needed – so vital for capturing timely learning opportunities.

A collaborative programme underway with Thames Valley Police – areas being discussed include training and reporting on Boundaries of Offence and Public Order
Roles and Responsibilities: ***Refers to the allocation of specific roles and responsibilities within the organisation to effectively supervise and manage the risk to employees from V&A***
Steps taken by your organisation in recent years at Senior level to address the risks from V&A
Our MVAUB policy makes it clear the responsibilities of colleagues, including those at a senior level. Ie. who is responsible for doing what and the processes they should follow to respond to a situation from initial awareness to the point where a yellow, or a final red card is issued, and the person concerned is removed from Trust premises. The policy socialisation campaign ensured wider organisational awareness and senior lead endorsement ensures adequate provision of time and resource in the event of an incident to follow through on all policy processes. The roles and responsibilities and sign off authorities within the policy reflect appropriate bands required to carry out the policy. This ensures the appropriate competence of those with specific roles and responsibilities to carry out that work. The socialisation campaign also highlighted where any additional training was required.
Monitoring and Review: ***Refers to conducting effective monitoring and review of existing risk control measures to ensure they are effective and that the risks to employees from V&A are being effectively managed***
Steps taken by your organisation in recent years at Senior level to address the risks from V&A
BHT Datix incidences are monitored on a daily basis at a senior level. Recent upgrades to our Datix system have also reinforced knowledge and understanding of how and what to report within the system and this, together with the socialisation campaign, reinforced the value and importance of reporting. We also have provision within Datix for the reported to identify when the psychological wellbeing of colleague/s has been affected and whether they would like the inhouse BHT Wellbeing team to contact them. The Wellbeing team is then immediately notified of the incident and follow up within 48 hours (Mon-Fri, 8am-4pm). In the event of a potentially traumatic incident, the Wellbeing team also have the ability to refer to one of 35 TRiM (Trauma Risk incident Management) Practitioners who work in varied clinical and non-clinical roles across the Trust, who can complete a Trauma Risk Assessment, under the governance of the Wellbeing team. Prior to the MVAUB policy socialisation campaign, in addition to analysis of Datix data, the working group conducted research with all senior ward matrons and key stakeholders across all directorates to ascertain, for example, the top 3 drivers of V&A, the 3 main medical conditions contributing to incidents, what was working effectively to manage/reduce V&A and what wasn't, what caused negative outcomes and what training was required. It is planned to repeat this survey to monitor impact/progress.

2.Managing Musculoskeletal Disorders – summary of actions

Risk Assessment: ***This refers to the steps taken by NHS employers to conduct suitable and sufficient risk assessments to control the risk to employees from MSDs***		
Area/Issues Identified by HSE	**Steps taken by your organisation in recent years at Senior level to address the risks from MSD's**	**Detail**
Individual wards/departments	At BHT, colleagues in wards and departments (Clinicians and managers) undertake risk assessments for moving and handling for each patient on their ward upon arrival, this will encompass the manual handling needs of that patient so that staff are aware of the demands of that patient to decrease the MSK risk to the staff and patient. Local managers will complete risk assessments for their employees who have reported MSK pain which is directly impacting their ability to perform their role. If the MSD began as a result of an accident or incident at work this will be recorded within Datix.	Local wards will hold the risk assessments of each patients manual handling need to decrease the risk of MSK pain as a result of poor handling technique. These risk assessments will be held locally on the ward. Datix reports are reviewed by Heath and Safety team and Occupational Health as required, to advise further actions needed.
Management reports written by Occupational Health Physiotherapists to staff and line managers following a detailed assessment of pain and working role, requesting a risk assessment be performed.	Within each management report, Occupational Health give recommendations on how to support staff to reduce their risk of continuing MSK pain while at work.	OH Physiotherapists recommend that the Line manager (and in some cases the staff member) undertake a risk assessment regarding their condition and work function
Display Screen Equipment Policy	DSE policy is available to all BHT colleagues on CAKE (the Trust intranet), and gives staff and managers information regarding where to access DSE Training module on IApsire (the Trust training platform), and how to complete the DSE self-assessment form and when this should be completed.	If defined as a DSE user individual colleagues must: Comply with the requirements of the Trust's General Health and Safety Policy. Undertake a DSE self-assessment) on first becoming a DSE user at the Trust, if there are any significant changes to the workstation(s) used or if advised by OH to do so.

	Occupational Health Physios are able to make an Onward referral to an external company who provide onsite desk assessments for the Trust	Understand and know how to minimise discomfort and health risks from using DSE by completing the e learning module Display Screen Equipment and Training before undertaking the DSE user self-assessment. Report any defects in equipment immediately to manager. Follow the prescribed safe working procedures as detailed in the information and training provided. Report any incident/accident or dangerous occurrence or any other work-related ill health as per the Display Screen Equipment Policy - BHT Pol 033 (v5.0) 9Final April 2022 Report to their manager, any ill effect that they consider may be attributed to the use of DSE as soon as it occurs and carry out a reassessment of their workstation. Co-operate with their department manager in the implementation of any measures provided within the department in the interests of safety.
Assessments being too generic, with high-risk areas not being identified	Within BHT there are two risk assessment tools that are in circulation. The first is the risk assessment for handling patient and the second is used in the moving and handling of loads. As outlined in the Moving and Handling Policy it is a requirement that an individual is asked to complete a risk assessment at the time in which moving and handling is required. BHT managers complete an appropriate risk assessment for the moving and handling of loads (in animate objects such as medical equipment). As these risk assessments are completed at the time they are encountered and reviewed at least every 6 months for loads and 7 days for patient handling to ensure that they remain accurate to the load, environment and patient's circumstances. The patient handling risk assessments are routinely audited by the Moving & Handling service which	The is risk assessment tool is specific to the 'TILE' acronym which ensures that the task is assessed on a case-by-case basis and contributory high-risk factors are assessed on a patient by patient and load-by-load basis. If the risk is identified has being high for the handling of loads and cannot be resolved by good moving and handling technique it is then assess by the Health & Safety Team to find a safe approach to handle the load. In high-risk patients it is advised to reduce the risk to an acceptable level if able by improving the conditions of the procedure such as lighting, increasing the number of staff participating in the procedure.

	the results are presented at the governance meeting within the Health and Safety Committee.	
Assessments not including non-clinical workers who were exposed to the risk	Non-clinical workers are not expected to be exposed to the moving and handling of patients however all colleagues undertake mandatory moving and handling training. Non- clinical colleagues may be exposure to the moving and handling of loads. This risk would be covered within the existing Moving & Handling of Loads risk assessment tool.	It is the responsibility of the manager to fully orientate new members of staff to the associated risks within their job responsibilities. It would also be within their duties to create new risk assessments and update them if there were significant changes within the non-clinical work environment. As the risk assessment may have a degree of subjectivity, it is also recommended that individuals assess the risk prior to the manoeuvre and their personal ability to complete the manoeuvre.
Inconsistencies in the approach to risk assessment across the same organisation	All members of the Trust are trained in the completion of the Moving and Handling Risk Assessments within their induction. The risk assessments are also a vital part of the face-to-face update training and the eLearning package which is delivered to all staff. Both of the risk assessments that are used for patients and loads are used throughout all hospital sites and community services.	Collaborative workplace assessments can also be conducted if identified as a risk from their occupational health assessment following an MSD. These workplace assessments are focused on any training deficits that the member of staff may have and as an advisory service for any additional equipment that the member of staff may need.
Training too generic and lacked evidence it was based on a training needs analysis	The face-to-face training delivered at induction and update sessions are based on the guidance from the National Back Exchange and informed by best practice as outline in our best practice guide on Clinicalskills.net.	
Where training was identified as mandatory, in practice it was optional for relevant workers to attend	Moving and Handling Training is mandatory for all staff within the organisation. Non-clinical staff are required to this within their induction and are required to complete their Level 1 training update every 3 years. Clinical staff are	

	required to attend a face-to-face training session within their induction programme and must attend a Level 2 face to face update every 2 years. The training compliance is monitored monthly and feedback to areas where compliance is a concern.	
Non-clinical workers who were exposed to the risk were not included in the training	Non-clinical workers who are exposed to the risk of handling loads are trained in their mandatory corporate induction program and have updates via the eLearning package. There is a separate eLearning package for display screen assessments and correct posture for prolonged desk usage.	
No suitable assessment of the competency of the trainers	The Moving & Handling team who conduct the training have completed a level 3 qualification from the Royal Society for the Prevention of Accidents in Moving and Handling. As this role also requires an education component they also hold a level 3 or higher qualification in education and training. Clinical Key Trainers are also required undertake training prior to them being able to conduct their own training within their clinical areas. These trainers participate in a 4-day BHT training program in which their competency is assessed by a MCQ test and observed teaching sessions to ensure adequate quality is delivered. These key trainers are then required to undertake regular update training to maintain their own compliance.	

Training: ***This refers to the training on controlling risk from MSDs provided to employees***		
Area	**Steps taken by your organisation in recent years at Senior level to address the risks from MSD's**	**Detail**
MSK Occupational Physiotherapists	Line managers are able to formally refer their staff with MSD's for review by the Occupational Health in house team Physiotherapists within 10 days. They can request any work/condition specific advice that they require, including return to work plans and onsite assessment.	Colleagues can self-refer to the Physiotherapists also for assistance with MSD's. Occupational Health Physiotherapists have access to generic sickness data, so are able to review the number of referrals by department to see where the frequent referrals are generated and work pro-actively with the relevant departments.
DSE Policy including self-assessment form, and DSE training module	BHT has all of this available via i-aspire– plus the further support of in-house Occupational Health Specialists Training video created to show staff how to adjust their workstation to meet their needs Training video created to show staff desk exercises to promote staff strength and flexibility.	Monitored through i-aspire for compliance Created and in editing phase. Created and in editing phase.

Roles and Responsibilities: ***This refers to the allocation of specific roles and responsibilities within the organisation to effectively supervise and manage the risk to employees from MSDs***		
Area	**Steps taken by your organisation in recent years at Senior level to address the risks from MSD's**	**Detail**
Risk Management Policy, roles and responsibilities	The Associate Chief Nurse for Governance, along with Health and Safety Team, deliver training focusing on risk assessment and communication. Monitored through an annual appraisal. Line managers are responsible for ensuring that their team have fulfilled all their statutory training	All colleagues receive risk-related training as part of induction and annual mandatory training. This will be monitored through an annual appraisal. Line managers are responsible for ensuring that their staff have fulfilled all their statutory training requirements each year and for escalating through a disciplinary route where there is persistent non-compliance. Indicative outline: Risk Management Policy BHT Pol 079 Version 7.11 Oct 2022

	requirements each year and for escalating through a disciplinary route where there is persistent non-compliance.	Health and Safety Risk Assessors trained through the Risk Assessor Training Course run by the Health and Safety Facilitator with the support of the training department. Other risk-specific training across clinical and non-clinical services will receive specialist training through the Training Department, Trust Advisors or approved external providers.
DSE Roles and responsibilities (given within the DSE policy)	DSE policy lays out the responsibilities of Trust Board, Executive Officers, department managers, Staff, H&S team, Occupational Health and Wellbeing team.	Occupational Health and Wellbeing Team: Provide advice to the individual and management for colleagues referred with possible health concerns relating to DSE use. Identify to management any new colleague who may require reasonable adjustments to their workstation for relevant pre-existing health reasons before they commence work. Assist with unresolved ergonomic issues relating to DSE assessments carried out at department level. Undertake workplace visits to assist managers with DSE assessments in more complex cases. Issue eye test vouchers on receipt of completed manager request form. Advise managers when a RIDDOR notifiable disease related to DSE use has occurred e.g. tendonitis/tenosynovitis in in the hand or forearm, where the person's work is physically demanding and involves frequent, repetitive movements, or cramp of the hand or forearm: where the person's work involves prolonged periods of repetitive movement of the fingers, hand or arm. These conditions are rare with modern DSE equipment and working practices.

Monitoring and Review: ***This refers to conducting effective monitoring and review of existing risk control measures to ensure they are effective and that the risks to employees from MSDs are being effectively managed***		
Area	**Steps taken by your organisation in recent years at Senior level to address the risks from MSD's**	**Detail**
Occupational Health Physiotherapists	Occupational Health Physiotherapists access sickness data to review the frequency with which different departments refer for MSK pain, and work proactively to help reduce the risk for further MSD's.	

Meeting: Trust Board Meeting in Public

26 July 2023

Agenda item	External Reviews Update
Board Lead	Karen Bonner, Chief Nurse
Type name of Author	May Parsons, Associate Chief Nurse for Risk, Governance and Compliance Kelly Hardwood, Regulatory Compliance Administrator
Attachments	Appendix 1: External Review Register
Purpose	Assurance
Previously considered	EMC 04.07.2023

Executive Summary

This report provides an update on the External Agency Visit activity between December 2022 to June 2023. The register is attached at Appendix 1.

Assurance in relation to the recording, implementing, and progression of action plans following an external visit is via the relevant Trust group/committees identified in the register.

There is variation in data completeness and quality, the number of reported visits has increased from 58 to 65 with most Divisions represented.

Further work is required to improve both the completeness and the quality of the central register. This will be progressed through the Divisional Governance Leads and the Risk & Compliance Monitoring Group.

Divisions should commence exception reporting to the identified Board Committees to enable ongoing assurance gathering.

The External Visits, Inspections and Accreditations Policy and Procedure is currently under review and scheduled for ratification in September 2023.

The Executive Management Committee considered this report on 4 July and noted the work ongoing to strengthen the oversight of external reviews and resultant actions across the Trust, including the potential use of the Datix system. The Chief Nurse is due to report back to EMC on this matter in September.

Decision	The Committee is requested to note the updates and support the continued action to increase assurance.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	Patient safety risk may not be recognised and or resolved if the findings from an external review are not shared and acted upon in a timely manner.
Risk: link to Board Assurance Framework (BAF)/Risk Register	Links to BAF Risks: **Risk 1** - Failure to provide care that consistently meets or exceeds performance and quality standards including safety, experience and outcomes

	Risk 5 - Failure to support improvements in local population health and a reduction in health inequalities. **Risk 8** - Failure to learn, share good practice and continuously improve
Financial	Possible financial consequences if recommendations are not monitored and acted upon.
Compliance Select an item. **Good Governance**	A structured approach to learning from external reviews is evidence of a Well Led responsive organisation as well more broadly supporting compliance with current statute, regulation and best practice.
Partnership: consultation / communication	N/A
Equality	An EIA was completed as part of the Policy management process. BHT is committed to reduce inequalities in healthcare. The clear actions from external reviews being undertaken across the organisation can support this.
Quality Impact Assessment [QIA] completion required?	N/A

1 Introduction/Position

This report provides an update on the External Agency Visit activity between December 2022 to June 2023

1.1 Details of the existing external reviews registered are summarised at Appendix 1.

1.2 Following the last update, the number of External Agency Visits, Inspections and Accreditations (External Visits) registered has continued to increase from 58 to 65.

- Finance 2 (2)
- People Directorate 13 (14)
- Integrated Medicine 4 (3)
- Specialist Services 26 (24)
- Trust-wide 4 (3)
- Women's, Children and Sexual Health 4 (3)
- EPRR 1 (1)
- Health & Safety 1 (1)
- Informatics 1 (1)
- Maternity 3 (3)
- Surgery and Critical Care 5 (3)
- Corporate/HR 1 (0)

- CARF review for NSIC: this review will no longer be undertaken and will be archived from the list.

1.3 Assurance in relation to the recording, implementing, and progression of action plans as a result of a given External Visit is gained via the relevant Trust groups and committees where identified in the register rather than this report.

2 Problem

2.1 There is variation in monitoring of External Visits, inspections and accreditations but improvement in the number registered.

2.2 Dates of next review

2.2.1 Of the 65 External Reviews, 55 have entries under "*date of next review*". 7 of these are future dates however a significant number are passed or TBC. In some cases, previously planned visits remain unscheduled following the pandemic.

2.3 Action Plans:

2.3.1 Action Plans are in place following 27 of 65 External Visits recorded as having been previously undertaken.

2.4 Date considered at RCMG and any other relevant group

2.4.1 Of the 65 External Reviews, 12 have reference to consideration at RCMG or other Group.

2.5 Board Committee receiving assurance

2.5.1 Of the 65 External Reviews, 23 have an identified Board Committee to receive Assurance.

2.5.2 5 External Reviews have been identified as having been to a Board Committee.

3 Proposal, conclusions recommendations and next steps.

3.1 Further work is required to improve both the completeness and the quality of the central register. The Associate Chief Nurse - Director for Risk, Governance and Compliance will progress this through Divisional Governance Leads.

3.2 Divisions should commence exception reporting to the identified Board Committees to enable ongoing assurance gathering.

3.3 The BHT Policy 271 for the Management of External Agency Visits, Inspections & Accreditations Policy and the external review recording process is currently under review and scheduled for ratification in September 2023.

4 Action required from the Board/Committee

4.1 The Committee / Board is requested to:

a) Note the updates and support the ongoing development of assurance in relation to External Reviews.

Appendix 1: External Agency Visit Register June 2023
(Light blue text indicates updates)

Name of review	Date of last review	Review Body	Dates of next review (if known)	Executive Lead	Division	Date final report due	Date final report received	Action Plan in place?	Final Deadline for actions	Date considered at RCMG and any other relevant group	Board Committee receiving assurance	Board Committee receiving exceptions reports	Date (to be) reviewed at Board Committee	Notes
Antenatal and newborn screening QA visit (3 yearly)	Nov-22	Public Health England	unscheduled	Chief Operating Officer	Maternity									24/11/2022: mentioned in briefing this happened last week? + Gift +another one?
Blood Safety & Quality Regulations 2005 review	09/11/2020	MHRA	Not notified as yet	Chief Operating Officer	Specialist Services									25/11/2020: Initial action plan in place awaiting agreed deadlines for some items and sign off 19/05/23 - no inspections current scheduled
CARF review for NSIC	May-18	Commission on Accreditation of Rehabilitation Facilities	Jul-21	Chief Operating Officer	Specialist Services	Jul-18	July 2018 - Accreditation confirmed	Yes	Jul-21		QCGC	QCGC		July 2018: Accreditation confirmed - next review July 2021 05/06/23: To be removed as will not be reapplying due to staffing.
Cervical Screening QA Review	Feb-18	Public Health England	Virtual tours until further notice	Chief Operating Officer	Specialist Services									07/05/2021: The January visit was postponed and they are completing virtual tours. We are sending paperwork when requested. This is a duplicate of the NHSCSP SQAS. Cervical screening is no longer performed at BHT, Only now Colposcopy and Histology reporting of referred cases taken at Colposcopy.
Colposcopy QA (3yrly)	May-21	Public Health England ANNB Screening Quity Assurance	Nov-22	Chief Operating Officer	Maternity	Jun-21	01/06/2021	y	TBC	Gynae Governance, Divisional Quality Mtgs	QCGC	QCGC	Jun-21	Tracking and monitoring of action plans also undertaken at the Antenatal and Newborn Screening Programme Board
CQC Inspection	Feb-22	Care Quality Commission (CQC)	2025	Chief Nursing Officer	Trust-wide	Jun-22	Jul-22	Y	May-23	N/A	EMC/QCGC/Trust Board	EMC/QCGC/Trust Board	Oct-22	
CQC Well-Led Inspection	01/03/2022	Care Quality Commission (CQC)	2025	Trust Board Business Manager	Trust-wide	Jun-22	Jul-22	Y	May-23	N/A	EMC/QCGC/Trust Board	EMC/QCGC/Trust Board	Oct-22	
EA Review of Nuclear Medicine/Radioisotope Facilities	Jul-21	Environment Agency	Not annual/regular review	Medical Director	Specialist Services	Jul-21	Jul-21							Review carried out and report received
EARLY YEARS EDUCATION FUNDING - AMERSHAM NURSERY	21/11/2017	Buckinghamshire Council, Commissioning compliance	circa 2022	Chief People Officer	People Directorate	Jan-18	Jan-18	Y			SWC	SWC		
EARLY YEARS EDUCATION FUNDING - WYCOMBE NURSERY	25/09/2015	Buckinghamshire Council, Commisioning compliance	circa 2020 - delayed due to C-19	Chief People Officer	People Directorate	Sep-15	Sep-15	Y			SWC	SWC		
EL 97/52 (SMH)	Oct-18	Regional Pharmaceutical Quality Assurance Service	Unscheduled - see notes	Medical Director	Specialist Services	Oct-19	17-Oct-19	Yes	Oct-19	Spec Services Divisional Governance	Monitored through Pharmacy Governance Meetings			02/06/2021: The EL97 (SMH) is not currently scheduled. This unit is undergoing a refurbishment starting this week and will take approximately 3 months, then a further 6-10 week validation process. During the validation time we will be expecting Regional QA to visit and undertake an inspection prior to being put into use for patient doses. **Likely window for SMH inspection will be September to October** barring unexpected delays in the work programme.
EL 97/52 (WH)	Oct-18	Regional Pharmaceutical Quality Assurance Service	Jul-21	Medical Director	Specialist Services	Oct-19	17-Oct-19	Yes	Nov-19	Spec Services Divisional Governance	Monitored through Pharmacy Governance Meetings			Assessed as low risk

FOOD HYGIENE / H&S INTERVENTION - AMERSHAM NURSERY	17/10/2018	Buckinghamshire Council, Environmental Health Dept.	Autumn 2021	Chief People Officer	People Directorate	Oct-18	17/10/2018	Y			SWC	SWC		
FOOD HYGIENE / H&S INTERVENTION - WYCOMBE NURSERY	07/02/2019	Buckinghamshire Council, Environmental Health Dept.	Spring 2022	Chief People Officer	People Directorate	Feb-19	07/02/2019	Y			SWC	SWC		
GIRFT - Acute SDU					Integrated Medicine									
GPhC (SMH)	Jan-19	General Pharmaceutical Council	Not notified as yet	Medical Director	Specialist Services	Feb-19	19/02/2019	To be completed		Spec Services Divisional Governance		Chief Pharmacist and Aseptic Services Leads Monitored through Pharmacy Governance meetings		02/06/2021: the GPHC has restarted their pharmacy inspection schedule and normally provide 6-8 weeks notice. Almost certainly they will be prioritising new pharmacies or ones who had a higher risk rating, our last couple of inspections have scored us pretty low, so it could be a while before they turn up. Generally we assume our operating processes should be audit ready at any time.
GPhC (WH)	Sep-19	General Pharmaceutical Council	Not notified as yet	Medical Director	Specialist Services	Oct-19	Oct-19	To be completed		Spec Services Divisional Governance		Chief Pharmacist and Aseptic Services Leads Monitored through Pharmacy Governance meetings		02/06/2021: the GPHC has restarted their pharmacy inspection schedule and normally provide 6-8 weeks notice. Almost certainly they will be prioritising new pharmacies or ones who had a higher risk rating, our last couple of inspections have scored us pretty low, so it could be a while before they turn up. Generally we assume our operating processes should be audit ready at any time.
Grant Thornton External Financial Audit	Jul-22	Grant Thornton	Unscheduled	Finance Director	Finance	Jul-22	Jul-22	Not required	N/a	N/a	F&BP	F&BP		July 2021: Accounts accurate and complete July 2022: Unqualified sign off - no material disagreements - piece of work now closed off.
Health & Safety Executive review of Asbestos Management following a complaint	Mar-20	Health & Safety Executive	One-off	Commercial Director	Health & Safety	Jul-20	Jul-20	Y	28/08/2020	Health and Safety Committee	SWC	SWC		March 2020: HSE visit following a complaint from Unison regarding asbestos management. A Notice of Contravention was issued in July 2020. No follow up visit has been programmed by them, although they could come in at any time. The Asbestos Policy and Management Plan was formally adopted by the Trust in August 2020. All documented through Health and Safety Committee. Some asbestos risks are on the Risk register, relating to Plant rooms.
HSE review of microbiology	Jun-17	Health & Safety Executive	04/10/2022	Medical Director	Specialist Services									15/06/2022: Update from GS H&S - routine COSHH inspection 18/07/2022: GS reported July inspection deferred to September. Inspection of CL3 facilities at Buckinghamshire Healthcare NHS Trust (Stoke Mandeville Hospital), on Tuesday 4th October 2022, to commence at approximately 9 am. I will be accompanied by my colleague Dr HD (cc'd). The inspection will focus on safety matters relating to biological agents and will include discussions of management arrangements (9am – 3pm with a break for lunch) as well as a physical inspection of the CL3 laboratory (from specimen reception to waste removal)(3pm- 4.15 pm)
Human Tissue Authority inspection of Wycombe Hospital post mortem licence	Sep-17	Human Tissue Authority		Chief Operating Officer	Specialist Services									Re-registered for all Trust sites in 2019 High Wycombe only now used a Body storage which is included in the Trust HTA, Separate licence not required.

ICU GIRFT virtual deep dive	23-Feb-21	GIRFT		Medical Director	Surgery and Critical Care									No update as of 30.11.22
JACIE - Stem Cell accreditation	Oct-21	Joint Accreditation Committee ISCT-Europe		Medical Director	Specialist Services		Dec-22	yes	N/A		Monitored through CG Meetings (SDU and Board) and Risk and Compliance Committee Meeting			16/12/2022: Further JACIE accreditation achieved Asha – is working on an overview paper and action plan to address •Established support for data management; this can be facilitated by having a dedicated Data manager in post for the wider programme. •Patient feedback is derived from Trust's Friends and Family survey however it would be helpful for the service to gain feedback in the form of a questionnaire.
JAG Accreditation	Feb-20	JAG	Aug-20	Chief Operating Officer	Integrated Medicine	Aug-20		Yes	Aug-20	CQC Improvement Group 05/02/2020				05/02/2020: JAG visit undertaken. Awarded a 6 month deferral – there are actions to be put in place and 6 months to do it. Most of the review was positive. Some work to be done around storage of decontamination fluids and the purchase of cupboards, but should be compliant in 6 months. Plans in place to move the WGH decontamination downstairs. JAG action plan in place.
Macmillan Quality Environment Mark (CCHU)	Jun-21	Macmillan	Jul-24	Chief Operating Officer	Specialist Services						QCGC	QCGC		29/06/2021: passed with flying colours and improved scoring for the unit even with the Covid challenges! The team will review the recommendations made and provide a small action plan ***it is important to note that some of the recommendations are beyond the influence of the department (ie car parking)***, however these issues will be shared with estates colleagues. The action plan will be monitored through the Cancer and Haem governance structure with divisional oversight. 19/05/23 - MP to set up meeting to confirm actions and prep for next review
Macmillan Quality Environment Mark (Ward 5, SMH)	Dec-21	Macmillan	Dec-24	Chief Operating Officer	Specialist Services									07/05/2021: Next visit pp from April to October 2021. Preparatory work underway 12/2021: review carried out and report received. 19/05/23 - MP to set up meeting to confirm actions and prep for next review
National Peer Review of Paediatric Diabetes service for CYP of Buckinghamshire	30/03/2022	Paediatric Diabetes service for CYP of Buckinghamshire	Unscheduled	Chief Operating Officer	Womens, Children & Sexual Health									JI - Paediatric Diabetes Team Administrator
NHS Digital Review of DSPT Workoff Plan	30/09/2021	NHS Digital	31/12/2021	Director of Strategy	Informatics	Sep-21	Sep-21	Y	31/12/2021	EMC 20/09/2021	EMC	EMC	Early Dec 21	Agreed not to escalate to Corporate Risk Register by DW but is logged on Divisional Risk Register as IT-308
NHSE Breast Screening Review	Aug-21	NHS England	Jun-23	Medical Director	Specialist Services	Sep-21	Sep-21	Completed	Completed		QCGC	QCGC		22/09 - no change to report 07/04/22 - no change, we have no date for a review yet but it will be mid 2023 at the earliest.
Ockenden Review of Maternity	Jun-20	NHSE South East Ockenden Insight and Assurance	Aug-22	Chief Nurse	Maternity	TBC					QCGC	QCGC		
OFSTED INSPECTION - AMERSHAM NURSERY	24/10/2017	Dept. for Education / Gov.	circa 2023	Chief People Officer	People Directorate	Oct-17	25/10/2017	Y			SWC	SWC		
OFSTED INSPECTION - OUT OF SCHOOL CLUB AMERSHAM	06/02/2018	Dept. for Education / Gov.	Unscheduled	Chief People Officer	People Directorate	Feb-18	07/02/2018	Y			SWC	SWC		
OFSTED INSPECTION - WYCOMBE NURSERY	Mar-22	Dept. for Education / Gov.	circa 2026	Chief People Officer	People Directorate	Mar-22					SWC	SWC		
Pharmacy - Home Office CD licence (CDWDL)	Jul-21	Home Office	Not notified as yet	Medical Director	Specialist Services									14/05/23 - awaiting date for next visit

Pharmacy MHRA Quality Assurance audit.	Nov-20	MHRA	01/07/2021	Medical Director	Specialist Services	Compliance report is sent off on a yearly basis	Compliance report is sent off on a yearly basis	Yearly internal audit of compliance	N/A	N/A	QCGC	N/A	N/A	07/07/21: No review scheduled currently 21/09/21 - no change. 06/04/22 - no change
Pharmacy MHRA Wholesaler Dealer Licence (WDL)	SMH 25-9-13 WH 21-8-14	MHRA	Unknown - risk based assessment (BHT Low risk)	Medical Director	Specialist Services	Compliance report is sent off on a yearly basis	Compliance report is sent off on a yearly basis	Yearly internal audit of compliance	N/A	N/A	QCGC	N/A	N/A	07/07/21: No review scheduled currently 21/09/21 - no change. 06/04/22 - no change
QSIS for cancer services (inc chemotherapy) (Cancer Peer Review)	Jun-19	NHS England	Paused until Q4	Medical Director	Specialist Services	Oct-19	Jan-20	AP for previous review in 2017 completed and returned	N/A	Discussed at Cancer Delivery Group Feb 2020	QCGC	QCGC		20/01/2022- QSIS stated that due to the impacts of Covid 19, submission for Q3 2021/22 was not mandatory. We await a further update for Q4.
QUALITY ASSURANCE VISIT - AMERSHAM NURSERY	04/05/2021	Buckinghamshire Council,	May-22	Chief People Officer	People Directorate	May-21	May-21	Y			SWC	SWC		
QUALITY ASSURANCE VISIT - WYCOMBE NURSERY	17/05/2021	Buckinghamshire Council, Ed. Dept.	May-22	Chief People Officer	People Directorate	May-21	May-21	Y			SWC	SWC		
Quality Governance Review	Nov-21 - Mar-22	Facere Melius	One-off	Chief Nursing Officer	Trust-wide	Sep-21	Mar-22	Y			EMC/QCGC	EMC/QCGC		Trust Quality governance review including support with SaferStaffing and Datix upgrade.
RSM Temporary staffing Audit	Aug-21	RSM		Chief People Officer	People Directorate	Aug/Sept								08/2021: Awaiting final report
SCAS Hazmat response audit	Dec-19	SCAS	Jun-22	Accountable Emergency Officer/COO	EPRR	Jul-22	28/06/2022	Y	Dec-22	Resilience Committee	Resilience Committee	Resilience Committee	Jul-22	SCAS Audit taking place 22/06/2022. Report and findings to be published following audit. Action plan will be delivered by EPO & HazMat ED Lead and presented at Resilience Committee. Board Report will also be produced for update.
SEQOHS Accreditation	Jan-18	Royal Society of Occ Health Physicians	2022	Chief People Officer	People Directorate	2018					SWC	SWC		SEQOHS accreditation, inspections and accreditation suspended due to COVID. Membership is in place and will continue in 2022
Thames Valley and Wessex Paediatric Critial Care Network	13/07/2021	Thames Valley and Wessex Critical Care Operation Delivery Network		Chief Operating Officer	Womens, Children & Sexual Health	Aug-21	Mar-22							17/03/2022: We have just been sent the Paediatric Critical Care report for review. We have sent it back and then they will resend for dissemination hopefully by the beginning of April
Thames Valley Trauma Network Education visit	11-Feb-20	Thames Valley Trauma Network	Suspended due to pandemic	Medical Director	Surgery and Critical Care		13-Jul-22	pending TVTN approval from 07.06.22	Before next TVTN review June 2023					29.11.22: Update from Mr A - action plan sent to TVTN July/Aug 2022. BHT awaiting feedback from TVTN. 05.06.23: Update from Mr A - TVTN were happy with the action plan and the interventions suggested. I have not yet heard from them regarding the annual external visit and review for this year. I will let you know as soon as I have an update from them.
UKAS Assessment Cellular Pathology	May-23	UKAS		Medical Director	Specialist Services	2023	May-23	Yes	06/12/2023	N/A	Monitored through CG Meetings (SDU and Board) and Risk and Compliance Committee Meeting	N/A		Full surveillence visit May 2023. Final report recieved, findings being actions for return by 12/06/2023. Accrediation remains.
UKAS assessment microbiology	Jul-19	UKAS	To be announced	Medical Director	Specialist Services									26.07.21 - No update from SGB 07/04/22 - no news regarding visit although we have been informed about a change to our assessment manager
Visa Sponsorship Licence	Mar-13	UK Borders Agency (now UK Visas)	Unscheduled	Chief People Officer	People Directorate		Not available	N	NA		SWC	SWC		
Wycombe Aseptic Unit Section 10 audit.	22/07/2021	Regional Quality Assurance	Not notified as yet	Medical Director	Specialist Services									14/05/23 - awaiting date for next visit

ED Quality Assurance Walk Around	29-Jun	CCG		Medical Director	Integrated Medicine	Jul-22								
HTA - Mortuaries	Oct-22	Human Tissue Authority (HTA)		Medical Director	Specialist Services	2022	Feb-23	Yes	End June 2023					04/07/2022: We have also been made aware that HTA are visiting mortuaries around our region. They usually give us 3 months notice, nothing as yet, but we are expecting our assessment visit to occur within this year TA inspectedOct 2022. Action plan in place address findings but continued licence granted.
NHS Cervical Screening Programme - Annual Review	2022	NHSCSP	TBC	Medical Director	Specialist Services	2022	2022	Yes	Mar-23					04/07/2022: In addition to our normal quarterly external NHSCSP Programme Board meetings and our yearly external assessment visit, we have a teams meetings from our SQAS NHSCSP team re the turn around time targets of the Gynae Cervical Biopsies reporting in histopathology. They are looking to see how they can offer support and assistance where possible. No dates as yet for a full assessment visit. 22/05/2023 still awaiting dates. Annual report submitted for 2022/2023 by CSPL ME
RSM Internal Audit regarding compliance with CQC regulations: -Reg 9 Person-centred Care with a focus on Mental Health, -Reg 18 Safe Staffing, -Reg 20 Duty of Candour.	Jul-22	RSM	Unscheduled	Chief People Officer	People Directorate	Jul-22					SWC	SWC		The CNO will be leading on Regs 9 and 18 and the CPO on Reg 20. 18/07/2022: Report to RSM - feedback report expected Mid-July
CCG Quality Visit ED	27/06/2022	CCG	One-off	Medical Director	Specialist Services		Jul-22	Working towards			Various			02/08/2022: RDS meeting with PJ today to plan looking to incorporate into existing Governance workstreams
Burns Quality Assurance Review	Not known	LSEBN - London and South East of England Burns Network	01/11/2022	Chief Nurse	Surgery and Critical Care		awaited as of 29.11.22	pending report with recommendations						SMH and John Radcliffe review of the paediatric and adult burns service on 1st November with self-declaration due end Sept 2022 29.11.22: Update from Miss M; visit went well with very good feedback on our burns service, highlighted key issue of Paeds staff and space as the major problem – which we were very open about. Formal report still not issued, but it will come through to CEO, CMO and Miss M to disseminate. Miss M leading on the output of the review as burns lead
Human Tissue Authority (HTA) Inspection - Antenatal and Gynae	Sep-17	Human Tissue Authority (HTA)	25-27 October 2022	Chief Operating Officer	Womens, Children & Sexual Health	Dec-22		TBA			Pathology clinical governance committee			Wycombe and Stoke Mandeville
HFMA Audit	Nov-22	HFMA	TBC	Finance Director	Finance	TBA					F&BP	F&BP		
GIRFT Neonatal	20/07/2022	GIRFT	TBC		Womens, Children & Sexual Health			Y	no dates on AP					Actions to be completed ahead of next data submission (unknown)
Engineering Review in Endoscopy	22/02/2023	IHEEM	TBC	Chief Operating Officer	Integrated Medicine									
Controlled Drugs Renewal Application (Ref: 8233808)	07/03/2023		TBC	Chief Operating Officer	Specialist Services									
Aseptic Audit	1-2/03/2023			Chief Operating Officer	Specialist Services									
Olympic Lodge Visit		CQC			Integrated Elderly & Community Care									
Accreditation against the Standards in Anaesthetics Dept	11/05/2023	ACSA	TBC	Chief Operating Officer	Surgery and Critical Care									11/05/23: received some informal feedback with includes some areas that the team found particularly exemplary and also some clues as to the few areas which we need to do some work on to gain re-accreditation. Await report.

Amersham Day Nursery	May-23	OFSTED	within the next inspection cycle i.e. 6years	Chief People Officer	Corporate/HR	16th June 2023	7th June 2023	N/A	N/A					The nursery received 'Good'.
ISO 13485 Accreditation Sterile Services	Apr-22	BSI	Jul-23	Chief Operating Officer	Surgery and Critical Care	Apr-22	Apr-22	NA	NA					2nd Surveillance audit completed April 22 no non conformances raised .
Surgical Site Infection Surveillance	Unknown	UKHSA	Annual	Chief Nurse/ Director IPC	Trust-wide	Mar-24					Infection Control Committee			Trust noncompliant since 2019. IPC to lead once SSI team in place

Meeting: Trust Board Meeting in Public

26 July 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	Appendix 1 - Corporate Risk Register (CRR) Report Appendix 2 - CRR Heatmap Appendix 3 - Board Assurance Framework Report (BAF)
Purpose	Assurance
Previously considered	EMC 06.06.2023 Audit Committee 13.07.2023

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 ED flow and interventional radiology has increased. The residual risk score related to patients 'on hold' has been reduced.

On 6 June 2023 EMC approved closure of risk 50 (midwifery) and risk 43 (PDU capacity).

The Audit Committee considered this report on 13 July 2023 and noted the processes in place to obtain monthly updates on risks within the BAF and CRR. The review of relevant risks by Board Committees on a quarterly basis was noted and dates of these reviews will be included in the BAF report going forwards. Noting significant waiting lists for community services, particularly paediatrics, a thorough review of Principal Risk 4 was requested with relevant actions to rectify or mitigate the current position being more clearly articulated.

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.

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 No change
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	-	-	- No change
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 No change
8	For buildings and facilities to be great places to work	3	16	6	20	9	15 No change
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.

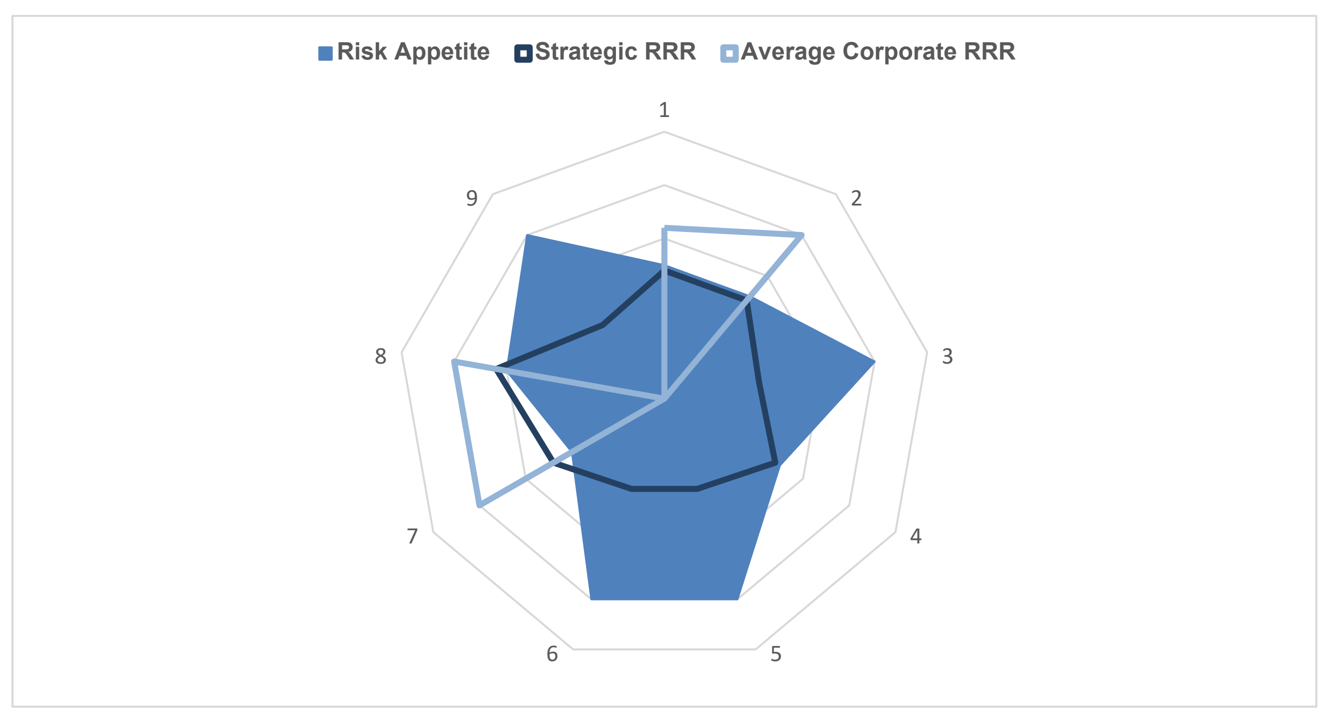
Key changes since the last report to Board include:
- Risk 82 (ED flow) residual rating has been increased from 12 to 15.
- Risk 36 (interventional radiology) residual rating has been increased from 9 to 16.
- Risk 119 (on hold) residual rating has been reduced from 16 to 12.

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, due for presentation to EMC in Autumn 2023. 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 Organisational Risk Management

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

a) Training

Risk Management Training has been delivered to c200 individuals in the organisation by RSM, with Datix drop-in sessions have been run alongside these to complement the theoretical training. Further compulsory sessions will be set up once Datix 14 training has been launched and this will encompass all aspects of the system covering Incidents and Risk. A bespoke risk management workshop for the Board was conducted on 28 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. A revised Trust wide performance and governance framework was considered by EMC in July 2023.

5 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%
May 2023	75%	93%	67%	Med	0	1	0%	0%	100%	14%	6%	80%

At the end of the month of May:

- Not all strategic risks had been reviewed in month; 6/8 had. All but one of the operational risks were reviewed either through individual meetings with risk owners/executive leads or via RCMG.
- 67% of actions were overdue related to operational risks. This applied to 16/24 operational actions and 5/12 strategic actions.
- The balance of assurances across both registers continues to be considered as medium.
- The risk related to backlogs in radiology reporting was de-escalated from the CRR in May 2023.

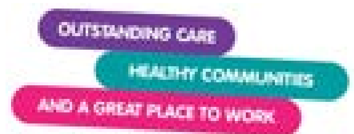
5 Action required from the Board/Committee

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: Corporate Risk Register (CRR) update report
Appendix 2: CRR Heatmap
Appendix 3: Board Assurance Framework (BAF) 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

On 6 June 2023, EMC were asked to consider the escalation of Risk 76 (Electrical Failures in Theatres) but this was not supported. Results of the ongoing audit remained pending and the requested further review of this risk following audit completion. Capital had been allocated to support improvements.

5. Risks requiring EMC approval to remove from the CRR

EMC were asked to consider the de-escalation of Risk 82 (poor flow in ED) due to the progress with actions to address this risk. However, whilst the Committee acknowledged the considerable improvements to ED flow and processes in place, there had not been significant shift in ED metrics to de-escalate the risk. For further review subject to performance changes.

On 6 June EMC approved the closure of:

- Risk 50 (midwifery staffing) due to the removal of requirements under ‘Continuity of Carer’. The midwifery staffing risk within the divisional risk register is under review and EMC may be requested to consider this for escalation in the CRR at a later date.
- Risk 43 (PDU capacity) following the opening of the Waddesdon Wing which includes the new Paediatric Emergency Department.

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	Failure to provide Interventional radiology procedures	As of 17/01/2023 Fluoroscopy at WGH t(RM3) equipment has been condemned and therefore there is currently no IR service at WGH. Urology patients requiring intervention are having to be transferred to SMH creating delays to treatment.	16/06/2023 – 20 week lead time for AHU pump now which has caused further delays as room cannot be used without this. Recovery room will be available for use shortly and will be used where needed but IR suite cannot be used until AHU is in place.	20	16	↓ ↑
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.		15	15	↔
54	Shortage of chemotherapy nurses	There is a significant vacancy in chemotherapy-trained nurses within ward 5, 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. In chemotherapy units, the chairs capacity is closed to reflect the nurses on duty. The Community hubs were closed for the pandemic response, and there is a risk to opening them as previously planned (paused till Sept). There is a risk to National cancer targets for Primary SACT.	15/06/23 – Update from SDU that they are comfortable the risk can now be closed. Staff have undergone Chemo training meaning that services are running as they should, additional training is also underway and planned to help support the service further. Just need confirmation from EMC	25	9	↓
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.	On a daily basis ED has seen increase in attendances and lack of flow out of the department. On occasions there are up to 100 patients in the department. This results in long waits to be seen, delays in ambulance off-loads, delay in assessments and treatment of critically ill patients (which may result in patient harm) and poor patient experience. Previous CRR number 150	19/06/2023 – Risk for use of non-designated clinical areas near ED on SDU Risk Register since 28/11/202 - Risk No. 261. Latest review 12/06/2023 - risk remains at 16. Risks being discussed with wider team at SDU Clinical Governance meeting on 20/06/2023.	25	15	↓ ↑
93	There is a risk that the Trust will become non-compliant with cancer performance standards.	The Trust is non-compliant with the 62-day standard due to various contributing factors such as the number of referrals above baseline, delays in diagnostics and Theatre capacity.	Discussed at RCMG 17/07/23 – Risk is monitored at cancer board and there have been improvements overall. RCMG agreed for de-escalation. To go to EMC	20	16	↔↔

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
		This does present a risk to patient harm and the quality of service that the patients receive. However there is also a risk that we could be highlighted in the media as a poorly performing Trust which could have further negative impacts.				
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	↓↓
119	There is a risk that patients are not being followed up appropriately due to being on the 'on hold' list	Review of data (captured in June 2022) demonstrates 116,575 “on-hold” records affecting a total of 108,458 patients. There is a potential for unmanaged clinical risk unless the status of these patients are understood and actioned appropriately.	19/07/23 – Discussed at RCMG for de-escalation. Long term project plan in place and papers presented to EMC. RCMG approved de-escalation, for discussion at EMC	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.	25/05/23 – RCMG notes 16.05.2023 - Deterioration of interior of tower block – water distribution systems, electrical, ventilation, asbestos and infrastructure etc. Spending £1-1.5M per year to keep it maintained without solving the problem. £23M scheme needed to start moving services out of tower block and provide alternative locations. IM/Endoscopy/2A steering groups with mitigations on risk register and BAU group in place and also dependent on staffing vigilance and safe ways of working. No patients can be cared for above 2nd floor as poor fire evacuation available.	25	20	↔↔
189	Risk of industrial action in relation to national pay award	Risk of industrial action in relation to national pay awards. Patient care may be impacted if the industrial action takes place.	15/05/2023 – Updated action 290, 638 and 317 have all been reviewed and updated.	12	20	↑↑

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
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.	02/05/2023 – Risk reviewed no changes and timeframe still uncertain for capital project or relocation	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.	30/05/2023 – updated with handler to be changed to Deputy CFO when available on Datix	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.	15/05/2023 – Reworded the action description, assessed the current risk with no change and the empty actions have been closed as complete. Review action plan with Technology Director - required.	20	20	↔↔
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.	30/05/2023 – Updated with CFO; handlers changed for risk and action.	20	12	↔↔
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	↔↔
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	↔↔

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				~~43- Insufficient PDU Capacity.⇔⇔⇔~~ 93- There is a risk that the trust will be non-compliant with cancer performance standards⇔⇔↓ 36- There is currently no IR Service at BHT ⇔↓↑	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 ⇔↓↓	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. ⇔↓⇔ 119- There is a risk that patients are not being followed up appropriately due to being on the 'on hold' list ⇔⇔↓	51- Workforce – nursing ⇔⇔⇔ 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 ⇔↓↑
2					
1					

Board Assurance Framework

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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 31 May 2023, a review of the Board Assurance Framework has been undertaken by the Chief Finance Officer, Chief People Officer, Chief Medical Officer and Director of Midwifery; updates are reflected in the report under the relevant risks.

- Principal Risk 1d: **Action update** – Revised maternity reporting now in place.
- Principal Risk 2: **Action update –** Revised performance and governance framework considered by EMC on 11 July 2023.
- Principal Risk 3: **Action update –** ICB strategy considered by Board in May 2023. Comments provided. Board awaiting final strategy for approval.
- Principal Risk 5: **Action updates –** Director of Strategic Programme Delivery now in post. Board Seminar on Health Inequalities rescheduled to October to make most effective use of time.
- Principal Risk 7b: **Action update** – EPR OBC approved June 2023.
- Principal Risk 8: **Action update –** executive dashboards all set up, being refined to enable best use. (as per PR 2 on performance and governance framework action).

Following a Board Seminar on 28 June 2023, further developments will be considered to this reporting including use of risk scoring, risk appetite and a global review of controls and assurances. Migration to the new version of 4risk is planned for Autumn/Winter 2023.

The Audit Committee considered this report on 13 July 2023 and requested dates of Committee review of risks to be articulated within the report. A thorough review of Principal Risk 4 was requested by the Executive Lead in view of the significant waiting lists for community services and lack of clear actions to address detailed within the report.

2.0 Strategic Objectives

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* - last review April 2023	

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 22 June 2023 Associate Chief Nurse 20 February 2023		CRR 36	Interventional radiology service
			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

			- 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)~~ **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 – last review July 2023	
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

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. - S106 Proforma in place (collaborative working with Bucks Council)	- 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:** Awaiting local plans **Action:** ICB strategy and strategic plan (awaited for Board approval) **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 – last review April 2023

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 – last review July 2023

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 09 June 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) – October 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 – last review July 2023

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 19 June 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. AfC pay accepted (paid June 2023). RCN re-balloting. Consultants ballot closed 27 June.

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

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

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 – last review April 2023

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)~~

3.0 Emerging Risks; Board & Board Committees

Month	Meeting	Risks Noted
May 2023	Audit	- Patients within 'on-hold' follow up waiting lists (as per risk 119). - Partial assurance opinion related to management of complaints.
	F&BP	- 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.
	Q&CG	- Occurrence of Never Events; highlight to the Board. - Rise in MRSA cases. - 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: o Increase in children's safeguarding activity. o Ongoing risk related to Deprivation of Liberty Applications.
	SPC	No new risks noted.
	Public Board	- Ongoing internal and external challenges and resultant impact on colleague wellbeing. - Risks to financial position including the achievement of ERF income. - Conflicting objectives including activity, finance and maintaining safe staffing.
	Private Board	No new risks noted.
June 2023	Q&CG	No meeting in June 2023.
	F&BP	- Risk to financial position: o Previous and pending junior doctor strikes and implication of these on strategic and financial performance. o Income; ability to achieve ERF and contract negotiation. o Limited recurrent CIPs. o Potential risk related to pay award. - Pressure on capital position related to external pressures.
	Public Board	- Planned industrial action by medical colleagues and impact of this on both strategic and financial performance. - Potential for clinical negligence claims related to COVID-19 noting national work underway related to this. - Size and complexity of the 2023/24 Capital Programme
	Private Board	No new risks noted.

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
Partial assurance opinion related to management of complaints.	As per Internal Audit Management Actions	Via Audit Committee	Chief Nurse	As per action plan
Areas of non/partial HTM compliance including ventilation.	Deep dive into areas of non/partial compliance	EMC	Chief Commercial Officer	End August 2023
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.	Details to be confirmed.			
Lack of capacity related to tissue viability and poor adherence to the National Wound Care strategy noting this is a national issue.	Details to be confirmed.			
Capacity within safeguarding team: - Increase in children's safeguarding activity. - Ongoing risk related to Deprivation of Liberty Applications.	Ongoing collaborative working at Place and System level	Q&CGC	Chief Nurse	As per action plan
Potential for clinical negligence claims related to COVID-19 noting national work underway related to this.	Details to be confirmed.			

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/staffi ng/ 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 in Public

26 July 2023

Agenda item	Committee Terms of Reference
Board Lead	Trust Board Business Manager
Type name of Author	Joanna James, Trust Board Business Manager
Attachments	Nomination & Remuneration Committee ToR DRAFT June 2023
Purpose	Approval
Previously considered	n/a

Executive Summary

The attached document details the Terms of Reference (ToR) for the Nomination & Remuneration Committee including the requirement for these to be reviewed on an annual basis in line with best practice. The document has been reformatted in line with the ToR of other Board Committees. No material changes have been made to the content.

The ToR were considered by the Nomination & Remuneration Committee on 28 June 2023 and recommended for approval by Trust Board.

Decision	The Board 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	Principal Risk 6 – Failure to deliver our people priorities
Financial	Good governance is the foundation of strong financial performance and the regular review of Committee Terms of Reference supports this.
Compliance Select an item. **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.
Equality	The terms of reference set out the key functions of the Committee in considering the composition of the Board, including diversity.
Quality Impact Assessment [QIA] completion required?	No

See attached document.

Nomination & Remuneration Committee
Terms of Reference

1. Purpose

The overall purpose of the Committee is to regularly evaluate the composition of the Trust Board, oversee talent management and succession planning arrangements related to the Board and consider and advise on matters of nomination and remuneration.

2. Constitution

The Board resolves to establish a standing Committee of the Board to be known as the Nomination and Remuneration 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 membership shall comprise all voting and non-voting Non-Executive Directors on the Board.

The Committee shall be chaired by the Trust Chair or, in their absence, the Senior Independent Director (SID).

The following shall attend the Committee at each meeting but as attendees rather than members and unless there is a conflict of interest relating to a specific agenda item:

- Chief Executive Officer
- Chief People Officer
- Trust Board Business Manager

4. Quorum

The quorum necessary for the transaction of business shall be three members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Where a Committee meeting is not quorate 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 meet as and when required but at least annually. Meetings of the Committee shall be summoned by the Committee Secretary (Trust Board Business Manager) at the request of the Committee Chair.

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 other attendees as appropriate five days ahead of the date of the meeting.

6. Authority

The Board of Directors has delegated to the Committee the authority to deal with the matters

set out in the paragraphs below.

The Nomination and Remuneration Committee is an advisory body with no executive powers; it is not the duty of the Committee to carry out any function that properly belongs to the Board of Directors or the Executive Management Committee. The Committee is, however, authorised by the Board to investigate any activity within its duties as set out below and to seek any information it requires from any employee, who are directed to co-operate with any request made by the Committee.

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

The Committee has the authority to seek any information it requires from any member of staff and request any member of staff to attend its meetings. All members of staff are directed to comply with such requests.

7. Duties

The Committee shall be responsible for the following duties:

I. Nomination

- Regularly review and evaluate the structure, size and composition of the Board including the knowledge, skills, diversity and experience individually and collectively and make recommendations accordingly.
- Oversee and review the Trust's talent management strategy and succession planning arrangements in relation to the Trust Board, ensuring this supports effective and robust succession planning including both internal identification and development of talent and appropriate external environment scanning.
- Fully consider and make plans for succession planning for the Chief Executive Officer, Executive Directors and specified Senior Officers, taking into consideration the challenges and opportunities facing the Trust and the skills and expertise needed on the Board at that time and in the future.
- Before advertising a position, evaluate the balance and composition of the Board and, in light of the evaluation, prepare a description of the role and capabilities required for that particular appointment.
- Oversee the Board recruitment process, using open advertising or external advisers to facilitate the search, considering candidates from a wide range of backgrounds and on merit against set objective criteria.
- Consider any matter relating to the continuation in office of the Chief Executive, Executive Directors or specified Senior Officers including suspension or termination of service as an employee of the Trust.
- Consider the engagement or involvement of any suitability qualified third party or adviser to assist with any aspects of the Committee's responsibilities.

II. Remuneration

- Consider and advise on the remuneration of the Chief Executive Officer, Executive Directors and specified Senior Officers on locally determined pay. This advice will include all aspects of salary including performance related bonuses,

provisions for other benefits, including pensions and cars, and arrangements for termination of employment or other contractual terms.

- Oversee and advise on appropriate contractual arrangements for the Chief Executive Officer, Executive Directors and specified Senior Officers including the proper calculation and scrutiny of termination payments, taking into account of such national guidance as is appropriate.
- Ensure the basis for employment of the Chief Executive Officer, Executive Directors and specified Senior Officers is set out in properly constructed written contracts of employment.
- Ensure that the Board of Directors emoluments are accurately reported in the Trust Annual Report.

III. Other

In the course of its duties, the Committee will also take account of the following:

- Remuneration packages must be such as to enable people of appropriate ability to be recruited, retained, developed and motivated, within levels of affordability and maintaining cost effectiveness.
- All NHS bodies are part of the public sector and remuneration of officers must be publicly defensible.
- A properly defensible remuneration package requires a clear statement of responsibilities with rewards linked to an individual's performance.
- Where possible, it is advisable to seek independent advice about pay structures and the state of the market for relevant appointments, including consultation with other NHS bodies.
- No individual should be involved in determining their own remuneration.
- All candidates should be considered on merit against objective criteria.

8. Reporting

The minutes of all meetings shall be formally recorded. These will be retained by the Chair and not shared with the Executive Directors. Information related to changes to remuneration, termination agreements etc will, however, be shared with relevant Executive Director (e.g. Chief People Officer, Chief Finance Officer) to enable the necessary finance and human resource functions and duties to be undertaken accordingly.

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

Request received under the Freedom of Information Act (2000) for any disclosure of the minutes of Committee meetings will be handled in accordance with the Act.

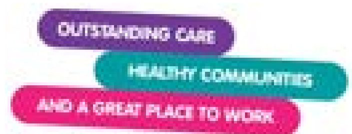
9. Review

The Committee shall carry out an annual review of these terms of reference followed by a review by the Trust Board.

10. Support

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

- The agreement of the agenda with Chair and attendees and collation of papers. Papers will be distributed five working days before the meeting in electronic copy.
- Advice to the Committee on pertinent areas is provided.



- That minutes are taken and a record of matters arising and issues to be carried forward is made.

Document Control

Version	Date	Author	Comments
1.2	28 June 2023	J James	Annual review by Committee

Meeting: Trust Board Meeting in Public

26 July 2023

Agenda item	Modern Slavery Act – Annual Statement
Board Lead	Neil Macdonald, Chief Executive Officer
Type name of Author	Joanna James, Trust Board Business Manager
Attachments	None
Purpose	Approval
Previously considered	n/a

Executive Summary

The Modern Slavery Act 2015 requires organisations operating in the UK with an annual turnover of above £36m, including public sector bodies with a budget or £36m or greater, to take action to identify, prevent and mitigate modern slavery in the organisation and its supply chains and produce an annual statement to report on such actions.

The statement applying to 2022/23 is due to be published, with Board approval and Executive Director sign off, on the Trust website by 30 September 2023.

Decision	The Board is requested to approve the annual statement for publication on the Trust website.

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	Healthcare organisations may offer victims of human slavery a unique opportunity to access help and support.
Risk: link to Board Assurance Framework (BAF)/Risk Register	Principal Risk 1 – Failure to provide care that consistently meets or exceeds quality and performance standards.
Financial	The Trust is required to comply with procurement regulations within this Act as well as other relevant guidance.
Compliance	Modern Slavery Act 2015 (section 54)
Partnership: consultation / communication	The 2022/23 statement has been updated through collaborative working with leads for Procurement, Safeguarding, Communications, Recruitment and the Trust Freedom to Speak Up Guardian. The updated statement will be published on the Trust website in line with requirements.
Equality	This report does not have any detrimental impact on any protected characteristics. It provides positive reinforcement of the need to protect vulnerable individuals.
Quality Impact Assessment [QIA] completion required?	No

1 Introduction

Modern slavery is the recruitment, movement, harbouring or receiving children, women or men through the use of force, coercion, abuse of vulnerability, deception or any other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK and they may have been trafficked for a number of reasons including sexual exploitation, forced labour, criminal activities, domestic servitude and organ harvesting.

Healthcare settings should be safe places where victims of modern slavery have what may be their only opportunity to come into contact with people who have knowledge of modern slavery, can identify signs of trafficking and can refer them to organisations which can provide support. It is estimated that more than 130,000 individuals are trapped in slavery in the UK.

2 Modern Slavery Act

In March 2015, the Modern Slavery Act was passed by Parliament and the provisions of this Act came into force in October 2015. The Act sets out a range of measures on how modern slavery and trafficking should be dealt with in the UK.

The Act requires organisations operating in the UK with an annual turnover of above £36m or public bodies with a budget of £36m or more to both take action to identify, prevent and mitigate modern slavery in the organisation and its supply chains and publish an annual statement to report on such actions within six months of the financial year to which they apply.

The statement is required to cover a number of specific areas:

- Organisation and supply chain structure.
- Policies on modern slavery and human trafficking.
- Due diligence processes.
- Risk assessment and management.
- Actions taken to prevent modern slavery.
- Staffing training.

Statements for 2022/23 are required to be published by 30 September 2023 and include Board approval and Executive Director sign off.

3 BHT Annual Statement

In line with the above requirements, below is the statement relating to the financial year 2022/23:

Modern Slavery Act 2015 Section 54 – Slavery and Human Trafficking Statement

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

Buckinghamshire Healthcare NHS Trust (BHT) aims to follow good practice and take all reasonable steps to prevent slavery and human trafficking. We are committed to ensuring that all of our employees are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that the individual may be or is at risk of modern slavery/human trafficking.

We are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. This statement sets out actions taken by BHT to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

Trust Structure and Principle Activities

BHT is a major provider of integrated hospital and community services for people living in Buckinghamshire and the surrounding area, including Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire), providing care to over half a million patients every year in our hospitals, community settings and people's own homes.

We are recognised nationally for a number of our services that we provide. Stoke Mandeville Hospital is home to the internationally recognised National Spinal Injuries Centre, our stoke service is one of the best in the region and we are a regional centre for burn care, plastic surgery and dermatology.

We are part of the Buckinghamshire Place-base Partnership which is comprised of Buckinghamshire Healthcare NHS Trust, Oxford Health NHS Foundation Trust, South Central Ambulance Service NHS Foundation Trust, FedBucks GP Federation and Buckinghamshire Council. The Trust is also part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS) and works closely with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB).

We procure goods and services from a range of providers. Contracts vary from small one-off purchases to large service contracts. All spend, aside from a few exceptions such as rates, is paid via PO. The Applicable Contract Terms Policy applies to any NHS organisation and states that where an NHS body issues a PO the standard Terms & Conditions apply.

Organisational policies in relation to slavery and human trafficking

BHT has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking.

The BHT Safeguarding Adult and Children Policy includes information on modern day slavery/human trafficking.

The BHT Incident Reporting Policy states that colleagues should report incidents of all types and this includes concerns regarding modern slavery and human trafficking. By using the local risk management system (Datix) appropriate teams, including safeguarding are made aware.

All colleagues have access to the BHT Safeguarding team for support and guidance when they are concerned about modern day slavery or trafficking.

BHT has a small team of Freedom to Speak Up Guardians who provide daily outreach to colleagues across the Trust offering support to an individual or to teams who wish to raise a concern. The role of the Freedom to Speak Up Guardian is covered at the Trust's monthly corporate induction, the

Trust has a ‘Speaking Up, Raising Concerns’ Policy in place and the importance of speaking up is celebrated annually via October Speaking Up Month.

Trust activities and policies are required to have an Equality Impact Assessment (EQIA) completed.

Assessing and managing risk and due diligence processes in relation to slavery and human trafficking

We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business.

The Trust reviews its Modern Slavery and Human Trafficking Statement on an annual basis and presents it at a Board meeting in Public. This demonstrates a public commitment, ensures visibility and encourages reporting standards.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain:

- The Trust adheres to the National NHS Employment Checks/Standards (this includes employees UK address, right to work in the UK and suitable references).
- The Trust has systems to encourage the raising and reporting of concerns and the protection of whistle-blowers.
- The Trust purchases a significant number of products through NHS Supply Chain, whose Supplier Code of Conduct includes a clause stating that ‘the supplier shall make no use of forced or compulsory labour’. Where possible, all other contracts are governed by standard NHS Terms & Conditions which include significant requirements related to modern slavery as well as environmental, social and labour laws.
- The majority of our purchases use existing supply contracts or framework agreements which have been negotiated under the NHS Standard Terms and Conditions of Contract. The framework agreements are governed by NHS Standard Terms & Conditions.
- All suppliers are required by law to comply with the provisions of the UK Modern Slavery Act (2015). This will be reinforced where appropriate by Standard Selection Questionnaires as part of tender processes along with use of NHS Standard Terms and Conditions either direct with suppliers or through framework agreements. The 2022 updates to these contracts strengthen the position on Modern Slavery, including the option to terminate for breaches.

Effective action taken to address modern slavery – Performance Indicators

The Trust is committed to social and environmental responsibility and has zero tolerance for Modern Slavery and Human Trafficking. Any identified concerns regarding Modern Slavery and Human Trafficking are escalated as part of the organisational safeguarding process. This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes BHTs slavery and human trafficking statement for the current financial year.

All employees have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance.

A Freedom to Speak Up Report is submitted quarterly to the Trust Strategic People Committee and twice a year to the Trust Board. Any themes or trends are highlighted through these reporting mechanisms but should something be of concern such as trafficking or modern slavery these would be raised immediately either by exception reporting or direct to an executive director as appropriate.

Training on modern slavery and trafficking

Safeguarding training is mandatory for all colleagues and includes information on trafficking and modern-day slavery in order to promote the knowledge and understanding of escalating concerns via the Home Office national referral mechanism/duty to notify process.

Conclusion

This statement has been approved by the Board, who will review and update it on an annual basis.

4 **Action required from the Board/Committee**

The Board is requested to note the activities in place related to modern slavery which are reflected in the above statement and approve the statement for publication on the Trust website.

Meeting: Trust Board Meeting in Public

26 July 2023

Agenda item	Private Board Summary Report 28 June 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 meeting held in private on 28 June 2023.

The matters considered at this session of the Board were as follows:

- Anaesthetic Machines & Theatre Monitoring Equipment
- Spinal Robot Business Case
- FedBucks Urgent Treatment Care / Out of Hours Contract
- Annual Report
- Electronic Patient Records Outline Business Case
- Private Finance Initiative (PFI) Investment Fund
- Ophthalmology contract
- Keyworker accommodation Memorandum of Understanding

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

Meeting: Trust Board Meeting in Public

26 July 2023

Agenda item	Annual Organisation Health and Safety Reports
Board Lead	Chief Commercial Officer
Type name of Author	Property Services Risk Manager
Attachments	Annual Report
Purpose	Assurance
Previously considered	H&S Committee and Strategic People Committee

Executive Summary

During the last year a full review of compliance with all elements of H&S legislation was completed and we have expanded the range of assurance to include relevant elements from Occupational Health and Wellbeing and Waste and Sustainability.

Following an extensive review of our overall Compliance with Legislation, it was agreed there are adequate controls in place for all parts except one. The area of noise and hand/arm vibration required more investigation and we have arranged for external auditors to take readings and report back finding/recommendations to the H&S Committee this year.

Other key points to note:

- There has been an overall increase in reporting of all incidents following implementation of a new Datix system.
- There have been no major fires resulting in loss or injury.
- There continues to be a major increase in managing incidents of violence and aggression, 467 cases reported this past year, representing a 40% increase.
- We have significantly improved our staff survey score on the question: 'My organisation takes positive action on health and wellbeing. We are now 16% points above a sector score of 55.1% and ranks us second place against all our comparator trusts.
- Unfortunately, our trial with Anaerobic waste digestion on site was not successful, however we are partnering with other providers so that the same outcome is achieved, ie our waste is bio degraded, turned to flock which produces energy.

This paper was presented to the Strategic People Committee on 10 July 2023 and received the following comments which are being addressed:

1) Does the Trust have a policy to remove drugs and alcohol from patients on-site? (Linked to violence and aggression).
2) What is the ideal number of people to attend the conflict resolution 'Train the Trainer' course? (Linked to violence and aggression).
3) Request that the Noise and Hand Arm/ Vibration Assessments come back to the Committee in October

Decision	For Assurance

Relevant Strategic Priority

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

Implications / Impact

Patient Safety	Compliance with H&S Legislation will ensure the safety of our patients, staff visitors and contactors.
Risk: link to Board Assurance Framework (BAF)/Risk Register	H&S risks are included on divisional risk registers and higher-level risks are included on the Corporate risk register.
Financial	Potential non-compliance with statutory requirements may lead to fines and litigation from personal injury claims.
Compliance Select an item. **Safety**	CQC Standard SAFE H&S at Work Act The Regulatory Reform (Fire Safety) Order
Partnership: consultation / communication	H&S Committee, EMC to follow
Equality	This report is inclusive of all groups
Quality Impact Assessment [QIA] completion required?	Not required

Annual Organisation Health & Safety Report

2022 / 2023

Executive Summary

Last year's annual report provided assurance to the Board on the disciplines of H&S, Fire Safety and Security. During the last year a full review of compliance with all elements of H&S legislation was completed and we have expanded the range of assurance to include relevant elements from Occupational Health and Wellbeing and Waste and Sustainability.

In terms of overall Compliance with Legislation, 24 pieces of H&S Legislation are relevant to Trust activities. Following an extensive review of these through the health and safety committee, it was agreed there are adequate controls in place for all parts except one. The area of noise and hand/arm vibration required more investigation and we have arranged for external auditors to take readings and report back finding/recommendations to the H&S Committee this year.

Key Highlights are as follows

- **Health and Safety.**

  Overall increase in reporting of all incidents following implementation of a new Datix system. In the context of this it has been notable that there has been a 15% Reduction in slips, trips and falls, and the number of serious accidents reportable to the Health and Safety Executive under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations have remained constant and compare similarly to Trusts of comparable size.

- **Fire Safety**.

  There have been no major fires resulting in loss or injury. The number of unwanted fire signals attended by the Fire Service continues to fall and demonstrates a downward trend from previous years.

- **Security**.

  There continues to be a major increase in managing incidents of violence and aggression, 467 cases reported this past year, representing a 40% increase. We have set up a task force focused on prevention and de-escalation, added additional members of the security team in ED, increased available training in conflict resolution and increased availability of bodycams.

- **Occupational Health and Wellbeing**.

  We have significantly improved our staff survey score on the question: 'My organisation takes positive action on health and wellbeing' moving from 67.4% in 2021, to 71.1% in 2022. We are now 16% points above a sector score of 55.1% and ranks us second place against all our comparator trusts. We have opened a new dedicated Health & Wellbeing Hub and wellbeing garden at Stoke Mandeville in order to provide easy access to staff on our largest site.

- **Waste and Sustainability**.

  Unfortunately, our trial with Anaerobic waste digestion on site was not successful, however we are partnering with other providers so that the same outcome is achieved, ie our waste is bio degraded, turned to flock which produces energy.

  We have changed patient dining to Apetito at Stoke Mandeville which provides recyclable and reusable packaging.

Health and Safety:

There has been a significant increase in the reporting of Incidents / Accidents this year (41%). There are several reasons for this – An increase in the amount of service users attending and using Trust sites following the pandemic. The Trust has also invested in a new Incident / Accident reporting system that was widely publicised. This along with the Health and Safety Team re-enforcing the importance of reporting Incident / Accidents has contributed to the increase.

The increase in the reporting of violence and aggression towards staff has also increased due to the reasons given above and are explained more fully in the Security report. The Health and Safety Team are working with colleagues in Human Resources and Security as well as the patient experience manager to ensure staff remain as safe as reasonably practicable.

The decrease in Slips, Trips and Falls is pleasing to note (15%). This is the result of pro-active audit by managers and the Health and Safety Team identifying Trip / Slip hazards and working with Estates for the quick elimination of premises defects.

Lifting accidents have also increased this year. It is believed that there was under-reporting in previous years and the Health and Safety Team are working with the Manual Handling Team to identify how the Trust can improve in this area.

The number of serious accidents reportable to the Health and Safety Executive under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations have remained constant and compare similarly to Trusts of comparable size.

The Health and Safety Executive attended the Trust in October 2022 on a planned inspection of the Category Three Laboratory in Microbiology at Stoke Mandeville. Some improvements were identified relating to staff training and security and these have now all been addressed.

100 additional colleagues qualified as COSHH risk assessors this year which ensures compliance with the regulations (Control of Substances Hazardous to Health regulations) in this important area relating to staff and patient safety.

66 additional colleagues completed and qualified in the IOSH (Institution of Occupational Safety and Health) accredited health and Safety training. This enables managers at local level to manage Health and Safety and reduce the number of Incidents / Accidents occurring for the future.

Fire Safety:

There have been no major fires resulting in loss or injury. The number of unwanted fire signals attended by the Fire Service continues to fall and demonstrates a downward trend from previous years. This has been achieved by maintaining and the upgrade of the Trusts fire alarm system across all sites.

A new compartmentation breach permit for trust staff and contractors has been introduced which now allows the Estates department to record all breaches of fire compartments, and this mitigates against the fire safety rating of the compartment walls/ceilings.

The fire reporting system has been upgraded to use the new Datix system, the previous system in place could not record all fire incidents in detail. From March 2023 a new fire risk assessment is being introduced, this new format will provide all wards/departments with a fire risk assessment to their specific area of responsibility, which can be reviewed by staff and the fire safety team. This is replacing the site-specific fire risk assessment currently in place.

Since the Covid restrictions have been lifted the fire safety team have delivered fire training (face2face) for clinical staff incorporating evacuation training. Fire Warden training for clinical & non-clinical staff is also being delivered.

Security:

There continues to be a major increase in managing incidents of violence and aggression, 467 cases reporting this year, representing a 40% increase from the previous year. We have continued to focus on personal safety. Increasing lone worker device usage by 7% to address risks associated with lone working by community colleagues; increasing the security officer numbers in at risk areas, with three new officers at SMH; addressing verbal abuse and disruptive behaviour by continuing to provide ED colleagues with body cameras; improving site safety with better lighting.

We provide a full programme of conflict resolution training to all staff, with both online and face-to-face courses, with over 5,800 courses completed, an increase of 9% on the previous year.

We continue to support site security and projects, particularly the new Waddesdon Wing; installing 78 new Paxton access control systems across the Trust; installing 160 new Abloy Cliq key systems to control access to doors, medicine and drug storage areas; installing 90 new cameras on to the Trust's CCTV system and ensuring that on average 99.9% of cameras were fully operational during the year.

We have maintained 100% compliance with NHS E/I standards, HTMs, HBNs, CQC and other relevant legislation and regulations, as in previous years. we were also found to be compliant with relevant security requirements during a recent external mortuary security audit.

Waste and Sustainability

Unfortunately, the trial of the Anaerobic Digestion plant was not successful. There was only a 27% volume reduction driven by the fact that there is not enough organic material (food waste) within the general waste on site which is required to help the volume reduction process. To enable this to be successful financially, a minimum of 60% reduction is required. However the

Food Waste:

All our food waste is treated via anaerobic digestion (AD), either to one of their own three AD plants or to a partner's AD plant where they have reciprocal agreements to cut down on miles travelled. The used cooking oil is recovered within their biodiesel plants

Clinical Waste:

Our clincal waste provider has achieved a 71% reduction in its carbon footprint and since 2014 their entire fleet has been certified as Carbon Neutral. This means that their journeys are offset through the investment in the Ugandan Reforestation Scheme, cookstove and water infrastructure Projects.

Non-Clinical Waste:

Our supplier specialises in providing a national recycling led waste management service concentrating on providing a zero to landfill solution, using waste to energy as a solution wherever possible. They partner with a mix of local and large suppliers to suit client needs and ensure carbon footprint is minimised.

Hospital Retail Food Waste

We have a Waste Watch programme which prevents on average 50% of food wasted. Using the program, our team can rapidly and easily capture food waste data, getting clear insights into what is being wasted in the kitchens and why.

Patient Dining

In May 23 we switched our supply of patient food from TVF to Apetito, prior to this all our containers for the food went into the general waste increasing the volume and cost. Working with Apetito we have launched a great initiative to reduce and reuse the plastic containers.

Meeting: Trust Board Meeting in Public

Date: 26 July 2023

Agenda item	Corporate Safeguarding Annual Report
EMC Lead	Karen Bonner, Chief Nurse
Author	Tina Charlton, Deputy Chief Nurse Louise Pegg, Named Nurse for Safeguarding Adults Fadzai Mashingaidze, Lead Named Nurse for safeguarding children Emma Steadman, Named Midwife for safeguarding
Appendices	Appendix 1 Team structure
Purpose	Information
Previously considered	Not previously considered

Executive summary

The report summarises how the corporate and maternity safeguarding team have worked over the last year to ensure that BHT meets their legal obligations to safeguard. This is achieved by supporting the staff through; training, education supervision and specific guidance when required. The report covers services provided for patients within BHT who have; a learning disability, dementia and delirium, Children who are Looked After and maternity.

- Overall demand for the services required from the team for adults and children has increased year on year. This is for advice and support as well as for investigations, and multi-agency discussion.
- Safeguarding training has increased in compliance from 66.9 % 21/2022 to 87.3% 22/23.
- BHT has met all its obligations for Multi-Agency work (Including practice reviews) over the year
- MASH activity has continued to increase and BHT are having to prioritise attendance at strategy meetings to those children with the greatest health need. Information sharing is maintained for all cases.
- The safeguarding team has recognised that BHT requires, increased knowledge and practical application about our compliance with the application of the Mental Capacity Act. In January 2023 a new risk was placed on the corporate risk register relating (Current score 15) to the misapplication of the Mental Capacity Act including unlawful deprivation of liberty. Legislation for Liberty Protection safeguards has been delayed.
- The Learning Disability team have continued some excellent practice including specialised clinics throughout the year. This has been published nationally.
- In hospital services for dementia are key in identifying undiagnosed cases of Dementia which is being improved using the single question.
- Compliance for Looked After Children Health reviews (Initial and review) remains a challenge which is reported to the Corporate Parenting Board.
- Midwifery specialist team referrals have increased with the overall percentage being 28.9% of the birth rate total, with mental health being the most frequent reason for referral.
- The team will undertake a gap analysis of the BHT service against the Safeguarding Assurance and Accountability Framework (SAAF) during 2023. This will be reported back to the committee.

Three key points for the Board to note:

1. Overall training compliance has increased within the year to 87.3%.

2. Recognition of Excellent care delivered by the learning disability team.
3. The management of the Risk identified for the application of the Mental Capacity Act will be overseen by the safeguarding committee and reported to Quality Committee quarterly.

The Quality & Clinical Governance Committee considered the report on 19 July 2023 and noted the significant improvement in training compliance. A number of risks were noted related to capacity within the Team recognising this as a wider issue with work ongoing to support this at a system level. The Board are asked to note risks related to the delay in Deprivation of Liberty (DoL) applications, specific capacity issues related to Multi-Agency Safeguarding Hub (MASH) and the organisational capacity to apply the Mental Capacity Act (MCA) oversight of which will remain via the Q&CG Committee.

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	Safeguarding Adults and Children in our care is fundamental to patient safety.
Risk: link to Board Assurance Framework (BAF) or relevant Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards Corporate risk register re Mental Capacity Act (CRR 388)
Financial	Failure to meet safeguarding obligations across the organisation will have a negative financial impact including litigation
Compliance CQC Standards Safeguarding	Safety/ Safeguarding
Partnership: consultation/communication	Safeguarding is delivered in partnership with colleagues across all areas of Health (including Primary Care and ICB colleagues, Social Care and Education. This report will be shared with the safeguarding leads in Buckinghamshire in the ICB.
Equality	Potential for inequality due to known health inequalities across the county. The risk of discrimination against patients from diverse backgrounds and poorer socio-economic communities increases the risk for these groups to be vulnerable to abuse. The safeguarding function needs to provide safeguards for all parts of our population. This is undertaken with the understanding that vulnerability is increased in some population groups who

	have English as a second language and particularly adults and children with disability.
Quality Impact Assessment [QIA] completion required?	Not required for this paper

Outstanding Care

Buckinghamshire Healthcare NHS Trust (BHT) aims to ensure that all children, young people and adults are cared for in a safe and compassionate environment. The BHT safeguarding team has continued throughout 2022/2023 to provide a centralised expert resource as well as lead in developing local expertise by improving the knowledge of Trust staff through training, education, supervision, and targeted support in the management of safeguarding concerns.

Living a life that is free from harm and abuse is a fundamental human right of every person and an essential requirement for health and well-being. Healthcare staff are often working with patients who for a range of reasons may be less able to protect themselves from neglect, harm, or abuse.

This report assures the Board that the Trust has in place effective arrangements to safeguard patients from the harm caused by abuse. The report provides evidence that the Trust complies with all statutory safeguarding requirements under Section 11 of the Children Act 2004 for Safeguarding Children and is compliant with the statutory guidance (Working Together 2018).

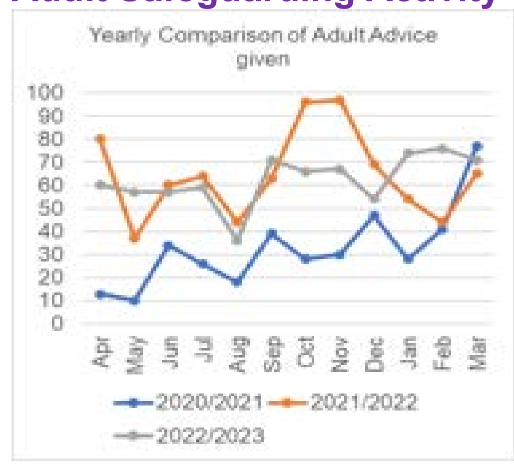
Policy and practice are underpinned by the Buckinghamshire Safeguarding Children's Partnership (BSCP) which sets out how agencies and individuals should work together to safeguard and promote the welfare of children and young people.

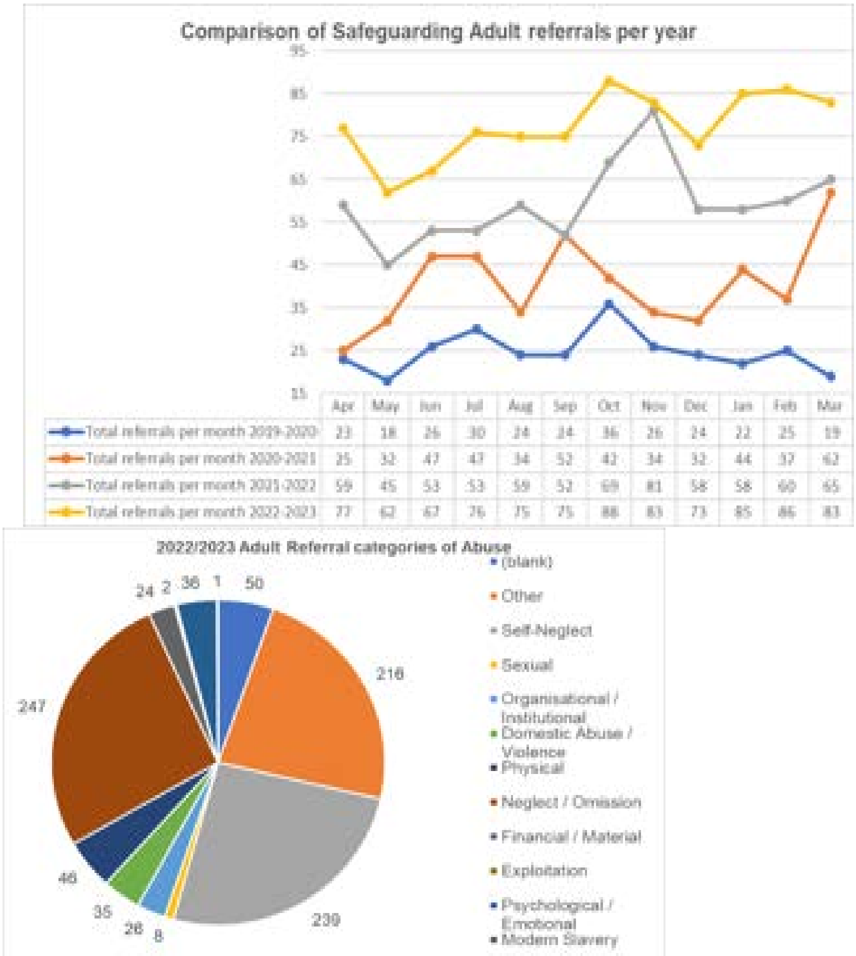
For Safeguarding Adults BHT achieves this by ensuring as far as possible that each allegation of abuse is managed under the Care Act 2014, statutory guidance, and the Buckinghamshire Adult Safeguard Board (BSAB).

The core functions of the corporate safeguarding team are to provide advice and support to practitioners across both community and acute services, safeguarding supervision, training, and working within the Multi-Agency Safeguarding Hub to support providing health information. The Safeguarding team continue to work in partnership with the Children Safeguarding Partnership and Buckinghamshire Safeguarding Adults Board.

This report highlights the work of the corporate Safeguarding team and key functions across 2022/2023.

Adult Safeguarding Activity





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total referrals per month 2019-2020	23	18	26	30	24	24	36	26	24	22	25	19
Total referrals per month 2020-2021	25	32	47	47	34	52	42	34	32	44	37	62
Total referrals per month 2021-2022	59	45	53	53	59	52	69	81	58	58	60	65
Total referrals per month 2022-2023	77	62	67	76	75	75	88	83	73	85	86	83

These graphs demonstrate continued year on year growth of the safeguarding referral activity across adults. There is an evident upward trend in activity for adult referrals. Requests for advice this reporting year compared to 20/21 have decreased by 8%. The categories of abuse, remain unchanged in the most reported categories of abuse this year and are in line with the local picture as reported by the Local Authority.

The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.

The local authority can delegate enquiries to providers where it is seen that the provider is the most appropriate agency to complete this. BHT has been delegated 42 s42 enquiries in 2022/23 which is an increase on 2021/22 (32 previously). Of those 42 enquiries, 37 have been completed.

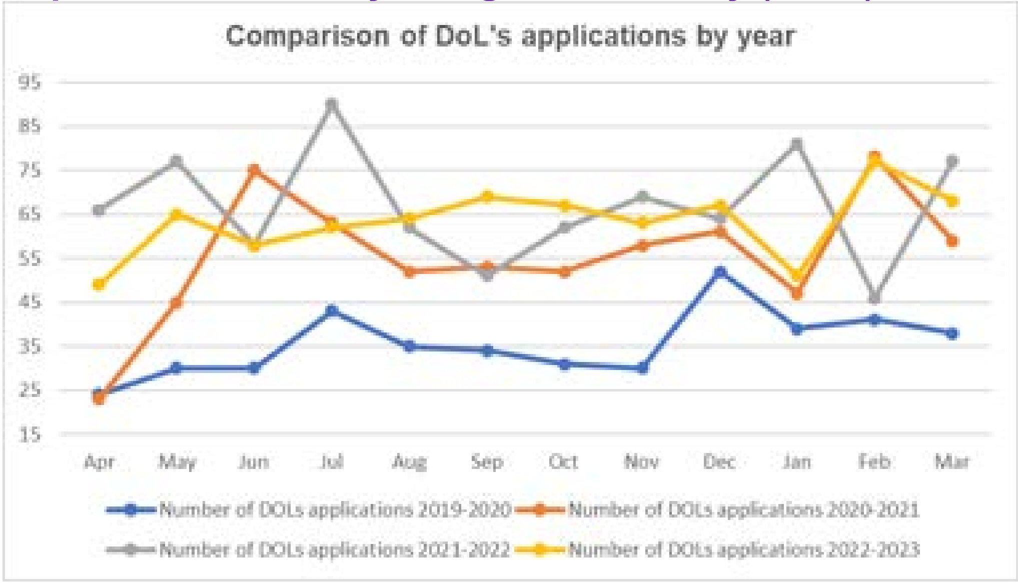
BHT has received 94 requests for information sharing and held 6 strategy discussions as part of a pilot with the local authority. Additionally, to this, there were 10 cases for which information has been provided as an alternative process has been taken (i.e., SI or complaints).

Of the 37 completed delegated s42, 8 were substantiated, 8 were partially substantiated, 18 were unsubstantiated and 3 were inconclusive.

Thematic reviews of these enquiries are shared with the Safeguarding Committee. The leading themes are neglect and acts of omission relating to pressure ulcers, missed fractures and discharge planning.

Actions taken to mitigate against this include strengthening the discharge checklist and increasing awareness of pressure area care.

Deprivation of Liberty Safeguards Activity (DoLs)



Year on year comparison of DOLs applications	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of DOLs applications 2019-2020	24	30	30	43	35	34	31	30	52	39	41	38
Number of DOLs applications 2020-2021	23	45	75	63	52	53	52	58	61	47	78	59
Number of DOLs applications 2021-2022	66	77	58	90	62	51	62	69	64	81	46	77
Number of DOLs applications 2022-2023	49	65	58	62	64	69	67	63	67	51	77	68

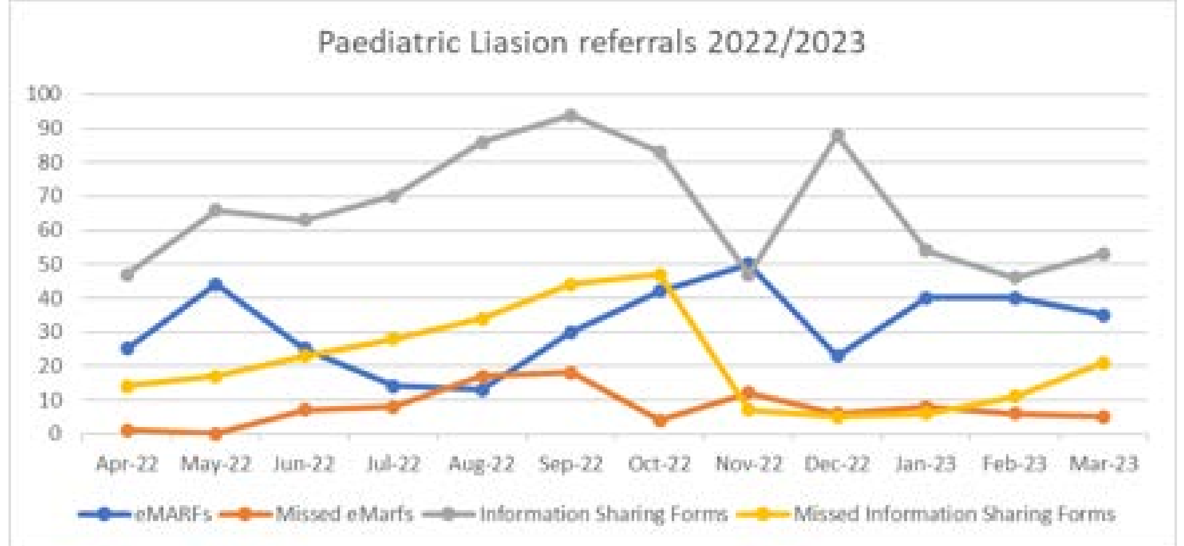
There is a decrease of 6% in DoLs applications being made this year across BHT. NHS Digital publish England level statistics each August about DoLs activity, the next publication is due on 10/08/23 and further work to compare metrics for the time 2022-2023 will be completed during Q3 of this year.

In January 2023 a new risk was placed on the corporate risk register relating to the misapplication of the Mental Capacity Act including unlawful deprivation of liberty (CRR 388). The actions which will address this include further and more detailed diagnostics including audits and questionnaires which will be led by the Practice Development Nurse this will be overseen by the safeguarding committee. The risk score is currently 15 and will be reviewed considering these actions.

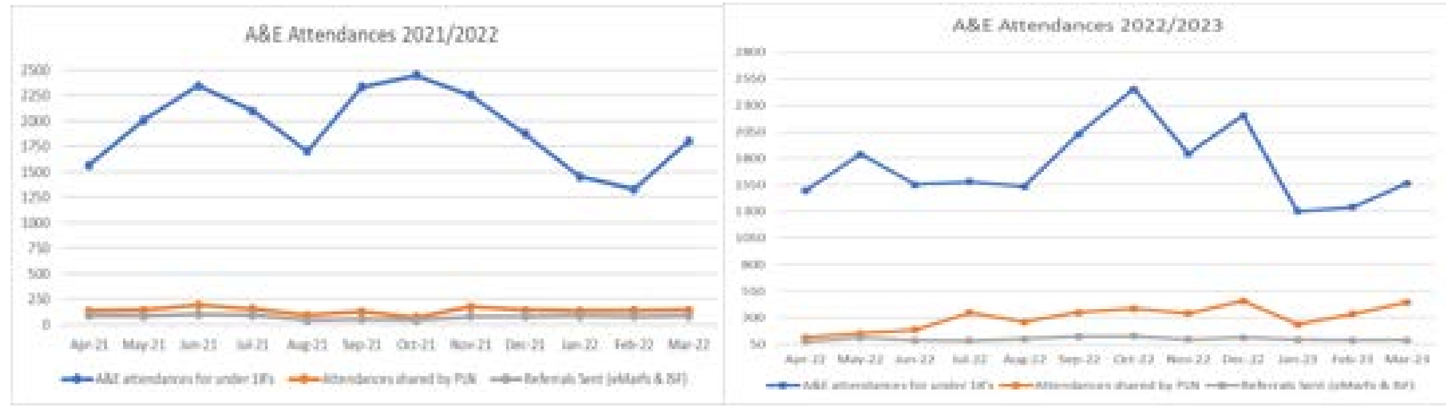
Mental Capacity Act awareness training is currently 93%

Liberty Protection Safeguards (LPS) have been delayed. The UK Government confirmed that they would be delaying the implementation of LPS beyond the life of its parliament. A new Mental Capacity Act code of Practice will likely be published taking into consideration feedback from the LPS consultation. Further updates will be made across the forthcoming year. Any required changes in practice will be taken to the Executive Management Committee.

Paediatrics Liaison Nurse Activity (PLN)



In 2022-3 the Paediatric liaison service was able to share more information and identify more missed referrals using administrative support as highlighted in the graph above. The availability of admin support in the 2022-3 financial year allowed the PLN service to be able to review all under 18year olds attendances to A & E. Information is shared between acute and community services including out of area children. There is scope to replace the administrative function using digital and robotic systems which is being worked on.

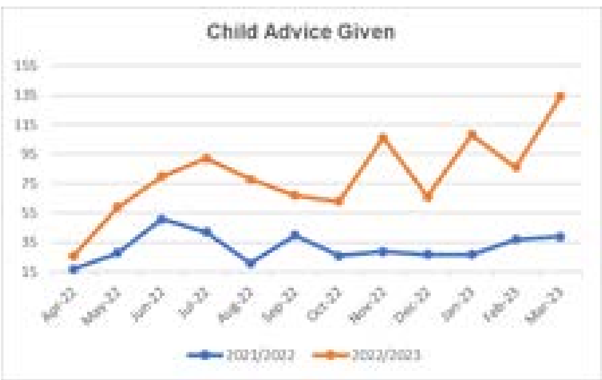


Attendances to A+E are comparable to the previous year with episodes of high attendance in November 2022 due to respiratory presentations to A+E. Public Health England notes a continued upward trend in attendance amongst 0-4yr old since 2017 as indicated below reflecting the demand and trend seen in BHT

Recent trend: ⬆ Increasing attendance of 0-4yr olds to A+E in England

Period	England				
		Count	Value	95% Lower CI	95% Upper CI
2017/18	●	2,095,158	619.0	618.1	619.8
2018/19	●	2,193,044	655.3	654.4	656.1
2019/20	●	2,177,170	659.8	658.9	660.7

Source: Hospital Episode Statistics (HES) Copyright © 2022, Re-used with the permission of NHS Digital. All rights reserved.



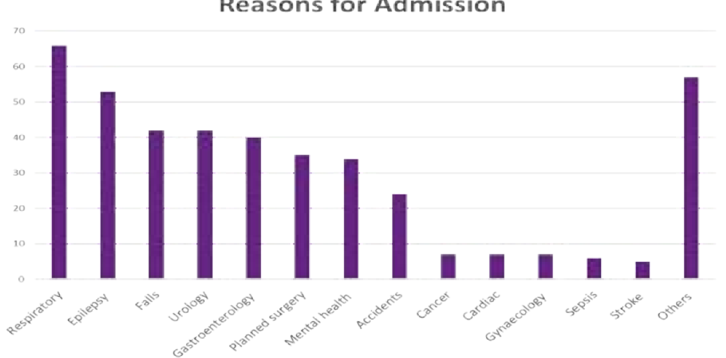
This graph demonstrates the child advice given by the safeguarding team to staff across acute and community services. There has been an increase, particularly in March 2023 MASH activity data in the section below. The safeguarding team run a duty consultation line where the practitioner can phone and access advice and support. The team also do daily walk about ward areas providing spot supervision and support.

Healthy Communities

Learning Disability and Autism Liaison Nurse (Adults)

The service has continued to support autistic people and people with learning disability across the Trust.
The number of inpatient referrals rose by 36% (586) from the previous year. This continues the upward trend since 2019. Of the 586 referrals, 16 % were for people with Autism.

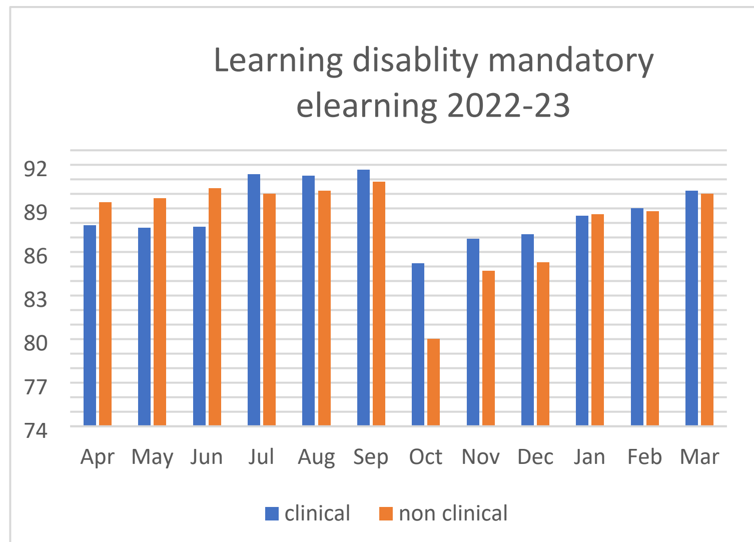
The graph below demonstrates that this reporting year respiratory closely followed by epilepsy were the leading reasons for admission in comparison to last year which noted that Gastroenterology was the lead admission cause for people with a learning disability.



The LeDer national reports indicate 6 out of 10 people with LD (60%) died before they were 65.

In line with trust process all deaths of a person with an LD are subject to the SJR and reporter LeDeR.

The LDN's contribute to learning reviews and disseminate any learning.



October saw a dip in performance due to a change in the compliance criteria and following this compliance continues to increase.

The LDN's continue to provide bespoke training to departments within the trust and are part of the regular Nutrition training and ED training days.

Areas of Excellence

- In 2022 the CQC highlighted the learning disability team within the Outstanding Practice "The trust's learning disability liaison team supported patients through their pathway. They supported with consent and mental capacity assessment processes and supported patients through any procedures or interventions. They also supported staff to make any reasonable adaptions to support the wellbeing of patients with a learning disability."
- The LDN's have been included in several stakeholder groups with BOB ICB including rolling out the Oliver McGowan Mandatory training, Learning Disability Transition to Adulthood and the Autism and Learning Disability Crisis Care workstream.
- The LDN's presented at the Access All Areas events to promote the BHT learning disability team. This is attended by members of the public and other stakeholder groups.
- The LDN's have participated in the NHS Improvement benchmarking data collection.
- The LDN's have continued with the Covid vaccination clinics and shared our experience and unique approach with the National Covid-19 vaccination programme Team and at the NHS Southeast Quality Improvement Forum. In Q2 of 2022/23, The team were delighted to have received a Trust award for Inclusion and Equality.

A case study for the vaccination clinic has been published in NHS Futures. (Supporting people with learning disabilities to receive their COVID-19 vaccine - COVID-19 Vaccination Programme - FutureNHS Collaboration Platform)

Dementia and Delirium

Within the acute and community inpatient beds there will be patients admitted with a known dementia and recognition of the stage and type of dementia will help plan and personalize the care experience. Delirium is a separate disease from dementia but can occur alongside dementia or separately. Both conditions must be considered and screened for.

- The National Dementia Strategy focuses on improving rates of dementia diagnosis via referrals to the Memory Clinic which is run by Oxford Hospital Foundation Trust. Buckinghamshire currently has a diagnostic rate for dementia of 57.3% against the national target of 62.2% so services within Buckinghamshire Healthcare NHS Trust are likely to be meeting people with undiagnosed dementia.

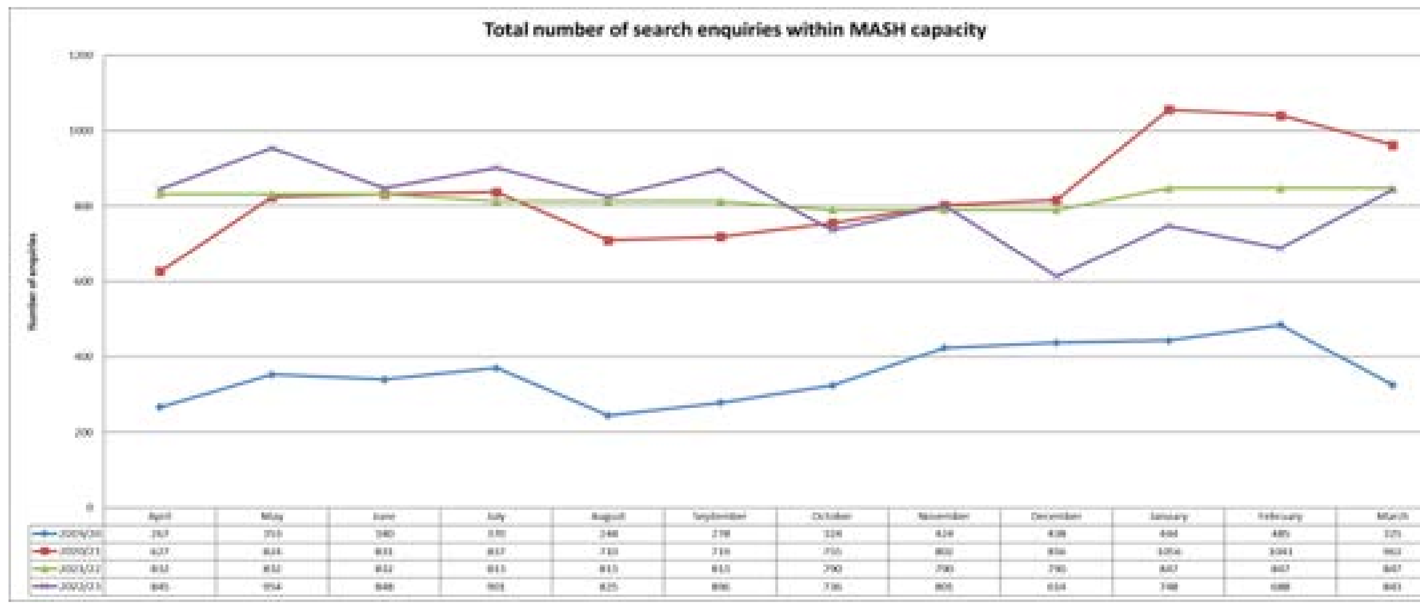
- The Single Question Identifying Dementia is asked on acute admission followed by a series of screening tools and investigations to exclude physical diseases that may cause cognitive changes – if cognitive changes continue thereafter, it is appropriate to navigate the person and those closest to them through the memory diagnostic pathway. This includes a referral to Memory Clinic and third sector agencies such as Carers Bucks and Alzheimer's Society

- Delirium is a separate syndrome and has its tools for assessment using the Acronym PINCH MEE covering the most common causes of and non-pharmacy treatments of delirium. Delirium rates have increased, and the Team have worked with the CCG to develop an awareness of delirium

- The Dementia and Delirium Team have seen an increase in referrals with key themes being the management of behaviour (ideally without sedation) and mental capacity. The Team leads case conferences on treatment decisions and ethical dilemmas and ensures the person living with Dementia and or Delirium and their loved ones are included in decision-making. Wherever possible treatment plans should have minimal use of antipsychotic medications and there should be a commitment to reduce usage at the earliest opportunity

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Referrals	12	21	17	19	30	21	27	32	28	31	20	18
Behaviour	8	10	4	14	6	10	22	16	12	14	8	6
Mental Capacity	3	10	12	3	18	7	3	10	10	12	8	6

MASH (Multi-Agency Safeguarding Hub)



The Multi-Agency Safeguarding Hub (MASH) is a key function in dealing with safeguarding concerns within Buckinghamshire. The data demonstrate an increase in demand. The number of

enquiries that BHT MASH staff processed, includes demographic requests, enquiries, and strategy meeting checks.

MASH Enquiry Concerns	2021/2022	2022/2023
drug misuse	23	60
alcohol misuse	17	26
Sexual abuse	25	34
DVA - parent/carer	107	158
DVA - child	3	6
Concerns for child welfare	188	210
Neglect abuse	18	58
Physical abuse	40	61
Mental health - adult	54	75
Mental health - child	78	92
behavioural problems	30	35
Other (comments)	16	15
Total	599	830

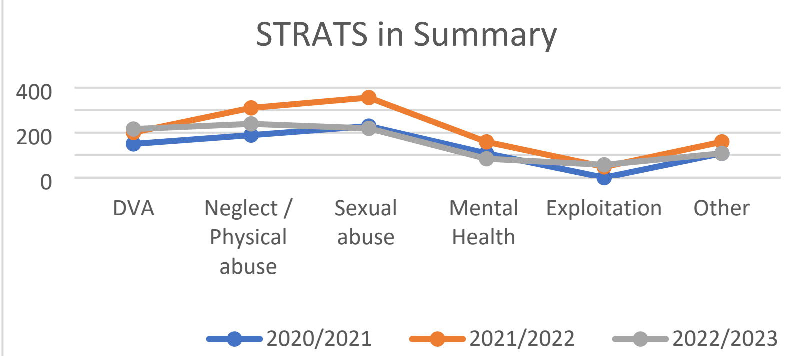
Year	Total Enquiries	Workload increase from 2016/2017	Increase from previous year
2016/17	1110		
2017/18	1534	38%	38%
2018/19	3045	174%	99%
2019/20	4292	287%	41%
2020/21	7520	577%	75%
2021/22	9333	741%	24%
2022/23	9699	774%	4%

Concerns for the welfare of the child remain the reason for MASH contact as indicated by the data to the left. Parental domestic abuse is well reported within the Thames Valley police force and there is ongoing work across the safeguarding partnership to strengthen knowledge and understanding of domestic abuse. The MASH service is on the safeguarding risk register (current score 9) due to service pressure. The graph below demonstrates a year on and year increase in the number of inquiries coming through MASH.BHT work with other partners in the MASH to prioritise attendance at strategy meetings for the cases which have the greatest health need

Children's Social Care are required to hold a Strategy Discussion whenever there is reasonable cause to suspect that a child has suffered or is likely to suffer Significant Harm whether or not it appears that a criminal offence against a child has been committed (Working together, 2018).

In Buckinghamshire, sexual abuse concerns as indicated below featured in the financial year 2022-3 mainly due to issues around online safety and the use of smartphones amongst young people. This is understood to reflect the national picture reflected in the discussions around the Online Safety bill that is going through parliament at the time of this report being written.

Data published by The Internet Watch Foundation (IWF) today (January 27) shows:



In 2022, 63,050 reports related to imagery had been created of children aged 7-10 who, in many cases, had been groomed, coerced, or tricked into performing sexual acts on camera by an online predator.
This is a 129 per cent increase on the 27,550 reports in this category in 2021.
The 2022 figures are a 1,058 per cent increase on the 5,443 such reports in 2019 before the outbreak of Coronavirus.

Children Who are Looked After LAC Health Assessment Activity

- Health assessments continue to form part of a dynamic and continuous cycle of care. Specialist nurses case loading children looked after with health assessments becoming part of a continuous cycle of SMARTER care planning and not isolated events.
- Children's homes within the county have allocated named specialist nurses who have contributed to the 'Outstanding' Ofsted inspections this year.
- Specialist nurses attend Foster Carer support groups and provide training to our carers.
- Specialist nurses complete 'Lifestyle Assessments' for older children and Unaccompanied Asylum-Seeking Children new into care during Initial Health Assessment clinics.
- Health action plan template for Unaccompanied Asylum-Seeking Children developed.

- Specialist nurses are engaging in activities with the children in the care council and supported the annual celebratory event.
- Continued delivery of training on roles & responsibilities of corporate parenting within BHT & beyond **'ONE of your OWN'.**
- Continued delivery of training on meeting the health needs of children looked after.
- Notification & reporting systems improving the timeliness of health assessments.
- Review Health Assessment visual forms fully embedded into practice within Children & Young Peoples Services.

Initial Health Assessment Data (IHA)

Initial - IHA's	2019/20	2020/21	2021/22	2022/23
Total number	167	184	169	166

In 2022/23 60% of IHA's were for 'in county' children and 40% for those children placed out of the county. 57% of all the IHA's were achieved within statutory timescales. (20 working days of the child being placed in care) Breaches are monitored and reported to the Corporate Parenting Panel with the majority due to external reasons (SC influences, young people going missing & Other LA capacity challenges for children living outside of Buckinghamshire).

Review Health Assessment Data (RHA)

Review – RHA's	2019/20	2020/21	2021/22	2022/23
Total number	423	432	443	451

In 2022/23 50% of completed RHA's were for children living 'in county' and 50% for children living 'out of county'. 71% of all RHA's were achieved within statutory timescales (six monthly for children under five years and yearly for children over five years). For the RHA's that breached statutory timescales 24% were 'in county' children and 76% for children placed 'out of county'. Timely health assessments are a priority for the team and if this is not achieved escalation pathways are followed.

Age & Gender Demographics 31/03/23

Age Group	Female	Male	Total
Under 1	11	8	19
1-4	23	23	46
5-9	38	33	71
10-15	84	118	202
16	23	58	81
17	31	66	97
Total	210	306	516

Comparison data LAC children 31/03/23

On 31/03/23 **516** CLA. Rate per 10 000 children aged under 18 years = **40**

Maternity

Between 1st April 2022- 31st March 2023 - 4577 women/birthing people gave birth at Buckinghamshire Healthcare NHS Trust.

1260 women/birthing people who gave birth at the trust in this time (28.9%) were referred to the specialist midwifery safeguarding, mental health, and teenage pregnancy team.

Graph 1 shows the rate of monthly referrals

Graph 1

The most frequent reasons for referral to the team were due to mental health issues and domestic abuse (see Graph 2).

Graph 2

Safeguarding

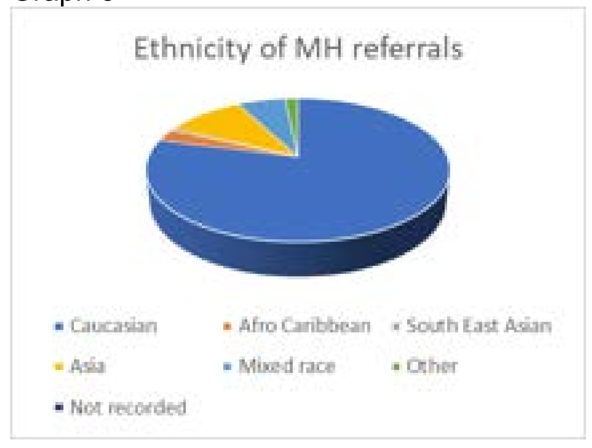
463 (11.8% of the total women /birthing people) were referred for safeguarding concerns. This is an increase of 7.3% from 2021/22. The most common reason for safeguarding referral is domestic abuse which has increased by 7.7%. The focus for 2023/24 level 3 training in maternity, is domestic abuse due to the increase in referrals and the publication of the Domestic Abuse Act 2021. Domestic abuse articles and updates feature in the maternity practice development newsletter for staff in

addition to information and resources on learning boards for both service users and staff in clinical areas. The second most common reason for safeguarding referrals is mental health.

Mental Health
784 (17.1% of the total women/birthing people) were referred to the specialist mental health midwifery team. This is an increase of 1.8% from 2021/2022. Not all women required an additional safeguarding referral.

Most women who were referred for mental health were Caucasian and/or from the most deprived postcodes in the county. This is indicative of the health inequalities faced by women in areas of social deprivation (see Graphs 3 and 4).

Graph 3



Graph 4

However, it is recognised in national reports that women of Black and Asian heritage are less likely to disclose mental health issues and may experience inequalities in access to services. Maternity services need to ensure that they are providing antenatal and postnatal continuity of care, inaccessible locations with direct access to mental health support to improve disclosure rates and provision of support

Teenage pregnancy
79 (1.7% of the total women/birthing people) were referred to the teenage pregnancy midwife. This has remained static from the previous year. Teenage pregnancy does not require immediate referral to the safeguarding team; each young parent is individually assessed. In this reporting period, 15 teenage parents required safeguarding referrals. The most common reasons for referral are being a previously Looked After Child (LAC) or lack of family support.

Female Genital Mutilation (FGM)

- FGM is nationally reported by the maternity safeguarding team. In this reporting period, 10 cases of FGM were reported. 9 of the FGM cases were identified in maternity and 1 case in urology. The case identified in urology highlighted a possible gap in accurate reporting of FGM cases identified outside of maternity. The pathway is being reviewed with the adult safeguarding lead, and the multi-disciplinary to ensure that there is robust recording and data collection for FGM (Female Genital Mutilation) across the organisation.

Health Inequalities
Moving forward, the demographic data will need to be collated for all referrals (including safeguarding, teenage pregnancy and FGM) to evidence how many women/birthing people are affected by both risks associated with ethnicity and deprivation, so that targeted improvements can be made. Additionally, a pre-conception scoping project is planned for 2023 reaching out to

underrepresented groups to better understand how early access to services can be achieved for those who are the most vulnerable.

Service and quality improvements for maternity safeguarding in 2023/24 include:

- Role of the ISVA (Independent sexual violence advisor) to be in place by September 2023.- midwife currently undertaking training
- Remodel specialist team, to increase ability to provide enhanced support for our families with social complexities.
- To drive improvement with cross border Liaison groups to improve care and information sharing for women within Buckinghamshire and out of area choosing to birth at our trust.

Serious Violence Duty

The 'Serious Violence Duty' came into effect in January 2023, placing a new legal requirement on a range of public sector organisations to work together to reduce incidents of violence, including knife and gun crime, and to prevent loss of life. It is designed as a multi-agency public health approach to understanding the drivers and impacts of serious violence and a focus on prevention and early intervention.

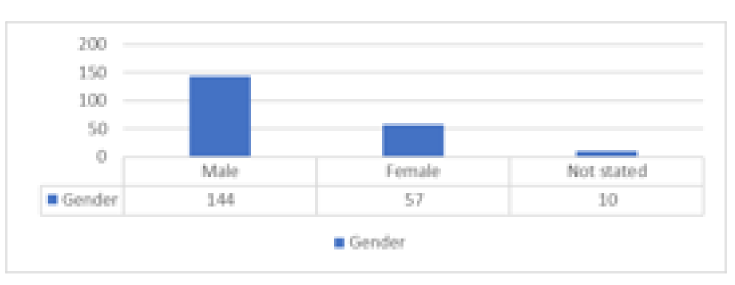
Hospital Navigator Programme

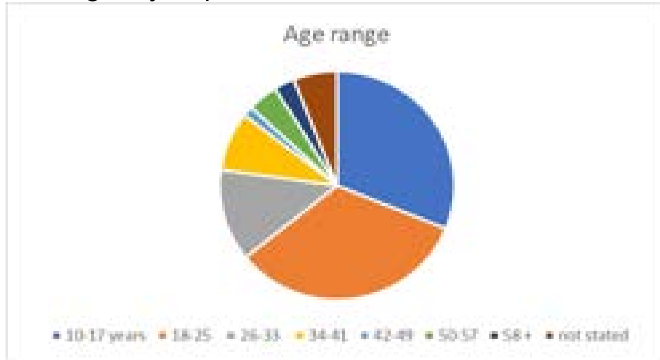
The Hospital Navigator Programme seeks to take advantage of a 'teachable moment' as defined by Brice and Boyle as a 'period following a traumatic experience where individuals are more receptive to behavioural change'. Their team is comprised of non-clinical professionals with the knowledge (and often the lived experience) with the focus on helping the individual to engage, build rapport and provide effective links to appropriate services in the local community.

The scheme started at Stoke Mandeville Hospital ED in September 2021 and is run by the organisation, 7Roadlight. Such a scheme aims to reduce violence in our communities and to reduce violence related ED attendance as well as supporting BHT service users in making positive changes to their health, safety, and wellbeing.

In 2022/23, 211 referrals were made to the Hospital Navigator Scheme. Individuals' ages range from 10 years of age to 71 years of age.

Whilst this is a great number of referrals with many positive outcomes for BHT service users. Further work is needed to facilitate direct referrals from the emergency department





Multi-Agency working

BHT has a statutory requirement to engage in child safeguarding practice reviews (CSPR, formally Serious Case Reviews), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs) where BHT has been involved in the care of the victim, perpetrator, or their family.

The corporate safeguarding team delivers this statutory requirement by supporting all aspects of statutory multiagency reviews. This includes the coordination of chronologies, internal management reviews (IMR) and attendance at appropriate multiagency meetings. The safeguarding team identifies recommends and supports any change in practice that emerges from this work. There were six newly commissioned SARs and one ongoing from the previous year.

There were no Child Safeguarding Practice Reviews commissioned during this period with 3 ongoing reviews that are due to be published at the time of report writing. The recommendation from these practice reviews will be disseminated through the safeguarding committee.

Work for the forthcoming year will be to continue to strengthen the DHR process internally and to ensure that staff understand their duty regarding case reviews. There have been two newly commissioned DHRs that BHT are supporting.

BHT staff continue to attend the Safeguarding Adult Board and Children's Partnership and the subgroups, to support multi-agency best practices across the county. The main priorities for the safeguarding children partnership were 'Think family', training and development, combatting neglect, exploitation, and serious violence. BHT was able to contribute to that strategy through participation in the sub-groups.

Effective multi-agency safeguarding work continued via the quarterly county-wide meetings where all key agencies across the county come together to share practice, new guidance, learning and networking.

In July 2022 the Integrated Care Boards came into effect and BHT remains committed to partnership working with executive leads and being involved in key safeguarding committees and meetings.

A Great Place to Work

Training

Prevent Training Compliance

92.00%
90.00%
88.00%
86.00%
84.00%
82.00%

Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23

% of staff completed WRAP training
% of staff completed Prevent E-Training Compliance

Safeguarding 21/22 v 22/23

	31/03/2023	31/03/2022
TOTAL	87.38%	66.69%
Safeguarding Children (level 3)	83.99%	54.24%
Safeguarding Children (level 2)	91.19%	78.04%
Safeguarding Adults (level 3)	78.22%	40.55%
Safeguarding Adults (level 2)	91.09%	79.88%

0.00% 10.00% 20.00% 30.00% 40.00% 50.00% 60.00% 70.00% 80.00% 90.00% 100.00%

31/03/2023 31/03/2022

Overall, there has been an upward trajectory in training in all key subjects and this has been due to training drive and support provided throughout the financial year 2022-3. The plan is to continue to strengthen the training offer and a joint adults and children passport has now been completed. The team have continued to provide induction, statutory and mandatory training as per respective intercollegiate guidance for adults and children. Bespoke and divisional sessions were also delivered.

Managing Allegations

Buckinghamshire Healthcare NHS Trust (BHT) has specific statutory duties in respect of safeguarding people of all ages; included in these duties is a requirement to have in place a clear policy and process for dealing with allegations against people who work with adults at risk or with children.

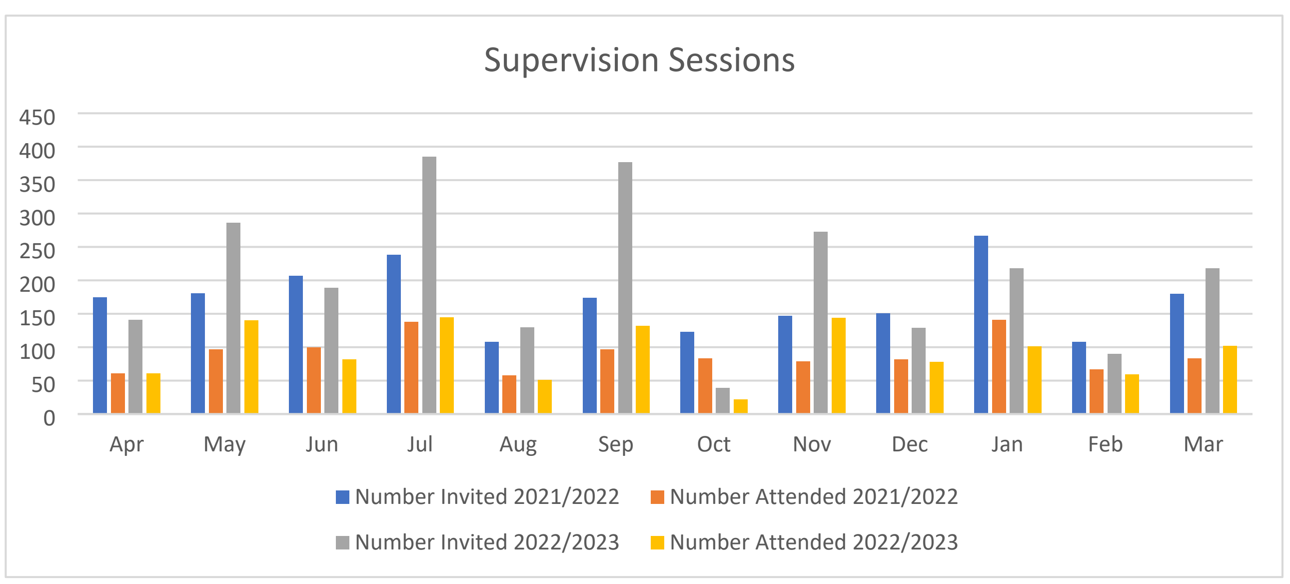
There is a policy being drawn up between the safeguarding team and the people directorate which will guide managers to undertake appropriate levels of investigation and risk assessments in these cases.

Supervision

The Children Act 1989 Section 11 (2004) states that organisations involved with safeguarding children must ensure that “there is effective supervision and mentoring of work with individual children and their families”. Safeguarding Supervision is mandatory for all registered clinical staff

working directly with children and adults at risk of harm. A formal Safeguarding Supervision framework supports front-line clinicians to examine, reflect and plan and evaluate interventions in complex clinical situations.

BHT practitioners attend safeguarding supervision as per supervision policy, either in a group or 1:1 supervision session provided by the safeguarding team Supervision is recorded on IAspire and monitored by the individual and their line manager.

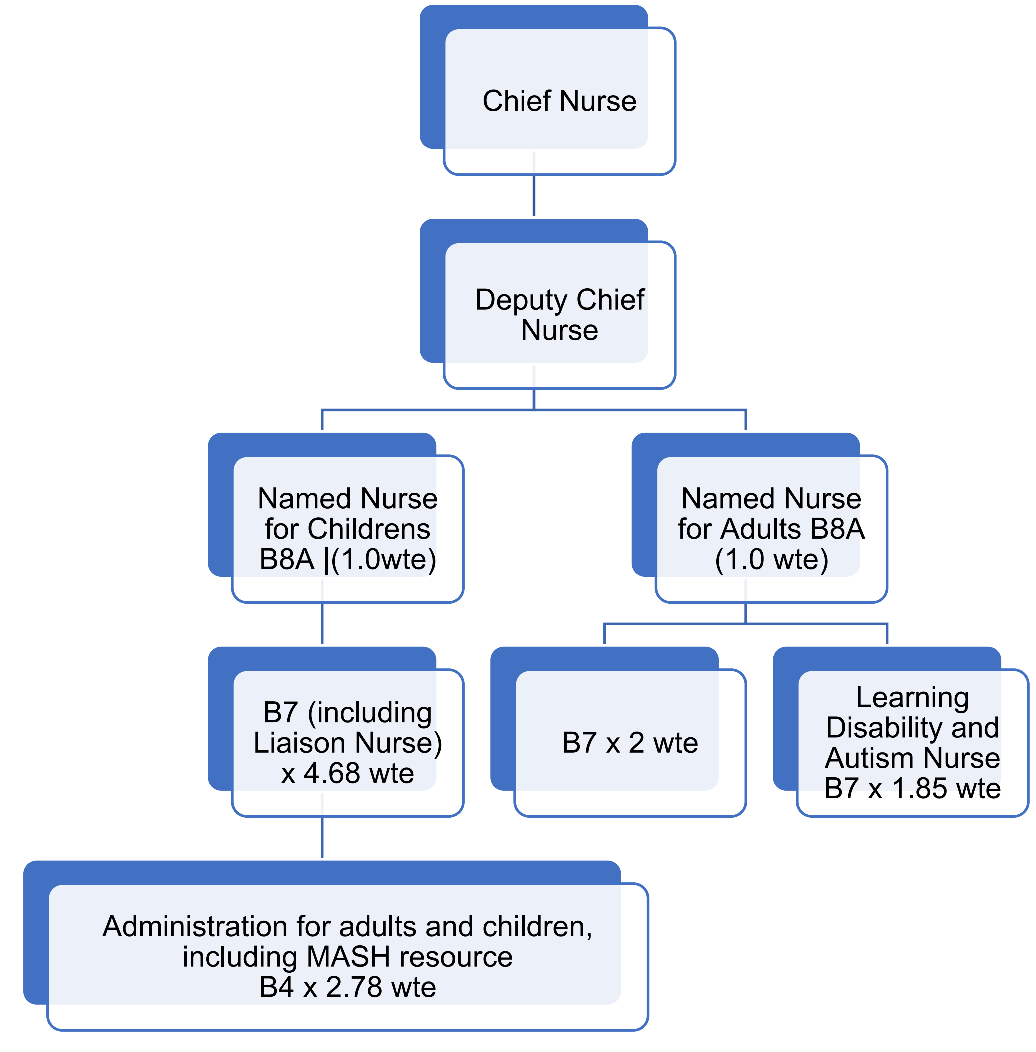


Team priorities 2023/2024

- Undertake a gap analysis of the BHT service against the Safeguarding Assurance and Accountability Framework (SAAF)
- Write a business case for additional resources to support with key functions identified i.e. MCA DOLs and children's MASH
- Build and maintain the upward trajectory of training
- In co-production with Maternity review the FGM pathway including reporting mechanisms across BHT

Appendix 1 Corporate safeguarding team structure

Corporate Safeguarding Team Structure



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

- 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

- 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&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

- 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

- 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

- 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

- YTD - Year to Date