Meeting: **Trust Board Meeting in Public**

Date: **Wednesday, 27 September 2023**

Time: **09:30 – 12.00**

Venue: **Hampden Lecture Theatre, Wycombe 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
General Business					
09.35	**3.**	Minutes of the last meeting held on 26 July 2023	Approval	Chair	Paper
	4.	Actions and Matters Arising	Approval	Chair	Paper
	5.	Chief Executive's Report	Information	Chief Executive Officer	Paper
Committee Reports					
09.50	**6.**	Audit Committee Chair Report	Assurance	Committee Chair	Paper
	7.	Finance and Business Performance Committee Chair Report	Assurance	Committee Chair	Paper
	8.	Quality and Clinical Governance Committee Chair Report	Assurance	Committee Chair	Paper
	9.	Strategic People Committee Chair Report	Assurance	Committee Chair	Paper
	10.	Charitable Funds Committee Chair Report	Assurance	Committee Chair	Paper
Performance					
10.10	**11.**	Integrated Performance Report • Elective Recovery	Assurance	Chief Operating Officer	Paper Paper
	12.	Setting Trust Breakthrough Objectives for 24/25	Discussion	Chief Digital Information Officer	Paper
10.30		QUESTIONS FROM THE PUBLIC			
	COMFORT BREAK – 10 minutes				
Finance					
10.40	**13.**	Finance Report	Assurance	Chief Finance Officer	Paper

Time	Item	Title	Purpose	Presenter	Format
People					
10.50	**14.**	Equality, Diversity & Inclusion - WRES/WDES/PSED	Assurance	Chief People Officer	Paper
	15.	Trust Organisational Development Framework	Assurance	Chief People Officer	Paper
	16.	Flexible Working	Approval	Chief People Officer	Paper
Quality					
11.10	**17.**	Safe Staffing	Assurance	Chief Nurse	Paper
	18.	Quarterly Maternity Quality and Safety Report	Assurance	Chief Nurse	Paper
Risk & Governance					
11.30	**19.**	Organisational Risk Report	Assurance	Chief Executive Officer	Paper
	20.	Fit and Proper Persons Test	Information	Chief People Officer	Paper
Information					
11.45	**21.**	Private Board Summary Report	Information	Trust Board Business Manager	Paper
	22.	Guardian of Safe Working Hours Annual Report	Information	Chief People Officer	Paper
	23.	Organ and Tissue Donation Annual Report	Information	Chief Medical Officer	Paper
	24.	Infection Prevention Control Annual Report	Information	Chief Nurse	Paper
	25.	Paediatric CQC Inspection	Information	Chief Nurse	Paper
AOB					
	26.	Risks identified through Board discussion	Discussion	All	Verbal
		ANY OTHER BUSINESS			
		QUESTIONS FROM THE PUBLIC			
		Date of Next Meeting: 25 October 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

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

Public Board Action Matrix

4action ID	Agenda Item	Summary	Target Date	Exec Lead	Status	Update
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	Due (deferred)	Verbal update to be provided at the meeting
1750	Health & Safety Executive (HSE) Letter & Trust Response	Triangulation of colleagues working from home, with sickness related to stress and musculoskeletal injury and use of risk assessments	27/09/2023	Chief People Officer	Propose close	Move to Strategic People Committee Action Matrix
1751	Safeguarding Annual Report	Ethnicity metrics to be considered within the next safeguarding quarterly report	27/09/2023	Chief Nurse	Propose close	Move to Quality & Clinical Governance Committee Action Matrix
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.
1752	External Reviews	Combine reporting with the annual Compliance with Legislation Report	31/01/2024	Chief Nurse	In Progress	Compliance with Legislation Report next due to Board in January 2024

Meeting: Trust Board Meeting in Public

Date: 27 September 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 – NHS England letter verdict Lucy Letby case Appendix 2 – NHS England MPox Programme letter Appendix 3 – CARE Value awards 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 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 ☒

Relevant objective

☒ Improve waiting times ☒ Improve safety ☒ Improve productivity	☒ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☒ Upskill operational and clinical managers

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

In August I wrote to the organisation following the unimaginable actions of Lucy Letby, and I have attached the letter all NHS organisations received from NHS England (Appendix 1). I am a firm believer that it is our role, and that of the NHS, to provide a place of safety and care to the most vulnerable in our community – a responsibility that we should put above all others. Our strongest defence against a similar event occurring here, is the culture within which we work – one that listens; values hearing feedback, no matter how good or bad; and strives, amongst all our competing priorities, to do the right thing as a result. The events are a reminder of the critical importance of having a culture of speaking up, and our Freedom To Speak Up Guardian (FTSUG) has conducted a gap analysis of our services against the five priorities outlined in the letter from NHS England. This will be reviewed by the Executive Management Committee this month, and subsequently reported at the next Strategic People Committee. Whilst this review identified no material gaps, there are areas we can further improve including more proactive outreach work with international and student nurses who are new to our organisation, and how the FTSUG team links in to the Board sub-committee focused on quality. We are also on track to adopt the national FTSU policy by January 2024.

There has also been significant national news regarding the risk of failure of RAAC (concrete) in public buildings including schools and hospitals. When this was first highlighted as a potential issue in hospitals, we undertook a detailed desktop review of all sites, and carried out intrusive testing at both Stoke Mandeville and Wycombe hospitals during 2020 and 2021 under NHS England guidance. We were also part of the NHS RAAC oversight group, one of 30 trusts in England. At the time we confirmed that none of our hospital sites have RAAC and the Trust Board received a report to this effect in September 2021.

Ongoing national industrial action by junior doctors and consultant bodies continues to have a significant impact on our services, contributing to delays in providing outpatient appointments or planned procedures. We would like to extend our continued gratitude to those that have been affected for their patience and understanding.

Colleagues will have seen the government's commitment to 'Martha's Rule' following the tragic death of Martha Mills and campaign by her mother, Merope Mills. Whilst patients or relatives can already request a second medical opinion if they have concerns about their care, we will review our processes to confirm we have a structure to ensure this takes place if requested.

Outstanding care

Key performance data are reported in the Integrated Performance Report with supporting narrative. It now includes a slide summarising the measures we are focusing on this year through our 'breakthrough' objectives (i.e. those which we are using to tell us if we are on track with our multi-year goals.

In terms of performance in urgent and emergency care (UEC) and cancer, we are starting to see some improvement overall in UEC metrics, which is particularly important as we head into the winter period. We are also seeing some improvement in our 62-day cancer performance, as well as in length of stay. We do continue to experience significant challenge on our diagnostic performance, and substantial planning is going in to driving improvements.

I am delighted to congratulate our Inpatient Pain Team who have won the Deteriorating Patients and Rapid Response Initiative of the Year at the HSJ Patient Safety Awards. The Mobile Block Unit provides rapid regional anaesthesia for patients admitted with traumatic rib fractures at risk of deterioration – the first for an NHS Trust in the region. Winning this award is fantastic recognition for a passionate team striving to deliver exceptional patient care.

The team are also shortlisted for this year's HSJ Awards alongside our breast unit who were one of the first in the UK to offer the MagTotal approach to improve the surgical process for treating some breast cancers. Read more about both services here.

I am pleased to advise we have received funding to build a new unit at the Stoke Mandeville Hospital site to provide space for up to 21 additional inpatient beds to boost capacity. It is hoped this new unit will help to lessen the wait faced by patients arriving in our Emergency Department need to be admitted to hospital and is due to open early next year. The cost is coming out of £250 million of government funding allocated to NHS hospitals to increase capacity as part of the national Urgent and Emergency Care Recovery plan.

Earlier this year we attended the Buckinghamshire Health and Adult Social Care Select Committee to seek approval to develop Wycombe as a centre of excellence for ante and postnatal care; the papers and webcast for this meeting on 11 May 2023 can be viewed here. At its meeting on 20 July 2023, the HASC confirmed its support for this change and requested updates in due course on key performance data and service user engagement; papers and draft minutes from the meeting can be viewed here.

The Care Quality Commission (CQC) National Adult Inpatient Survey report findings have been published from data collected in November 2022 and can be read here. The survey involved 133 NHS acute trusts in England. 463 of our adult inpatients responded to the survey, which was equivalent to a 38.4% response rate. Our results were broadly in line with other trusts, despite November 2022 being a particularly challenging time for the organisation due to high demand for inpatient and emergency services. However, we were disappointed to score worse than most other trusts for: food; opportunity to give views on the quality of care; and being prevented from sleeping particularly due to hospital lighting. Actions to address these areas will be monitored and reviewed by the Quality & Clinical Governance sub-committee of the Board.

Earlier this year the CQC visited Stoke Mandeville Hospital paediatric emergency department to conduct an unannounced focused investigation following concerns raised around early detection of sepsis and the robustness of incident investigations. The inspectors found that children and young people were receiving safe care with leaders running services well. We were also pleased that they reported that our colleagues felt respected, supported and valued. However, whilst the overall findings of the inspection were positive, there were some areas highlighted for improvement which we are addressing. The full report can be read on the CQC website here.

We also had a planned inspection from the CQC of our maternity services at Stoke Mandeville Hospital. We are currently awaiting the final report from their inspection and will update the Board when the results of their findings are published.

This month we celebrated World Health Organisation (WHO) World Patient Safety Day. This year the focus of this international day was 'Engaging Patients for Safety' with the slogan "Elevate the voice of Patients!" This was timely as we begin our transition to the new Patient Safety Incident Response Framework (PSIRF), a new approach to responding to patient safety incidents.

Healthy communities

Congratulations to our sexual health service which has been supporting the national response to the Mpox outbreak since June last year. I have appended a thank you letter from NHS England (Appendix 2).

Our Research & Innovation (R&I) team has close links with the University of Buckingham Medical School, and it was a pleasure to be involved in the final judging of the third year medical Student Selected Component on Clinical Innovation and Enterprise. The groups worked on real-life problems faced by colleagues working in fast-paced clinical research at Stoke Mandeville Hospital. My thanks to the R&I team for their time and energy in supporting the development of our next generation of clinicians.

Our new Bright Futures @BHT work experience programme has just been awarded the Silver Quality Standard by NHS England. The new standard helps healthcare organisations to quality assure their work experience placements, assessing planning, delivery and evaluation. It also aims to ensure that all learners across the country can access high quality exposure to health careers regardless of location or organisational interpretation. Since we piloted this in February this year, we have welcomed more than 250 students on individual work experience or small group workplace visits across the Trust. Creating an early talent pipeline – engaging and upskilling our local workforce supply – is vital to fulfil future workforce requirements. Work experience is also key to delivering the NHS Workforce Plan: we need to ensure enough young people are interested in pursuing a healthcare career if the expansion of training places is to be successful. The Schools Engagement Team are now developing plans to achieve a Gold Award, and applications for 2023/24 academic year placements are now open here.

Great place to work

In line with the national vaccination programme, we have begun our internal campaign to offer COVID-19 and flu vaccinations to all colleagues.

Huge thanks to the 30 employees from Shirley Parsons recruitment, who spent the afternoon working in our gardens at Brookside Clinic in the centre of Aylesbury earlier this month. Brookside Clinic is where several of our community health services are based, and the gardens continue to go from strength to strength; it is wonderful to see a local business engaged in helping our colleagues and patients through improving their outdoor space.

Finally, it was an honour to be invited to join in and speak at the Bucks Kerala Nurses celebration this month, reflecting the Kerala Festival Onam. Our workforce is increasingly diverse and with this comes welcome opportunities for all of us to learn about beliefs and cultures that may be different from our own. My thanks to colleagues working in services across the Trust for putting on such a special and vibrant event.

Appendices

Appendix 1 – NHS England letter verdict Lucy Letby case
Appendix 2 – NHS England MPox Programme letter
Appendix 3 – CARE Value awards
Appendix 4 – Executive Management Committee and Transformation Board
Appendix 5 – Place & System Briefing

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

18 August 2023

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

Publication reference: PRN00719

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

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communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

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To: The Chief Executive of Buckinghamshire Healthcare

NHS England
Public Health Commissioning
Hampshire and Thames Valley
South East Region
Oakley Road
Southampton
SO16 4GX

29 August 2023

Dear Neil Macdonald

Re: Mpox Programme

I am sure you will be aware that your sexual health service has been supporting the national response to the Mpox outbreak since June last year. Your teams have been working with us throughout that time to ensure that their highest risk clients were able to access vaccination to protect them from the disease. The programme has been unique in that it was in response to a national outbreak in a cohort that is largely invisible to the rest of the NHS and the programme had to be established with no advanced planning and very short notice. Your teams rose to the challenge, standing up the vaccination programme at pace, and responding flexibly and creatively to a continuously evolving situation.

Nationally, a total of 115,000 vaccinations have been delivered: 76,000 first doses and 39,000 second doses. By end June 2023 in our Hampshire Thames Valley sub-region, our five providers collectively delivered 3,112 first doses and 1,835 second doses. UKHSA stood down the outbreak.

There is no doubt that the programme was hugely important in terms of the UKHSA aims of reducing harm and suppressing UK transmission of the disease.

As the programme draws to a close on 31st July 2023, we wanted to take this opportunity to recognise the hard work, dedication, professionalism and patience of your service managers, clinical leads and teams and to thank them formally for the work they have done to protect vulnerable men. It has been a great pleasure to work with your teams.

Yours sincerely,

Caroline Reid
Regional Director of Commissioning
SRO – Flu & Covid Vaccination Programmes
NHS England – South East

Nikki Osborne
Head of Public Health Commissioning
Hampshire and Thames Valley

Executive Management Committee and Transformation Board

Executive Management Committee 25 July to 12 September 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
Integrated Performance Report
Operational run rate reduction measures
Critical care outreach services
Dementia rapid review cabinet recommendation response
Patient Safety Incident Response Framework update
Maternity staffing update
Maternity safety quarterly report
Safe Staffing
Radiology services
Infection prevention & control quarterly and annual reports
Diagnostics performance and funding
Cellular pathology
Care Quality Commission (CQC) paediatric emergency department report June 2023
CQC national inpatient survey report
Research & Innovation quarterly report
South 4 Laboratory Information Management System collaboration agreement
Urgent & emergency care national survey results
Progress against the Written Statement of Action for Special Educational Needs & Disabilities services
Operation Flow business case

Governance
Quality governance oversight framework
Internal audit reports
Summary of internal audit work and actions
Organisational risk report
Corporate performance reviews quarterly report
Trust Policy sub-group ratification report
Buckinghamshire Healthcare Projects Ltd contract oversight
Minutes from EMC sub-committees

Money
Monthly finance report
Monthly capital report
Productivity and efficiency weekly updates
2023/24 BOB ICB operating plan next steps
Project initiation documents for major capital projects
Waivers of Standing Financial Instructions

Digital and Estates
Critical infrastructure
Theatres
Cyber programme phase 1
Wycombe tower scaffolding
Wycombe tower bridge survey

People
Key worker accommodation
CARE value award winners
Equality, diversity & inclusion annual report
Employee relations update
National Staff Survey
Freedom to Speak Up Guardian quarterly report
COVID-19 and flu vaccination programme

Transformation Board 16 August and 20 September 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
Integrated Performance Report
Performance Activity & Income
Elective Recovery Plan
2024/25 Breakthrough objectives
Transformation portfolio overview
- Organisational Development framework
- Admin & Clerical transformation

Transformation portfolio updates:
- Urgent and emergency care
- Healthy communities
- Digital
- Diagnostics

Productivity and efficiency weekly update
Temporary staffing programme
Medicines optimisation progress report

Appendix 5

Place and System Briefing

September 2023

Place

Buckinghamshire Executive Partnership (BEP) meeting 12 September 2023

Item	Summary	Impact
Priorities update	Progress report on delivery of three priorities (transforming SEND, joining up care, and tackling health inequalities, including key milestones and quantitative metrics. Improvements in some areas e.g. total lost bed days; but deterioration in other measures e.g. proportion of children seen for initial OT assessment within 18 weeks	These priorities represent the most significant challenges that can be improved through working with place partners, and therefore improvement in these areas will reflect an improved experience and outcomes for BHT patients and Buckinghamshire residents.
Progress on SEND investment and transformation programme	Detailed report on investment in SEND services to make improvements outlined in the Written Statement of Action	Some of BHT children's and young people's services are involved in delivering SEND services and therefore funding decisions will affect how BHT services are delivered.
CQC ICS inspections and Right Care Right Person	Summary of interim guidance published in March 2023 on ICS assessments, which focus on quality and safety, integration and leadership. Right Care Right Person is an initiative to ensure the most appropriate care is given to people experiencing mental health difficulties.	Some changes in the Right Care Right Person initiative will impact how patients with mental health difficulties attending our Emergency Department are best supported.
ICS digital and data strategy	Discussion to agree the role of the place partnership in delivering the 3-year ICS' digital and data strategy	Objectives are: digitise providers to reach Minimum Digital Foundations requirements; connect care using technology; transform data foundations to provide insights required to transform our system. BHT will see a range of positive impacts through the delivery of this strategy.
2023/24 discharge programme financial recovery plan	Report on the financial position for the discharge transformation programme and plans to achieve financial balance.	This programme is critically important for improving patient experience around discharge from hospital and ensuring the right care is available in the right place for the patient.
BOB ICS: defining our long-term ambitions and model of care	Proposal to develop a model of care for Buckinghamshire focused on prevention and community-based care.	The principles of this proposal reflect the opportunities BHT as an integrated trust have in evolving services to best meet the needs of Buckinghamshire residents, by bringing more healthcare services into the community and engaging residents preventative health.

Buckinghamshire Health & Wellbeing Board 21 September 2023
Papers are available here.

Item	Summary	Impact
Healthwatch Annual Report	A review of the work undertaken by Healthwatch Bucks for the past year.	Healthwatch provides a valuable voice of the patient and resident for us in the design and continues review of our services.
Buckinghamshire Executive Partnership	Update from the place-based partnership meeting in July.	
Winter Plan	The 2023/24 Urgent and Emergency Care Winter Plan for Buckinghamshire.	Ensuring we have robust plans in place and are as prepared for the anticipated high levels of demand winter typically brings, is critical for how we will manage our services this winter.
Integrated Care Board updates	Verbal update from the BOB ICB, and a written update from the neighbouring Bedfordshire, Luton and Milton Keynes Integrated Care Board.	

System

BOB Integrated Care Board (ICB) 19 September 2023
The BOB ICB meeting takes place every other month. Papers are available here.

In addition to standing items regarding quality, performance, finance and risk, the Board discussed its initial response to the letter from NHS England (see Appendix 1) regarding the trial of Lucy Letby.

I would also draw the Board's attention to the Quality Assurance Framework, which sets out the quality and safety oversight of commissioned services.

The Board also reviewed a progress report against the Joint Forward Plan published earlier this year and a review of the first quarter of the system Operational Plan for this year.

Lastly, the Board are establishing a Change Programme Board led by the Chief Executive, Nick Broughton, to develop and implement a revised operating model for the organisation.

Acute Provider Collaborative 31 July 2023
The Acute Provider Collaborative is a collaborative of the three 'acute' providers in the BOB ICS, namely BHT (as we provide acute as well as community services), Oxford University NHS Foundation Trust, and Royal Berkshire NHS Foundation Trust. It is relatively newly formed, and therefore some elements, including formal governance arrangements, are still being developed.

At the July meeting, CEOs and Chairs from the respective Trusts discussed the scope and ambitions of three priority workstreams: clinical services, corporate services, and elective care. It also discussed a proposal to form a Collaborative Committee in Common, and some early proposals for resources to deliver the three priorities.

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.

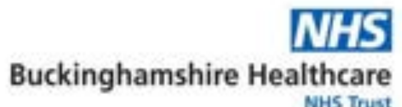
July 2023

Category	Name	Role	Nomination	Nominated by
Collaborate	Ben Tofte Patrick Blanche, Graham Podbury, Ian Hunter, Jason Steptoe , Danny Clarke, Jake White, George Burton, Brendon Barrett, Paul Oakley, Tony Cruickshank & Stephen Burton.	Helpdesk Manager, Wycombe Hospital Estates/Property Services	When we advertised the Trust was holding an AGM/Open Day/Careers Fair and 75th celebrations, Ben contacted me to say he would like to volunteer to help on the day. Ben wanted to give something back to the Trust having spent some time this past year in ICU at SMH. Ben took the time to understand what was needed on the day and basically pitched in and did whatever we asked of him. He spent the whole day helping the Communications team. The individuals named above all went out of their way to ensure we had everything in place for the AGM, they sorted out the electric points, erected Gazebos and rallied around as a team and got stuck into helping. Thank you all for being there in the background, being present on the day and for supporting this really important event.	Colleague
Aspire	Nurses	Florence Nightingale Hospice at Home	I was at my Mum's home for her last 9 days, helping to care for her whilst the team visited twice daily. I had previous experience because my husband was attended by another H@H team 22 years ago (also good). By 01/07/23 I had met many of the nurses, who were all great, and some even better. Their relationships with Mum were evident, with personal details about her clearly remembered and discussed with her. Their respect and gentleness stood out, which helped her to feel safe in their hands and able to trust. Nothing was too much trouble and they always had time to answer questions	Patient relative

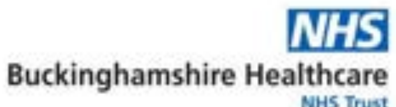
			and arrange extra things needed or desirable. They were never in a hurry to complete a visit, and constantly offered words of support to family. Individuals were authentic and used humour or solemnity in conversation totally appropriately. The dynamics within our family are complicated, and several of the nurses became aware of delicate situations where I needed an extra word, which they accommodated with quiet understanding. When someone is dying, professionals attending have a lot of "power" over a situation, and everyone in the family, especially the patient is vulnerable. Not only did the nurses work well as a team, but I was made to feel that we were all a team, toiling towards Mum's comfort and peace. The work that H@H nurses do is vital towards a "good" ending of someone's life - I cannot praise this team highly enough and could have used any of the 4 categories.	
Respect	Pam Price	Nurse, Pre-Op SMH	I was very anxious about my pre-op assessment as I fear needles. Pam quickly realised this, put me at ease, came with me to Phlebotomy and made sure I did not have to wait. In the past some people have dismissed my fear, telling me to pull myself together, saying it is not that bad, but Pam did not judge me and knew having blood taken was a big deal for me. She stayed with me whilst the blood was being taken, distracting me, and keeping me calm. She made sure I was ok to go home and walked me to my car. Her actions went along way to make me feel less anxious about my upcoming surgery, thank you Pam.	Patient
Enable	Jessica Royce	Service Manager MFOP/FNH (IECC) Stoke Mandeville	Jess has hit the floor running as one of newest team members and has been phenomenal in supporting the medical and operational teams to prepare each time for the industrial action. She is proactive and responsive to any requests for help, has often completed templates etc ahead of the main plan enabling the rest of us to set the plans and actions required in super quick time, nothing is too much trouble and she is a pivotal and very much appreciated extension to the IECC team	Colleague

Report from Chair of Audit Committee
Date of Committee 07 September 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 13 July 2023	Approved	None	n/a	n/a
Action Matrix & Matters Arising	Consideration of actions ongoing and proposed to close Focussed discussions on compliance with Trust policies	Partially assured – noting rigour around the governance of policy management	Consideration of how best to seek assurance from compliance with Trust Policies	n/a	n/a
Organisational Risk	Overview of risk within the Trust including details from the Corporate Risk Register (CRR) and Board Assurance Framework (BAF)	Assured by overall reporting mechanism noting specific risks as outlined below	Committee members requested to provide specific queries on individual risks ahead of the meeting to ensure most effective discussions Improved signposting between documents to gain assurance on actions (e.g. improvement plans and key IPR metrics)	n/a	To note report and Committee discussions



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Caldicott & Information Governance Report	Update on progress related to Information Governance for Q1 2023/24 (April-June 2023) Verbal update provided on meta-data incident and subsequent serious incident (SI) report	Assured – noting anticipated changes to the Data Security and Protection Toolkit (DSPT) in the coming year	Inclusion of trend information for incidents in future reports Clarify resource implications of changes to DSPT requirements within next report	n/a	n/a
External Audit	Update on external audit function including an indicative audit document from Ernst & Young (EY) outlining the 2022-23 annual audit strategy Request for ratification of the appointment of EY for two years	Appointment of EY recommended to Trust Board – noting all due diligence completed regarding auditor independence	Formal engagement letter to be signed off Provision of more granular timetable for the provision of information for the 2022/23 annual audit	n/a	Approve the appointment of EY for a two-year period for the purpose of conducting the Trust and Charity annual audits
Internal Audit; Progress Report	Update on progress with annual plan including presentation of two final reports: - UK Visas and Preparation for Renewal of Tier 2 Licence (RA)* - IT Assets (MA)*	Partially assured – noting levels of assurance as stated by Internal Audit function	Focus on the impact of implementing actions Completion of a lessons learned exercise to support implementation of other Trust systems	n/a	n/a



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Internal Audit; Recommendations Follow Up Report	Update on actions and recommendations followed up since last meeting	Assured – noting additional verbal updates received on those overdue actions awaiting evidence to close	None	n/a	n/a
Local Counter Fraud Specialist (LCFS) Update	Verbal update confirming the presence of no significant issues since the previous meeting in the absence of a formal report	Noted	None	n/a	n/a
Single Tender Waivers (STW)	Overview of STW between June-July 2023 including those considered to be avoidable and retrospective	Noted	None	n/a	n/a
Losses and Special Payments	Summary of YTD losses including pharmacy and patient property	Noted	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Outstanding Invoices	Overview of process to clear old or low value invoices	Approved – noting the opportunity to re-focus efforts on areas with greater materiality	None	n/a	n/a
Minutes of Finance & Business Performance Committee	Minutes from F&BP Committee Meeting on 25 July 2023 (approved)	Noted	Circulate framework to ensure clear understanding of Committee ownership of oversight of individual IPR metrics	n/a	n/a
Minutes of Quality & Clinical Governance Committee	Minutes from Q&CG Committee Meeting on 19 July 2023 (approved)	Noted		n/a	n/a
Minutes of Strategic People Committee	Draft minutes from SPC Committee Meeting on 10 July 2023	Noted		n/a	Consider frequency of comprehensive reporting to Board on Health & Safety matters

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

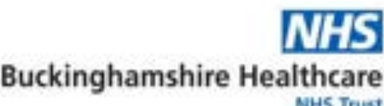
Emerging Risks Identified:

- Specific risks as highlighted within the Corporate Risk Register (CRR) with focus on:
    - Culture within the Emergency Department and impact on the ability to improve processes and patient flow.

  - Trust Capital requirements.
  - Concrete panels on Wycombe Tower.
- Lack of application of IT Asset tracking system and need to ensure lessons learned and shared organisation wide in view of the imminent implementation of significant new systems (e.g. EPR).
- Need for more comprehensive and frequent health and safety reporting to Trust Board, particularly in view of the critical nature of the Trust estate.

Report from Chair of Finance and Business Performance (F&BP) Committee
Date of Committee 22 August 2023

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the meeting on 25 July 2023	Approved	None	Refer to Audit Committee for noting	n/a
Monthly Integrated Performance Review (IPR)	Monthly reporting on Trust performance metrics and actions/progress with actions to address negative variance (July 2023) Reporting defined by NHS System Oversight Framework, BHT Strategic Priorities and Operating Plan	Assured – noting plans in place to improve MRI capacity, improvements in Medically Optimised for Discharge (MOfD) numbers and plans to maintain these over winter months and challenges related to productivity including underlying data architecture and a set of finalised metrics	Work underway to support Community waiting list management, learning from acute services Provision of full update on Hospital@Home services next month noting currently off trajectory	None	To take assurance from the report and discussions held by the Committee
Monthly Finance Report	Update on financial position at M04 including year to date, capital and efficiency position against plans and cash flow analysis	Assured – noting significant work related to pay spend and risks to the delivery of the efficiency plan	Review of coding of staffing groups within the report Enhanced Efficiency plan/CIP reporting from M05 to Committee	None	To take assurance from the report and discussions held by the Committee



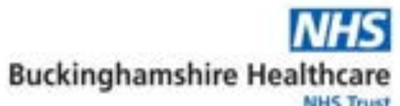
Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Capital Report	Overview of the 2023/24 Capital Programme and position at M04	Assured – noting greater controls within the overall programme and large projects underway currently on track	Phased spending profiles to be including in future reports	None	n/a
Elective Recovery Plan (draft)	Overview of actions to support achievement of the 2023/24 activity plan	Assured – noting risks as per below	Updated overall plan to be presented to the Committee in September with monthly progress update through the IPR thereafter	None	n/a

Emerging Risks noted:

- Demand and capacity related to MRI scanning.
- Delivery of the 2023/24 efficiency programme.
- Risks to delivery of the elective recovery plan (as outlined in the paper).
    - Elective Recovery Funding (ERF) clawback if required activity levels not met.

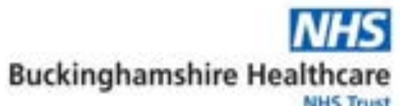
Report from Chair of Quality and Clinical Governance Committee (Q&CG)
Date of Committee 16 August 2023

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the Q&CG meeting on 19 July 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	Assured – noting improvements in early warning score performance and stable mortality metrics The Committee noted the changes in Cancer targets, key indicators related to these and active engagement with patients and local GPs in this area	Addition of narrative related to thematic analysis of Serious Incidents and Never Events noting the change in approach with the implementation of the Patient Safety Incident Response Framework (PSIRF)	n/a	To note the quality metrics for July 2023 and associated Committee discussions
Falls Report	Overview of numbers of falls, themes and Quality Improvement (QI) plan for the previous two years (Action raised at March Committee meeting)	Assured – noting significant progress made in this area The Committee noted work underway by therapy teams on prevention of deconditioning and the considered risk of non-preventable falls associated with therapy to achieve discharge and other rehabilitation goals	Further work to target patients with delirium and efforts to reduce falls in this area Update from Provider Collaborative on current gap related to the Fracture Liaison Service	n/a	n/a

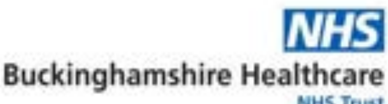


Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Safe Staffing Update	Overview of Trust nursing and midwifery staffing for the month of June 2023 Reporting aligned with National Quality Board (NQB) standards, Expectations for Safe Staffing and Developing Workforce Standards	Assured – noting NQB standards had been achieved National challenges in community nursing recognised alongside the risk of midwifery staffing (full regular paper due to Committee in October 2023) Committee welcomed verbal update on July metrics noting there had been a reduction in requests for additional staffing in line with the reduction of patients in escalation areas, recognising this reflected a lack of 'normalising' of such pressures	Report due end September related to Community nursing pilot Work to roll out initiatives in place at Thame Hospital to support community nursing engagement and staff morale more broadly within Community services	n/a	To take assurance from the staffing metrics, including achievement of NQB standards, and Committee discussions and actions set
Maternity Safety Report	Overview of maternity safety and quality issues during Quarter 1 (April-June) 2023/24 Verbal update on recent CQC inspection including positive feedback on maternity culture; written report awaited. Two concerns raised related to maternity triage (national issue) and medicines management in hot weather, both addressed and appropriate evidence provided to CQC	Assured – including the positive relationship with the Maternity Voices Partnership (MVP) and the work of this group in tackling inequalities Focussed discussions related to Birthrate Plus The Committee welcomed the revised reporting format and work underway to maximise the ability to take assurance from such reports	Any incidents related to inability to provide 1:1 care to continue to be provided within the regular midwifery staffing report (due October 2023)	n/a	To take assurance from the suite of reports and Committee discussions Note the split of information between Public and Private Board from September 2023

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Infection Prevention & Control (IPC) Quarterly Report	Overview of IPC performance and activities during Quarter 1 (April-June) 2023/24	Partially assured – noting risks as outlined below	'Back to Basics' campaign including a focus on screening regimes, acting on suspected cases and cleaning regimes	Update on vaccination programme to Executive Management Committee	n/a
National Early Warning Score (NEWS) Audit	Audit results from Quarter 4 2022/23 related to the use of the NEWS system with a focus on documentation	Assured	Trust wide audit to be considered as part of the twice yearly CQUIN report (next due September 2023) and the monthly IPR. Ongoing reporting to be presented on specific data related to the Emergency Department	n/a	n/a
Patient Experience Quarterly Report	Update on Patient Experience within Quarter 1 (April-June) 2023/24 including numbers of and learning from complaints, PALS concerns and compliments, Friends & Family Test results, an update on the Chaplaincy and Interpreting Services and a summary of the current Improvement and Patient Engagement Plans	Assured – noting performance improvements in numerical metrics within the report Drop in compliments alongside stable Friends and Family performance noted	Need to ensure a Trust wide transformational approach to themes identified within complaints across the board e.g. communication Actions required to address speciality-specific issues in a timely manner plus work preventatively to minimise the risk of these issues arising elsewhere	n/a	n/a



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Non-Executive Director (NED) Complaints Review	Overview of the Complaints Review process and summary of the outputs from the review undertaken in May 2023 (focus on Emergency Department)	Assured – recognising this as a more qualitative report alongside the quantitative quarterly Patient Experience reporting in place	Offline discussion to ensure joined up patient experience reporting noting the benefits of an external lens on complaints and closing the loop on actions set following complaints – to maximise the use of Datix in this area	n/a	n/a
Equality Quality Impact Assurance (EQIA) Assurance Report	Update on the EQIA process and projects reviewed (including those approved/not approved) between February-July 2023	Assured – improvements in the process welcomed and commended by the Committee	None	n/a	n/a
Infection Prevention & Control (IPC) Annual Report	Summary of actions taken in the prevention and control of Healthcare Associated Infections (HCAI) during 2022/23	Noted – recognising imminent staffing changes within the IPC team	None	n/a	To note
Care Quality Commission (CQC) Report	Final report following the unannounced CQC inspection into the Paediatric Emergency Department	Noted – including the summary of both positive feedback from the CQC and required 'Must Do/Should Do' actions	Feedback to be provided to the family following the inspection noting this was triggered by a concern related to early recognition of sepsis	Action plan to be signed off by the Executive Management Committee	To note



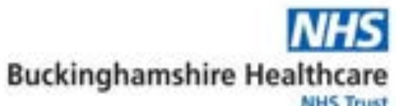
Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Quality & Patient Safety Group Minutes	Minutes of the meeting on 29 June 2023	Noted	Work to improve medical attendance at the Committee	n/a	n/a
AOB	Thanks provided to Head of Nursing for Infection, Prevention and Control ahead of her leaving the Trust				

Emerging Risks noted:

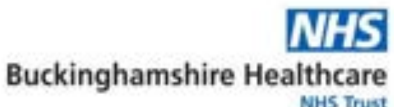
- Longstanding gap in the Fracture Liaison Service noting work planned with the Acute Provider Collaborative to address this.
- Gap in community nursing workforce within specific Trust locations (e.g. Marlow) alongside national challenges in attracting nursing colleagues to this area of work. A significant number of Trust initiatives noted to be in place to support improvements and were recognised by the Committee.
- Ongoing risk related to midwifery staffing (current vacancy rate 27-28%) noting escalation processes and mitigations in place (already reflected within Corporate Risk Register, CRR)
- Infection Prevention & Control risks including:
    - Waning immunity within population and limited national vaccination strategy/campaign this year (recognising this is reflected within the IPC Board Assurance Framework).
    - Current COVID-19 numbers and risk of winter surge alongside potential for early flu.
    - Capacity challenges particularly with added escalation beds throughout the year but particularly during winter months.
    - Ongoing risk related to the estate, specifically ventilation and availability of side rooms.

Report from Chair of Strategic People Committee (SPC)
Date of Committee 11 September 2023

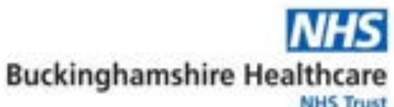
Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the Strategic Workforce Committee meeting on 10 July 2023	Approved subject to minor amendments	None	Refer to Audit Committee for noting	n/a
Chief People Officer Report	Update on key people developments since the previous Committee meeting (July 2023)	Assured	Continue to plan for the upcoming industrial action and celebrate our colleagues	n/a	n/a
NHS Long Term Workforce Plan	Summary of the NHS Long Term Workforce Plan and next steps	Assured – the Committee welcomed the summary report produced and noted the three priority areas: 1. Train 2. Retain 3. Reform	Report back to the Committee in six months with measurable actions (including targets where possible), action owners and timescales for BHT's top priorities	n/a	n/a



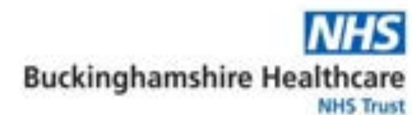
Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Public Sector Equality Duty (PSED) Report	Annual Report for 2022/23 including an overview of activities related to: - Workforce Race Equalities Standard (WRES) - Workforce Disability Equalities Standard (WDES) - Gender Pay Gap (GPG)	Approved – noting the new objectives	Consider how the Trust can create and publish a 'good news story' in relation to the successes in attracting such a diverse workforce	n/a	To note
Addressing Violence & Aggression	Update on work underway to prevent, manage and support those involved in incidences of racism, violence, sexism, aggression and psychological safety issues	Assured	Continue with the agreed plan and ensure focus is maintained	n/a	n/a
Freedom to Speak Up Guardian (FTSUG) Quarterly Report	Quarterly report for 2023-24 (Q1; April-June 2023) including national and local updates, key themes and next steps	Assured	Consider what the Trust can do to increase the focus on patient safety Introduce lessons learnt from other sectors e.g. aviation	n/a	n/a



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Guardian of Safe Working Hours (GSWH) Report	Quarterly Report for 2023-24 (Q1; April-June 2023) including exception reports, issues raised and next steps	Assured	None	n/a	To note
Employee Relations Update	Overview of employee relations cases arising from the following policies during Q4 2022/23 and Q1 2023/24: - Standards of Behaviour & Conduct - Maintaining High Professional Standards - Grievance - Dignity & Respect at Work	Assured	Continue to issue this useful and informative report	n/a	To note (to close relevant action)
Staff Survey	Update on planning for the 2023 survey including areas for focus and proposed communications plan	Assured	Development of plan to increase medical participation Aim for 60% response rate for next survey Consider ‘peer to peer’ trolley dashes	n/a	n/a



Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Colleague Story	The voice of 'Head of Careers' and a student from Holmer Green School	Assured – inspired by the story	Consider inviting the speakers to present at a forthcoming Board meeting to share the progress so far	n/a	n/a
People Directorate Risk Register	Review of 'People' risks within divisional and corporate risk registers and update on Internal Audit work ongoing	Assured – noting risk score relating to Industrial action	None	n/a	n/a
Transformation Objectives	Update on Trust Breakthrough Objectives related to People	Assured	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 July 2023 data presented within formal IPR with verbal update for August 2023	Committee assured following further improvements in: - Overall vacancy rates - Turnover rates - Average time to replace vacancies	None	n/a	To note content and Committee discussions



Emerging Risks Identified:

- Upcoming industrial action.

Report from Chair of Charitable Funds Committee (CFC)
Date of Committee 25 August 2023

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Minutes of the previous meeting(s)	Minutes from the meeting on 26 May 2023	Approved	n/a	n/a	n/a
Scannappeal Funded Bids	Summary of purchases transacted through the Charity, noting 'pass-through' costs	Noted – recognising significant contribution made by Scannappeal and small financial risk related to the processes in place	Consider whether a change in process is required Forward plan for activities funded by the Trust Charity	n/a	Highlight contribution of Scannappeal to Board
Key Worker Accommodation Investment	Update re alternative funds through BHT available for this project; Charity will no longer pursue investment	Noted	None	n/a	To note

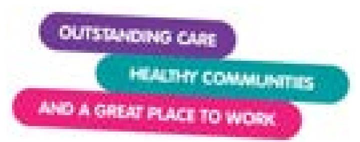
Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Bids for Approval; Replacement Patient Monitoring, National Spinal Injuries Centre	Replacement monitoring equipment on St Andrews and St Patricks Wards offering advanced functionality and improved patient experience	Approved in principle – recognising further work required on sources of funding	Review wording within the Management of Charitable Funds Policy & Procedure (BHT Pol 063) to ensure this supports appropriate stewardship of Charitable Funds for enhanced patient benefit and is fully aligned with national guidance Ongoing work to review and streamline restricted and unrestricted funds available	n/a	Note recommendation to Board (as Corporate Trustee)
Bids for Approval; Replacement Patient Monitoring, Emergency Department	Replacement patient monitoring equipment within Resus offering advanced functionality supporting improved patient safety				
Bids for Approval; Theatre Anaesthetic Equipment	Replacement anaesthetic machines and associated patient monitoring equipment to support enhanced patient safety				
Bids for Approval; Fetal Heart Monitors	Replacement monitoring equipment within maternity services to ensure compliance with best clinical practice	Approved in principle (full/part support) –with the option to revert to Scannappeal funding later in the year			

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Charitable Funds Activity & Financial Statements	Overview of financial, operational and governance information related to the Charitable Fund as at 30 June 2023	Assured – noting the proposed change in volunteer mileage payments	None	n/a	n/a
Cazenove; Portfolio Investment Report	Update on value of the current investment portfolio as of 30 June 2023 Committee discussion related to pending investment review	Partially assured – noting concerns related to performance over past 3 years	Provision, by Cazenove, of executive summary which addresses Committee concerns and mitigating actions Options appraisal with recommendations for investment manager review	n/a	n/a
Fundraising & Engagement	Update on fundraising and engagement activity in 2023/24, future opportunities and next steps	Noted – including the excellent work and visibility of the team	Further information provided to the Committee on the breast cancer appeal Consider the use of Charity Champions	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
AOB; Training Opportunity	Request for part funding for training course for Neurology medic	Approved	Review of delegated limits (underway)	n/a	n/a

Emerging Risks:

- Investment portfolio performance, noting the long-term nature of the target and potential to achieve proposed return.



Meeting: Trust Board Meeting in Public

26 September 2023

Agenda item	Integrated Performance Report – For Review	
Board Lead	Raghuv Bhasin, Chief Operating Officer	
Type name of Author	Wendy Joyce, Director of Performance	
Attachments	Trust IPR August 2023	
Purpose	Information	
Previously considered	n/a	

Executive Summary

Attached to this paper is the Trust's Integrated Performance Report for review ahead of submission to the Public Board.

This report was discussed at The Trust's Transformation Board on 20 September 2023 alongside detail on elective recovery which is presented to the Committee in parallel.

Key points made in discussion include:

Recognition of the progress that has been made on Urgent and Emergency Care performance through the delivery of the Urgent and Emergency Care Improvement plan which has impacted across the pathway

Noting the improvement in 62-day cancer performance which has been driven in part by reducing our 62-day backlog position over the past year.

Recognition of the positive position on our quality indicators and particularly the low levels of C.Difficile

The importance of productively increasing elective capacity, particularly new outpatients, as rapidly as possible to reduce waiting times for patients

Continued strong progress on our people metrics across the Trust.

Decision	The Committee is requested to consider performance and risk impact

Relevant Strategic Priority

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

Relevant objective

☒ Improve waiting times ☒ Improve safety ☒ Improve productivity	☒ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☒ Upskill operational and clinical managers

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 Select an item. Select CQC standard from list.	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

August 2023

CQC rating (July 2022) - GOOD

Integrated Performance & Quality Report

Introduction & Contents

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

The contents of the report are defined by the 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

- ED performance trajectories
- Elective length of stay
- Cancer 31 day performance

Removed

- 21 day LOS - Acute
- Cancer 2 week wait

Changed

- 78 week RTT waits benchmarking changed to 65 week wait
- Cancer 2 week wait benchmarking changed to Faster Diagnosis standard

Integrated Performance & Quality Report

Executive Summary

August saw an improvement across our Urgent and Emergency Care indicators as some of the measures put in place through the Urgent and Emergency Care Improvement Plan started to impact after implementation and a period of bedding in.

In particular the Trust returned to trajectory for overall and type 1 performance and continued to deliver ahead of trajectory for 12 hour waits in ED. In particular it is worth noting the continual reduction in the number of days 'lost' for MOFD patients and the increase in volumes in SDEC. Further actions including the opening of our new Clinical Decision Unit at the start of October and Transfer of Care Hub in mid-October are planned to build on this momentum and further increase performance and resilience ahead of the winter months. The Trust's winter plan will be presented to the Board in October.

Cancer performance has also increased across both the 28 Faster Diagnosis Standard and 62-days to treatment, where we are now 4th in the region having been 16th a year ago. There remain challenges in delivery particularly around Dermatology and Urology (Prostate) with improvement plans in place to drive resilient performance and continuing to reduce waiting times for patients. It is worth noting that whilst we seek to safeguard cancer care during Industrial Action there is an impact on our cancer pathways particularly in specialties with a heavy emergency workload and/or colleagues who also work at Oxford given the large volume of emergency cover needed there. Diagnostic performance has stabilised with some improvements made in Endoscopy. A trajectory has been agreed for delivery which shows slight improvement over the course of the year recognising the significant costs of further reducing diagnostic waits and constrained financial environment.

Elective performance is challenged and the Board is receiving an elective recovery update. We are 10% behind our activity plan which is driven by Industrial Action impact (c.40% of the gap), unplanned theatre closures due to estates issues (c.30% of the gap) and internal productivity gaps (c.30% of the gap). This gap to our activity gap has reduced from 18.5% behind plan to 8% behind plan for elective activity between M1 and M5 and 21% behind plan to 11% behind plan for outpatient activity between M1 and M5. We are also seeing continued improvements in theatre utilisation and average cases per list. There now needs to be a relentless focus on seeing new outpatients who may be at risk of 65 week breaches by the end of March so as to start their onward treatment (if necessary) as well as validation which is the fundamental tenet of our elective recovery plan. This may require additional funding to be balanced off against the financial pressures we are facing.

With regards to Quality we continue to perform well on our Hospital Standardised Mortality and have sustained improvements in complaint response timeliness. Our falls rate remains below the set target and there has been a reduction in inpatient falls since September 2022. It is also important to note the low rates of C.Difficile which has been a significant focus of our antimicrobial resistance team in pharmacy as well as engagement on our wards. There was a sharp increase in preterm birth rates in August 2023 with the key drivers being abnormal fetal heartrate and placental abruption.

Looking at Healthy Communities we now have measures to reflect all of our breakthrough objectives and are establishing trajectories for these. It is important to note that we are already achieving the frailty identification in ED breakthrough objective and are now working across ED and Medicine for Older People to consider how we act differently based on these frailty scores. There has been further good progress on feeding with breastmilk at discharge and continued delivery of the health visitor appointment at 14 days.

Turning to a Great Place to Work we continue our focus on recruitment and retention of our colleagues. This is having a positive impact on our people metrics, with vacancy rates reducing for the fifth month in a row and turnover continuing to fall, consistently since Jan 22. We are also recruiting current bank and agency staff into our substantive workforce vacancies, to support the reduction of temporary staffing programme of work. Improving the overall starting experience for colleagues joining BHT, through both recruitment and induction initiatives, is an aspect of our retention work and we are introducing more opportunities for connecting and listening events for all our colleagues during their first year.
The numbers of referral into the OH&WB team increased in month and our overall sickness is slightly above threshold. The anticipated further rise in respiratory conditions this winter is being mitigated by an early launch of the Flu and Covid vaccination programme. An emphasis on the importance of each of our responsibilities to create a culture in which all colleagues feel safe to speak up and that they feel confident that their concerns would be addressed has been shared widely this month.

We have increased coverage of productivity in the IPR to reflect the work ongoing in the Trust. This is still in development but included is the NHS England measure of productivity as well as internal supporting measures. Important to note the improvements that are being made on length of stay in our acute and community beds and also the continued increased volume of work in theatres. The next steps are to break down the productivity analaysis to individual team level to support interrogation of where there is variance and actions to recover the position. As part of this we will also assess the impact of Industrial Action and Theatre closures on productivity losses.

The Board should note further improvements that have been made to the presentation of the IPR which include a summary slide of our breakthrough objectives; clearer reporting against trajectories and action plans and increased number of indicators in certain areas. The IPR will continue to evolve however the presentation form is now largely set. Feedback is welcome on content and structure

Integrated Performance & Quality Report

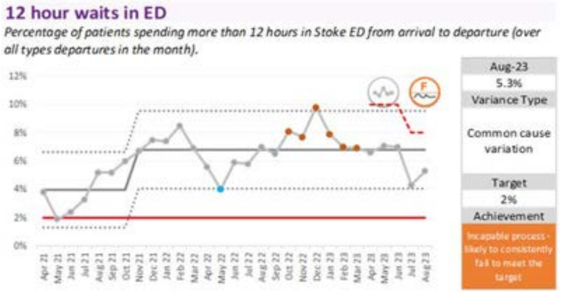
Breakthrough objectives

Buckinghamshire Healthcare NHS Trust

Outstanding Care

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).



Clinical Accreditation Programme

The total number of accreditation assessments completed in month.

Overall NHSE measure of productivity

Comparison between the cost base and weighted activity provided in our acute settings in 23/24, against equivalent periods in 19/20.

Healthy Communities

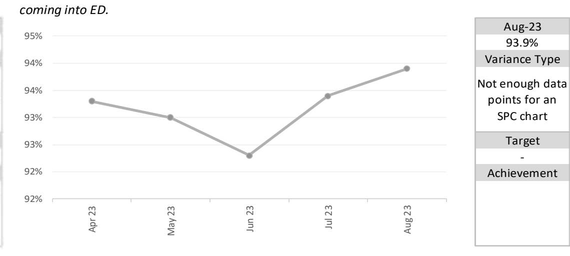
Cardiology referrals from deprived wards

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

Maternity smoking at time of delivery

Frailty

Patients aged 65+ coming into ED having a documented frailty score, over all patients aged 65+ coming into ED.



Place to work

Leavers < 1 year service

Number of leavers with <1 year service with BHT. Rolling 12 months.

Peaks programmes

Number of managers participating in Peaks programmes.

Peak 1 – face-to-face Cohort 4
Day 1 was scheduled and delivered, with 38 managers attending and graduating beginning of September.

Peak 2 – virtual
There was 1 module scheduled in August attended by 1 manager.

Peak 2 – face-to-face
There was no face-to-face cohort scheduled in August. The next cohort is scheduled for September with 25 managers enrolled.

Peak 3 Cohort 1
There was no module scheduled in August.
The first cohort, 18 participants, will be graduating on 13th September.

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.

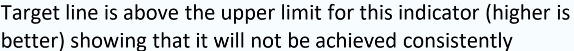
However, there are certain patterns of new results which it is unlikely will have occurred randomly if nothing has changed on the ground. For example a run of several points on one side of the average or a significant change in the level of variability between one point and the next.

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.

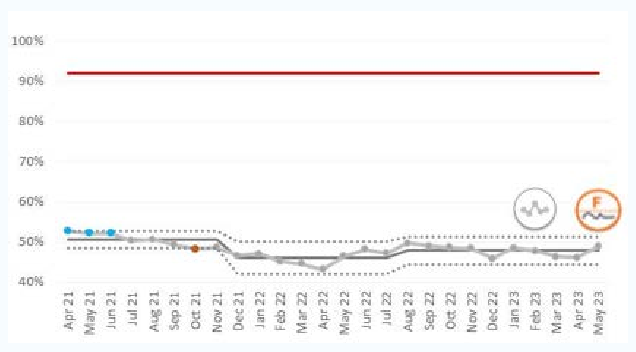
Likewise, if there is no change in overall average result or variability this suggests that actions taken to improve performance have not had the desired effect.

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

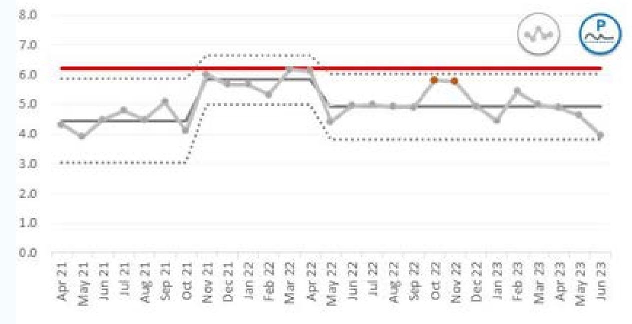
Target lines are also plotted on the charts. This allows users of the charts to see whether targets can be expected to be achieved consistently, whether achievement in the current month is due to common cause or special cause variation or whether the target cannot be achieved unless there is a change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



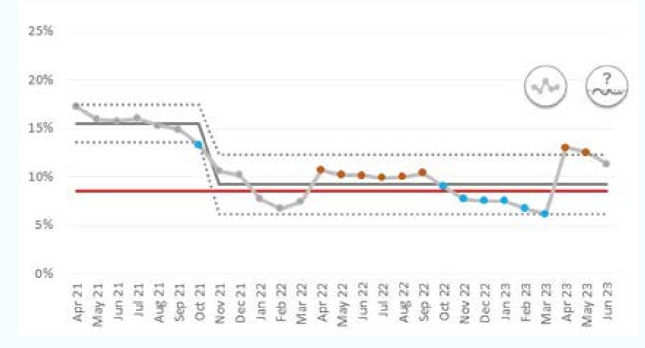
Target line is above the upper limit for this indicator (higher is better) showing that it will not be achieved consistently



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

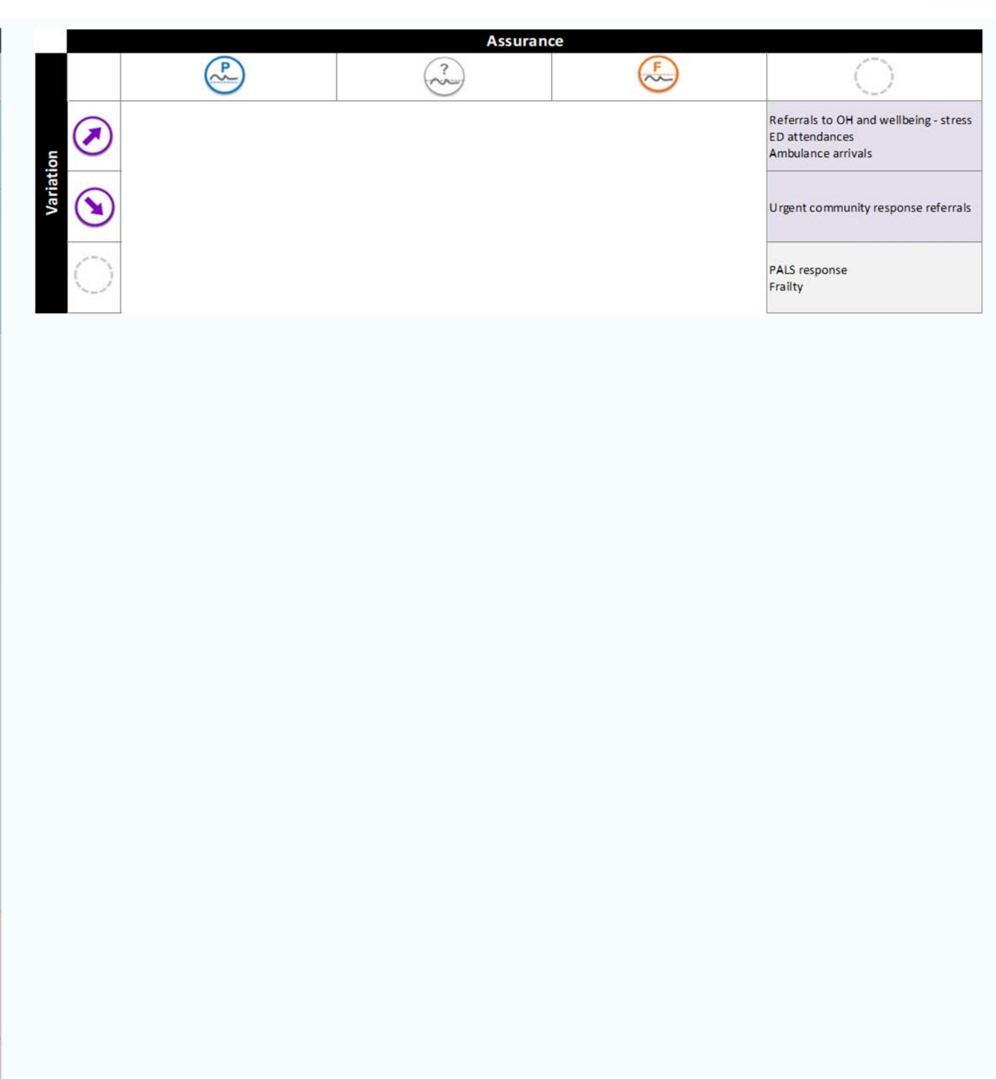
	Assurance			
Variation/Performance	P	?	F	
H	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** **Celebrate and Understand** • 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	**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.
	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	**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	**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.
				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.
				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.
				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

Overall Performance Summary

Buckinghamshire Healthcare NHS Trust

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (none)
H (improvement)		Early Warning Score Breastfeeding at discharge Statutory & Mandatory training	Theatre utilisation Cancer wait times - 31 day to first treatment Data security awareness training	Health Visitor appointment - 14 days
L (improvement)	Pre term birth < 24 weeks		Ambulance handovers over 60mins Cancer waiting times - 104 day waits Complaints outstanding at 90 days	Medically optimised for discharge bed days lost Community hospitals avg LOS Cancer wait times - 62 day waiters Leavers <1 year service Sickness - mental health
Common cause	Falls per 1,000 bed days HSMR VTE assessment Term birth <10th centile Corporate induction	ED 4 hour type 1 performance Reduce OP follow up Cancer screening Faster dianosis standard (28 days) Incidents that are low/no harm Medication incidents as SIs SIs declared as never events MRSA bacteraemia Clostridioides difficile 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 booking Maternity smoking at time of delivery Breastfeeding at birth Trust overall vacancy rate Nursing and midwifery vacancy rate Average time to replace vacancies Occupational Health management referrals	ED 4 hour performance 12 hour waits in ED Ambulance handovers within 15 & 30 mins Acute open pathway performance Acute open pathway 65 week breaches Theatre cases per planned time Outpatient DNA rate Cancer performance 62 day pathway Diagnostic compliance Endoscopic patients waiting > 6 weeks	Number of patients seen in SDEC Medically optimised for discharge patients Discharges by 5pm 14 day LOS Occupancy Urgent 2 hour response Cancelled elective operations Elective activity New OP 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 Cardiology referrals from deprived wards Breastfeeding at 6-8 weeks
H (concern)			Acute open pathway 52 week breaches Non endoscopic DM01 breaches	Acute waiting list size Mean waiting time for first OP appointment Community waiting list 52 week breaches Community waiting list 65 week breaches
L (concern)			Senior decision maker seen within 60 mins	

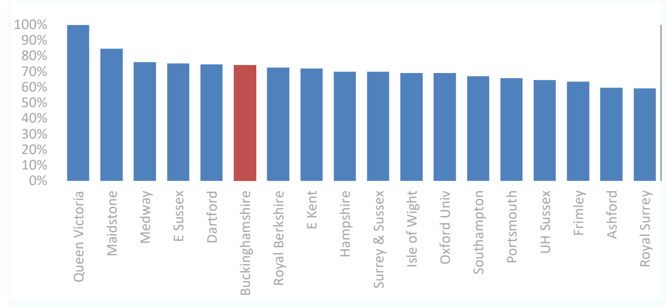


Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (none)
Upward				Referrals to OH and wellbeing - stress ED attendances Ambulance arrivals
Downward				Urgent community response referrals
(none)				PALS response Frailty

Integrated Performance & Quality Report

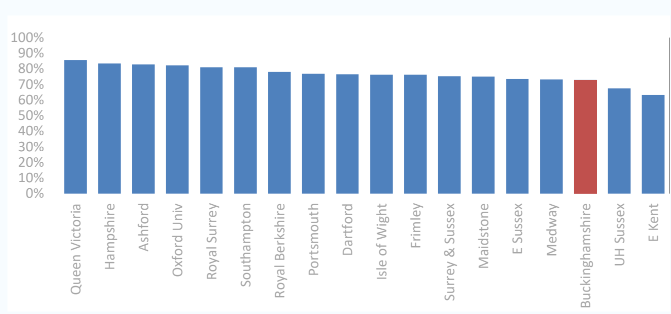
ED 4 hour performance

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



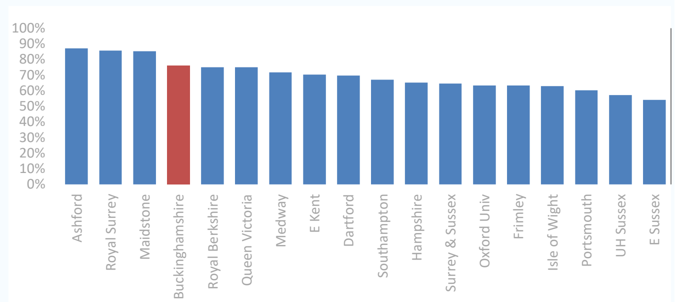
Faster diagnosis standard cancer

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



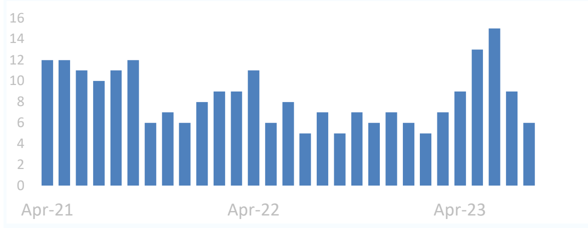
62 day wait cancer

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



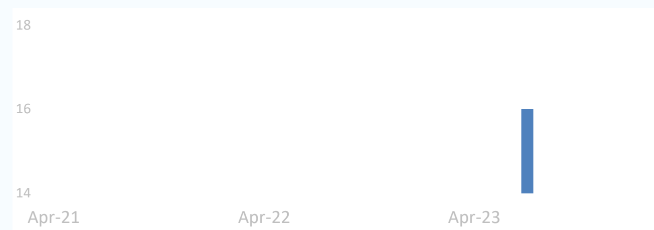
ED 4 hour performance ranking

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



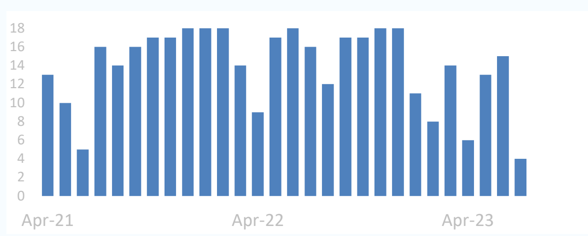
Faster diagnosis standard cancer

South East region faster diagnosis standard 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.

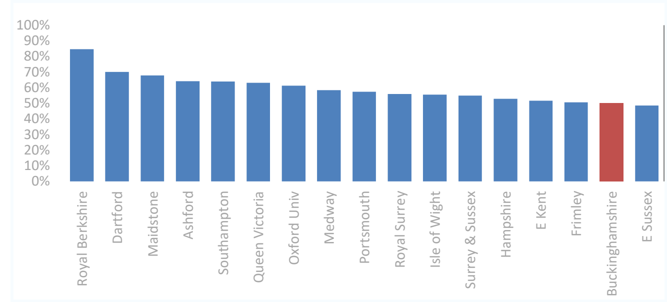
Source: NHS England - https://www.england.nhs.uk/statistics/statistical-work-areas/

Integrated Performance & Quality Report

Benchmarking Summary for South-East Region

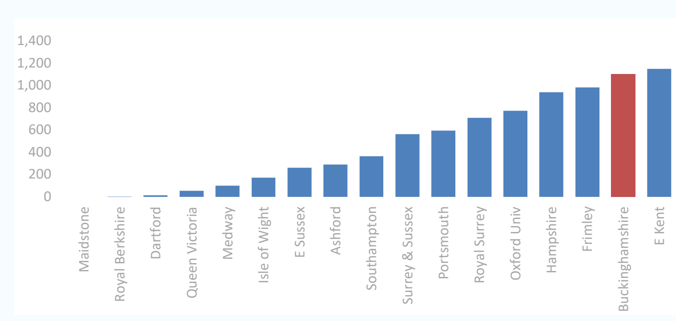
RTT performance

South East RTT performance benchmarking - Jul-23



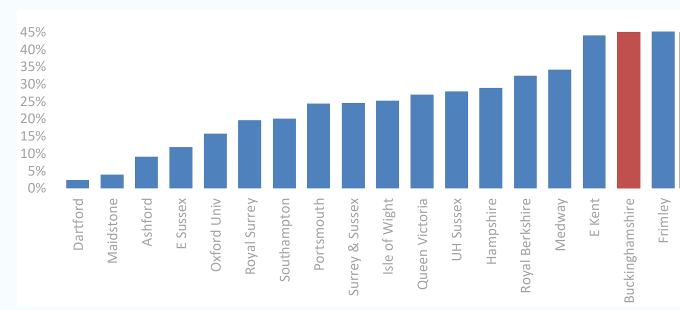
65 week waits

South East over 65 week waits benchmarking - Jul-23



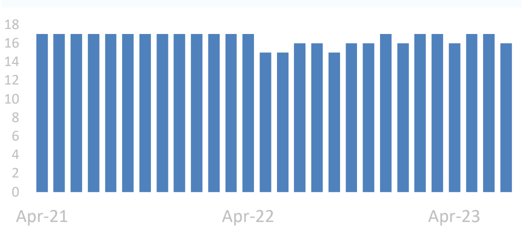
Diagnostic performance

South East diagnostic performance benchmarking - Jul-23



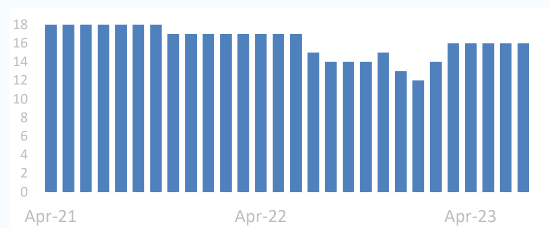
RTT performance ranking

South East RTT performance benchmarking - historic rankings currently out of 18



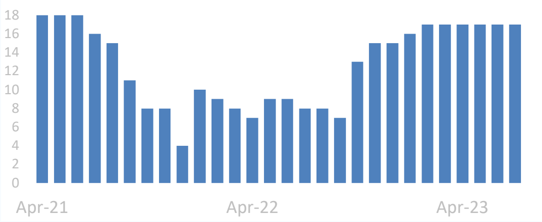
65 week waits ranking

South East over 65 week waits benchmarking - historic rankings currently out of 18



Diagnostic performance ranking

South East diagnostic performance benchmarking - historic rankings out of 18



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

Outstanding Care

Operational Standards - Urgent Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
ED 4 hour performance	Aug 23	73.9%	95.0%			72.4%	66.4%	78.4%
ED 4 hour type 1 performance	Aug 23	62.1%	-			60.4%	52.7%	68.1%
12 hour waits in ED	Aug 23	5.3%	2.0%			6.8%	4.0%	9.6%
ED attendances	Aug 23	13081	12170			12677	10252	15102
Senior decision-maker seen within 60 minutes	Aug 23	25.5%	100.0%			29.5%	17.4%	41.6%
Number of patients seen in SDEC	Aug 23	1601	-			1551	1236	1865
Number of admissions - conversions from attendance			-					
Ambulance handovers within 15 mins	Aug 23	35.2%	65.0%			35.1%	17.8%	52.5%
Ambulance handovers within 30 mins	Aug 23	85.2%	95.0%			83.2%	73.9%	92.4%
Ambulance handovers over 60 mins	Aug 23	57	0			89	13	164
Ambulance arrivals	Aug 23	2079	-			2049	1811	2286
Urgent 2 hour response - community	Jun 23	85.1%	-			85.8%	75.8%	95.8%
Urgent community response referrals	Aug 23	321	-			368	300	437
Medically optimised for discharge patients	Aug 23	92	-			100	71	129
Medically optimised for discharge bed days lost	Aug 23	2505	-			3153	2398	3908
14 day LOS - acute	Aug 23	129	-			146	110	182
Occupancy	Aug 23	95.6%	-			92.8%	81.0%	104.6%
Discharges by 5pm	Aug 23	48.6%	-			49.3%	44.7%	54.0%
Average LOS - community hospitals	Aug 23	15.6	-			20.7	14.1	27.4

What the charts show us

ED 4 hour performance: This metric is experiencing common cause variation i.e. no significant change. 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.

ED attendances: This metric is experiencing special cause variation of neither an improving nor a concerning nature with the last six data points falling above the central line.

Senior decision maker seen within 60 minutes: This metric is experiencing special cause variation of a concerning nature with the last ten 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 eight 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.

Ambulance arrivals: This metric is experiencing special cause variation of neither an improving nor a concerning nature with the last six data points falling above the central line.

Urgent community response referrals: This metric is experiencing special cause variation of neither an improving nor a concerning nature with the last two out of three data points falling close to the lower control limit.

Medically optimised for discharge bed days lost: This metric is experiencing special cause variation of an improving naturing with the last two out of three data points falling close to the lower control limit.

Average LOS - community hospitals: This metric is experienceing special cause variation of an improving naturing with the last two out of three data points falling close to the lower control limit.

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

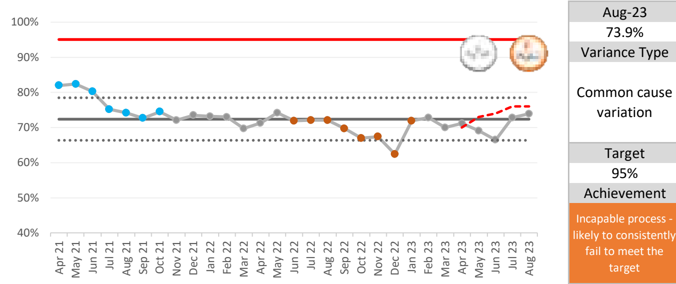
Outstanding Care

Buckinghamshire Healthcare NHS Trust

Operational Standards - Urgent Emergency Care

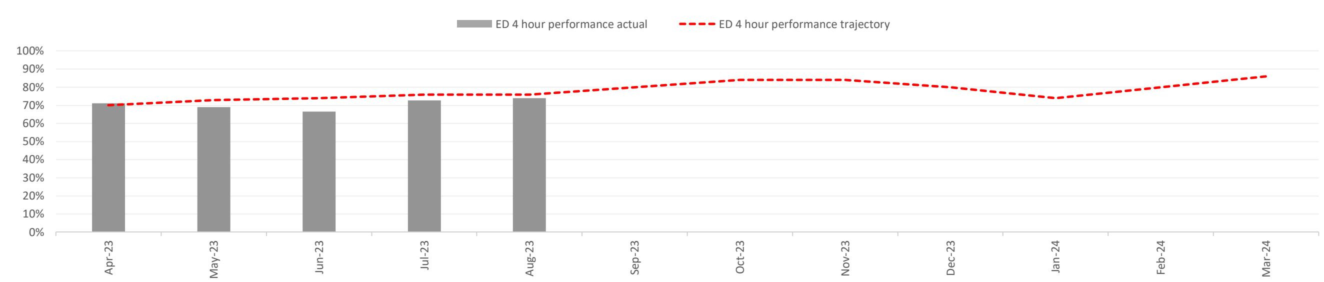
ED 4 hour performance

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



Aug-23
73.9%
Variance Type
Common cause variation
Target
95%
Achievement
Incapable process - likely to consistently fail to meet the target

ED 4 hour performance trajectory



Summary:

This metric is experiencing common cause variation i.e. no significant change.

The target lies above the current control limits and so cannot be achieved unless something changes in the process.

The trajectory lies within the current control limits and so the metric will consistently hit or miss the trajectory.

Actions to achieve trajectory:

T**1st September 2023:** UTC Pathway 24/7 including 111 direct bookings and cultural change initiatives. Expectation: 5% less ED attendances.

8th October 2023: Clinical Decision Unit Live. Expectation: 19 additional spaces (beds and reclining chairs) available to ED to support flow.

16th October 2023: Transfer of Care Hub opens with the council to manage all discharges.

23 October 2023: Olympic Lodge opens with 22 additional beds

6 November 2023: Single Point of Access to provide clinical triage across all admission pathways starts

1st December 2023: Anticipated impact of winter pressures including higher volume of respiratory presentations.

1st January 2024: Anticipated impact of winter pressures including higher volume of T&O presentations.

1st February 2024: New 21-bedded ward opens. Expectation: Additional Acute Medical capacity to support flow.

21st February 2024: Anticipated reduction in winter pressures.

8th March 2024: Anticipated further reduction in pressures and improvement in flow.

Assurance:

The Type one and overall, 4-hr performance has seen a sustained improvement in the last two reporting periods.

The UTC pathway went live 24/7 on the 24th of July 2023 and in the same period Same Day Emergency Department (SDEC) extended hours to midnight, early analysis suggests a positive impact on this key indicator demonstrating improvement in performance and supporting flow with patients seen in the right place fist time.

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 next key step in the programme is the opening of a 12 bedded and 12 chaired Clinical Decision Unit on 2 October to expand capacity further in ED.
This programme has a number of key deliverables over the coming months to drive further improvement led by the Urgent and Emergency Care Board chaired by the Chief Nurse.

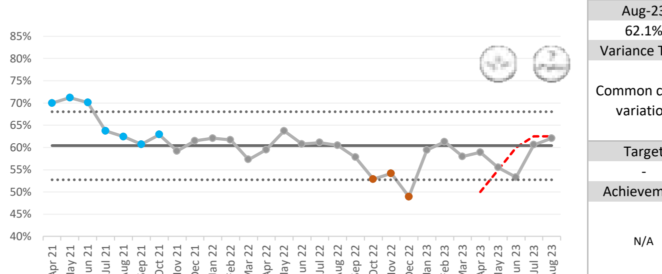
Outstanding Care

Operational Standards - Urgent Emergency Care

Buckinghamshire Healthcare NHS Trust

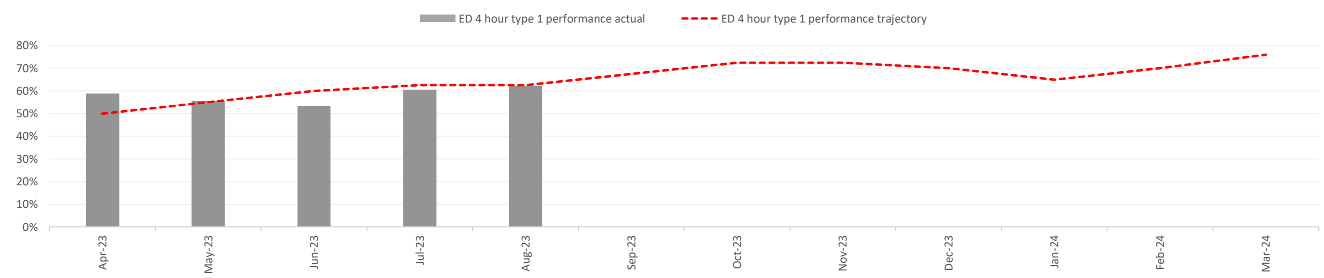
ED 4 hour type 1 performance

The percentage of patients spending 4 hours or less in ED type 1 from arrival to departure over all types of in month departures from ED type 1.



Aug-23
62.1%
Variance Type
Common cause variation
Target
-
Achievement
N/A

ED 4 hour type 1 performance trajectory



Summary:

This metric is experiencing common cause variation i.e. no significant change.

The trajectory lies within the current control limits and so the metric will consistently hit or miss the trajectory.

Actions to achieve trajectory:

1st September 2023: UTC Pathway 24/7 including 111 direct bookings and cultural change initiatives. Expectation: 5% less ED attendances

.

17th September 2023: New Consultant rota in place following recruitment. Expectation: Additional 1 patient seen per consultant per hour.

8th October 2023: Clinical Decision Unit Live. Expectation: 19 additional spaces (beds and reclining chairs) available to ED to support flow.

1st December 2023: Anticipated impact of winter pressures including higher volume of respiratory presentations.

Assurance:

A significant programme of work is underway to support improved Type 1 ED performance through the Urgent and Emergency Care Board described above. Tis is paired with a ten-point action plan agreed with the ED Leadership Team that is overseen through weekly meetings with the Chief Operating Officer.

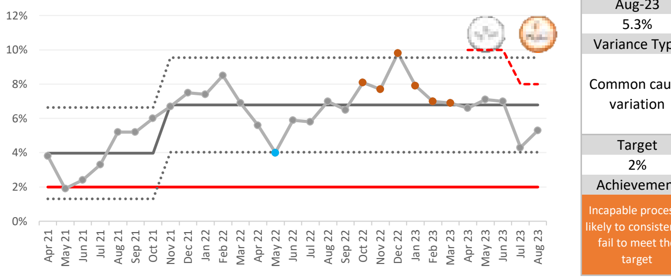
Outstanding Care

Buckinghamshire Healthcare NHS Trust

Operational Standards - Urgent Emergency Care

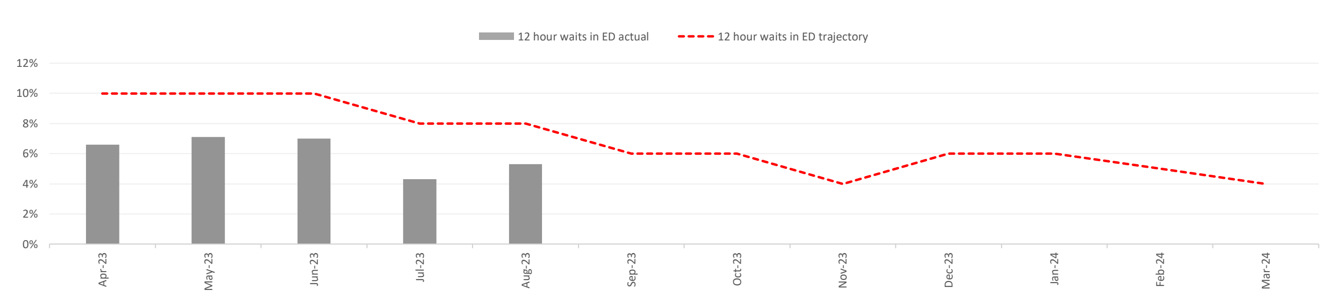
12 hour waits in ED

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



Aug-23
5.3%
Variance Type
Common cause variation
Target
2%
Achievement
Incapable process - likely to consistently fail to meet the target

12 hour waits in ED trajectory



Summary:

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.

The trajectory lies within the current control limits and so the metric will consistently hit or miss the trajectory.

Actions to achieve trajectory:

1st September 2023: Cultural change initiatives. Expectation: 10% target with reduction in 12-hr waits.

8th October 2023: Clinical Decision Unit Live. Expectation: 19 additional beds available to ED to support flow.

1st November 2023: New Consultant rota in place following recruitment. Expectation: Additional 1 patient seen per consultant per hour to reduce long waits.

1st December 2023: Increase in Virtual Ward capacity to support respiratory and the Hot Clinics Expectation: Will support flow and reduce waits.

1st February 2024: New 21-bedded ward opens. Expectation: Additional Acute Medical capacity to support flow and reduce waits.

1st March 2024: Maintain management of pressures and improvement in flow.

Assurance:

In the last reporting period, we have seen a deterioration in the number of 12hr stays in ED but remains in trajectory.

Our ambition is for this to continue to improve further and consistently be within a 4% threshold, this is supported with our improvement works through the overall UEC improvement programme and particularly the Clinical Decision Unit opening mentioned above.

Outstanding Care

Operational Standards - Urgent Emergency Care

Seen by a Senior decision maker within 60 minutes
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. This should improve now that we are fully established in our Emergency Consultant workforce.

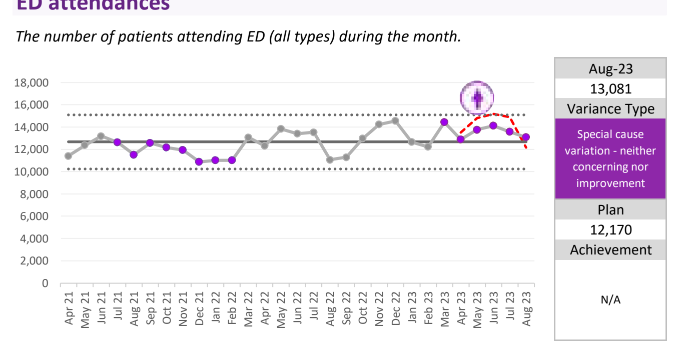
Same Day Emergency Department (SDEC)
The Same Day Emergency Department is a collaborative care delivery approach between Acute and Emergency teams.

Since June 2023 when we increased the opening hours of the Same Day Emergency Care Department as the workforce model was optimised, we have seen a consistent increase in activity going through this service.

Plans in progress to evolve the services provided with hot clinics, virtual ward pathways and a hot lab.

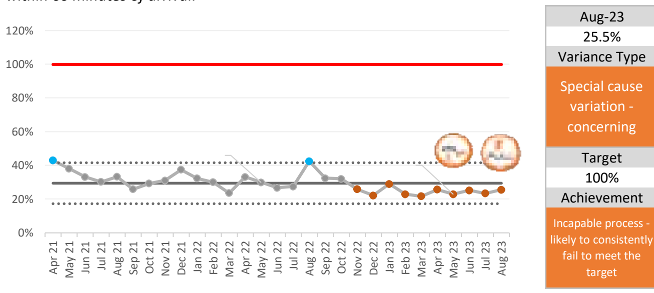
ED attendances

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



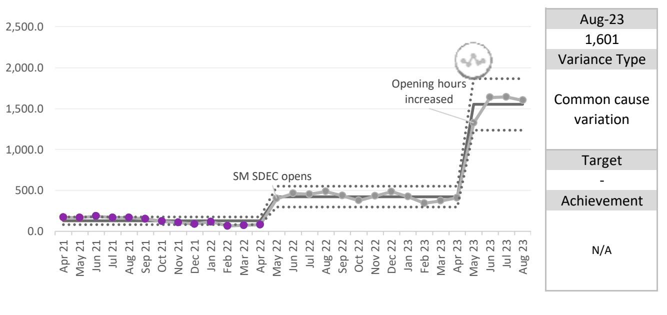
Senior decision-maker seen within 60 minutes

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

Total number of ward stay episodes on SM SDEC or SM Frailty SDEC in month.



Number of admissions - conversions from attendance

Awaiting definition

Outstanding Care

Operational Standards - Urgent Emergency Care

Buckinghamshire Healthcare NHS Trust

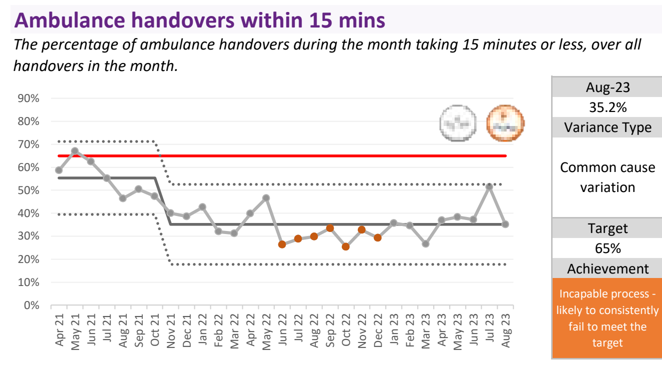
Ambulance handovers
In this reporting period ambulance conveyances to Stoke Mandeville Hospital have remained static.

All performance indicators have seen a deterioration in handover performance in this reporting period. This is aligned to challenges we have seen with higher acuity presentations and flow.

We continue to review and modify our processes and pathways. Recent rota changes due to recruitment allows the consistent allocation of a senior decision makers to this pathway to support flow.

Ambulance handovers within 15 mins

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



Aug-23
35.2%
Variance Type
Common cause variation
Target
65%
Achievement
Incapable process - likely to consistently fail to meet the target

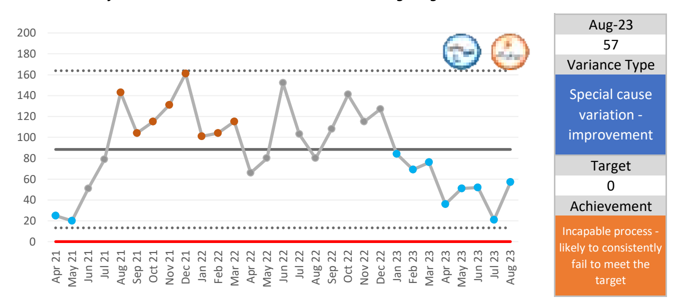
Ambulance handovers within 30 mins

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

Aug-23
85.2%
Variance Type
Common cause variation
Target
95%
Achievement
Incapable process - likely to consistently fail to meet the target

Ambulance handovers over 60 mins

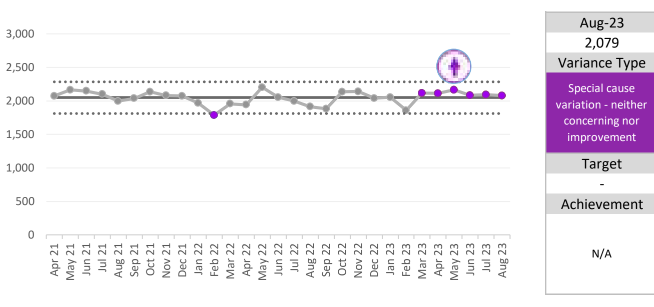
The number of ambulance handovers in the month taking longer than 60 minues.



Aug-23
57
Variance Type
Special cause variation - improvement
Target
0
Achievement
Incapable process - likely to consistently fail to meet the target

Ambulance arrivals

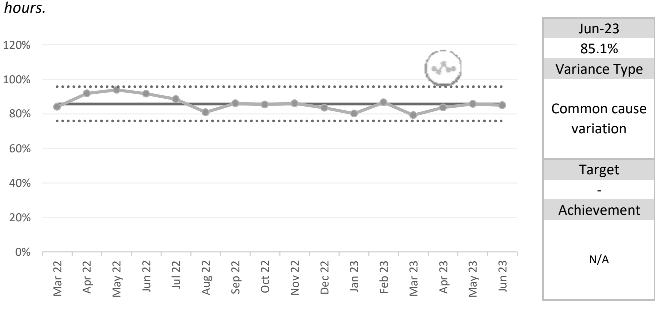
The number of ambulance arrivals at Stoke Mandeville ED in the month.



Aug-23
2,079
Variance Type
Special cause variation - neither concerning nor improvement
Target
-
Achievement
N/A

Urgent 2 hour response - community

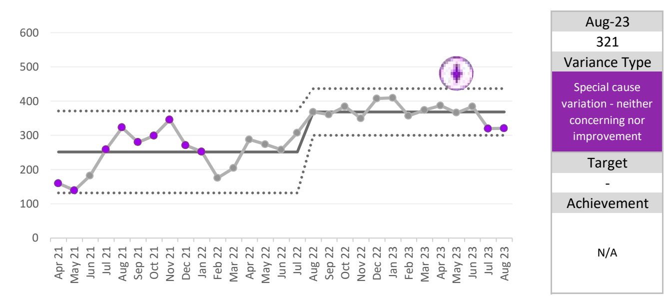
Percentage of urgent referrals (2 hour) from community services or 111 that are seen within 2 hours.



Jun-23
85.1%
Variance Type
Common cause variation
Target
-
Achievement
N/A

Urgent community response referrals

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



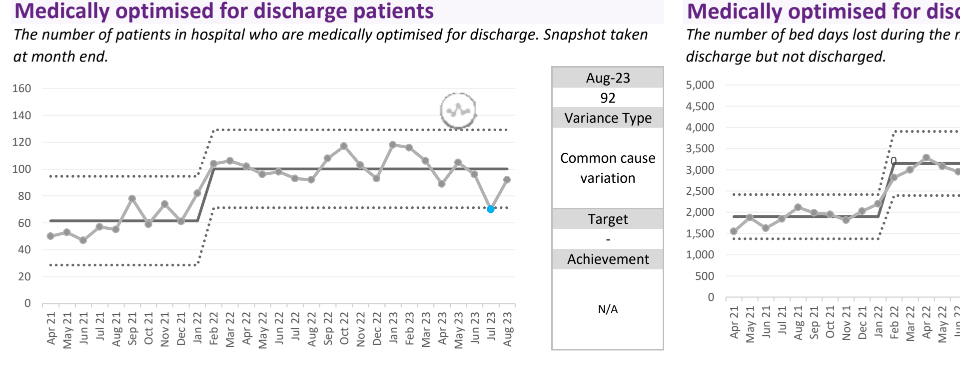
Aug-23
321
Variance Type
Special cause variation - neither concerning nor improvement
Target
-
Achievement
N/A

Outstanding Care

Operational Standards - Urgent Emergency Care

Medically optimised for discharge patients

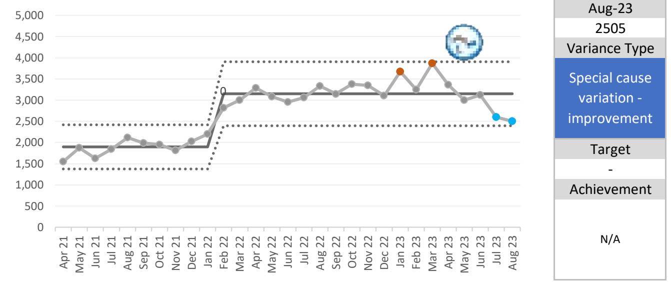
The number of patients in hospital who are medically optimised for discharge. Snapshot taken at month end.



Aug-23
92
Variance Type
Common cause variation
Target
-
Achievement
N/A

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.



Aug-23
2505
Variance Type
Special cause variation - improvement
Target
-
Achievement
N/A

Outstanding Care

Operational Standards - Urgent Emergency Care

NHS
Buckinghamshire Healthcare
NHS Trust

14 day LOS
We have seen a decrease in patients remaining in hospital >14days on the last reporting period which is linked to our overall reduction in MOFD patients.

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

A rapid improvement event is underway (to conclude at the end of October) covering all wards in Stoke Mandeville to look at ward processes and changes in detail that will drive improvement in this figure.

The introduction of the live bed boards and electronic bed management by the December will aid capturing ward processes / delays / and discharges.

Hospital at Home
At end of September 2023, H@H is on target to reach expected bed capacity as at this time in the project.

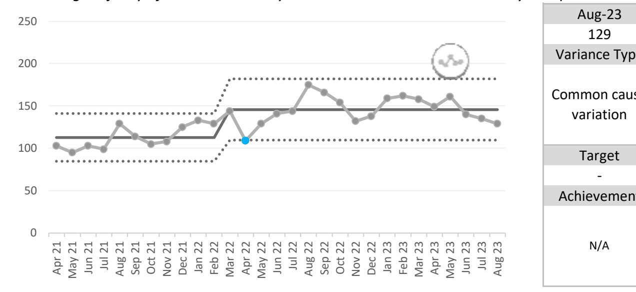
In the previous month, August 2023, bed capacity has increased to 75 beds, with >80% capacity utilisation. The project is on target to achieve Q2 target capacity of 84 by end of Sept 23

During the next two months, October and November 2023 the plan is to develop and introduce more pathways which are at present being worked on, for example; asthma and heart failure starting at the end of November 2023, , ESD stroke at the end of October 2023, paediatrics in december 2023.

In addition, clinical - Single Point of Access (Clinical-SPA) development underway, model developed awaiting signoff, Job descriptions done, recruitment plan being developed, and working towards going live beginning of Nov 23.

14 day LOS - acute

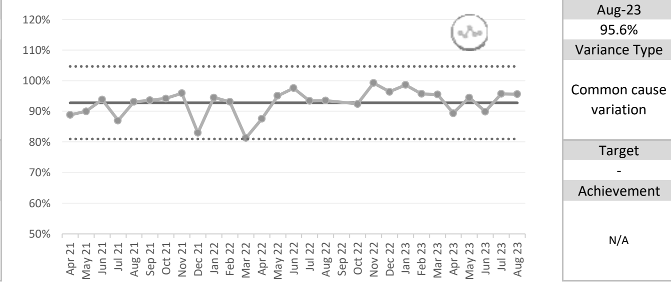
Count of patients in an acute bed (Stoke and Wycombe only) at the end of the month who have a total length of stay of more than 14 days. Based wards included in the daily Sitrep.



Aug-23
129
Variance Type
Common cause variation
Target
-
Achievement
N/A

Occupancy

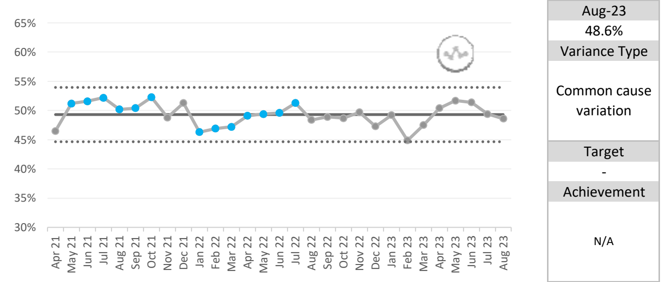
Number of patients occupying a G&A bed divided by number of available G&A beds (including escalation beds). Taken from Daily SITREP snapshots over the month.



Aug-23
95.6%
Variance Type
Common cause variation
Target
-
Achievement
N/A

Discharges by 5pm

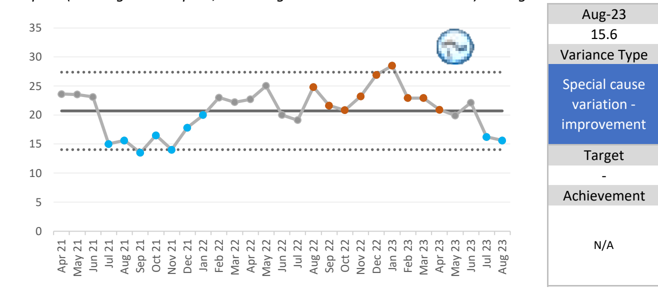
Proportion of inpatients discharged between 5am - 5pm of all discharges. Excludes maternities, deceased, purely elective wards and patients not staying over midnight.



Aug-23
48.6%
Variance Type
Common cause variation
Target
-
Achievement
N/A

Average LOS - community hospitals

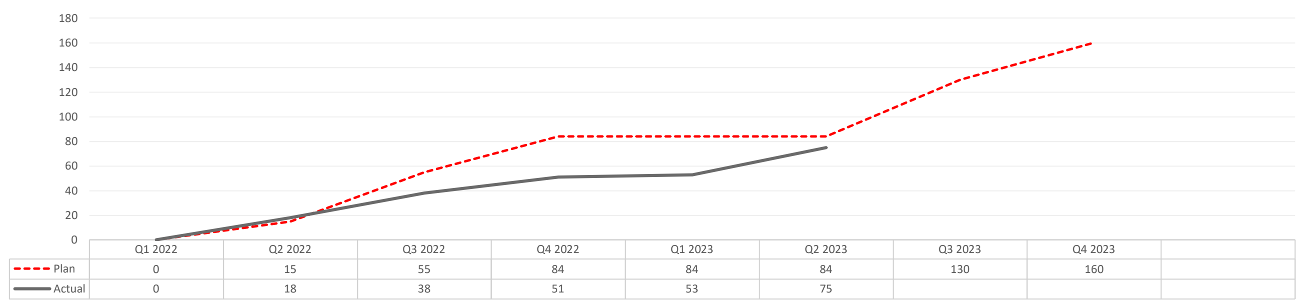
Mean length of stay in days in a community bed for patients discharged from a community hospital (Buckingham hospital, Chartridge ward and Waterside ward) during the month.



Aug-23
15.6
Variance Type
Special cause variation - improvement
Target
-
Achievement
N/A

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	53	75			

Outstanding Care

Operational Standards - Elective Recovery

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Acute waiting list size	Jul 23	46537	-			38378	36121	40634
Acute open pathway performance	Jul 23	49.9%	92.0%			48.3%	45.2%	51.3%
Acute open pathway 52 week breaches	Jul 23	4402	0			3569	2861	4278
Acute open pathway 65 week breaches	Jul 23	1101	780			1094	839	1349
Theatre utilisation	Aug 23	91.2%	95.0%			88.4%	84.5%	92.2%
Theatre cases per 4 hours planned time	Aug 23	2.7	3.0			2.6	2.4	2.8
Cancelled elective operations	Aug 23	28	-			29	-5	64
Elective activity	Aug 23	4224	4578			3846	3032	4660
Outpatient DNA rate	Aug 23	7.1%	5.0%			7.0%	6.1%	7.9%
Reduce OP follow up	Aug 23	25105	-			25511	19207	31814
Mean waiting time for first outpatient appointment	Aug 23	70.3	-			56.9	45.1	68.7
New OP	Aug 23	17905	18392			18600	14088	23113
Community waiting list size	Aug 23	15016	-			15615	14847	16383
Community waiting list 52 week breaches	Aug 23	4795	-			4793	4573	5013
Community waiting list 65 week breaches	Aug 23	4083	-			3918	3739	4096

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 two data points 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 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.

Theatre utilisation: This metric is experiencing special cause variation of an improving nature with the last two out of three data points falling close to the upper control limit. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

Theatre cases per 4 hours planned time: 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.

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.

Mean waiting time for first outpatient appointment: This metric is experiencing special cause variation of a concerning nature with the last data point falling above the upper control limit.

Community waiting list 52 week breaches: This metric is experiencing special cause variation of a concerning nature with the last seven data points falling above the central line.

Community waiting list 65 week breaches: This metric is experiencing special cause variation of a concerning nature with the seven data points falling above the central line.

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

Outstanding Care

Operational Standards - Elective Recovery

Waiting list size
The number of patients waiting for treatment continues to rise . This is not due to increasing referrals but two main factors:

- earlier clearance of referrals from the referral system to a single waiting list
- few treatments due to lower activity levels

Referrals received via the referral system eRS are electronically transferred to a single waiitng list immediately after triage. This has caused a rise in the waiting list size over recent months while current and backlog referrals are cleared.

Activity levels are rising, but have not yet returned to pre COVID levels which causes more patients to remain on the waiting list longer. This is being addressed as part of our target to reduce patients waiting over 65 weeks.

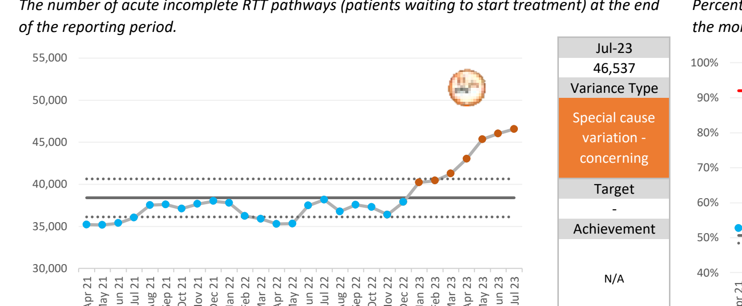
Open pathways 52 week breaches
As the more urgent and longest waiting patients are offered appointments, there is a rise in patients towards the middle of the waiting list which is 52 weeks. A validation process is due to start in October whereby patients will be contacted to check if an appointment is still required. This will cleanse the 52 week position.

Following 65 week recovery, we will be focussing on patients waiting 52 weeks and this work will continue into 2024/25.

Open pathway 65 week risks
More patients remain at risk of 65 week breach than trajectory. This is due to some patients still waiting for their first outpatient appointments, and subsequent diagnostic procedures before treatment. Plans are being worked up to expedite first appointments into October which will result in earlier decisions to treat patients and reduce those at risk of breaching.

Acute waiting list size

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



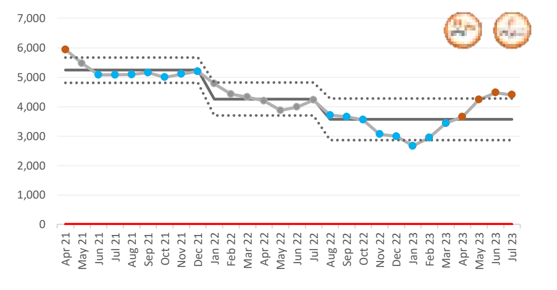
Acute open pathway performance

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

Jul-23
49.9%
Variance Type
Common cause variation
Target
92%
Achievement
Incapable process - likely to consistently fail to meet the target

Acute open pathway 52 week breaches

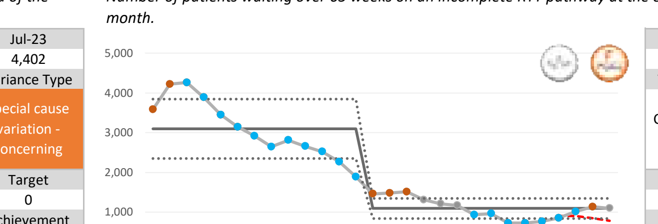
Number of patients waiting over 52 weeks on an incomplete RTT pathway at the end of the month.

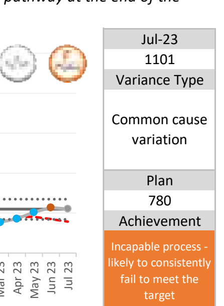


Jul-23
4,402
Variance Type
Special cause variation - concerning
Target
0
Achievement
Incapable process - likely to consistently fail to meet the target

Acute open pathway 65 week breaches

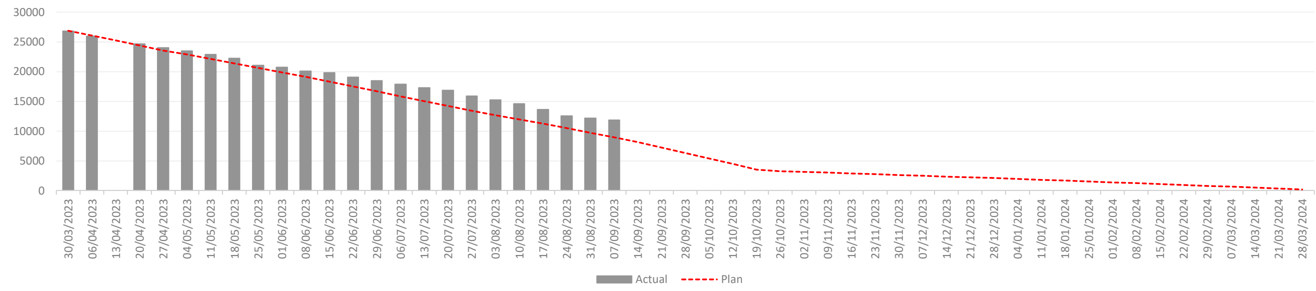
Number of patients waiting over 65 weeks on an incomplete RTT pathway at the end of the month.





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.



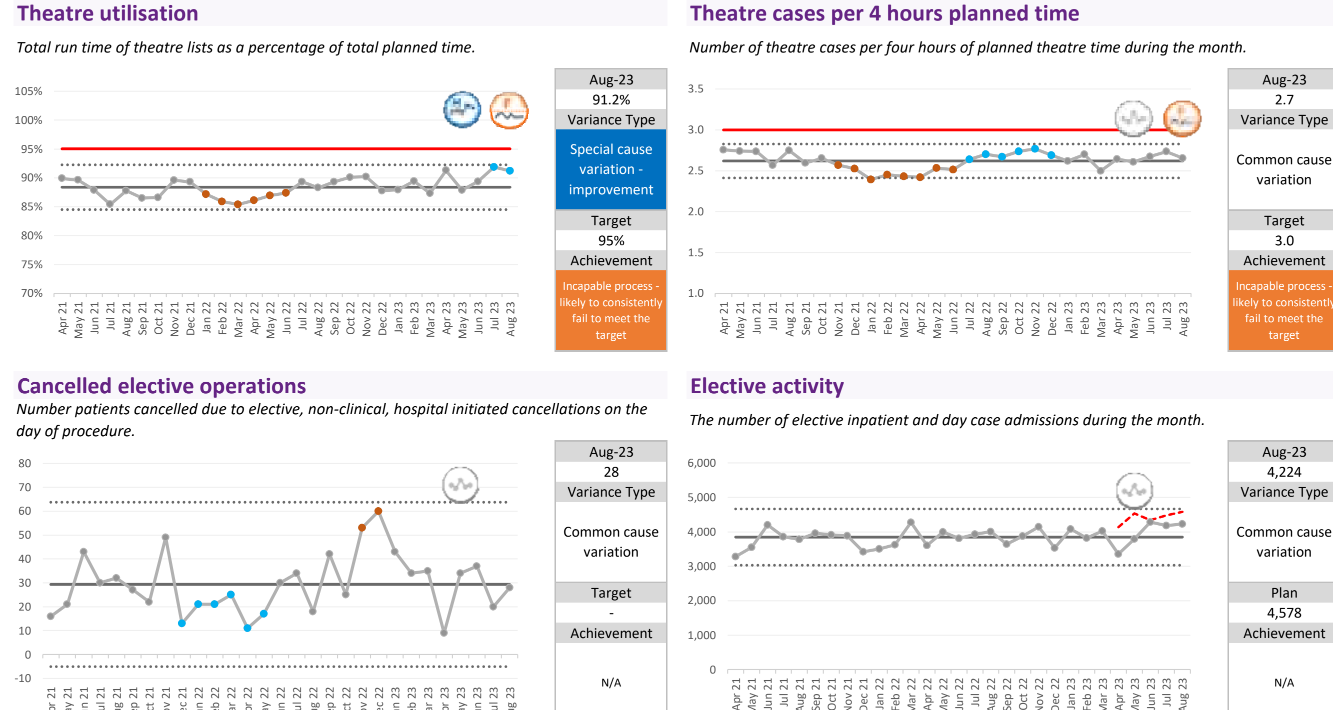
Outstanding Care

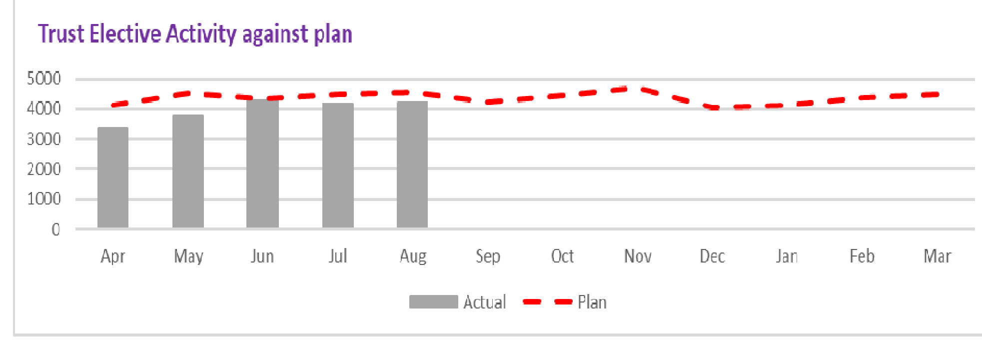
Operational Standards - Elective Recovery

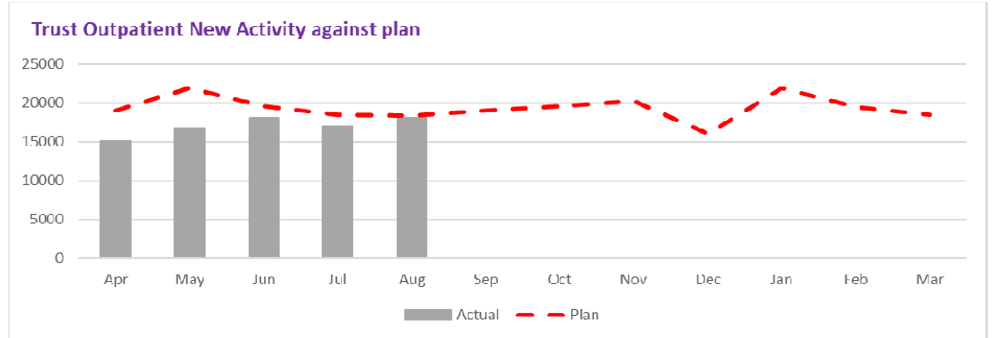
Theatre utilisation
Utilisation continues to be monitored closely, with every effort made to backfill lists and ensure all capacity is booked. August has seen a slight drop due to annual leave but September is expected to improve towards meeting a target of 95%

Activity against plan 23/24
Activity levels continue to rise with August seeing elective inpatient and day case activity rising to 91.95% of plan compared to 89.36% the previous month.

The number of outpatient new appointments are also rising with September delivering 89.18% of plan compared to 84.6% the previous month.







Outstanding Care

Operational Standards - Elective Recovery

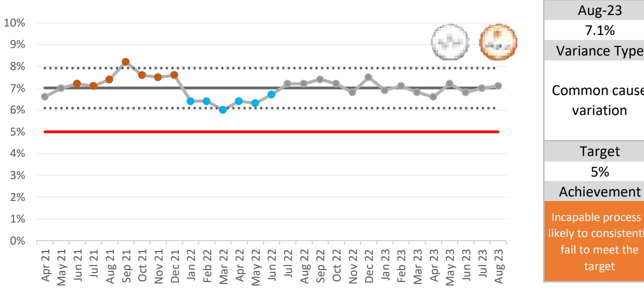
Outpatient DNA rate
We aim to telephone more patients to agree appointment dates and times with an aim of reducing DNAs. This does continue to be a problem, particularly with some of our long waiting patients but increased patient contact is due to start in October.

Mean waiting time for first outpatient appointment
Emphasis on treating long waiting patients is apparent over recent months, and this has caused the mean waiting time for first outpatient appointment to increase as we bring this cohort of patients in for their appointments. We aim to bring this down as waiting times reduce and our longest waiters are seen and treated appropriately.

New Outpatient attendances
The number of outpatient attendances are generally increasing and closer to target. They do however continue to be affected by Industrial Action down time and additional activity is sought at weekends to enable capacity to be optimised.

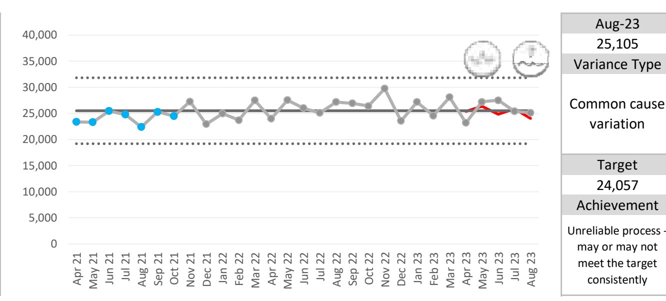
Outpatient DNA rate

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



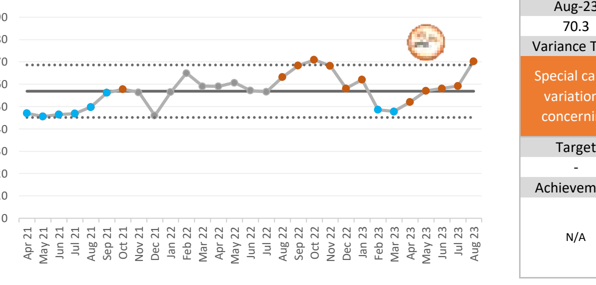
Reduce OP follow up

Total number of follow up attendances during the month.



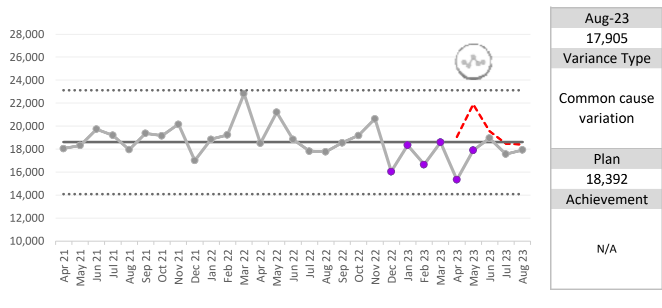
Mean waiting time for first outpatient appointment

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



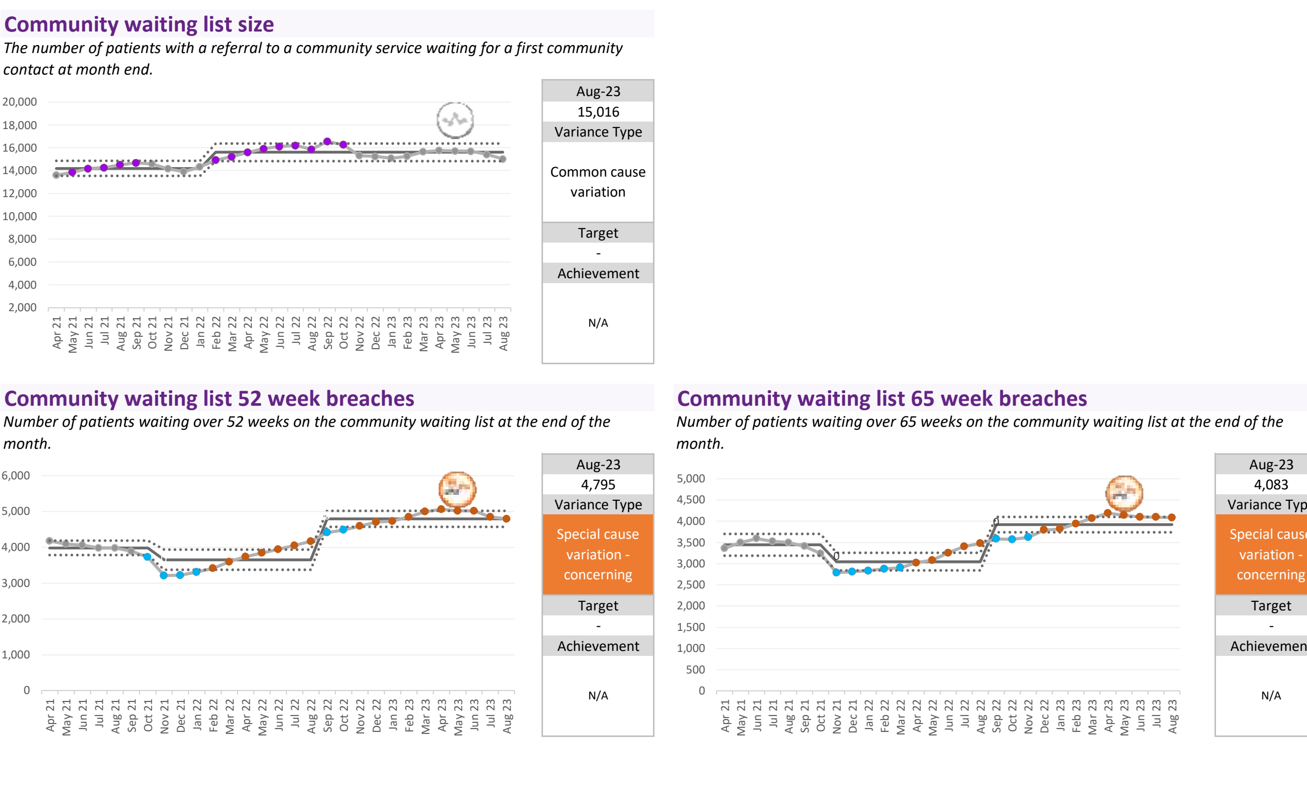
New OP

Total number of new attendances during the month.



Outstanding Care

Operational Standards - Elective Recovery



Outstanding Care

Operational Standards - Diagnostics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic activity levels	Jul 23	11773	-			11830	8987	14673
Diagnostic compliance	Jul 23	54.9%	99.0%			56.2%	44.9%	67.5%
Endoscopic patients waiting > 6 weeks	Jul 23	1159	0			1114	751	1477
Non-endoscopic DM01 breaches	Jul 23	4318	0			3162	2261	4063

By modality

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Magnetic resonance imaging	Jul 23	2461	-			1927	1383	2470
Computed tomography	Jul 23	232	-			209	120	299
Non-obstetric ultrasound	Jul 23	1499	-			503	63	943
DEXA scan	Jul 23	13	-			9	-21	39
Audiology - audiology assessments	Jul 23	2	-			40	-46	126
Cardiology - echocardiography	Jul 23	95	-			208	-20	436
Respiratory physiology - sleep studies	Jul 23	0	-			0	0	0
Urodynamics - pressures & flows	Jul 23	16	-			11	-6	28
Colonoscopy	Jul 23	391	-			381	280	481
Flexi sigmoidoscopy	Jul 23	199	-			183	121	246
Cystoscopy	Jul 23	137	-			146	77	215
Gastroscopy	Jul 23	432	-			412	230	593

What the charts show us

Diagnostic compliance: From the data, there appears to have been a step change in October 2022 so the limits have been recalculated at this point. This metric is now experiencing common cause variation i.e. no significant change. The target still 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.

Non-endoscopic DM01 breaches: This metric is experiencing special cause variation of a concerning nature with the last eight data points falling above the central line and four of the last five data points (including 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.

For patients waiting > 6 weeks for a diagnostic test **Non-obstetric ultrasound** is showing special cause variation of a concerning nature with the last six data points for each falling above the central line.

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

Outstanding Care

Operational Standards - Diagnostics

Buckinghamshire Healthcare NHS Trust

Radiology
Activity levels
Radiology are looking for ways to increase capacity and have plans to install new MRI and CT machines at Amersham Hospital. Currently, the process is undergoing internal governance and we hope it will enhance our capacity. We anticipate going live in April 2024, once all necessary approvals have been granted.

Imaging MRI: Additional funding has been requested from the CDC commissioners for a Mobile MRI that will help with CDC work and be located at SMH. The bid is currently being reviewed by NHSE commissioners, and we expect to receive a response by the end of the week. If approved, this will help reduce the backlog and improve the situation for approximately six months.

CT: Continues to be challenged we anticipate that once the CT is installed at AMH CDC this will start to reduce the backlog.

Non Obs US: Our backlog is starting to reduce as we have a mutual aid funding arrangement that is being funded by the ICS to clear our backlog via a private provider. This has started to positively impact our backlog is now showing a downward trajectory which if all goes to plan will be cleared by the end of this fiscal year.

Endoscopy
Activity levels

- Dept has taken on NHSP support until we fully recruit.
- TNE serviced paused due to issues with physical space.
- Increase drive to backfill lists.
- Clinical vetting started has started and is reducing waits and safeguarding patients.
- Increased clinical vetting with training of CE's underway.
- Continuation of GutCare insourcing for weekend

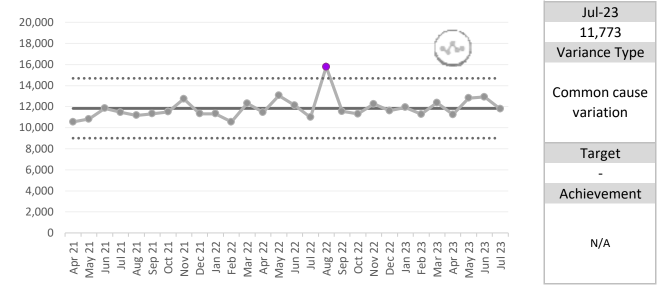
Patients waiting > 6 weeks

- Endoscopy continues to backfill as many dropped lists as possible.
- Clinical vetting started has started and is reducing waits and safeguarding patients.

Trust Recovery of DMO1
Diagnostic services continue to be challenged, recovery is impacted by the need for new equipment which will be available later in the financial year. This will lead to a faster recovery next year. Outsourcing was paused earlier this year due to financial contraints, elements of which are now being restarted and this will stabilise diagnostic performance.

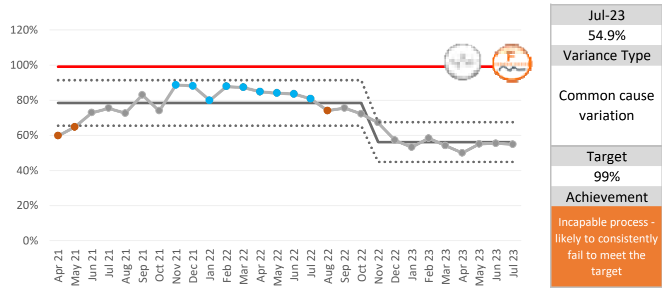
Diagnostic activity levels

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



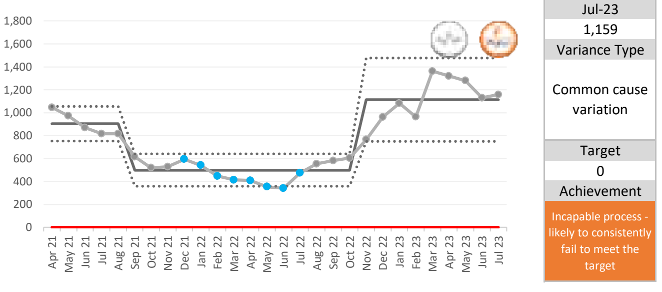
Diagnostic compliance

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



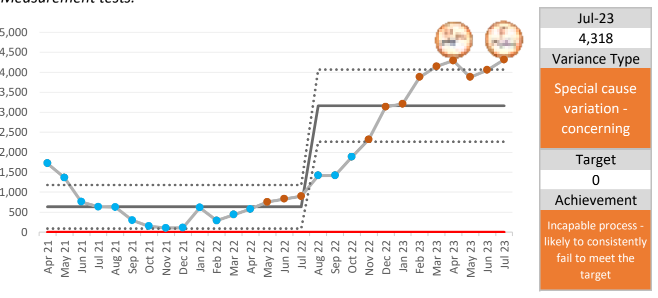
Endoscopic patients waiting > 6 weeks

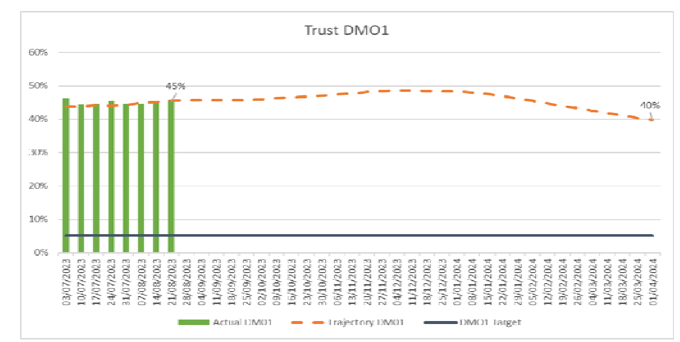
The number of patients waiting more than 6 weeks at month end for an Endoscopic procedure.



Non-endoscopic DM01 breaches

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





Outstanding Care

Operational Standards - Diagnostics

Diagnostic waiters > 6 weeks by modality

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

Imaging

Magnetic resonance imaging

Computed tomography

Non-obstetric ultrasound

DEXA scan

Physiological measurement

Audiology - audiology assessments

Cardiology - echocardiography

Respiratory physiology - sleep studies

Urodynamics - pressures & flows

Endoscopy

Colonoscopy

Flexi sigmoidoscopy

Cystoscopy

Gastroscopy

Outstanding Care

Operational Standards - Cancer

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer Performance 62 day pathway	Jul 23	76.9%	85.0%			62.4%	40.4%	84.4%
Cancer Wait Times 62 day waiters	Jun 23	136	-			321	175	467
Cancer Wait Times - 31 day to first treatment	Jul 23	89.5%	96.0%			83.0%	70.0%	95.9%
Cancer Wait Times - 104 days	Jul 23	38	0			70	39	100
Cancer screening	Jul 23	78.6%	90.0%			72.8%	37.7%	107.9%
Faster diagnostic standard (28 days)	Jul 23	72.3%	75.0%			69.5%	58.0%	81.0%

Faster diagnosis standard by tumour site

Tumour site	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Breast	Jul 23	90.6%	75.0%			94.5%	84.1%	104.8%
Skin	Jul 23	85.3%	75.0%			83.0%	61.4%	104.6%
Head & Neck	Jul 23	49.2%	75.0%			60.2%	28.9%	91.5%
Lung	Jul 23	88.2%	75.1%			75.9%	49.1%	102.6%
Urology	Jul 23	56.3%	75.0%			49.4%	17.7%	81.2%
Gynaecology	Jul 23	72.3%	75.0%			57.4%	25.1%	89.7%
Upper GI	Jul 23	38.8%	75.0%			48.2%	16.4%	80.0%
Lower GI	Jul 23	59.8%	75.0%			38.9%	12.2%	65.6%
Brain	Jul 23	0.0%	75.0%			41.4%	-70.4%	153.3%
Haematological	Jul 23	46.2%	75.0%			45.5%	-20.7%	111.8%
Paediatric	Jul 23	100.0%	75.0%			88.9%	66.6%	111.3%
Prostate	Jul 23	23.5%	75.0%			11.9%	-15.8%	39.6%
Testicular	Jul 23	0.0%	75.0%			81.5%	18.3%	144.7%

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.

Cancer waiting times - 62 day waiters: This metric is experiencing special cause variation of an improving nature with the last six data points falling below the central line, and the last four points below the lower control limit. However the latest data is not available at the time of report production.

Cancer waiting times - 31 day to first treatment: This metric is experiencing special cause variation of an improving nature with the last six data points falling above the central line. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

Cancer waiting times - 104 days: This metric is experiencing special cause variation of an improving nature with the last six data points falling below the central line, and the last four points below the lower control limit. However the target lies below the current control limits and so cannot be achieved unless something changes in the process.

Faster diagnosis by tumour site:

Breast: This metric is experiencing common cause variation i.e. no significant change. However the target lies below the current control limits and so can be expected to be achieved unless something changes in the process.

Skin: This metric is experiencing special cause variation of an improving nature with the last six 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.

Lower GI: This metric is experiencing special cause variation of an improving nature with the last six data points falling above the central line. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

Prostate: 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.

Testicular: This metric is experiencing special cause variation of declining nature with the last 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. Numbers of cases are low for this tumour site.

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

Outstanding Care

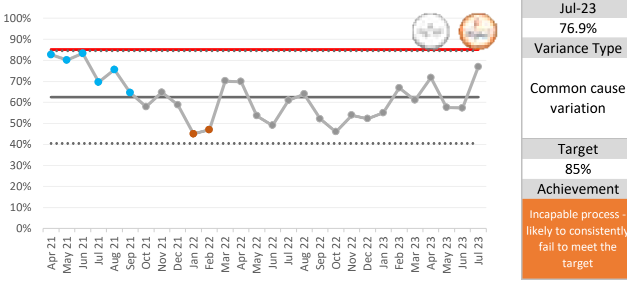
Operational Standards - Cancer

July 2023 62 days performance was 76.9% compared with June 2023 performance which was 57.2%, showing an improvement. Issues impacting performance in month were access to timely definitive diagnostics for urology and Head and Neck. PET PSMA wait remains at 40 days. Dermatology had an increase in referrals due to summer and demand was over capacity. The high polling of 40 days in dermatology affected plastics' performance as patients are referred from dermatology to plastics.

The industrial actions had an impact on 62 day performance for some tumor sites.

Cancer performance 62 day pathway

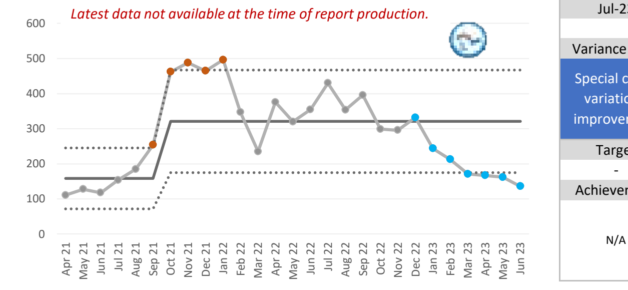
The percentage of patients treated in month within 62 days of being referred for suspected cancer over all patients treated in month. For 62 day pathway patients.



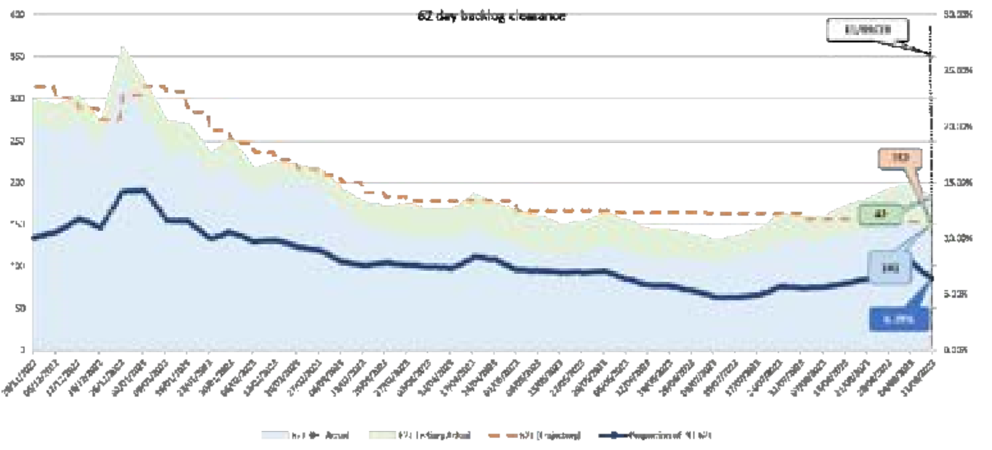
Jul-23
76.9%
Variance Type
Common cause variation
Target
85%
Achievement
Incapable process - likely to consistently fail to meet the target

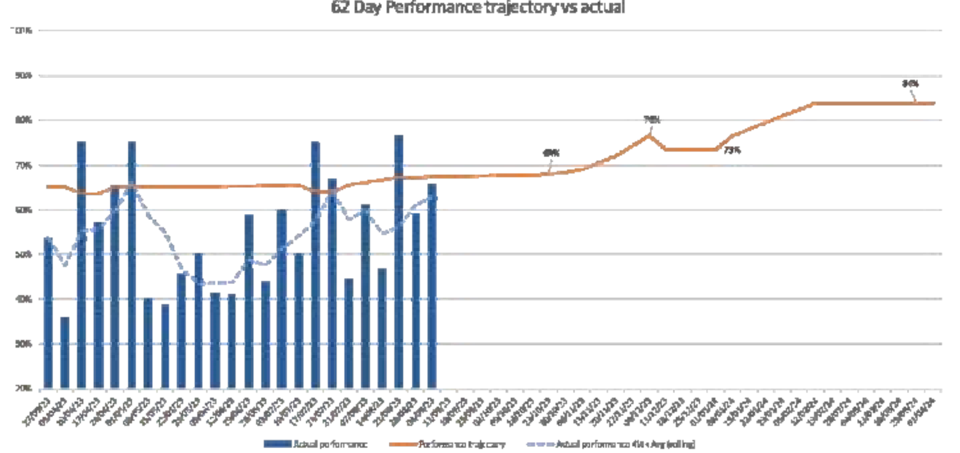
Cancer Wait Times 62 day waiters

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



Jul-23
Variance Type
Special cause variation - improvement
Target
-
Achievement
N/A





Outstanding Care

Operational Standards - Cancer

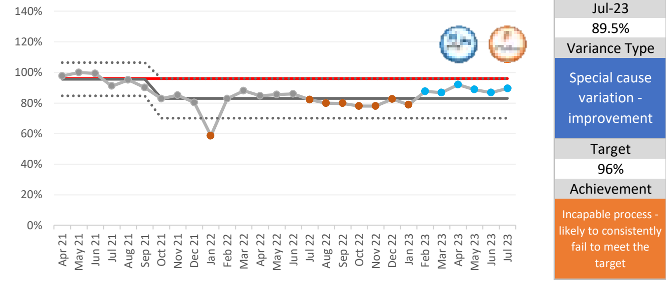
31 Day
31 day target showed a slight improvement in July with a performance of 89.5% against a target of 96%.

104 days
There was a slight increase in 104 days in July due to theatre capacity, workforce, industrial actions, summer holidays and complexity of the pathways. Medical staffs have been recruited in Urology, Head & Neck, Dermatology due to start in September and October. Plan to recruit physician associates in gynae. Additional theatre lists have been put in place.

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

Cancer Wait Times - 31 day to first treatment

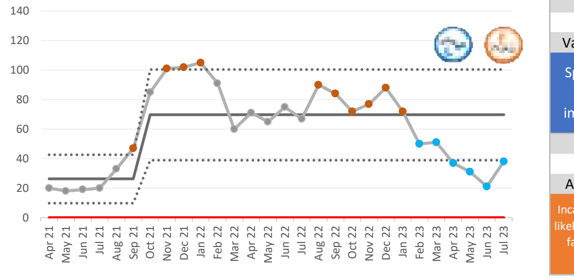
Percentage of patients treated who began first definitive treatment within 31 days of receiving their cancer diagnosis. Over all patients who began first definitive treatment in month.

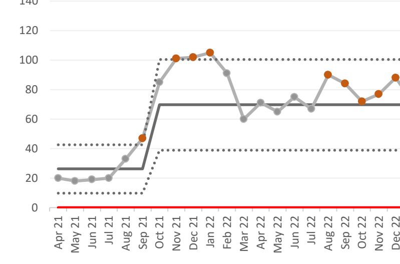


Jul-23
89.5%
Variance Type
Special cause variation - improvement
Target
96%
Achievement
Incapable process - likely to consistently fail to meet the target

Cancer Wait Times - 104 days

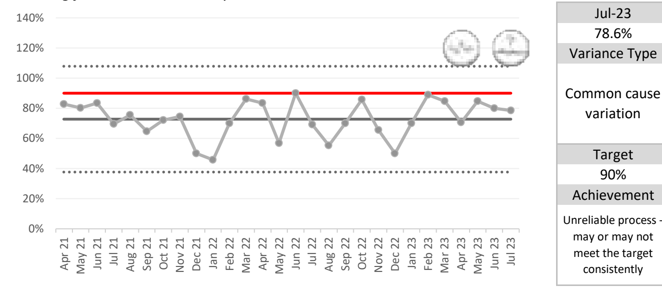
The number of cancer patients waiting 104 days or more from referral to first treatment at month end. Taken from weekly report closest to month end.





Cancer screening

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



Jul-23
78.6%
Variance Type
Common cause variation
Target
90%
Achievement
Unreliable process - may or may not meet the target consistently

Outstanding Care

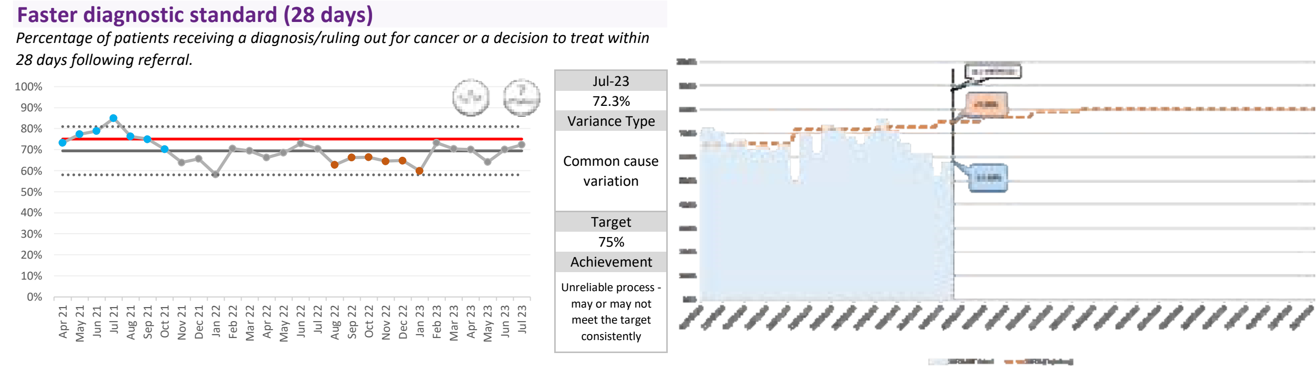
Operational Standards - Cancer

Lung, breast, prostate and skin tumour sites are all very close to the national Best Practice Timed Pathway;Ýiscussion is ongoing via Cancer board as to how best to resource and deliver the NSS pathway sustainably and efficiently;Îhe FD team and cancer leads are working closely with the remaing tumour site teams to support them to meet the FD standard in accordance with their plans developed earlier this year.

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.

Jul-23
72.3%
Variance Type
Common cause variation
Target
75%
Achievement
Unreliable process - may or may not meet the target consistently



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.

Breast

Skin

Head & Neck

Lung

Urology

Gynaecology

Upper GI

Lower GI

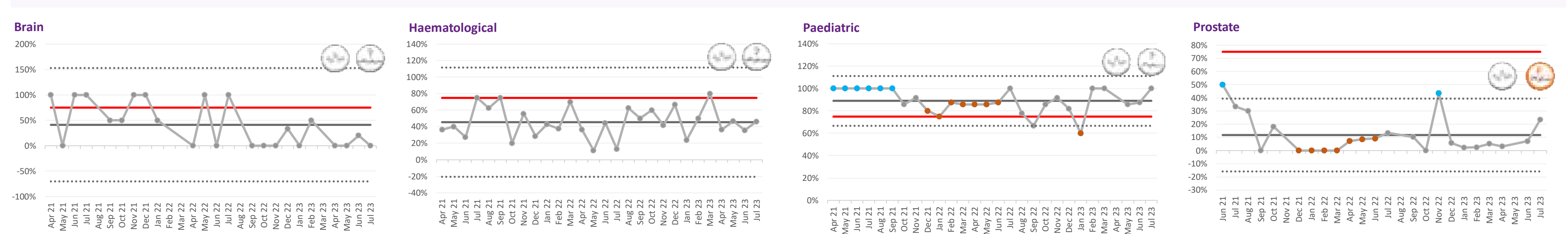
Outstanding Care

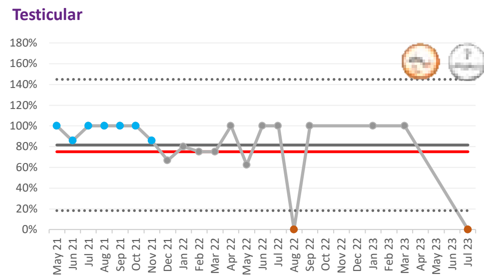
Operational Standards - Cancer

Buckinghamshire Healthcare NHS Trust

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.





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	Aug 23	1212	-			1201	946	1456
Incidents that are low/no harm	Aug 23	97.7%	98.0%			98.3%	96.7%	99.9%
Medication incidents	Aug 23	84	-			100	48	152
Medication incidents as Sis	Aug 23	0	0			0	-1	1
Inpatient falls	Aug 23	95	-			108	80	136
Falls per 1,000 bed days	Aug 23	4.7	6.2			4.9	3.8	6.0
SIs confirmed	Aug 23	5	-			6	-1	14
SIs declared as never events	Aug 23	0	0			0	-1	1
Pressure ulcers - category 2	Jul 23	48	-			35	13	57
Pressure ulcers - category 3	Jul 23	2	-			2	-4	7
Pressure ulcers - category 4	Jul 23	0	-			0	-1	1
Pressure ulcers - unstageable	Jul 23	6	-			4	-2	10
MRSA bacteraemia	Aug 23	0	0			0	-1	2
Clostridioides difficile	Aug 23	4	4			4	-3	10
MSSA bacteraemia	Aug 23	2	0			2	-2	7
E Coli bacteraemia	Aug 23	6	5			6	-1	13
Pseudomonas aeruginosa bacteraemia	Aug 23	1	1			1	-1	3
Klebsiella spp bacteraemia	Aug 23	2	3			3	-2	8
HSMR	May 23	91.0	100.0			92.1	86.1	98.1
VTE assessment	Jul 23	96.7%	95.0%			96.6%	95.2%	98.0%
Treatment escalation plan compliance	Aug 23	83.0%	90.0%			87.6%	77.7%	97.6%
Early warning score	Aug 23	99.2%	99.0%			99.1%	98.8%	99.5%
Excellence reporting	Aug 23	114	-			110	12	209
Clinical Accreditation Programme								

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.

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 eight 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
Overall incidents reporting and medication incidents showing common cause variation. No medication related incidents declared as serious incident in August 2023. Falls rate per 1,000 occupied bed days remains below set target and with reducing trajectory for inpatient falls since September 2022.

Falls
Inpatient falls incidents quarterly thematic review and trust wide quality improvement monitored by Harm Free Care Group including specific actions for areas with high incidents.

Falls education and communication campaign with an emphasis on post falls management and promotion of the recently updated trust falls policy, scheduled on 18-22 September which aligns to the National Falls Awareness week.

Incidents reported

Total number of incidents reported on DATIX during the month.

Aug-23
1,212
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.

Aug-23
97.7%
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.

Aug-23
84
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.

Aug-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.

Aug-23
95
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.

Aug-23
4.7
Variance Type
Common cause variation
Target
6.2
Achievement
Capable process - likely to always meet the target

Outstanding Care

Operational Standards - Elective Recovery

Serious Incidents
No serious incidents declared as Never Event in August 2023.

There were five serious incidents declared in August 2023 and investigations are ongoing. Recent serious incident investigation themes for safety actions include:

- Adherence to safeguarding processes to avoid impacting on timely multi-agency working
- Listening to patient voice to ensure appropriate administration of medicines
- Diligence in documentation of sepsis screen and recognition of deteriorating patient for timely intervention

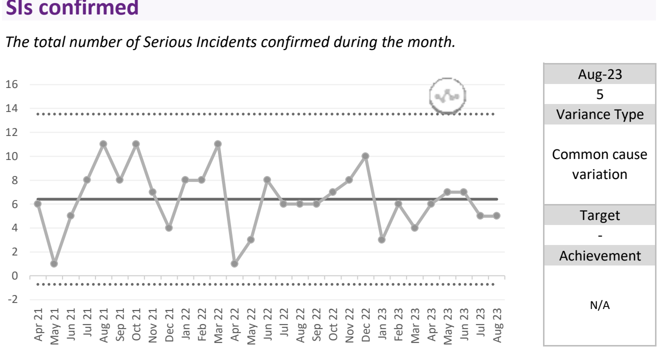
Pressure ulcer incidents showing common cause variations. Theming of PU incidents and subsequent improvement plan continued to be monitored through the Harm Free Care Group.

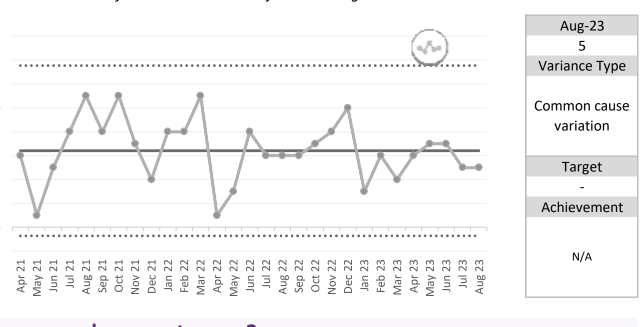
The Trust has proudly participated in marking the WHO World Patient Safety Day each year since the start in 2019 as part of the global network of healthcare. This year the focus is 'Engaging Patients for Safety' with the slogan "Elevate the voice of Patients!" and this will be promoted during the celebrations in September 2023.

Sepsis Steering Group review of trust sepsis compliance and deep dive that will be reported to the Deteriorating Patient Group chaired by the Deputy CMO.

SIs confirmed

The total number of Serious Incidents confirmed during the month.





Aug-23
5
Variance Type
Common cause variation
Target
-
Achievement
N/A

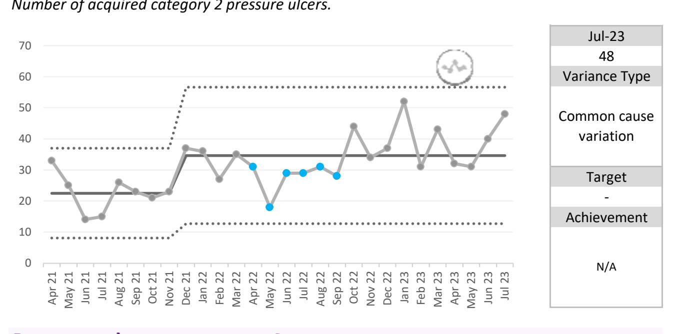
SIs declared as never events

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

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

Pressure ulcers - category 2

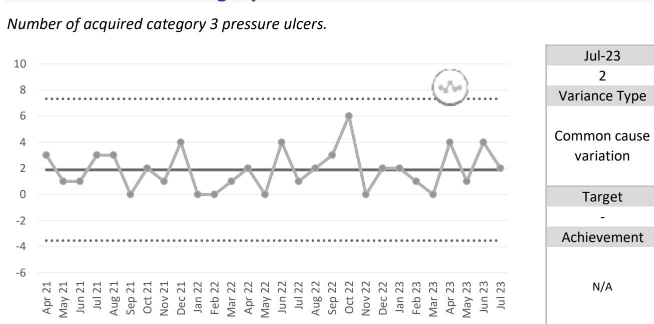
Number of acquired category 2 pressure ulcers.



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

Pressure ulcers - category 3

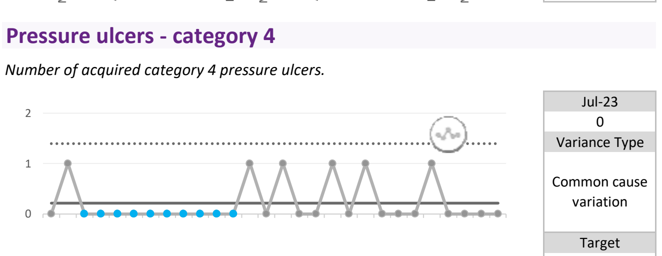
Number of acquired category 3 pressure ulcers.



Jul-23
2
Variance Type
Common cause variation
Target
-
Achievement
N/A

Pressure ulcers - category 4

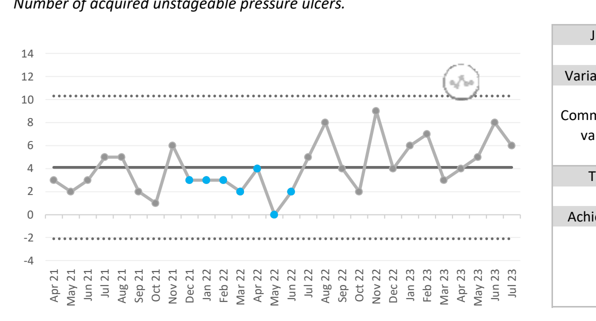
Number of acquired category 4 pressure ulcers.

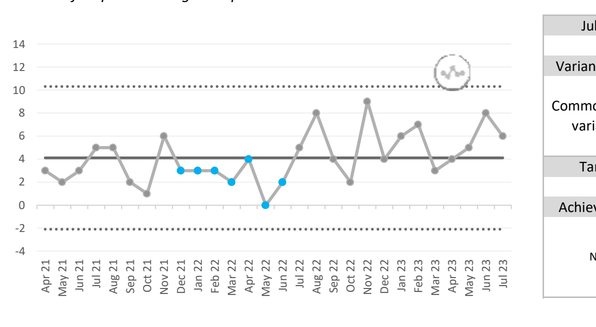


Jul-23
0
Variance Type
Common cause variation
Target
-
Achievement
N/A

Pressure ulcers - unstageable

Number of acquired unstageable pressure ulcers.





Jul-23
6
Variance Type
Common cause variation
Target
-
Achievement
N/A

Outstanding Care

Operational Standards - Elective Recovery

Buckinghamshire Healthcare NHS Trust

Infections

No cases of Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections reported in August. Two cases of MRSA bacteraemia have been reported so far this year against the target of zero. Continuous implementation of key strategies to reduce MRSA transmission and minimise its impact on vulnerable patients. These include hand hygiene, correct use of PPE, transmission-based precautions, screening and surveillance, environmental cleaning, antibiotic stewardship, and screening and decolonization in high-risk areas like ITU and Spinal unit.

Four cases of *Clostridium difficile* infection (CDI) reported in August 2023. Two of the investigation RCAs have been completed so far and learning identified around prompt sampling and isolation. Year to date, 27% of the trajectory has been met. Antimicrobial usage has been closely monitored and reviewed to prevent avoidable CDI due to inappropriate use of antibiotics. Weekly multidisciplinary rounds with IPC Team review inpatients with CDI.

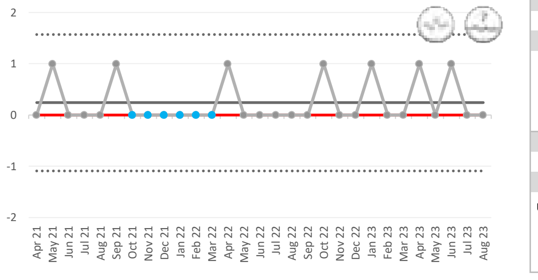
Six of the nine reported cases of Gram-negative bloodstream infection (GNBSI), were E. coli. Additionally, there was one case of Pseudomonas aeruginosa, with a total of eight cases this year, just below the threshold of nine. There were two cases of Klebsiella, bringing the year-to-date total to 11, which is below the threshold of 32.

Root cause analysis (RCA) is conducted for all GNBSI cases to identify themes and lapses in care.

The recent E. coli RCA discovered a high prevalence of indwelling urinary catheters, which is a significant risk factor for E. coli bloodstream infections. Catheter-related infections preventive measures will be developed in collaboration with stakeholders.

MRSA bacteraemia

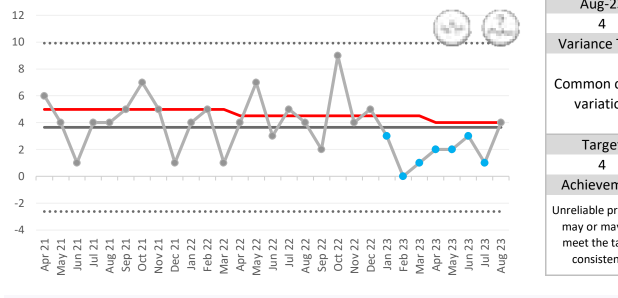
Number of MRSA cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



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

Clostridioides difficile

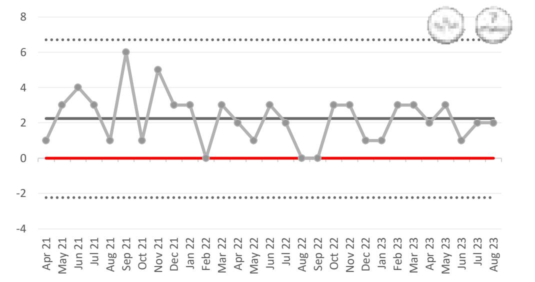
Number of C-diff cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



Aug-23
4
Variance Type
Common cause variation
Target
4
Achievement
Unreliable process - may or may not meet the target consistently

MSSA bacteraemia

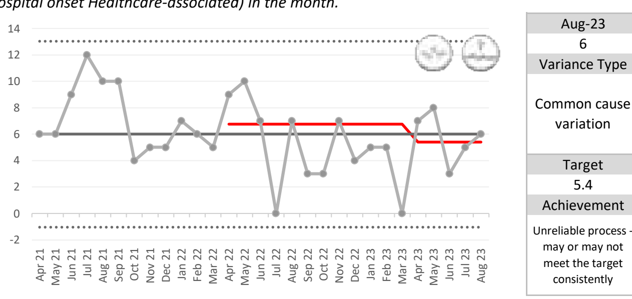
Number of MSSA cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



Aug-23
2
Variance Type
Common cause variation
Target
0
Achievement
Unreliable process - may or may not meet the target consistently

E Coli bacteraemia

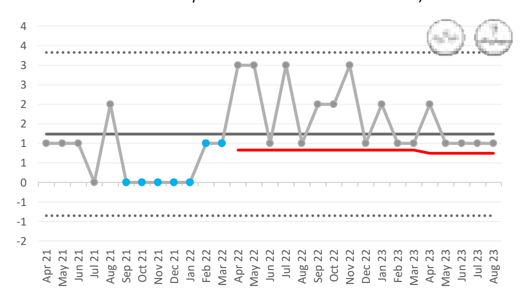
Number of E-Coli cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



Aug-23
6
Variance Type
Common cause variation
Target
5.4
Achievement
Unreliable process - may or may not meet the target consistently

Pseudomonas aeruginosa bacteraemia

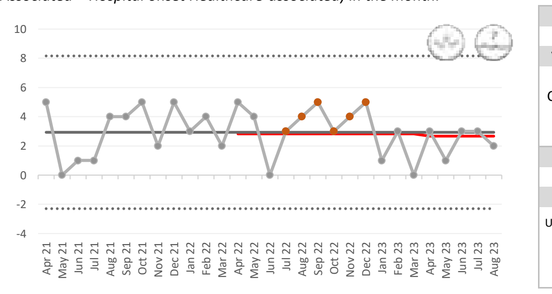
Number of Pseudomonas aeruginosa cases Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated) in the month.



Aug-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.



Aug-23
2
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

NHS Buckinghamshire Healthcare NHS Trust

HSMR
Our rolling 12-month HSMR for May 2023 is 91.0 and classified as "lower than expected".

VTE
Continue to achieve set target on VTE risk assessment and EWS compliance

Treatment escalation plan compliance
Targeted work on areas with reduced compliance on TEP completion ongoing with support from CCOT and Deputy CMO. TEP and DNACPR compliance to be reported into Mortality Review Group and compliance data for circulation to SDU leads and reporting into respective clinical governance meetings

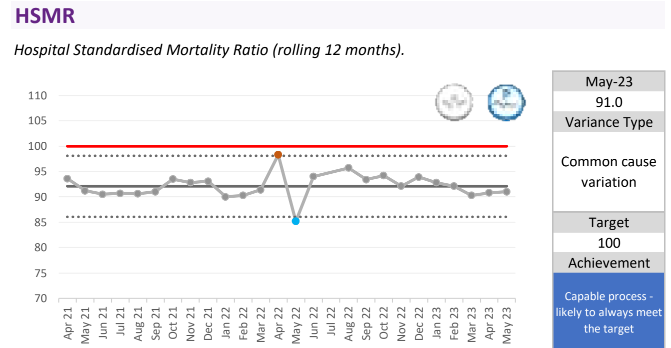
Clinical Accreditation Programme:
The trust has accredited 50 areas, and 46 areas have received their awards with four areas awaiting their accreditation results. The total of 50 accreditations also includes three areas of re-assessment.

Trust accreditation numbers achieved to date since January 2023 are 23 Bronze, 22 Silver and 1 Gold.

Trust has set a target linked to patient safety quality objectives. There are 99 areas to complete with a target of 80% (79 areas) and 40% (32 areas) of areas achieving silver award by March 2024.

HSMR

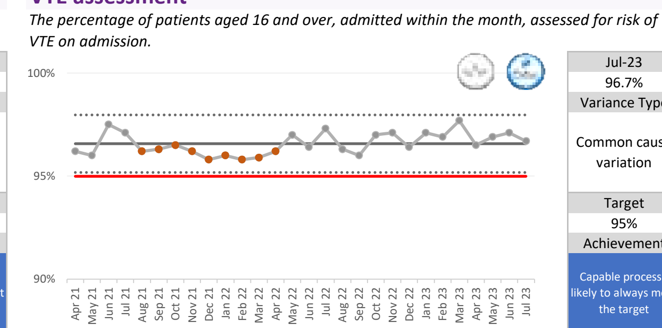
Hospital Standardised Mortality Ratio (rolling 12 months).



May-23
91.0
Variance Type
Common cause variation
Target
100
Achievement
Capable process - likely to always meet the target

VTE assessment

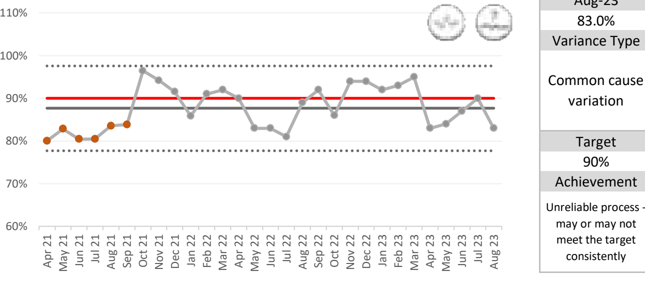
The percentage of patients aged 16 and over, admitted within the month, assessed for risk of VTE on admission.



Jul-23
96.7%
Variance Type
Common cause variation
Target
95%
Achievement
Capable process - likely to always meet the target

Treatment escalation plan compliance

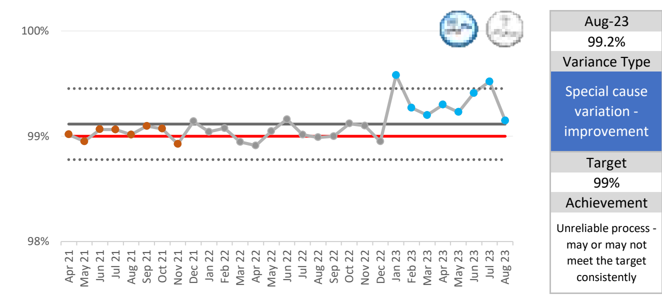
Treatment Escalation Plan completion rate based on documentation audit conducted via Tendable app.



Aug-23
83.0%
Variance Type
Common cause variation
Target
90%
Achievement
Unreliable process - may or may not meet the target consistently

Early warning score

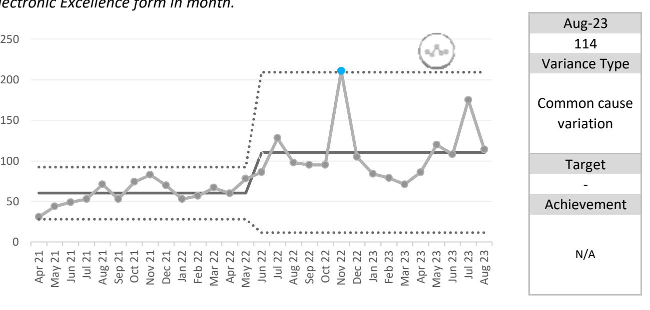
Percentage compliance with early warning score (EWS) completion.



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

Excellence reporting

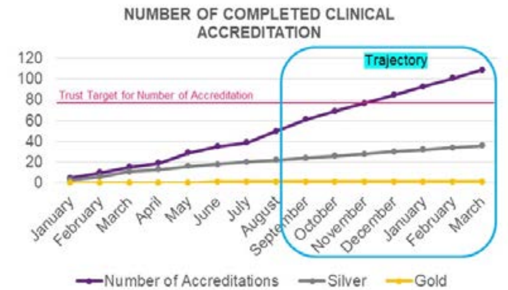
Total number of positive examples of great practice and care observed and reported via electronic Excellence form in month.



Aug-23
114
Variance Type
Common cause variation
Target
-
Achievement
N/A

Clinical Accreditation Programme

The total number of accreditation assessments completed in month.



Outstanding Care

Operational Standards - Patient Experience

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Complaints received	Aug 23	55	-			44	21	66
Complaints response rate	Jul 23	97.0%	85.0%			74.0%	43.2%	104.8%
Complaints outstanding at 90 days	Aug 23	0	0			3	1	6
PALS contacts	Aug 23	423	-			391	234	547
PALS responses	Aug 23	85.0%	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 ten 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

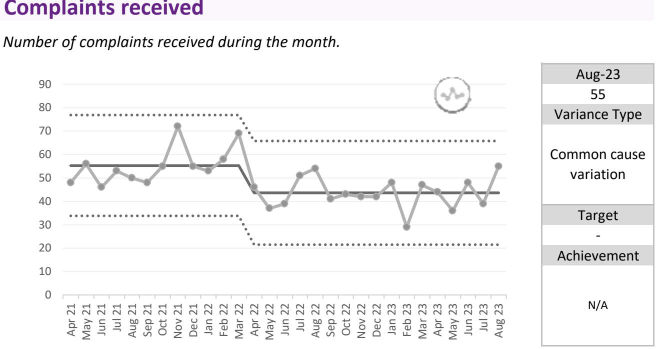
Complaints
All divisions achieved 100% compliance apart from the IECC division with one breached complaint. This is an exceptional breach as the team were awaiting review by outsourced legal advisors, prior to submitting the final response leading to delay in responding within 25 days set target.

Voicemails 100% - All voicemails answered and logged within 1 working day.
Emails 85% of emails answered and logged within 3 working days.

No complaints outstanding for 90 days as of August 2023.

Complaints received

Number of complaints received during the month.



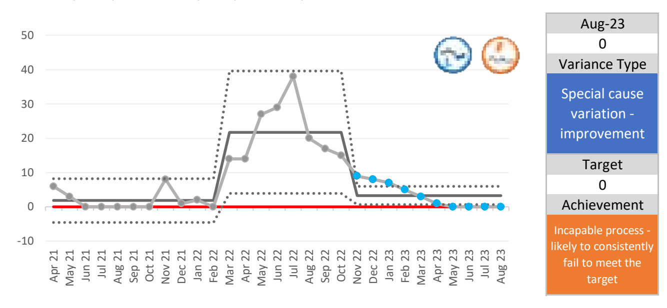
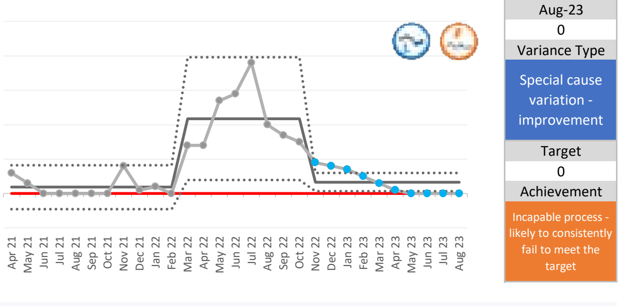
Complaints response rate

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

Jul-23
97.0%
Variance Type
Common cause variation
Target
85%
Achievement
Unreliable process - may or may not meet the target consistently

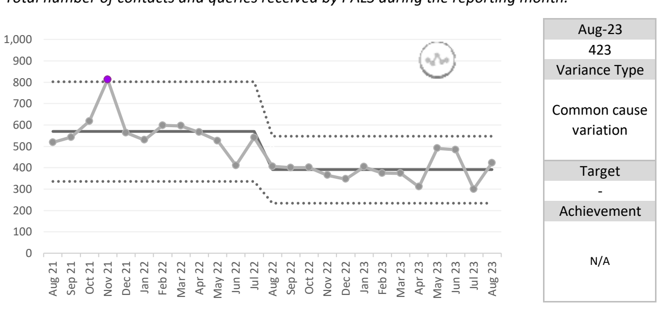
Complaints outstanding at 90 days

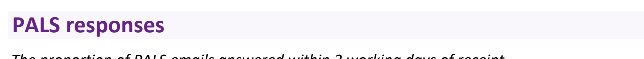
Number of complaints still open after 90 days.

PALS contacts

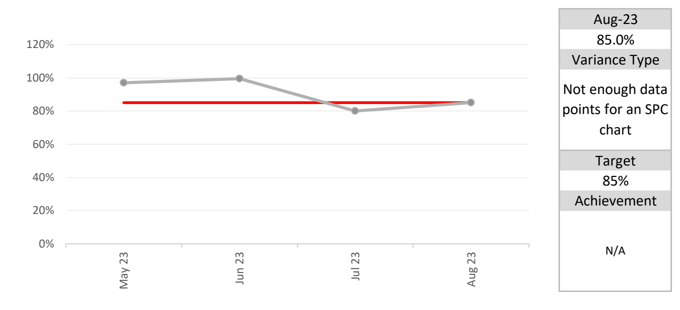
Total number of contacts and queries received by PALS during the reporting month.





PALS responses

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



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	Aug 23	3	0			1	-2	5
Neonatal deaths	Aug 23	0	0			0	-1	2
Term birth <10th centile	Aug 23	3.0%	7.0%			3.4%	0.7%	6.1%
Term admissions to neonatal unit	Aug 23	2.7%	5.0%			4.2%	1.5%	6.8%
Preterm birth	Aug 23	8.6%	6.0%			5.7%	1.4%	10.0%
Preterm birth < 24 weeks	Aug 23	0.0%	6.0%			0.1%	-0.3%	0.4%
Preterm birth > 24 weeks	Aug 23	8.6%	6.0%			5.6%	1.5%	9.7%

Pre term birth optimisation

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Place of birth achieved	Jul 23	100%	80%			97%	87%	107%
Magnesium sulphate achieved	Jul 23	100%	80%			91%	55%	128%
Antibiotics achieved	Jul 23	100%	80%			64%	-2%	131%
Steroids achieved	Jul 23	0%	80%			50%	-63%	163%
Optimal cord management achieved	Jul 23	40%	80%			57%	-35%	149%
Thermoregulation achieved	Jul 23	100%	80%			84%	13%	155%
Expressed breatmilk achieved	Jul 23	60%	80%			79%	20%	139%

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 ten 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 ten 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 2 stillbirths in August. One was a 36-week intrauterine death following placental abruption, no care issues were identified. The second was a 33-week loss, following diagnosis of intrauterine death during a routine antenatal clinic appointment, ultrasound scan one week prior showed a normally growing fetus with a low-lying placenta, there was no evidence of immediate concerns regarding care, however a more detailed review of the case is underway.

Neonatal death
No neonatal deaths occurred in August.

Term admissions to the neonatal unit
There was a positive decline in the number of babies born after 37 weeks requiring admission to the neonatal unit. This remains within common cause variation, there have been no service changes that have facilitated this. The admission rate has been below the 5% target for the previous 3 months.

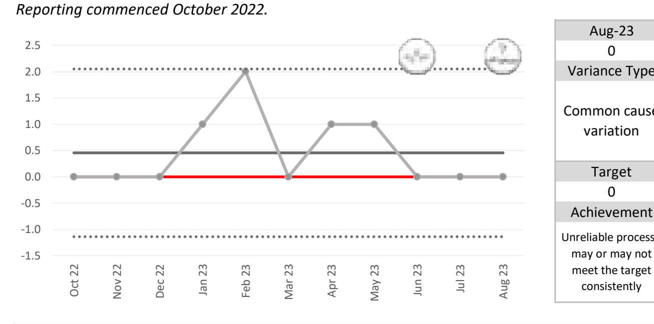
Stillbirths - total cases

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

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

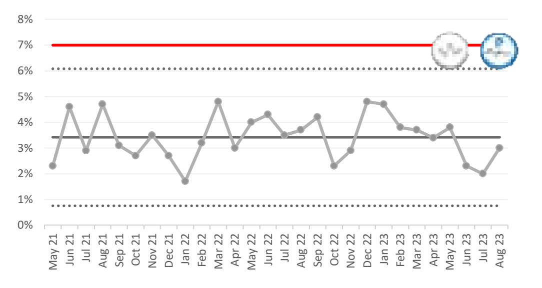
Neonatal deaths

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



Term birth <10th centile

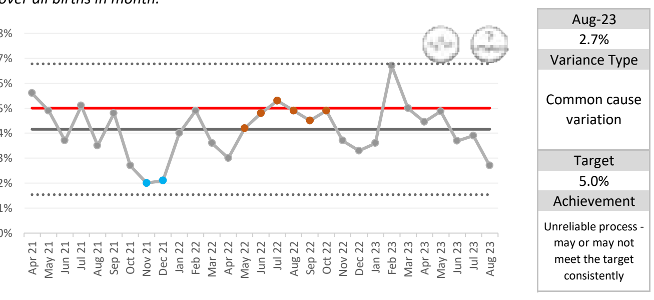
The number of babies born after 37 week gestation with a weight below the 10th centile over all births in month.



Aug-23
3.0%
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.



Outstanding Care

NHS
Buckinghamshire Healthcare
NHS Trust

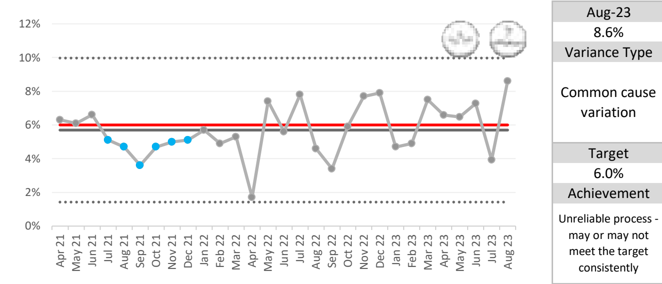
Operational Standards - Maternity

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

Pre term birth > 24 weeks
There was a sharp increase in preterm birth rates in August. A total of 23 babies were born before 37 weeks. The most common reasons for preterm birth were abnormal fetal heartrate monitoring and placental abruption. A more detailed case reviews of preterm births is due to commence in September. Over the coming months this will enable the extraction of themes so that opportunities for improvement can be identified.

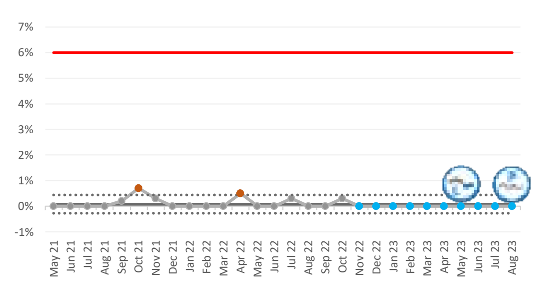
Preterm birth

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



Preterm birth < 24 weeks

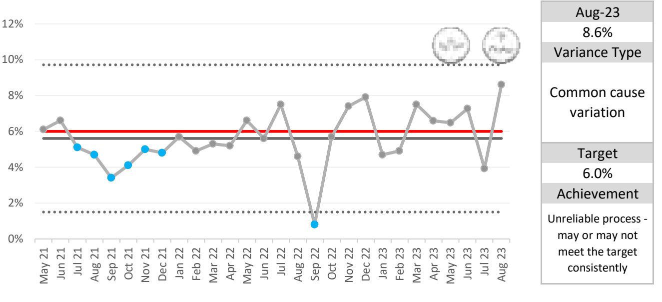
The number of babies born before 24 weeks gestation over all births in the month.



Aug-23
0.0%
Variance Type
Special cause variation - improvement
Target
6.0%
Achievement
Capable process - likely to always meet the target

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

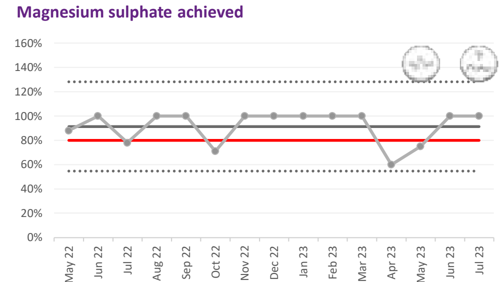
Pre term birth optimisation

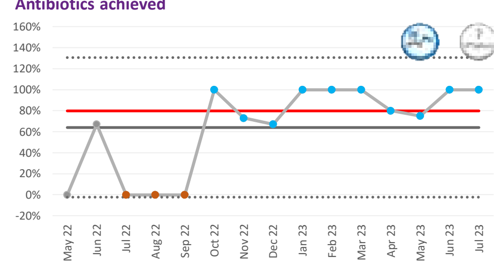
Percentage of pre term birth optimisation elements achieved.

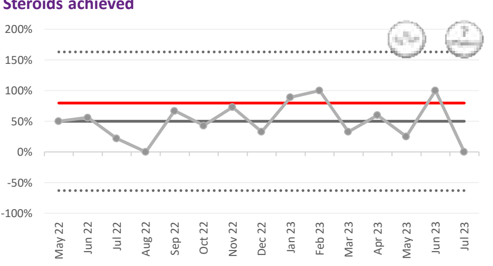
The optimisation bundle is presented one month in arrears. Performance was low for steroid administration and optimal cord management in July. This was owing to all births occurring within 12 hours of diagnosis in labour, or the presence of fetal concerns meaning that birth had to be achieved before a full course of steroids could be completed. In the cases where optimal cord management was not achieved, this was as a result of the need for neonatal resuscitation making it unsafe to delay the clamping of the cord.

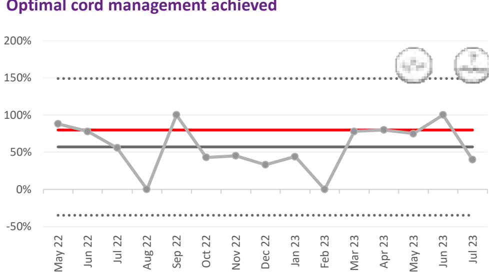
Place of birth achieved

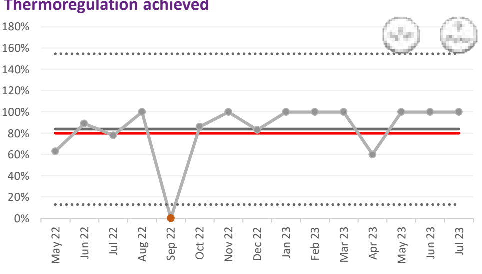
140%
120%
100%
80%
60%
40%
20%
0%
May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23

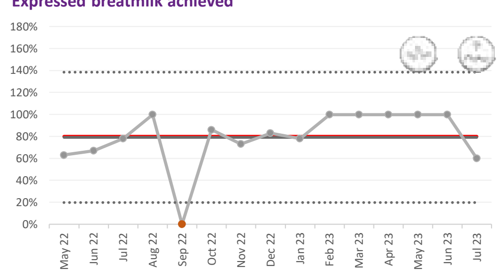












Healthy Communities

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Community Contacts	Aug 23	50945	-			49590	41876	57304
Cardiology referrals from deprived wards	Aug 23	24.2%	-			20.5%	16.7%	24.2%
Maternity smoking at time of booking	Aug 23	3.9%	5.0%			6.4%	1.8%	11.1%
Maternity smoking at time of delivery	Aug 23	4.2%	5.0%			6.1%	2.4%	9.9%
Breastfeeding at birth	Aug 23	74.9%	80.0%			72.6%	61.4%	83.8%
Breastfeeding at discharge	Aug 23	81.3%	80.0%			67.0%	49.4%	84.6%
Health visitor appointments - 14 days	Jul 23	80.7%	-			73.0%	61.2%	84.8%
Breastfeeding at 6-8weeks	Jul 23	36.5%	-			38.5%	31.5%	45.5%
Children having 1 year health review			-					
Children having 2 year health review			-					
Frailty	Aug 23	93.9%	-	Not enough data points for an SPC chart				

What the charts show us

Breastfeeding at discharge: This metric is experiencing special cause variation of an improving nature with the last seven data points falling above the central line. However the target lies below the current control limits and so cannot be achieved unless something changes in the process.

Health Visitor appointments - 14 days: This metric is experiencing special cause variation of an improving nature with the last seven data points falling above the central line.

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

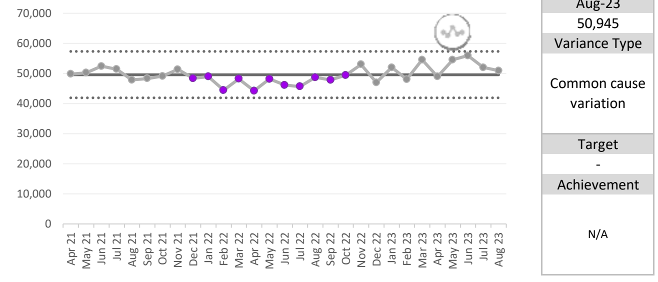
Healthy Communities

We have started to make progress in delivering our Healthy Communities breakthrough objectives with the frailty objective already delivered. We expect to start to see improvement in the majority of these metrics in the autumn as a result of work being put in place over the summer.

The progress on feeding with breastmilk at discharge is particularly notable and the result of significant work from the maternity team over the past year.

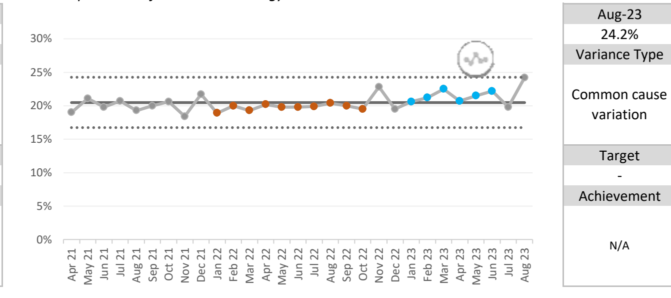
Community Contacts

Total number of attended community contacts in the month.

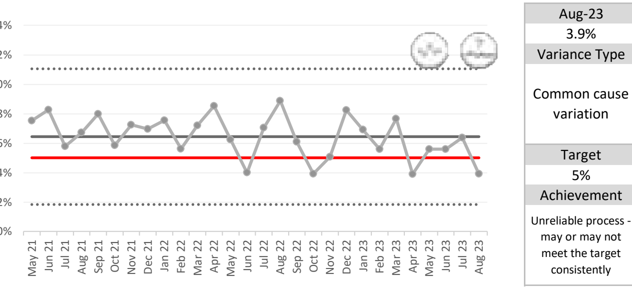


Cardiology referrals from deprived wards

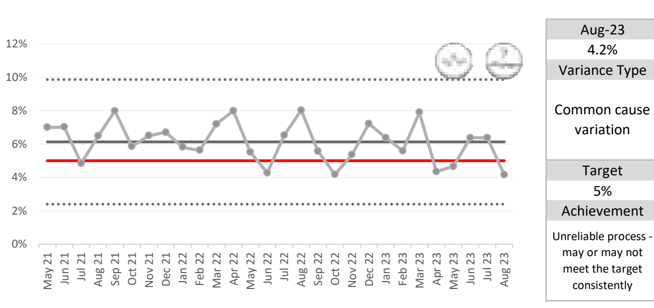
The percentage of patients being referred to cardiology services from the most deprived areas over all patients referred to cardiology services in the month.



Maternity smoking at time of booking

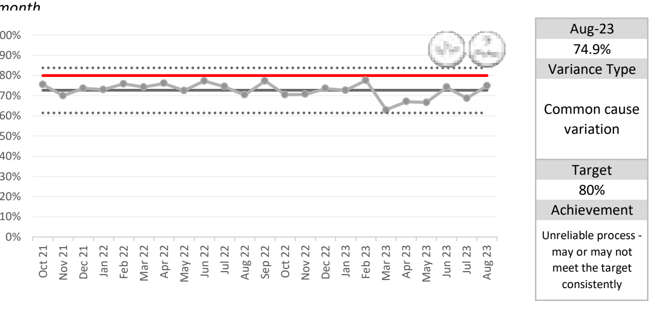


Maternity smoking at time of delivery



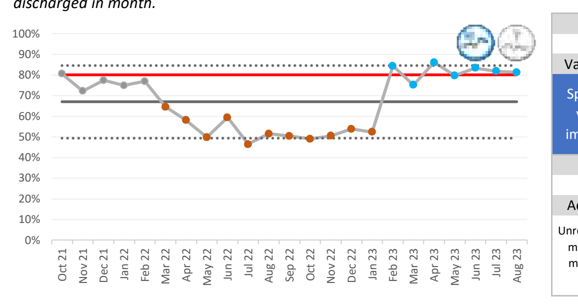
Breastfeeding at birth

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



Breastfeeding at discharge

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



Healthy Communities

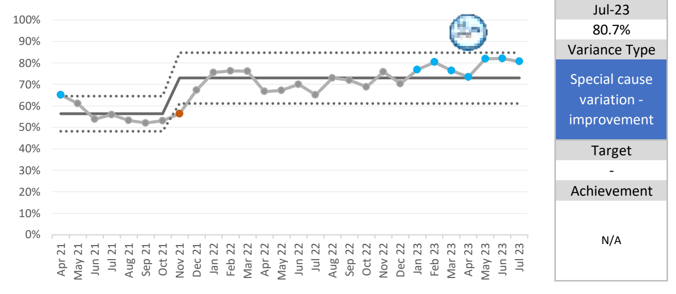
Health Visitor appointments
Improvement has been enabled by a focused effort on contacting all new parents and ensuring the visits are completed, reported, and validated in a more co-ordinated way

Frailty
This is a new data set, it will evolve over the coming months, the trust has exceeded the target of 90% all patients having a score recorded in ED. The data set is already indicating that

- 60% of all frail patient attend Out of hrs.
- More work is needed to map how the scores affect and ultimately decide which is the best pathway for every patient
- The frailty team are working with ED colleagues to articulate what action needs to take place as a result of the score

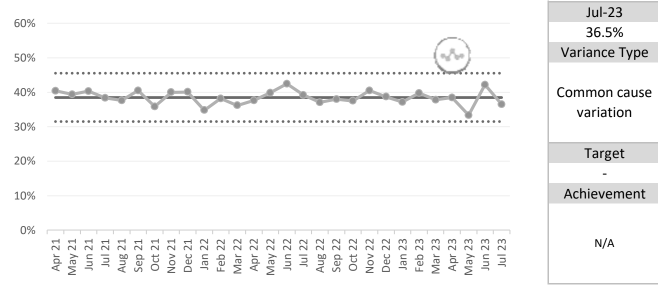
Health visitor appointments - 14 days

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. Based on babies who are 8 weeks old in month.

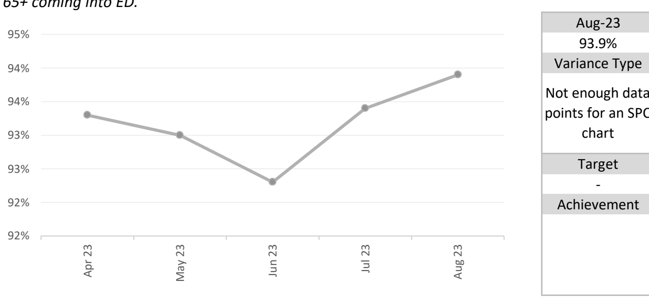


Children having 1 year health review

Children having 2 year health review

Frailty

Patients aged 65+ coming into ED having a documented frailty score, over all patients aged 65+ coming into ED.



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	Aug 23	9.6%	10.0%			8.4%	5.4%	11.5%
Nursing and midwifery vacancy rate	Aug 23	10.2%	8.5%			9.4%	6.4%	12.3%
Turnover rate	Aug 23	11.4%	12.5%			12.4%	11.8%	13.0%
Average time to replace vacancies	Aug 23	52.8	56.0			48.3	36.6	60.0
Leavers < 1 year service	Aug 23	16.5%	-			16.7%	15.9%	17.6%
Sickness	Jul 23	3.7%	3.5%			4.4%	3.0%	5.8%
Sickness - mental health	Jul 23	0.61%	-			0.73%	0.54%	0.92%
Occupational health management referrals	Aug 23	94%	95%			94%	84%	103%
Referrals into OH and Wellbeing - stress	Jul 23	126	-			117	92	142
Data security awareness training	Aug 23	92.0%	95.0%			87.9%	85.2%	90.7%
Statutory and Mandatory training	Aug 23	92.7%	90.0%			88.3%	86.4%	90.2%
Corporate induction	May 23	100.0%	95.0%			99.0%	96.5%	101.4%
Peaks programmes			-					

What the charts show us

Turnover rate: This metric is experiencing special cause variation of an improving nature with the last three 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 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.

Sickness - mental health: This metric is experiencing special cause variation of an improving nature with the last six data points falling below the central line.

Referrlas into OH and Wellbeing - Stress: This metric was experiencing special cause variation of an increasing nature where up is neither improvement nor concern, with the last twelve data points falling above the central line. A step change has been added to the chart at this point of observed change.

Data security awareness training: This metric is experiencing special cause variation of an improving nature with the last seven data points sitting above the central line. 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 only just inside the current control limits and so is unlikely to 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

Nursing and Midwifery Recruitment
Recruitment activity continues to contribute to a further reduction in both our N&M (0.3%)and overall vacancy rates (0.6%)

We are now allocating the internationally educated nurses we recruited from our successful in country event in India in July and also the cohort of Student Nurses that are due to qualify and will be continuing their career with BHT.

We continue to hold monthly HCA Recruitment events. A further 30 candidates were appointed this month.

Turnover
In August, turnover fell again by 0.1%, to 11.4%. This remains the lowest since January 2022 and this is below target.

The ongoing work to embed the People Promise programme is impacting positively on our colleague's experience and we are using this to also improve our ability to attract as well as retain talent.

During August, a total of 61 colleagues left BHT (excluding end of fixed term contracts). This represents a slight drop (2) from last month. Of the 61 leavers, 18 were Nursing and Midwifery, 15 Support Staff and 12 Admin and Estates.

The top four reasons colleagues left were relocation (12), leaving to undertake further education or training (12), retirement (9) and work life balance (9).

Average time to replace
The increase in the reported data for time to hire reflects the current increase in our volume of recruitment, including the HCA assessment days.

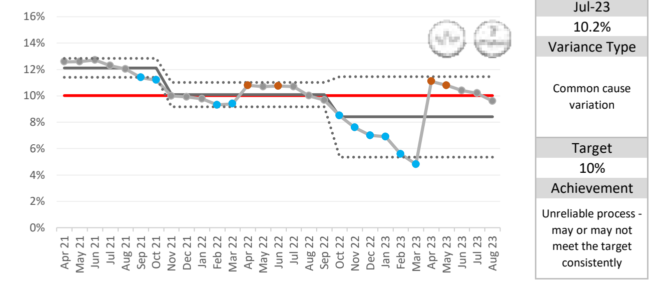
We have initiated a new recruitment survey, sent with all offer letters. This will help us improve the onboarding experience of all new starters.

No of leavers with <1 year service with BHT
Turnover of colleagues with under 1 years' service, was 16.5%
This remains broadly stable and we expect the impact of our programme of work to be seen over the coming months.

In August, 19 colleagues left BHT with under a year's service. The top 3 reasons colleagues cited for leaving were, work life balance/child dependency reasons (7), relocation (5) and to undertake further education or training (4).

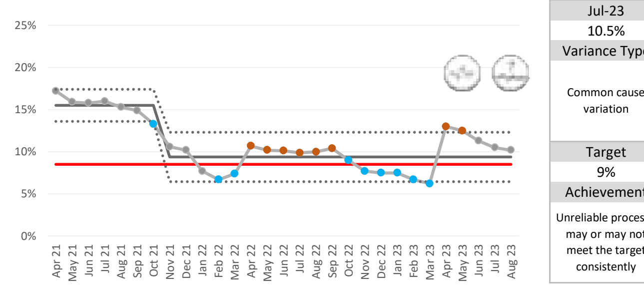
Trust overall vacancy rate

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



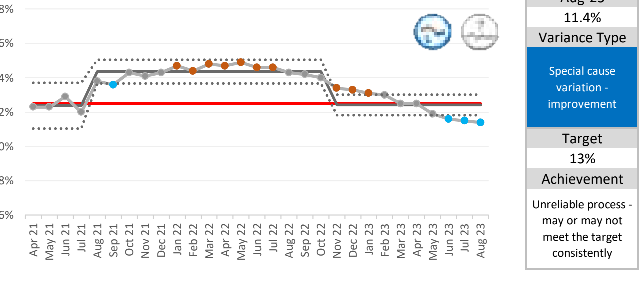
Nursing and midwifery vacancy rate

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



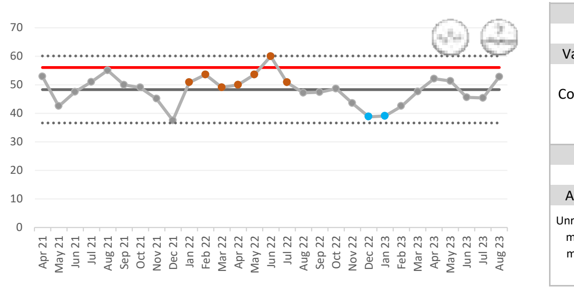
Turnover rate

% 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.



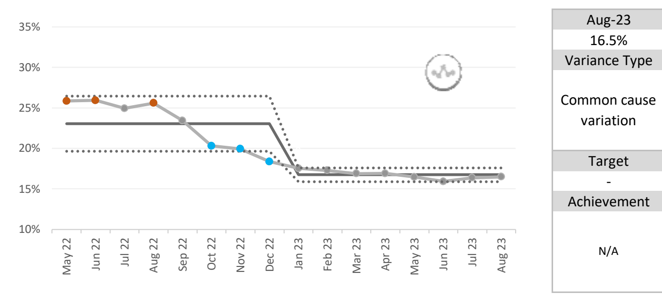
Average time to replace vacancies

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. Rolling 12 months.



A Great Place to Work

Ensuring our people are listened to, safe and supported

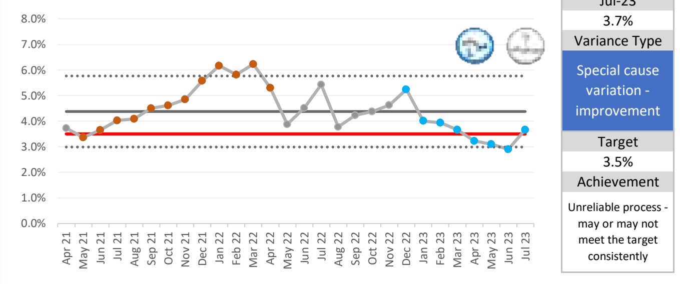
OH Management Referrals and All other Sickness
Management referrals into OH were 117 for, which is the highest since April. In consequence our management referral response KPI has fallen 1% below target. Work is underway to improve the triage process, to return the department to above 95%.
The sickness rate in July was 3.66%, slightly above the target of 3.5%.
There has already been a rise in respiratory infections and the Autumn Flu and COVID vaccinations will start early (mid-September) to mitigate the anticipated further increase in respiratory absence during the coming months.

Mental Health and Stress Sickness and Referrals to Wellbeing
Stress referrals have reduced (by 20) to 106

The wellbeing team are further extending their reactive and proactive individual and team support from October as part of our winter support plan.

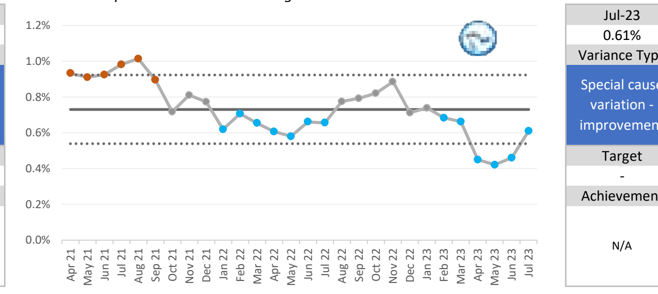
Sickness

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



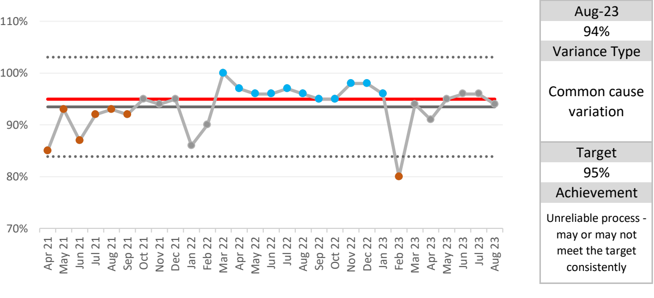
Sickness - mental health

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



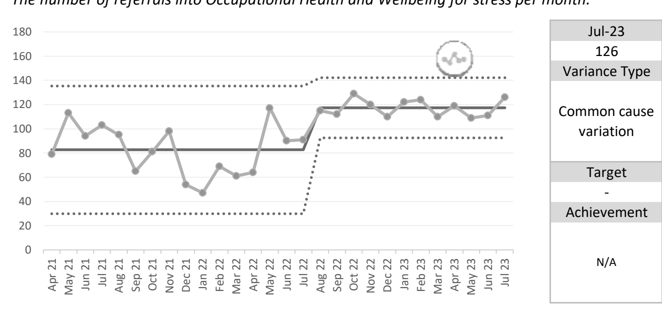
Occupational health management referrals

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

Data Security awareness training
The overall compliance rate remained at 92%.
The 2023-24 version of the DSP Toolkit has now been released and there is no longer a requirement to evidence 95% compliance. The requirement now focuses on evidence of a robust trust wide training needs analysis in place for data security awareness training, incorporating the current e-learning, but also bespoke training for certain staff cohorts e.g. IAOs, SIRO, DPO etc., However, the IG Team will continue to monitor the percentage compliance.

Statutory and man training
Statutory and Mandatory training compliance continues to rise incrementally and as at end of August is 92.7%
All divisions are achieving the 90% Trust target.
Next step is to focus on the six SDUs that are below the 90% target and support will be provided.

Corporate induction
A 99% attendance record has been achieved at the Trusts monthly welcome and Induction event. During the August event a large cohort of Junior Doctors were welcomed to the Trust.
The most recent Trust face to face quarterly event 'BHT connect' took place on the 13 September and was warmly received.

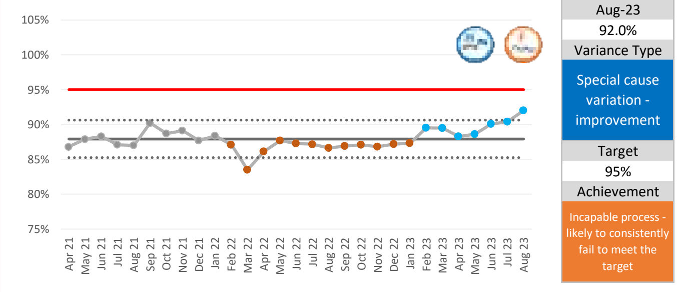
No of managers participating in Peaks programme
Peak 1 – face-to-face Cohort 4
Day 1 was scheduled and delivered, with 38 managers attending and graduating beginning of September.

Peak 2 – face-to-face
The next cohort is scheduled for September with 25 managers enrolled.

Peak 3 Cohort 1
The first cohort, 18 participants, will be graduating on 13 September.

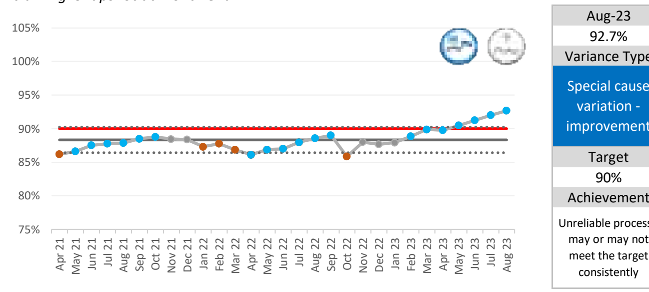
Data security awareness training

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



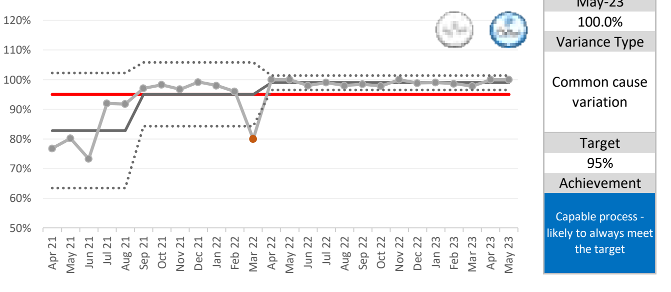
Statutory and Mandatory training

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.

Peak 1 – face-to-face Cohort 4
Day 1 was scheduled and delivered, with 38 managers attending and graduating beginning of September.

Peak 2 – virtual
There was 1 module scheduled in August attended by 1 manager.

Peak 2 – face-to-face
There was no face-to-face cohort scheduled in August. The next cohort is scheduled for September with 25 managers enrolled.

Peak 3 Cohort 1
There was no module scheduled in August.
The first cohort, 18 participants, will be graduating on 13th September.

Outstanding Care

Operational Standards - Productivity

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Overall NHSE measure of productivity	Jun 23	-17.3%	5.0%			-13.9%	-15.7%	-12.1%
Theatre utilisation	Aug 23	91.2%	95.0%			88.4%	84.5%	92.2%
Theatre cases per 4 hours planned time	Aug 23	2.7	3.0			2.6	2.4	2.8
Outpatient DNA rate	Aug 23	7.1%	5.0%			7.0%	6.1%	7.9%
Outpatients utilisation								
Tests per population (Radiology & Pathology)								
14 day LOS - Elective			-					
14 day LOS - Non-Elective			-					
14 day LOS - Community			-					
Number of admissions – conversions from attendance			-					
Bed utilisation			-					
A&E activity	Aug 23	13081	12170			12677	10252	15102
Non-Elective activity			-					
Elective activity	Aug 23	4220	4578			3846	3033	4659
New outpatient activity	Aug 23	17905	18392			18600	14088	23113
Follow up outpatient activity	Aug 23	25105	24057			25511	19207	31814
Headcount			0					

What the charts show us

Overall NHSE measure of productivity: This metric is experienceing special cause variation of a concerning naturing with the last two data points below the lower control limit. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

Theatre utilisation: This metric is experiencing special cause variation of an improving nature with the last two out of three data points falling close to the upper control limit. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.
Theatre cases per 4 hours planned time: 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.

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.

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

Outstanding Care

Operational Standards - Productivity

The NHS Productivity measure is the overall measure for BHT's productivity; this is a relative measure comparing productivity to 19/20. This is supplemented by a bundle of other productivity measures, linked to our key transformation programmes for theatres, outpatients and UEC. Key measures are now in the IPR.

Re the national measure, during 2022/23 BHT made material improvements, from a starting point in M02 of -16.1% to -10.6% in M12; the latter comparing favourably to the national average of -14.7%.

However in M03 of 2023/24, BHT productivity is -17.3% compared to national average of -16.7%. Reduced activity levels for Admitted pathway is a key factor, with activity at M03 18.3% below 2019/20 (Outpatient first and Follow up are both above 2019/20).

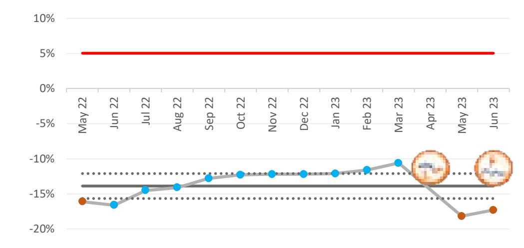
Key drivers : industrial action; theatre closure; but also lack of delivery of plan (and some other issues such as coding).

Activity recovery plans are being developed, with a range of actions agreed to increase activity. Cost improvement continue to be Trustwide priority to support a reduction in cost; alongside transformation programmes which will further drive productivity.

In relation to other measures, we have seen positive progress is some metrics e.g. we have 10-15 fewer MOFD patients in our beds than at this time last year

Overall NHSE measure of productivity

Comparison between the cost base and weighted activity provided in our acute settings in 23/24, against equivalent periods in 19/20.



Jun-23
-17.3%
Variance Type
Special cause variation - concerning
Target
5%
Achievement
Incapable process - likely to consistently fail to meet the target

Meeting: Trust Board Meeting in Public

26 September 2023

Agenda item	Elective Recovery Update and Board self-certification
Board Lead	Raghuv Bhasin, Chief Operating Officer
Type name of Author	Jon Berry, Divisional Director Surgery and Critical Care Wendy Joyce, Director of Performance
Attachments	Elective recovery pack and board self-certification checklist
Purpose	Assurance
Previously considered	n/a

Executive Summary

The Trust has made significant strides in reducing the activity gap to plan – halving the gap since the start of the year. The current gap of c.10% is driven by:

- Industrial Action - >40%
- Unscheduled theatre closures due to estate issues - ~30%
- Internal productivity challenges, e.g. delayed recruitment - <30%.

The elective recovery plan is nearly finalised with a focus on seven at risk SDUs. The aim is to finalise the plan and consequent investment by the end of the first week in October. It is important in viewing this plan that we consider not just delivery of 65-week reduction in this year but moving to eliminate 52-week waiters next year and return towards the 18 weeks standard.

In addition, the Board received a letter on 4 August from Sir Jim Mackey, interim COO NHS England, asking for each Board to undertake a self-certification process focused on validation and outpatients. The Board is asked to sign-off the self-certification that results from this letter.

Decision	The Committee is requested to note the update on elective recovery and sign off the Board self-certification.

Relevant Strategic Priority

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

Relevant objective

☒ Improve waiting times ☒ Improve safety ☐ Improve productivity	☒ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☐ Upskill operational and clinical managers

Implications / Impact

Patient Safety	Achieving long wait target will support patient safety
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards Assurance focuses on quality and performance
Financial	Potential additional resources required for recover activity lost to Industrial Action and unscheduled theatre closures
Compliance NHS Regulation Person-centred Care	NHSE operating plan
Partnership: consultation / communication	Collaborative working with BOB colleagues through the ICS Elective Care Board

Equality	Additional activity will benefit all patients and support a focus on more deprived communities in areas such as Cardiology.
Quality Impact Assessment [QIA] completion required?	Not required at present

1. On 4 August 2023 the Board received a letter from NHS England focused on validation and outpatient transformation – https://www.england.nhs.uk/wp-content/uploads/2023/08/PRN00673-protecting-and-expanding-elective-capacity-letter.pdf

2. The letter asks for the Board to undertake a self-certification specifically focused on outpatients and validation as two areas that the national NHSE team feel that benefit can be derived from.

3. Regarding validation the Trust has identified a target of 10-15% of the waiting list that could be reduced through this process. This is based on internal analysis and an independent review of our waiting list by an external expert firm.

4. Additional resource has been put into our validation team and further colleagues are being sought to ensure sufficient capacity to deliver this waiting list reduction target. This activity will be tracked through the elective recovery plan.

5. However, the key ask in the letter that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023 will be very challenging to meet. These patients will have a data quality validation check – e.g. ensuring that they have not received treatment elsewhere in the Trust – but may not have all been contacted.

6. This is due to the (a) the volume of patients involved; (b) the significant amount of work involved in contacting and recontacting patients around industrial action rescheduling which is using significant administrative resource; and (c) the focus of our booking teams in booking as many patients as possible into clinic.

7. We would therefore recommend that the Board states they have received partial assurance on this area.

8. Turning to the outpatient measures there is further work as part of elective recovery to increase the volume of new outpatients undertaken working with the independent sector and this will be confirmed in the next fortnight. Whilst significant progress has been made on the ambition to see all new outpatient 65-week cohort patients by the end October – which was a trust ambition prior to this letter - this is unlikely to be met in all specialties. As at the 22nd of September 38% of the 65 week cohort have been booked in before the end of October.

9. The Trust performs relatively well on its outpatient new to follow-up ratio with the fourth best ratio in the region. There is more to do to drive further outpatient transformation but good progress has been made in increasing patient initiated follow-up numbers and use of advice and guidance. A lot of work has been done with BOB colleagues at a management and clinical level to share best practice, benchmark and agree joint programmes to improve follow up reduction.

10. In looking at the scope for outpatient transformation it is also worth noting the that the Trust has a significant on hold reduction programme to clean up the follow-up PTL which is a necessary enabler for follow-up pathway transformation.

11. In light of the progress made on follow-up reduction, patient initiated follow-up increases and use of advice and guidance we would recommend that the Board states they have received full assurance on this area.

12. Progress on both validation and outpatient transformation will be tracked through the elective recovery plan with additional metrics included in the IPR.

Update on Elective Recovery

22 September 2023

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

Overall summary

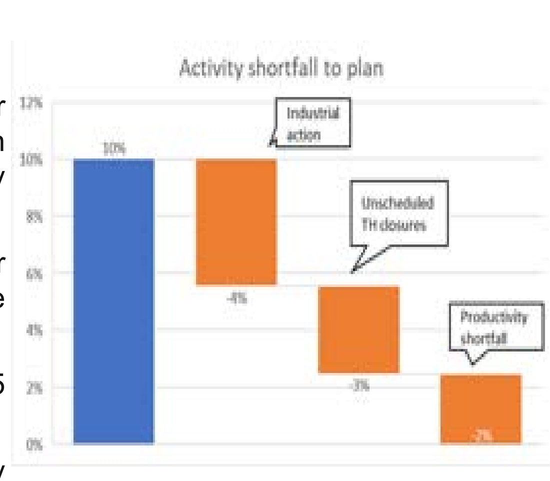
Lead commentary

There have been significant improvements for month on month activity, however in terms of both 65+ week clearance trajectory and in year activity we are still behind plan.

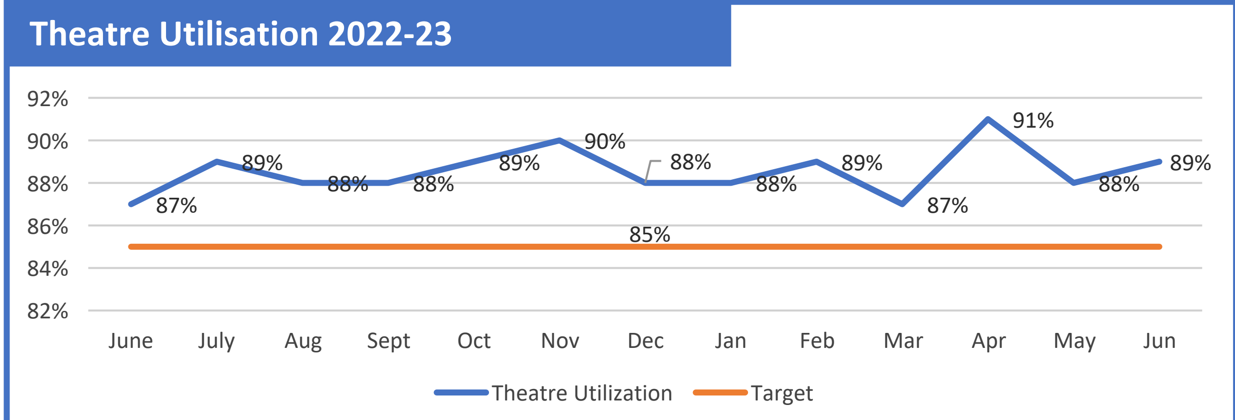
The waterfall chart right shows the key drivers for our variance to plan. And far right tracks Theatre intra-session utilisation (uncapped).

The gap to plan has halved between M1 and M5 despite Industrial Action.

A SDU by SDU recovery plan will be in agreed by the end of the first week in October.



Theatre Utilisation 2022-23



Key achievements in Q1 -3

- **DMAS:** Both offered and accepted mutual aid support from other trusts. Finalising contracts to be let at the start of October.
- **Bookers:** Additional booking capacity is enabling more activity to be scheduled.
- **Cadence improvements & Non-admitted focussed PTL:** Stood up 3 x weekly Long wait oversight meeting reviewing the booking profile at an SDU level in terms of elective, non-elective and cancer long waits. In addition have activated focussed non-admitted pathway meeting to focus upon booking out out-pts/ reducing DNAs impact etc
- **Trailblazing New Pre-op Triage tool:** New triage tool adopted (1st in BOB ICB) (Graphnet), that taps into primary and secondary information which triages pt cohorts into categories according to their co-morbidities, allowing early and fast tracked assessment achieving more capacity and throughput overall.
- **Theatre utilisation:** By delivering Prompt Start Time behaviours, new booking team KPI's, weekly utilisation reviews and overbooking lists we have achieved and sustained above KPI % theatre utilisation

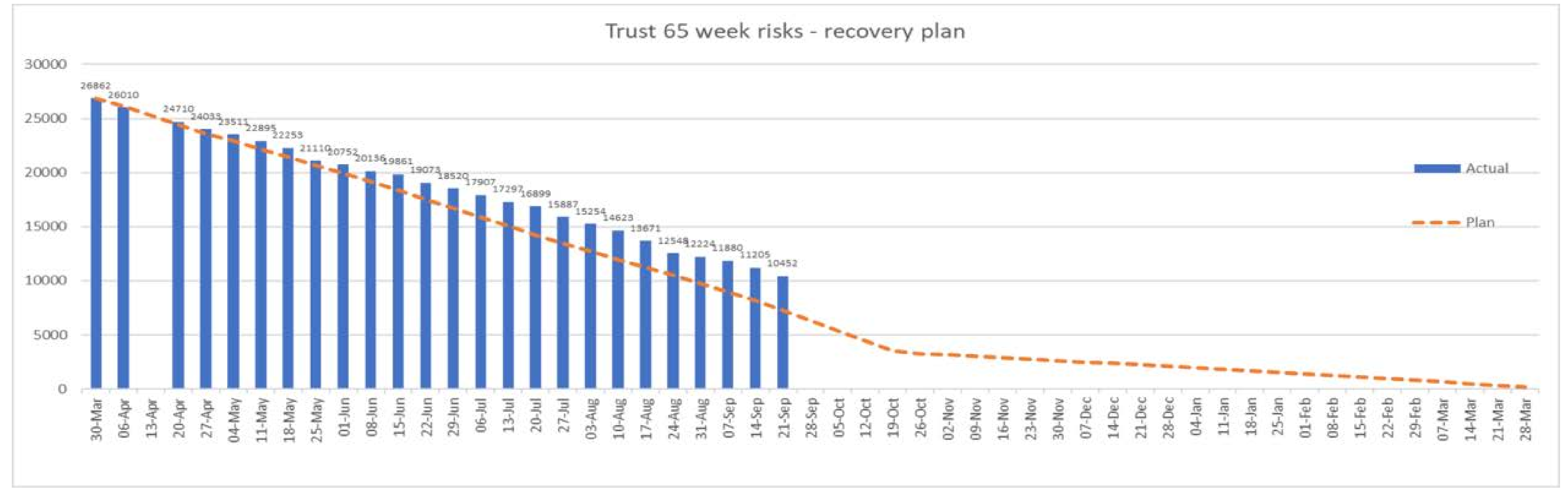
Key planned next steps (Sept/Oct)

- **SDU recovery programme:** Local recovery plans are being developed at SDU level to address the drivers of the variance and recover activity. Seven key SDUs at risk – Dermatology, ENT, General Surgery, Gynae, Ophthalmology, Trauma and Orthopaedics and Urology. These will include performance and activity trajectories (start of October)
- **Opening of additional theatre space:** Amersham and Day Surgery Unit at Stoke Mandeville (October)
- **Pathway Co-ordinators & Validation team:** Multi faceted approach to validating the PTL, inc new boking pathway co-ordinators and validators to ensure the PTL is cleansed and right sized. C.10-15% clearance predicated to be achieved. Additional plans ref Admin teams members to contact pts to support further clock stops where appropriate.
- **Coding improvements:** Activity is not always coded correctly, e.g. procedures coded as follow. Correct coding will increased both reported activity and the value of this activity (October 23)
- **AI Tech to improve scheduling inc demand & capacity for theatres:** working with GIRFT team using new AI tech to support smarter booking and improve pathways utilising capacity in a more efficient way. This will be a first worldwide if successful.
- **Right procedure right place:** By maximising day case and outpatients procedure activity productivity will increase. Stopping non-evidence-based interventions will release capacity for other interventions with higher VWA (January 24). This incudes moving procedures to the correct place such as the Amersham skin centre (opening mid sept).

Risks and support required

- **Industrial action:** Continued industrial action throughout the year could reduce impact of recovery actions. It may also make the plan more expensive by relying on WLIs.
- **Estates:** Unscheduled theatre down time related to ageing estate may reduce trust capacity to deliver elective activity
- **Staffing:** Challenges in recruitment, longer lead times and higher absence rates may decrease ability to deliver activity
- **Diagnostics:** Challenges in delivering sufficient scanning and reporting activity may delay pathways, increasing risk of long waits

We are behind our recovery plan for 65 weeks. This plan was front-loaded into the year and a revised trajectory will now be set that sees more activity in Q3 with the focus turning to 52 week reduction through Q4.



Recovery of 65 week waiting times – key focus

- **The biggest driver of 65+ breach risk relates to non-admitted booking rates**. Patients are being seen too late to enable a diagnostic and surgery (if required) within 65 weeks.

- Conversely, considering admitted risk, current admitted list booking to the end of March is approximately 12% of all capacity. **This indicates that there will be sufficient admitted capacity available to book the 65 week risks** so long as they are seen in outpatients in the allotted time and prioritised appropriately including appropriate clock stops.

- The 65 week recovery plan **therefore focuses primarily on non-admitted booking requirements,** however this is to be balanced with a drive to increase and continue admitted booking profile trajectory.

There are seven key SDUs with the greatest 65 week risk

A clock stop analysis up to M5 has been conducted. The table below sets out the SDUs at risk of not clearing their 65+ week risks by the end of the year.

All 65 week risks				
Specialty	No of patients at risk 31 Aug	Month of recovery based on M1-5 clock stop rate		Additional OP capacity required
Row Labels		**Month**	**Year**	
Dermatology	651	April	24	591
ENT	1830	March	24	406
Gynaecology	1568	February	24	910
Ophthalmology	1468	February	24	993
Trauma & Orthopaedics	1731	February	24	325
Urology	1094	May	24	644
General Surgery - Vascular	408	June	24	92

65 week recovery plans will focus on the SDUs above with additional activity delivered through a combination of:

- Internal BAU work – improvements in productivity, new colleagues starting, etc.
- Internal waiting list initiatives
- Insourcing or outsourcing activity including the use of DMAS

We are currently behind trajectory to see all new outpatients in the 65 week 'cohort' before the end of October. Additional capacity is being brought online and booking levels increasing day by day with recovery trajectories to be confirmed for the key SDUs.

	Patients to be seen	Booked before end October	%booked before end October	Booked after end October	Not booked	% Not booked
Dermatology	607	22	4%		585	96%
ENT	1215	763	63%		452	37%
Gynaecology	1397	348	25%		1049	75%
Ophthalmology	1157	100	9%	6	1051	91%
Trauma & Orthopaedics	634	315	50%	2	317	50%
Urology	744	83	11%	12	649	87%
Vascular	278	190	68%		88	32%
Total trust figures	6893	2593	38%	298	4002	58%

Area	Assurance statement	Current position	Next steps
Validation	The Board has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	External validation analysis using LUNA system has demonstrated that validation levels are good (90%+ clean data from weeks 35+). External analysis of our waiting list suggests a 10-13% opportunity from validation that is now being worked through.	Patient validation project commissioned as part of elective care recovery programme within the planned care portfolio. Manual validation underway with additional resource in place. Trajectory in development to provide week by week updates on numbers of patients validated from the list.
Validation	The Board has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.	The trust maintains a regular programme of validation and patient contact for people on RTT pathways. Current focus is on long waiters with ambition to expand regular validation across entire PTL. This will be supported by validation targeting software and services.	Report on proportion of 12+ week patients validated and contacted as part of the elective recovery programme. The ambition to book as many outpatients before end October as possible will support delivery towards this ambition.
Validation	The Board ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	The trust maintains a clear local access policy setting out implementation of the RTT rules. This is in addition to the systemwide access policy. Adherence with access policies regularly reviewed and maintained by the Trust's Director of Performance and Planning who provides 'external' scrutiny to divisions on their application of the access policy.	Continues to review adherence with access policy, particular focus on areas where this will support long wait reduction led by the Trust's Director of Performance and Planning. Trust engaging in BOB wide validation working group as part of the ICS Elective Care Board.
Validation	The Board has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	A clinical risk report has been shared with board around 'On Hold' patients and plans to manage this cohort. This cohort includes non-RTT patients. The management plan focuses primarily on technical and administrative review prior to application of clinical resource.	Continued implementation of on hold improvement plan. However, having demonstrated that this cohort contains little risk through initial validation the trust is prioritising limited capacity towards interventions to support in year activity and achievement of the 65+ week target
First appointments	The Board has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	A 65+ week elimination trajectory is in place with an ambition that no patients in the 65 week 'cohort' will be waiting for a first outpatient appointment after 31 October 2023. The trust is currently behind trajectory for elimination by March 24, largely due to industrial action and estates issues. A recovery plan is nearly finalised.	SDU level activity and long wait recovery plans are in place and are being aggregated into a single trust wide elective recovery plan. Further decisions on resourcing to take place by the start of October. Thereafter monitoring of these plans will begin alongside continued delivery of the planned care portfolio.
First appointments	The Board has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers	Independent sector capacity has been secured in line with trust business planning and subsequent 'sustainability paper'. This has been built in as a core part of 23/24 planning. The Trust has signed off on the plan with DMAS being actively used. The trust has offered out vascular capacity and has requested Urology and dermatology capacity with decisions to be made on utilisation (given funding constraints) as part of the elective recovery plan.	Agreement to increase utilisation of independent sector activity including DMAS as part of the elective recovery plan.
Outpatient follow-ups	The Board has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	The Trust's New:FU ratio overall is 1:1.57 which is the fourth lowest in the region. The Trust is running at 96.4% of 19/20 follow-ups against a submitted plan of 95%. Further work is underway to further reduce follow-ups through introducing patient initiated follow up in multiple specialties and through clinical triage of the follow up list through the on hold programme.	On Hold reduction has begun. New staff in coming to speed up progress Clinic template review in progress. Methodology established. First SDU to be reviewed is dermatology. Expectations set to increase 1st OPDs. Further expansion of the PIFU approach in targeted specialties.

Outpatient follow-ups	The Board has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	There has been a 57% increase in the number of follow-ups moved to PIFU in the past year from 569 to 894 (July 2023). The Trust is ranked 40th out of 131 Trusts in the country for this measure. We are currently at 2% of the 5% target. Trust has plan to achieve minimum increase of 5% based on highest use outpatient follow-up appointments. This is overseen by the Outpatient Transformation Board. Currently focus on ramping up non-cancer pathways with commitment from the following SDUs - Cardiology, Diabetic Medicine, Endocrinology, Respiratory Medicine, Rheumatology and Urology. BOB-wide meetings have been held with each specialty to look at variation and opportunity for PIFU which have informed ongoing plans. PIFU has also successfully been implemented in our community and therapy services including in dietetic services.	Discussion with cancer clinical lead around building in PIFU roll out to focus on Cancer Pathways. Detailed plans in place per SDU to ensure delivery of the 5% target to be tracked in the IPR.
Outpatient follow-ups	The Board has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.	The Trust's DNA rate is 7.1% against a national median of 7.1%. The trust has implemented a text messaging and digital letter service to improve information available to patients in order to support attendance at appointments. Text message reminders are sent in advance. Work is currently ongoing to ensure application of the access policy around multiple DNAs and non-acceptance of reasonable appointment offers. Clinics with particularly high DNA rates - e.g. diabetes - are starting to be overbooked against the DNA rate with this expected to be trustwide policy for those with high DNA rates in the coming months.	Renewed focus on application of the access policy via booking and validation teams with a focus on multiple DNAs and non-acceptance of reasonable appointment offers. Service level DNA reviews being encouraged as part of elective recovery plan to increase activity. Additional digital opportunities being explored to help reduce the DNA further including through the introduction of a patient portal.
Outpatient follow-ups	The Board has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data to identify further (via the Model Health System and data packs) areas for opportunity.	Our specialist advice service has grown 45% in the past year to 9,203 requests in June 2023. This is the 21st highest volume in the country. In June 2023 achieved a level of 31 specialist advice requests processed per 100 referrals. For services where volumes are high clinic templates have been reviewed to ensure capacity.	Continue to review the effectiveness of specialist advice area by area and ensure there is sufficient 'diversion' in these specialties.
Outpatient follow-ups	The Board has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	The Trust is has a comprehensive outpatient transformation programme looking at reducing the numbers of patients on-holds, pathway reviews to drive Patient Initiated Follow Up, group clinics and other models and supporting digital tools such as a digital outcome form. Continuous pathway redesign at a service level is taking place to streamline processes and increase capacity	Current outpatient improvement programme focusing on increasing in year activity of 1st appointments through clinic template review and the rollout of Patient Initiated Follow-Up. More detailed pathway reviews are planned in the coming months.
Support required	The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	Discussions ongoing with acute care collaborative, ICB and region (through SOF forums) around support required to meet elective needs.	Continue discussion and coordination at system and regional level balancing improved access and activity with financial constraints

Meeting: Trust Board Meeting in Public

27 September 2023

Agenda item	BHT 2024/25 Breakthrough Objectives
Board Lead	Duncan Dewhurst, CDIO
Type name of Author	Debbie Hawkins, Head of QI &Transformation
Attachments	BHT Breakthrough Objectives 2024/25
Purpose	Discussion
Previously considered	Transformation Board 20/09/23

Executive Summary

This paper sets out the proposed 2024/25 Breakthrough Objectives. These are a small set of organisation-wide priorities which are understood and owned by everyone, helping to achieve step changes towards achievement of our medium-term goals.

Breakthrough objectives were introduced for the first time in the Trust for 2023/24. This has been positive in providing a consistent shared focus on priority outcomes, with tangible progress being demonstrated in the achievement of these.

For 2024/25, the intention is to build on this year's breakthrough objectives, to keep it simple and help embed these at a team level to drive further improvements.

The proposed 2024/25 breakthrough objectives have been developed through discussion with the leadership team, informed by evidence to target our focus on the areas that will have the biggest impact in achieving our medium-term goals.

Decision	The Board is requested to discuss the proposed breakthrough objectives for 2024/25.

Relevant Strategic Priority

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

Relevant objective

☐ Improve waiting times ☐ Improve safety ☐ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☐ Improve the experience of our new starters ☐ Upskill operational and clinical managers

Implications / Impact

Patient Safety	As business plans are developed, any impacts on patient safety will be identified and addressed as part of the QIA process.
Risk: link to Board Assurance Framework (BAF)/Risk Register	1. Failure to provide care that consistently meets or exceeds performance and quality standards including safety, experience and outcome. 2. Failure to deliver our annual financial and activity plans. 3. Failure to work effectively and collaboratively with external partners 4. Failure to 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	Any financial implications related to achievement of breakthrough objectives will be addressed via standard trust processes.
Compliance CQC Standards Good Governance	This report provides assurance on the development of the Trust's annual breakthrough objectives.
Partnership: consultation / communication	Draft objectives have been developed with input from relevant leads and other senior leaders.
Equality	As plans are developed to achieve breakthrough objectives, 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.

Breakthrough Objectives 2024/25

Vision

Outstanding Care, Healthy Communities, Great Place to Work

Mission

Personalised, compassionate care every time

	Outstanding Care	Healthy Communities	Great Place to Work
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 2024/25	Improve waiting times in our emergency department, with <2% of patients waiting more than 12 hours Improve safety, with 100% of 99 areas accredited and 40% maintaining Silver awards for the next 2 years Improve Trust productivity by a further 5% to ensure no patients wait more than a year to be seen	Improve children's development for communities experiencing the poorest outcomes, with 85% attending 12 month review by age 15 months Improve identification of hypertension, with x% of patients having a blood pressure check at Outpatient appointment	Improve colleagues experience of inclusion in the Trust, by reducing bullying by 2%

Meeting: Trust Board Meeting in Public

27 September 2023

Agenda item	Month 5 2023/24 Finance Report
Board Lead	Jon Evans – Chief Finance Officer
Type name of Author	Yasmeen Rabindranath – Head of Financial Management
Attachments	Month 5 2023/24 Finance Report
Purpose	Assurance
Previously considered	EMC, F&BP

Executive Summary

As at Month 5 2023/24, the Trust is reporting a Month 5 YTD deficit of -£10.7m, in line with the Month 5 YTD Planned Deficit of -£10.7m. As at Month 5 there are no adjustments to funding in relation to level of Variable or Elective Recovery Activity undertaken, with all contracted funding assumed.

Month 5 2023/24 YTD the Trust has delivered Efficiencies of £8.7m, -£0.3m behind the Month 5 YTD Plan of £9.0m, as at Month 5 2023/24 the Trust is forecasting to deliver £30.52m of the £36.22m 2023/24 Efficiency Plan, based upon latest assessment of Divisional forecasts and one-off programmes under ‘finance controls’. This forecast £5.7m shortfall in efficiency plan delivery will require to be mitigated either by mitigating actions in Efficiency Plans or through reductions in planned run rate of expenditure or delayed / reduced investments.

As at Month 5 20223/24 the Trust has delivered £2.9m of the £50.1m 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 5 2023/24 was £14.2m (£4.6m better than plan), with the forecast Cash Balance at the end of 2023/24 being £1.92m.

A verbal update following discussions at the Executive Management Committee and Finance & Business Performance Committee on 26 September 2023.

Decision	The Board is requested to take assurance from the report

Relevant Strategic Priority

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

Relevant objective

☐ Improve waiting times ☐ Improve safety ☒ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☐ Improve the experience of our new starters ☐ Upskill operational and clinical managers

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 the annual financial plan
Financial	Achieving our financial targets for 2023/24
Compliance NHS Regulation	Achieving the NHSE approved 2023/24 financial plan
Partnership: consultation / communication	Achieving our part of the BOB ICB 2023/24 Financial Plan

Equality	Equality is considered in all aspects of financial planning, support and reporting
Quality Impact Assessment [QIA] completion required?	N/A

Finance Report Month 5 - 31st August, 2023

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Executive Summary

Table 1 - Income and Expenditure Summary

£m	Annual Plan	Year to Date			In Month		
		Plan	Actuals	Variance	Plan	Actuals	Variance
I&E Surplus / (Deficit)	**(12.1)**	(10.7)	(10.7)	**0.0**	(1.2)	(1.3)	**(0.1)**

The Trust planned a deficit of £(10.7)m by Month 5 and reported an actual deficit of £(10.7)m, a position in line with plan.
In month, there was a worsening of performance versus plan of £(0.1)m.

Key drivers of performance to date are:

Description (£m)	Variance	Narrative
Outsourced diagnostics	(1.3)	Higher than planned use of radiology MRI and CT scanning and reporting to recover performance
Industrial action pay costs	(0.7)	Net medical pay costs. Does not include cost of carrying out lost activity
High Cost drugs	(1.0)	Net effect of PbR excluded drugs income overachievement and overspend in expenditure
Utilities	0.7	Gas and electricity costs lower than additional planned spend
Investments	2.5	Lower than planned spend in agreed investments
GRNI reversal	1.5	Additional benefit against £1.5m non-recurrent CIP
PFI Unitary payment	(2.0)	No benefit taken YTD against the £2.0m non-recurrent CIP
Specialist Services income	0.6	Prior year Thames Valley Cancer Alliance income and blood sciences income
Other	(0.3)	
I&E Surplus / (Deficit)	0.0	

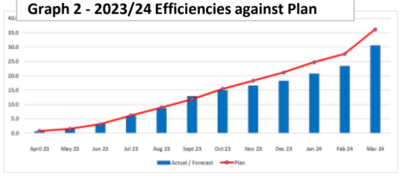
Drivers of financial performance:
- Performance includes the following one-off items:
  - £(0.7)m net medical pay industrial action costs, not in plan
  - £3.0m GRNI reversal benefit, against £1.5m YTD plan
  - £1.6m VAT benefit, against £1.6m YTD plan
  - £0.6m prior year Specialist Services income

Year end forecast remains in line with plan, a deficit of £(12.1)m, with a detailed re-forecast being carried out before the reporting of Month 6 / September.

Graph 1 - Income & Expenditure YTD position & Forecast

Efficiencies:
- Reported efficiencies are £8.7m, £(0.3)m adverse (97%) of the year to date plan. 25% of the annual plan has been phased into budgets to date.
- The main forecast variances are in the Surgery & Critical Care and Integrated Medicine divisions.
- Major programmes to implement in next 4-6 weeks are: PFI Unitary payment, £2.0m, planned in M5 to be delivered M6.

Graph 2 - 2023/24 Efficiencies against Plan



Clinical activity and income:
Activity variance is £1.84m; 1.3% ahead of plan at M4 YTD. Main variances to plan are:
- PbR excluded drugs: £1.49m,12.0%
- ITU: £0.52m, 18.1%
- Outpatient Procedures: £0.15m, 2.7%
- Elective Daycases: £(0.43)m, (3.4)%
- Other: £0.50m
- Spinal activity: £0.81m, 9.9%
- Non Elective IP: £(0.66)m, (2.1)%
- Outpatient First attendances: £(0.78)m, (7.6)%
- Elective Inpatients: £(0.22)m, (4.2)%

Key assumptions in reported performance:
- No adjustment made for Elective activity subject to variable API payment.
- Payment made for volume driven activity across High Cost Drugs/Devices and Direct Access Diagnostics.
- No generic accrual for costs of any future inflationary rises in non-pay.
- No additional accrual for medical or VSM pay awards, income or expenditure.
- Accrual of outsourced diagnostics costs (PPG), with 2023/24 contract still to be agreed and invoices still to be paid.

Workforce (including Agency):
- Pay spend is £157.6m YTD at Month 5, £(0.5)m adverse to plan.
- WTEs in Month 5 total 6738 (excluding pay savings target); 4 higher than last month and 333 higher than 12 months ago.
- Largest increases from Month 5 last year are Nursing: 245; Admin and Clerical: 54 and Prof & Tech: 40.
- Agency spend is £5.2m YTD, 3.3% of total pay spend of £157.6m and 0.4% lower than the 3.7% NHSE cap.

Issues, risks and opportunities:
- Ongoing impact of **industrial action** on planned care volumes and costs of maintaining safe staffing, with costs and impact of recovering activity still to be quantified.
- Delivery of **efficiencies** and **productivity** increases, in-year and recurrently into next year, see Page 8.
- Management of **Home First** (c100% above plan) and **outsourced diagnostics capacity** (£1.3m pressure), within plan levels.
- Elective activity subject to **variable Aligned Payment and Incentive** (API) payment. Lower than planned activity, with estimated risk at between £1.2m and £1.5m (TBC) YTD, if payment witheld. ICS planning assumptions agreed that variable payment would not operate in year, but NHSE guidance mandates it does operate unless specific dispensation agreed (not in place).
- Management of **investments** to ensure delivery of benefits, productivity and / or cost reductions.

Capital and cash:
- £2.9m of capital programme has been spent to date, £8.9m variance to plan and 5.8% of the annual capital programme.
- Main variances are due to the flat profile of the operating plan. Forecast spend has been prepared with project leads which ensures delivery by the end of the financial year.
- Cash receipts in M5 totalled £55.2m, £1.6m higher than forecast and £0.3m lower than in M4.
- Cash forecast is being monitored to ensure that any requirements for external cash support from NHSE is flagged in time to ensure draw down in Q4.

Capital Expenditure (£M)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Medical Equipment	2.0	0.7	1.3
Property Services	2.6	1.4	1.2
Information Technology	5.2	0.8	4.4
General	1.2	(0.0)	1.2
Flow	0.8	0.1	0.7
Total Capital Expenditure	**11.8**	**2.9**	**8.9**

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	45.9	46.1	0.2	229.3	229.5	0.1	549.3
Other income	3.7	4.2	0.6	16.1	18.0	2.0	41.1
Total income	**49.6**	**50.3**	**0.7**	**245.4**	**247.5**	**2.1**	**590.3**
Pay	(31.6)	(32.0)	(0.3)	(157.1)	(157.6)	(0.5)	(363.9)
Non-pay	(15.6)	(16.4)	(0.8)	(81.3)	(84.6)	(3.3)	(197.2)
Total operating expenditure	**(47.2)**	**(48.4)**	**(1.2)**	**(238.4)**	**(242.2)**	**(3.8)**	**(561.1)**
EBITDA	**2.4**	**1.9**	**(0.4)**	**7.0**	**5.3**	**(1.7)**	**29.2**
Non Operating Expenditure	(3.5)	(3.3)	0.2	(17.7)	(16.8)	1.0	(41.4)
Retained Surplus / (Deficit)	**(1.2)**	**(1.4)**	**(0.2)**	**(10.7)**	**(11.4)**	**(0.7)**	**(12.1)**
Adjusted financial performance excluding profit on disposal of assets and excluding impairment	**(1.2)**	**(1.3)**	**(0.1)**	**(10.7)**	**(10.7)**	**(0.0)**	**(12.1)**

Financial Performance Summary

• The Trust reports a position in line with plan as at August 2023/24: a £(10.7)m Month 5 YTD deficit. The Trust is forecasting to achieve the £(12.1)m deficit plan for 2023/24, as submitted to NHSE with mitigating actions.

• The Month 5 YTD capital spend is £2.9m against the £11.8m Month 5 YTD plan. Total Capital Resource Limit (CRL) funding of £50.1m includes BOB/ICS £21.3m, PFI Lifecycle £1.7m, and PDC allocations of £26.9m, £5.7m for ERF, £0.7m for Digital Diagnostic Capability programme, £10.6m for additional beds and £10m for the Business Centre. £0.1m of donated assets have been added to the programme in month. At Month 5 2023/24, a small overspend is forecast against the CRL of £(0.03)m. The forecast position is being continually reviewed with the project leads and managers.

• Contract Income includes Trust agreements for 2023/24 funding with BOB ICB as part of the 2023/24 annual plans submitted to NHSE 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 5 YTD Contract Income position also includes expected levels of funding from Commissioners for the 2023/24 Agenda for Change Pay Award. As at Month 5 YTD no adjustments have been made related to the Elective Recovery Funding (ERF) received by the Trust as part of our contract baseline values for 2023/24; or for Elective activity subject to variable API payment.

• Other income totals £18.0m YTD at Month 5 2023/24, £2.0m favourable to plan. Home First income is £0.8m favourable to plan at M5 YTD within Integrated Elderly and Community Care, offsetting pay and non pay costs due to activity being significantly ahead of plan. Specialist Services divisional income is overachieved by £0.8m YTD at M5, mainly relating to £0.2m prior year Thames Valley Cancer Alliance income; £0.1m prior year blood sciences income and £0.1m additional mortuary income.

• Pay costs for Month 5 YTD 2023/24 total £(157.6)m, a £(0.5)m adverse variance to plan. The expenditure includes 2023/24 M5 YTD Pay Award costs and £(0.8)m for Local CEA awards. Within this overall position clinical areas continue to experience unplanned temporary staff spend, particularly for Medical staff. The trust total agency, bank & locum spend is £22.4m at Month 5 YTD. These overspends are partially offset by vacancies.

• Non-pay operating expenditure totals £(84.6)m at M5 YTD 2023/24, a £(3.3)m adverse variance against the M5 YTD plan. Clinical supplies are underspent by £1.2m, mainly related to an overachievement against the GRNI reversal benefit non-recurrent CIP of £3.0m, against a plan of £1.5m and other divisional underspends; partially offset by outsourced MRI and CT scanning and reporting costs. PbR excluded drugs are £(1.5)m overspent YTD at Month 5; there is an adverse variance to plan of £(3.3)m in PFI YTD at M5. £(2.0)m of this relates to the PFI Unitary payment CIP plan phased in M5, which is expected to deliver but for which no benefit has been taken YTD. PFI costs are also overspent in Property Services. In Premises and Plant costs, there is a £0.7m underspend on energy YTD at M5. There is also a £0.6m underspend on contracts and £0.4m underspend on local area network costs. Miscellaneous costs are overspent by £(0.6)m YTD at M5 in the Integrated Elderly and Community Care division related to Olympic Lodge costs and prior year virtual ward costs.

• Non operating expenditure reports a £1.0m favourable variance to plan YTD at Month 5 2023/24 related to owned depreciation and income receivable with £0.7m and £0.2m respective favourable variances to plan.

Key Highlights: Income

NHS Income and Activity

• The Contract Income position totals £229.45m YTD at Month 5 2023/24 which is £0.15m ahead of the Month 5 YTD plan, with the 2023/24 plan based on contract offers where available and risk-adjusted expected contract values assumed where contracts are not yet agreed. Within Contract Income, a £(0.39)m adjustment has been made for the risk to Home First income that is showing a favourable variance in Integrated Elderly and Community Care. For PbR excluded drugs, in Specialist Commissioning £0.83m overachievement has been accrued YTD at M5 and an adjustment has been made for an estimated YTD adverse variance to budget for Cancer Drugs Fund drugs of £(0.32)m.

• As at Month 5 YTD no adjustments have been made related to the Elective Recovery Funding (ERF) received by the Trust as part of our contract baseline values for 2023/24. Organisational level ERF performance for this year is published nationally by the NHSE national pricing team. To date only performance relating to Month 1 and Month 2 has been published. The YTD Month 2 2023/24 actual ERF performance against the NHSE target indicates a potential claw back to the Trust's commissioners of £(0.38)m (£1.1m before application of cap on clawback which is a maximum of 16% of the ERF value), as shown in Table 4 below. For 2023/24 there is no additional funding expected if the ERF target is exceeded. This Month 2 YTD ERF performance is consistent with Trust reported Elective activity levels delivered. The YTD target may change as we are awaiting confirmation of the target phasing by NHSE, including the impact of the 2% reduction in target due to Industrial Action (IA), assumed to be phased equally across the year. There may also be future additional adjustments to targets to reflect IA beyond April; there is currently no confirmation of this.

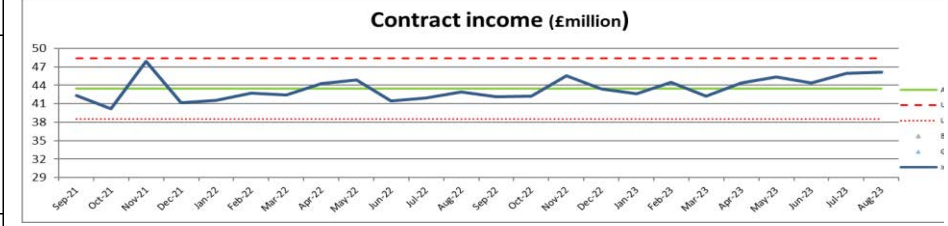
• For Elective activity subject to variable API payment, performance at Month 4 (based on Months 1 to 3 frozen data and Month 4 flex data) is worse than plan by £(1.2)m, despite the activity plan having been set at c.10% below 2019/20 outturn in Elective / Day Case points of delivery (PODs). Due to commissioning finance, performance and activity plans not being triangulated at the plan submission stage, further work is likely to be required to align them for in year reporting purposes. A more detailed breakdown of API performance by division and POD is shown in Appendix 2. Other than the PbR excluded drugs adjustments mentioned above, no adjustments have been made to the position for this.

• 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 increases in income in September 2022 and June 2023 reflect the pay award funding for the previous 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	170.8	170.6	(0.3)
BOB ICS (Additional Inc)	0.0	0.0	0.0	0.0
Bob Block Sub Total	**410.0**	**170.8**	**170.6**	**(0.3)**
Associates	37.9	15.8	15.7	(0.1)
Specialist Commissioners	77.4	32.2	32.8	0.5
Regional Specialist	4.6	1.9	1.9	(0.0)
Other NHS	3.5	1.5	1.6	0.1
Bucks Council	14.9	6.7	6.6	(0.0)
Other Income	1.0	0.4	0.3	(0.1)
Total	**549.3**	**229.3**	**229.5**	**0.1**

Graph 3 - 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	0.7	0.8	0.1
Education And Training	13.2	5.5	5.7	0.2
Non-NHS PPS & Overseas Visitors	3.5	1.5	1.8	0.3
Injury cost recovery scheme	1.2	0.5	0.5	0.0
Donated Asset Income	1.7	0.7	0.1	(0.6)
Other Income	19.8	7.2	9.2	2.0
Total	**41.1**	**16.1**	**18.0**	**2.0**

Other Income is £2.0m favourable to plan at Month 5 YTD, driven by:

• Home First income which is £0.77m favourable to plan at M5 YTD within Integrated Elderly and Community Care, offsetting pay and non pay costs due to activity significantly above planned levels (income risk from ICB mitigated within Contract Income).

• Specialist Services income overachievement of £0.79m YTD at M5, mainly relating to prior year Thames Valley Cancer Alliance income; prior year blood sciences income and additional mortuary income.

• Overseas Visitor and Private Patient income is £0.3m above plan and Education and Training income £0.2m above plan at M5 YTD.

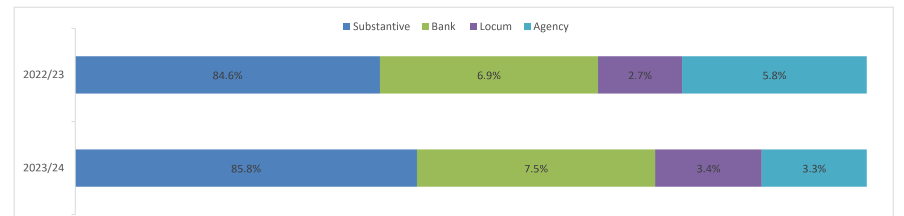
Table 4 - M1-2 2023/24 ERF Performance, by Commissioner

2023/24 ERF Performance to M2 (NHSE on NHS Futures) (£k)							
Commissioner	M2 YTD Target	M2 YTD Actual	M2 YTD variance	Maximun annual risk @ 16%	Maximum Actual Risk @ M2 YTD @ 16%	M2 potential claw back	
BOB ICB	14,865	13,859	(1,006)	(2,016)	(336)	(336)	Against target of 105% of 19/20 VWA
Associate ICBs	1,775	1,496	(279)	(231)	(39)	(39)	
Sub total ICBs	**16,640**	**15,355**	**(1,285)**	**(2,247)**	**(375)**	**(375)**	
NHSE	**2,094**	**2,284**	**190**	**(645)**	**0**	**0**	No expected ERF gain for over performance
Total	**18,734**	**17,639**	**(1,095)**	**(2,892)**	**(375)**	**(375)**	

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	156.3	135.2	21.1	85.8%	120.4	84.6%
Bank	0.4	11.9	(11.5)	7.5%	9.8	6.9%
Locum	0.2	5.3	(5.1)	3.4%	3.8	2.7%
Agency	0.2	5.2	(5.1)	3.3%	8.3	5.8%
Total	**157.1**	**157.6**	**(0.5)**	**100.0%**	**142.3**	**100.0%**



• Pay expenditure totals £(157.60)m at Month 5 YTD 2023/24 which is £(0.52)m adverse to the M5 YTD plan. The expenditure includes 2023/24 M5 YTD Pay Award costs and £(0.80)m for Local CEA awards. Key pressure areas in pay include:

- A significant overspend in Medical staffing costs of £(1.69)m YTD at Month 5. This relates to a temporary medical staff overspend of £(5.37)m, partially offset by a substantive medical staff underspend of £3.68m at M5 YTD. This overspend is across all clinical divisions, with the majority of the overspend, £(1.17)m within Surgery and Critical Care. This is partially due to the impact of the industrial action as well as maternity leave and long term sickness cover.

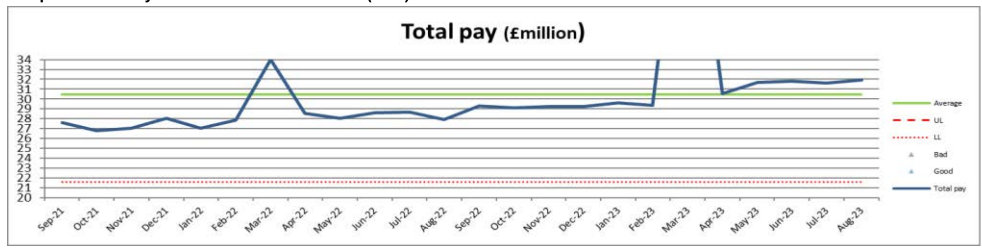
-The medical pay overspend is offset by a large underspend in nursing costs of £(1.44)m at M5 YTD, across all clinical divisions with the exception of Integrated Medicine which shows a nursing overspend of £(0.22)m due to high temporary staffing usage in Emergency Department, Acute Medicine, Diabetes & Endocrinology and Respiratory. Additionally, there is a £0.59m underspend in divisional investment nursing budgets in Corporate Services.

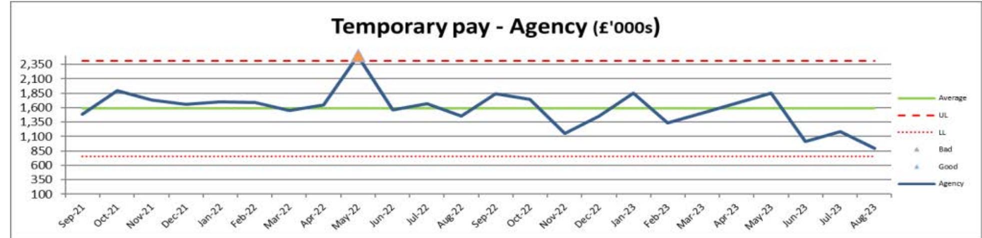
• Temporary staffing expenditure (bank, agency & locum) totals £(22.4)m at Month 5 YTD. These costs are partially offset by vacancy related underspends within substantive budgets. Agency expenditure totals £(5.23)m at Month 5 YTD, equating to 3.3% of total pay costs YTD, below the 3.7% cap for 2023/24. Agency costs have been declining this financial year with M5 incurring the lowest costs, offset by an increase in bank costs which are the highest to date 2023/24 in M5.

• There has been a year-on-year increase in actual WTEs from 2019/20 to 2023/24 (excluding pay savings targets), as shown in Graph 7. In Month 5 2023/24, there is a 18% increase in WTE compared to 2019/20.

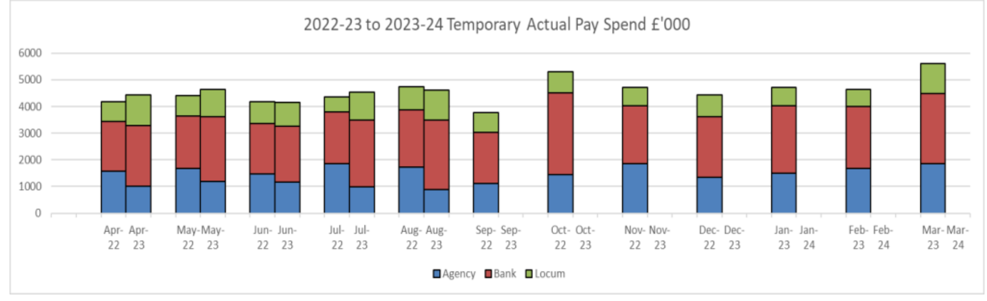
• The Pay Statistical Process Control Charts are detailed below (Graph 3 & 4). Key highlights include the increase in total pay costs in March 2022 and 2023 includes year end pay related adjustments which included a £(13.52)m employers pension top up in March 2023. This is reflected in the subsequent 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. In this financial year, the pay award payments were made to substantive workforce in June 2023 which included backdated pay awards for April 2023 and May 2023, as well as a non-consolidated pay award related to 2022/23.

Graphs 4 & 5 - Pay Statistical Process Control (SPC) Charts

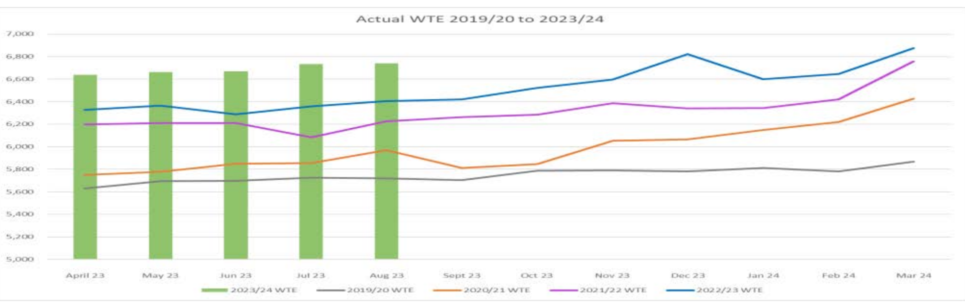




Graph 6 - 2022/23 to 2023/24 Temporary Pay Expenditure



Graph 7 - 2019/20 to 2023/24 Actual WTE



Key Highlights: Expenditure (Non Pay)

Table 5 - YTD non-pay position

Non-Pay category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Drugs	51.2	21.3	22.6	(1.2)
Clinical supplies	35.3	14.4	13.2	1.2
Other non-pay	110.8	45.6	48.8	(3.2)
Total Expenditure	**197.2**	**81.3**	**84.6**	**(3.3)**

Table 6 - YTD drugs position

Drug Categories (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
PBR Drugs	12.4	5.2	5.0	0.1
PBR excluded Drugs	37.0	15.4	16.9	(1.5)
Other Drug Items	1.8	0.7	0.6	0.1
Total expenditure	**51.2**	**21.3**	**22.6**	**(1.2)**

Non pay expenditure totals £(84.6)m for Month 4 2023/24 YTD, an overspend of £(3.3)m against the Month 5 YTD non pay plan. Key drivers of the non pay position include:

• Clinical supplies £1.2m underspend YTD at M5:
-£1.59m YTD favourable variance in Corporate Services driven by an overachievement against the GRNI reversal benefit non-recurrent CIP of £2.98m, against a plan of £1.50m.
- Specialist Services M5 YTD overspend of £(1.96)m, mainly related to outsourced MRI and CT scanning and reporting to address the activity backlog. Radiology outsourcing is now being prioritised to cancer pathway and long wait patients.
- Clinical supplies underspends across all other divisions, with the largest in Surgery and Critical Care of £0.49m YTD at M5, mainly related to reduced theatre activity during industrial action.

• Drugs expenditure is £(1.24)m adverse to the M5 YTD plan of £(21.33)m. PbR excluded drugs are £(1.48)m overspent at Month 5 YTD, of which £(0.69)m relates to Gastroenterology.

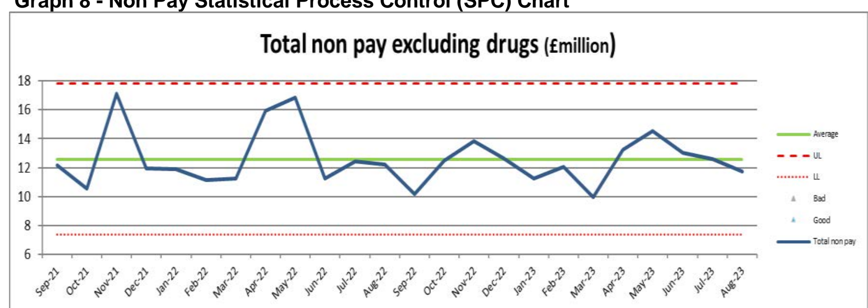
• There is an adverse variance to plan of £(3.34)m in PFI YTD at M5. £(2.0)m of this relates to the PFI Unitary payment CIP plan phased in M5, which is expected to deliver but for which no benefit has been taken YTD. PFI costs are also overspent in Property Services by £(1.13)m mainly related to: additional North and South Bucks PFI costs; scaffolding overspend for Wycombe Tower and pre-work for the Innovation Centre, Mandeville Wing & Tower and Sale Projects.

• Miscellaneous costs are overspent by £(0.56)m YTD at M5 in the Integrated Elderly and Community Care division related to Olympic Lodge costs and prior year virtual ward costs.

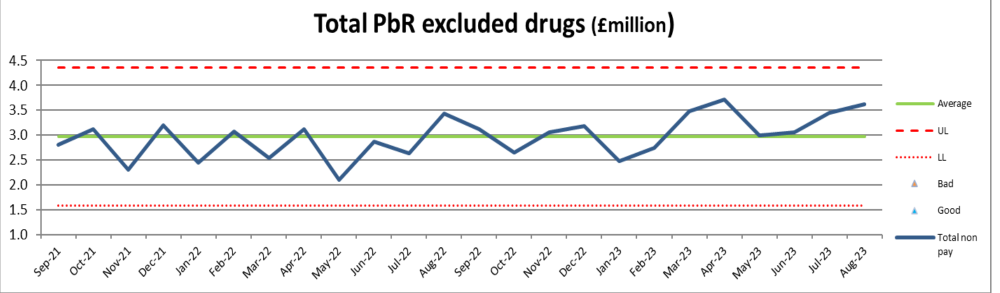
• In Premises and Plant costs, there is a £0.69m underspend on energy YTD at M5. There is also a £0.56m underspend on contracts and £0.35m underspend on local area network costs.

Statistical Process Control charts (SPC) for non pay and PBR Excluded drugs expenditure are detailed below (Graphs 5 & 6):
- 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 8 - Non Pay Statistical Process Control (SPC) Chart



Graph 9 - PbR Excluded Drugs Statistical Process Control (SPC) Chart



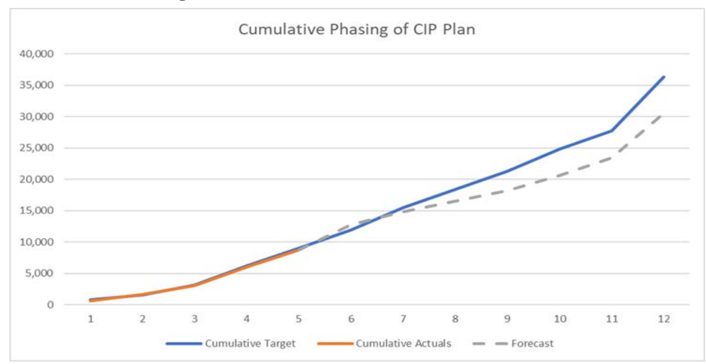
2023/24 Efficiencies

Division	Lead	Target	M05 YTD Delivery Value (£'000)	M05 Forecast Delivery Value	Forecast Variance	Forecast RAG
Integrated Medicine	HB	3,761	128	1,839	(1,922)	
Integrated Elderly Care	JR	1,998	326	1,998	0	
Specialist Services	ID	3,732	1,245	3,707	(24)	
Surgery & Critical Care	JB	4,626	618	2,820	(1,806)	
Women's and Children's	DM/GP	2,600	28	2,633	33	
Clinical Divisions		-	-		-	
Total Clinical		**16,717**	**2,346**	**12,998**	(3,719)	
Chief Executive	NM	156	84	201	45	
Chief Operating Off-Management	RB	199	76	197	(3)	
Information Technology	DD	1,009	514	1,103	94	
Finance Dept	JE	395	160	395	0	
Property	AW	2,450	382	1,613	(837)	
People Directorate	BoK	421	165	421	(0)	
Medical Director	AM	14	11	14	(0)	
Nursing Director	KB	779	191	717	(62)	
Corporate	JE	1183	-	1,183	-	
Corporate Total		**6,607**	**1,583**	**5,844**	(763)	
Commercial*	AW	738	-	-	(738)	
Trustwide		-	-	-	-	
Unallocated		1,553	-	-	(1,553)	
Total (excl. NR)		**25,615**	**3,929**	**18,842**	**(6,773)**	
Finance Controls (Non-Rec)	JE	10,700	4,796	11,680	980	
Grand Total		**36,315**	**8,725**	**30,522**	**(5,793)**	

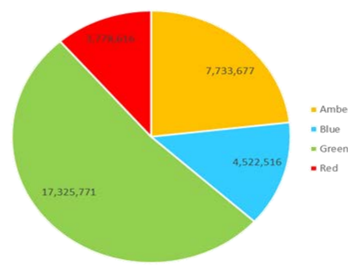
The 2023/24 full year efficiency plan target is £36.2m. This is made up of:
• £23.3m (4% plus non-recurrent 2022/23 savings in corporate departments)
• £10.7m non-recurrent savings (referenced as 'Finance controls' in the table above)
• £0.7m Commercial - The full Commercial plan target is £2m; the balance contributes to the divisional 4% target
• £1.6m Unallocated.

At Month 5, YTD efficiency plan achievement is £8.7m of which £1.6m is recurrent and £7.1m non-recurrent. This is against a Month 5 YTD plan of £9.0m, of which £3.9m is recurrent and £5.1m non-recurrent. Efficiency achievement for 2023/24 is currently forecast at £30.5m against the full year plan of £36.2m, of which £9.7m is forecast to deliver recurrently. This is based on the latest assessment of divisional forecasts which includes significant one-off programmes under 'Finance Controls'. There are identified Opportunities that need further development; additional schemes remaining to be identified and significant progress to be made on development of non-recurrent schemes to deliver recurrently. Of the plan identified value, the full year effect of recurrent schemes is £19.6m.

Table 7 - Plan Phasing



Graph 10 - Delivery Risk against Identified Plan Value*



* Based on assessment at scheme level of risk in delivery of planned scheme saving.

Divisional Positions

Breakdown of financial position by division

Table 8 - Divisional income and expenditure

Division / (£m)	YTD Budget	YTD Actuals	YTD Variance against Plan	Current Month Run Rate				
				M01	M02	M03	M04	M05
Integrated Medicine	(42.9)	(44.1)	(1.3)	(8.4)	(8.6)	(9.3)	(8.8)	(9.0)
Integrated Elderly Care	(24.2)	(24.4)	(0.2)	(4.9)	(4.7)	(5.3)	(4.7)	(4.8)
Surgery And Critical Care	(50.3)	(50.8)	(0.5)	(9.5)	(10.0)	(10.6)	(10.3)	(10.5)
Women and Children	(22.4)	(22.3)	0.1	(4.2)	(4.4)	(4.7)	(4.5)	(4.5)
Specialist Services	(37.3)	(38.8)	(1.5)	(7.7)	(7.4)	(8.2)	(7.8)	(7.7)
Total Clinical Divisions	**(177.1)**	**(180.5)**	**(3.4)**	**(34.7)**	**(35.1)**	**(38.1)**	**(36.2)**	**(36.4)**
Chief Executive	(1.6)	(1.5)	0.1	(0.3)	(0.2)	(0.4)	(0.3)	(0.3)
Chief Operating Officer	(1.4)	(1.8)	(0.4)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)
Commercial Director Mgmt	0.0	0.0	0.0	0.1	(0.0)	(0.0)	0.0	0.0
Finance Dept.	(2.6)	(2.6)	0.0	(0.5)	(0.5)	(0.6)	(0.5)	(0.5)
Information Technology	(8.1)	(8.1)	0.1	(1.6)	(1.3)	(1.8)	(1.8)	(1.6)
Property Services	(28.7)	(29.1)	(0.4)	(5.1)	(6.6)	(5.7)	(5.5)	(6.2)
Human Resources	(1.0)	(0.7)	0.4	(0.2)	(0.1)	(0.3)	(0.3)	0.1
Medical Director	(0.3)	(0.3)	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)
Nursing Director	(8.3)	(8.2)	0.1	(1.6)	(1.7)	(1.6)	(1.6)	(1.6)
PDC And Depreciation	(12.3)	(12.0)	0.3	(2.6)	(2.3)	(2.4)	(2.3)	(2.4)
Total Corporate	**(64.4)**	**(64.3)**	**0.1**	**(12.2)**	**(13.1)**	**(13.2)**	**(12.8)**	**(13.0)**
Contract Income	229.3	229.5	0.1	44.3	46.0	47.2	45.9	46.1
Corporate Services / Provisions	1.5	3.9	2.4	(1.8)	0.2	1.8	1.8	1.9
Retained Surplus / (Deficit)	**(10.7)**	**(11.4)**	**(0.7)**	**(4.3)**	**(2.1)**	**(2.3)**	**(1.4)**	**(1.4)**
Adjusted Financial Performance excl. Profit on disposal of Assets	**(10.7)**	**(10.7)**	**(0.0)**	**(4.2)**	**(1.9)**	**(2.2)**	**(1.2)**	**(1.3)**

For 2023/24, the Trust is forecasting a deficit of £(12.15)m in line with the 2023/24 annual plan as submitted to NHSE. This forecast includes mitigating actions on run rate and an expectation that efficiencies are delivered in line with £36.2m 2023/24 CIP Plan, these mitigating actions are being worked up by divisions. Key reasons for the Month 5 YTD 2023/24 divisional variances are:

Integrated Medicine £(1.26)m overspend M5 YTD
Integrated Medicine pay costs are overspent by £(0.80)m M5 YTD due to: temporary medical pay spend in Emergency Department, Neurology, Gastroenterology, Acute Medicine and Cardiology £(0.36)m; Nursing £(0.22)m due to high temporary pay spend pressures in Emergency Department, Acute Medicine, Diabetes & Endocrinology and Respiratory. Integrated Medicine non pay is £(0.55)m adverse to plan YTD at M5, driven by drugs pressures in Gastro, Neurology, Emergency Department and Dermatology and the division is reviewing current protocols. This is partially offset by an underspend in clinical supplies of £0.19m. Divisional income is overachieving by £0.44m, mainly due to Long COVID income in Respiratory, supporting costs and private patient income, mainly in Cardiology.

Integrated Elderly and Community Care £(0.22)m overspend M5 YTD
The division is overspent across pay by £(0.79)m and non pay by £(0.52)m; offset by income overachievement of £1.1m. The workforce overspend is mainly related to Admin & Clerical £(0.25)m and Medical staffing £(0.38)m driven by temporary cover for consultant vacancies. Actions are being undertaken to review medical staffing rotas and reduce this spend going forwards (e.g. by combining ward medical staff rotas), alongside actions to achieve the 5% A&C savings target. Non pay is overspent by £(0.52)m at Month 5 YTD, this is driven by Olympic Lodge costs and prior year costs for virtual wards. Divisional income overachievement is mainly related to Home First project income. The risk to this income from the ICB is being mitigated centrally within Contract Income.

Surgery & Critical Care £(0.53)m overspend M5 YTD
Pay is £(1.03)m adverse to budget YTD at M5, this mainly relates to temporary medical workforce costs across Anaesthetics & Critical Care, General Surgery, T&O, Urology and Plastic Surgery & Burns; partially due to the impact of the industrial action as well as for maternity leave and long term sickness cover. Accelerated recruitment is being worked on to fill vacant medical posts and reviews of current backfilling and locum oncall arrangements are being undertaken. Non pay is £0.30m underspent YTD at Month 5, mainly related to clinical supplies costs due to reduced theatre activity during industrial action. Income is £0.20m favourable to plan YTD at M5, mainly due to private patient income overachievement in Anaesthetics and Trauma & Orthopaedics.

Women & Children £0.12m underspend M5 YTD
The Month 5 YTD underspend is mainly due to income overachievement of £0.21m driven by midwifery salary support from NHSE and additional funding from BOB ICB for the children with special educational needs and disabilities (SEND) specialty service. There is a small underspend in non pay of £0.48m. These offset a pay overspend of £(0.14)m YTD at M5: Nursing is underspent by £0.46m due to vacancies in Community Paediatrics, Obstetrics and Sexual Health and there are overspends across the other staffing groups, with the largest overspend in Medical of £(0.35)m due to increased temporary staffing costs in Gynaecology and Acute Paediatrics.

Specialist Services £(1.48)m overpend M5 YTD
Non Pay in Specialist Services is overspent by £(2.25)m at Month 5 YTD. This is primarily driven by clinical supplies costs in Radiology and Pathology; MRI / CT scanning and reporting is being used to address the activity backlog. Outsourcing costs are now being prioritised to cancer pathway patients and long wait patients. In Pathology, there have been one off costs for lab reagents and recurrent overspend on managed service contracts and lab equipment. These overspends are partially offset by income overachievement of £0.79m YTD at M5, mainly relating to £0.2m prior year Thames Valley Cancer Alliance income; £0.13m prior year blood sciences income and £0.12m benefit of mortuary income in month.

Property Services £(0.42)m overspend M5 YTD
Driving factors in the Property Services M5 YTD non pay overspend of £(0.41)m are the Wycombe Tower scaffolding additional costs; PFI costs and pre-work activity costs for the Innovation centre, Mandeville Wing & Tower and Sale projects. Divisional income is under-recovered by £(0.29)m due to the vacancy of Chalfont and reduced level of accommodation income. This is mostly offset by a pay underspend of £0.28m M5 YTD, related to vacant posts.

Chief Operating Officer £(0.36)m overspend M5 YTD
This overspend mainly relates to COO Management £(0.24)m YTD at M5, driven by consultancy costs and pay overspends.

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	365.2	355.1	(10.1)	(0.8)
Cash and cash equivalents	9.6	14.3	4.7	1.8
Trade and other current assets	46.3	35.7	(10.6)	(3.4)
Total Assets	**421.1**	**405.1**	**(16.0)**	**(2.4)**
Current Borrowing	(3.5)	(3.2)	0.3	0.7
Other Current liabilities	(80.8)	(72.5)	8.3	0.3
Non Current Borrowing	(40.2)	(38.5)	1.7	0.0
Other Non-current liabilities	(1.4)	(1.4)	(0.0)	0.0
Total Liabilities	**(125.9)**	**(115.6)**	**10.3**	**1.0**
TOTAL NET ASSETS	**295.2**	**289.4**	**(5.7)**	**(1.4)**
PDC and Revaluation reserve	428.9	424.4	(4.5)	0.0
Income and Expenditure Reserve	(133.8)	(135.0)	(1.2)	(1.4)
TOTAL EQUITY	**295.2**	**289.4**	**(5.7)**	**(1.4)**

- Non Current assets have decreased by £0.8m from the prior month. This is due to depreciation in month (£1.7m) exceeding capital additions. Non current assets are £10.1m behind plan due to capital spend being behind projections.
- Trade and other current assets are lower by £3.4m compared to prior month and £10.6m lower than plan. This is mainly due to a decrease in prepayments which fluctuates in general from month to month.
- Movements in plan numbers of current assets and current liabilities are in line with working capital management.
- The change in Income and Expenditure reserve of £1.4m from the prior month is consistent with the planned position for M5.

Accounts Receivable

Table 10 - Accounts Receivable

Month 5

(£m)	Current	31-60 days	61-180 days	6 mths - 1 year	1 year - 2 years	More than 2 years	Total
NHS	1.7	1.0	1.0	0.1	0.1	0.1	3.9
Non-NHS	1.1	0.3	0.4	0.3	0.3	0.8	3.2
Total	**2.8**	**1.3**	**1.4**	**0.4**	**0.4**	**0.9**	**7.1**
% of total	40%	18%	20%	5%	5%	12%	100%

Month 4

(£m)	Current	31-60 days	61-180 days	6 mths - 1 year	1 year - 2 years	More than 2 years	Total
NHS	1.3	0.9	1.0	0.1	0.2	0.1	3.7
Non-NHS	1.7	-0.1	0.4	0.4	0.2	0.8	3.4
Total	**3.1**	**0.8**	**1.4**	**0.5**	**0.4**	**0.8**	**7.1**
% of total	43%	11%	20%	7%	6%	12%	100%

- Debtors have remained constant across M4 and M5 at £7.1m.
- Outstanding debt outside payment terms has increased by £0.3m which is principally caused by one invoice from the NHS Bucks, Oxfordshire And Berks West ICB moving from current to overdue receivables.
- Included in the Non-NHS debt is £0.4m of aged debt that has been put forward to write off as it is considered irrecoverable. This will be covered by general bad debt provision hence no impact on revenue.
- **Top 5 overdue debts at month 5 are:**
  1 - Oxford University Hospitals NHS FT £1.1m
  2 - NHS Bucks, Oxfordshire And Berks West ICB £0.6m
  3 - The Shelburne Hospital £0.3m
  4 - Imperial College Hospital NHS Trust £0.3m
  5 - Buckinghamshire Council £0.1m

The table has been revised to extend 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	31-60 days	61-90 days	91-120 days	>120 days	Total
NHS	0.2	0.0	0.0	0.0	-0.0	0.1
Non-NHS	7.8	-0.1	0.1	0.2	-0.0	8.0
Total	**7.9**	**-0.1**	**0.1**	**0.2**	**-0.1**	**8.1**

The creditors table reflects creditors which have been approved on the ledger, authorised for payment and are awaiting payment. There have been payments on account for some suppliers which have a different ageing profile than the invoice to which the payment relates. This has created the credit balance within some ageing buckets.
The invoice register shows invoices that are outstanding and not been approved for payment.

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 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
Month 4	4.1	442	2.6	100	0.2	35	0.8	119	0.2	77	0.2	67	0.1	44
Month 5	3.3	370	1.5	66	0.6	44	0.7	97	0.2	56	0.2	65	0.1	42

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 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
Month 4	13.6	2,606	4.0	787	3.0	274	5.0	679	0.9	340	0.5	331	0.2	195
Month 5	11.3	2,712	3.4	718	2.2	400	4.4	689	0.6	370	0.6	341	0.2	194
Total M5	14.7	3,082	4.9	784	2.8	444	5.1	786	0.8	426	0.8	406	0.3	236

Overview (NHS/Non-NHS)
M5 shows positive trends for both NHS and non-NHS in both value and count of invoices on the register with only a slight movement up in the count for non-NHS invoices compared to M4.
Count - on the count total 3082 invoices, we only saw an overall marginal increase of 34 invoices with NHS reporting a reduction of 72 invoices whereas non-NHS saw a marginal increase of 106 invoices.
Value - on value (£14.7m) we reported overall £3.1m reduction in the value of invoices compared to M4 with NHS accounting for £0.8m and non-NHS £2.3m.
Detailed Analysis (NHS/Non-NHS)
Non NHS - For non-NHS, 17 invoices (>=£100K each) account for £4.1m of the total £14.7m register value at M5.
Top Six non-NHS Suppliers with Invoice(s) Value>=100k (£3.59m)
1. Practice Plus Group Hospitals Ltd - £2.04m
2. Abbott Laboratories Ltd - £0.42m
3. Siemens Healthcare Ltd - £0.36m
4. Rennie Grove Hospice Care - £0.33m
5. Moduleco Healthcare Ltd - £0.30m
6. Bytes Software Services - £0.15m

The number of high value invoices not current (0-30 days) has increased on the register this month due mainly to purchase orders for the cost not being raised by the departments in a timely manner. These delays are normally due to the approval being sort due to the high value of the Purchase order needed for the year. Both the senior management and accounts payables teams are working with the departments to move these approvals through the process.

NHS - 6 NHS invoices (>=100k each) account for £1.2m (40%) of the 3.3m NHS register value at M5. £1.17M Oxford University Hospital 93%/ SCAS - £771k of invoices have no PO approved. Various staffing invoices with a count of 120 invoices totalling £1.15M have no valid PO. Its expected that month 5 will see a number of these high value items resolved.

Top NHS Suppliers (>=£100K value) Invoices
1. South Central Ambulance (SCAS - 2invs) - £0.75m
2. Oxford Univ Hosp NHS FT (3invs) - £0.33m
3. MWL Teaching Hosp NHS Trust (1inv) - £0.15m

Better Payment Practice Code

Table 12 - Better Payment Practice Code

	Count Total	Count Pass	% Pass	Total (£m)	Pass (£m)	% Pass
NHS	1,044	703	67%	25.5	23.4	92%
Non-NHS	24,754	22,316	90%	128.7	116.1	90%
Total	**25,798**	**23,019**	**89%**	**154.2**	**139.5**	**90%**

Adherence to the BPPC requires 95% of suppliers to be paid within 30 days of receipt of a valid invoice.
Movement in the invoice register of old invoices (>30days) successfully matched to a PO has a direct impact on the BPPC targets.
NHS - In M5 significant number of invoices outside payment terms were successfully paid which led to a slight decrease in BPPC count target for NHS invoices (67%). AP team are working with the wider organisation to improve the PO raising/matching processes with the view of meeting Trust's BPPC targets.
Non-NHS - Work continues to improve the performance to the target level . However in the short term this includes an exercise to clear very old payables from the register which may have an adverse impact on BPPC performance in the short term.

CHART OF YTD M5 BPPC TARGET BY COUNT

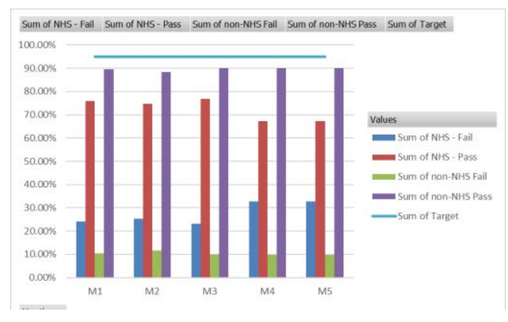
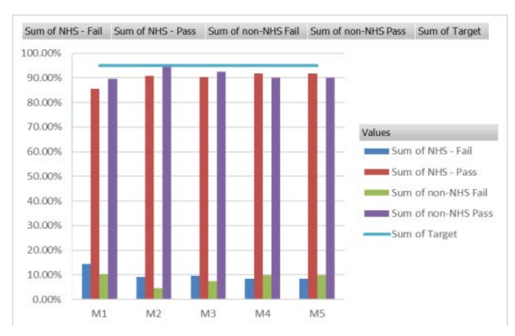


CHART OF YTD M5 BPPC TARGET BY VALUE



Cash Position

Cash

Table 13 - Cash summary position

£'000	Actual Mar-23	Actual Apr-23	Actual May-23	Actual Jun-23	Actual Jul-23	Actual Aug-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
INCOME														
Clinical Income	44,424	43,508	44,038	52,192	45,942	47,014	47,000	46,000	46,000	46,000	46,000	46,500	46,500	46,500
Clinical Income top up / Covid / Growth	0	0	0	0	0	1,800	0	0	0	0	0	0	0	0
Education and Training	0	3,719	0	0	3,072	0	0	0	3,072	0	0	3,072	0	0
Other Income	3,330	2,387	1,830	738	1,641	2,261	1,000	1,500	1,200	1,200	1,200	1,200	1,200	1,200
HMRC vat reclaim	0	4,006	546	0	3,522	3,460	4,500	2,853	2,000	2,000	2,000	2,000	2,000	2,000
Payroll Support	552	0	0	11,324	537	0	537	0	0	0	0	0	0	0
PDC capital	4,200	0	0	0	0	0	0	0	0	0	5,150	9,026	6,055	12,235
Revenue PDC	5,302	0	0	0	0	0	0	0	0	3,336	5,372	3,396	4,616	2,651
External Cash Support ICB	0	0	0	0	0	0	0	0	1,000	0	0	0	0	0
Other Receipts	2,099	607	521	578	858	680	600	600	600	600	601	600	599	600
TOTAL RECEIPTS	**59,907**	**54,227**	**46,935**	**64,832**	**55,572**	**55,214**	**53,637**	**50,953**	**53,872**	**53,136**	**60,323**	**65,794**	**60,970**	**65,186**
							1,577							
PAYMENTS														
Pay Costs - Substantive	(26,217)	(25,682)	(26,297)	(27,264)	(27,671)	(27,704)	(27,050)	(27,895)	(27,895)	(27,895)	(27,895)	(27,895)	(27,895)	(27,895)
Back dated Payroll	0	0	0	(7,715)	(5,399)	-	-	-	-	-	-	-	-	-
Pay Costs - Temporary Staffing	(7,012)	(4,202)	(3,884)	(3,906)	(3,427)	(2,836)	(3,700)	(3,696)	(3,817)	(3,696)	(3,867)	(3,867)	(3,576)	(3,817)
Creditors	(17,762)	(12,969)	(12,840)	(16,054)	(14,748)	(13,702)	(17,500)	(15,150)	(14,150)	(14,150)	(14,150)	(14,150)	(14,150)	(14,150)
Creditors - Capital Spend	(3,632)	(4,043)	(496)	(1,082)	(1,785)	(1,443)	(1,500)	(1,500)	(1,500)	(924)	(6,650)	(12,120)	(9,150)	(9,150)
NHSLA	280	(1,562)	(1,562)	(1,432)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	(1,562)	-	-
PDC Dividends	(3,728)	0	0	0	-	-	-	(4,679)	-	-	-	-	-	(3,975)
PFI CHARGE	(1,858)	(3,099)	(6,511)	(4,661)	(6,170)	(6,228)	(5,400)	(6,200)	(6,200)	(6,200)	(6,200)	(6,200)	(6,200)	(6,200)
TOTAL PAYMENTS	**(59,930)**	**(51,557)**	**(51,589)**	**(62,113)**	**(60,762)**	**(53,475)**	**(56,712)**	**(60,682)**	**(55,123)**	**(54,427)**	**(60,323)**	**(65,793)**	**(60,970)**	**(65,186)**
NET CASH FLOW IN PERIOD	(23)	2,670	(4,654)	2,719	(5,190)	1,739	(3,075)	(9,729)	(1,251)	(1,291)	(0)	1	(0)	(0)
OPENING CASH BALANCE	16,930	16,907	19,577	14,923	17,642	12,452	12,452	14,191	4,462	3,211	1,920	1,920	1,920	1,920
CLOSING CASH BALANCE	**16,907**	**19,577**	**14,923**	**17,642**	**12,452**	**14,191**	**9,377**	**4,462**	**3,211**	**1,920**	**1,920**	**1,920**	**1,920**	**1,920**

• The cashflow above is based on historical trends and averages and does not necessarily reflect assumptions around income and expenditure movements such as cost improvement plans. As such it is the worse case scenario and important to ensure maintenance of minimum cash balances.

Clinical Income receipts forecast has been aligned to the Income and expenditure assumptions as per the operating plan. The forecast need to be updated to reflect subsequent movement and will be brought back in M6 reporting.

• **Total receipts** - Total receipts(£55.2m) in M5 were slightly higher (£1.6m) than forecast (£53.6m) and marginally (£0.3m) lower than M4's. Receipts from Clinical Income was £3m more compared to M4 but was offset by reduction in income from other areas like Education & Training income which is received quarterly. There was a moderate improvement in receipts from 'Other Income', £1.3m more than forecast and nearly £1m increase from M4. This was largely due to payments for old invoices received from Imperial £272k - Oxford £500k - Univ of Bucks £369k - Oxford health £81k.

• **VAT Reclaim** - VAT reclaim received was £1m less than forecast and no material change from M4's.

• **Pay Cost** - Substantive pay cost (£27.7m) for M5 was largely in line with forecast (£27.0m), and very marginal change from M4's.

Temporary pay cost in M5 £2.8m is nearly £1.0m less than forecast £3.7m and £0.6m less compared to M4's. This according to AP is due to delays in processing payments and/or less activity in the holiday period.

• **Capital Creditors** - assumes that £20.6m PDC for the schemes for additional beds and visual outpatient clinic/digital hub at Stoke Mandeville, which will be spent and drawn down over the last 4 months of the year.

• Cash forecast in M5 assumes a shortfall of £16.4m 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. The forecast is being monitored to ensure that any requirements for external cash support from NHSE is flagged in time to ensure draw down in Q4.

Capital Position

Table 14: Capital Overview - M5 2023-24 YTD

Capital Expenditure (£M)	YTD Actual (£m)	Prior Month YTD Actual (£m)	Movement In Spend
Medical Equipment	0.7	0.1	0.6
Property Services	1.4	1.0	0.4
Information Technology	0.8	0.9	(0.1)
General	(0.0)	(0.0)	0.0
Flow	0.1	0.0	0.1
Total Capital Expenditure	**2.9**	**2.0**	**0.9**

Table 15: Capital Overview - M5 2023-24 Full Year

Capital (£m)	Full Year
Funding Streams	
Funded By Trust	21.3
PDC	26.9
PFI Lifecycle	1.7
Donated/Grant	0.1
Total Capital Funding	**50.1**
Expenditure	
Medical Equipment	4.8
Property Services	29.7
Information Technology	12.8
General	1.7
Flow	1.0
Total Capital Expenditure	**50.1**
Total	**(0.0)**

Table 16: Capital Detail

	£000's					£000's	
Capital Expenditure Plan	**BOB/ICS**	**Lifecycle**	**PDC Plan**	**Donated**	**2023/24 Total**	**Forecast Spend**	**Full Year Variance**
Medical Equipment	**4,811**			**99**	**4,910**	**4,812**	**98**
Property Services	**7,358**		**20,444**		**27,802**	**29,721**	**(1,919)**
Information Technology	**6,031**		**6,451**		**12,482**	**12,845**	**(363)**
General	**1,148**	**1,728**			**2,876**	**1,740**	**1,136**
Flow	**2,000**				**2,000**	**980**	**1,020**
Total	**21,348**	**1,728**	**26,895**	**99**	**50,070**	**50,097**	**(27)**

The month 5 capital spend is £2.9m. This is 5.8% of the total capital plan at the end of the M5

As at month 5 the Trust is forecasting an small overspend against its capital resource limit of £27k. However, actual spend will be managed towards the end of the financial year to ensure that this overspend does not materialise.

Total CRL Funding of £50.1m includes BOB/ICS £21.3m, PFI Lifecycle £1.7m, and PDC allocations of £26.9m, £5.7m for ERF, £0.7m for Digital Diagnostic Capability programme, £10.6m for additional beds and £10m for the Business Centre. £0.1m of Donated assets have been add to the programme for M5.

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	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	Cost Improvement Plan
ERF	Elective Recovery Fund
VWA	Value Weighted Activity

Appendix 1: 2023/24 Efficiency Plan by Workstream

1. Plan Identified by Workstream

Portfolio	Lead	Idea (£'000)	Opportunity (£'000)	Plans in Progress (£'000)	Fully Developed (£'000)	Risk Adjusted Value (£'000	Plan identified (£'000)	Productivity/ Cost Avoidance/
01. UEC	HB	-	-	500	-	325	500	1,058
02. Planned Care	JB	-	-	-	-	-	-	3,640
03. Integrated Community	JR	-	-	100	50	115	150	-
04. Diagnostics	ID	-	-	-	-	-	-	100
05. Service Re-design	All	-	-	-	49	49	49	-
06. Productivity & Waste	All	-	-	-	-	-	-	-
07. Digital	DD	-	-	-	-	-	-	150
08. Medicines Optimisation	AM	-	-	685	131	576	816	1,305
09. Non-Pay	JE	500	737	183	737	929	1,656	240
10. Income	All	114	1,052	643	5,063	5,586	6,757	150
11. Commercial Plan	AW	-	-	566	1,606	1,974	2,172	-
12. Medical Workforce	AM	-	240	162	60	189	462	-
13. AHP & Nursing Workforce	KB	195	423	-	-	42	423	-
14. Temporary Staffing	BoK	-	-	-	-	-	-	6,220
15. Corporate Services		-	-	-	-	-	-	-
16. Good Financial Governanc	JE	100	815	2,367	5,583	7,203	8,765	406
20. Establishment Review	All	-	88	-	332	341	420	-
21. Estates	AW	-	-	-	489	489	489	280
22. Finance Controls	DH	-	-	-	10,700	10,700	10,700	-
23. Unallocated	DH	1,830	-	-	-	-	-	-
Total		**2,739**	**3,355**	**5,205**	**24,800**	**28,519**	**33,361**	**13,549**

Appendix 2: API Month 4 YTD Variable Payments by Division and POD against Plan

BHT Variable Payment by Division. Month 4 YTD

Division	POD	POD2	23/24 Activity Plan	23/24 Actual Activity	23/24 Value Plan	23/24 Actual Value	Activity variance	Value variance
Integrated Elderly and Community	**Elective**	Daycase	493	438	£232,923	£203,841	-55	-£29,082
	Elective	Inpatient	7	16	£7,680	£20,597	9	£12,917
	Elective	Excess beddays	0	6	£0	£2,297	6	£2,297
	Outpatient	Outpatient First - Face To Face	1,699	2,730	£89,358	£129,904	1,031	£40,546
	Outpatient	Outpatient First - Non Face to Face	1,118	681	£121,978	£110,650	-437	-£11,328
Integrated Elderly and Community Total			**3,317**	**3,871**	**£451,939**	**£467,289**	**554**	**£15,350**
Integrated Medicine	**Elective**	Daycase	4,397	4,532	£3,046,787	£3,230,032	135	£183,245
	Elective	Inpatient	75	64	£186,569	£131,463	-11	-£55,106
	Elective	Excess beddays	174	9	£55,739	£2,961	-165	-£52,778
	Outpatient	Outpatient Procedure	6,812	7,394	£1,132,785	£1,211,701	582	£78,916
	Outpatient	Outpatient First - Face To Face	9,759	10,209	£2,256,150	£2,283,524	450	£27,374
	Outpatient	Outpatient First - Non Face to Face	7,023	5,333	£1,262,990	£942,392	-1,690	-£320,598
Integrated Medicine Total			**28,240**	**27,541**	**£7,941,020**	**£7,802,073**	**-699**	**-£138,947**
Specialist Services	**Elective**	Chemo	1,776	2,069	£578,028	£664,821	293	£86,793
	Elective	Daycase	1,306	1,435	£795,363	£974,856	129	£179,493
	Elective	Inpatient	37	57	£143,417	£187,031	20	£43,614
	Elective	Excess beddays	52	42	£19,720	£15,860	-10	-£3,860
	Outpatient	Chemo	1,180	1,427	£193,940	£234,501	247	£40,561
	Outpatient	Outpatient Procedure	1,547	1,414	£374,616	£332,537	-133	-£42,079
	Outpatient	Outpatient First - Face To Face	889	813	£263,564	£249,506	-76	-£14,058
	Outpatient	Outpatient First - Non Face to Face	1,333	1,233	£212,679	£191,187	-100	-£21,492
Specialist Services Total			**8,120**	**8,490**	**£2,581,329**	**£2,850,299**	**370**	**£268,970**
Surgery and Critical Care	**Elective**	Daycase	5,379	4,634	£7,870,547	£6,949,517	-745	-£921,030
	Elective	Inpatient	859	815	£4,262,333	£4,076,165	-44	-£186,168
	Elective	Excess beddays	170	128	£58,268	£43,351	-42	-£14,917
	Outpatient	Outpatient Procedure	18,346	21,211	£3,316,900	£3,404,229	2,865	£87,329
	Outpatient	Outpatient First - Face To Face	22,914	19,370	£3,940,643	£3,291,394	-3,544	-£649,249
	Outpatient	Outpatient First - Non Face to Face	4,782	4,408	£705,927	£615,511	-374	-£90,416
Surgery and Critical Care Total			**52,451**	**50,566**	**£20,154,617**	**£18,380,167**	**-1,885**	**-£1,774,450**
Women Children and Sexual Health	**Elective**	Chemo	1	3	£242	£1,366	2	£1,124
	Elective	Daycase	521	459	£518,589	£432,960	-62	-£85,629
	Elective	Inpatient	140	136	£474,528	£451,413	-4	-£23,115
	Elective	Excess beddays	24	5	£12,252	£2,596	-19	-£9,656
	Outpatient	Outpatient Procedure	1,966	1,460	£745,614	£553,285	-506	-£192,329
	Outpatient	Outpatient First - Face To Face	5,618	6,310	£1,164,719	£1,279,519	692	£114,800
	Outpatient	Outpatient First - Non Face to Face	1,086	918	£184,851	£159,315	-168	-£25,536
Women Children and Sexual Health Total			**9,356**	**9,291**	**£3,100,794**	**£2,880,454**	**-65**	**-£220,340**
Grand Total			**101,483**	**99,759**	**£34,229,699**	**£32,380,282**	**-1,724**	**-£1,849,417**

Meeting: Trust Board Meeting in Public

Date: 27 September 2023

Agenda item	Annual Equality, Diversity & Inclusion Report f/y 2022-23
Board Lead	Bridget O'Kelly, Chief People Officer
Author	Carley Brown, Head of Leadership & ED&I
Appendices	Equality, Diversity & Inclusion report f/y 2022-23
Purpose	Approval
Previously considered	EMC, SPC

Executive summary

This report provides an update on our Equality, Diversity and Inclusion work during f/y 2022-23

The report includes details about how we are meeting our annual Public Sector Equality Duty obligations for our colleagues, alongside an overview of our Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and Gender Pay Gap (GPG) programmes.

- WRES - Continuous improvements have been made in relation to equal outcomes from recruitment processes for the sixth consecutive year. Bullying and Harassment and equal representation in senior leadership roles remain areas of development.
- WDES – Both our rate of disclosure and the recruitment ratio for disabled vs non-disabled applicants improved this year. Bullying and Harassment and work to improve access to reasonable adjustments remain areas of development.
- GPG – There has been a reduction in the mean and median fixed pay gap between men and women, although a pay gap still remains in favour of men.

We are proud of the progress we have made this year in our pursuit of developing a more diverse and inclusive organisation for our colleagues, patients and visitors. As we look forward, we are committed to reducing the inequalities which our colleagues are experiencing and remain steadfast in our aim to embed inclusivity and belonging within our organisation and local communities. In particular we recognise the increased diversity in our workforce as a result of our successful international recruitment, the value that these new colleagues bring to colleagues and patients and our obligations to them.

We have set ourselves two clear objectives for f/y 2023-24:

- Improve representation of BME colleagues in senior roles – specifically that representation in AfC Band 8b+ roles will be 24% or above, recommitting to our aim from 2020
- Reduce occurrence of bullying and harassment from managers and other colleagues - by a minimum of 2% per year. We are committed to creating an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

We have developed an EDI Improvement Plan to support us in achieving these objectives The action plan has been based on the national NHS Equality Diversity & Inclusion (EDI) Improvement Plan published in June 2023, which uses the latest data and evidence to

identify six high impact actions organisations across the NHS can take to considerably improve equality, diversity and inclusion.

The Executive Management Committee considered this report on 22 August 2023 and discussed the following:

- The shift in workforce demographics largely due to international recruitment, demographics related to bullying and harassment and a need to focus on this going forwards.
- A need to be more ambitious in the management of talent within the organisation.
- The gender profile of consultants within the Trust and the process for awarding Clinical Excellence Awards.
- Improvement in identifying and supporting reasonable adjustments for individuals with disabilities.
- Widening of recruitment opportunities through working with schools and linking with graduate schemes alongside other potential ideas.
- The need for ED&I to be more prominent/frequent within Committee discussions.

The report was also considered by the Strategic People Committee.

Decision	The Board is requested to approve the report for publication		
Relevant strategic priority			
Outstanding Care ☒	Healthy Communities ☐	Great Place to Work ☒	Net Zero ☐

Relevant objective		
☐ Improve waiting times ☒ Improve safety ☒ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☒ Upskill operational and clinical managers

Implications / Impact	
Patient Safety	Evidence shows a direct link between better engaged staff and patient safety
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 6: Failure to deliver our People priorities
Financial	Lack of belonging reduce engagement and moral leading to more sick leave & turnover
Compliance NHS Regulation	NHS People promise NHSE ED&I Improvement plan Gender Pay Gap requirements NHS Workforce Race Equality Standard (WRES) NHS Workforce Disability Equality Standard (WDES)
Partnership: consultation / communication	Colleague networks Staff side (JMSC and JCNC)
Equality	This annual report covers all areas of our equality, diversity and inclusion work. Included are our WRES & WDES action plans, key KPIs in ensuring we meet ED&I

	standards across the Trust in addition to our gender pay gap reporting.
Quality Impact Assessment [QIA] completion required?	NA

Annual Equalities Workforce Report 2022-2023

A reflection of progress in relation to Equality Diversity & Inclusion, including our statutory equality standards

OUTSTANDING CARE
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Executive Summary

As a publicly funded organisation, Buckinghamshire Healthcare NHS Trust (BHT) is required to publish information annually on how it has met the Public Sector Equality Duty (PSED) and taken steps to eliminate unlawful discrimination, advance equality of opportunity for people with protected characteristics and foster good relations between those who share protected characteristics and those who do not. The information provided demonstrates how we have considered how our services and activities, both as an employer and a service provider, affect people with different protected characteristics.

This report provides assurance to the Trust Board and to the Public that BHT is meeting its PSED obligations and continuing to promote an inclusive culture across the organisation. The report summarises our workforce equality, diversity and inclusion activity in 2022/23 alongside our PSED requirements and Equality Standards data. A separate report is published annually in relation to the PSED requirements for our service users.

Meeting the PSED Standards

1. Part of meeting the PSED requirements is publishing information relating to employees who share protected characteristics. Our workforce data relating to protected characteristics of our colleagues is contained within this report. For the third consecutive year, we have reduced the number of colleagues with 'undisclosed' status on various protected characteristics. This is reflective of efforts to cleanse our workforce data and ensure we capture accurate demographic profiles of our workforce.
2. Equality objectives for the Trust were published in 2019 and have been renewed in 2023 to reflect the NHS EDI Improvement Plan 6 high impact actions, which all NHS organisations are encourage to meet. We are committed to implementing these objectives as part of our duties and importantly, in line with our values as a Trust. A supporting action plan is included at the end of this document.
3. We are required to publish information on work we undertake to eliminate discrimination and foster equal opportunities for those with protected characteristics. Analysis and recommendations relating to our Equality Standards are contained within this report.

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Executive Summary Continued

What is our Equalities Data telling us?

Workforce Race Equalities Standard (WRES): Our data highlights continued improvements in recruitment, disciplinaries and access to training and development, with BME and White colleagues now achieving equivalent outcomes in these areas. Despite work to improve our recruitment outcomes for candidates, BME colleagues make up 32% of our Band 1-7 workforce but only 18% of the Band 8a+ leadership workforce; a percentage difference of 14%. This has increased from 5.5% difference in 2022. Experiences of bullying, harassment and discrimination increased for BME colleagues this year in all areas, including from patients where BHT performed worse than the NHS average. BME colleagues consistently report higher numbers of these experiences than White colleagues. In line with the NHS EDI Improvement Plan, reducing such instances will be a key focus for BHT this year.

Workforce Disability Equality Standard (WDES): Our data demonstrates an increase in the number of colleagues at BHT who have declared via ESR that they have a Long Term Condition (LTC) or disability compared to last year (3.4% in 2022 to 5.42% in 2023) . Colleagues with disabilities are experiencing equal outcomes in relation to recruitment and performance management, and more colleagues have been able to access reasonable adjustments within their roles (73.6% in 2022 to 77.2% in 2023). Incidents of bullying and harassment from patients increased in 2023 for colleagues with and without LTCs, with incidents being 4% higher for colleagues with LTCs. BHT is performing worse than the national average in this area, and colleagues with LTCs are also more likely to report experiencing harassment from their managers and other colleagues.

Gender Pay Gap (GPG): We are pleased to report an improvement (reduction) in both the hourly fixed pay gap between men and women for the mean pay gap – 26.9% for f/y 2022/23, compared to 27.6% for financial year f/y 2021/22, and the median hourly fixed pay gap –15.5% for f/y 2022/23 compared to17.2% for f/y 2021/22. Analysis has identified that our gender pay gap is driven by a higher percentage of men in the highest quartile of pay, mainly due to significantly different gender splits within the medical & dental and administrative & clerical staffing groups

However, there was an increase in our mean bonus gap this year, which has increased from 20.8% to 25.5%. There is also a 9% difference in the number of men and women who received a bonus for their performance in f/y 2022/23. Bonus Pay applies to fewer than 4% per cent of all our staff employed. This is because only certain medical staff (from within the consultant body) receive pay that is classified as bonus pay. A bonus pay element is awarded as a result of recognition of excellent practice over and above contractual requirements and has no gender bias. In f/y 2022/23 this payment was awarded equally to those meeting the criteria in line with national guidance and in agreement with the BMA.

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Executive Summary Continued

Progress against Objectives

In 2020 we set four equalities objectives in line with our WRES & WDES data (page 9). We have achieved two of these objectives fully: there are now equal outcomes for BME and White candidates and disabled and able-bodied candidates in our recruitment processes. More work is required to improve the diversity of our senior leaders (Band 8b+) which is currently 17% BME compared to 32% of our overall workforce. Whilst we have previously made improvements against this objective, reaching parity in 2022, the percentage of BME Band 8b+ colleagues has declined whilst the total number of roles at this level has increased. We have also increased the diversity of our workforce through our successful recruitment of approximately 300 international nurses. Further work is also required to improve access to reasonable adjustments (currently 77%), despite making some progress in this area from previous years.

New Objectives

We are committed to meeting the new national NHS EDI Improvement Plan and implementing the six high impact areas to embed EDI work further into the organisation. Details of our progress against these areas is documented on pages 43-47. In keeping with these six areas, we have set two priority Equalities Objectives for BHT which also take into consideration our equalities data and progress to date. Our two priority objectives for the next three years will be:

1. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity. Specifically, Improve representation of BME colleagues in AfC Band 8b+ roles to 24% or above by July 2026.
2. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. Specifically, Reduce occurrence of bullying and harassment from managers and other colleagues by a minimum of 2% per year.

An associated Action Plan to achieve these objectives is included at the end of this document.

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Report Introduction

The Trust's Equality, Diversity and Inclusion journey began in earnest in 2010, with the introduction of the Equality Act and then the launch of the Public Sector Equality Duty (PSED). Through the PSED and the Equality Delivery System (EDS2) the Trust has strived to improve the experience at work for Trust colleagues.

In 2015 the Workforce Race Equality Standard was introduced, with specific measures and goals to enable improvements in the working lives of our Ethnic Minority colleagues. Then in 2017, the Trust began to report on the Gender Pay Gap, as a way of ensuring that we are both remunerating women fairly and enabling their progression to more senior roles in BHT. In 2019, our newest Equality Standard was introduced. The Workforce Disability Equality Standard aims to improve the workplace experience of colleagues who have a Long-Term condition or a Disability and contains specific measures and goals to enable this.

The Trust previously reported on its compliance with the Public Sector Equality Duty in October 2022.

This Report focusses on our colleagues and covers the 2022/23 Financial Year. It encompasses the information required to meet our Equality Duties in relation to our workforce for 2022/23. The data contained within the report is taken from our electronic colleagues record system as of 31st March 2023, unless otherwise specified. This report also highlights our work in Equality, Diversity and Inclusion throughout the year, and the work we have undertaken to achieve progression. A separate report will be published in relation to our PSED requirements for our patients.

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What is The Public Sector Equality Duty

The Public Sector Equality Duty (PSED) came into force across the UK in 2011 and is related to the Equality Act 2010. It means that public organisations have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. It requires that public bodies have due regard to the need to:

- Eliminate unlawful discrimination, harassment & victimisation
- Advance equality of opportunity for people with Protected Characteristics
- Foster good relations between people with and without Protected Characteristics

Special Duties:

To ensure transparency, and to assist in the performance of this duty, PSED Special Duties also require public organisations to publish:

- Information to demonstrate their compliance with the Equality Duty, at least annually
- Equality objectives, at least every four years
- Information relating to employees who share Protected Characteristics
- Information relating to service users who share protected characteristics

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The Nine Protected Characteristics

There are nine Protected Characteristics which are covered by the Equality Act 2010 and the Public Sector Equality Duty. Our report provides an overview of our data and activities in relation to some of these characteristics.

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Progress Against Previous Equalities Objectives

In 2020 we set four equalities objectives in line with our WRES & WDES data. Below is a summary of progress against those objectives.

2020 Objective	Progress
The ethnic make-up of our Board and senior leaders will be 24% from Ethnic Minorities, reflecting that of our workforce by 2022	This was met in 2022, however currently 17% of our Band 8b+ workforce are from a BME background and 78% are white.
Our recruitment processes will be fair, with equal outcomes for Ethnic Minority colleagues and white applicants by the end of 2021.	Achieved. The ratio of appointment from interview is 1.15 (parity).
Our recruitment processes will be fair, with equal outcomes for disabled and non-disabled applicants by the end of 2021	Achieved. The ratio of appointment from interview is 1.14 (parity).
All disabled staff will be provided with reasonable adjustments where needed by end of 2022	Currently 77.2% of colleagues with long term conditions report being able to access reasonable adjustments if required, up from 73.6% in 2022.

Our Equality, Diversity & Inclusion Objectives for f/y 2023-24

We are required to set new Equality Objectives for the next three years in line with our PSED requirements. We have chosen to align our objectives to the NHS EDI Improvement Plan and our staff survey results. We are committed to meeting these objectives across the lifetime of this plan and continuing to embed equity and inclusion across our organisation.

What	How (NHSE Aim)	When	Measure
Improve representation of BME colleagues in AfC Band 8b+ roles to 24% or above	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	July 2026	WRES Indicator 1
Reduce occurrence of bullying and harassment from managers and other colleagues by a minimum of 2% per year	Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	July 2026	WRES Indicator 5 WRES Indicator 8 WDES Indicator 4ii WDES Indicator 4iii

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Section 1: ED&I Progress 2022-2023

This section contains a snapshot of some of our activities undertaken this year in support of equality, diversity and inclusion.

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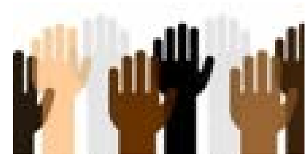
Our Colleague Networks

We currently have 9 Colleague Networks across the organisation representing different communities and protected characteristics.

BHT Belonging Network (LGBTQ+)



BHT Embrace Network (BME)

BHT Kalinga Network (Filipino Community)

BHT VIBES Network (Values, Identity, Beliefs, Ethics, Spirituality)

BHT Armed Forces Network

BHT 1:4 Network (Mental Health)

BHT Carers Network

BHT Disability Network

BHT Women's Network

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Colleague Network updates

By growing and developing our Colleague Networks, we directly contribute to better patient care and a more inclusive culture at BHT. Creating an authentic and accepting culture leads to improved team productivity and enhances the quality of patient care (CIPD, 2021). Colleague Networks play a significant role in increasing respect at work and enhancing colleagues' understanding of marginalised groups, leading to fair and equitable care for all patients, and improved wellbeing for our colleagues.

Each of our Colleagues Networks has recently been assigned an executive sponsor.

The network sponsors assume a crucial role in advancing network objectives and establishing the network within the organisation. Their responsibility involves advocating for the network and representing its perspectives in leadership and executive spaces. This engagement provides both the sponsor and network members with prospects for personal growth, learning, and fostering allyship.

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2023 Objectives:

Membership Growth and Enhanced Allyship: Implementing promotional initiatives and commemorating significant diversity and inclusion events to attract new members and foster increased allyship.

Improved Network Structure: Our Colleague Networks with large membership will benefit from a more robust structure through incorporating a comprehensive Terms of Reference. In addition, Chairs will receive protected time within their job roles for Network involvement, supported by compensation. This empowers the Networks to actively drive change and contribute essential insights on matters that impact their community.

Examples of Colleague Network activities

BHT Embrace Network

To celebrate South Asian Heritage Month and NHS 75, the Embrace Network organised a cricket match against Milton Keynes University Hospital to collaborate and connect the two BME networks.

Around 60 colleagues, family and friends, and volunteers attended. There was a South Asian feast provided to celebrate the culture and food for South Asian History Month, and the day was a huge success with positive feedback.

The Embrace Network organised the event with support from their executive sponsor, Neil MacDonald, CEO.

BHT Kalinga Network

The Kalinga Network organised the 2nd Annual BHT Sportsfest to promote health and well-being and improve colleague retention. The event supported with raising awareness for the Kalinga Network, whilst creating a culture of inclusivity and belonging.

Over 300 colleagues, friends and family members attended the event which was organised with the support of the network's executive sponsor, Bridget O'Kelly, CPO.

BHT Disability Network

In March 2023 to support BHT colleagues, the Disability Network launched the Sunflower Badge Pin to help discreetly alert others that a little help or consideration may be needed. The scheme supports with raising awareness around invisible disability, and the sunflower is recognised nationally to identify invisible disability and signifies happiness, positivity and strength.

This scheme is continuing into the 23/24 year, with more badges being distributed to keep up with growing interest across the Trust.

EDI Engagement

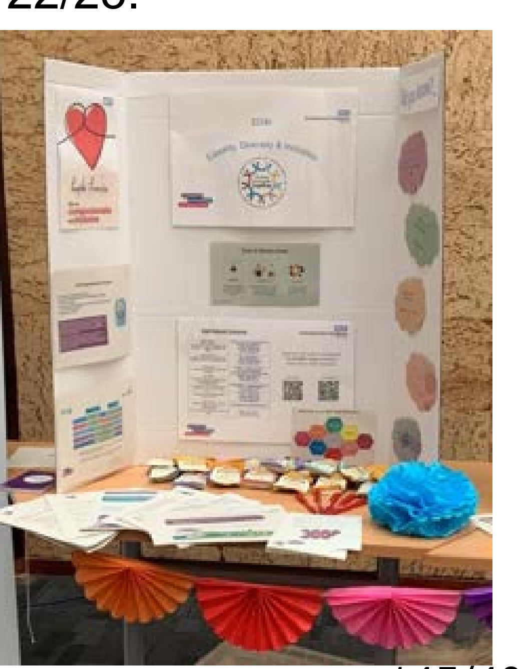
The EDI team attended multiple engagement events to promote and raise awareness of all the EDI-related offerings for colleagues - including Colleague Networks, the Allyship Programme, and Reciprocal Mentoring.

Disability declaration was promoted at these events which included declaration forms to be filled out at these events and supported with increasing the disability declaration rate in the Trust by 1.12% in 22/23.

By promoting Colleague Networks at these
Events, we have increased membership and allyship.

Examples of events attended:

- Healthcare Support Worker Conference
- Multiple onboarding events for new colleagues



Living Libraries

National Inclusion Week 2022 was celebrated in the Trust during September. A series of events were held for colleagues which aimed to increase understanding of differences, promote key messages and celebrate diversity and culture.

These events included a living library for the first time at BHT. A Living Library is a library where the 'books' are BHT colleagues sharing their lived experience story and the reading consists of a conversation. 6 BHT colleagues volunteered to share their lived experience to encourage colleagues to learn and understand different life experiences.

Following the success of the face-to-face Living Library, 3 virtual sessions were held to allow colleagues who could not attend face-to-face.

The Embrace Network are planning to run Living Library sessions where Embrace members could share their own experiences and stories with the wider organisation to celebrate Black History Month

So inspirational! Just a bit of consideration can make such a difference to someone. And just giving some the chance and time to share – there are incredible stories here!

One thing that worked well was… The openness (and courage) of the human books

Nice to be able to talk with colleagues with lived experience rather than specialists.

Policy Developments

This year we have updated various policies to lay the foundations for managing unacceptable behaviour and reducing inequalities.

EDI Policy

The EDI Policy was updated to explicitly specify the types of behaviour deemed unacceptable. Additionally, it outlined the principles and regulations of the Equality Act 2010, and expanded the roles and responsibilities of colleagues, line managers and the organisation in reducing inequalities.

Managing Violence, Aggression and Unacceptable Behaviour Policy

This year we have updated our Managing Violence, Aggression and Unacceptable Behaviour Policy to tackle unacceptable behaviour from patients. The policy was socialised at various engagement events, meetings, and forums across the Trust, as well as presented at the Leadership Briefing to 100 leaders. Socialising the policy was essential to ensure understanding and full implementation and endorsement across all levels of the organisation. The 2023/24 focus is to work closely with local police forces on managing criminal acts of discrimination.

Employee Relations Policy Updates

Throughout this year, we have persistently engaged in policy review through collaborative efforts with staff -side colleagues.

- The Standards of Conduct & Behaviour Policy (previously named the disciplinary policy) has been refined to integrate insights from Restorative Just Culture principles. This policy is currently in its concluding stages of ratification.
- Similarly, the Resolution Policy, which replaces our grievance and dignity and respect policies, also embodies Restorative Just Culture principles. This policy is presently undergoing consultation with staff -side colleagues, with an intent to publish it later this year.

These guiding principles have notably contributed to achieving parity in our Workforce Race Equality Standard (WRES) metrics, particularly from an Employee Relations (ER) perspective.

Buckinghamshire, Oxfordshire & Berkshire (BOB) Integrated Care System EDI Activities

Our organisation is an active partner within the BOB EDI programme. This group has led a number of EDI related activities this year, which have benefitted our organisation. Highlights include:

- **Inclusive Recruitment:** ICS partner Trusts and 1 local authority participated in an Inclusive Recruitment Training pilot and received a toolkit – including a co-produced guidance framework, a training module and a 7-minute video. This has helped to inform inhouse training and a review of practices within all our Trusts – which is being shared at a bi-monthly Inclusive Recruitment Working Group. Plans are underway to source and test a digital tool to support debiasing of shortlisting processes.

- **Health Inequalities at the workplace:** To support colleagues with disabilities and long-term conditions, the ICS commissioned an e-learning Disability Essentials eLearning module for 500 colleagues across the ICB. Useful feedback was gathered from participants for future training and resources to support reasonable adjustments in the workplace.

- **Voice and Engagement:** Colleague Network representatives benefitted from a Lunch and Learn Workshop demonstration of a network development toolkit designed by Kent and Medway ICB. Representatives from across partner Trusts and local authorities participated and received the toolkit to use within their organisations.

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Empowerment Passports

In 2021/22 we received national funding to implement Empowerment Passports for colleagues across BOB ICS with disabilities or long-term conditions as a pilot. This project trial has been extended to October 2023. We received 300 licenses to be used for colleagues across BOB ICS, and 120 licenses have been utilised.

The Empowerment Passport is an interactive online tool which generates suggested Reasonable Adjustments for colleagues with disabilities and long-term conditions. Through the Empowerment Passport it will be easier to identify and put in place supportive measures for individuals including individualised flexible working plans, reasonable adjustments and an inclusive return to work if absent due to sickness.

The project has also enabled us to promote disability more widely across the Trust.

‘Well you have put a smile on my face this morning. I feel this Passport should be standardised and mandatory across the NHS’

‘I have to say that filling in this assessment did really make me think about what I need / would help me, which I have to be honest I don’t think I have ever truly listed that out previously.’

‘’I already have Reasonable Adjustments in place but the passport is useful in terms of enabling me to summarise my needs and easily review any changes.’’

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Reasonable Adjustments

The Occupational Health and Wellbeing Team now have a dedicated Disabilities and Reasonable Adjustments lead, to increase ease of access to reasonable adjustments for colleagues.

Benefits of this role:

Case Management: The Disability Lead overseas all reasonable adjustments requests and case manages complex and sensitive cases that require further support within the Trust and signposts to external support – e.g. Access to Work, Empowerment Passports

Visibility and Engagement: The Disability Lead attends Health Summits, delivers Health and Wellbeing Checks (available to all colleagues) and attends the Disability Network meetings. This engagement fosters increased visibility and accessibility

Collaborative discussion: The MSK specialists and Disability Lead meet bi-monthly to discuss cases and upcoming proactive work around reasonable adjustments

Accelerated support: A request for fast-tracking appointments are made, where appropriate, for colleagues requiring diagnostic investigations or treatment

Plans to increase access to reasonable adjustments:

Review Manual Handling Strategies

- Successful initiatives in Blood Sciences and Radiology with positive feedback.
- Focus on top 3 departments with the most frequent MSK referrals.
- Collaboration with Moving and Handling & Health & Safety for this review.

Wellbeing Champion Training

- Training for 102 Wellbeing Champions to raise awareness about DSE assessments.

Dedicated OH Physio support

- Specialist advice on posture and micro breaks.
- Basic training for muscle strength and balance.
- Reasonable Adjustments webinar – raising awareness for managers and colleagues

Assistive Technology

- QI and Transformations Team engaging with Disability Network to identify requirements for Assistive Technology.

Improving Dragon Software Access

- Plans to streamline ordering of Dragon software through the IT portal.

Allyship and Talent Management

Allyship Development Programme

In 2022, national funding enabled the launch of a four-week allyship programme by Inclusive Employers. 96 senior leaders (Bands 8+, including medics) and executives completed the programme, enhancing understanding of marginalised colleagues' experiences. This fosters proactive allyship, advocating for colleagues, and creating inclusive practices for colleague and patients' equality.

Feedback Summary:

- Clarity on the role of an ally was reported by 74% of respondents.
- 87% indicated increased confidence in addressing discrimination.
- 74% felt highly confident in advocating for underrepresented groups.
- 94% believed the training would facilitate positive behaviour change.

In light of the positive feedback in line with the programme's aims to improve understanding of underrepresented groups and proactively champion and advocate for change in the role of an ally, we are looking to conduct a content review of the Allyship Development Programme. Our aim is to bring the programme in-house and integrate its key themes and insights into our internal Peaks training programmes.

Developing You Developing me Talent Programme

Summary of Interventions

- Mastering Storytelling and Listening into Action
- Talent Management in Action Masterclass
- Advancing Equality Workshop
- Psychological Reflective Sessions
- Scope for Growth Masterclass
- Monthly support from the Project Team

Culture Intervention:
A 'Reverse Mentoring and Talent Management Programme' for Nursing and Maternity, focusing on cultural transformation and reducing health inequalities among BME patients and colleagues .

Talent Intervention:
Initiative aimed at advancing career growth for underrepresented groups. Band 7 colleagues from BME backgrounds will be paired with Senior Sponsors for mentoring and sharing experiences, supported by senior managers to foster progress within the organisation.

Inclusive Organisation:
The programme aims to inspire diverse thinking and behaviour in daily work, aligning with the NHS Long Term Plan, the People Plan, and diversity and inclusion goals.

Section 2: Workforce Information

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In keeping with our PSED requirements, this section contains an overview of our workforce data in relation to some of the protected characteristics.

Gender Profile

Occupational Group	Female %	Male %
Total	80	20
Support Staff	83	17
Nursing and Midwifery registered	90	10
Medical and Dental	50	50
Managers	60	40
Healthcare Scientists	68	32
Healthcare Assistants	78	22
Allied Health Professionals	86	14
Admin and Estates	83	17
Add Prof Scientific and Technical	79	21

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

■ Female % ■ Male %

What does this tell us?

In alignment with the national NHS workforce profile, our workforce gender profile remains predominantly female (80%) and 20% male.

The Medical & Dental and Manager occupational groups have the most diverse split of female and male role incumbents.

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Age

What does this tell us?

The UK has an ageing population and workforce.

The age profile of our workforce has changed slightly since 2021.

In 2021, our largest age groups were 46-60 years. In 2023, our biggest age groups are 31-40 years.

Workforce Percentage

	<=20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71
2023	1%	6%	11%	14%	13%	12%	12%	12%	12%	6%	1%	0,5%
2022	0,80%	5,70%	12,10%	12,90%	12,10%	12,20%	11,80%	12,90%	11,40%	6,30%	1,50%	0,30%
2021	0,60%	6,70%	11,50%	11,80%	11,70%	11,80%	12,90%	13,10%	12,00%	6,40%	1,30%	0,30%

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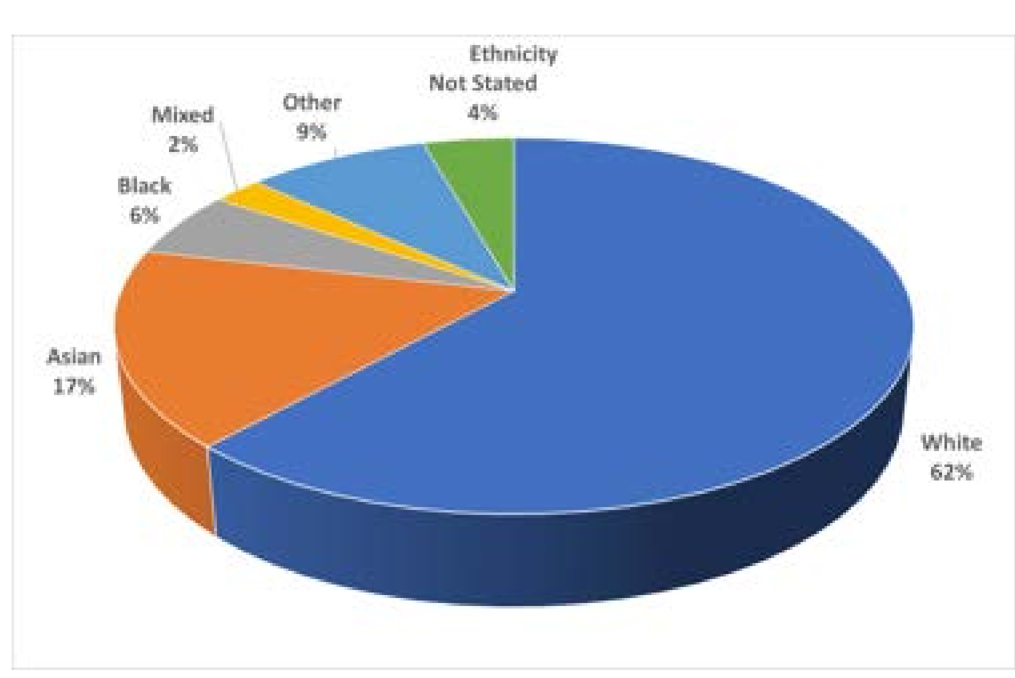
Ethnicity



What does this tell us?

The chart on the left demonstrates that 62% of our colleagues overall are from a White background; the next largest group is colleagues from an Asian ethnic background representing 17% of the workforce.

In 2023, 34% of colleagues identified as being from an ethnic minority background compared with 27% in 2022, and 26% in 2021. There has also been a 4% reduction in 'not stated' since 2022; reflecting work to cleanse our workforce database and encourage colleagues to identify their ethnicity.

How does this compare to Buckinghamshire residents?

The 2021 Census Data for Buckinghamshire found that 20% of Buckinghamshire residents identified as being from an ethnic minority group. 12% of Buckinghamshire residents identified their ethnic group as Asian, 2.6% as Black, 3.5% as Mixed or Multiple ethnic groups and 1.6% identified as Other ethnic groups.

This means that BHT has a higher percentage of colleagues from an ethnic minority than Buckinghamshire residents as a whole (14% more). Our workforce ethnicity profile is also more diverse than the National NHS average.

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Disability declaration rates

What does this tell us?

5% of our workforce identified as having a disability or long-term condition in 2023, up from 3.4% in 2022. This represents the third consecutive year of increasing declaration rates within the Trust.

There has been a 2% decrease in colleagues with an unknown disability status in 2023 (10% in 2022).

Disability

Disability Unknown/Null 8%

Yes 5%

No 88%

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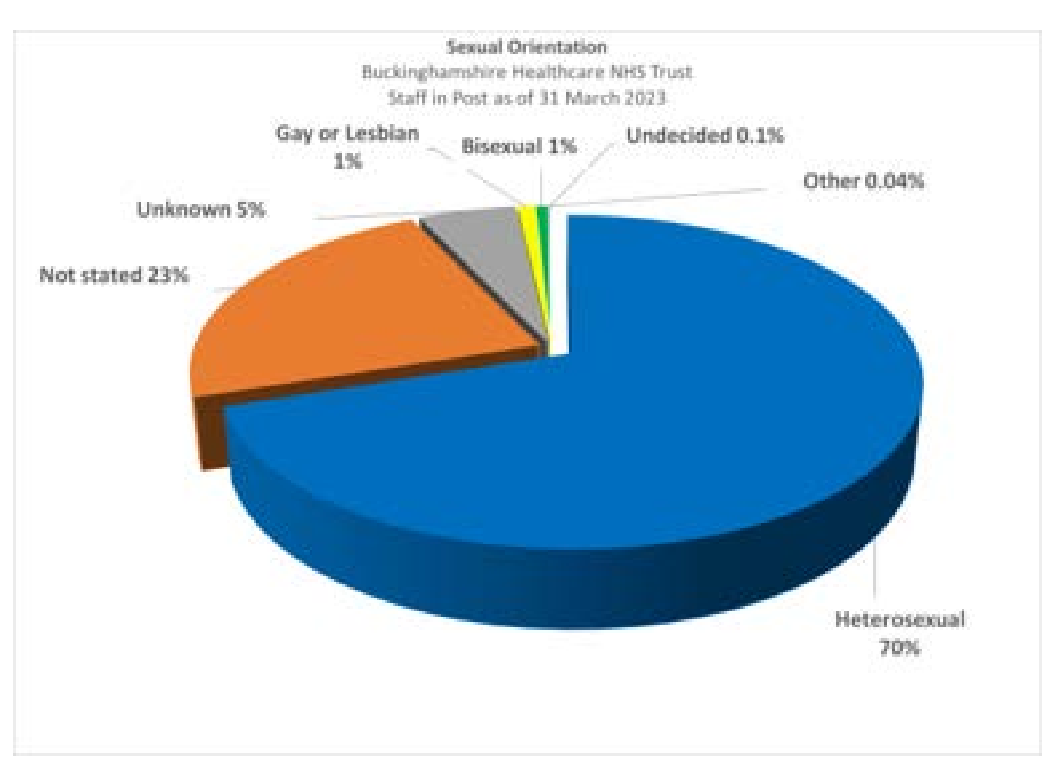
Sexual Orientation



What does this tell us?

- 2% of colleagues have declared that they are from an LGBTQ+ background, as captured on our Electronic staff Record system. This represents a 0.7% increase since 2022 and the third consecutive year of an increase in sexual orientation declaration. There have been subsequent reductions in the 'unknown' and 'not stated' categories.
- 3.1% of our 2022 Staff Survey respondents identified as LGBTQ+ which is in line with the national average for the NHS.

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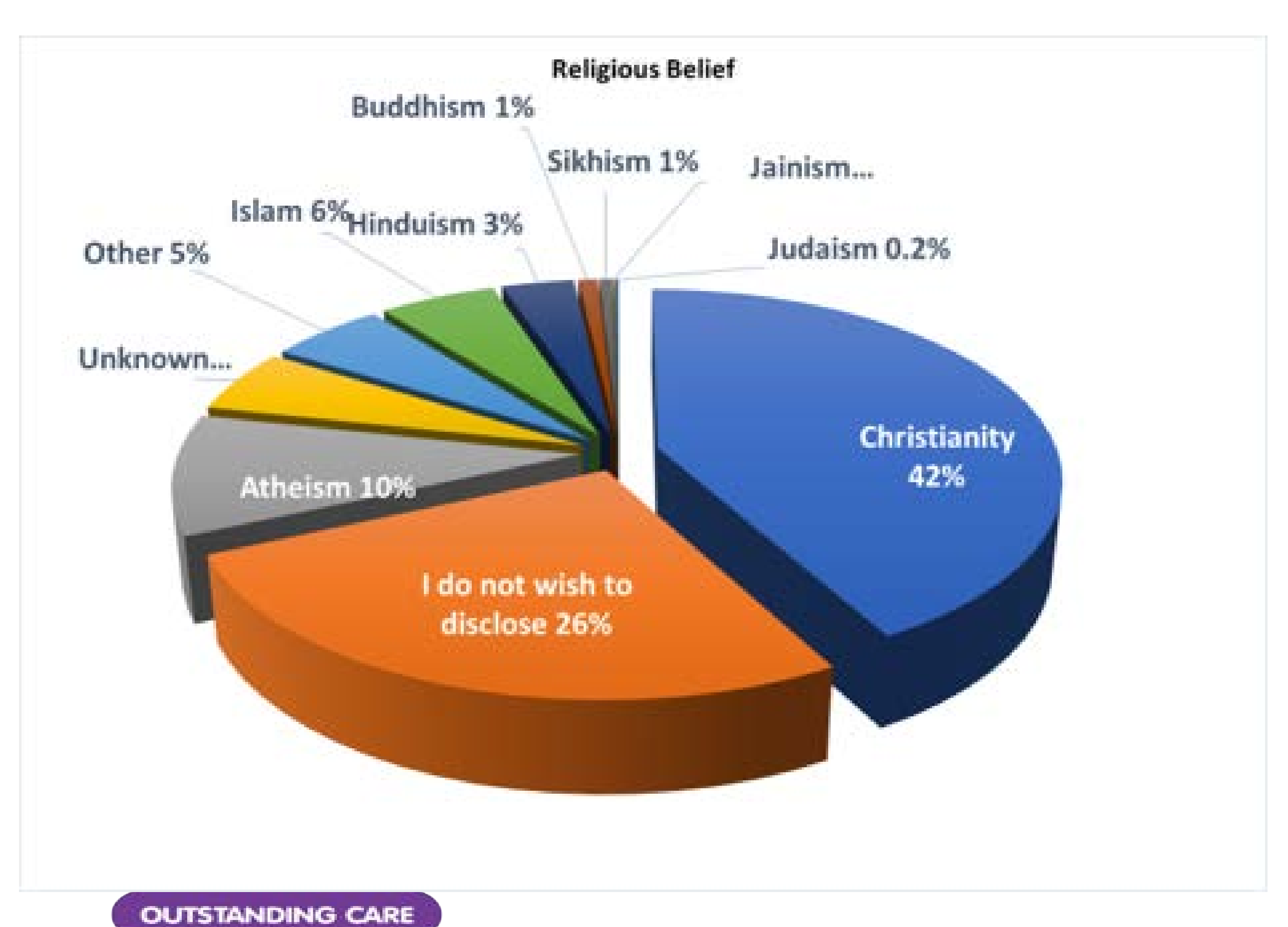
Religion and Belief



What does this tell us?

- The religious profile of our workforce since 2021 remains fairly static.
- Our most frequently stated religious group is Christianity (42% of our colleagues)
- 26% of colleagues have not disclosed their religious/belief group, down from 28.4% in 2022. This is reflective of efforts to cleanse our workforce data and ensure we capture accurate demographic profiles of our workforce.

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Section 3:The Equality Standards

This section contains an overview of our latest data in relation to our Equality Standards.

Introduction to the Equality Standards

As part of our PSED obligations, the Trust is required to report annually on the following Equality Standards and to use the outputs to inform an Action Plan to address inequalities.

The Equality Standards are:

- **Workforce Race Equality Standard (WRES)** – This was introduced in 2015 and is designed to measure and enable improvement of the working lives of colleagues from an ethnic minority background.

- **Workforce Race Disability Standard (WDES)** – This was introduced in 2019 and is designed to measure and enable improvement of the working lives of colleagues with disabilities and/or long-term conditions in keeping with the Equality Act 2010.

- **Gender Pay Gap Reporting (GPG)** – This is an annual exercise designed to measure the gap in pay between men and women and is designed to enable organisations to close this gap through appropriate actions.

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Workforce Race Equality Standard (WRES)

Implementation of the Workforce Race Equality Standard (WRES) is a requirement for all NHS Provider organisations. BHT is expected to show progress against 9 indicators which measure whether or not employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Summary of WRES Progress in 2023

Our WRES indicators 2-4 indicate that BHT has made further improvements this year in relation to recruitment, disciplinaries and access to training and development, with BME and White colleagues now achieving equivalent outcomes in these areas. This is the sixth consecutive year we have achieved improvement in our recruitment outcomes, reducing from 2.44 in 2018 to 1.15 (parity) in 2023. There has also been an increase in perceptions of equal career development opportunities from BME colleagues (50.5% in 2023, 47.9% in 2022).

Despite work to improve our recruitment outcomes for candidates, this year there has been a decrease in representation of BME colleagues within leadership roles (Band 8a+). BME colleagues make up 32% of the Band 1-7 workforce but only 18% of the Band 8a+ leadership workforce; a percentage difference of 14%. This has increased from 5.5% difference in 2022, largely due to our international recruitment campaigns. This suggests that more work is urgently required to achieve equal representation and progression pathways into leadership positions for colleagues from ethnic minority backgrounds.

A further area of concern is the experiences of bullying, harassment and discrimination experienced by our workforce. Experiences of bullying, harassment and discrimination increased for BME colleagues this year in all areas, including from patients where BHT performed worse than the NHS average. BME colleagues consistently report higher numbers of these experiences than White colleagues. In line with the NHS EDI Improvement Plan, reducing such instances will be a key focus for BHT this year.

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WRES Indicator 1 Progress - Workforce Representation Bands 1 to VSM

1) **Workforce representation.** Number of white and BME colleagues in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of colleagues in the workforce.

	WRES Indicator 1 – 31 March 2022			WRES Indicator 1 – 31 March 2023		
	White	BME	Not Stated	White	BME	Not Stated
Up to Band 7	3493 66%	1298 24.5%	499 9.4%	3467 65%	1759 32%	248 4%
Bands 8A to VSM	289 74.3%	74 19.0%	26 6.7%	344 76%	83 18%	25 5%

What does this tell us?

The above tables highlight the differing ethnicity profile of our workforce across the various pay bands. BME colleagues represent 32% of our Bands 1-7 workforce compared with 18% of our Bands 8a+ workforce. BME representation within the Band 8a+ workforce has also decreased since 2022, largely linked to our international recruitment campaigns. This suggests that more work is required to achieve equal progression pathways into senior leadership roles for BME colleagues.

WRES Progress f/y 2022-23

Metric	f/y 2021/22 Score	f/y 2022/23 Score	Progress 2023/ Parity between groups
2) Recruitment. Relative likelihood of white candidates being appointed from shortlisting across all posts compared to BME candidates	1.25	1.15	**Improvement in ratio- Parity between groups maintained**
3) Disciplinaries. Relative likelihood of BME colleagues entering the formal disciplinary process compared to White colleagues, as measured by entry into a formal disciplinary investigation	1.35	0.96	**Improvement in ratio- Parity between groups achieved**
4) Training & Development. Relative likelihood of colleagues accessing non-mandatory training and CPD	1.12	0.86	**Improvement in ratio- Parity between groups achieved**
5) Patient Bullying & Harassment. Percentage of colleagues experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White = 26.7% BME = 26%	White=28.8% BME=31.5%	**Deterioration in figures. BHT performed worse than the NHS average.**
6) Staff Bullying & Harassment. Percentage of colleagues experiencing harassment, bullying or abuse from other colleagues in last 12 months	White = 22. 6% BME = 25.1%	White = 21.3% BME = 26%	**Deterioration in figures for BME colleagues. BHT performed better than NHS average.**
7) Career progression perceptions. Percentage of colleagues believing that the Trust provides equal opportunities for career progression or promotion	White = 60% BME = 47.9%	White = 63.4% BME = 50.5%	**Improvement since 2021. BHT performed better than NHS average, however perceptions not even between groups.**
8) Discrimination. Percentage of colleagues who have experienced discrimination at work from their manager/team leader or other colleagues	White = 6.8% BME = 13.8%	White = 5.2% BME = 15.5%	**Deterioration in figures for BME colleagues. BHT performed better than NHS average.**
9) Board representation. Percentage difference between the organisations' Board voting membership and its overall workforce	Board Voting = 36.4% BME Overall Workforce = 26% BME	Board Voting = 50% BME Overall Workforce = 34% BME	**The Board's voting membership is representative of the BME workforce**

Workforce Disability Equality Standard (WDES) Progress

The Workforce Disability Equality Standard (WDES) is a set of ten specific metrics which requires all NHS organisations to compare the workplace and career experiences of colleagues with a long term condition (LTC) or disability as defined by the Equality Act 2010, and those without a LTC or disability. The WDES enables BHT to better understand the experiences of our disabled colleagues and supports positive change for all existing employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS. Year on year comparisons enables us to measure progress against the indicators of disability equality.

Summary of WDES Progress 2023

WRES Indicator 1 demonstrates an increase in the number of colleagues at BHT who have declared via ESR that they have a LTC or disability compared to last year (3.4% in 2022 to 5.42% in 2023) . This compares to approximately 20% of BHT Staff Survey respondents identifying themselves as having a LTC or disability.

Our data indicates that colleagues with LTCs are experiencing equal outcomes in relation to our recruitment and performance management processes compared with colleagues without LTCs (Indicators 2 & 3). There has also been an increase in colleagues reporting that they have been able to access reasonable adjustments within their roles (73.6% in 2022 to 77.2% in 2023) and BHT is performing above the NHS average in this area.

Incidents of bullying and harassment from patients increased in 2023 for colleagues with and without LTCs, with incidents being 4% higher for colleagues with LTCs. BHT is performing worse than the national average in this area, and colleagues with LTCs are also more likely to report experiencing harassment from their managers and other colleagues. It is positive that we have seen an increase in the number of colleagues reporting such experiences, although work to reduce incidents of discriminatory or harassing behaviour towards colleagues is fundamental.

BHT currently has no Board members with a declared disability or LTC. Having a least 1 Board member with a LTC would create equal representation to the percentage of colleagues within our workforce with a LTC.

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WDES Indicator 1 - Percentage of colleagues in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (VSM) compared with the percentage of colleagues in the overall workforce

	WDES Indicator 31 March 2022			WDES Indicator 31 March 2023		
	Colleagues with a LTC	Colleagues without a LTC	Not Stated	Colleagues with a LTC	Colleagues without a LTC	Not Stated
Up to Band 7	3.93%	87.43%	8.68%	5.48%	87.60%	6.98%
Bands 8a to VSM	2.93%	86.63%	10.45%	4.63%	87.08%	8.28%
Medical & Dental	3.2%	81.8%	15.1%	3.55%	82.72%	13.73%
Number of colleagues in workforce	**3.4%**	**87.4%**	**9.2%**	**4.52%**	**87.82%**	**7.65%**

What does this tell us?
The table above demonstrates that the percentage of colleagues reporting that they have a long term-condition or disability has increased by 1.12% since 2022, to 4.52%. There has also been an associated decreased in ‘not stated’. Colleagues with long-term conditions are currently most likely to work in Band 1-7 roles although there is less than 1% difference in Band 8a+ roles, suggesting even progression pathways. Colleagues from our Medical & Dental workforce were least likely to report having a long term condition or disability.

WDES Progress

Metric	2021/22 Score	2022/23 Score	Progress 2023/ Parity between groups
2) Recruitment – relative likelihood of Non-disabled applicants compared to disabled applicants being recruited from shortlisting	1.11	1.14	**Parity between groups**
3) Performance Management – Relative likelihood of disabled compared to non-disabled colleagues entering the formal capability process	0	0	**Parity between groups**
4. Bullying and harassment – percentage of disabled colleagues compared to non-disabled colleagues experiencing harassment bullying or abuse from:- **i) patients or service users**	Colleagues with a LTC = 29.9% Colleagues without a LTC = 25.7%	Colleagues with a LTC = 32.6% Colleagues without a LTC = 28.8%	**Deterioration for both groups. BHT performed in line with NHS average for colleagues with LTC.**
4ii) Managers	Colleagues with a LTC = 18.5% Colleagues without a LTC = 9.6%	Colleagues with a LTC = 15.1% Colleagues without a LTC = 8.8%	**Improvement since 2021. BHT performed better than NHS average, however perceptions not even between groups.**
4iii) Other colleagues	Colleagues with a LTC = 24.7% Colleagues without a LTC = 16.4%	Colleagues with a LTC = 21.5% Colleagues without a LTC = 17.1%	**Improvement since 2021. BHT performed better than NHS average, however perceptions not even between groups.**
4iv) Reporting harassment – percentage of disabled colleagues compared to non-disabled colleagues saying that the last time they experienced bullying, harassment or abuse, they or a colleague reported it	Colleagues with a LTC = 42.9% Colleagues without a LTC = 47.4%	Colleagues with a LTC = 48.4 Colleagues without a LTC = 49.2%	**Improvement since 2021. Experiences within groups differ by less than 1%.**
5) Career progression perceptions. Percentage of disabled colleagues compared to non-disabled colleagues believing that the Trust provides equal opportunities for career progression or promotion.	Colleagues with a LTC = 54.0% Colleagues without a LTC = 58.0%	Colleagues with a LTC = 56.6% Colleagues without a LTC = 60.8%	**Improvement since 2021. BHT performed better than NHS average, however perceptions not even between groups.**

WDES Progress Continued

Metric	2021/22 Score	2022/23 Score	Progress 2023/ Parity between groups
6) Pressure to work. Percentage of disabled colleagues compared to non-disabled colleagues saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Colleagues with a LTC = 26.8% Colleagues without a LTC = 18.1%	Colleagues with a LTC = 20.6% Colleagues without a LTC = 16.5%	**Improvement since 2021. BHT performed better than NHS average, however perceptions not even between groups.**
7) Feeling valued. Percentage of disabled colleagues compared to non-disabled colleagues saying that they are satisfied with the extent to which their organisation values their work.	Colleagues with a LTC = 36.7% Colleagues without a LTC = 45.0%	Colleagues with a LTC = 40.5% Colleagues without a LTC = 49.3%	**Improvement since 2021. BHT performed better than NHS average, however perceptions not even between groups.**
8) Reasonable adjustments. Percentage of disabled colleagues saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	73.6%	77.2%	**Improvement since 2021. BHT performed better than NHS average.**
9a) Engagement. The staff engagement score for disabled colleagues, compared to non-disabled colleagues.	Colleagues with a LTC = 6.6 Colleagues without a LTC = 7.0	Colleagues with a LTC = 6.7 Colleagues without a LTC = 7.1	**Improvement since 2021. BHT performed better than NHS average, however perceptions not even between groups.**
9b) Engagement. Has your Trust taken action to facilitate the voices of disabled colleagues in your organisation to be heard? (Yes) or (No)	Yes	Yes	**Yes, we have a Colleague Network for disabled colleagues**

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WDES Progress Continued

Indicator 10		2022			2023			Progress 2023/ Parity between groups
10. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting and non-voting membership of the Board. • By Executive and non-exec membership of the Board.		Disabled	Non-Disabled	Unknown	Disabled	Non-Disabled	Unknown	
	Difference (Total Board - Overall Workforce)	-3%	13%	-9%	-5%	12%	-8%	BHT has no Board members with a declared disability
	Difference (Voting membership - Overall Workforce)	-3%	13%	-9%	-5%	12%	-8%	
	Difference (Executive membership - Overall Workforce)	-3%	13%	-9%	-5%	12%	-8%	

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Introduction

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 apply to all public sector employers with 250 employees or more, which means that BHT must report its Gender Pay Gap data annually, by 30 March each year. However, understanding the Gender Pay Gap and the drivers behind it is also an important tool, which helps us determine how we can enable the closing of our Gender Pay Gap. This is crucial to increasing inclusivity within BHT through achieving parity between men and women in the Trust. This is the sixth year that the Trust has produced its Gender Pay Gap report.

The table shows our overall mean and median gender pay gap based on hourly rates of pay as at the snapshot date (31 March 2023). It also captures the mean and median difference between bonuses paid to men and women in Buckinghamshire Healthcare NHS Trust in the year up to 31 March 2023 (i.e. 1 April 22 – 31 March 23).

	Difference between men and women				
	Mean			Median	
	2022	2023		2022	2023
Hourly fixed pay	27.6%	26.9%		17.2%	15.5%
Bonus Pay Gap	20.8%	25.5%		33.3%	0%

We have seen an improvement (reduction) in both the hourly fixed pay gap between men and women for the mean pay gap –26.9% for f/y 2022/23, compared to 27.6% for financial year f/y 2021/22, and the median hourly fixed pay gap –15.5% for f/y 2022/23 compared to17.2% for f/y 2021/22. Analysis has identified that our gender pay gap is driven by a higher percentage of men in the highest quartile of pay, mainly due to significantly different gender splits within the medical & dental and administrative & clerical staffing groups. We have observed an increase in our mean bonus gap this year, as this has increased from 20.8% to 25.5%.

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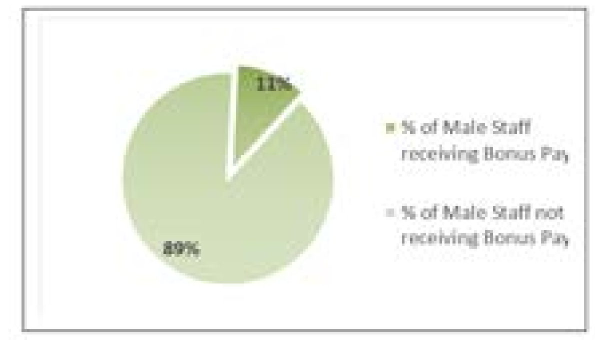
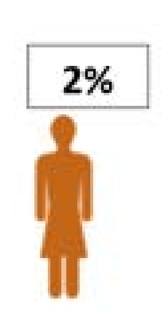
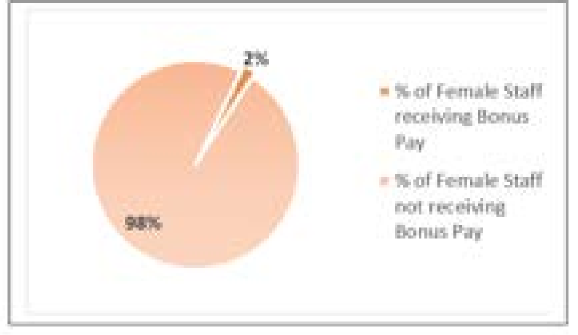
Proportion of employees receiving a bonus







This shows a 9% difference in the number of men and women who received a bonus for their performance in 2022/23. Only certain medical colleagues (within the consultant body) receive pay that is classified as bonus pay in line with their contracts; this equates to less than 4% of all our colleagues employed. A bonus pay element is awarded as a result of recognition of excellent practice over and above contractual requirements and has no gender bias.

In f/y 2022-23, these payments were awarded to all eligible medical colleagues – resulting in a median pay gap of 0%. Working with the BMA, we will look to take action to reduce this gap, for example re-introducing a competitive process.

OUTSTANDING CARE
HEALTHY COMMUNITIES
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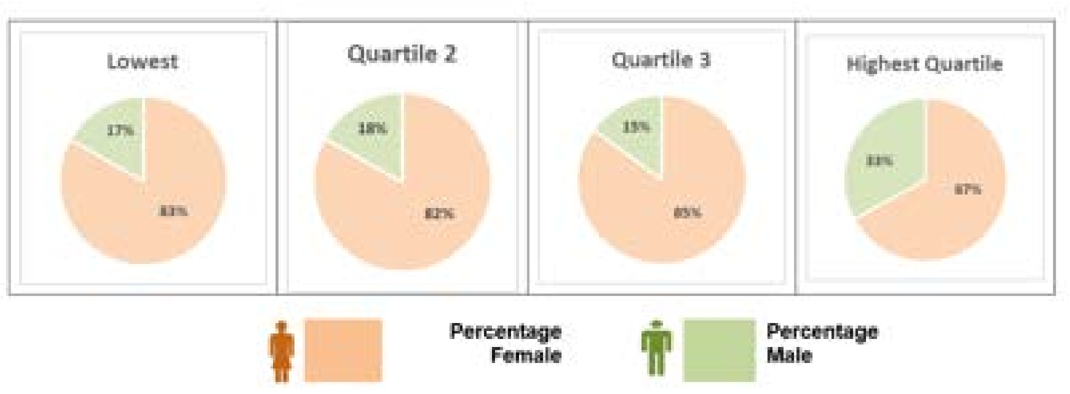
Pay Quartiles



The above images illustrate the gender distribution across Buckinghamshire Healthcare NHS Trust in four equally sized quartiles. In order to create the quartile information all colleagues are sorted by their hourly rate of pay, this list is then split into 4 equal parts (where possible).

This demonstrates that in quartile 1, 2 and 3 the split between male and female employees is fairly consistent, however in the highest quartile there are more male employees than the previous quartiles.

The variance in the highest quartile is mainly due to significantly different gender splits within the medical & dental and administrative & clerical staffing groups. We will use our talent management programmes to address these differences.

We are confident that men and women are paid equally doing equivalent jobs across the Trust. Our aim is to reduce the gender pay gap throughout the organisation but accept that this may take several years to achieve.

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Section 4: EDI Improvement Action Plan

EDI Improvement Plan

We are proud of the progress we have made this year in our pursuit of developing a more diverse and inclusive organisation for our colleagues, patients and visitors. We've achieved improvements in our recruitment outcomes for the sixth consecutive year and have diversified our population and Buckinghamshire county residency through our international recruitment programmes. The richness of diversity, culture, heritage and backgrounds of our workforce is something we are extremely proud of and is widely regarded as an asset at BHT.

As we look forward, we are deeply committed to reducing the inequalities which our colleagues are experiencing and remain steadfast in our aim to embed inclusivity and belonging within our organisation and local communities. The work we undertake to achieve our objectives will be evidenced-based and rooted in the experiences of our Colleague Networks. It will also be informed by national metrics and action plans such as the Medical Workforce Race Equality Standard (MWRES) and EDI best practice publications such as "NMC Combatting racial discrimination against minority ethnic nurses, midwives and nursing associates".

We have developed an EDI Improvement Plan to support us in achieving the objectives set on page 10. The action plan has been based on the national NHS Equality Diversity & Inclusion (EDI) Improvement Plan published in June 2023, which uses the latest data and evidence to identify six high impact actions organisations across the NHS can take to considerably improve equality, diversity and inclusion. The six high impact actions within the plan are designed to be intersectional. This recognises that people have complex and multiple identities, and that multiple forms of inequality or disadvantage sometimes combine to create obstacles that cannot be addressed through the lens of a single characteristic in isolation. Alongside this approach, BHT have added additional actions to target improvement in our organisational equalities data where appropriate, such as actions from the national MWRES report.

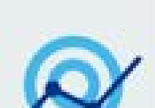
The following pages contain an overview of the six high impact actions with success metrics, and our BHT Improvement Plan including a gap analysis and milestones for achieving the six impact actions. The Plan is intended to be an iterative document, which will be adapted as we achieve our objectives or if evidence suggested an alternative intervention would be more suitable.

Six High Impact Actions

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).



Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

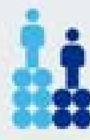
2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap



Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

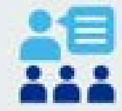
Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff



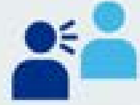
Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)



OUTSTANDING CARE
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BHT EDI Improvement Plan

High Impact Area (HIA)	Ref.	Action	Suggested Owner	NHSE Deadline	Are we currently meeting this at BHT?	Recommended plan to meet this deliverable at BHT	By When?
1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	1.1	Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process	CEO	**March 2024**	No. Some Executive Team members currently have EDI related objectives but not all.	All executive team members to have EDI objective set during performance year 2023/24 with CEO.	31/03/2024
	1.2	Board members should demonstrate how organisational data and lived experience have been used to improve culture	CEO	**March 2025**	Staff survey and engagement mechanisms (e.g. Colleague Networks, Unions) currently provide data and evidence which is used to make organisational improvements.		No change needed
	1.3	NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework	CEO	**March 2024**	Annual PSED/EDI paper includes WRES/WDES/GPG data and recommendations presented to Board annually.	Following publication of the PSED report, the prioritised actions are linked to the Board Assurance Framework and tracked accordingly.	Nov 2024
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	2.1	Create and implement a talent management plan to improve the diversity of executive and senior leadership teams and evidence progress of implementation	CPO	**Create and implement TM plan by June 2024. Evidence progress by June 2025**	No. a TM programme to develop B7 nurses from BME backgrounds is currently underway. Once this has completed, we will iterate the programme and roll it out more widely to other occupational groups at B7-8+. We do not currently have a positive action policy in place within recruitment for senior leaders or executive roles, therefore any increases in diversity are random rather than intentional.	Seek advice from Capsticks on positive action interventions available to BHT in relation to recruitment and talent management, and form task and finish group to take this forward. All Band 8b+ role adverts to include inclusive positive action statement with recruitment materials, and inclusivity to be measured as p[art of recruitment competencies. Rollout talent management intervention(s) to increase ethnic diversity of colleagues in Band 8b+ roles in line with our workforce profile. Milestone objectives to be set following Capsticks advice. Review the recruitment policy to actively support our EDI objectives.	30/06/2024
	2.2	Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes. Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint.	CPO	**October 2024**	BHT has a number of initiatives currently in place which meet this deliverable, including: • Guaranteed interviews scheme • Apprenticeships • Offering placements to graduate management trainees • School engagement service • Recruitment open days		No change needed
	2.3	Continue to increase access to Reasonable Adjustments for colleagues with long term conditions/disabilities as defined in the equalities act.	CPO	**BHT Action**	BHT has put a number of processes in place to address this in recent years including: • Empowerment passports to further support identification of adjustments required • New Occupational Health role to support with reasonable adjustments and Access to Work applications	Further plans include: • QI and Transformations Team engaging with Disability Network to identify requirements for Assistive Technology. • Rolling out trust-wide software for common conditions such as Dyslexia	July 2024

High Impact Area	Ref.	Action	Suggested Owner	NHSE Deadline	Are we currently meeting this at BHT?	Recommended plan to meet this deliverable at BHT	By When?
3. Develop and implement an improvement plan to eliminate pay gaps.	3.1	Implement the Mend the Gap review recommendations for medical colleagues and develop a plan to apply those recommendations to senior non-medical workforce	CMO	**March 2024**	There are 20 actions within the Mend the Gap review. A review is needed to understand which actions are in place and which need implementing.	CMO to identify a Medical Lead to support Head of Leadership, Talent & Inclusivity to review actions and create gap analysis. Plan presented to EMC to apply recommendations.	1st December 2023 31st March 2024
	3.1a	BHT Action - Implement the national Medical WRES recommendations for medical colleagues.	CMO	**BHT Action**	There are 13 actions within the national MWRES report. A review is needed to understand which actions are in place and which need implementing.	CMO to identify a Medical Lead to support Head of Leadership, Talent & Inclusivity to review actions and create gap analysis. Plan presented to EMC to apply recommendations.	1st December 2023 31st March 2024
	3.2	Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards	CPO	**Sex and Race - 2024 Disability - 2025 Other protected characteristics – 2026**	No. Pay gap data currently only analysed by gender.	ESR Team to disaggregate pay gap data race, disability and any other protected characteristics possible. This data will be presented with PSED 2024 which is published annually in October.	31st October 2024
	3.3	Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns	CPO	**March 2024**	Flexible working policy currently in place at BHT and was last reviewed at the beginning of the COVID pandemic. BHT job adverts include flexible working options (e.g. full time, part time) but do not give examples of flexible working arrangements available such as compressed working week, annualised hours, term time only contracts.	Programme planned for 2023/24 to further improve working flexibly in line with legislation and best practice. This encompasses recruitment and full employee journey through to and including retirement flexible options. As a follow on from this work all related policies will also be reviewed.	
4. Develop and implement an improvement plan to address health inequalities within the workforce.	4.1	Line managers and supervisors should have regular effective wellbeing conversations with their teams, using resources such as the national NHS health and wellbeing framework	CPO	**October 2023**	Yes. One to one wellbeing conversations currently offered to all colleagues via the Wellbeing Team,. Wellbeing conversations implemented in previous years instead of appraisals. REACT training rolled out across BHT as part of Peak 1 to support managers in having sensitive and controlled wellbeing conversations.	To further strengthen BHT's approach to this, wellbeing conversation template to be added to 1:1 template and rolled out as part of existing project to operationalise the performance management cycle at BHT (1:1s, appraisals, career conversations).	31st March 2024
	4.2	Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare		**April 2025**	Yes. BHT already works with a number of partner organisations on reducing health inequalities and inequalities across our workforce. For instance, the Bucks Health & Social Care Academy includes partnerships with voluntary, educational, primary care, and social care partners.		No change required
5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited colleagues.	5.1	Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment ; including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options	CPO	**March 2024**	Yes. Prior to landing in the UK International Nurses receive extensive information from the organisation including the information outlined in action 5.1.		No change required
	5.2	Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured from, for example, turnover, colleague survey results and cohort feedback	CPO	**March 2024**	BHT recruits currently attend an extensive Corporate Induction programme. The IR team are in the process of creating an 'international Recruitment' Standard Operating Procedure' and updating the 'Welcome Pack' ensuring information and assurance is provided.	Publish Standard Operating Procedure and Welcome Pack	31st March 2024
	5.3	Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety	CPO	**March 2024**	All line managers undertake mandatory EDI training and are encouraged to attend a comprehensive management development programme (Peak 1). The development of the IR process, including Pastoral Care is regularly reviewed and line managers are encouraged to maintain cultural awareness.	Peak 1 could be mandated for line managers who are welcoming international recruits.	31st March 2024
	5.4	Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international colleagues, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression	CPO	**March 2024**	Upon receipt of the NMC pin, all IENMs are given the opportunity to undertake professional development and our WRES data demonstrates equality of opportunity in accessing non-mandatory training.	Creating personal development plans to be added to existing project to operationalise the performance management cycle at BHT (1:1s, appraisals, career conversations).	31st March 2024

High Impact Area	Ref.	Action	Suggested Owner	NHSE Deadline	Are we currently meeting this at BHT?	Recommended plan to meet this deliverable at BHT	By When?
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	6.1	Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set and plans implemented to improve colleague experience year-on-year.	CPO	**Reduction targets set by March 2024**	Data on bullying, harassment and discrimination currently disaggregated by ethnicity and disability status but not for other protected characteristics. Reduction targets not currently set. Work currently underway to partner with Thames Valley Police on managing incidents which meet criminal threshold.	Data analysis to be undertaken by protected characteristic to identify colleague communities most likely to be affected by B&H. Task and Finish group to be established. Use existing EDI data and colleague lived experience to set reduction targets and implement action plan, including targeting interventions in departments/areas/occupations with highest incidences. Reduction targets to be linked to performance frameworks across Trust (e.g. management appraisal objectives or division/department performance metrics).	31st March 2024
	6.2	Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all colleagues who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this	CPO	**March 2024**	ER processes and policies already reviewed as part of WRES and restorative just culture work. Triage put in place some years ago. Parity of outcomes achieved for protected characteristics ethnicity and disability as per WRES & WDES standards.		No change required
	6.3	Ensure safe and effective policies and processes are in place to support colleagues affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and colleagues should know how to access it	CPO	**June 2024**	Yes. A domestic abuse policy is in place and all colleagues are able to access support within the Trust, including through the Safeguarding Team and Wellbeing Team.		No change required
	6.4	Create an environment where colleagues feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all colleagues	FTSUG	**March 2024**	FTSUG Service established across BHT and expanded to increase outreach. FTSUG data is reviewed against all protected characteristics to ensure equality of access and reported in line with governance processes.		No change required
	6.5	Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence	CPO	**March 2024**	Yes. The Managing Unacceptable Behaviours, Violence & Aggression Policy, EDI Policy and Standards of Behaviours and Conduct Policy each contain clear information on the extensive wellbeing support available to colleagues who experience these types of behaviours.		No change required
	6.6	Have mechanisms to ensure colleagues who raise concerns are protected by their organisation.	CPO	**TBC**	colleagues are able to confidentially raise concerns via the FTSUG Service.		No change required

Meeting: Trust Board Meeting in Public

27 September 2023

Agenda item	Trust Organisational Development Framework
Board lead	Bridget O'Kelly, Chief People Officer
Type name of author	Amir Khaki, Deputy HR Director
Attachments	None
Purpose	Assurance
Previously considered	Trust Board, January 2023 Transformation Board, August & September 2023

Executive Summary

This paper provides an update about progress made since January and sets out our approach for an organisational development framework based on an evidence-based Organisational Development (OD) model.

The paper highlights how the Programme has been grouped and stratified to provide focused interventions on the most appropriate groups of colleagues at the most appropriate times.

The original 12 project areas have been grouped into 3 overarching delivery domains, namely:

- **Culture & leadership** – Developing leadership behaviours and competencies to create a high performing culture.
- **Improvement systems & processes** – Developing and implementing systems and processes to embed an improvement methodology, practice, and culture.
- **Organisational design & structures** – Creating a structure that supports effective & efficient collaboration both externally and internally, particularly within and between teams.

The paper reflects areas which have been identified as requiring strengthening to deliver our 'breakthrough objectives' this year, and ultimately our vision of outstanding care, healthy communities and a great place to work.

The focus has been identified as a shift in our organisational culture to a more inclusive & high performing culture where everyone is focussed on continuous improvement. As such and in line with our model we have prioritising focus on the following three key groups to maximise impact:

- The senior leadership team (The Board)
- The extended executive management group (including divisional leaders)
- The leaders of our clinical service delivery units (managers, clinical leads, and matrons)

Decision	The Board is requested to note the report.

Relevant Strategic Priority

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

Relevant objective

☐ Improve waiting times ☐ Improve safety	☐ Improve access and effectiveness of Trust services	☒ Improve the experience of our new starters

☒ Improve productivity	for communities experiencing the poorest outcomes	☒ Upskill operational and clinical managers

Implications / Impact	
Patient Safety	Highlights activities to support high quality patient care.
Risk: link to Board Assurance Framework (BAF)/Risk Register	Links to all strategic objectives of the BAF.
Financial	Activities in this report may require investment; others will lead to efficiencies. The overall OD plan will also require some additional resource.
Compliance	All activities will be in line with relevant compliance.
Partnership: consultation / communication	This plan describes activities taking place internally; however, some activities may involve partnership with external agencies.
Equality	All activities will be conducted in line with equality standards and having an equality impact assessment completed where appropriate.
Quality Impact Assessment [QIA] completion required?	Not required for this report; may be required for individual activities.

1 Introduction

In January 2023, the Board approved an outline organisational development plan – to develop the organisation and enable us to deliver our breakthrough objectives.

This paper provides an update about progress made since January and sets out our approach for an organisational development framework based on an evidence-based OD model.

2 Problem

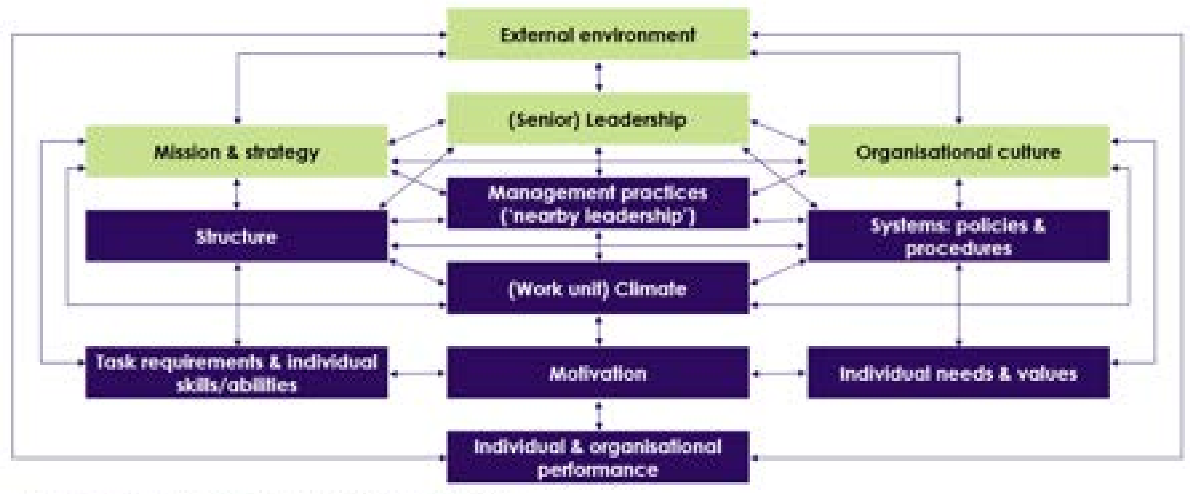
There are several definitions of organisation development. We are using the following definition as the basis for our work: "Organisation development (OD) is an intervention that focuses on improving an organisation's capability through the alignment of strategy, structures, people, reward& recognition, metrics, and management processes." Key is that it is broader than simply leadership and HR interventions.

The paper in January (drawing on data from staff surveys, pulse surveys and leadership away days) identified specific areas that require strengthening. Since then based on additional data and diagnostics, we also know that there are significant changes that we need to make to the culture of the organisation – including improving inclusion, empowering colleagues to make improvements and enabling high performance. To build a high performing, inclusive culture, we need to intervene at team level to shape the team and subsequently the organisational climate. The team climate across the Trust varies significant between SDUs and teams.

Also since January as well as delivering a number of these projects, we have worked to draw this into a coherent framework aligned with a tested OD model. The purpose of this is to provide greater assurance about the impact of this work – to maximise the benefits of the change and to provide coherence of approach across the various interventions.

3 Possibilities

To take our work forwards, and develop an OD framework for the Trust, we have drawn on a well-established model of OD to inform our approach – the Burke-Litwin model, which illustrates the elements of an organisational system and how they are connected.



Burke-Litwin model - ref: Burke, Organisational Change Theory and Practice, 2002

The transformational elements (in green) are the primary drivers of major organisational change (or lack of it), likely to require a step change in organisational behaviour. Transactional elements (in blue) are about day-to-day operations, gradual change, evolutionary rather than revolutionary

To ensure our interventions are aligned and effective, we have started with the transformational elements of the model. To set a baseline in these areas we will undertake a culture diagnostic to ensure that we have a more fine-grained understanding of the challenges and better indicators to measure progress. Influencing culture cannot be done directly – but through influencing targeted SDU leadership development (i.e., nearby management behaviours), EMC leadership and more supportive systems and processes.

4 Current position

We have grouped the original 12 project areas into 3 overarching delivery domains, namely:

- **Culture & leadership** – Developing leadership behaviours and competencies to create a high performing culture.
- **Improvement systems & processes** – Developing and implementing systems and processes to embed improvement methodology, practice, and culture.
- **Organisational design & structures** – Creating a structure that supports effective & efficient collaboration both externally and internally particularly within and between teams.

Delivery domains	Project area
Organisational culture and leadership	Executive development & use of time Wider leadership engagement & development Clinical & operational leadership Internal communication
Improvement systems & processes:	Digitisation of how we do things Approach to transformation Quality Improvement strategy Quality
Organisational design & structure	Organisation design review Integration with Partners Governance structure

An update of progress against these areas is included at Appendix 1.

The governance going forwards will be via a senior SRO for each domain, who will report progress to Transformation Board monthly. The board will then receive a quarterly update.

5 Proposal

The three delivery domains which we have grouped our projects in, align well with the Burke-Litwin model, and allow us to test the inter-dependencies and coherence of our work.

Based on feedback and diagnostics thus far we have identified the focus for each deliver domain as below:

- **Leadership & Culture** – The number of colleagues who experience bullying, harassment and discrimination from colleagues and managers.
- **Improvement Systems & processes** – Teams' ability & ownership for improvement of services
- **Organisational design & structures** – Organisations structure & governance review

Our next step to identify our OD priorities for 2024 will be to undertake an organisational diagnostic such as a culture audit.

The model suggests that focussing on interventions which impact those transformational elements on the middle column (the spine) will have the greatest impact on culture. This aligns with our own assessment of needs for our people, focussing on three key groups which will have the greatest impact on the organisation:

- Our senior leadership as we look to develop further as a Board, particularly how we interact and influence the external environment and build and develop our mission and strategy. The Board has a key role in developing the organisation's culture – a key determinant will be how its strategic leadership is perceived by the organisation. We will be looking to plan some of this via the next Board development days and through the refresh of our clinical strategy
- The extended executive management group (including Divisional Directors, Divisional Chairs and Heads of Nursing) to achieve a high performing senior leadership culture – how this group is perceived by the organisation through their management practices (nearby leadership) – resetting expectations and defining relationships - will have a significant impact on the organisational culture as well as the more immediate work climate.
- The leaders of our clinical service delivery units (managers, clinical leads and matrons) to embed high performing clinical and operational leaders with strong management practices (nearby leadership) as above, and also the team climate at the core of our business (the clinical service delivery units). This group has a significant impact on the "climate" of the organisation – i.e., what the organisation feels like on a day-to-day basis and the emotional commitment of colleagues to the organisation – i.e. engagement.

In addition to this focus on our people activities, we are reviewing the Trust organisational structure and maintaining our work on improvement systems.

Led by the Chief Operating Officer, we are engaging with the organisation about the structure and shape of the organisation. We have also taken forward other work (as set out in the appendix) which relates to the structures and governance of the organisation.

The embedding of a quality improvement approach, supported by digital systems continues. The detail of progress to date is set out in Appendix 1.

6 Conclusions

Work to develop the organisation has been ongoing since January this year. The next stage to develop the organisational culture is to focus on the development of three key groups, which our internal evidence, supported by a well-established model, suggests will provide the organisation with the greatest chance of success of delivering change and moving the organisation forwards.

In parallel, we will continue to take forward the review of the organisational structure and embed an improvement approach. Key will be to ensure that our approach in each of these areas, aligns with our overall aims for the culture of the Trust.

7 Action required from the Board/Committee

The Board is requested to note the progress made to date and endorse the approach outlined.

APPENDICES

Appendix 1: Update against the 12 projects as set out in the original programme plan:

Timescales & status Key: Completed In-progress Not started

Projects	Workstreams	Update	Timescale & status
Wider leadership engagement & development	Embed a new behavioural framework Implement an operational management framework Design a talent management programme	Embedded into all inductions and Peak programmes. 'Operational Excellence' is designed and will be implemented by 2 separate pilot projects (Scope for Growth) and (develop you, develop me) are being trialled across the Trust	**Q2 2023/24** **Q4 2023-24** **Q2 2023/24**
Clinical & operational leadership	Reviewed Service Delivery Unit (SDU) lead role and redesigned the SDU lead development programme. SDU Triumvirate (MDT) leadership training (Sept 23 & Mar 24) to focus on collaborative working	In collaboration with the Deputy CMO & the SDU leads this has now been completed Collaboration between CMO, COO and CNO has resulted a very successful MDT session in September, March session is being planned.	**Q1 2023-24** **Q2 2023/24**
Organisation design review	Review the structure of the organisation to identify the most efficient and effective structure	Engagement across the organisation has taken place over the summer looking at reducing clinical Divisions from 5 to 4	**Q3 2023-24**
Approach to transformation	Set a small number of breakthrough objectives for this year Use a revised performance management framework to ensure accountability and develop effective delivery unit / PMO	We have set a small number of breakthrough objectives for f/y 2023-24 and set multi-year strategic goals In progress	**Q2 2023-24** **Q3 2023-24**

Internal communication	A more structured and planned approach to corporate communications using multiple channels to support consistency of messaging + A mechanism for feedback from teams	Launched a 'Team Brief' multi-media communications cascade for 2023/24 through 'town hall' monthly briefings – via leadership brief	**Q1 2023-24**
Integration with partners	Transparency and engagement, and alignment of strategic priorities	aligned with the Health & Wellbeing Strategy and the BOB ICB forward plan and strategy Integrate intermediate care services with Buckinghamshire Council	**Q1 2023-24** **Q3 2023-24**
Governance structure	A simplified structure that is clear to all colleagues, eliminates duplication, and retains appropriate Executive oversight	Review and standardise the sub-groups reporting into EMC Set a divisional performance review structure, including for corporate departments	**Q1 2023-24** **Q1 2023-24**
Quality	The fundamentals of care to be right, every time, supported by an open culture of reporting and accountability at all levels	Clinical accreditation across our clinical services has started.	**Q4 2023-24**
QI strategy	Trialled vertical delivery plan for Improvement System in Surgery & Critical Care including performance board, leadership training and team-based QI Huddles Embed GEMBA as business as usual for senior leadership team–	Underway, but predicated on leadership development & BI Underway, positive progress with execs & specific leadership teams	**Q3 2023-24** **Q4 2023-24**
Digitisation of how we do things	BHT to be clinically-led, operationally-driven, and digitally-enabled More flexible use of digital tools to support service development Investing in people so they can maximise their use of digital technology and data	Define clear roles and responsibilities for clinical, operational and digital teams Define a skills matrix for roles and a plan for embedding these across the Trust Define new, more flexible ways of working across digital, data and technology and ensure that clinical teams have the capabilities to use this flexibility to improve services	**Q3 2023-24** **Q3 2023-24** **Q3 2023-24**
Exec development & use of time	Executive team development with shared team objectives Increased visibility in the organisation	Increase face-to-face time spent as a team Agree and set objectives at an individual and team level Review individual skills gaps aligned to delivery of breakthrough objectives and invest in appropriate training	**Q1 2023-24** **Q1 2023-24** **Q4 2023-24**

Corporate services interface	Transformation of the interface between corporate and clinical services	Review, for each corporate service: • Existing use of resources and future demand • Productive use of technology • Processes – to ensure simplified and streamlined	**Q4 2023-24**

Meeting: Trust Board Meeting in Public

Date: 27 September 2023

Agenda item	Working Flexibly at BHT
EMC Lead	Bridget O'Kelly, Chief People Officer
Author	Karon Hart, Deputy Director Workforce and Wellbeing
Appendices	None
Purpose	Approval
Previously considered	EMC

Executive summary

This paper sets out a dedicated programme of work to shift our approach and embed a culture of working flexibly at BHT.

We are bringing this to Board as, while it will involve changes to policies, it is more significantly a culture shift in how we fully encompass working flexibly, to be an employer of choice to all generations of employee and continue to increase our retention rates.

We request that the Board endorses this programme of work and role models

The programme addresses the need to support a balance between employees' needs and the needs of the patients, service, team, and wider organisation.

We will deliver this change through our People Promise Exemplar Programme.

There is a clear evidence base for us to shift our approach.

1. **Retention** - Although we have seen a reduction in overall leavers, our data shows that the top reason for colleagues leaving is work life balance, for both leavers with under a year's service, as well as all leavers of various lengths of service.
2. **Attraction -** being best in class for working flexibly will improve our position as an employer of choice (as evidenced in National Staff Survey Data)
3. **Productivity** – COVID-19 triggered a significant shift in ways of working and this now needs a review. Taking the best from the opportunities provided by digital transformation and changes to our working environment, working in an agile and flexible way can lead to productivity and workforce efficiencies, as well as supporting employees.
4. **National and NHS legislation** - Guidance issued in August and coming into place from 2 October 2023, will be incorporated into the NHS Terms and Conditions handbook (new section 35 to be used in conjunction with section 33). This relates to flexible, agile and hybrid working and how this is articulated in our policies (appendix 6).
   Pension reforms in 2023 (April and October) increased flexible retirement options. The Employment Relations (flexible working) bill received royal ascent on 20 July 23 and is expected in come into law in summer 24.

In implementing the suggested improvements, our aim is to change our approach across the organisation, where working flexibly is viewed and considered equitably and positively.

Decision	The Board is requested to endorse this programme of work

Relevant strategic priority

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

Relevant objective

☐ Improve waiting times ☐ Improve safety ☒ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☐ Upskill operational and clinical managers

Implications / Impact

Patient Safety	Our colleagues feeling Safe, Supported and Listened to is key to patient safety is a core part of our quality plan and major contributor to our first strategic priority – to provide outstanding, best value care
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 6: Failure to deliver our People priorities CRR51 – ensuring adequate and appropriate workforce supply
Financial	National funding has been received to support the People Promise programme in 23/24
Compliance CQC Standards Fit and Proper staff	CQC Well Led – ensuring colleagues are working well, supported and operate in an environment of 'A Great Place to Work'
Partnership: consultation / communication	We are working with the NHSE/I national and regional teams. We have set up a buddying system with other NHS Trusts. We will consult across the organisation on the programme development and implementation. We have been updating our staff side forums and will continue to
Equality	The NHSE/I guidance requires that Trusts improve belonging and address inequalities in recruitment and promotion
Quality Impact Assessment [QIA] completion required?	The programme will be reviewed for equality in promotion and implementation on a regular basis

1. Introduction/Position

We want to support every colleague's work life balance, at each stage of their career at BHT and through their changing personal circumstances. To do this, our vision is to create a working flexibly culture that will positively impact on our ability to attract and retain.

As part of this year's pay and reward deal NHS England announced on 16 Aug 23 that a framework agreement for balancing work and personal life will be incorporated into the NHS Terms and Conditions handbook (new section 35 to be used in conjunction with current section 33) with effect from 2 Oct 2023.

Pension reforms in 2023 (April and October) increased flexible retirement options and the Employment Relations (flexible working) bill received royal ascent on 20 July 23 and is expected in come into law in summer 24.

By implementing national legislative change and our best practice recommendations, we are also aligning with our strategic people goals 2023-25. Our aim is for our people to feel they are part of a team that is flexible, compassionate and enables them to deliver excellent care, with the potential to opening opportunities to a career pathway that is right for them.

While changes to policies are key, the priority for this programme of work will be to move BHT to a highly visible working flexibly culture, with a holistic lens – balancing the needs of the service, team and individual so that our colleagues feel supported to balance their work and personal life and address how they can work well and productively, by providing increased opportunities for flexibility within their roles. The Board and Senior managers are asked to endorse this change and act as positive role models for this approach.

Through successful transformational change and adoption of a working flexibly culture across the organisation, we would expect to see an increase for formal flexible working requests, although this is not the primary driver, as the intent is for colleagues to feel more confident that their needs for flexibility are being met in an everyday approach. This will be achieved by improving associated policies (annual and other leave policy) and introducing new schemes (buying and selling of annual leave) By implementing these changes, we could trigger further benefits, such as decreasing short term sickness levels and therefore temporary staffing spend.

Integral to this piece of work is flexible retirement and we will positively communicate and support our colleagues to consider their flexible retirement options, so that they can continue to work at BHT for longer if this is right for them and us.

Our working flexibly culture will put us in a position of 'employer of choice' - linking to our People Priority to improve the experience of our new starters. We will able to retain our colleagues for longer, by improving the possibility of an improved work life balance, equitable for all, which will lead to more stable teams and make BHT ' A Great Place to Work'.

2. Problem

The current situation is that while we have agile working and flexible working policies in place, too much is left to managerial decision at a local level and they were last reviewed through the lens of COVID. This leaves it open to risk of inequity of options available to

colleagues across the Trust. Exit interview data indicates that a refusal of a flexible working request, or feeling that they could not make a request, has led to resignations, as well as employees citing general work/life balance issues.

Working flexibly needs to support the right balance between the employees needs and the needs of the patient, service, team, and wider organisation. Working in an agile and flexible way needs to be looked at through the lens of productivity and workforce efficiencies. Research has shown 60 % of employees and 77% of managers believe working flexibly increases productivity and 63% of employees say it increases motivation. (Flexible Working and the Future of Work: Managing Employees since COVID-19, Forbes et al, Universities of Birmingham, York, and Kent, 2022)

3. Definitions

Creating a working flexibly culture encompasses both agile and flexible working.

Agile working could also be referred to as 'smart working', which is about utilising the benefits from deploying new technologies and creating new working environments – both of which BHT has developed in recent years.
The key aspect is embracing both physical and digital workspace opportunities to support colleagues to work in a way that maximises their productivity, delivers best value to the organisation and is most efficient to the service provision.

Flexible working is described in government legislation as working that suits an employee's needs. All employees have the legal right to request flexible working and would expect their employer to manage this request in a reasonable manner. An employer can refuse an application, with a good business reason given, for example if it will affect quality, performance or costs or will not meet customer (patient's needs)

4. Possibilities

BHT to be an employer of choice, with a flexible and creative culture in how we work, balancing career goals and personal commitments. We want our colleagues to feel that being part of the BHT family means they have greater choice in when and how they work. This will support both attraction and retention and contribute to our 'Great Place to Work'

In becoming an employer that positively and empathetically approaches flexible opportunities, we believe that BHT will become best in class for colleague Wellbeing, with colleagues feeling they have an improved work life balance and cause further improvement in our retention rates and make BHT an employer of choice for attracting new talent.

Leaver's information
27% of leavers from Sept 22- Aug 23 cited reason for leaving as work life balance
2022 staff survey
50% of colleagues report that the Trust is committed to their work life balance
55% of colleagues report that they achieve a good work life balance
57% of colleagues are satisfied with opportunities for flexible working
71% of colleagues can approach their line manager about flexible working

5. Proposal

Whilst there is a need to ensure we reflect legislation in our policies, a true flexible working culture will only be realised by complimenting policy change with best practice initiatives to support doing things differently. This needs to be fully embraced across the organisation and role modelled by senior managers to support the change.

5.1 Working flexibly – the BHT approach. What will be different?

We will have a culture of working together within teams to discuss and agree balanced working patterns that work for patients and service delivery, individuals, and the team.

This will include

- Review all vacancy adverts for opportunity to offer flexible contracts (annualised, term time, fixed shift patterns for consolidated hours etc)
- Day one flexible working requests in place
- Change our approach to leave – including buying and selling leave and review of our current leave options
- Enabling a clear and transparent process for making flexible working requests
- Introducing team based rostering options
- Supporting colleagues who are approaching retirement to maximise options available

We will enable this through:

- Supporting managers to confidently and creatively look for ways to encourage teams working flexibly, whilst continuing to deliver outstanding care to our patients and service users and ensure productivity and efficiency of service delivery.
- Establish a flexible working and flexible retirement oversight panel for advice, escalation and appeal process
- Reviewing our policies to proactively support this culture
- Continuing our best-in-class approach to Wellbeing, to support work related issues and personal issues impacting work

5.2. Review of policies linked to working flexibly

We will review a range of policies to support our work to create a working flexibly culture within BHT. Most notably, within Q3:

- We will finalise updates and relaunch our Agile working and Flexible working policies
- Ratify our reviewed 'Annual and Other Leave' policy, with recommendations below:
    - Increase paid Child Bereavement leave to 20 days
    - Increase paid Compassionate/Bereavement leave to 10 days
    - Increase paid carers leave to 5 days
    - Increase domestic/crisis leave to 5 days
    - Clarification that bereavement leave does not need to be taken all at once.
    - 1 Day funeral leave in addition to other leave entitlements

We do not predict an overall additional cost to the Trust, as many colleagues impacted by these types of leave take this additional time off as sick leave if they feel unable to work.

Therefore, by taking this more empathetic and supportive approach we anticipate seeing a correlating decrease in sickness absence and improved retention.

5.3 Flexible Retirement (NHS pension scheme reform)

From 1 April 2023 all members have the option to retire and re-join the pension scheme. From 1 October 2023, partial retirement (also known as draw down) is available to members of all sections. This means that colleagues can take some (or all) of their pension and keep working without breaking their contract. To take partial retirement, their pensionable pay must reduce by at least 10%. This reduction can be achieved by reducing their hours, changing their level of responsibility, or moving to a different role.

To support line managers to equitably consider these requests and to support colleagues to think about the next steps in their career, we will be implementing the following:

- A Flexible Retirement brochure and associated webinars for colleagues and managers
- Creation of new ‘A Guide to Flexible Retirement’ section on CAKE, with relevant documentation, policy and guidance information for pension and retirement planning
- Improve our internal mover process so that colleagues that wish to partial retire but move to a different role can move within the organisation smoothly

6. Next Steps and communications plan

September 2023

- Prepare for alignment with NHS T&C’s Handbook revisions (Section 35)
- Review and revise Flexible Working and Agile Working policies
- Create flexible Retirement brochure and working flexibly guide for all colleagues
- Update CAKE with all relevant information, create dedicated page for signposting

October 2023

- CEO message to all colleagues the vision for creating a working flexibly culture
- Conclude review of polices that relate to Flexible and Agile Working (Appendix 4)
- Conduct listening events and knowledge cafes (with themes and questions compiled thereafter as an FAQ document) and present at leadership brief
- Compile a resource for managers and use leadership brief to inform managers
- Flexible Working survey will be circulated via Wellbeing Wednesday
- Improve our job adverts to entice new talent and promoting BHT as an employer that positively welcomes working flexibly
- First team-based roster in ITU initiated (trial pre wider roll out)
- Establish flexible working and flexible retirement application appeals oversight panel

6. Action required from the Board

The Board is requested to endorse this programme of work.

Meeting: Trust Board Meeting in Public

Date: 27 September 2023

Agenda item	Nursing & Midwifery Safe Staffing
EMC Lead	Karen Bonner, Chief Nurse & Director of Infection, Prevention & Control
Author	Jose Loreto Facultad, Associate Chief Nurse, People, Transformation & Professional Practice
Appendices	Maternity BR+; Divisional Training Compliance; Establishment v. Gaps; CHPPD; HealthRoster KPI Exception Report
Purpose	Assurance
Previously considered	EMC 01.08.2023 Q&CGC 16.08.2023

Executive summary

This document outlines our organisation's Nursing & Midwifery workforce approach to utilise effective staffing deployment and key measures to ensure the safest staffing levels are maintained proportionately as possible.

The report highlights key risk issues arising from June 2023 data and action by the Trust and/or Divisional levels to support safe staffing, provides a Trust overview, highlights areas of challenge, and further provides updates on what action has been taken.

The use of escalation areas, above the bed base capacity and 1:1 support for enhanced care needs are highlighted in this report.

Safe Staffing metrics (Table 1) show stable and positive trends providing assurance of meeting the NQB expectation.

The registered nursing & midwifery vacancy rate is at 11.3% (a 1.2% reduction from the previous month) with an overall reduction in annual turnover of 1.6% registered and HCA combined.

NQB expectation- Right Skills: Overall Statutory and Mandatory training compliance at 91% above Trust's target.

Resolved red flags at 96.5% demonstrating compliance with the CQC indicator of responsiveness to meeting people's needs.

There is a consistent reduction of agency staffing usage to fill the gaps in workforce requirements without jeopardising staffing safety.

Three key points for the board to note:

1. M03 staffing position consistently shows a stable trend. All data supports that we are delivering care in line with the NQB (2016) guidance: Right Staff, Right Skills, and Right Place at a Right Time
2. The Trust recognises the impact of providing corridor care and additional capacity above the bed base on staff and patient safety and has addressed operational processes on capacity and patient flow.

3. The Committee is advised that the Trust complies with the NQB set of expectations through the implementation of the daily safety brief where staffing, skill mix, patient acuity, dependency, and caseload are reviewed.

This report was considered by the Executive Management Committee on 1 August 2023 who welcomed the global review of nursing staffing but requested additional information alongside this on variation in practice noting the benefits of sharing where practices were working well, e.g. in the management of Bradford Scores and sickness absence. Additionally, the Committee sought greater triangulation with finance and requested future reports contained performance against budget.

On 16 August 2023, the Quality & Clinical Governance Committee took assurance from this report noting the achievement of the NQB standards. The Committee recognised the national challenges in Community nursing and looked forward to a report due later in the year on a community nursing pilot. It was acknowledged that successful initiatives related to nursing engagement and morale at specific community sites were being rolled out more broadly. The Committee also recognised the reduction in requests for additional staffing in line with the reduction of patients within escalation areas.

Decision	The Committee is requested to take assurance from the report and seek clarification if required		
Relevant strategic priority			
Outstanding Care ☒	Healthy Communities ☐	Great Place to Work ☒	Net Zero ☐
Relevant objective			
☐ Improve waiting times ☒ Improve safety ☒ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☐ Upskill operational and clinical managers	

Implications / Impact	
Patient Safety	Safe staffing levels are paramount and one of the key priorities in N&M Workforce Planning to deliver safe, quality, and effective patient care
Risk: link to Board Assurance Framework (BAF) or relevant Risk Register	Principal Risk 9: Failure to learn, share good practice and continuously improve Principal Risk 6: Failure to deliver our People Priorities
Financial	Associated temporary staffing costs to ensure safe staffing levels are maintained. However, dependence on temporary staffing and at times high-cost agencies is a cost pressure.
Compliance NHS Regulation	1. National Quality Board (NQB) Standards and Expectations for Safe Staffing (2016 &2018) 2. Developing Workforce Safeguards (2018) 3. CQC Standards Staffing 4. Regulations of the Health & Social Care Act: Safe Care and Treatment (12) Staffing (18)(1).
Partnership: consultation / communication	Consultation with NHSE Safe Staffing Faculty Work with colleagues in BOB ICB/ICS on temporary staffing Partnership and collaborative engagement with BOB ICB Recruitment & Retention Advisory Group in supporting to address key issues in the workforce, sharing of best

	practices, and collegiate discussions in delivering the Peoples' Promise Programme. In regular communication with Regional/National NHSE/I Workforce teams with regard to staffing, workforce standards, recruitment, retention, and related agenda.
Equality	Patients who pose known or potential infection risks are equally entitled to treatment. IPC measures to support their safe management should be in place to support this.
Quality Impact Assessment [QIA] completion required?	None Required

1 Purpose of the Report

1.1 This briefing provides the Trust Board and Quality & Safety Committee with an overview of the Nursing and Midwifery workforce during June 2023 as is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing (2016 & 2018) and Developing Workforce Safeguards (DWS 2018).

1.2 The report further provides assurance that arrangements are in place to safely staff our services with the right number of nurses and midwives with the right skills, at the right place, and at the right time

2 Background

2.1 Safe staffing is one of the standards that all healthcare providers must meet to comply with the Care Quality Commission (CQC) regulations. The Nursing and Midwifery Council (NMC) also sets out the nursing and midwifery responsibilities relating to safe staffing.

2.2 Trusts must follow the National Quality Board (NQB) Standards and Expectations for Safe Staffing guidance published in 2016 and NHSEI Developing Workforce Safeguards (DWS) guidance published in 2018.

3 Key Highlights

3.1 Escalations areas and above bed-base capacity

As in the previous month's report, M03 continue to feature additional capacity above the bed base in most of the wards, used of escalation area in CSRU, and the significant corridor care in our adult ED continues to put pressure on the current establishment and has resulted in a continuous redeployment of staff from one area to another, as well as an increase of additional duties requested. The Trust recognises the impact of providing corridor care and additional capacity above the bed base on staff and patient safety and has addressed operational processes on capacity and patient flow.

3.2 1:1 Specialing

As in the previous month's report, M03 continue to feature the provision of 1:1 support for enhanced care, creating additional duties for the temporary workforce to cover. The Enhanced Care Project is in progress and will be exploring transformational

approaches to improve the Trust's provision of 1:1 care safely and effectively in an efficient and affordable way.

4 NQB Expectation 1: Right Staff

4.1 Evidenced-Base Workforce Planning

Having the right establishment and staffing in post is essential to ensuring the safe and effective delivery of patient care. The Trust meets this expectation by undertaking twice-yearly establishment reviews against which an increase in an establishment is substantiated through business planning. Table 1 below sets out the current overall nursing workforce metrics used to monitor performance against this expectation.

	Staffing Measures	Apr-23	May-23	Jun-23	Trends
Registered	Nursing Establishment WTE	2174.5	2174.5	2174.5	→
	Nursing Staff in Post WTE	1897.7	1903.3	1929.3	↑
	Vacancies WTE	277.8	271.2	245.2	↓
	Actual v Planned Hours used	89.4%	90.5%	91.3%	↑
	Annual turnover (Registered)	11.5%	10.8%	9.8%	↓
HCA	Annual turnover (HCA)	16.8%	15.7%	15.1%	↓
	Actual v Planned Hours used (HCA)	86.2%	86.9%	87.9%	↑

Table 1: Nursing Workforce Metrics (Source: HR Workforce and HealthRoster KPIs)

Performance metrics in Table 1 is showing positive results in M03 and a consistent stable trend in our N&M workforce throughout the Q1 period. In M03, the vacancy rate is at 11.3% (a 1.2% reduction from the previous month). Overall reduction in annual turnover of 1.6% registered and HCA combined. Actual hours in staffing deployment continue to close the gap from the required/planned hours, meeting the demand in patient care.

5 Activity and Acuity

Table 2 below shows the overall average bed days against patients' level of acuity. In M03, the Trust had 153 fewer bed days than the previous month in relevant patients' acuity levels. There is an increase of patients with level 0 (stable and needs met by the provision of normal ward care). Level 1b (heavily dependent or acutely unwell) for patients in non-critical care beds remained consistent to be the most prevalent acuity score across acute medical-surgical wards. The increase in level 3 care is attributed to classifying patients with complex respiratory dependency in our specialist spinal unit to align with the Standards for Specialist Rehabilitation of Spinal Cord Injury.

	Count of bed days (average)							Proportion of bed days					
	Level 0	Level 1a	Level 1b	Level 2	Level 3	1:1 Care	Grand Total	Level 0	Level 1a	Level 1b	Level 2	Level 3	1:1 Care
Apr-23	3024	2661	9499	1284	129	735	**17,333**	17.45%	15.35%	54.80%	7.40%	0.74%	4.24%
May-23	3635	3170	9586	1323	113	635	**18,462**	19.68%	17.17%	51.92%	7.17%	0.61%	3.44%
Jun-23	4015	3085	9201	1127	273	608	**18,309**	21.92%	16.84%	50.25%	6.15%	1.49%	3.32%

Table 2: Acuity v Bed Days (Source: SafeCare/HealthRoster Perform Systems)

6 Midwifery – BirthRate Plus®

BirthRate Plus® (BR+) is a nationally recognised tool to calculate Midwifery staffing levels. Maternity service provides the trust board with a 6-monthly report on midwifery

staffing and undertakes a six month in line with maternity incentive scheme recommendations.

The staffing v acuity status of Labour Ward and Aylesbury Birth Centre (ABC) for M03 showed an amber rating in patient acuity and identified staffing shortfalls (Appendix 1). Mitigations as per the division's BCP to maintain safe staffing support increased clinical activity are in place.

7 Community Nursing Service – District Nursing

Safe staffing for community nursing teams is sighted at the corporate nursing level through the CNO Workforce at the daily Safety Briefing. The OPEL status on demand and capacity is benchmarked against the national triggers on an escalation of OPEL status. Figure 1 below shows that in M03 78.8% of the overall activity was declared OPEL1 which is consistently the trend throughout the Q1 period. Areas identified with staffing risk are mitigated by redeploying staff from areas with lower risk to areas requiring additional support to maintain staff and patient safety.

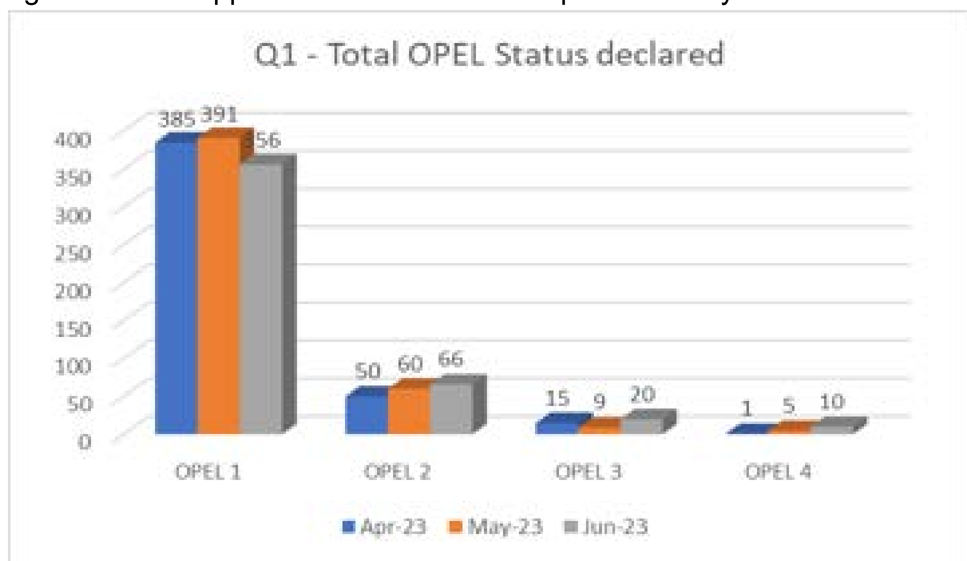


Figure1 Community Nursing OPEL Status

In M03, the vacancy factor in ACHT (RN & HCA) is on average 22%, ranging from 8% in Thame ACHT to 35% in Marlow ACHT. International recruitment to bridge the vacancy gap with no success to date, however, local support for applicants to undertake District Nursing Specialist Qualification with currently 8 starting in September.

8 NQB Expectation 2: Right Skills

8.1 Statutory/Mandatory Training, Development, and Education

Statutory training is legally reportable, e.g., Infection Control, Information Governance, Fire, Manual Handling, Health& Safety, Equality & Diversity, and Safeguarding Adults and Children.

Registered Nursing & Midwifery overall compliance in M03 for Statutory Training at 91.8% and remained above the Trust's target of 90% throughout the Q1 period. Figure 2 below demonstrates the breakdown of compliance at Divisional levels. Specialist

Services Division has slightly improved from the previous month however, still below the Trust's target throughout Q1.

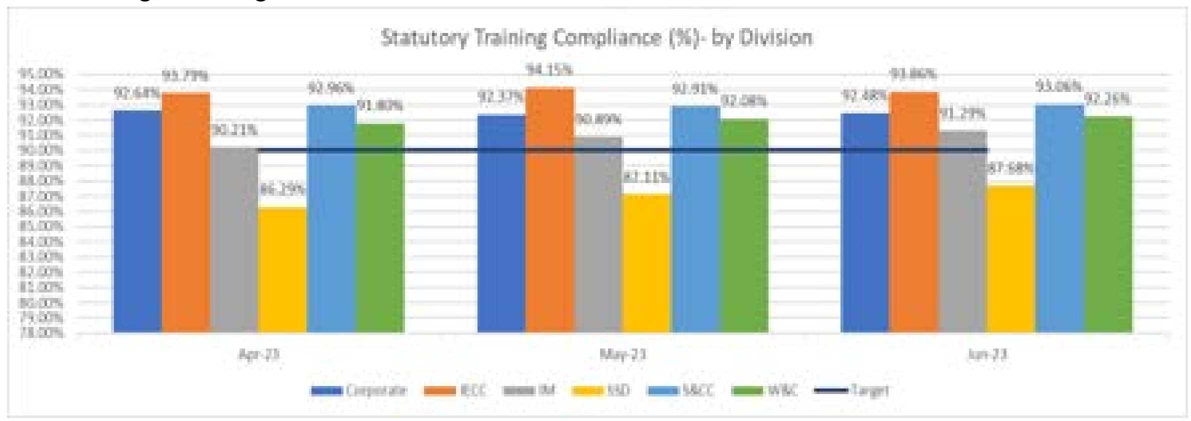


Figure 2 (Source: ELD Business Information Data)

Mandatory Training e.g., Resuscitation, Hand Hygiene, Prevent, and Dementia

Registered Nursing & Midwifery overall compliance In M03 for Mandatory Training at 91.6% and remained stable above the Trust's target of 90% throughout the Q1 period. Figure 3 below demonstrates the breakdown of compliance at Divisional levels wherein the Specialist Services Division shows below the Trust's target throughout Q1.

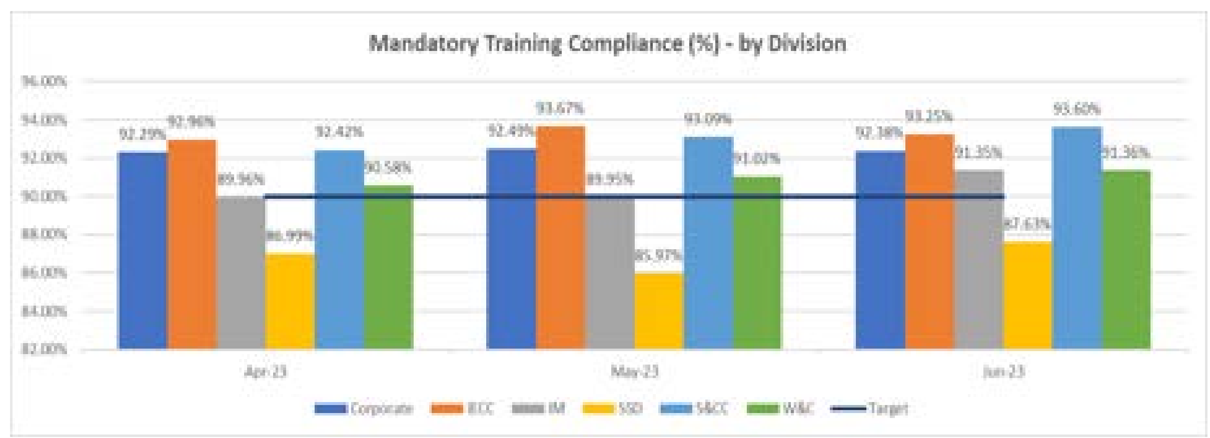


Figure 3 (Source: ELD Business Information Data)

Appendix 2 breaks down the divisional training compliance per individual training courses and demonstrates courses with non-compliance below the Trust's target. There has been a big push in compliance with Safeguarding Adults Level 3 training which resulted in much-improved figures to date.

9 NQB Expectation 3: Right Place and Right Time

The Trust meets this expectation because it uses tools to support efficient and effective decision-making around the deployment of staff to meet patient needs.

9.1 Efficient Deployment & Flexibility

Red Flags:

In M03, the total Red Flags raised are 254 which was 105 less than the previous month, of which 5 were raised in error, subsequently rectified. A total of 245 (96.5%) red flags were resolved, demonstrating compliance with the CQC indicator of responsiveness to meeting people's needs. Figure 4 below shows the Red Flags raised and resolved in 17 acute medical and surgical wards. There were 4 remaining Red Flags

opened/unresolved, escalating the need for 1:1 support to patients. Two red flags were raised for less than 2 RN on the shift, subsequently resolved. There were no issues affecting staffing safety on these unresolved red flags during this period. Staff are encouraged to raise red flags where there may be concerns relating to safe staffing levels. The Chief Nurse sets out clear expectations at the daily Safety Briefings from Divisional Heads of Nursing and Matrons to review and action red flags with evidence of professional judgments and mitigations to maintain patient safety and quality care.

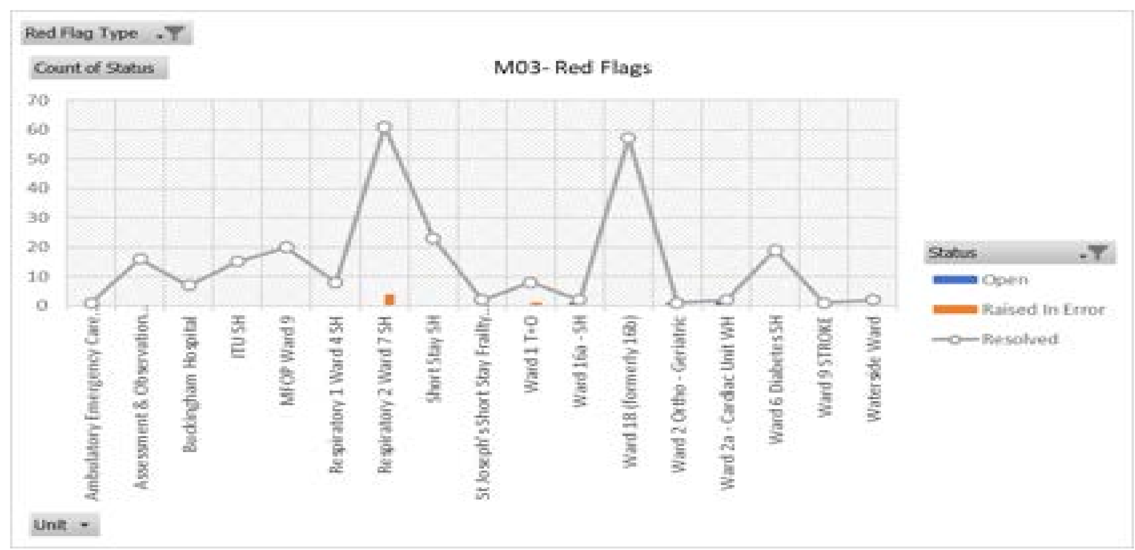


Figure 4 (Source: HealthRoster/SafeCare Systems)

9.2 **Agency Usage and Temporary Spend**

Having efficient rosters will support the measures taken to reduce agency spend across rostered areas. Appendix 3 shows the graph demonstrating the total establishments of relevant clinical areas against the workforce gaps filled with bank and agency shifts in terms of WTE figures.

Figures 5 & 6 show overall spending for Bank and Agency (B&A) usage against the set thresholds. In M03, B&A usage and spending for qualified nursing is below the Trust's threshold with no agency usage for unqualified workforce. An overall reduction in agency staffing spend is £85K less than the previous month with a comparable reduction in bank staffing of £77K less than M02. A continued governance oversight on the progress to reduce agency spending to 3.7% of the total pay bill is monitored fortnightly at the N&M Temporary Staffing Working Group led by the Associate Chief Nurse.

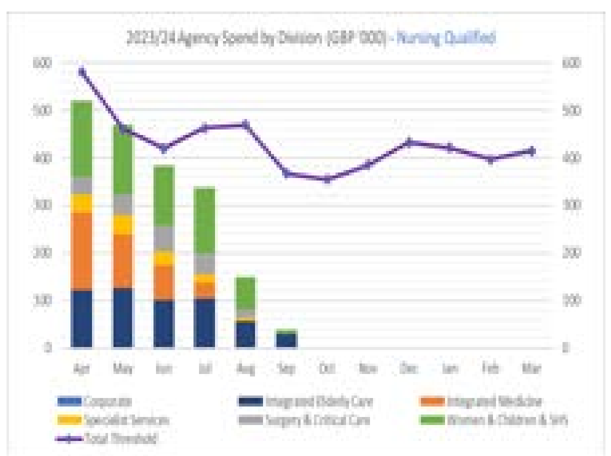


Figure 5

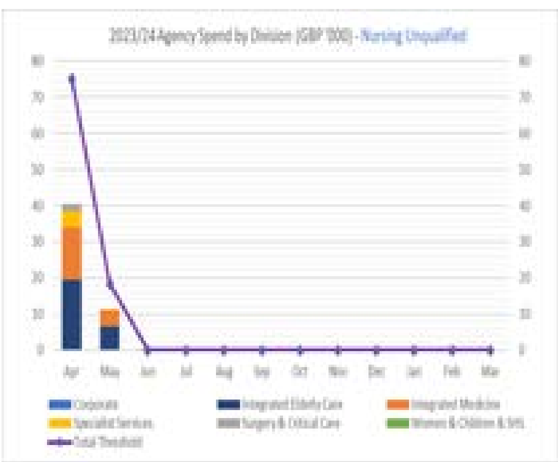


Figure 6

9.3 **Care Hours Per Patient Day**

A measure of ward-level productivity and transparency on variation in staff-to-patient ratios across wards, specialities, and organisations. Very low rates may indicate a potential patient safety risk. Very high rates may suggest the organisation has several unproductive wards or inefficient staff rostering processes.

In M03 the overall CHPPD for Nursing & Midwifery is at 8.8 which is above the peer regional average (8.5) and peers national median (8.1). As a Trust, we remained in quartile 3, and benchmarking against our peers we sit on par with the median within our peer group (Model Hospital data). Appendix 4 shows CHPPD for all nursing and midwifery staff, and a comparison for registered nurses and midwives alone so that we can see that the CHPPD requirement is being met by registered nurses.

9.4 **Exception Report for HealthRoster KPI (Appendix 5)**

The HealthRoster KPIs are measurable metrics recommended in the NQB (2016) and Developing Workforce Safeguards (2018) on Safe, Efficient/Affordable, and Effective staffing.

Key Themes:

Safety – Overall, M03 metrics on safety are showing stable trends, and no risks to staffing safety identified. Raised red flags responded to and resolved with 95.6% red flags resolved. No risk to staffing and patients for the remaining unresolved red flags.

Efficient & Affordable – Additional duties above funded establishment continue to feature in M03 however, there were 98 fewer additional duties in comparison to the previous roster period. This is in response to additional bed capacity, increased activity e.g., ED, and specialing e.g., RMN requirement, Agency staffing usage is at 3.5% which is a 50% reduction from the previous roster period. Bank staffing usage remains constant at 13%. Total hours owed to Trust and owed to staff is averaging between 23-30 hours.

Effective – Short-term sickness during this roster period has a similar trend from the previous roster for Q1 at 4.20% above the Trust's target of 3.5%.

10 Conclusion

In conclusion, the impact of the escalation areas, additional patients above the bed base as well as corridor care in our Adult ED cannot be underestimated. This has a significant

cost (use of temporary staffing) to maintain safety. It also has an impact on the well-being and morale of the overall nursing and midwifery workforce. There is a potential risk to patient safety and experience, which the teams work to mitigate daily.

Our wards and ED are as safe as they can be under highly these circumstances. The plans are in place – new ED workforce modelling, bi-annual patient acuity and establishment reviews, and recruitment (local and international) are underway to fill those vacancies.

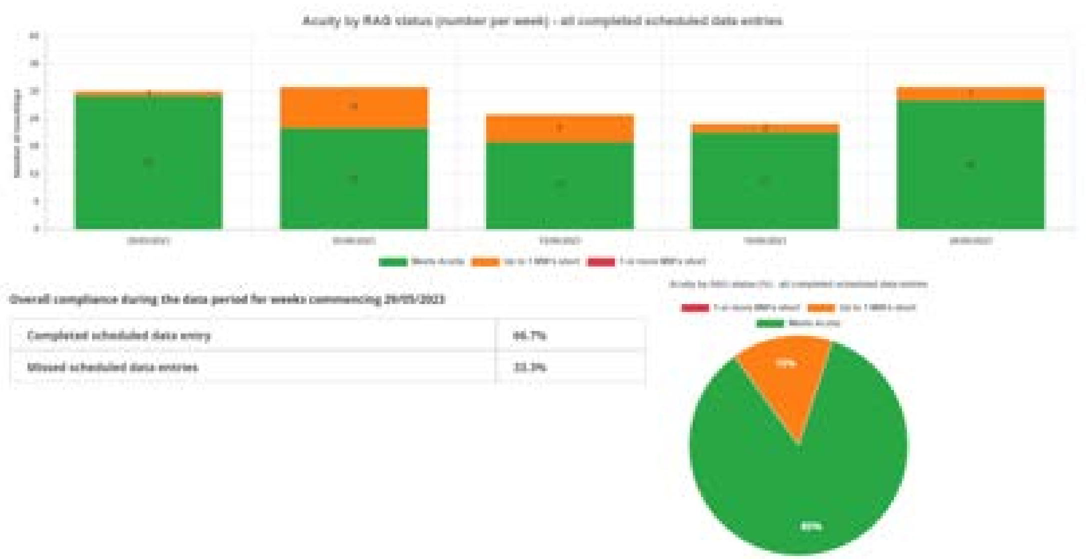
11 The Committee / Board is requested to:

a) **NOTE** information contained in this report for M03 of FY 2023-24
b) Receive **ASSURANCE** that the safe staffing monitoring and any improvement plan are on track.
c) **NOTE** the progress being made in relation to efficiency in the reduction of bank and agency usage/spend with **ASSURANCE** of maintaining safe staffing levels.

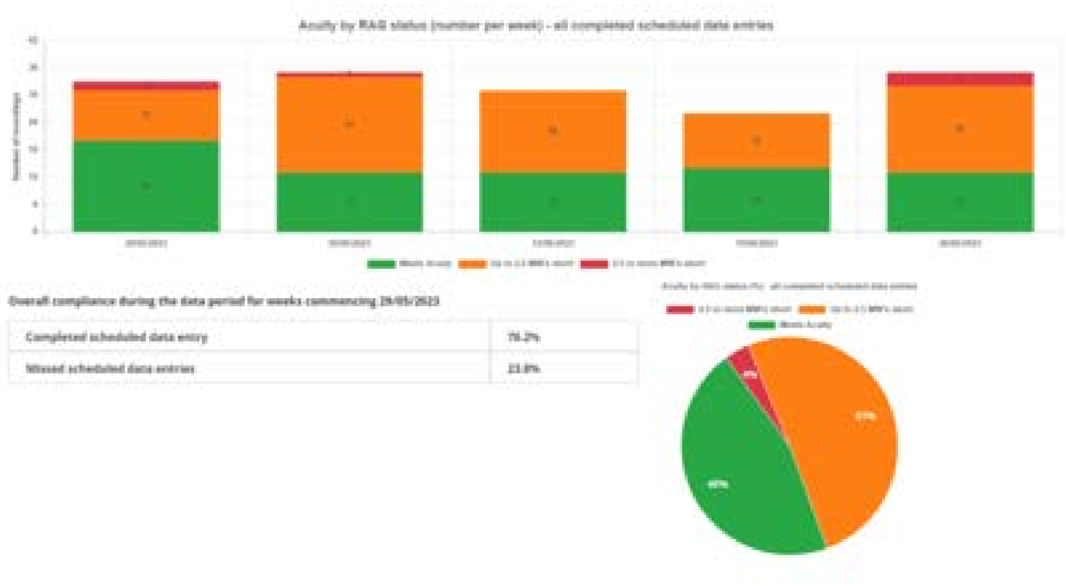
APPENDICES

Appendix 1: Maternity BR+ Acuity and Capacity M03

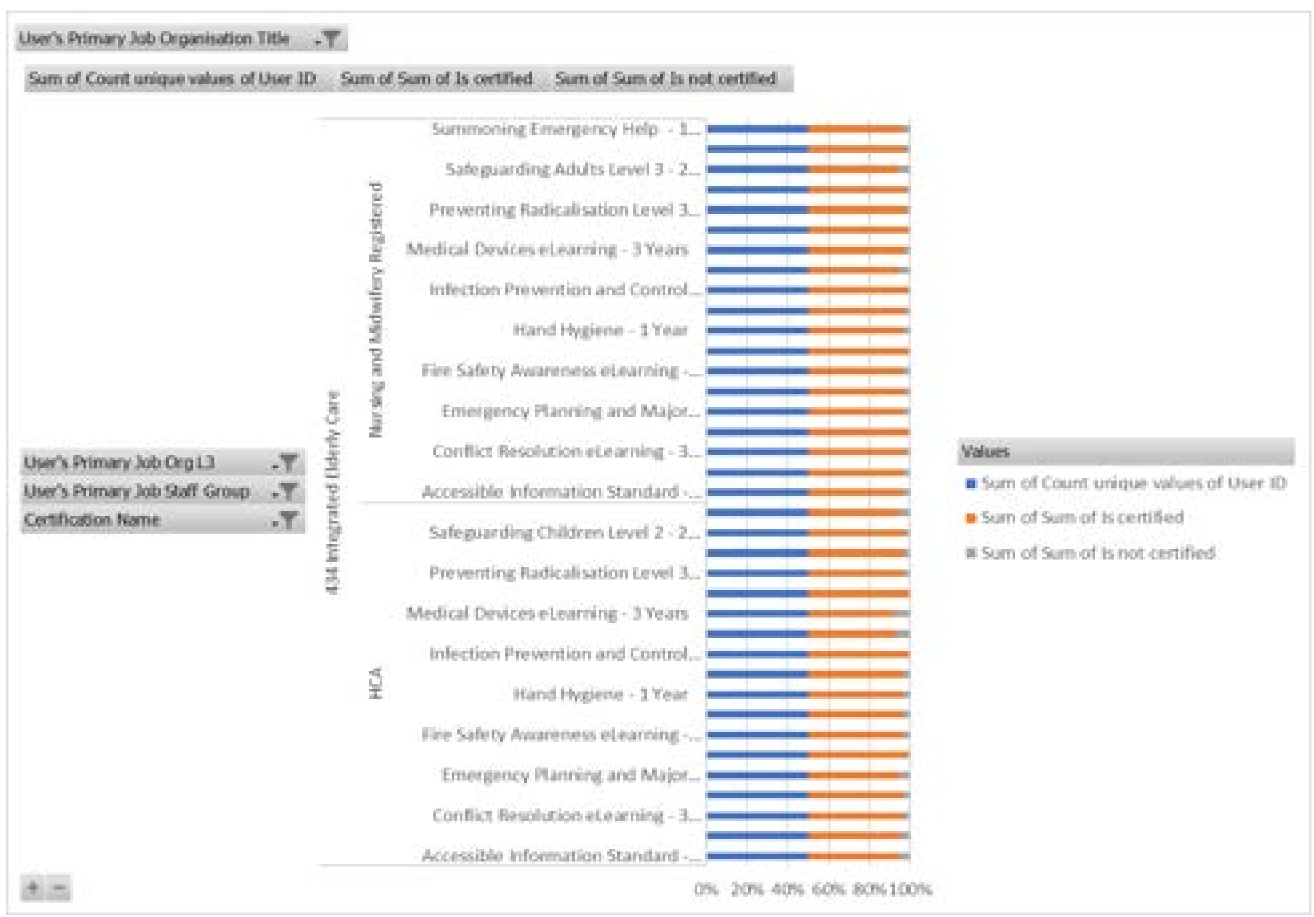
Buckinghamshire Healthcare NHS Trust - Aylesbury Birth Centre

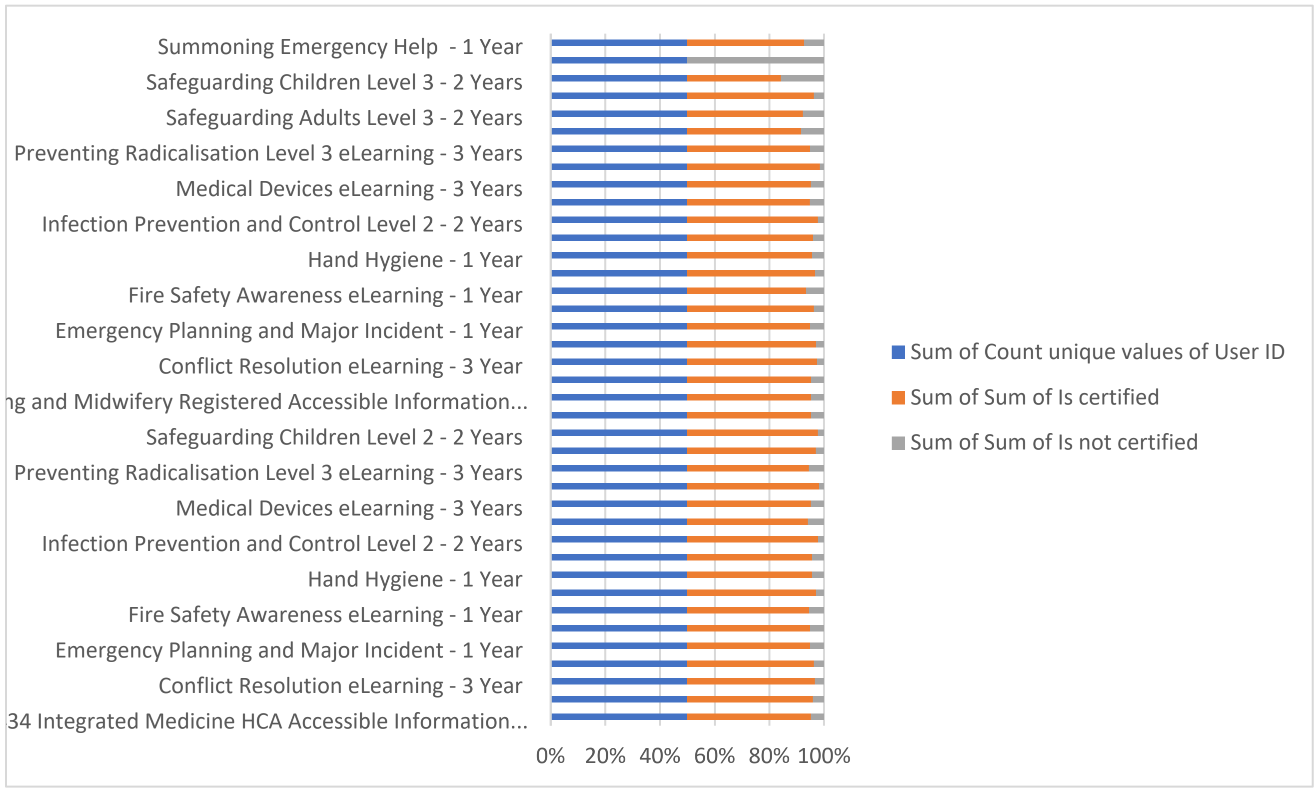


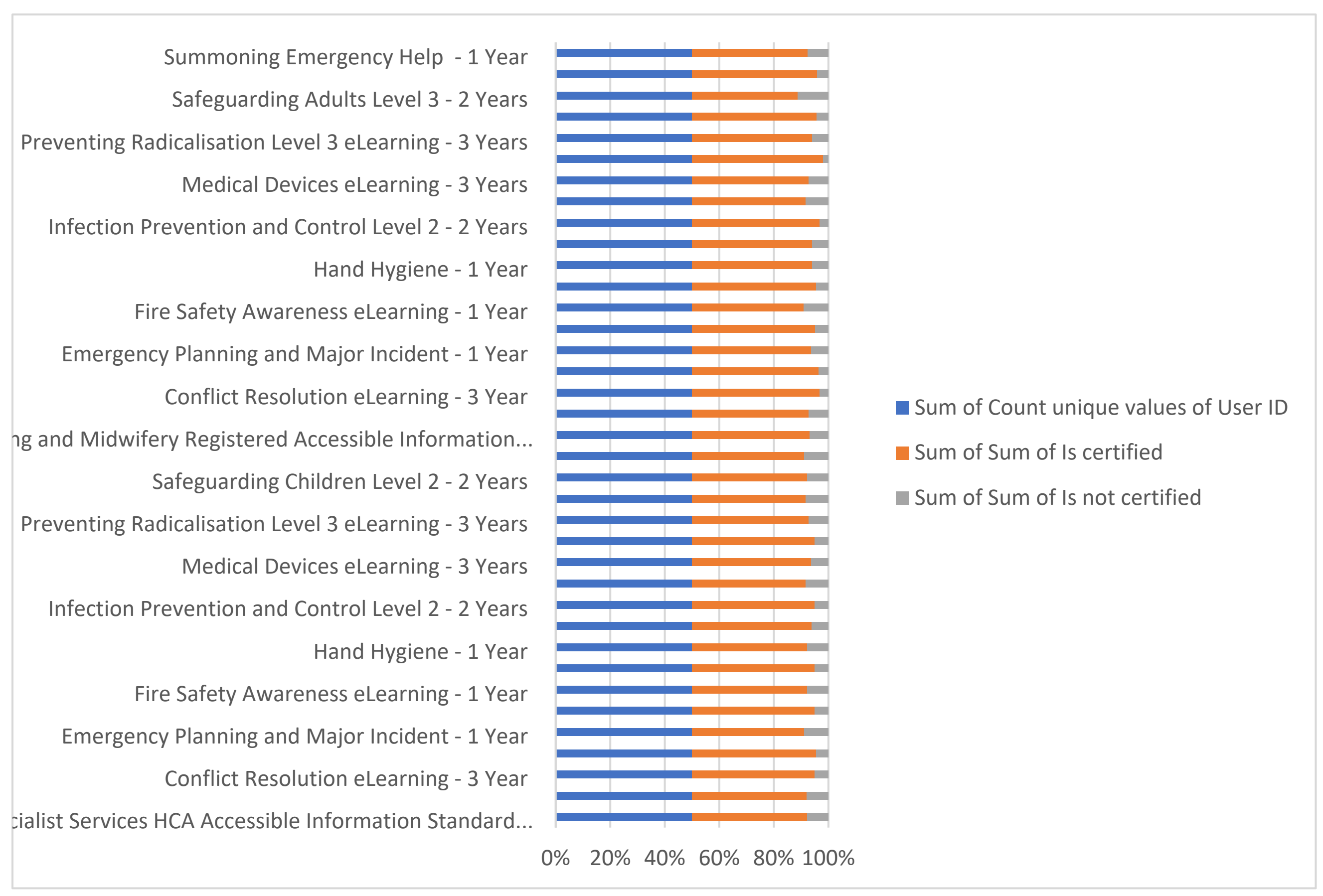
Buckinghamshire Healthcare NHS Trust - Labour Ward

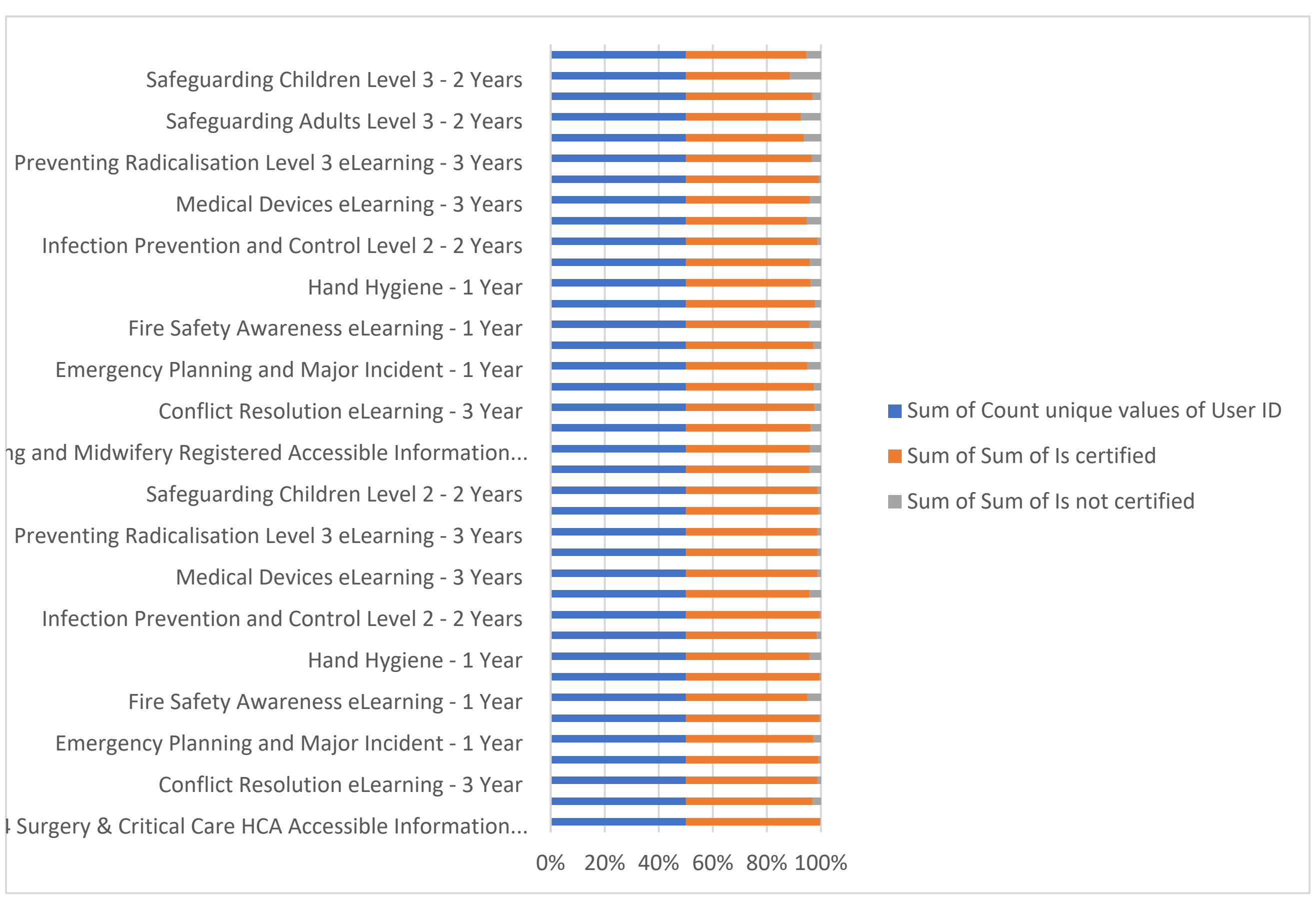


Appendix 2: Divisional Training Compliance per Individual Training Courses
(Source: ELD Business Information Data)






Summoning Emergency Help - 1 Year
Safeguarding Adults Level 3 - 2 Years
Preventing Radicalisation Level 3 eLearning - 3 Years
Medical Devices eLearning - 3 Years
Infection Prevention and Control Level 2 - 2 Years
Hand Hygiene - 1 Year
Fire Safety Awareness eLearning - 1 Year
Emergency Planning and Major Incident - 1 Year
Conflict Resolution eLearning - 3 Year
ng and Midwifery Registered Accessible Information...
Safeguarding Children Level 2 - 2 Years
Preventing Radicalisation Level 3 eLearning - 3 Years
Medical Devices eLearning - 3 Years
Infection Prevention and Control Level 2 - 2 Years
Hand Hygiene - 1 Year
Fire Safety Awareness eLearning - 1 Year
Emergency Planning and Major Incident - 1 Year
Conflict Resolution eLearning - 3 Year
cialist Services HCA Accessible Information Standard...
0% 20% 40% 60% 80% 100%
Sum of Count unique values of User ID
Sum of Sum of Is certified
Sum of Sum of Is not certified


Safeguarding Children Level 3 - 2 Years
Safeguarding Adults Level 3 - 2 Years
Preventing Radicalisation Level 3 eLearning - 3 Years
Medical Devices eLearning - 3 Years
Infection Prevention and Control Level 2 - 2 Years
Hand Hygiene - 1 Year
Fire Safety Awareness eLearning - 1 Year
Emergency Planning and Major Incident - 1 Year
Conflict Resolution eLearning - 3 Year
ng and Midwifery Registered Accessible Information...
Safeguarding Children Level 2 - 2 Years
Preventing Radicalisation Level 3 eLearning - 3 Years
Medical Devices eLearning - 3 Years
Infection Prevention and Control Level 2 - 2 Years
Hand Hygiene - 1 Year
Fire Safety Awareness eLearning - 1 Year
Emergency Planning and Major Incident - 1 Year
Conflict Resolution eLearning - 3 Year
Surgery & Critical Care HCA Accessible Information...
0% 20% 40% 60% 80% 100%
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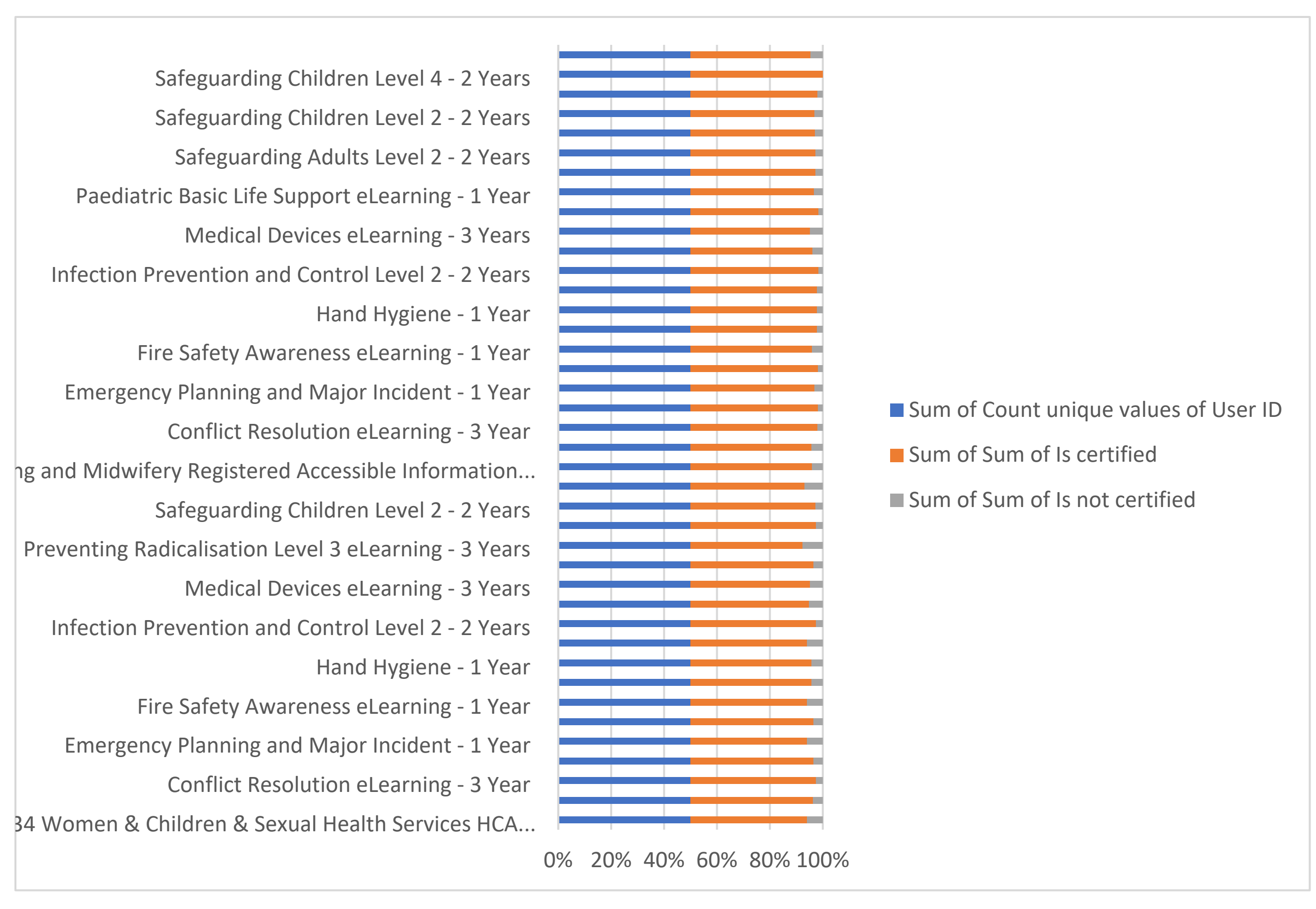
Safeguarding Children Level 4 - 2 Years
Safeguarding Children Level 2 - 2 Years
Safeguarding Adults Level 2 - 2 Years
Paediatric Basic Life Support eLearning - 1 Year
Medical Devices eLearning - 3 Years
Infection Prevention and Control Level 2 - 2 Years
Hand Hygiene - 1 Year
Fire Safety Awareness eLearning - 1 Year
Emergency Planning and Major Incident - 1 Year
Conflict Resolution eLearning - 3 Year
ng and Midwifery Registered Accessible Information...
Safeguarding Children Level 2 - 2 Years
Preventing Radicalisation Level 3 eLearning - 3 Years
Medical Devices eLearning - 3 Years
Infection Prevention and Control Level 2 - 2 Years
Hand Hygiene - 1 Year
Fire Safety Awareness eLearning - 1 Year
Emergency Planning and Major Incident - 1 Year
Conflict Resolution eLearning - 3 Year
34 Women & Children & Sexual Health Services HCA...
0%
20%
40%
60%
80%
100%
Sum of Count unique values of User ID
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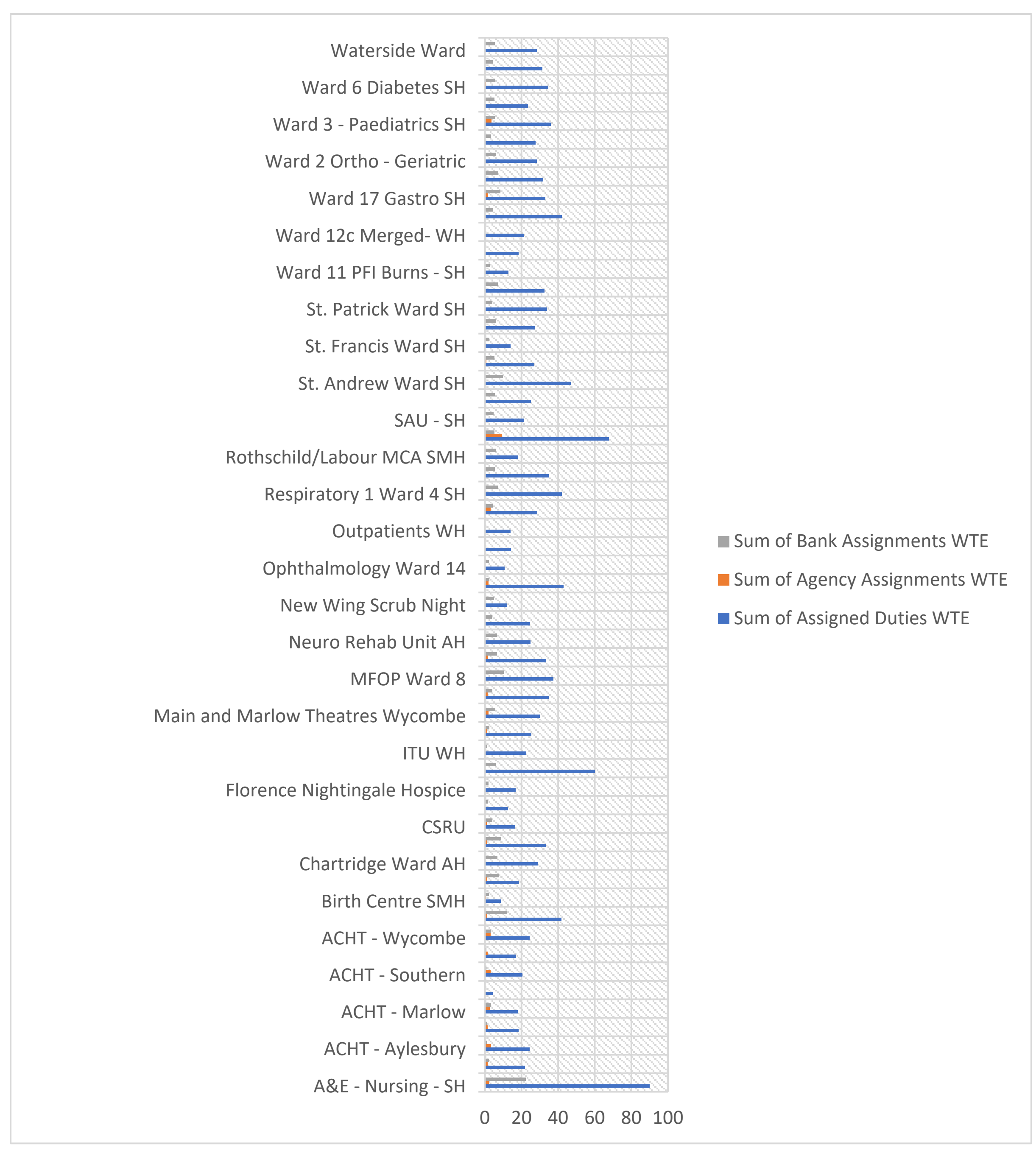
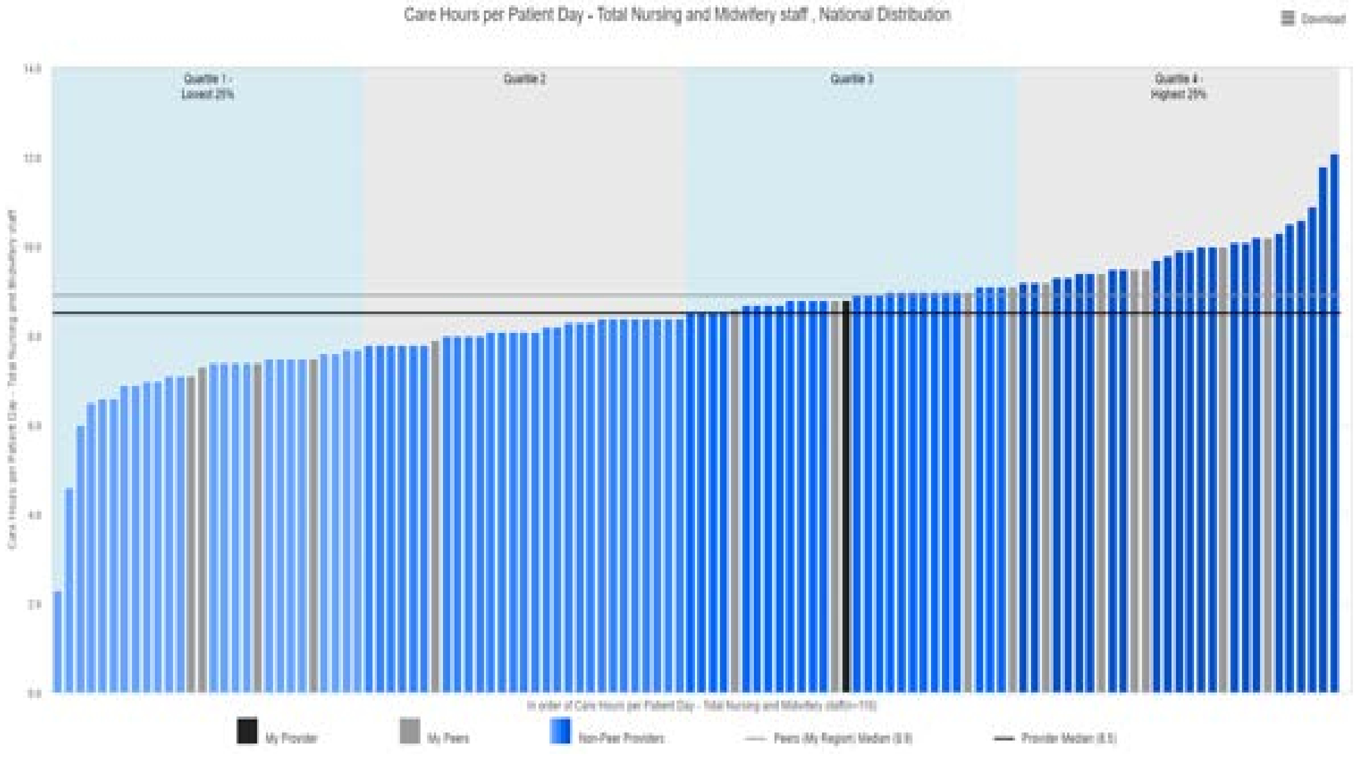
Sum of Sum of Is not certified

Appendix 4: Establishments vs Gaps (Filled with Bank & Agency)

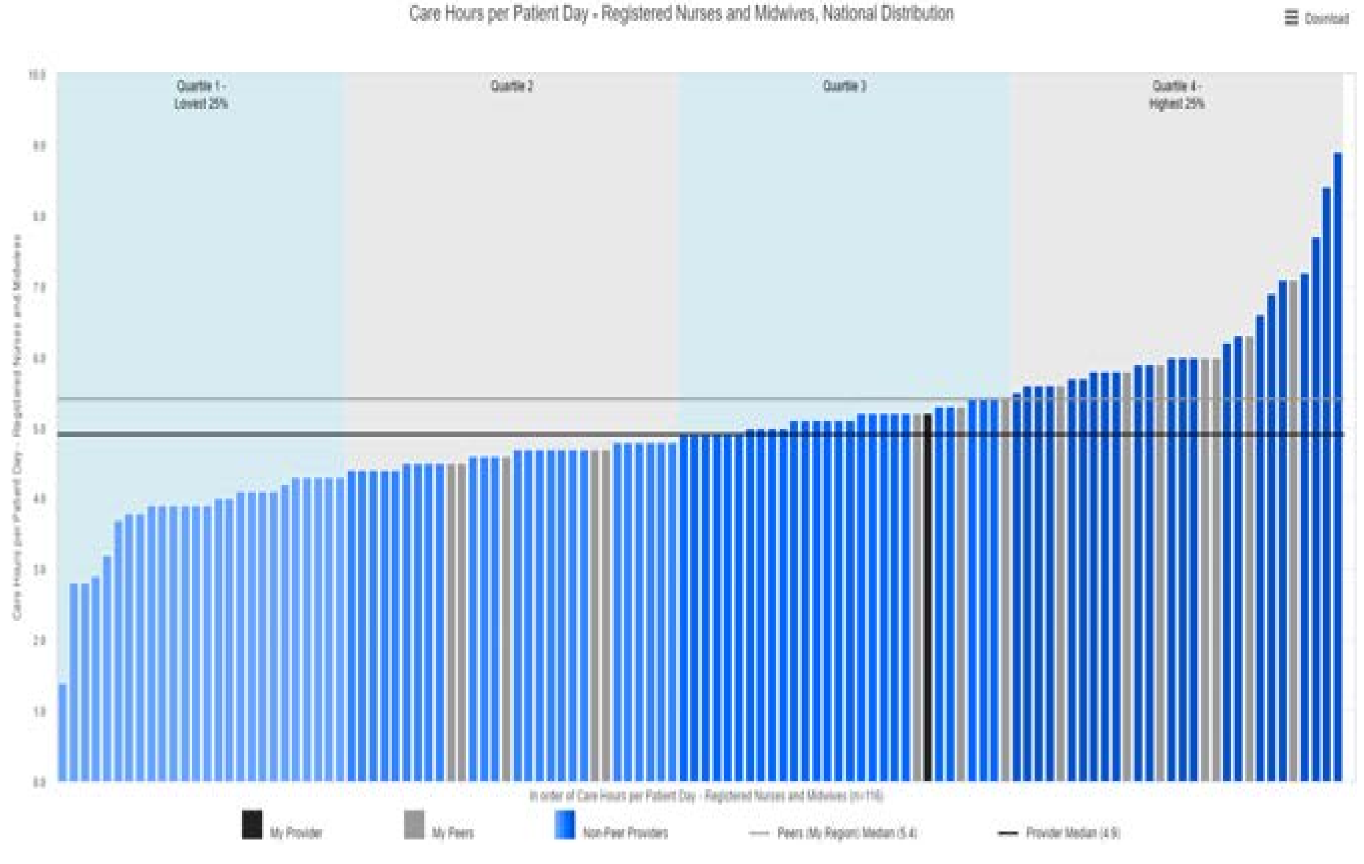


Source: HealthRoster

Appendix 4: CHPPD – All Nursing & Midwifery Staff



CHPPD – Registered Nurses & Midwives (Only)



Appendix 5: Exception Report for HealthRoster KPI (roster period 17April – 14 May 2023)

Title: Exception Reports- HealthRoster KPI

Reporting period:15 May 2023- 11 June 2023

Summary & RAG status justification	• Additional duties above establishments – these were for escalation e.g., CSRU; increased bed -base with 1:1 specials required; increased activity in ED supporting corridor care, enhanced care support requiring RMN • Increased use of temporary staffing covering for: vacancies, increased AL cover for EINs workforce, several new starters on skills training and competencies, short-term/long -term sickness/ maternity leave, additional activity e.g. extra theatre list • Agency staffing usage is at 3.5% which is a 50% reduction from the previous month however Bank usage remains constant at 13% • Total owed hours to Trust of 6017.17 hours by 201 staff equivalent to 30 hours/staff. Total owed hours owed to Staff of 4457.35 from 190 staff equivalent to 23 hours/staff. • Sickness rate for the roster period at 4.20% above Trust's target at 3.5%	Overall RAG status:
Accomplishments this period	• Compliance with resolving Red Flags is consistent with very minimal opened Red Flags (n=4) for this roster period • CHPPD consistently within peers and national medians – this means the organisation has sufficient staff deployed at the right place and right time - NQB 2018 expectation 3 (Unify National reporting data for April 2023) • Agency usage at 3.5% against the total staff in-posts at ward/departmental levels. A 50% reduction from the previous roster period at 6.7%.	
Actions for next period	• Continue to reduce additional duties requested above establishment • Continue monitoring Bank and Agency staffing usage against staffing establishment • Focus on reduction of owed hours	

Issues & risks as changed during reporting period [1]

ID	Risk / Issue	Description	Issue & risk mitigation update	RAG status
1	Bank Staffing Usage	High bank staffing usage at 13%	Migration of agency LOW arrangements to bank staffing, reduction in the timeframe for the automatic cascade of shifts to agency and stopping the use of agency for HCA shifts have contributed to the increase in bank usage. Monitoring of these usages is governed by the fortnightly N&M Temporary Staffing Working Group. Monitoring of the daily staffing fill rate and challenge additional requests for temporary staffing when the overall staffing fill rate is ≥ 90%.	
2	Owed Hours	Owed hours to Trust at 30 hours/staff (201 staff) vs owed hours owed to staff at 23 hours/staff (190 staff)	Non-ward areas have mostly contributed to the increase in owed hours. Administrative/system issue (greenlight process) - Delay in removing leavers from the rosters. Term time -only working arrangements e.g. HV teams skew the data for the relevant teams. Monthly HealthRoster Challenge Boards – governance oversight for ward -level rosters. System issue (Greenlight) feedback to ESR and action underway to resolve. Safe Staffing Matron to work with HV and HealthRoster teams to address term -time hours and reflect on the roster in real-time.	

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

Meeting: Trust Board Meeting in Public

Date: 27 September 2023

Agenda item	Maternity Quarterly Quality Report Q1 23/24
Board Lead	Karen Bonner Chief Nurse
Author	Heidi Beddall Director of Midwifery
Appendices	Appendix 1-3 April, May, June PQSM reports Appendix 4 MVP annual report Appendix 5 5th June maternity and neonatal safety champions Appendix 6 maternity triage improvement plan
Purpose	Assurance
Previously considered	EMC 08.08.2023 Q&CGC 16.08.2023

Executive summary

This report provides an overview of current maternity safety and quality issues in line with NHS England (NHSE) guidance on perinatal quality surveillance and NHS Resolution (NHSR) maternity incentive scheme standards.

The trust had a Care Quality Commission (CQC) maternity inspection on 12th June 2023. Immediate feedback including a letter of concern about maternity triage and medicines management has been actioned and the CQC notified. Positive feedback was received about maternity culture, staff, theatre practice and clinical oversight on labour ward.

The year 5 NHSR maternity incentive scheme is on track. There has been improvement in anaesthetic training compliance (80.5%) but further improvement to >90% is required.

Areas for improvement in quality metrics include personalised care and support plans (PCSP), smoking cessation referral and skin to skin contact.

- All women are required to have a PCSP by December 2023. Currently 0% have a PCSP. The PCSP is being developed by the transformation midwives across BOB Local maternity and neonatal system. A “Go Live “date has been requested.
- 25% of women were referred for smoking cessation support. The introduction of a maternity tobacco dependency advisor has led to a subsequent 100% referral rate.
- All babies should receive skin to skin contact after birth. At present 83% of babies are recorded as receiving skin to skin contact. The infant feeding lead is working with the clinical teams to promote the benefits and increase compliance.

Obstetric staffing meets requirements. Midwifery staffing frequently does not meet acuity on the labour ward and is mitigated through escalation processes.

Service user feedback is largely positive but postnatal ward care is highlighted as an area for improvement.

Staff have not raised any issues of concern to maternity and neonatal safety champions.

The maternity triage rapid improvement project is in progress. Actions undertaken include:

- development of a local (red, amber, green) RAG rated clinical prioritisation model,
- cessation of maternity support workers answering telephone calls from women
- new telephone assessment proformas

- introduction of a designated waiting area

The maternity leadership team is involved in a regional maternity culture project and a national perinatal leadership and culture programme.

The Executive Management Committee considered this paper on 8 August 2023. The Committee welcomed the evolving format of the report and made suggestions to support the ability of the Committee and the Board to take assurance including the provision of an acronym buster and clear follow on between reports to demonstrate where identified gaps had been closed or remained open with action plans in place. The Committee recognised the need to test the assurance related to the key quality metrics within the IPR and the requirements to review information such as serious incidents, noting other forums within the organisation where these were also considered. The Committee was assured by the maternity safety metrics.

On 16 August 2023, the Quality & Clinical Governance Committee considered these reports and welcomed the revised format. The Committee agreed the Quality & Safety Report should be split between public and private board noting the importance of transparency alongside the maintenance of confidentiality related to serious incident reports. The Committee recognised the positive relationship with the Maternity Voices Partnership and the work of the group in tackling inequalities.

Decision	The Board is requested to discuss and take assurance		
Relevant strategic priority			
Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☐

Relevant objective		
☐ Improve waiting times ☒ Improve safety ☐ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☐ Improve the experience of our new starters ☐ Upskill operational and clinical managers

Implications / Impact	
Patient Safety	This paper provides updates on patient safety and maternity quality improvement work streams, issues and any risks to compliance.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards CRR Midwifery staffing
Financial	NHSR Maternity Incentive Scheme: Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.
Compliance CQC Standards Safety	Safety

	Person centred care Duty of candour Good governance Complaints
Partnership: consultation / communication	Acute paediatrics- neonatal services Local Maternity and Neonatal System Maternity voices partnership Maternity and neonatal safety champions
Equality	It is essential to have an increased focus on reducing health inequalities for Black, Asian and minority ethnic women and women who are affected by social deprivation. Maternal mortality is 3.7 times greater for Black women and 2 times greater for Asian and mixed ethnicity women than white women (MBRRACE 2022). Perinatal mortality is greater for Black and Asian babies- the highest rates of stillbirth affect Black African and Black Caribbean babies from the most deprived areas; the highest rates of neonatal death affect Pakistani and Black African babies from the most deprived areas (MBRRACE 2022).
Quality Impact Assessment [QIA] completion required?	No

Glossary and Abbreviations

ATAIN	A patient safety programme (an acronym for '**avoiding term admissions into neonatal units**') to reduce avoidable causes of harm that can lead to infants born at term (i.e. ≥ 37+0 weeks gestation) being admitted to a neonatal unit.
BOB LMNS	Buckinghamshire, Oxfordshire and Berkshire West local maternity and neonatal system - a partnership of maternity and neonatal service providers, commissioners, local authorities and maternity and neonatal voices partnerships, who are working together to transform maternity services
CQC	Care Quality Commission
ED	Emergency department
MIS	Maternity Incentive Scheme - The scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST.
MNVP	Maternity and Neonatal Voices Partnership - is a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
NHSE	NHS England – leads the national health service for England
NHSR	NHS Resolution- the operating name of NHS litigation authority, is an arm's length body of the department of Health and Social Care

PCSP	Personalised care and support plan – a holistic person centred process that enables the person to identify their needs and outcomes
PQSM	Perinatal Quality Surveillance Model – a framework for increasing oversight of perinatal clinical quality in the NHS, England
RCOG	Royal College of Obstetrics and Gynaecology
SBAR	A communication tool to convey critical information requiring immediate action and advice

1 Introduction/Position

This report provides an overview of current maternity quality issues in line with NHS England (NHSE) guidance on perinatal quality surveillance and NHS Resolution (NHSR) maternity incentive scheme standards.

2 Perinatal Quality Surveillance Model (PQSM)

The BOB local maternity and neonatal system (BOB LMNS) have a defined perinatal quality surveillance reporting model to ensure standardised reporting process.

Buckinghamshire Healthcare NHS Trust (BHT) perinatal quality surveillance data for this reporting period is detailed in full in Appendices1-3.

2.1 HSIB/NHSR/ENS/CQC/RCOG/Coroner Reg 28/HEE concerns of requests for action

The trust had a CQC maternity inspection on 12th June 2023.

Immediate feedback included a letter of concern about maternity triage. A response and supporting evidence about the actions undertaken and highlighting the progress of the triage quality improvement work that commenced in February 2023.

In addition, further feedback was received by the trust on 21st June about:

- maternity triage processes and ensuring women are seen efficiently
- medicines management relating to the storage of emergency drugs and management of medications in hot weather

which has been responded to and supporting information/evidence provided.

The feedback also included positive comments about:

- welcoming, friendly and helpful maternity team
- positive culture – learning and teamwork
- theatre practice
- electronic smartboard providing oversight of activity and acuity

The draft inspection report is awaited.

2.2 ATAIN - % of term admissions to the Neonatal Unit

In this quarter the term admission rate to neonatal unit was 4% (Target 5%). The 23/24 ATAIN action plan has been developed and is available on request.

2.3 Babies born in the right place

In April, one baby was born at 27-weeks gestation in an ambulance enroute to the hospital. An exception report has been submitted in line with neonatal network reporting guidance.

2.4 Training compliance related to the maternity incentive scheme (MIS)

Midwifery and obstetric staff training compliance is over 90%. Anaesthetic staff training compliance has improved but remains below target at 80.5%.

2.5 Minimum staffing

2.5.1 Consultant cover and attendance 100% in this reporting period.

2.5.2 Midwifery staffing in labour ward versus acuity:

Month	Percentage of time that midwifery staffing met acuity
April	63%
May	42%
June	45%

When midwifery staffing did not meet acuity, this was risk assessed and mitigated through escalation processes to ensure the safest patient care was maintained.

A six monthly midwifery staffing report is submitted separately to the trust board to provide information on current vacancies, recruitment and retention, safe staffing red flags, mitigations and any clinical impacts (next report due October 2023).

2.6 Service user feedback

2.6.1 The Maternity Voices Partnership (MNVP) undertook a “15 steps” assessment in March 2023. This was largely positive, however identified that improvement could be made to the parent sitting room on Rothschild ward. Charitable funds have been sought and will be used for redecoration.

In May, the MNVP undertook a survey specifically for maternity triage as part of the intelligence gathering as part of the triage rapid improvement project. Key themes from this were the length of time spent waiting for obstetric review and empathy for the midwifery teams regarding the workload in triage. Timely review is a key aspect of the triage improvement plan (see section 4).

The MNVP have published their annual report for 2022 -23 which highlights the work undertaken over the last year and the workplan for the year ahead (See appendix 4).

2.6.2 Themes emerging from complaints in this quarter relate to the ability to continue to provide routine care, particularly experience on the post natal ward. This triangulates with

user feedback shared at MNVP meetings and has been fed into the co-designed improvement plan for the postnatal ward. Current actions ongoing in this plan are the introduction of electronic observations, trial of a modified Situation, Background, Assessment, Recommendation (SBAR) tool, recruitment of a practice development midwife to introduce a programme to upskill maternity support workers.

2.7 Safety Champions

2.7.1 There have been no issues raised at maternity safety champion walkabouts.

2.7.2 The minutes of the last safety champions meeting on 5th June are included as appendix 5.

3 Quality Measures:

3.1 Key performance indicators:

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Smoking at time of booking	Jul 23	6%	5%			7%	2%	11%
CO at booking	Jul 23	95%	95%			58%	43%	73%
Smoking cessation referral	Jul 23	25%	100%			30%	-12%	71%
Risk assessments - FGR, PTB, PET, Diabetes	Jul 23	100%	100%			99%	98%	101%
VTE risk assessment	Jul 23	100%	100%			99%	97%	101%
CO at 36 weeks	Mar 23	65%	100%			40%	#N/A	#N/A
Preterm birth >24 weeks	Jul 23	4%	6%			5%	2%	9%
Preterm Birth <24 weeks	Jul 23	0%	6%			0%	0%	1%
Term birth <10th centile	Jul 23	2%	7%			3%	1%	6%
Birth <3rd centile	Jul 23	1%	2%			2%	-1%	5%
Apgar less than 7 at 5 minutes	Jun 23	5.0	1.0			3.4	-0.2	7.0
Arterial pH less than 7	Jun 23	5.0	1.0			2.9	-1.6	7.4
MOH	Jul 23	1%	3%			2%	-1%	5%
OASI	Jul 23	4%	3%			5%	2%	9%
Breastfeeding at delivery	Jul 23	69%	80%			72%	62%	83%
Smoking at time of delivery	Jul 23	6%	5%			6%	3%	10%
Skin to skin	Jul 23	83%	100%			81%	73%	88%
Term admissions	Jul 23	3%	5%			4%	1%	7%
Breastfeeding at discharge	Jul 23	82%	80%			66%	48%	85%
PCSP at booking	Jul 23	72%	100%			86%	67%	105%
Perinatal mortality (over 24 weeks)	Jul 23	1.0	0.0			1.3	-2.0	4.7
Overdue Datix	Jul 23	25.0	10.0			69.3	-8.4	146.9
			-					
			-					
			-					

3.2

- All women are required to have a personalised care and support plan (PCSP) by December 2023. Currently 0% of women have a PCSP. The PCSP is being developed by the transformation midwives across BOB local maternity and neonatal system. A "Go Live "date has been requested.
- 25% of women were referred for smoking cessation support. The introduction of a maternity tobacco dependency advisor has led to a subsequent 100% referral rate.
- All babies should receive skin to skin contact after birth. At present 83% of babies are recorded as receiving skin to skin contact. The infant feeding lead is working with the clinical teams to promote the benefits and increase compliance.

3.3 The following infrequent events are reported as days between measures. A look back exercise from 2021 has been undertaken.

Clinical Event	Date of last event	Days between
Eclampsia	No events since prior to 2021	N/A
Post partum hysterectomies	26/05/23	69
Hospital acquired thrombosis	08/09/22	329
HIE 2 and 3	07/06/21	757
ITU admissions	21/05/23	74
Meconium aspiration	14/07/23	20

4 Improvement / Safety Projects

4.1 Prior to the CQC inspection a maternity triage rapid improvement project was underway in collaboration with the trust quality improvement team. Actions undertaken include:

- a local RAG rated clinical prioritisation model,
- cessation of maternity support workers answering telephone calls from women
- new telephone assessment proformas
- designated waiting area

The full improvement plan and current progress is included in appendix 6.

4.2 In the previous quarterly report (January – March 2023) the fetal monitoring audit and action plan was shared. Since then, a revised fetal monitoring guideline audit has been implemented to improve timely and appropriate review of cardiotocographs in labour. Continuous audit is in progress and results will be shared in the next quarterly report.

5 Culture

5.1 The Buckinghamshire, Oxfordshire and Berkshire West local maternity and neonatal system (BOB LMNS) have funded the three maternity services in the integrated care system (ICS) to work with ASCENT WELLBEING as part of a psychological safety project. This is currently in the scoping phase and ASCENT will be attending the next maternity safety champions meeting to share with the board level champions the focus of the project.

5.2 BHT have been selected to join the fourth intake of the national perinatal culture and leadership programme. This is a programme developed as part of the single delivery plan. The divisional director and medical maternity and neonatal safety champions are attending.

6 Proposal, conclusions, recommendations, and next steps.

- Await draft CQC maternity inspection report for factual accuracy check
- Continue improvement in anaesthetic obstetric emergency training compliance

- Continue progress with quality improvement plans for maternity triage, post natal care and fetal monitoring
- Continued focus on improving quality metrics for personalised care plans, smoking cessation referral and skin to skin contact

7 Action required from the Board/Committee

The Board is requested to:

a) Discuss and gain assurance

APPENDICES
Appendix 1-3 April, May, June PQSM reports
Appendix 4 MVP annual report
Appendix 5 5th June maternity and neonatal safety champions
Appendix 6 maternity triage improvement plan

Trust's Perinatal Quality Surveillance Model Report (PQSM Report)
Data request: Q1 2023 – 2023 April 2023
Deadline: 19/05/23 12:00

Trust name: Buckinghamshire Healthcare NHS Trust Submitted by: Michelle East
Date submitted: 16/05/2023

The following report template is based on the Perinatal Quality Surveillance guidance published by NHSE/I in Dec 2020. It has been further edited to allow a standardised reporting form across the BOB LMNS. The PQSM report is produced at trust level and feeds into the trust board before it goes to the LMNS board on a bimonthly. The data requested is for a three-month period. Elements of this will feed into the Regional Maternity and Neonatal Safety Concerns Group (RMNSG) on a quarterly basis and it will also go directly to the ICB Systems Quality Group (SQG).

Whenever PQSM reports are requested, the LMNS will also require a **dashboard** from each trust.

Please contact the LMNS if you require any assistance.

1. Findings of reviews of Perinatal deaths

Provide a summary based on the months of reporting for example: how many cases in each month went via the PMRT, share any themes or concerns have been raised, and grading. **Please provide all data for the quarter in Table 1 and Table 2 below.**

Data is required for April '23

Table 1: Number of perinatal deaths recorded trust.

Months	Enter numerical Data	April '23
Total Number of Deaths		5
Type of Mortality	Antepartum Stillbirths	3
	Intrapartum Stillbirths	1
	Neonatal Deaths	1
Gestational Age	<24 weeks	1
	24-27 weeks	1
	28 - 31 weeks	1
	32 - 36 weeks	1
	37-41 weeks	1
	≥ 42 weeks	0

Table 2: Themes/Trends and Actions from cases closed at PMRT for April 2023

Themes/Trends	Actions
Case 1 - IUD at 32 weeks (Dec 22). Placed on growth scan pathway at booking owing to history of hypertension. IUD occurred prior to first growth scan. There was a delay in starting aspirin as GP referral had not been sent. Graded of care = C, B.	Improve use of partogram when providing intrapartum care following a fetal loss.

Case 2 – IUD at 24 weeks (Dec 22). First pregnancy, no risks identified at booking. Attended emergency department at 24 weeks feeling unwell, deteriorated rapidly in ED, admitted to ITU with Group A strep sepsis. Mother ventilated, IUD confirmed shortly after admission. Grading of care = A, A.	Improve use of partogram when providing intrapartum care following a fetal loss.

(For ease of use, insert PMR formatted information if preferred below)

Did you have an external panel member for this quarter for all your panels? *(expected 100%). Base this on* **data for April 2023.**

Month	April '23
% attendance	**100**

2. Findings of reviews of all cases eligible for referral to HSIB

Provide a summary based on the months of reporting for example: how many cases were reported to HSIB **Please provide all data for April'23 in Table 2.** If any final reports were received**, please ensure this data into table 3.**

Table 3: Summary of cases referred to the HSIB

Investigation reference	Summary (to include ethnicity)	Duty of Candour Letter sent	Duty of Candour information given
NA		**Yes/No**	**Yes/No**

Table 4. Recommendations from any final HSIB reports in this reporting period

Investigation Reference	Recommendations
2022/215990	The Trust to ensure placentas are sent for pathological examination including histology in line with national guidance.
2022/11537	None

3. Findings of reviews of declared SI cases closed at BOB LMNS SI panel (*only if not already referable to the HSIB*)

Provide a summary based on the months of reporting for example: how many cases were declared as an SI and did not meet the HSIB referral criteria**. Please provide all data for this quarter in the following table.**

(Data is required for April '23)

Table 5: Summary of Closed SI's and seen at BOB LMNS SI panel

Investigation reference	Report Summary with findings, recommendations, actions plans and learning shared (to include ethnicity).

2022/25914	

APPENDIX 2

Buckinghamshire Healthcare NHS
NHS Trust

Serious Incident (SI) shared learning on a page

Date of Incident:	17/11/2022	SI Reference:	2022/25914
Service Delivery Unit/Division:	Division of Women and Children and Sexual Health Paediatric SDU	Duty of Candour completed y/n:	Yes – the family were informed, an apology given, and their questions were included and responded to within the SI report

Brief summary of the incident investigation for a case of a patient who experienced ......
Baby born at 37+1 weeks gestation, was noted to be jaundiced during a newborn and infant physical examination (NIPE) on day 1. The baby's initial Jaundice level, indicated by measuring the serum bilirubin level (SBR), was found to be above the exchange line when plotted on the National Institute for Health and Care Excellence (NICE) recommended threshold graph.
Learning:
The diagnosis of jaundice on the post-natal ward was well-documented and escalated and there is evidence of a clear initial management plan. Effective communication between the entire team would have highlighted the seriousness of the baby's condition prompting earlier escalation and liaison with the Tertiary Centre for advice on management would have avoided a delay in the management of extreme hyperbilirubinaemia.
Key recommendations which form part of the action plan, to support learning and improvement in service and care together with key action:
• Review of BHT Guidance • Staff training and education to include SBAR, escalation, professional challenge and responsibility

2022/26478	APPENDIX 2 — Buckinghamshire Healthcare NHS Trust — Serious Incident (SI) shared learning on a page (see below)

APPENDIX 2

Buckinghamshire Healthcare NHS

NHS Trust

Serious Incident (SI) shared learning on a page

Date of Incident:	**31.10.2022**	**SI Reference:**	2022/26478
Service Delivery Unit/Division:	**WC&SH**	**Duty of Candour completed y/n:**	Yes – the family were informed, an apology given, and their questions were included and responded to, within the SI report

Brief summary of the incident investigation for a case of a patient who experienced ……
A woman required admission in the intensive care unit following a caesarean section under general anaesthetic due to a high block. The baby was born in poor condition however both mother and baby are doing well. An investigation was undertaken to understand whether any improvements can be made to reduce the occurrence of this type of event
Root Cause/s:
This was a multifactorial case where it was not possible to identify one root cause. Lack of adherence to guidance, loss of situational awareness by the team along with inadequate escalation were thought to be contributory.
Learning:
An interpreter should always be offered. Communication challenges can play a role in compromising the care given. The entire clinical picture should be borne in mind when assessing women and making decisions for oxytocin/caesarean section. Appropriate escalation and adherence to guidance should always be followed.
Key recommendations which form part of the action plan, to support learning and improvement in service and care together with key action:
1. Improve process around documentation of epidural sensory and motor levels to enable improved recognition and escalation of abnormal result through modification to current documentation that includes clearer visible triggers for escalation. 2. Improve recognition and escalation of abnormal CTG trace particularly in the context of suspected infection by addressing disconnect between current documentation and theory that is being taught. 3. Improve communication in relation to the use of interpreters.

2022/21597

APPENDIX 2

Serious Incident (SI) shared learning on a page

Date of Incident:	22/08/2022	**SI Reference:**	2022/21597
Service Delivery Unit/Division:	Obstetrics	**Duty of Candour completed y/n:**	Yes – the family were informed, an apology given, and their questions were included and responded to, within the SI report

Brief summary of the incident investigation for a case of a patient whose baby was transferred to a tertiary neonatal unit for therapeutic cooling
A 29-year-old woman in her first pregnancy underwent induction of labour for short femur length. During the intrapartum period, the fetal heart became bradycardic with no sign of recovery. A decision was made for and delivered by a category one Caesarean section. The baby required resuscitation at birth and was transferred to the neonatal unit. The baby was subsequently transferred to the tertiary neonatal unit in Oxford for active cooling.
Root Cause/s:
The investigation was not able to identify any factors that contributed to the outcome in this case.
Learning:
There should be consistent documentation of the discussion that takes place regarding shared decision making for induction of labour. Fetal monitoring should be continuous during induction of labour. Any pauses at the request of the patient (e.g. to permit bathroom breaks) should prompt a discussion regarding the risks and benefits of this. There should be an objective assessment of priority of cases awaiting transfer to labour ward to encourage more accurate risk assessment.
Key recommendations which form part of the action plan, to support learning and improvement in service and care together with key action:
There should be a consistent process to follow-up patients when there is a failure to contact in community. Where an intervention such as induction of labour is proposed there should be documented evidence of shared decision making between the patient and healthcare professional in order to facilitate informed choice. There should be a change in guidance with associated messaging to doctors and midwives that once active induction of labour is underway all efforts should be made to prevent breaks in the fetal monitoring for bathroom visits. A bedpan should be offered in order to facilitate passing of urine unless the patient explicitly asks for this to be paused. The risks of pausing monitoring whilst receiving the hormone drip should be explained to patients to facilitate informed decision making. A tool should be developed and implemented to enable objective assessment of the priority of transfer to labour ward along with the recognition of antenatal CTG events when there is either high acuity on labour ward or more than one patient awaiting transfer.

2022/26511	

APPENDIX 2

Serious Incident (SI) shared learning on a page

Date of Incident:	29/11/2022	SI Reference:	2022/26511
Service Delivery Unit/Division:	WC&SH	Duty of Candour completed y/n:	Yes – the family were informed, an apology given, and their questions were included and responded to, within the SI report

Brief summary of the incident investigation for a case of a patient who experienced an admission to the neonatal unit

This was a woman in her second pregnancy with a history of a previous pre-term birth at 34 weeks gestation and therefore was booked for consultant led care.

At 31+3 the woman attended maternity triage with suspected rupture of membranes which was confirmed with an amnisure test. The neonatal unit was closed at this stage, an attempt was made for in utero transfer, but no cots were available at other maternity units contacted. During this time, the woman remained in labour ward triage, once it was confirmed that a transfer was not possible the woman was transferred to the antenatal ward.

While on the antenatal ward fetal monitoring was undertaken with a Dawes Redman CTG (computerised cardiotocograph) which did not met criteria on 3 occasions, each time this was reviewed by the registrar on call and an appropriate plan was made. Following the 3rd CTG this was discussed with the fetal medicine consultant and a plan was made to repeat the CTG in the morning and a fetal medicine scan was planned. Later that evening the patient was experiencing reduced fetal movement and a CTG was commenced. The CTG showed a raised fetal heart rate, and the patient was transferred to labour ward for ongoing care, continuous CTG monitoring, and a septic screen based on a raised fetal heart rate and possible augmentation of labour in view of possible chorioamnionitis. Augmentation commenced and baby was born via vaginal delivery at 07:21 baby taken to the paediatrician who was present and waiting at the resuscitaire.

The baby was born in good condition requiring stimulation and inflation breaths at delivery. Immediately following delivery, the baby required non-invasive respiratory support including supplemental oxygen which quickly elevated to mechanical ventilation. Over the course of the morning the baby required increasing respiratory support leading to early liaison with the tertiary unit. Southampton and Oxford Transport Service (SONeT) arrived at 19:30 to transport the baby to the John Radcliffe Hospital (JRH) for ongoing care, SONeT left the NNU 30/11/22 at 01:20. The baby was repatriated to NNU on the 19/12/22 and was discharged home on 03/01/2023 with follow-up by the local neonatal team.

Learning:

On admission a plan was made to transfer to a tertiary unit due to the neonatal unit not currently having any available cots. During this time, the patient remained in maternity triage and was later moved into a birth centre room. In this situation the patient should be admitted onto the observation bay or onto the antenatal ward while awaiting transfer so that routine care can continue. There was a gap of 14 hours where routine observations were not undertaken and although the patient was well during this time this was a missed opportunity to assess for symptoms of developing sepsis, antibiotic and steroids were given in this time.

There were difficulties monitoring the fetal heart rate as labour was progressing quickly, this was appropriately escalated and management however good practice would be to provide a second person to help with fetal heart rate monitoring in the room if possible.

The neonatal care was reviewed, and all care was provided and reviewed in line with guidance. There were some complications, and these were managed appropriately.

Key recommendations which form part of the action plan, to support learning and improvement in service and care together with key action:

Case to be presented at the CTG meeting/ intrapartum teaching

Consider transfer to observation bay while undergoing discussions for transfer to allow oversight

4. Number of current open SI and HSIB cases

Please only enter a numerical figure with no detail of the case.

(Data is required for April'23).

Table 6: Number of current open SI's and HSIB cases

	April'23
Number of open SI's	**1**
Number of open HSIB cases	**2**

5. Incidents logged as moderate or above and any themes identified

Provide a summary based on the months of reporting for example: how many incidents were graded red/amber or moderate or above in the months of reporting i.e. red/amber incidents reports in ***month*** **22 were X. Please provide data for April '23 (***Please note this section may change as the PSIRF is implemented)*

Table 7: Number of reported incidents logged as moderate or above

Actual Impact reported per month	*April '23* Number
Death	**0**
Minor	**9**
Moderate	**1**
Near Miss	**0**
No Harm	**74**
Total	**84**

Table 8-Themes and Trends identified within reported incidents at moderate or above

MONTH	Themes and Trends identified
April 2023	One moderate harm incident, neonatal death at 27 weeks. This case has been declared as an SI, however the immediate after action meeting did not highlight any significant gaps in care.

6. HSIB/NHSR/ENS/CQC/RCOG/Coroner Reg 28/HEE concerns of requests for action

Please raise any concerns of requests from the following organisations/regulations. **Please provide data for April'23-if not applicable state N/A**

Category	Concerns of request for action
HSIB	NA
NHSR/ENS	NA
CQC	NA
RCOG	NA
Coroner Reg 28	NA
HEE	NA

7. **ATTAIN-% of term admissions to the Neonatal Unit**

Percentage	April'23
	4%
Action Plans if any	
	New action under development

8. **Babies born in the right place**

Were all babies born at 27 weeks or under delivered in maternity hospitals with a designated NICU	April 2023 Yes/No-if no how many
	No. One case of a 27-week gestation infant born in an ambulance enroute to hospital. Exception report completed.

9. **Training compliance related to MIS Year 4 Safety Action & core competency framework**

Provide a summary based on April '23 of reporting for example: *if figures are below target provide reasons why or if above target share best practice etc.* **Training plan and compliance in line with MIS Year 4 Safety Action 8 and Core Competencies (if not applicable state N/A)**

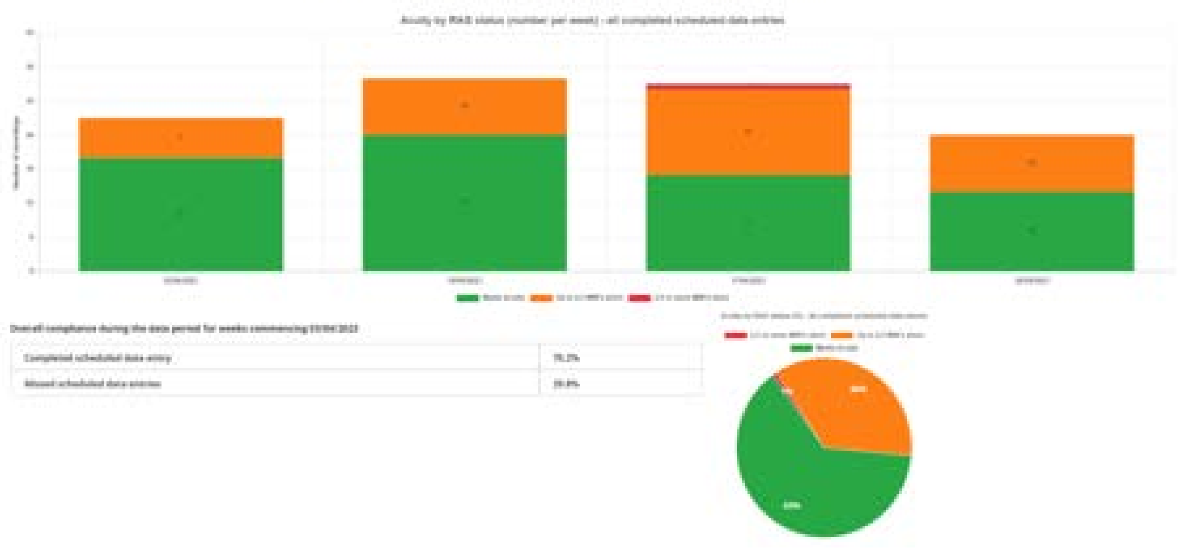
Subject	Metric	Goal (%)	April'23(%)
Education and training - **PROMPT** attendance at maternity specific mandatory training days *(CNST Year 4-at least one of the 4 emergency scenarios should be conducted in the clinical area, ensuring full attendance from MDT team)*	Midwives	90%	98.9
	MSWs	90%	87.8
	Consultant Obstetricians, Trainees ST1-7, Staff Grades, and FY DRs who contribute to obstetric rota	90%	100
	Obstetric Anaesthetic consultants, all Anaesthetic Drs who contribute to obstetric rotas	90%	51.9
	All other Obstetric Anaesthetic contributing to the obstetric rota	90%	Included in above
Education and training – **FETAL MONITORING** attendance at maternity specific mandatory training days	Midwives	90%	81.9
	Consultant Obstetricians, Trainees ST1-7, Staff Grades, and FY DRs who contribute to obstetric rota	90%	76.9
Education and Training- **NEWBORN LIFE SUPPORT** (local)	Midwives	90%	Included in PROMPT
	Neonatal/Paediatric Consultants, Junior	90%	To follow from LW –

	neonatal Drs (who attend births), ANNP's		new requirement
	Neonatal Nurses	90%	62

10. Minimum staffing (Please provide Red flag data for reporting data)

Subject	Metric	Goal	Red Flag	Measure	April '23
Support in Labour	Weekly hours of dedicated senior obstetric cover on delivery suite				**74.5**
Consultant attendance for clinical incidence- as per RCOG guidance	Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person.	100%	<100%		**100%**

Buckinghamshire Healthcare NHS Trust - Labour Ward



11. Service users voice feedback

Provide thematic summary of MVP feedback for latest quarter. Complaints and key themes from these can also be used in this section (general themes and actions taken).

MONTH	Themes and Trends identified, actions taken
April '23	There was an increase in the number of complaints relating to care on the postnatal ward. Themes emerging from these is the ability to continue to deliver routine care when acuity increases. This has been fed into the improvement plan for the postnatal ward. Current actions ongoing in this plan are the introduction of electronic observations, trial of a modified SBAR tool, recruitment of a practice development midwife to introduce a programme to upskill maternity support workers. MVP 15 steps took place in March 2023. Largely positive, however identified that improvement could be made to the parent sitting room. Charitable funds have been sought for this space and will be utilised for redecoration.

12. Staff feedback from Safety Champions walkabout for April '23

Issue Raised	Summary	Action Taken
None		

13. Progress with MIS 10 safety actions

Provide RAG rating & outstanding actions for each safety action as below. Any overall risks and issues can be summarised. No data required this month.

Safety actions		Actions/Comments	
		April '23	
SA 1	PMRT		
SA 2	MSDS		
SA 3	Transitional care services		
SA 4	Clinical workforce planning		
SA 5	Midwifery workforce planning		
SA 6	SBLCBv2		
SA 7	Service user feedback		
SA 8	In-house MDT Training & Core competency framework		
SA 9	Safety Champions		
SA 10	HSIB cases & NHSR ENS		

12. CQC Maternity Ratings (*required for Sep 2023 report ONLY*)

CQC Maternity Ratings Overall	Overall	Safe	Effective	Caring	Well – Led	Responsive

13. Annual Staff Survey responses (*required for Sep 2023 report ONLY*)

% of midwives responding with agree or strongly agree that they recommend their trust as a place to work/receive treatment (annually)	**X%**
Proportion of speciality trainees in Obs and Gynaecology responding with excellent/good on rate of clinical supervision out of hours (annually)	**X%**

Appendix A.1 LMNS reporting deadlines

LMNS board dates	Trust gives data for…	DEADLINE to send	RMNCG	BOB SQG
9th May 2023	**Q4.2022-2023** January, Feb, March 2023	**14th April 2023 Midday**	Q1 meeting on. 31st May 2023, data for Q4 Jan, Feb, March '22-'23	17th May 2023
	FROM HERE ON	**THE REPORTING**	**WILL BE MONTHLY**	
20th July 2023	**Q1. 2023-2024** April 2023	**19th May 2023 Midday**	Q2 meeting on 28th August 2023 data for **Q1.** '23-24	19th July 2023
20th July 2023	**Q1.2023-2024** May 2023	**16th June 2023 Midday**	Q2 meeting on 28th August 2023 data for **Q1.** '23-24	19th July 2023
20th July 2023	**Q1.2023-2024** June 2023	**10th July 2023 Midday**	Q2 meeting on 28th August 2023 data for **Q1.** '23-24	19th July 2023
8th November 2023	**Q2.2023-2024** July 2023	**16th August 2023 Midday**	Q3 meeting on 15th November 2023 data for **Q2** July, August, September '23-24	13th November 2023

8th November 2023	**Q2.2023-2024** August 2023	**14th September 2023** **Midday**	Q3 meeting on 15th November 2023 data for **Q2** July, August, September '23-24	13th November 2023
8th November 2023	**Q2.2023-2024** September 2023	**11th October 2023** **Midday**	Q3 meeting on 15th November 2023 data for **Q2** July, August, September '23-24	13th November 2023
10th January 2024	**Q3.2023-2024** October 2023	**15th November 2023** **Midday**	Q4 meeting on 28h February 2024 data for **Q3** October, November, December '23-'24.	17th January 2024
10th January 2024	**Q3.2023-2024** November 2023-	**14th December 2023** **Midday**	Q4 meeting on 28th February 2024 data for **Q3** October, November, December '23-'24.	17th January 2024
10th January 2024	**Q3 2023-2024** December 2023	**12th January '24** **Midday**	Q4 meeting on 28th February 2024 data for **Q3** October, November, December '23-'24.	17th January 2024
TBC	**Q4. 2023-2024** January 2024	TBC	Q1 RMNCG date TBC-the data request will be **Q4** Jan, Feb, March '23-'24.	20th March 2024
TBC	**Q4 2023-2024** February 2024	TBC	Q1 RMNCG date TBC-the data request will be **Q4** Jan, Feb, March '23-'24.	20th March 2024
TBC	**Q4 2023-2024** March 2024	TBC	Q1 RMNCG date TBC-the data request will be **Q4** Jan, Feb, March '23-'24.	15th May 2024

Appendix B: Dashboard

Please insert dashboard below

Trust's Perinatal Quality Surveillance Model Report (PQSM Report)
Data request: Q1 2023 – 2024 May 2023

Trust name: Buckinghamshire Healthcare NHS Trust **Submitted by: Michelle East**
Date submitted: 20/06/2023

The following report template is based on the Perinatal Quality Surveillance guidance published by NHSE/I in Dec 2020. It has been further edited to allow a standardised reporting form across the BOB LMNS. The PQSM report is produced at trust level and feeds into the trust board before it goes to the LMNS board on a bimonthly. The data requested is for a three-month period. Elements of this will feed into the Regional Maternity and Neonatal Safety Concerns Group (RMNSG) on a quarterly basis and it will also go directly to the ICB Systems Quality Group (SQG).

Whenever PQSM reports are requested, the LMNS will also require a **dashboard** from each trust.

Please contact the LMNS if you require any assistance.

1. Findings of reviews of Perinatal deaths

Provide a summary based on the months of reporting for example: how many cases in each month went via the PMRT, share any themes or concerns have been raised, and grading. **Please provide all data for the quarter in Table 1 and Table 2 below.**

Data is required for April '23

Table 1: Number of perinatal deaths recorded trust.

Months	Enter numerical Data	May '23
Total Number of Deaths		1
Type of Mortality	Antepartum Stillbirths	0
	Intrapartum Stillbirths	0
	Neonatal Deaths	1
Gestational Age	<24 weeks	0
	24-27 weeks	0
	28 - 31 weeks	0
	32 - 36 weeks	0
	37-41 weeks	1
	≥ 42 weeks	0

Table 2: Themes/Trends and Actions from cases closed at PMRT for May 2023

Themes/Trends	Actions
There were no cases closed at PMRT in May.	

Did you have an external panel member for this quarter for all your panels? *(expected 100%). Base this on* **data for May 2023.**

Month	April '23
% attendance	100

2. Findings of reviews of all cases eligible for referral to HSIB

Provide a summary based on the months of reporting for example: how many cases were reported to HSIB **Please provide all data for May 23 in Table 2.** If any final reports were received**, please ensure this data into table 3.**

Table 3: Summary of cases referred to the HSIB

Investigation reference	Summary (to include ethnicity)	Duty of Candour Letter sent	Duty of Candour information given
MI-026652	**Term neonatal death following an unattended birth at home. The baby was initially resuscitated and transferred to the tertiary unit for ongoing management where care was withdrawn.** **The family have consented to HSIB investigation which is now underway.** **(White British)**	**Yes/No**	**Yes/No**

Table 4. Recommendations from any final HSIB reports in this reporting period

Investigation Reference	Recommendations
None	

3. Findings of reviews of declared SI cases closed at BOB LMNS SI panel (*only if not already referable to the HSIB*)

Provide a summary based on the months of reporting for example: how many cases were declared as an SI and did not meet the HSIB referral criteria**. Please provide all data for this quarter in the following table.**

(Data is required for May '23)

Table 5: Summary of Closed SI's and seen at BOB LMNS SI panel

Investigation reference	Report Summary with findings, recommendations, actions plans and learning shared (to include ethnicity).
2023/2232	Neonates admitted to the NNU arrive with ID bands in place which in most instances, are written and have their mother's details on them, as at this

	point they have no personal identifier i.e. hospital number or NHS number. Once a personal identifier has been generated the information is printed onto two ID bands and put onto a limb of the baby. It is recognised that neonates by virtue of their size, activity and the many procedures that take place during their admission, that ID bands often fall off or are taken off regularly. In this instance the parents remember that their baby's ID band was removed during cannulation. Babies have their ID bands checked for many reasons throughout their stay, prior to medication administration and when they are given an enteral feed for example. Additional to this, during the nursing handover, a checklist is completed to ensure that every baby has two identity bands on at the beginning and end of the day. There is local Trust guidance and a Trust policy to support this practice which requires: - All patients within a clinical area should have two ID bands in place and that they should be checked regularly (at least weekly) and replaced immediately if found to be faded, damaged, missing, or unreadable. - Patient identification is included in both corporate and local induction programmes indicating staff responsibility. - If an ID band is removed at any time during the patient's stay, it is the responsibility of whoever has removed it to ensure it is replaced. Where the patient has removed it, it is the responsibility of the health care professional (HCP) caring for the patient to ensure that it is replaced. Any member of staff removing an ID band is responsible for ensuring it is replaced as soon as possible. - All staff must positively check the identification of the patient prior to the delivery of any treatment or care. Trust guideline 449 requires positive patient identification for neonates or newborns: - ID bands to be checked daily and replacement ID bands to be counter checked if being produced by a non-regulated staff member and documented in the clinical notes. - Parents should be involved in the recognition of missing ID bands and in identifying their baby if an ID band needs replacing.

4. Number of current open SI and HSIB cases

Please only enter a numerical figure with no detail of the case.

(Data is required for May '23).

Table 6: Number of current open SI's and HSIB cases

	May '23
Number of open SI's	**1**
Number of open HSIB cases	**3**

5. Incidents logged as moderate or above and any themes identified

Provide a summary based on the months of reporting for example: how many incidents were graded red/amber or moderate or above in the months of reporting i.e. red/amber incidents reports in ***month*** **22 were X. Please provide data for May '23 (***Please note this section may change as the PSIRF is implemented)*

Table 7: Number of reported incidents logged as moderate or above

Actual Impact reported per month	*May '23* Number
Death	**0**
Minor	**0**
Moderate	**0**
Near Miss	**0**
No Harm	**96**
Total	**96**

Table 8-Themes and Trends identified within reported incidents at moderate or above

MONTH	Themes and Trends identified
May 2023	NA

6. HSIB/NHSR/ENS/CQC/RCOG/Coroner Reg 28/HEE concerns of requests for action

Please raise any concerns of requests from the following organisations/regulations. **Please provide data for May '23-if not applicable state N/A**

Category	Concerns of request for action
HSIB	NA
NHSR/ENS	NA
CQC	NA
RCOG	NA
Coroner Reg 28	NA
HEE	NA

7. ATTAIN-% of term admissions to the Neonatal Unit

Percentage	May '23
	4%
Action Plans if any	
	New action plan awaiting approval

8. Babies born in the right place

Were all babies born at 27 weeks or under delivered in maternity hospitals with a designated NICU	May 2023 Yes/No-if no how many
	Yes

9. Training compliance related to MIS Year 4 Safety Action & core competency framework

Provide a summary based on May '23 of reporting for example: *if figures are below target provide reasons why or if above target share best practice etc.* **Training plan and compliance in line with MIS Year 4 Safety Action 8 and Core Competencies (if not applicable state N/A)**

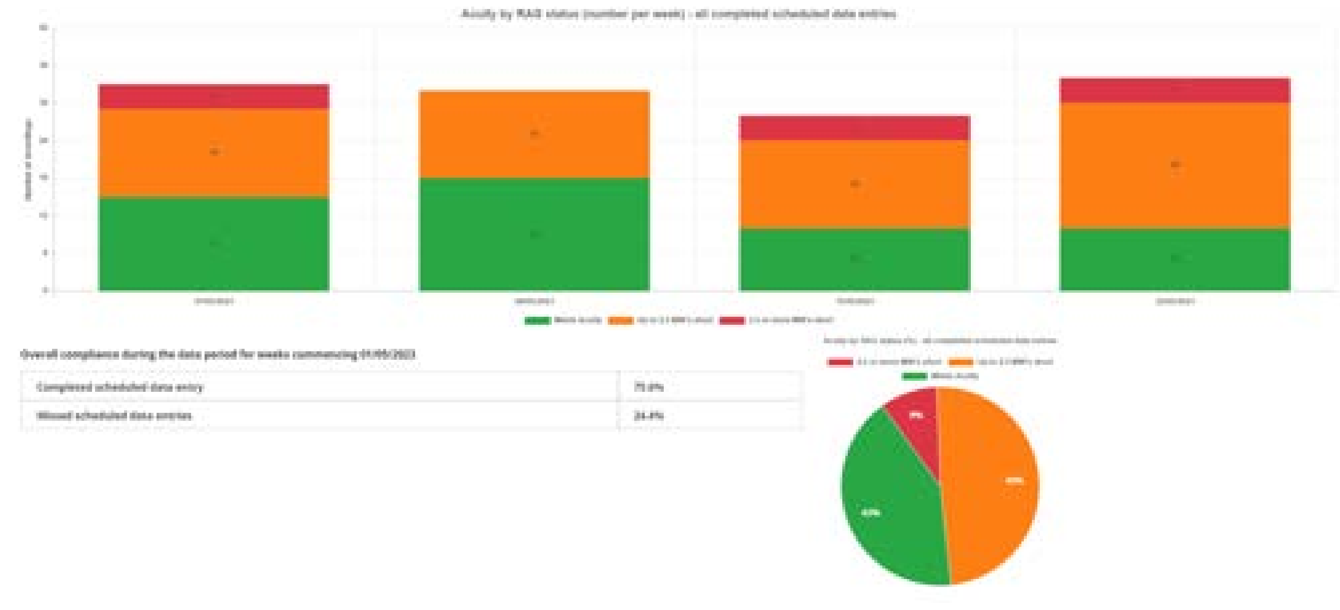
Subject	Metric	Goal (%)	May '23(%)
Education and training - **PROMPT** attendance at maternity specific mandatory training days *(CNST Year 4-at least one of the 4 emergency scenarios should be conducted in the clinical area, ensuring full attendance from MDT team)*	Midwives	90%	91.9
	MSWs	90%	88.1
	Consultant Obstetricians, Trainees ST1-7, Staff Grades, and FY DRs who contribute to obstetric rota	90%	97.4
	Obstetric Anaesthetic consultants, all Anaesthetic Drs who contribute to obstetric rotas	90%	51.9
	All other Obstetric Anaesthetic contributing to the obstetric rota	90%	Included in above
Education and training – **FETAL MONITORING** attendance at maternity specific mandatory training days	Midwives	90%	95
	Consultant Obstetricians, Trainees ST1-7, Staff Grades, and FY DRs who contribute to obstetric rota	90%	82.9
Education and Training- **NEWBORN LIFE SUPPORT** (local)	Midwives	90%	Included in PROMPT
	Neonatal/Paediatric Consultants, Junior neonatal Drs (who attend births), ANNP's	90%	
	Neonatal Nurses	90%	

10. Minimum staffing (Please provide Red flag data for reporting data)

Subject	Metric	Goal	Red Flag	Measure	April '23
Support in Labour	Weekly hours of dedicated senior				**74.5**

	obstetric cover on delivery suite				
Consultant attendance for clinical incidence- as per RCOG guidance	Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person.	100%	<100%		**100%**

Buckinghamshire Healthcare NHS Trust - Labour Ward



11. Service users voice feedback

Provide thematic summary of MVP feedback for latest quarter. Complaints and key themes from these can also be used in this section (general themes and actions taken).

MONTH	Themes and Trends identified, actions taken
May '23	There were two formal complaints in May, one relating to care on the postnatal ward, the other relating to the attendance of children at antenatal ultrasound scans. MVP undertook a survey specifically for maternity triage as part of the intelligence gathering for the triage rapid improvement project. Key themes from this were the length of time spent waiting for obstetric review and empathy for the midwifery teams regarding the workload in triage.

12. Staff feedback from Safety Champions walkabout for May '23

Issue Raised	Summary	Action Taken
None		

13. Progress with MIS 10 safety actions

Provide RAG rating & outstanding actions for each safety action as below. Any overall risks and issues can be summarised. No data required this month.

Safety actions		Actions/Comments	
		May '23	
SA 1	PMRT		
SA 2	MSDS		
SA 3	Transitional care services		
SA 4	Clinical workforce planning		
SA 5	Midwifery workforce planning		
SA 6	SBLCBv2		
SA 7	Service user feedback		
SA 8	In-house MDT Training & Core competency framework		
SA 9	Safety Champions		
SA 10	HSIB cases & NHSR ENS		

12. CQC Maternity Ratings (*required for Sep 2023 report ONLY*)

CQC Maternity Ratings Overall	Overall	Safe	Effective	Caring	Well – Led	Responsive

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% of midwives responding with agree or strongly agree that they recommend their trust as a place to work/receive treatment (annually)	**X%**

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Appendix A.1 LMNS reporting deadlines

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Appendix B: Dashboard

Please insert dashboard below

Trust's Perinatal Quality Surveillance Model Report (PQSM Report)
Data request: Q1 2023 – 2024 June 2023

Trust name: Buckinghamshire Healthcare NHS Trust Submitted by: Michelle East
Date submitted: 07/07/2023

The following report template is based on the Perinatal Quality Surveillance guidance published by NHSE/I in Dec 2020. It has been further edited to allow a standardised reporting form across the BOB LMNS. The PQSM report is produced at trust level and feeds into the trust board before it goes to the LMNS board on a bimonthly. The data requested is for a three-month period. Elements of this will feed into the Regional Maternity and Neonatal Safety Concerns Group (RMNSG) on a quarterly basis and it will also go directly to the ICB Systems Quality Group (SQG).

Whenever PQSM reports are requested, the LMNS will also require a **dashboard** from each trust.

Please contact the LMNS if you require any assistance.

1. Findings of reviews of Perinatal deaths

Provide a summary based on the months of reporting for example: how many cases in each month went via the PMRT, share any themes or concerns have been raised, and grading. **Please provide all data for the quarter in Table 1 and Table 2 below.**

Table 1: Number of perinatal deaths recorded trust.

Months	Enter numerical Data	June '23
Total Number of Deaths		3
Type of Mortality	Antepartum Stillbirths	3
	Intrapartum Stillbirths	0
	Neonatal Deaths	0
Gestational Age	<24 weeks	0
	24-27 weeks	0
	28 - 31 weeks	0
	32 - 36 weeks	2
	37-41 weeks	1
	≥ 42 weeks	0

Table 2: Themes/Trends and Actions from cases closed at PMRT for May 2023

Themes/Trends	Actions
There were no cases closed at PMRT in June.	

Did you have an external panel member for this quarter for all your panels? *(expected 100%). Base this on* **data for May 2023.**

Month	April '23
% attendance	100

2. Findings of reviews of all cases eligible for referral to HSIB

Provide a summary based on the months of reporting for example: how many cases were reported to HSIB **Please provide all data for June 23 in Table 2.** If any final reports were received**, please ensure this data into table 3.**

Table 3: Summary of cases referred to the HSIB

Investigation reference	Summary (to include ethnicity)	Duty of Candour Letter sent	Duty of Candour information given
None			

Table 4. Recommendations from any final HSIB reports in this reporting period

Investigation Reference	Recommendations
2022/27089	No safety recommendations
2022/27684	Ensure that staff are supported to undertake the actions following antepartum haemorrhage, including ultrasound scanning as outlined in local guidance. Ensure that staff are facilitated to maintain a dynamic risk assessment for mothers with cumulative and accruing risk

3. Findings of reviews of declared SI cases closed at BOB LMNS SI panel (*only if not already referable to the HSIB*)

Provide a summary based on the months of reporting for example: how many cases were declared as an SI and did not meet the HSIB referral criteria**. Please provide all data for this quarter in the following table.**

(Data is required for June '23)

Table 5: Summary of Closed SI's and seen at BOB LMNS SI panel

Investigation reference	Report Summary with findings, recommendations, actions plans and learning shared (to include ethnicity).
	None

4. Number of current open SI and HSIB cases

Please only enter a numerical figure with no detail of the case.

(Data is required for May '23).

Table 6: Number of current open SI's and HSIB cases

	June '23
Number of open SI's	**2**
Number of open HSIB cases	**3**

5. Incidents logged as moderate or above and any themes identified

Provide a summary based on the months of reporting for example: how many incidents were graded red/amber or moderate or above in the months of reporting i.e. red/amber incidents reports in *month* 22 were X. **Please provide data for June '23 (***Please note this section may change as the PSIRF is implemented)*

Table 7: Number of reported incidents logged as moderate or above

Actual Impact reported per month	*June '23* Number
Death	**0**
Minor	**3**
Moderate	**0**
Near Miss	**0**
No Harm	**82**
Total	**85**

Table 8-Themes and Trends identified within reported incidents at moderate or above

MONTH	Themes and Trends identified
June 2023	NA

6. HSIB/NHSR/ENS/CQC/RCOG/Coroner Reg 28/HEE concerns of requests for action

Please raise any concerns of requests from the following organisations/regulations. **Please provide data for June '23-if not applicable state N/A**

Category	Concerns of request for action
HSIB	NA
NHSR/ENS	NA
CQC	Maternity triage processes to ensure women seen efficiently. Medicines management relating to the storage of emergency drugs and management of medications in hot weather
RCOG	NA
Coroner Reg 28	NA
HEE	NA

7. ATTAIN-% of term admissions to the Neonatal Unit

Percentage	June '23
	4%
Action Plans if any	

	23/24 action plan approved between maternity and neonates.

8. Babies born in the right place

Were all babies born at 27 weeks or under delivered in maternity hospitals with a designated NICU	**June 2023** **Yes/No-if no how many**
	Yes

9. Training compliance related to MIS Year 4 Safety Action & core competency framework

Provide a summary based on June '23 of reporting for example: *if figures are below target provide reasons why or if above target share best practice etc.* **Training plan and compliance in line with MIS Year 4 Safety Action 8 and Core Competencies (if not applicable state N/A)**

Subject	Metric	Goal (%)	June '23(%)
Education and training - **PROMPT** attendance at maternity specific mandatory training days *(CNST Year 4-at least one of the 4 emergency scenarios should be conducted in the clinical area, ensuring full attendance from MDT team)*	Midwives	90%	95
	MSWs	90%	97.7
	Consultant Obstetricians, Trainees ST1-7, Staff Grades, and FY DRs who contribute to obstetric rota	90%	94.7
	Obstetric Anaesthetic consultants, all Anaesthetic Drs who contribute to obstetric rotas	90%	80.5
	All other Obstetric Anaesthetic contributing to the obstetric rota	90%	Included in above
Education and training – **FETAL MONITORING** attendance at maternity specific mandatory training days	Midwives	90%	97.5
	Consultant Obstetricians, Trainees ST1-7, Staff Grades, and FY DRs who contribute to obstetric rota	90%	92.1
Education and Training- **NEWBORN LIFE SUPPORT** (local)	Midwives	90%	Included in PROMPT
	Neonatal/Paediatric Consultants, Junior neonatal Drs (who attend births), ANNP's	90%	
	Neonatal Nurses	90%	

10. Minimum staffing (Please provide Red flag data for reporting data)

Subject	Metric	Goal	Red Flag	Measure	April '23

Support in Labour	Weekly hours of dedicated senior obstetric cover on delivery suite	74.5	<74.5		**74.5**
Consultant attendance for clinical incidence- as per RCOG guidance	Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person.	100%	<100%		**100%**

Buckinghamshire Healthcare NHS Trust - Labour Ward

11. Service users voice feedback

Provide thematic summary of MVP feedback for latest quarter. Complaints and key themes from these can also be used in this section (general themes and actions taken).

MONTH	Themes and Trends identified, actions taken
June '23	There were seven new complaints in June. The majority related to inpatient care. Common themes include poor communication, particularly regarding post birth debrief of events and general levels of care on the postnatal ward. 243 Friends and Family feedback received. Total positive rating 92%, negative 7%

12. Staff feedback from Safety Champions walkabout for June '23

Issue Raised	Summary	Action Taken
None		

13. Progress with MIS 10 safety actions

Provide RAG rating & outstanding actions for each safety action as below. Any overall risks and issues can be summarised. No data required this month.

Safety actions		Actions/Comments	
SA 1	PMRT		On trajectory
SA 2	MSDS		On trajectory
SA 3	Transitional care services		On trajectory
SA 4	Clinical workforce planning		On trajectory
SA 5	Midwifery workforce planning		On trajectory
SA 6	SBLCBv2		New element – diabetes, gap analysis in progress
SA 7	Service user feedback		On trajectory
SA 8	In-house MDT Training & Core competency framework		On trajectory
SA 9	Safety Champions		On trajectory
SA 10	HSIB cases & NHSR ENS		On trajectory

12. CQC Maternity Ratings (*required for Sep 2023 report ONLY*)

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Appendix B: Dashboard

BHT Maternity Performance

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Smoking at time of booking	Jun 23	6%	-			7%	2%	11%
CO at booking	Jun 23	96%	95%			90%	76%	104%
Smoking cessation referral	Jun 23	38%	100%			30%	-12%	72%
FGR risk assessment	Jun 23	100%	100%			100%	100%	100%
Preterm birth risk assessment	Jun 23	100%	100%			100%	100%	100%
PET risk assessment	Jun 23	100%	100%			100%	100%	100%
Haemhorrage risk assessment			100%					
Diabetes risk assessment	Jun 23	100%	100%			100%	100%	100%
VTE risk assessments	May 23	100%	100%			99%	97%	101%
CO at 36 weeks	Mar 23	65%	95%			40%	#N/A	#N/A
MoH	Jun 23	5%	3%			4%	1%	7%
OASI	Jun 23	2%	3%			2%	-1%	5%
Preterm birth >24 weeks	Jun 23	7%	6%			6%	2%	9%
Preterm Birth <24 weeks	Jun 23	0%	6%			0%	0%	1%
Term birth <10th centile	Jun 23	2%	7%			3%	1%	6%
Birth <3rd centile	Jun 23	1%	-			2%	-1%	5%
Breastfeeding at delivery	Jun 23	74%	-			73%	62%	83%
Smoking at time of delivery	Jun 23	6%	5%			6%	2%	10%
Skin to skin	Jun 23	81%	100%			81%	73%	88%
Term admissions	Jun 23	4%	5%			4%	1%	7%
Breastfeeding at discharge	Jun 23	83%				66%	46%	85%
PCSP at booking	Jun 23	77%	100%			87%	67%	106%
	Apr 23	0.0	10.0				#N/A	#N/A
Perinatal mortality (over 24 weeks)	Jun 23	3.0	0.0			1.3	-2.0	4.6
Overdue Datix	Jun 23	23.0	-			15.8	-25.7	57.3

ANNUAL REPORT 2022-23

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7 - Who we are

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10 - What we have done in 2022-23

12 - Plans for 2023-24

13 - Conclusion

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Foreword from the Co-chairs

Fiona Dite and Ashleigh Oswin

Well it has been a whirlwind of a year with both the workplan and the Maternity Voices Partnership (MVP) team continuing to grow. After Ashleigh and Shamaila came on board in December 21 and Jan 22, the 22-23 year gave plenty of opportunity to ensure service user voice is at the heart of improving maternity services here in Buckinghamshire with two new engagement leads also on board and plans to expand the team even further over the coming year.

From running 15 steps at Stoke Mandeville and Wycombe to Ockenden insight visits, delivering and attending training sessions, representing service users at local and regional meetings, co-producing projects and more, the work continues to grow. We have been delighted to get back out in the community to gather feedback face to face - listening to the experiences of families across the area to support and build on the online work which had been carried out during COVID. This feedback is critical to all we do as an MVP so ensuring we hear voices from across the breadth of our community is hugely important.

Inequality has been and will continue to be the cornerstone of our workplan. Embracing the Local Maternity and Neonatal System (LMNS) equity strategy and asset mapping we are working hard to listen to communities who have previously been less heard.

We have been attending community open days, events such as Vale in the Park and health and wellbeing events, talking to women and birthing people and their families. We have held multiple listening clincs and started a Mamas and Babas group aimed at the South Asian community in Wycombe to regularly speak to families in the area. We hope to build on this, this year and going forward with plans for further listening clinics in the pipeline.

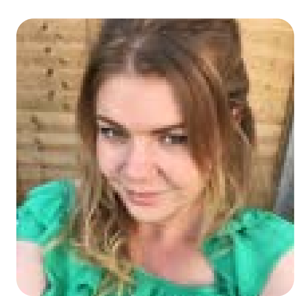
The constructive relationship with the clinical team at Buckinghamshire Healthcare Trust (BHT) continues to develop, regularly meeting with members of the team from all areas of maternity. They listen to our feedback and we have been working in coproduction on many projects, large and small to address areas of improvement as well as to build on what is going well.

We have been involved in recruitment of new staff members, celebrated International Day of the Midwife and Christmas at the hospital and were delighted to collaborate on the aesthetics of the new maternity building.

We have also continued to engage with our external partners including the Family Nurse Partnership, Family Centres within the county and the Council to contribute ideas towards the new Family Hub model as well as continuing to work with Bucks New Uni - helping with the curriculum, assessments and recruitment of future midwives. It was particularly inspiring to attend their communication day and witness the importance of equity within their curriculum and engage with students

We are very much looking forward to seeing more people in person this year and hearing first hand the experiences of families - amplifying their voices to continue to drive service improvement..

Fiona and Ashleigh



Foreword from the Vice Chair

Shamaila Bashir

I would like to start by saying a huge thank you to the Mama's and Baba's group, in particular the mothers who attended and fed back . This group has been running for over a year now following our first listening event in March 22 for women in the South Asian community and it has continued to grow.

The raw, honest feedback from these families has been so valuable in helping to shape some of the projects underway to improve maternity services going forward. This including a service user voice video that we created from the first listening event which helped to develop a wider understanding around some of the cultural issues faced locally.

We have been using feedback to shape how we decide what we are going to do next, Cultural antenatal education is likely to be a key focus going forward as it seems to come up time and time again.

Postnatal support as well as perinatal mental health in general came through as key themes. This has been fed back to the Trust and there is ongoing work to address some of the gaps identified in these areas. I am very grateful to be collaborating with the Raham project - already, some of the members of the Mama's and Baba's group have reached out to them for support.

I would like to finish saying that its been a really insightful first year as Vice chair, I have learnt so much and it has transformed my own maternity journey. Not only from being pregnant now but also revisiting and reflecting on my previous pregnancies and labours, its really helped me heal and has given me a holistic view on how the maternity services could look like in the future in Bucks.

Shamaila

Heidi Beddall - Director of Midwifery

During this last year, improving safety and experience of care across maternity services in all NHS Trusts in the country has been a key priority.
The reports into maternity services at Shrewsbury and Telford, and East Kent have highlighted the essential need for women, birthing people and their families to be listened to. In addition, the recent Black Maternal Health parliamentary report and MBRRACE findings demonstrate that there continues to be stark inequalities for women of Black, Asian or minority ethnic heritage.
In view of this, NHS England published their 3 year delivery plan for maternity and neonatal services setting out 4 key priorities for NHS maternity services; the first priority being "Listening to women and families with compassion".
It is therefore with increasing importance that the maternity voices partnership enables the voice of women, birthing people and families to be heard, and directly influence co-produced quality and service improvements in maternity services at Buckinghamshire Healthcare NHS Trust. As we move forward, the partnership will expand to ensure those families who experience care in the neonatal unit will equally be heard and enable the Trust to be responsive to their specific needs.
This annual report highlights the fantastic work that has been possible due to the commitment of colleagues in the maternity voices partnership. I am grateful for their expertise and tenacity to lead positive change that enables maternity care in Buckinghamshire to be continuously responsive to the families we serve.

Heidi Beddall

Director of Midwifery
Buckinghamshire Healthcare NHS Trust

David Williams - Deputy Director of Quality

As the outgoing Chair of the Buckinghamshire Maternity Steering Group, I have thoroughly enjoyed the collaborative working with the Buckinghamshire Maternity Voices Partnership (MVP), the collaboration is key to development and improvement of Maternity Services in Buckinghamshire, the working relationship with the MVP, Buckinghamshire Healthcare NHS Trust and colleagues within the Integrated Care Board (ICB) is critical in ensuring that the voices of women are heard, use of feedback and collaboration to review and design our services with women is so important. The MVP has helped us hear voices of women from different backgrounds which helps us provide services that meet the needs of women, and additionally the MVP has been a critical external objective eye to the important work and collective improvements we need to make. Furthermore, the work of the MVP enables us to communicate to a much broader range of the population who use our services and long may this positive collaboration continue, and all my best wishes and positive thoughts for you all for the future,

David Williams,

Deputy Director of Quality,
Maternity Steering Group Chair,
Buckinghamshire Locality Berkshire Oxfordshire & Buckinghamshire (BOB) ICB

What is a Maternity Voices Partnership?

A Maternity Voices Partnership (MVP) is an independent NHS working group: a team of volunteers, women and birthing people, and their families; commissioners; and providers (midwives and doctors) and other partners working together to review and contribute to the development of local maternity care by putting the experiences of women and birthing people, and their families at the centre.

MVP's are an ideal platform for the co-production of maternity services and a way for commissioners and Trusts to consult with the public – also helping them fulfil their statutory obligations for patient participation involvement. They provide a mechanism for real time ongoing feedback and co-design of services, enabling co-production on maternity development projects and ensuring that women and birthing people, and their families are actively involved in service development and improvement.

In March 2022 the Ockenden 2 review again highlighted the importance of an effective Maternity Voices Partnership, stating that

''All maternity services must involve service users (ideally via their Maternity Voices Partnership) in developing complaints response processes that are caring and transparent"

The MVP listen to the experiences of women and birthing people, and their families throughout their maternity journey as a critical friend. The Single Delivery Plan (Mar 23) has outlined that Neonatal services will now be included - making us an MNVP (Maternity and Neonatal Voices Partnership) which is an exciting integration that will address the essential support needed for neonatal parents and their families.

Who we are

The Buckinghamshire Maternity Voices Partnership is a partnership team of maternity professionals and lay individuals who work together to review and improve maternity services across the area

The Buckinghamshire MVP is multidisciplinary in nature and brings together healthcare professionals and other partners from organisations involved in maternity care with local women and birthing people and their families.

Our professional membership includes the Director and Head of Midwifery, Consultant Midwife, Infant feeding midwives, Transformation midwife, Quality Improvement leads, Local Maternity and Neonatal System representatives, Matrons from Community, Birth Centre, Labour Ward and Rothschild Ward, Obstetricians, Health Visiting and more.

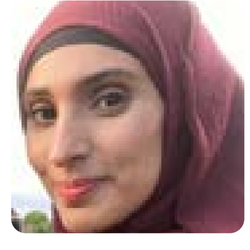
We have attendance from Buckinghamshire Health Trust Board members, representatives from Buckinghamshire County Council, Buckinghamshire Family Information Service, Healthwatch Bucks and Bucks New University.

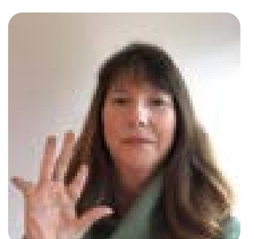
We also have a dedicated group of volunteers who help us reach out and engage with women and birthing people and their families across the area.

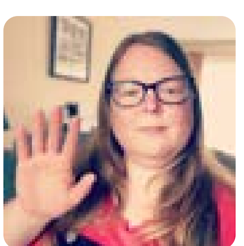
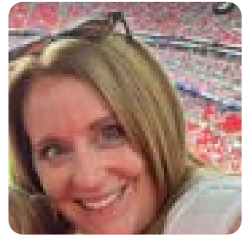
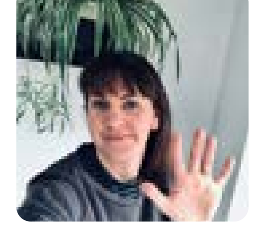
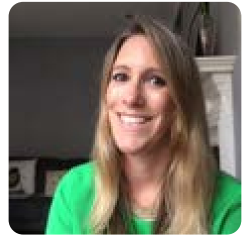
We are always looking for more volunteers and are also actively seeking to increase the diversity of the MVP moving forward.

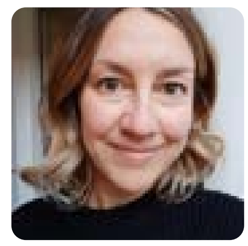
Particular thanks go to our Treasurer Leanne, Social Media rep Michelle and engagement reps Sobia and Lisa - thanks for all you do!

Some of our fantastic volunteers...







Thoughts from some of our partners.

'Working with the MVP has given me invaluable insight into those we care for, we gain greater understanding of women and birthing peoples cultures and values. Working closely with our MVP also allows us to be able to share our knowledge and for it to be communicated to a wider audience.'

Michelle Dunne
Transformation Midwife

'It's a pleasure working with the Bucks MVP team! I'm not from Bucks so they really help me to get a sense of what our service users experience, as well as teaching me about all the local areas, local issues etc. The MVP team always have a raft of amazing ideas and solutions – the team are real 'can do' people and are so passionate about their work. They have welcomed me and I value their knowledge and wisdom so much, I know I'm getting real service user voice involvement.'

Liz Stead (she/her)
Head of Midwifery, Maternity, Neonatal and Women's Services
Deputy Senior Responsible Officer BOB Local Maternity Neonatal System (LMNS)
Buckinghamshire, Oxfordshire, Berkshire West (BOB) ICB

'Collaboration with our maternity and neonatal service user colleagues is a key enabler underpinning the delivery of the Maternity and Neonatal Safety Improvement programme. (MatNeo SIP) .
In my role as the MatNeo SIP Lead for the Oxford Patient Safety Collaborative / Oxford Academic Health Science Network , I have the privilege of working with a diverse group of service users (MNVP's) to optimise outcomes for preterm babies.
The value of their unique perspectives and lived experience is remarkable and has enriched our improvement work in so many ways. The sense of ownership and shared responsibility that has emerged from our collaboration is inspiring.
Through their articulate and empathetic advocacy they have ensured that our work genuinely reflects the needs and aspirations of parents and families.
I look forward to continuing collaboration and coproduction.'

Eileen Dudley
Senior Programme Lead & MatNeoSIP Lead
Oxford Academic Health Science Network, Patient Safety Collaborative

What we do

We make sure the voices of women and birthing people, and their families are included at every level of maternity care.

Buckinghamshire Maternity Voices Partnership (BMVP) have a formal meeting every quarter, where all partners get together and discuss maternity services in the area - challenges, successes, ongoing projects, feedback received and outstanding issues. There is also an informal quarterly volunteer/service user meeting in advance of the formal meeting - usually held in a variety of venues across the area.
.
In between meetings we are talking to women and birthing people, as well as their families to hear about their experience of maternity care in Buckinghamshire. This can be on a face to face basis via 'walking the patch' in hospital or at other clinics, at events, dedicated listening clinics or it could be online, or via one of our electronic surveys.

We collate and anonymise all feedback received, identify themes and then discuss these with the Trust with a view to making positive changes to the maternity service.

We get involved in specific projects that might be happening within the Trust, we are consulted on proposed service changes, we review and co-produce maternity leaflets and communications and carry out events such as 15 steps for maternity. coffee mornings, drop in feedback sessions and more.

We attend local regional and national forums to represent the voice of maternity service users - these forums also allow us to learn from the success and challenges of other organisations across the UK.

We maintain a significant social media presence across multiple channels, engaging with local users of the maternity service, sharing information and also providing a forum for Q & A sessions with clinical staff, education videos and more.

We are also actively seeking out the voices of local communities we do not often hear from - we are establishing community links and hoping that we will be able to provide feedback from a more representative cross section of service users.

We are always looking for new volunteers who would like to be involved and have plans to recruit several new regular volunteers in 2023.

What we have done in 2022-23

Getting back out there.

Following two new additions to the MVP Chair team with Ashleigh joining as Co Chair in Dec 21 and Shamaila joining as Vice Chair in January 22 the team began focusing on getting back out into the community again post Covid.
We began attending meetings in person, ran listening events, attended community engagement events in the summer and piloted a mother and baby feedback group in High Wycombe focusing on women and birthing people from the South Asian community.

Feedback

Our feedback this year has been gathered both in person and online. General feedback has been collected via coffee mornings, listening clinics and other community events, where more detailed feedback has been obtained online. Our main feedback survey has been running all year and results collated quarterly, but further detailed surveys have been carried out around this year - including information about induction of labour, diabetes information and the experience of neonatal parents around advice re place of birth.
Survey engagement online has been declining - particularly for the general survey so work is ongoing to rexamine this in 23/24.

Social Media

Our social media rep Michelle has continued to engage our service users on Facebook (@BucksMVP), Instagram (@BucksMVP) and Twitter (@BucksMatVoices) where we now have engagement with 4500+ service users and followers. The Facebook page has been particularly popular and has been used for information sharing, updates to services, responding to queries, signposting, talking to service users about their experiences, public health messaging and more.

The MVP have also produced a positive feedback video which was taken to NHS board, a seperate video highlighting feedback from Pakistani and Kashmiri women and several 15 steps videos which showed a walkarounds of Wycombe and Stoke Mandeville with recommendations.

Co-production

Throughout the year we have been having bi-weekly and often weekly meetings with our Trust partners to discuss service changes and improvements and of course to provide feedback. We have continued to be able to inform decision making with the voices of service users and have been involved in co-producing information and communications where needed.
We have been getting involved in local transformation plans, including personalised care plans, website review and improvements to the care enviroment. We have been involved in helping to implement the national asks following the Ockenden Review, We review all maternity leaflets, have been involved in the creation of new ones including a place of birth leafet and new postnatal leaflet as well as the regional personalised care plan and the regional equity plan.

Partnership working

We have been delighted this year to continue helping Bucks New University with their new midwifery program - providing service user voice to inform training, interview potential midwifery students and assess existing ones. This work is ongoing and will continue in 2022-23.
We have also worked with Bucks County Council and Youth Voice Bucks to encourage young parent participation as well as working with the local family centres to inform the new Family hub model.
We continue to work with Healthwatch locally - supporting each other on a variety of projects.

What we have done in 2022-23 contd.

Local, Regional and National Forums

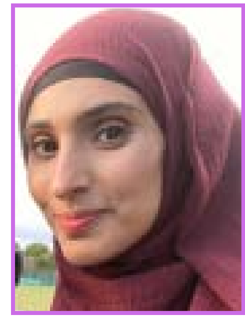
We have been attending a number of different forums over the past year - locally we take part in a number of regular meetings; Labour Ward Forum, Postnatal improvement, Obstetric Governance and Quality, Quality Improvement and Audit Maternity Steering Group, and Buckinghamshire Health Trust Patient Experience Group. We also meet regularly with members of the clinical teams to stay up to date and inform ongoing work as well as with the non-exec BHT board maternity safety champion. Regionally we attend the Local Maternity and Neonatal System Board meetings, incuding the Serious Incident Panel, Ockenden Steering Group, Prevention and Equity, Quality and Safety Forum and others. We also attend Regional and National Maternity Voices meetings, the Neonatal Parent Advisory Group, South East (SE) Perinatal Mental Health webinars, the Ready for Parenthood coproduction group and more. We also attended the Maternity and Neonatal Service User Voice Summit in Jan 23 and the Maternity and Neonatal Summit in Mar 23. We have also presented about the importance of co-production and including parents voices in maternity and neonatal care locally at the BHT Reflect and Review, regionally at the Acaemic Health Science Network shared learning event and nationally on an National Health Service England neonatal webinar.

Mamas and Babas group

Following a successful initial engagement event for Pakistani and Kashmiri parents in March 22 a fortnightly Mama's and Baba's group was set up by our amazing Vice Chair Shamaila. This group provides a safe space in the Wycombe community for women in the local South Asian community to meet up, chat, have some play sessions with their babies and also share their experiences of and opinions around maternity services. Fantastically this group has now become peer led within the community with continued support from BMVP.
We hope to take this peer led model into other geographic areas to provide the same safe space for women and birthing people in other communities to be able to share their maternity experience. This feedback will then be taken back to the Trust to inform service improvement.

Volunteer recruitment

We have continued to recruit for new volunteers this year and are delighted to have welcomed 2 new Engagement representatives Sobia and Lisa on board as well as a number of other volunteers.



Sobia

Lisa

What are our plans for 2023-24?

We are looking forward to becoming a BMNVP

We have a busy year planned and are looking forward to building on the work that has been done over the last 12 months. Growing our team further to reach areas of minority and social deprivation and including Neonatal families in the voices we hear.

Our priorities for the coming year are as follows

- Continue collecting feedback and supplying service user voice feedback quarterly via walk the patch, community engagement and other sources.
- Focus this year remains Health Inequalities- improving engagement with identified lesser heard voices – continuing work with Pakistani Kashmiri community, but extending network to specifically include engagement with Black African/Black Caribbean community and areas of social deprivation.
- 1/2 events also to be held at RAF Halton
- 1/2 events to be specifically aimed at our LGBTQ community
- Continue active work to improve diversity of MVP itself
- Equity lead to be recruited -2 year fixed term from equity funding
- 2 more engagement reps to be recruited from Aylesbury & Chesham areas
- Bereavement and pregnancy loss engagement project to begin
- Website to be refreshed and social media pages for Bucks MVP to continue
- Electronic survey to be reviewed as engagement dropping and new surveys issued to improve reach and data collection
- Provide service user representation at Trust meetings as well active involvement in changes to services
- Support delivery of NHS Equity plan
- Support delivery of Maternity and Neonatal Single Delivery Plan
- Celebrating staff
- Continue co-production of patient communications and documentation – including website review and PCSP's
- 15 steps to be carried out around the county
- Service rep training
- Continue support for Ockenden and CNST compliance

Conclusion

Buckinghamshire Maternity Voices Partnership has had an incredibly productive year and we are very proud of what has been achieved and extremely grateful for all the hard work that has been carried out and for everyone that has shared their experiences with us.

We have grown our reach and engagement further than we would have believed possible, represented the views of birthing women and people at every level of the Trust and helped to identified areas for improvement as well as celebrating success wherever we can.

We are looking forward to building on our great working relationships over the coming year with some exciting projects and workstreams, making co-production a part of everyday service development and putting the voice of birthing women and people at the heart of everything we do.

Appendix 1 Treasurers Report

The MVP Account closed the financial year at £46,175.78.
We began the year with £46,169.09 carried forward from 2021/22. This figure was carried across to 2023/24.

This gives the impression that it has been an incredibly quiet year financally for Bucks MVP.

However, incoming across the year we had £31,000 in payments from CCG Payment.

This payment has facilitated more events, more committee members and a much greater number of people able to spread the word and ensure that the MVP is reaching and supporting more people.

Outgoings across the year were £31,006.69 which mainly comprised of committee remuneration payments of £23,512.50. A 4 fold increase on previous which highlights the extra headcount needed to keep everything running smoothly.

In addition, we continue to use our Inequalities Funding, which we received last fiscal. A further £2,085.15 has been billed to that.

Now that covid has passed a little more and face to face events are running, once more, some of this spending has also been assigned to attending events again.

So, thanks to the funding we receive, we begin the 23/24 Financial from a great position and an ability to invest our funding going forwards and continue our great work.

Division of Women, Children & Sexual Health Services

Maternity and Neonatal Safety Champions Meeting

Via MS Teams

5th June 2023 at 9:30am

Present:	**Apologies:**
Heidi Beddall (HB) – Director of Midwifery (Chair)	Gaynor Tyler (GT) – Matron NNU
Elaine Gilbert – (EG) – Head of Midwifery	
Karen Bonner (KB) – Chief Nurse	
Sanjay Salgia (SS) – Paediatric Consultant	
Alison Barker (AB) – Paediatric Clinical Governance Administrator	
Amy White – Secretary to Maternity (Minutes)	

It was noted that Dipti Amin's tenure expires in May 2023 and a new non-executive will be appointed for Maternity.

This meeting is to focus on maternity safety champions business and only the local Safety Champions are required to attend the meeting, along with the Board Safety Champion, the Chair, Non-Executive Director and the Administrator.

The minutes are to be included in the Quarterly Safety Report and will also be added to the Paediatric Clinical Governance agenda. Any key issues highlighted will also be added to the Exec Summary.

1	**Minutes of the last meeting** dated 23rd February 2023 Also are the minutes from 26th April 2023 – this meeting didn't take place due to lack of quoracy.	MWL3 Mat and Neo Safety Champions M MWL3 Mat and Neo Safety Champions M

2	**Confirm any items for AoB** None	
3	**Regional/National Reports and Publications** EG advised 'Single Delivery Plan' and 'Saving Babies Lives III' have been published/launched. More support is needed from Obstetric and Neonatal colleagues from them to be processed. An exercise if taking place this afternoon that will help plan for this. EG reported quite a lot of reports from maternity services and James Pagent was recently released, Chelsea and Westminster one was a downgrade, one was sustained. There's a lot of learning which needs to be pulled together to get us prepared and move forward. HB reported the Year 5 Maternity Incentive Scheme has been published, 7 out of 10 was our score. We are waiting for confirmation of there is any reimbursement around that 50% of trust did not achieve full compliance with CNST. There's quite a significant reduction compared to the two years before.	
4	**Staffing**: Obstetrics – *Audit of compliance with Guideline 504.8.1 Obstetric Consultant Staffing and Role/Responsibilities on Labour Ward (April and October)* • SH reported that extra funding has been received for governance roles	
	Neonates medical workforce - Compliance with BAPM over any six month period in line with the maternity incentive scheme safety requirements • SS reported that a meeting took place to discuss the new Maternity Incentive Standards, requirements and evidence was requested. This will be circulated once the document has been updated. No major issues were identified.	
	Neonatal nursing - *Nursing workforce review has been undertaken at least once annually in line with the maternity incentive scheme safety requirements* • HB advised that there is a requirement for Maternity Incentive Scheme to have an annual update, the document from last year was excellent so using this as a template would be good. • SH reported some funding has been received which will also be for the FBI care lead, and we're going to add some additional funding. Psychological support for families, which was one of the areas were, through the GIRFT are not achieving the target. The finance will be from Paediatrics. • **ACTION** – agreed the quarterly maternity safety report will include Paediatric and Neonates governance updates and highlight any safety issues.	

	Midwifery - *Six monthly midwifery staffing report (April and October)* HB stated this is a requirement for Ockenden compliance and likely to be in the new standards for MIS. Audits need to take place to demonstrate when emergency consultants attend, this will take place every 6 months. 100% of the cases the consultants attended, a sample is taken of postpartum hemorrhages because there's quite a large number and 80% of the time the consultants attended, but you can see where they did not attend. **ACTION** – HB to check if this is part of the schedule audit. *Report for noting – as retrospective as may's meeting didn't take place* Verbal report from EG: • Target recruitment around strengthening the triage team • Opportunity to review processes and how they flow, this is also being done alongside recruitment to tackle the triage issues, locally, nationally, and regionally. • Still looking on how to build the workforce • Looking to have 0 vacancies by December • Separate DAU hours has been extended	HB/EG
5	**Perinatal Quality Surveillance Model -** *Quarterly PQSM report (January, April, July and October)* • HB advised this is the summary report of the SI's in maternity, this also goes to LMNS. No new information has been added.	
	Avoiding Term Admissions to Neonatal Unit - *ATAIN Action Plan annually (March)* HB reported that it's been completed, we now need to 23/24 action plan which is an essential part of the maternity incentive scheme. Anything that was partially complete (this is because some of these objectives don't have a 12-month life span) as such because they are ongoing. SH confirmed the report shows a slight increase in admissions.	

	ACTION – reported to be updated offline as nothing new has been added since May last year and all deadlines have surpassed. KB asked that the ongoing concern around support worker vacancies which has noted from the last walkabout should be added.	
6	**Safety Intelligence Data** *Claims scorecard (September)*	
7	**Mat Neo Safety Collaborative -** *Update on current projects six monthly (March and September)* **SS verbally reported:** • early breast milk for babies born below 34 weeks gestation. • we are achieving consistently good success now and it just shows our journey through this as part of the preterm optimization and now more or less we're achieving 100%. • mother's own milk as the first feed within ideally 6 hours and we are doing well • poster going to the Qi conference.	SS
8	**Trust IPR Metrics:** *Maternity (Stillbirth/Neonatal Death/Preterm Births (monthly))* **HB verbally reported:** • Looking to demonstrate more neonatal metrics on the trust, IPR as well as maternity. • Governance changes have been reflected	
9	**Transitional Care -** *Quarterly Audit Findings (January, April, July and October)* **EG verbally reported:** • increase in our activity and we are the number of times that we are breaching our bed base in both quarters. We hadn't historically recorded this data through the DATEX system. • additional resources around nursery nurses to support the neonatal service, but this is an ongoing area that we need to focus on • revisit the bed base and the model around it.	

10	**AoB** Request from KB, please ensure you respond with your attendance to these meetings, if you are unable to attend apologies need to be sent and a colleague who can represent the department should be arranged to ensure medical representation is here. EG advised a talk about the psychological safety work that's being done across the element S there we have. There is a presentation I will send to be circulate with the Minutes and they will be attending for 30 minutes after our next meeting. Dipti Amin (DT) – Non Executive Director is due to leave the trust w/c 12th June replacement to be confirmed.	
11	**Date of Next Meeting (2023)**	

Date	Time	Duration	Reports to be discussed	
Wednesday 12th July	11.00am-12.30pm	90 minutes	Safety Intelligence Data – previous month action log	Neonates – term admissions to NNU and learning from review reports
			Trust IPR Matrix	NNAP Dashboard
			PREM 7	Transitional Care Quarterly Audit Findings
			Neonates – ATAIN Action Plan Quarterly Progress	PQSM Report
Thursday 24th August	9.30am-10.30am	45-60 minutes	Safety Intelligence Data – previous month action log	PREM 7
			Trust IPR Matrix	
Wednesday 4th October	11.00am-12.30pm	90 minutes	Safety Intelligence Data – previous month action log	Mat Neo Safety Collaborative - update on current projects
			Safety Intelligence Data – Claims scorecard	Neonates – ATAIN Action Plan Quarterly Progress

			Trust IPR Matrix	Neonates – term admissions to NNU and learning from review reports
			PREM 7	NNAP Dashboard
			Staffing - (Obstetrics/Midwifery/Neonates Medical/Neonates Nursing	Transitional Care Quarterly Audit Findings
			PQSM Report	
Thursday 16th November	9.30am-10.30am	45-60 minutes	Safety Intelligence Data – previous month action log	PREM 7
			Trust IPR Matrix	
Thursday 28th December	10.00am-11.30am	90 minutes	Safety Intelligence Data – previous month action log	PREM 7
			Trust IPR Matrix	

What is the problem we are trying to solve?	How do we know this is a problem?	What does good look like?	What is the first step we can take to make this better? (link to PDSA)	Who will own this?	When is it due for completion?	What is the current status?	Have we solved the problem?
There is a need to improve flow through the triage service and risk assess more effectively so that women are reviewed in order of clincal priority	Triage audit, staff and service user feedback via MVP	A formal triaging process that improves flow without compromising safety	Explore RAG rating systems from other organisations +/- BSOTS	SDV/MZ		12/22 - Meeting with BSOTS, unable to safely deliver pathway without estate to undertake 15 minute assessment, ensure always two midwives in triage and provide a 24/7 telephone triage service. Some concerns raised regarding condition specific triaging, ?evidence for effectiveness of BSOTs	
			Look at local modification of BSOTS that uses a RAG rating system	Rapid improvement team	Jun-23	5/6 Local model for RAG rating developed to be trialled and reviewed	
			Triage lead midwife to continue to use current triage process but undertake simultaneous risk assessment using new RAG system and feedback to team at end of day and record timings of admission and review this.	Rapid improvement team	Jun-23	6 /7th June - Triage lead fedback that the decision making was aligned to RAG rating, if we could implement this we would be offering a consistent service across all shifts but there is a need for a waiting room to enable women to be moved to free up beds whilst awaiting doctors review.	
			Need to incorporate RAG rating into a new admission proforma and trial this. Need to establish a suitable waiting space. Continue to record wait times.	Rapid improvement team	Jun-23	8/6 New proforma developed by the team, printed and passed to triage lead to be used in week two. Birth centre room 2 converted into a waiting area, bed removed and replaced with chairs, space reviewed by MVP and suggestions for environmental changes logged. Develop a poster to inform women that they will be seen in order of priority not arrival time. Develop telephone call proforma to ensure this aligns with the admission proforma and to ensure standardised triage process takes place.	
			Telephone proforma developed, to be trially Thursday/Friday and continued next week before formalising	Rapid improvement team	Jun-23	8/6 Awaiting feedback from triage team on telephone proforma	
			Approve final draft of telephone and admission proforma	Rapid improvement team	Jun-23	29/6 final documents reviewed and approved.	
			Feedback gained. Final modifications required and triage guideline to be updated. Agree launch date and implement	ME	Jul-23	16/6 Mop-up meeting with rpid improvement team. Guideine to be modified and ratified at July guideline meeting. Aim to launch first week August once guideline approved and uploaded to intranet	No
Need a space to store drugs in triage	Midwives constantly have to leave to visit LW drug cupboard which is the other side of LW. Drugs are unsafely stored in an unlocked cupboard in triage as a short cut.	A drug cupboard in triage	Find space and order a cupboard that meets drug regulation needs	SDV	Jul-23	Measurements provided, cupboard to be sourced and ordered. Decsion to order trolley as more flexible.	No
Knowing where to find guidelines is difficult, especially when you are in a rush	Feedback from staff	An easy way to locate and review guidelines	Collate a list of most frequently accessed guidelines in triage and prepare a poster/information sheet that incudes the guideline number so that it can be used to each within microguide app or on CAKE	Rapid improvement team		MZ pulled together list of guidelines, passed to SMcM to create poster. Awaiting poster from SMcM. Poster printed and placed in triage	Yes
Women quite often call triage with non-triage related issues	Feedback from staff and fed back from QI team observations in April	Better guidance for women so they know where to call	Ensure information on the website provides clear guidance, develop a sticker with a QR code that links to website for the purple notes. This will enable women to see the information in their own language. Send mock up for sticker to printers and obtain quote.	ES	Jul-23	16/6 - Information verified on Trust website, need to source suitable sized stickers to be used in the notes. 27/6 - ES to develop existing document proposed by CMW	No
Women can sometimes have to call back several times when the line is engaged, or are forced to just turn up as they cannot get through on the phone for advice	Noted in QI team observations during April	A call waitinig system that enbles women to wait in a cue to be answered	Explore whether there is an 8x8 solution to the problem.	ME	Aug-23	DB has reached out to IT team to enquire about possible solutions Call with Trust 8x8 and IT team 16/6. Need to await BT numbers being ported across to new system. Likely due to be completed by end July. Triage marked as a priority along with ED	No
Clinical environment is cluttered with lots of posters on the walls, not all in date	Observed by QI team, fedback by staff	Animproved working environment	Remove posters and ensure key information is bundled in a laminated set of pages that can be easily accessed.	Rapid improvement team		Posters removed, only relevant information printed, laminated and hung from the cupboard for easy access	Yes

	Completed
	On track
	At risk
	Overdue

Meeting: Audit Committee

07 September 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 05.09.2023 Audit Committee 07.09.2023

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.

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, above the Board's appetite for such risk.

On 5 September 2023, the Executive Management Committee considered this report and the escalation/de-escalation of a number of risks to/from the CRR. This is detailed within the report.

On 7 September 2023, the Audit Committee considered the report and requested further information on a number of risks. This information has been sought from risk owners and detail will be provided to the Audit Committee offline.

Decision	The Committee is requested to note the contents of the report and use this information to support risk-based discussions and decision making.

Relevant Strategic Priority

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

Relevant objective

☒ Improve waiting times ☒ Improve safety ☐ Improve productivity	☒ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☐ Upskill operational and clinical managers

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	25	15	18 Increased
2	Deliver a financially sustainable plan	2.5	12	2	25	9	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	7	20	5	18 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.

Key changes since the last report to Board include:

- Escalation of 4 risks to the Corporate Risk Register:

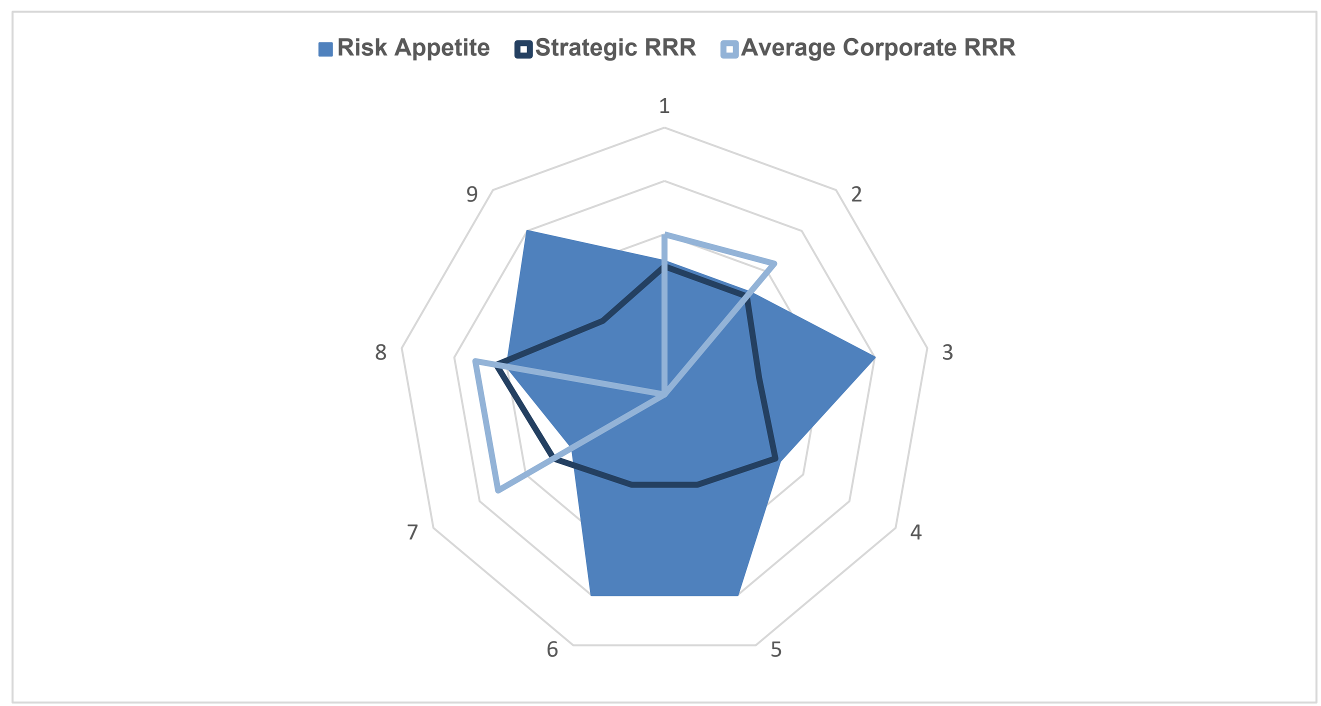
- Risk 410; Marlow & Wycombe theatres (Wycombe Hospital) not able to meet accreditation standards (August 2023).
    - Risk 415; New wing theatre block (Stoke Mandeville Hospital) end of life (August 2023).
    - Risk 320; Delays in endoscopy procedures and diagnosis (August 2023).
    - Risk 377; MRI Capacity (September 2023).
- De-escalation of 3 risks from the Corporate Risk Register:
    - Risk 226; Loss of emergency and non-emergency bleeps at Wycombe & Amersham Hospital (August 2023).
    - Risk 93; Cancer performance (August 2023).
    - Risk 54: Shortage of chemotherapy trained nurses (September 2023).

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. Profile risks are presented to Board Committees regularly (4-6 times per year) with deep dives scheduled by the Committee as appropriate.

3 Risk Appetite

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



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

4 Risk 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
Mar 2023	63%	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%
Jun 2023	38%	46%	50%	Med	0	2	0%	0%	100%	0%	0%	100%
Jul 2023	25%	27%	50%	Med	0	0	0%	0%	100%	0%	0%	100%
Aug 2023	88%	44%	58%	Med	3	0	0%	0%	100%	0%	0%	100%

At the end of the month of August:

- Not all strategic risks had been reviewed in month; 1/8 had not. Seven operational risks were reviewed.
- At the end of August 2023, 58% of actions were overdue. This applied to 14/24 operational actions. There were no overdue strategic actions.
- The balance of assurances across both registers continues to be considered as medium.

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.

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 16 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. **Risk & Compliance Monitoring Group (RCMG)**
   Following the RCMG meeting in August 2023, EMC were requested to consider the following.

   a) **Risks for escalation to the CRR**
      - Risk 377: MRI capacity (approved).
      - Risk 287: Maintenance of safe staffing levels (not approved – to split into individual staff groups and reconsider).
      - Risk 314: Outdated, failing equipment risking the ability to monitor fetal wellbeing (not approved, resolved).

   b) **Risks for de-escalation/removal from the CRR**
      - Risk 54: Shortage of chemotherapy trained nurses (approved).

   Minutes of RCMG meetings are provided to EMC for information.

5. **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.

6. **Action required from the Board/Committee**
   The Board are required to:
   a) Note and take assurance from the updates to the CRR and the process for escalation/de-escalation of risks.

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.	20/09/2023 - Risk discussed at RCMG team are hoping to increase recovery capacity at stoke which will hopefully mean they are able to see more patients but on the whole the risk remain unchanged as patients are still having to be transferred to and from Stoke in order to receive treatment. The future of this risk lies within the larger future plan for the Wycombe site and those ongoing conversations.	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.	20/09/2023 - Risk discussed at RCMG and agreement made for risk to be put forward to EMC for de-escalation. Vacancy rate reduced to 10.2%.	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	20/09/2023 – Discussed at RCMG, Committee updated with progress. To be reflected within Datix.	25	15	↓ ↑

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
118	The 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) Funding has been agreed for the WH LV works to commence. This will be raised as a separate risk.	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.	20/09/2023 - Risk discussed at RCMG, significant working group project underway at the moment cleansing the data to allow for clear clinical picture. Risk is monitored through performance and transformation but no overall change at this time.	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.	15/08/2023 – The post-mitigation risk has increased to reflect impact of ongoing industrial action on patient care. Operational management of industrial action sits with clinical divisions and EPRR, the People Directorate is supporting with key workstreams.	12	20	↑↑
190	The Ward 2a environment remains non-compliant with CQC Regulation 15 - premises and equipment	The premises (building fabric) and equipment (CD cupboard; medication mixing facilities) are non-compliant with CQC regulation 15 which stipulates that premises where care and treatment are delivered are clean, maintained and suitable for the intended purpose. This risk has been highlighted by the CQC (as	02/08/2023 - Actions updated with options paper with possible locations for a relocation of ward 2a.	20	20	↔↔

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
		an environment not fit for purpose) and documented in their reports following last two inspections.				
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.	16/05/2023 – Extra work completed, putting galvanised steel reinforcement in to prevent some weight distribution cracks to the columns external to the tower. Awaiting engineer reports – to be fed back to EMC.	25	20	↔↔
410	Wycombe Hospital Site - Marlow & Main THs block	Wycombe site Marlow theatres - currently theatre 2 out of action and 2 theatres struggling to meet accreditation standards regularly Ventilation and infrastructure, old and needs full refurbishment. Including inadequate recovery space. GPAS/RCoA guidance and HTM0301 not met. Currently, theatre 1 and 3 are maintained to HTM standard. Theatre 2 is not able to be maintained to HTM standard. Break down and downtimes becoming a regular occurrence	Extraordinary meeting held 3rd May 2023 between SCC Divisional Director, COO,Theatre and Estates Senior management to review all risks related to theatre infrastructure - Electrical and Ventilation in particular. To discuss current issues, recent increased reliance on BCPs, rolling maintenance schedule needed and long-term strategy re refurbishment WH Main & Marlow and SMH New Wing and DSU Theatres.	20	20	

Risk ID	Risk Title	Risk Description	Most Recent Update	Rating (Initial)	Rating (current)	Last 2 Key Movement of risks
		Wycombe Main: Theatre 3 upon revalidation is no longer compliance with HTM standards Theatre 1 and 2 just meeting HTM standards, however, the entire suite will need infrastructure and ventilation refurbishment. Not longer able to meet standards and breakdown are becoming a regular occurrence.				
415	New Wing Theatres Block (1-5)	New Wing Theatres block SMH (THs 1-5) currently at the end of life stage, and in need of full refurbishment in the next 12-24 months. Currently ventilation not meeting HTM standards in TH4 Anaes RM, and risk of electrical failure and ventilation failure in all theatres. Additionally heating coils and boilers at end of life and have frequent failures resulting in downtime and loss of service.	Extraordinary meeting held 3rd May 2023 between SCC Divisional Director, COO,Theatre and Estates Senior management to review all risks related to theatre infrastructure - Electrical and Ventilation in particular. To discuss current issues, recent increased reliance on BCPs, rolling maintenance schedule needed and long-term strategy re refurbishment WH Main & Marlow and SMH New Wing and DSU Theatres.	20	20	
320	Risks of Endoscopy Waiting Lists Leading to Delays in Procedures and Diagnosis.	Currently short of capacity in Endoscopy. This has been made worse by COVID. Delays in surveillance appointments, which means that there have been delays in removing polyps, which have now turned into cancer. Number of patients have been diagnosed with cancer, which may have been avoidable.	Discussed at 21. Aug. 2023 RCMG. Agreed by the panel that the risk is appropriate for inclusion on the CRR. PST informed IM that a new action needs to be created to keep a log of all SI and complaints related to this risk so they can be tracked with the progress of this risk. 20/09/2023 – Discussed at RCMG, Committee updated with progress. To be reflected within Datix.	25	25	
377	MRI Capacity	MRI capacity is not meeting the required demand of the service. All routine MRI requests are taking 3/4 months to complete. All MRI slots are currently being used for urgent work and as a result the routine list is growing. Once the second MRI scanner is fully installed at the Trust the department will be able to do double the work in half the time and should be able to clear the backlog relatively quickly.	20/09/2023 - Risk discussed at RCMG, risk remains unchanged at this moment in time. Risk is regularly discussed at EMC and the Radiology team have plans and kit in place ready to go but the estates work is really the key to moving this plan forwards.	16	16	

Risk Heat Map – Corporate Risk Register – September 2023

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.

Likelihood \ Consequence	1	2	3	4	5
5				190 – Ward 2a environment non-compliant with CQC Regulation 15- premises and equipment ⇔ 410 – Wycombe Hospital Theatres ⇔ 415 – SMH Theatres ⇔	320 – Risk of endoscopy waiting lists leading to delays in procedures and diagnosis. ⇔
4				36 – There is currently no IR Service at BHT ⇔ 377 – MRI Capacity	224 – There is a risk that Trust Capital Resourcing is insufficient to support operational objectives for 2023/24. ⇔ 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. ⇔ 189 – Risk of industrial action in relation to national pay award. ⇔
3			~~54 - There is a risk to chemotherapy service provision due to the lack of chemotherapy trained nurses~~ ⇔	234 – There is a risk to the delivery of the 2023-24 Financial Plan due to unplanned pressures ⇔. 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					118 –The main HV/LV electrical supply is insufficient for the current needs of the Estate and is not resilient.⇔

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 in July 2023, the Board Assurance Framework has been reviewed by the Director for Midwifery, Chief Commercial Officer, SDU Lead for Children and Young People Services, Chief Digital Information Officer, Chief Medical Officer and Chief People Officer and updates have been reflected in this report. This applies to Risks 1c, 3, 4, 5, 7, 8, 9. To note, Risk 2, has undergone a comprehensive review by the Chief Finance Officer.

Changes to those risks held within the Corporate Risk Register have been reflected in the report (de-escalated risks have been crossed out, new risks have been added in bold and comments added for those being considered for de-escalation).

In July 2023, the Audit Committee requested a thorough review of risk related to Children and Young People (Principal Risk 4) and this has been conducted by the SDU Lead. The Audit Committee also requested dates of Committee review of risks to be articulated within the report and these have been provided.

Following a Board Seminar in 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. This will be alongside the roll out of the new governance (including risk) and performance framework. Migration to the new version of 4risk is planned for Autumn/Winter 2023.

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* - last review July 2023 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 28 July 2023 Chief Operating Officer 10 May 2023 Director of Midwifery 23 August 2023 Associate Chief Nurse 20 February 2023		CRR 36	Interventional radiology service
			~~CRR 54~~	~~Shortage of chemotherapy trained nurses~~
			CRR 320	**Delays in endoscopy procedures and diagnoses**
			CRR 377	**MRI Capacity**

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).	**Action**: Endoscopy Improvement Programme – oversight through the IPR

			- IQVIA report (3). - 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 under ongoing consideration by the Committee*
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 all areas are complete apart from ED & UTC (Associate Chief Nurse) – update September 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 local maternity and neonatal system (LMNS) . - Regular workforce reviews, acuity monitoring and escalation, red flag surveillance. - Trust maternity IPR metrics, quality metrics, obstetrics scorecard - Perinatal quality surveillance model (PQSM) in line with LMNS. - External governance reporting. - Regional and national SitReps for maternity and neonatal capacity reporting. - Maternity and neonatal safety champions meetings/walkarounds. - Maternity and neonatal governance meetings. - Training programme aligned to core competency framework version 2 - Clinical audit. - Centralised governance function for maternity, neonates and acute paediatrics. - Resilient governance team infrastructure to meet national, regional and local compliance and assurance reporting requirements. - Divisional performance reviews. - Clear policies, clinical guidelines and procedures in place. - Midwifery and paediatric manager on call (in addition to site rota). - Co designed Quality Improvement (QI) plans. - - LMNS co-production strategy. - LMNS equity strategy. - Business continuity plans, escalation framework,LMNS mutual aid guidance and neonatal cot locator/peridash (management of bed base). - Manual/Paper orkarounds for lack of EPR. - Birthrate plus acuity app/Safecare.	- Quarterly maternity safety reports including full HSIB and SI reports for board oversight, scrutiny and transparency(1). - Quarterly maternity quality report including monthly perinatal quality surveillance report (PQSM) (1) - Outputs of relevant meetings (1). - HSIB investigation safety recommendations(3). -HSIB quarterly feedback (3) - External reviews(antenatal and newborn screening quality assurance, CQC)(3). - Annual Picker survey of women's experiences (3). - Maternity services dataset scorecard (3). - Outputs from QI projects (1). - Claims/litigation scorecard (1). - Annual maternal and perinatal MBRRACE reports (3). - Maternity Incentive Scheme (CNST) (1). - Ockenden compliance reports (1). - 'Saving babies lives bundle version 2' compliance(3). - Quarterly patient feedback survey via Maternity Voices Partnership (MVP) (3). -15 steps reports via MVP (3) - Annual MVP report (3) - Six monthly maternity staffing reports (1). - Implementation of single delivery plan oversight by Board ASSURANCE LEVEL **MEDIUM**	**Actions:** Action plans and trackers to monitor compliance with : - Maternity Incentive Scheme (CNST) - Ockenden immediate and essential actions - Saving Babies Lives version 2 - MBRRACE - NHSR Early notification scheme - Perinatal mortality review tool - Picker survey - External reviews - Serious Incidents/HSIB recommendations - MVP feedback - Single delivery plan (Director of Midwifery) **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)

**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	Chief Finance Officer 21 September 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 Inability to improve organisational productivity to pre-pandemic levels and above Inflationary pressures	- Negative impact on ICS financial position. - Reduced opportunities for service investment. - Block contract for locally commissioned services which does not reflect the increasing cost of meeting regulatory standards. - Inability to plan resourcing long term, to deliver strategic plans and activity at required levels. - Inability to invest in estates and digital improvements. - Inability to support structural shifts in activity between care settings (hospital to community).	- Scrutiny from Finance and Business Performance Committee. - Quarterly performance reviews and financial deep dives. - Transformation Board. - Productivity and efficiency programme. - Proactive engagement with regulators and System colleagues. - Budget setting and monitoring processes. - Continual engagement with NHSE and ICB regarding inherent risks. - Continue to seek alternative funding solutions to address the capital funding gap. - Financial governance framework in place. - Oversight of capital spend and capital plan by CMG and F&BPC. - Agreed 2023/24 budget, submitted to ICB/NHSE. - Targeting of productivity opportunities through Model Hospital System, quarterly service line reporting (SLR) data, and other external benchmarking. - 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, Transformation Board, CMG (1). - Financial deep dives (2). - Output of performance reviews meetings for financial deep dives (2). - Commercial strategy (2). - Meetings between CFO and Regional NHSE representative on month end position; outputs of meeting (3). - Fortnightly system meetings; providers and ICB (3). - Oversight of Commercial Strategy through F&BPC (2). 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 deficit as part of annual and medium-term planning (CFO) – Date TBC (national ask). **Assurance Gap:** Historic issues underpinning organisational capital deficit. **Action:** Need to pursue alternative external capital provision (eg. PFI bullet payments, MES and Asset Sales) – to complete by March 2024. ~~**Action:** Refresh of financial governance framework (linked to refreshed performance framework) (COO/CFO) – May 2023~~ **COMPLETE**

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	Chief Commercial Officer 31 August 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)~~ **COMPLETE** **Action:** Implementation of Health on the High Street pilot (Deputy Director of Strategy) –, facility opening September 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)**	n/a	n/a
Last Review	SDU Lead 08 August 2023 Chief Commercial Officer 31 August 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?*
Shortage of Community Paediatricians – recruitment of pharmacists, paediatrician Jan 2024, advertise for GP and specialty doctor, looked at efficiencies Waiting times for community paediatric services Space restrictions; lack of MDT appropriate clinical space within multiple sites Ability to manage current demand whilst reducing backlog Lack of digital solution for repeat prescriptions	Services do not provide care in a timely manner - Potential harm - Negative experience	- 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). - PilotMDT working model. - SDU Lead in place. - Deputy Divisional Director in place directly working with CYP. - Recruitment of two pharmacists - Ongoing recruitment efforts for Psychologist, GP, Specialty Doctor, therapists. - Working with The Owl Centre & Helios; outsourcing waiting list. - Tight criteria and triage for referrals. - Text messaging reminders for appointments. - Patient Initiated Follow Up (PIFU) in place. - Maintaining communication with families. - Clinical validation of waiting list. - Cohorting of waiting list following validation. - Review to Discharge processes in place to reduce follow up appointments. - Short notice waiting list in development for appointment utilisation. - Embedded harm review process. - Escalation of estates issues via COO.	- Outputs of relevant meetings (level 1). - SEND report (3). - SEND action plan, oversight by QCGC (2). - Evaluation of MDT working model (interim) (1). - Monthly reporting at service and divisional level, including minutes of meetings (1). - Monthly reporting to Commissioners (1). - Suite of letters to families re: waiting times (1). - Outputs of harm review process (1). ASSURANCE LEVEL **MEDIUM**	**Assurance Gap:** Estates plan for relocation of therapies at SMH **Action:** Redesign of therapy services (including those for children) – redesign buildings to facilitate this across Buckinghamshire **Assurance Gap:** Inability to commit to MDT working model **Action:** Estates solution at Rayners Hedge, Haleacre and Wycombe Hospital. **Action:** Abbey Place Children's Hub (opening September 2023) **Assurance Gap**: Digital immaturity within services **Action**: Explore options for digital solution with corporate teams (SDU Lead) – update November 2023 **Action:** Tender for children's services (completion date TBC) **Action**: Health on the High Street facility, with a focus on families (opening September 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 28 July 2023 Chief Commercial Officer 31 August 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 *Completion of above action plus further analysis required prior to further actions being set.* **Action:** Health on the High Street (CCO) – September 2023

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

<table>
<tr><td>Strategic Objective 7</td><td colspan="5">Deliver our people priorities</td></tr>
<tr><td>Achieve by 2025…</td><td colspan="5">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</td></tr>
<tr><td>Strategic Priority</td><td colspan="5">Ensure our workforce are listened to, safe and supported (“A Great Place to Work)</td></tr>
<tr><td>Principal Risk</td><td colspan="5">6. Failure to deliver on our people priorities related to recruitment & resourcing, culture & leadership, supporting our staff, workforce planning & development and productivity.</td></tr>
<tr><td>Executive Lead</td><td colspan="2">Chief People Officer</td><td>Oversight Committee</td><td colspan="2">Strategic People Committee – last review September 2023</td></tr>
<tr><td>Inherent Risk</td><td>Residual Risk</td><td>Risk Appetite</td><td colspan="3">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 3
Total Score 12</td><td rowspan="3">Minimal
(2)</td><td>CRR 51</td><td colspan="2">Shortage of nursing staff; registered and unregistered – recommended for de-escalation</td></tr>
<tr><td>CRR 189</td><td colspan="2">Risk of Industrial Action</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td>Last Review</td><td colspan="2">Chief People Officer 18 September 2023</td><td></td><td colspan="2"></td></tr>
<tr><td>Movement in Risk</td><td colspan="5">None</td></tr>
<tr><td>Strategic Threats
What might cause this to happen?</td><td>Effect
What might the effect be?</td><td colspan="2">Existing Controls
How are we managing the risk?</td><td>Assurance Record
What evidence do we have for the effectiveness of the controls?
What level is this assurance?</td><td>Action Required
Where are our gaps in assurance?
What actions are required?</td></tr>
</table>

Insufficient levels of qualified, experienced staff and training opportunities. Cost of living (nationally) Impact on morale, wellbeing and retention resulting from the pandemic, sustained operational pressures and industrial action 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 (IA)	- 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 ESR. - 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. - Supporting skill mixing to cover for IA. - Targeted support for colleagues affected by ongoing IA (awaiting outputs).	- 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). - ESR 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 for Consultant or Junior Doctor dispute. JD strike action planned for 20-22 Sept 2023 and 2-5 Oct 2023 and Cons action planned for 19-20 Sept 2023 and 2-5 Oct 2023.

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

Strategic Objective 8	**Our buildings and facilities will be great places to work and contribute to the health and wellbeing of staff**		
Strategic Priority	Ensure our workforce are listened to, safe and supported ("A Great Place to Work)		
Principal Risk	7. Failure to provide adequate buildings and facilities. a) Estates b) Digital		
Executive Lead	Chief Commercial Officer (Estates) Chief Digital Information Officer (Digital)	**Oversight Committee**	Finance & Business Performance Committee* – last review July 2023 Strategic Workforce 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 4 **Total Score 16**	**Cautious** **(3)**	CRR 225	Risk of disruption to Trust technology through cyber incidents
			CRR 118	HV/LV electrical supply
			CRR 56	Wycombe Tower concrete panels
Last Review	Chief Digital Information Officer 28 July 2023 Chief Commercial Officer 31 Aug 2023		CRR 184	Wycombe Tower interior; suitability for provision of healthcare
			CRR 190	Interior condition of ward 2a; CQC regulation compliance
			~~CRR 226~~	~~Failure of critical bleeps at Wycombe & Amersham Hospitals~~
			CRR 410	**Marlow & Wycombe Theatres (WH) not able to meet accreditation standards**
			CRR 415	**New Wing Theatre Block (SMH) not able to meet accreditation standards**
Movement in Risk	None			

Strategic Threats *What might cause this to happen?*	**Effect** *What might the effect be?*	**Existing Controls** *How are we managing the risk?*	**Assurance Record** *What evidence do we have for the effectiveness of the controls?* *What level is this assurance?*	**Action Required** *Where are our gaps in assurance?* *What actions are required?*
7a. Estates				
Lack of capital Ageing estates	- Low compliance with regulatory requirements - Staff leave due to feeling unsafe. - Loss of confidence of public in care received.	- Estates and Net Zero Strategy - Clinical strategy - QFM – prioritise through this. - PFI contracts; facilities management - Accommodation strategy - CMG prioritisation process (use of capital for critical areas)	- 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 Lack of available capital to mitigate all issues
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~~) **COMPLETE** **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 Medical Quality – 21 September 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. - Executive Dashboards in place. - Implementation of Patient Safety Incident Response Framework (PSIRF).	- 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) – due for implementation September 2023 **Assurance Gap:** Inability for Datix to identify trends within reporting (not possible on upgraded version)

3.0 Emerging Risks; Board & Board Committees

Month	Meeting	Risks Noted
July 2023	Audit	- Culture related to management actions; need to strengthen local ownership and commitment to timely completion of actions mandated by Board Committees. - DPST action timetable fitted to NHSE requirements may be unrealistic - Partial assurance on Chaperoning Policy demonstrated unknown/incomplete awareness/ compliance with Trust policies
	F&BP	- Concern related to elective activity and finances with a need for a recovery plan.
	Q&CG	- 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.
	SPC	No new emerging risks noted.
	Public Board	- Impact of industrial action including financial, colleague wellbeing and, specific to the planned strike in August 2023, the ability to provide full medical cover and impact on service provision. - Specific risks as escalated by Committee Chairs. - Elective recovery funding, risk of clawback related to year-to-date activity. - Ongoing mental health challenges noting collaborative working with system colleagues and local police.
	Private Board	
Aug 2023	Q&CG	- Longstanding gap in the Fracture Liaison Service noting work planned with the Acute Provider Collaborative to address this. - Gap in community nursing workforce within specific Trust locations (e.g. Marlow) alongside national challenges in attracting nursing colleagues to this area of work. A significant number of Trust initiatives noted to be in place to support improvements and were recognised by the Committee. - Ongoing risk related to midwifery staffing (current vacancy rate 27-28%) noting escalation processes and mitigations in place (already reflected within Corporate Risk Register, CRR) - Infection Prevention & Control risks including: o Waning immunity within population and limited national vaccination strategy/campaign this year (recognising this is reflected within the IPC Board Assurance Framework). o Current COVID-19 numbers and risk of winter surge alongside potential for early flu. o Capacity challenges particularly with added escalation beds throughout the year but particularly during winter months. o Ongoing risk related to the estate, specifically ventilation and availability of side rooms.
	F&BP	- Demand and capacity related to MRI scanning.

		- Delivery of the 2023/24 efficiency programme. - Risks to delivery of the elective recovery plan (as outlined in the paper). ○ Elective Recovery Funding (ERF) clawback if required activity levels not met.
	Public Board	No meeting in August.
	Private Board	No meeting in August.

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
Culture related to management actions; need to strengthen local ownership and commitment to timely completion of actions mandated by Board Committees.	Details to be confirmed.			
Partial assurance on Chaperoning Policy demonstrated unknown/incomplete awareness/ compliance with Trust policies.	Review and provide assurance on how best to assess and ensure compliance with Trust policies.	Audit Committee	Chief Nurse	September 2023
Further incidence of MRSA against annual trajectory of zero cases, noting this as a national issue.	Ongoing monitoring through regular reporting to the Quality & Clinical Governance Committee			
Safeguarding: - Ongoing risk related to delayed Deprivation of Liberty applications (DoLs). - Organisational capacity to apply the Mental Capacity Act (MCA).				
Ongoing mental health challenges noting collaborative working with system colleagues and local police.	New regular paper to be scheduled for greater oversight of Mental Health Services	Quality Committee	Chief Nurse	October 2023

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 Meeting in Public

Date: 27 September 2023

Agenda item	Revised Fit and Proper Person Test Framework
Board Lead	Bridget O'Kelly, Chief People Officer
Author	Bridget O'Kelly, Chief People Officer
Appendices	None
Purpose	Assurance
Previously considered	n/a

Executive summary

In August, 2023, NHS England published a revised Fit and Proper Person Test (FPPT) Framework in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT as it applies under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The review highlighted areas that needed improvement to strengthen the existing regime.

The Framework builds on what is in place in the existing regime. Changes include an update to the set of core elements for the FPPT assessment of all board members (now including information about training and development and any disciplinary findings relevant to the FPPT assessment) and the introduction of recording information relating to the testing requirements on ESR.

As is currently the case, NHS organisations must be able to demonstrate, annually, that they have carried out a formal assessment of the FPPT for each board member. The framework introduces a requirement for the Trust Chair to submit an annual return to the NHS England Regional Director. The recommendation is that Trusts should consider carrying out the assessment alongside the appraisal cycle.

A standard board member reference is being introduced, which organisations must complete and retain locally, whether or not a reference has been requested by a prospective employer.

An NHS Leadership Competency Framework is due to be published in the next few weeks. This will provide guidance for the competence categories against which a board member should be appointed, developed and appraised.

The Framework will be effective from 30 September 2023 and NHS organisations are expected to use it for all new board level appointments or promotions and for annual assessments for all board members going forward from that date. It should be read alongside the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework.

Decision	The Board is requested to note the requirements of the new framework and to approve the inclusion of the role of Board Affiliates in the Trust's internal FPPT processes.

Relevant strategic priority

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

Relevant objective

☐ Improve waiting times ☒ Improve safety ☐ Improve productivity	☐ Improve access and effectiveness of Trust services	☒ Improve the experience of our new starters

	for communities experiencing the poorest outcomes	☒ Upskill operational and clinical managers

Implications / Impact

Patient Safety	Patient Safety is at the centre of this policy – it is maintained by ensuring appropriate clinical staff are suspended / excluded from the work environment.
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. Risk of claims from employees; cost of backfill for some employees
Compliance Select an item. Select CQC standard from list.	Legislative and CQC Compliance NHS England Guidance
Partnership: consultation / communication	Trade unions/professional bodies
Equality	This update applies to all Board members
Quality Impact Assessment [QIA] completion required?	N/A

1 Introduction

In August, 2023, NHS England published a revised Fit and Proper Person Test (FPPT) Framework in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT as it applies under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The review highlighted areas that needed improvement to strengthen the existing regime. Full details are available on NHS England's website: NHS England » NHS England Fit and Proper Person Test Framework for board members

The Framework builds on what is in place in the existing regime. Changes include an update to the set of core elements for the FPPT assessment of all board members (now including information about training and development and any disciplinary findings relevant to the FPPT assessment) and the introduction of recording information relating to the testing requirements on ESR.

As is currently the case, NHS organisations must be able to demonstrate, annually, that they have carried out a formal assessment of the FPPT for each board member. The framework introduces a requirement for the Trust Chair to submit an annual return to the NHS England Regional Director. The recommendation is that Trusts should consider carrying out the assessment alongside the appraisal cycle.

A standard board member reference is being introduced, which organisations must complete and retain locally, whether or not a reference has been requested by a prospective employer.

An NHS Leadership Competency Framework is due to be published in the next few weeks. This will provide guidance for the competence categories against which a board member should be appointed, developed, and appraised.

The Framework will be effective from 30 September 2023 and NHS organisations are expected to use it for all new board level appointments or promotions and for annual assessments for all board members going forward from that date. It should be read alongside the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework.

2 Purpose

The purpose of the new Framework is to strengthen individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS and improving patient care.

It is a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

The Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

3 Applicability

The Framework applies to executive and non-executive directors of integrated care boards (ICBs), NHS trusts and foundation trusts, NHS England and the CQC, interim as well as permanent appointments where greater than six weeks and those who are called "directors" within Regulation 5.

If they wish, trusts can extend the framework to cover other senior managerial positions for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The annual submission requirement is, however, limited to board members only.

4 What is new?

The new framework builds on what is already in place. Key points are highlighted below.

4.1 A strengthened annual assessment

A strengthened annual assessment has been introduced for all Board members. The new checklist is included as Appendix 1 of this paper. (It forms appendix 7 of the framework.) The key developments are a review and record of:

- training and development
- disciplinary findings relevant to the FPPT assessment, including those arising from grievances, complaints and speaking up issues against the board member, behaviours not in accordance with organisational values/behaviours/local policies
- employment tribunal judgement check where the board member was implicated, and the issue relates to FPPT

4.2 Submission process

An annual summary signed off by the Trust Chair must be submitted to the Regional NHS England director by 31 March each year. The first submission is required by 31 March 2024.

4.3 Updates in the NHS Electronic Staff Record (ESR).

- New data fields in ESR record the testing of relevant information about board members' qualifications and career history, and that the Chair has reviewed and signed off as complete for each individual.
- Supporting documents/records in relation to FPPT will be held locally by each individual NHS organisation in compliance with GDPR and the NHS Records Management Code of Practice.
- Personal data in ESR relating to FPPT will not routinely be accessible beyond an individual's own organisation. There are no substantive changes to data controller arrangements from those already in place for ESR.
- A Data Protection Impact Assessment (DPIA) has been drafted by NHS England setting out the relevant lawful basis for processing data on ESR.
- Organisations must communicate with board members whose details will be included in ESR which allows directors the opportunity to object. A template privacy notice is available to use.
- The duty to store information relevant to the annual assessment (as set out in the checklist) will apply to existing directors (as they will have to comply with the assessment each year) and not only new appointees/promotions.

4.4 A new standard board member reference template

For board members who leave their position, organisations must complete and retain locally the new board member reference, whether or not a reference has been requested by a prospective employer. The completed reference should be retained locally in an accessible archive.

4.5 An NHS Leadership Competency Framework

This will provide guidance for the competence categories against which a board member should be appointed, developed and appraised. This is expected to be published in the next few weeks.

5 Roles and responsibilities

The roles and responsibilities of the new framework are set out below.

5.1 Chairs of NHS Organisations

- Have overall accountability for arrangements in the organisation.
- Ensure assessments carried out for board members on appointment and annually and at any time that something new comes to light.
- Ensure that the board member reference is completed for any board member who leaves for whatever reason, regardless of whether or not a reference has been requested.
- Conclude on assessments for the whole board (Executive Directors (EDs), Non-Executive Directors, permanent/temporary, voting/non-voting)
- Submit annual summary to relevant regional director.

5.2 Senior Independent Director /Deputy Chair

- Carry out FPPT assessment of the Chair

5.3 Chief People Officer/Company Secretary

- Support Chair in establishing arrangements for the FPPT. Specifically:
  - Accessing and entering information onto ESR.
  - Testing elements of FPPT assessment and recording outcome and evidence for the Chair to review and conclude.
  - Complete annual submission form.

5.4 CEO

- Carry out initial assessment of FPPT for EDs and share with the Chair.
- Support for the Chair.

5.5 NHS Regional Directors

- Oversight role covering:
  - Appointment and initial FPPT assessment.
  - Receipt of annual FPPT submission.
  - Disputes and appeals.

5.6 NHS England Central Team

- Being established to support the process going forwards.

6 Quality assurance and governance

Every three years, organisations should undertake an internal audit to assess the processes, controls and compliance supporting the FPPT assessments.

External quality assurance checks will be conducted by the CQC, NHS England and an external/independent review.

- The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations.
- NHS England has oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations

7 Possibilities

The framework is mandated for all board members in NHS trusts. However, if they wish, trusts can extend the framework to cover other senior managerial positions for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. There are two such roles for us to consider:

Board Affiliates

Our Trust Board Affiliates are a key part of the Trust Board at BHT and play a crucial role in providing direct insight into day-to-day operations of clinical activity. The Board Affiliate is a non-voting member of the Board and is not subject to the liabilities and statutory obligations of Board members. The Board Affiliate has a responsibility to constructively challenge in reaching decisions of the Board and to help develop proposals on priorities, risk mitigation, values, standards and strategy.

Deputy Chief Operating Officer

There is only one VSM role at BHT (the deputy COO) which is not part of the board. Although this post is a senior management role, they will not regularly attend board meetings and do not have individual significant influence on board decisions.

8 Recommendation

The recommendation is:

- to include the Board Affiliate Role in the Trust internal FPPT process
- to exclude the Deputy COO role from the Trust internal FPPT process.

9 Next steps

- From 30 September 2023:
  - Use the new board member reference template for references for all new board appointments.
  - Complete and retain locally the new board member reference for any board member who leaves their position.
  - Use the new NHS Leadership Competency Framework as part of the assessment process when recruiting to board level roles. (This is due by September 2023.)
- By 31 March 2024
  - First full FPPT annual review for board members, including individual self-attestations completed.
  - Annual submission form to regional director.
  - Privacy notices issued to Board members.
  - ESR updated.
  - CPO to review any local policies, contract and settlement agreement templates which may require amendment to enable compliance with the Framework.
- By end Q1 2024/25
  - A new board appraisal framework will also be published, incorporating the Leadership Competency Framework, by March 2024. NHS England will ask Trusts to use this for all future annual appraisals of board directors from this point.

10 Action required from the Board/Committee

The Board is requested to:

- Approve the recommendation as set out above.
- Note the next steps; an update will come to Trust Board in March 2024

Appendix 1: FPPT Checklist – appendix 7 of NHS England guidance PRN00238-ii-appendix-7-fppt-checklist.pdf (england.nhs.uk)

Appendix 7: FPPT checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First Name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second Name/Surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff Group	✓	x	✓	x – unless change	✓	✓		
Job Title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation Code	✓	x	✓	x – unless change	✓	✓		
Position Title	✓	x	✓	x – unless change	✓	✓		
Employment History Including: • job titles • organisation/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and Development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role
Last Appraisal and Date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Disciplinary Findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		
Type of DBS Disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS Received	✓	✓	✓	✓	✓	✓	ESR	
Date of Medical Clearance* (including confirmation of OHA)	✓	X	✓	x – unless change	✓	✓	Local arrangements	
Date of Professional Register Check (eg membership of professional bodies)	✓	X	✓	✓	✓	X	Eg NMC, GMC, accountancy bodies.	

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Insolvency Check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register Check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a Charity Trustee Check	✓	✓	✓	✓	✓	✓	Charities Commission	
Employment Tribunal Judgement Check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social Media Check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-Attestation Form Signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other Templates to be Completed								
Board Member Reference	✓	✓	X	X	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday whichever latest. Appendix 2 in Framework.
Letter of Confirmation	X	✓	✓	✓	✓	✓	Template	For joint appointments only - Appendix 4 in Framework.
Annual Submission Form	X	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director - Appendix 5 in Framework.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Meeting: Trust Board Meeting in Public

27 September 2023

Agenda item	Private Board Summary Report 26 July 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 26 July 2023.

The matters considered at this session of the Board were as follows:

- Data Security & Protection Toolkit (DSPT)
- Standards of Behaviour and Conduct Report
- Utilities Purchase Order Uplift
- Wycombe & Amersham Hospitals Infrastructure Project
- IT Business Case – Cyber
- Trainee Leadership Board 2022/23 Feedback

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 ☒

Relevant objective

☒ Improve waiting times ☒ Improve safety ☒ Improve productivity	☒ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☒ Upskill operational and clinical managers

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

27 September 2023

Agenda item	Guardian of Safe Working Hours – Annual Report
Board Lead	Bridget O'Kelly, Chief People Officer
Type name of Author	Nav Bahal, Guardian of Safe Working Hours
Attachments	None
Purpose	Assurance
Previously considered	SPC 10.07.2023

Executive Summary

This report has been provided to the Board as required by Schedule 6, Paragraph 4 of the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016 (Version 9).

This report summarises the progress made by the Trust in promoting a reporting culture amongst junior doctors. This paper sets out where concerns have been raised and the steps that have been taken.

- A higher number of Exception Reports and Immediate Safety Concerns were submitted compared to previous years
- CSRU was an outlier in the number of reports submitted – which has resulted in engagement with the affected departments to support the junior doctor workforce

The Strategic People Committee discussed this report at the meeting on 10 July 2023. The Committee asked for details about benchmarking, assurance that concerns were followed up (which they received) and more details about the breakdown by area and grade of doctor who raised concerns. This detail is included in this report.

Decision	The Board is requested to take assurance from the content of this report

Relevant Strategic Priority

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

Relevant objective

☐ Improve waiting times ☒ Improve safety ☐ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☐ Upskill operational and clinical managers

Implications / Impact

Patient Safety	No immediate concerns
Risk: link to Board Assurance Framework (BAF)/Risk Register	Principal Risk 6 – Failure to deliver our People priorities
Financial	No immediate concerns
Compliance NHS Regulation	The Trust is required to meet the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016
Partnership: consultation / communication	Liaising with rota co-ordinators, SDU leads, DME, FTSUG and Junior Doctor Forum. Promoting reporting culture amongst staff.
Equality	EDI data is shared in Appendix 1

Quality Impact Assessment [QIA] completion required?	n/a

1 Introduction

1.1 This report has been provided to the Board as required by Schedule 6, Paragraph 4 of the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016 (Version 9).

1.2 This report summarises the progress made by the Trust in promoting a reporting culture amongst junior doctors. This paper sets out where concerns have been raised and the steps that have been taken.

1.3 The total number of Doctors in Training in BHT (August 2022 intake) is set out in the table below:

Grade	Number
FY1	67
FY2	33
CT1-3/SHO	77
ST3+/SpR	38
Total	**215**

1.4 In the year 2022-23, 1058 exception reports were submitted.

Fiscal Year	Exception Reports	Immediate Safety Concerns
2022-23	**1058**	**84**
2021-22	503	24
2020-21	395	3
2019-20	458	15
2018-19	334	13
2017-18	446	10
2016-17* (Started in August 2016)	57	0

1.4.1 Exception Reports – By Grade of Doctor

Grade	Exception Reports
FY1	517
FY2	289
CT1-3/SHO	161
ST3+/SpR	91
Total	**1058**

1.4.2 Exception Reports – By Specialty
'General Medicine' is used for HealthRota reporting purposes, total is broken down by specialty.

Specialty	Exception Reports
Emergency Medicine	178
General Medicine	531
Acute Medicine	*22*
Amersham	*3*
BNRU	*4*
CSRU	*247*
Endocrine & Diabetes	*39*
Gastroenterology	*22*
MFOP	*55*
MuDAS	*18*
Respiratory	*43*
Rheumatology	*24*

On-call (Foundation Years)	*54*
General Surgery	130
Haematology	6
Obstetrics & Gynaecology	9
Paediatrics	113
Trauma & Orthopaedics	87
Urology	4
Total	**1058**

BNRU - Buckinghamshire Neurorehabilitation Unit; CSRU - Cardiac and Stroke Receiving Unit; MFOP – Medicine for Older People; MuDAS - Multi-disciplinary Day Assessment Unit

1.4.3 Exception Reports – By Type

Education Exception Reports are managed by the Director of Medical Education, the total is broken down below.

Type of Report	Exception Reports
Education	27
Missed Training Opportunities	*17*
Unable to complete WPBAs	*10*
Difference in Number of Hours Worked	942
Inadequate Support	17
Unable to take Breaks	72
Total	**1058**

WPBA – work-placed based assessment

1.5 Immediate Safety Concerns (ISCs)

This is a self-reported indication that there is an immediate and substantive risk to the safety or patients or of the doctor making the report. The threshold to submit such concerns is subjective.

1.5.1 Immediate Safety Concern – By Grade

Grade	ISCs
FY1	42
FY2	17
CT1-3/SHO	17
ST3+/SpR	8
Total	**84**

1.5.2 Immediate Safety Concerns – By Specialty

Specialty	ISCs
Emergency Medicine	12
General Medicine	43
Acute Medicine	*1*
Amersham	*0*
BNRU	*0*
CSRU	*7*
Endocrine & Diabetes	*6*
Gastroenterology	*0*
MFOP	*3*
MuDAS	*0*
Respiratory	*8*
Rheumatology	*5*
On-call (Foundation Years)	*13*
General Surgery	8
Haematology	0

Obstetrics & Gynaecology	0
Paediatrics	6
Trauma & Orthopaedics	15
Urology	0
Total	**84**

1.5.3 Immediate Safety Concerns – By Type

Type of Report	ISCs
Education	5
Missed Training Opportunities	*1*
Unable to complete WPBAs	*4*
Difference in Number of Hours Worked	60
Inadequate Support	14
Unable to take Breaks	5
Total	**84**

2 Detail

2.1 Exception Report Numbers

The number of Exception Reports submitted this year have more than doubled compared with the previous period. There were also a significantly higher number (as a proportion) of Immediate Safety Concerns.

The increased number of Reports is partly explained by increased engagement with reporting software (Doctors have moved to Healthrota which allows them to report using their rota app), and encouragement from various bodies (such as the Junior Doctors' Forum) to promote a reporting culture. There have also been reporting spikes in certain areas, namely Cardiac & Stroke Receiving Unit (CSRU), Obstetrics &Gynaecology and Trauma &Orthopaedics.

In addition, following a rota administration error in the department of General Surgery, it was agreed to use the Exception Reporting process to allow for individual correction which is demonstrated in the data. The affected doctors were given an explanation and an apology.

All Immediate Safety Concerns have been addressed with each doctor within their department.

2.2 Cardiac and Stroke Receiving Unit (CSRU) Exception Reports

CSRU was an outlier in number of Exception Reports submitted – with 247 reports in this year (with 7 ISCs). These were split as follows:
Cardiac – 111, Stroke – 136

CSRU – Grade	Exception Reports
FY1	169
FY2	32
CT1-3/SHO	43
ST3+/SpR	3
Total	**247**

CSRU – Type of Report	Exception Reports
Education	8
Missed Training Opportunities	*8*
Unable to complete WPBAs	*0*
Difference in Number of Hours Worked	213
Inadequate Support	5
Unable to take Breaks	21

Total	247

Engagement with the CSRU Doctors in Training and the Department have resulted in plans to improve working conditions in the department

3 Proposal, conclusions recommendations and next steps.

3.1 Exception Report Numbers
Future reporting periods will outline whether this number of reports is either an outlier or reflective of both the challenges and reporting culture of the Trust.

The Guardian of Safe Working Hours has raised the lack of regional and national benchmarking with NHS Employers and this issue will now be raised at the Guardian of Safe Working Hours Annual Conference in October 2023.

4 Action required from the Board/Committee

4.1 The Board is requested to:

a) Take assurance from the contents of this report.

APPENDICES

Appendix 1: EDI Data (August 2022 intake)

1.1 Working Pattern

Working Pattern	Number
Full Time	185
Less Than Full Time	30
Total	**215**

1.2 Gender Distribution

Gender	Number
Female	122
Male	93
Total	**215**

1.3 Ethnicity

Ethnic Origin	Number
Left Blank	38
A White - British	69
B White - Irish	<10
C White - Any other White background	11
E Mixed - White & Black African	<10
F Mixed - White & Asian	<10
G Mixed - Any other mixed background	<10
H Asian or Asian British - Indian	26
J Asian or Asian British - Pakistani	12
K Asian or Asian British - Bangladeshi	<10
L Asian or Asian British - Any other Asian background	11
M Black or Black British - Caribbean	<10
N Black or Black British - African	<10
R Chinese	10
S Any Other Ethnic Group	<10
SE Other Specified	<10
Z Not Stated	<10
Total	**215**

Meeting: Trust Board Meeting in Public

Date: 27 September 2023

Agenda item	Detailed Report – Actual and Deceased Organ Donation 1 April 2022 – 31 March 2023
EMC Lead	Mr Andrew McLaren
Author	Karen Davis / Dr Matthew Sames
Appendices	Appendix 1 – Explanation of abbreviations and specific terms used. Appendix 2 - Detailed Report – Actual and Deceased Organ Donation 1 April 2022 – 31 March 2023
Purpose	Information
Previously considered	BHT Organ and Tissue Donation Committee 222.05.2023 Q&CGC 20.09.2023

Executive summary

1. The Trust supported four deceased solid organ donors, which led to eight patients receiving a life-saving organ transplant. This meant that although we had one less proceeding organ donor this year, the same number of transplants happened.
2. In terms of tissue donation, we have seen an increase in referrals for tissue donation on both sites, sixty-five patients referred 2022 – 2023 compared to thirty-five patients referred in 2021-2022. Those patients referred this year resulted in eight corneal donors and one multi-tissue donor, again an increase on last year.
3. All of the patients who fulfilled the criteria to be referred from ICU or ED were referred to be assessed by the on call Specialist Nurse – Organ Donation (SNOD) or to the embedded SNOD within the Trust. Once again we had no missed referrals, one of the criteria measured within this Audit.
4. All of the conversations where families were formally approached for organ donation had a SNOD present, which supports Best Practice Guidelines.
5. We saw an increase in patients who had opted out of organ and tissue donation, either on the Organ Donor Register or verbally to their families. This reflects that more people are discussing this subject with their families which was the message promoted during last year's Organ Donation Week.

The Quality & Clinical Governance Committee reviewed this report on 20 September 2023 and commended the work of the team.

Decision	The Board is requested to continue supporting the ongoing role of Organ and Tissue Donation, and the embedded SNOD within Buckinghamshire Healthcare NHS Trust.

Relevant strategic priority

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

Relevant objective

☐ Improve waiting times ☒ Improve safety ☒ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☐ Improve the experience of our new starters ☐ Upskill operational and clinical managers

Implications / Impact

Patient Safety	Patient safety is embedded in the referral criteria.
Risk: link to Board Assurance Framework (BAF) or relevant Risk Register	There are no risks.
Financial	The Trust receives payment from NHS Blood and Transplant for each proceeding solid organ donor.
Compliance NHS Regulation	Organ and Tissue donation referral criteria is in line with the Academy of Medical Royal Colleges recommendations.
Partnership: consultation / communication	There is a close partnership working between NHS Blood and Transplant, South Central Organ Donation Services and the BHT Organ and Tissue Donation Committee.
Equality	Organ and Tissue donation suitability is measure by specific clinical criteria and no individual is disadvantaged because of their protected characteristics.
Quality Impact Assessment [QIA] completion required?	Not required for this paper.

1 Introduction/Position

1.1 During 22 – 23 we had four proceeding deceased solid organ donors leading to eight patients receiving a life-saving transplant.

1.2 Comparing this data in our region one comparable Trust had one deceased solid organ donor (one DBD donor), one Trust had six deceased solid organ donors (four DBD donors and two DCD donors) and another level three Trust, SEE APPENDIX 1, had one deceased solid organ donor (one DCD donor).

1.3 We have seen an increase in the number of patients referred for Tissue Donation which is really promising. We hope through promotional work and possibly teaching that by the end of the next financial year we will have seen a further increase in these numbers. We are fortunate in this Trust that we are able to retrieve multiple tissues on site due to geography/location of the Tissue Banks.

2 Problem

2.1 Throughout the year, we only had two family declines/unsupported Deemed Consents. One of these patients had opted out on the ODR and the family were aware of this decision. The other family decline was with a patient who had opted in on the ODR twenty years previously which the family were unaware of. Through further discussion with her next of kin, they identified that she had made this decision when she was a lot younger and prior to marriage, having children and expanding her spiritual faith. They were all sure that if she was asked again what her decision would be, the family

unanimously answered that she would say no. Lengthy discussions were had over a number of conversations.

2.2 One patient was not tested using the recommended Neurological Death Testing to confirm death, as per Academy of Medical Royal Colleges recommendations. These tests had been planned but were unable to be carried out due to the instability of the patient. This would be reflected in the narrative of the report which lists the reason for not testing.

3 Possibilities

3.1 We reviewed a case where a patient had opted in on the Organ Donor Register numerous times and the family were aware and raised organ and tissue donation during the Consultant discussion regarding futility of treatment and plans for withdrawal of life-sustaining surgery. He had been transferred to another centre for specialist surgery and had had a very prolonged ICU stay.

He was colonised with a number of multi drug resistant infections, which is a recognised risk of long ICU stays. Due to these infections this patient was declined on screening as a potential organ and tissue donor, as there would be too high a risk to the recipient who would be on immunosuppressant medication post transplant.

3.2 Each patient referred as a potential organ and tissue donor requires a thorough assessment of their current and past medical history, as well as social/behavioural and travel history to identify any potential risk of transferrable disease or infection. This can mean that we have to at times decline a patient but would carry out a rigorous assessment and also occasionally screen a patient with the transplant teams to see if they would accept an organ from the patient for one of their patients' on the transplant waiting list. This would not be due to a lack of resources, but safety reasons.

We would try to carry this out before approaching the family for organ donation as the approach and conversations are very time-consuming at a very traumatic time in a family's journey. If the patient has made a decision on the Organ Donor Register either to opt in or opt out, we would raise this with the family and explain why organ and tissue donation could not occur.

4 Proposal, conclusions recommendations and next steps.

4.1 To continue to share the messages around Organ and Tissue Donation with members of the Trust and the general public. We recognise that it is important to share the information and explore misconceptions with members of all faith groups in the community.

4.2 To continue highlighting to ED/ICU clinical staff the importance of early referral of patients where treatment has been deemed futile or when the unit are planning to carry out Neurological Death Testing to confirm brainstem death.

4.3 To continue to highlight the importance of not pre-mentioning organ donation to families early on in their ICU journey, particularly when referral criteria has not been achieved. It is seen that families need time to process the initial devastating news and pre-mentioning can be understandably viewed in a negative way by families. NHS Blood and Transplant (NHSBT) Best Practice Guidance recommends that this approach and discussion should be a collaborative process with the SNOD and the ICU Consultant, that it is timely and planned, as this increases consent rate and also the quality of support and information that is given.

4.4 To continue to identify ways of improving and supporting staff through the Organ Donation Process using a variety of methods including formal teaching, SIM study days and general promotion around organ and tissue donation.

5 Action required from the Board/Committee

5.1 The Committee / Board is requested to:

a) Continue their ongoing support of the work of Organ Donation and Transplantation with NHS Blood and Transplant and the embedded SNOD within the Trust.

APPENDICES
Appendix 1: Explanation of abbreviations and specific terms used.
Appendix 2: Detailed report

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2022 - 31 March 2023

Buckinghamshire Healthcare NHS Trust

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A.3 Table and figure description

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Trust metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2023 based on data meeting PDA criteria reported at 9 May 2023.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2022 and 31 March 2023, Buckinghamshire Healthcare NHS Trust had 4 deceased solid organ donors, resulting in 8 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2021/22. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

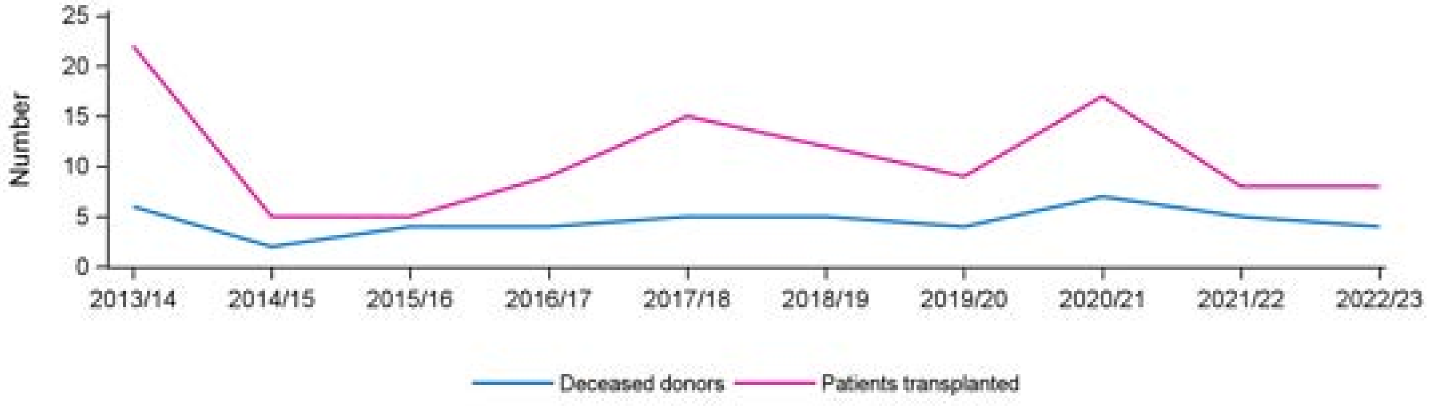
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		UK	
DBD	2	(3)	4	(6)	2.5	(3.3)	3.5	(3.4)
DCD	2	(2)	4	(2)	2.0	(3.0)	2.9	(2.7)
DBD and DCD	4	(5)	8	(8)	2.3	(3.2)	3.2	(3.1)

In addition to the 4 proceeding donors there was one additional consented donor that did not proceed, where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

	Number of organs transplanted by type											
Donor type	Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	2	(3)	1	(0)	2	(3)	0	(0)	0	(0)	0	(0)
DCD	4	(1)	0	(0)	0	(1)	0	(0)	0	(0)	0	(0)
DBD and DCD	6	(4)	1	(0)	2	(4)	0	(0)	0	(0)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2013 - 31 March 2023



2. Key Numbers in Potential for Organ Donation

A summary of the key numbers on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents key numbers in potential donation activity for Buckinghamshire Healthcare NHS Trust. This data is presented in Table 2.1 along with UK comparison data. Your Trust has been categorised as a level 3 Trust and therefore percentages in this section are only presented on a national level. A comparison between different level Trusts is available in the Additional Data and Figures section.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2021/22 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Table 2.1 Key numbers comparison with national rates, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	Trust	**UK**	**Trust**	**UK**	**Trust**	**UK**
Patients meeting organ donation referral criteria[1]	5	1980	21	5307	25	6910
Referred to Organ Donation Service	5	1965	21	4886	25	6482
Referral rate %		*99%*		*92%*		*94%*
Neurological death tested	4	1556				
Testing rate %		*79%*				
Eligible donors[2]	4	1439	13	3467	17	4906
Family approached	2	1244	4	1691	6	2935
Family approached and SNOD present	2	1190	4	1526	6	2716
% of approaches where SNOD present		*96%*		*90%*		*93%*
Consent ascertained	2	846	2	959	4	1805
Consent rate %		*68%*		*57%*		*61%*
- Expressed opt in	2	476	1	578	3	1054
- Expressed opt in %		*95%*		*84%*		*89%*
- Deemed Consent	0	284	1	306	1	590
- Deemed Consent %		*63%*		*52%*		*57%*
- Other*	0	86	0	74	0	160
- Other %*		*60%*		*38%*		*47%*
Actual donors (PDA data)	2	783	2	636	4	1419
% of consented donors that became actual donors		*93%*		*66%*		*79%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2018 - 31 March 2023

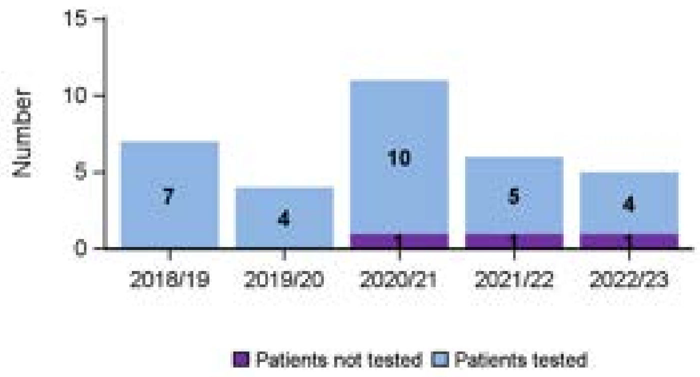


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2022 - 31 March 2023

	Trust	UK
Biochemical/endocrine abnormality	-	29
Clinical reason/Clinician's decision	-	62
Continuing effects of sedatives	-	6
Family declined donation	-	28
Family pressure not to test	-	48
Inability to test all reflexes	-	20
Medical contraindication to donation	-	5
Other	-	43
Patient had previously expressed a wish not to donate	-	2
Patient haemodynamically unstable	1	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	8
Treatment withdrawn	-	18
Unknown	-	3
Total	**1**	**424**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2018 - 31 March 2023

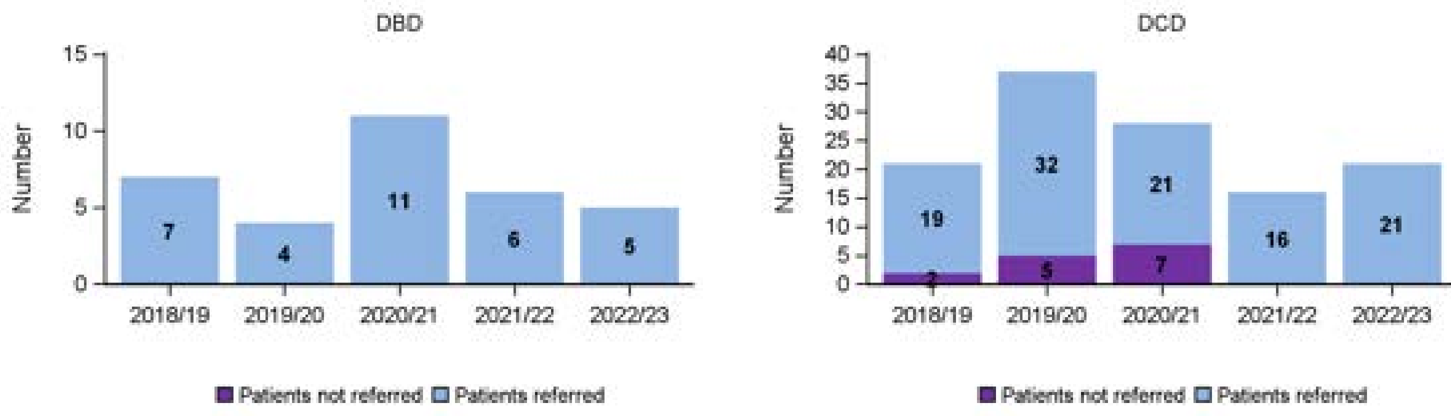


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Family declined donation following decision to remove treatment	-	1	-	15
Family declined donation prior to neurological testing	-	1	-	1
Medical contraindications	-	-	-	28
Not identified as potential donor/organ donation not considered	-	6	-	271
Other	-	-	-	27
Patient had previously expressed a wish not to donate	-	-	-	3
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	1	-	2
Thought to be medically unsuitable	-	1	-	53
Uncontrolled death pre referral trigger	-	5	-	16
Total	**-**	**15**	**-**	**421**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2022/23 there were 8 potential donors in your Trust with an ACI reported, 0 DBD and 8 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

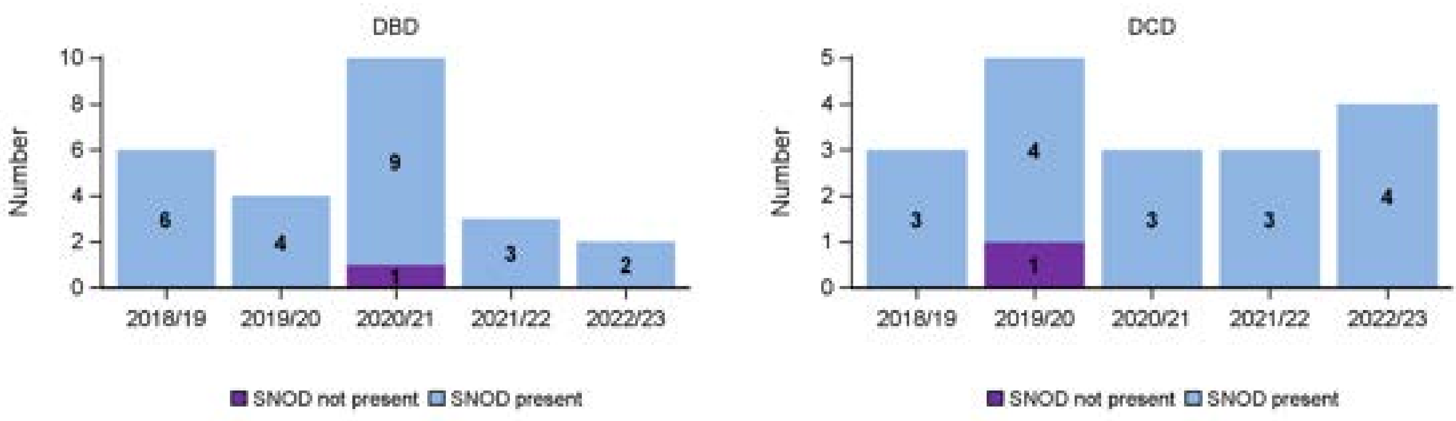
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2022/23, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 31% and 19%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 61%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2018 - 31 March 2023



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2023]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2023]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2023]

3.5 Consent

In 2022/23 less than 10 families of eligible donors were approached to discuss organ donation in your Trust therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2018 - 31 March 2023

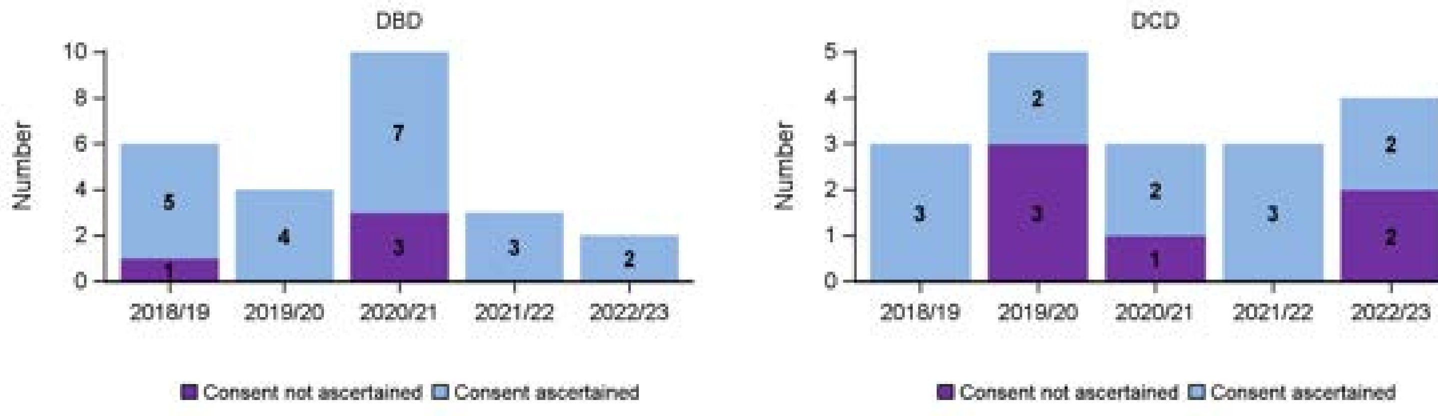


Table 3.3 Reasons given why consent was not ascertained, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family concerned donation may delay the funeral	-	2	-	1
Family concerned other people may disapprove/be offended	-	1	-	2
Family concerned that organs may not be transplantable	-	1	-	7
Family did not believe in donation	-	4	-	12
Family did not want surgery to the body	-	38	-	51
Family divided over the decision	-	21	-	18
Family felt it was against their religious/cultural beliefs	-	40	-	24
Family felt patient had suffered enough	-	22	-	62
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	20	-	13
Family felt the length of time for the donation process was too long	-	17	-	126
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	2	-	16
Family were not sure whether the patient would have agreed to donation	-	44	1	90
Other	-	22	-	73
Patient had previously expressed a wish not to donate	-	121	1	175
Patient had registered a decision to Opt Out	-	22	-	31
Strong refusal - probing not appropriate	-	17	-	31
Total	**-**	**398**	**2**	**732**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	-	10	-	8
Clinical - Cardiac arrest during referral	-	2	-	-
Clinical - Considered high risk donor	-	7	-	8
Clinical - DCD clinical exclusion	-	-	-	1
Clinical - No transplantable organ	-	6	-	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	10	-	51
Clinical - Organs deemed medically unsuitable on surgical inspection	-	7	-	3
Clinical - Other	-	3	-	10
Clinical - PTA post WLST	-	-	-	165
Clinical - Patient actively dying	-	4	-	19
Clinical - Patient asystolic	-	1	-	-
Clinical - Patient’s general medical condition	-	2	-	3
Clinical - Positive virology	-	1	-	3
Clinical - Predicted PTA therefore not attended	-	-	-	3
Consent / Auth - Coroner/Procurator fiscal refusal	-	5	-	10
Consent / Auth - NOK withdraw consent / authorisation	-	5	-	24
Logistical - Other	-	-	-	3
Total	**-**	**63**	**-**	**323**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 4.1 and 4.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 4.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Aylesbury, Stoke Mandeville Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	3	2	-	3	-	2	2	2	2	-	2	-	2
Other, please specify	0	0	-	0	-	0	0	0	0	-	0	-	0
Wycombe, Wycombe General Hospital													
General ICU/HDU	2	2	-	2	-	2	2	0	0	-	0	-	0
Other, please specify	0	0	-	0	-	0	0	0	0	-	0	-	0

Table 4.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Aylesbury, Stoke Mandeville Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	15	15	100	15	11	3	3	-	1	-	1
Other, please specify	3	3	-	3	1	0	0	-	0	-	0
Wycombe, Wycombe General Hospital											
General ICU/HDU	2	2	-	2	1	1	1	-	1	-	1
Other, please specify	1	1	-	1	0	0	0	-	0	-	0

Tables 4.1 and 4.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Buckinghamshire Healthcare NHS Trust in 2022/23 there were 0 such patients. For more information regarding the Emergency Department please see Section 5.

5. Emergency Department data

A summary of key numbers for Emergency Departments

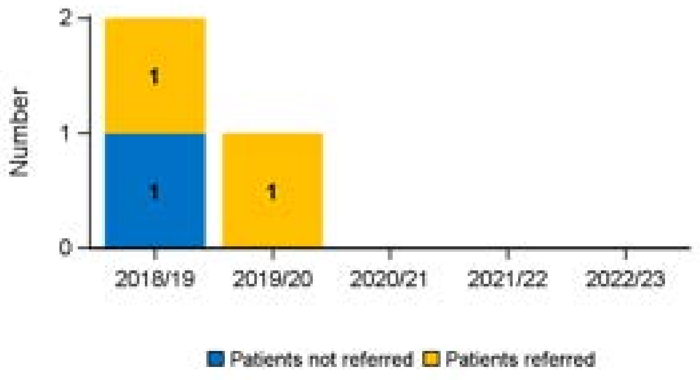
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

5.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

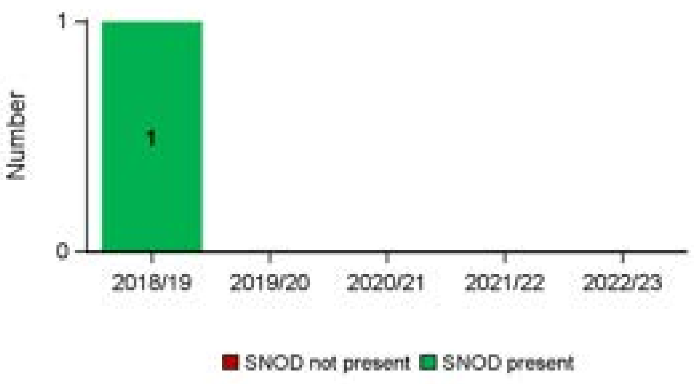
Figure 5.1 Number of patients meeting referral criteria that died in the ED, 1 April 2018 - 31 March 2023



5.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 5.2 Number of families approached in ED by SNOD presence, 1 April 2018 - 31 March 2023



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 9 May 2023]

6. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

6.1 Supplementary Regional data

Table 6.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South Central*	UK
1 April 2022 - 31 March 2023		
Deceased donors	115	1,429
Transplants from deceased donors	221	3,589
Deaths on the transplant list	20	441
As at 31 March 2023		
Active transplant list	416	6,959
Number of NHS ODR opt-in registrations (% registered)**	2,052,176 (48%)	28,567,574 (44%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 4.32 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

6.2 Trust/Board Level Benchmarking

Buckinghamshire Healthcare NHS Trust has been categorised as a level 3 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 6.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 6.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more ($\geq$ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 ($\geq$ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less ($\leq$ 3) proceeding donors per year	41

Tables 6.3 and 6.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 6.3 National DBD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	5	4	-	5	-	4	4	2	2	-	2	-	2
Level 1	1133	896	79	1124	99	879	831	714	677	95	474	66	438
Level 2	441	340	77	439	100	331	307	267	259	97	182	68	171
Level 3	287	229	80	283	99	224	216	188	184	98	135	72	124
Level 4	119	91	76	119	100	90	85	75	70	93	55	73	50

Table 6.4 National DCD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	21	21	100	21	13	4	4	-	2	-	2
Level 1	2564	2370	92	2464	1772	941	856	91	537	57	369
Level 2	1346	1239	92	1313	841	373	333	89	209	56	132
Level 3	979	910	93	944	571	269	241	90	155	58	97
Level 4	418	367	88	408	283	108	96	89	58	54	38

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient’s organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key numbers in potential for organ donation	
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Appendix A.1 gives a fuller explanation of terms used.

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.
Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 PDA data by hospital and unit	
Table 4.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 4.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

5 Emergency department data	
Figure 5.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 5.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

6 Additional data and figures	
Table 6.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 6.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 6.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 6.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.

Appendix 1: Explanation of abbreviations and specific terms used.

Specialist Nurse Organ Donation (SN-OD) – A Specialist Nurse who is employed by NHS Blood and Transplant supporting Trust staff in the facilitation of the Organ Donation Process. An embedded SN-OD is based within the Trust to carry out teaching, staff support, auditing referrals and working with the Trust Organ Donation Committee

Specialist Requester – A SN-OD who has had additional training in the family approach, collaborative discussion and consent process. They are usually mobilised first to a potential Organ Donor to support Trust staff and start the on-site.

Clinical Lead for Organ Donation (CLOD) - This is an ICU Consultant who works with the embedded SNOD and of behalf on NHS Blood and Transplant to support and facilitate organ donation within the Trust.

DBD – Donation after Brainstem Death. This is a patient who meets all four criteria for Neurological Death Testing to be performed. This tests are used to confirm that a patient has legally died, allowing the patient to be taken to theatre with the ventilator attached and their heart still beating, thus improving the outcome for the recipient as there is less time without oxygen to damage the transplantable organs.

DCD – Donation after Circulatory Death. This refers to the patients who are receiving assisted ventilation and cannot be confirmed dead using Neurological Criteria as the function of the brainstem is still intact. However, a clinical decision has been made by the ICU team to withdraw treatment and death of the patient is anticipated within a time frame to allow Organ Donation to occur.

Neurological Death Testing (NDT)– These tests are used to confirm death when a patient meets all of the following criteria: Apnoea, coma from known cause and unresponsive, ventilated and with fixed pupils (no response to light). The tests look at whether the brainstem reflexes are absent confirming brainstem death. These tests are completed by two clinicians, either two ICU Consultants or one ICU Consultant and one senior ICU Registrar.

Referral Criteria – These are criteria to guide ED and ICU staff as to whether to refer the patient as a potential Organ Donor to SN-OD. These are patients with severe brain injury where:

 One or more cranial nerve reflexes is absent and the Glasgow Coma Score is 4 or less and cannot be explained by sedation, or

- A decision has been made to perform Neurological Death Tests

Alternatively, patients for whom a decision has been made to withdraw life-sustaining treatment.

Absolute Medical Contraindications – These include specific medical conditions, some types of cancers, in particular active cancers with evidence of spread and active haematological malignancies and other severe infections, including being symptomatic corona virus infection without recovery. There are age limits but these only exclude people over 85 years as Organ Donors. These are the initial questions we ask when we take a referral.

Potential Donor Audit – This is carried out by the embedded SNOD auditing all deaths in ED and ICU to identify whether there were any potential organ donors that weren't referred. There is often an easily identifiable cause for them and this may lead to further teaching to address knowledge gaps or misunderstandings.

Why are ED numbers smaller? – Patients who are identified as those who have severe head injuries, following an intracerebral bleed, hypoxic brain damage following cardiac arrest. These patients are those who are generally admitted to ICU for a period of prognostication to see if there is any clinical improvement before decisions are made regarding End of Life Care.

Why is consent not always gained from relatives? – Often this relates to either knowing that the patient did not want to be an Organ Donor from previous discussions when they were alive, or from misconceptions around Organ Donation, including cultural and religious reasons, which we would always explore with the family. We accept that Organ Donation isn't right for all families and respect their decision. However, some relatives decline donation because they just didn't know what their loved one's decision would have been. The Deemed Consent Act (2020) is proving helpful in these situations as we can explain that if their loved one did not register their decision either to Opt In or Opt Out on the Organ Donor Register, we would assume that they had no objection to becoming an Organ Donor, therefore taking some of the responsibility away from bereaved relatives.

What is meant by the Levels of Trusts?

Level 1 12 or more (≥ 12) proceeding donors per year

Level 2 6 or more but less than 12 (≥ 6 to <12) proceeding donors per year

Level 3 More than 3 but less than 6 (>3 to <6) proceeding donors per year (Buckinghamshire NHS Trust falls into this category)

Level 4 3 or less (≤ 3) proceeding donors per year

Meeting: Trust Board Meeting in Public

Date: 27 September 2023

Agenda item	Infection Prevention and Control Annual Report 22-23
Board Lead	Karen Bonner, Chief Nurse, and Director of Infection Prevention & Control
Author	Jo Shackleton Hannah Bysouth Head of Nursing IPC
Appendices	Infection Prevention and Control Annual Report 22-23
Purpose	Information
Previously considered	IPCC 20.07.2023 EMC 08.08.2023 Q&CGC 16.08.2023

Executive summary

This report is being presented for information to describe the actions that have been taken to prevent Healthcare Associated Infections (HCAI) in Buckinghamshire Healthcare NHS Trust (BHT) for the reporting period of April 2022 to the end of March 2023 and has been reviewed and assurance received by the Infection Control Committee (IPCC).

The content of the Annual Report highlights the organisation's progress against national legislative assurance tools and related infection prevention guidance from other national bodies. It assures that the necessary actions have been in place to deliver the IPC Board Assurance Framework (BAF), which is set against the 10 criteria of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections, to prevent Healthcare Associated Infections (HCAI) in BHT and identifies areas of focus for the financial year 2023/24.

During 2022-23, BHT has faced significant challenges such as high bed occupancy, repeated COVID-19 outbreaks, and critical incident. These factors can increase the risk of infection transmission within the organisation. However, BHT has responded effectively by fostering close collaboration between teams to ensure the safest possible care. The IPC team played a crucial role in this response and is proud of the service provided over the past year. Unfortunately, there has been an increase in MRSA bacteraemia in BHT and in response, we have led detailed reviews of cases and shared learning at all levels of the organisation. However, these incidents have all been controlled effectively, to prevent continued patient harm with urgency to prevent continued harm to our patients.

This winter has seen a high number of influenza and COVID-19 infections, resulting in many outbreaks. As a result, IPC work has been demanding, requiring daily support to assess IPC risks, implement IPC guidance, and manage outbreaks. Unfortunately, this level of support has hindered our ability to focus on more reflective and proactive work. C. difficile ward rounds have continued to be undertaken, proving beneficial from a clinical and IPC perspective.

It is acknowledged that our current compliance with IPC BAF is lower than we would expect it to be. For example, lack of isolation facilities, a lack of capacity to allow for appropriate placement of patients, IPC guidance not accessible on the intranet, no mandatory surveillance for surgical site infection and implementation of the national cleaning standards 2021. The IPC Board Assurance Framework will ensure that all exceptions are addressed and gaps in compliance are promptly acted on. This will be presented and monitored at the quarterly Infection Prevention Control Committee.

The report acknowledges colleagues' hard work in enhancing patient care and mitigating infection risks. However, it also shows that the Trust has yet to achieve the key priority one patient safety. Notably, the goal of zero MRSA bacteraemia still needs to be met, and the number of nosocomial infections associated with Covid-19 decreased compared to 2021/22. There will be ongoing commitment during 23-24 to reducing HCAI.

On 8 August 2023 the Executive Management Committee noted the report. The Quality & Clinical Governance Committee also noted the report on 16 August 2023. Both groups recognised the imminent staffing changes within the team.

Decision	The Committee are asked to receive the IPC Annual Report as information and support the areas of focus for the financial year 2023-24.		
Relevant strategic priority			
Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☐
Relevant objective			
☐ Improve waiting times ☐ Improve safety ☐ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☐ Improve the experience of our new starters ☐ Upskill operational and clinical managers	

Implications / Impact	
Patient Safety	Healthcare-associated infection prevention is the cornerstone of patient safety. Infection Prevention & Control Risk - We will manage the risks related to infection prevention and control to reduce the transmission of infection in our hospitals.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards The Infection Prevention and Control Committee oversees the Trust's IPC programme, reporting to the Quality Clinical Committee. The Trust continue to operate within a level of risk for Healthcare Associated Infection.
Financial	It is accepted that Hospital acquired infection carries both a human and financial cost. There are no financial implications resulting from this paper.
Compliance Select an item. Select CQC standard from list.	Health and Social Care Act 2008 Care Quality Commission Guidance from Public Health England and NHSE CQC IPC Board Assurance Framework
Partnership: consultation / communication	This report is developed by the Infection Prevention and Control Team. Review, assurance and actions where agreed are undertaken at Trust and Divisional level where required and monitored through the various boards and committees The report will be made publicly available once approved by the Trust Board. Shared with the ICB and broader system, Care Quality Commission.
Equality	Patients with known or potential infection risks are equally entitled to treatment. IPC measures to support their safe management should be in place to support. COVID-19 has been found to disproportionally impact individuals from BAME communities, men and people over 50 This is not a new proposal as such and the paper documents process in line with Public Health England, NHSE and Trust HR guidance
Quality Impact Assessment [QIA] completion required?	No

Infection Prevention and Control (IPC) Annual Report

1st April 2022 - 31st March 2023

Infection Prevention Control
Annual Report 2022/23

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Introduction and Forward

I am pleased to present my third annual report on infection prevention and control (IPC) for Buckinghamshire Healthcare NHS Trust (BHT). Working with a dedicated and hardworking team who have received support from colleagues across the organisation has been a privilege. Working together, we have followed national guidance and best practices to achieve high infection prevention and control standards.

Despite the challenges faced over the past year, we can report that the Trust has made progress in reducing cases of Clostridiodes difficle (C.*difficile*). Our clinical teams have collaborated to improve antimicrobial stewardship, appropriate sampling, and patient placement. As we move to live with COVID-19, we aim to provide safe and efficient care with an emphasis on hand hygiene, personal protective equipment, cleanliness, and other infection prevention and control measures has been essential.

The vaccination program at BHT has played a vital role in managing the COVID-19 pandemic, and we are pleased to report that our colleagues have achieved a 59.5% uptake for the flu vaccine and 57.3% for the COVID-19 vaccine. BHT is the second highest among the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System (ICS). This success is due to the hard work of our vaccine team.

Karen Bonner
Chief Nurse, Director of Infection Prevention Control

Infection Prevention Control Annual Report 2022/23

1. National Guidance and Key Legislation

This Annual Report follows the format of the Code of Practice (known as the Hygiene Code 2015), as required by the Health & Social Care Act (2008) and demonstrates the Trust's compliance with the requirements of the Hygiene Code. The yearly report confirms compliance and outlines our goals and strategies for improving infection prevention in 2023/24.

2. Criterion 1: Systems to manage and monitor the prevention and control of infection.

These systems should use risk assessments to assess how susceptible service users are and any risks their environment and other service users may pose.

2.1 Governance and Monitoring

In May 2020, NHS England released an IPC Board Assurance Framework (BAF) to assist healthcare providers in conducting self-assessments of their compliance with national IPC guidelines. The framework also helps identify risks and serves as an internal assurance to uphold quality standards.

The IPC BAF offers a comprehensive overview of our adherence to the Code of Practice standards, outlining our accomplishments in the past year (2022/23) and identifying areas for improvement in the upcoming year (2023/24).

Upon review of the key lines of enquiry, it was determined that there are specific areas for further action to enhance assurance. The Trust's IPC Committee (IPCC) regularly monitors the IPC BAF and provides quarterly updates. Progress updates are shared through IPC reporting to the Trust's Quality & Clinical Governance and Executive Management Committees.

2.2 Infection Prevention Control Team (IPCT)

The IPC service is a multidisciplinary team comprised of specialist medical, antimicrobial pharmacy and nursing professionals. The IPCT is a team of specialist nurses with administrative support.

The Chief Executive Officer (CEO) is responsible for Infection Prevention at BHT. The Chief Nurse is the designated Executive Lead and Director of Infection Prevention and Control (DIPC), reporting directly to the Trust Board.

The DIPC collaborates closely with the Heads of Nursing for Infection Prevention and Control and the Infection Control Doctor (ICD), a Consultant Medical Microbiologist for the Trust. The IPC Team offers specialised knowledge and expertise in infection prevention and control to all services within the Trust.

In March 2021, the financial arrangement of the IPCT team underwent review, which resulted in an assessment of its establishment. Despite recruitment efforts, the Integrated Care Board (formerly CCG) Band 7 position has not been fulfilled since September. Additionally, the recently formed Integrated Care Board (ICB) has announced that it will withdraw funding from the IPCT.

IPCT currently consists of:

- Head of Nursing Infection Prevention and Control/ Deputy Director of Infection Control: (1.6 WTE) (until 1st April, then 1.2 WTE)
- Matron IPC (1WTE) Band 8a

- Infection Prevention & Control Nurse Specialist: (2 WTE) Band 7
- Infection Prevention & Control Nurse Specialist: (3 WTE) Band 6
- The Infection Control Doctor (0.2 WTE)
- Infection Prevention & Control Administrator (1 WTE)

The Outpatient Patient Antimicrobial Therapy (OPAT) team transitioned from the Integrated and Elderly Care division to the Corporate division in October 2022, with the Heads of Nursing for IPC assuming line management responsibilities.

The Trust employs antimicrobial pharmacists who work closely with the Antimicrobial Stewardship Lead, the Infection Control Doctor, and other members of the IPC team. There is robust management of antimicrobial stewardship throughout the Trust.

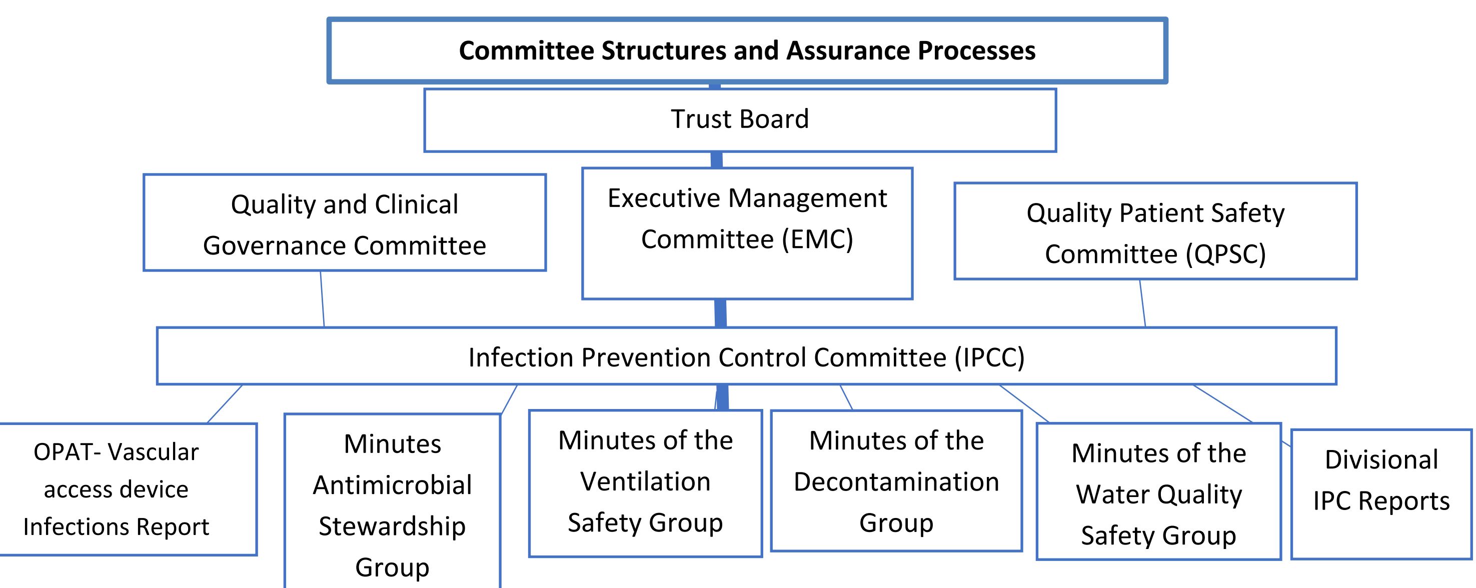
In November 2022, the IPC Link Practitioner group was relaunched to offer guidance and assistance and share information on IPC with colleagues in their respective wards/departments. Unfortunately, IPC lacks the resources to sustain ongoing support for the Link Programme. Redevelopment of the network is expected to occur in 2023/24.

2.3 Committee Structures and Assurance Processes

2.3.1 Infection Prevention and Control Committee (IPCC)

The Trust IPCC is chaired by the DIPC and held quarterly with representatives from all divisions and critical service areas. The committee structure for infection, prevention and control reporting is shown in Figure 1.

Figure 1 IPC Governance Structure and Assurance Process 2022/23



IPCT provides a monthly report on performance, good practice and concerns to the divisions that use the reports to create action plans presented to IPCC. The IPCT provide quarterly reports to the Executive Management Committee (EMC) and the Quality Clinical and Governance Committee (QCGC), which reports directly to Trust Board—attended by the DIPC. In addition, during the year, weekly reports to EMC on performance related to COVID-19 have been provided as requested.

2.3.2 Trust Board

The Trust Board must collectively agree upon and recognise its IPC responsibilities per the Code of Practice. At BHT, the CEO is responsible for infection prevention control. Moreover, the Trust has appointed the Chief Nurse as the Director of Infection Prevention and Control (DIPC). The DIPC is responsible for attending Trust Board meetings and providing comprehensive updates on infection prevent infection prevention and control updates.

2.3.3 Quality Clinical and Governance Committee (QCGC)

The QCGC is a sub-committee of the Trust Board and is the committee with overarching responsibility for managing organisational quality risks. The committee reviews high-level performance data about infection prevention and control, monitors compliance with statutory obligations, and oversees the management of the risks associated with infection prevention and control. QCGC is responsible for ensuring that there are processes for ensuring patient safety and continuous monitoring and improvement of infection prevention. IPC performance is reported monthly through the IPC Performance Dashboard to QCGC. The IPC team provides a monthly report on surveillance and outbreaks, which is reported to the IPC Committee and monthly to QCGC via the IPC Report.

2.3.4 CQC Assessment/ Infection Prevention Board Assurance Framework

The IPC Board Assurance Framework (BAF) was developed nationally to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. The framework offers providers a way to continually review processes and respond evidence-based to maintain the safety of patients, service users and colleagues. The Trust adopted the BAF in 2021. Further versions of the BAF were released in April 2023, containing revised key lines of enquiry (KLOE) to include the formation of ICBs.

2.4 Mandatory Surveillance of Healthcare-associated Infections to UK Health Security Agency (UKHSA).

The following organisms are subject to NHS England (NHSE) mandatory reporting: Methicillin-resistant Staphylococcus aureus bacteraemia (MRSA), Methicillin-sensitive Staphylococcus aureus bacteraemia (MSSA), C.difficle, and Gram-negative bloodstream infections (GNBSI) (these include Escherichia coli (E.coli), Klebsiella species, Pseudomonas aeruginosa).

Trust level thresholds include all healthcare-associated cases (i.e., Hospital Onset Healthcare Associated and Community Onset Healthcare Associated). Trusts are required to reduce healthcare-associated infection rates (HCAI) under the thresholds set by NHS England and NHS Improvement.

The threshold for 2022/23 was worked out on the previous year's cases up to November 2021.

- C.difficile infection (CDI) - if the number of cases were 10 or less, the threshold would equal that count. For all others, the threshold was reduced by 1.
- GNBSIs – For E. coli, Klebsiella and Pseudomonas, if the number of cases were 10 or less, the threshold would equal that count. For all others, the point would be reduced by 5%
- MRSA – not specified in the contract, but to remain at zero tolerance

BHT continues to comply with all internal reporting requirements. The Executive Management Committee (EMC) and Quality Clinical Governance Committees (QCGC) receive monthly updates via Integrated Performance Review reports and quarterly via the IPC Quarter report –

Figure 2 BHT HCAI (YTD) Cases

Healthcare-associated cases (Community onset Healthcare Associated + Hospital onset Healthcare-associated)	Totals 2022/23	% Threshold
Clostridioides difficile Infections	47	87%
MRSA Bacteraemia	3	300%
MSSA Bacteraemia	21	N/A
E-coli Bacteraemia	64	79%
Pseudomonas Aeruginosa	24	240%
Klebsiella spp	37	108%
CPE Bacteraemia	0	N/A
VRE Bacteraemia	0	N/A

2.4.1 Definitions

Hospital onset healthcare-associated (HOHA): cases where specimen date is >3 days after current admission (where the day of admission is 1)
Community onset healthcare associated (COHA): cases that occur in the community (or < 3 days after admission) when the patient has been an inpatient in the Trust reporting the case in the previous 28 days.

2.4.2 Healthcare-associated infection (HCAI) investigations

The IPCT conducts an in-depth Root Cause Analysis (RCA) in collaboration with the patient's multidisciplinary team to investigate all mandatory reportable HCAIs. RCAs are conducted regularly to identify best practices and areas for improvement. Post-infection reviews (PIR) are also conducted when necessary to identify any areas for learning. The Divisional Quality Boards have all been requested to develop and oversee an action plan to prevent HCAI.

2.4.3 Clostridium difficile

In the year 2022/23, the goal was to keep the cases of C. difficile under 54. However, this threshold has been exceeded as there were only 47 recorded cases.

Work continues to reduce the cases of C difficile, which relies upon appropriate antibiotic prescribing and advice, the earliest detection of possible C.difficile cases and prompt isolation of patients with diarrhoea. The IPC continues to conduct weekly C.difficile multidisciplinary rounds with ICD, antimicrobial pharmacist and clinical staff to review antimicrobial treatment and provides feedback to the relevant area and lead clinician. During Quarter 2, cases appeared to increase, and a multidisciplinary working group was set up.

Figure 3 BHT C. Difficile (YTD) Cases

Table	2020/21	2021/22	2022/23
Total C Difficile	36	56	47
HOHA (Hospital Onset Healthcare Associated)	29	47	31
COHA Community Onset Healthcare Associated)	7	9	16

2.4.4 Gram-Positive Blood Stream Infections (GPBSI)

Figure 4 BHT Number of Cases of GPBSI by Organism HOHA (Hospital Onset Healthcare Associated) COHA Community Onset Healthcare Associated)

	2020-2021	2021/2022	2022/2023
MRSA	**1**	**1**	**3**
Attributed to the Trust due to lapse in Care			**1**
MSSA	**23**	**33**	**21**

2.4.5 Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia

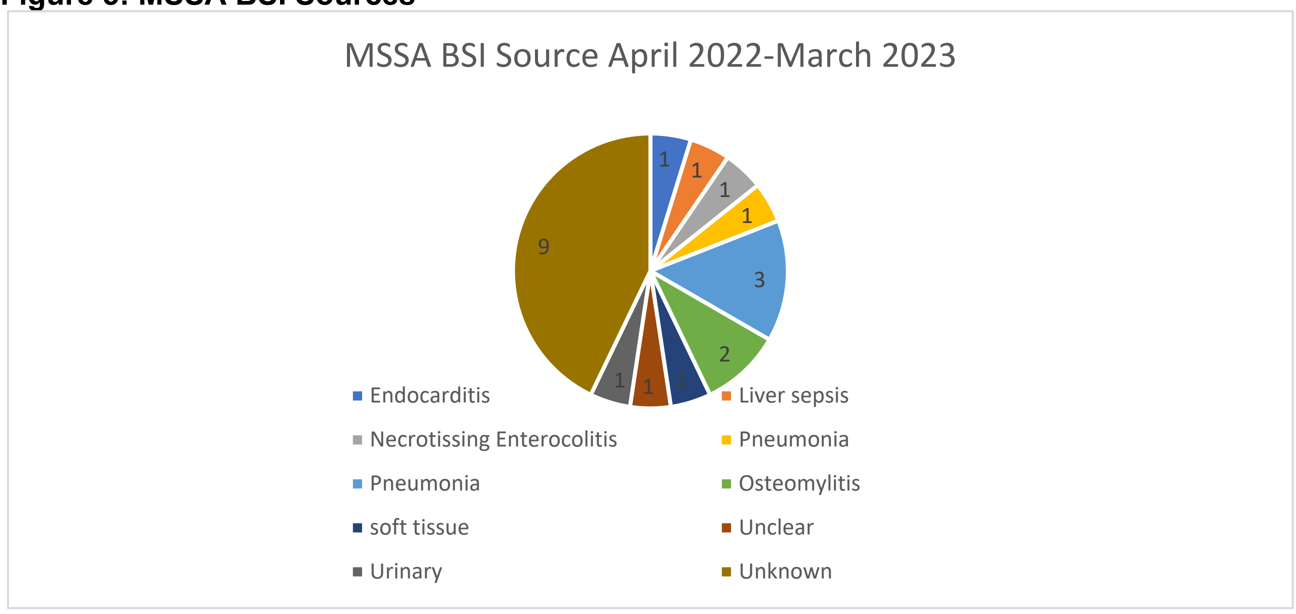
Although the bloodstream threshold was set at zero. Unfortunately, three cases of MRSA bloodstream infection were identified. To address this, post-infection reviews (PIR) were conducted to analyse the patients' journey and clinical practices. After investigation, two of the cases were found to be caused by a contaminant source. Areas of improvement were identified, including administering MRSA suppression therapy, prescribing chlorhexidine hair wash, providing patient information, and improving the ongoing care of invasive devices. Learning identified is shared with the clinical team and the wider organisation. A policy for the Management of MRSA and MSSA has been developed and will be implemented from April 2023, bringing us in line with national guidance and addressing the issues we identified.

2.4.6 Methicillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia

21 MSSA bacteraemia cases were apportioned to the Trust for 2022/23. The Trust does not have a formal threshold for reducing MSSA bacteraemia cases; however, we strive to minimise preventable infections. All cases undergo a PIR. The bloodstream infection cases have been associated with the following sources of infection:

- skin and soft tissue infections
- peripherally inserted central catheter (PICC) line infection
- peripheral cannula
- discitis and pyelonephritis

Figure 5: MSSA BSI Sources



2.4.7 Gram-Negative Blood Stream Infections (GNBSI)

Figure 6 BHT Number of Cases of GNBSI by Organism

	2020/21 Hospital Onset Healthcare Associated	**2021/22** Hospital Onset Healthcare-Associated (HOHA) Community Onset Healthcare-Associated (COHA)	**2022/23** Hospital Onset Healthcare-Associated (HOHA) Community Onset Healthcare-Associated (COHA)
E. coli	**32**	**85**	**64**
Klebsiella	**22**	**36**	**37**
Pseudomonas aeruginosa	**8**	**7**	**24**
TOTAL	**62**	**62**	**125**

The year-to-date totals for GNBSI are E. coli 83 (79% of threshold), Pseudomonas aeruginosa 24 (240% of threshold) and Klebsiella sp. 37 (108% of threshold). In response to the high prevalence of Pseudomonas blood stream infections in Quarter 2, a review of the cases was completed, and the Head of Nursing for IPC presented the findings and recommendations to UKHSA. No further action was required with the UKHSA being satisfied with the robust process for reviewing of HCAIs and the proposed approach to reducing all Healthcare Associated–GNBSIs in adults. This included setting up a trust-wide working group led by the Consultant Microbiologist Infection Control Doctor to establish initiatives to reduce GNBSIs and consider trajectories to measure progress. Initiatives are planned to minimise GNBSIs, mainly by preventing urinary tract infections (UTIs) and catheter-associated urinary tract infections. (CAUTI). We continue to focus on reducing the incidence of Pseudomonas BSI with initiatives including optimal antimicrobial stewardship (focusing specifically on using the right choice of antibiotics and duration), rehydration of inpatients, and optimised urinary catheter care).

Figure 7: Pseudomonas aeruginosa BSI Sources

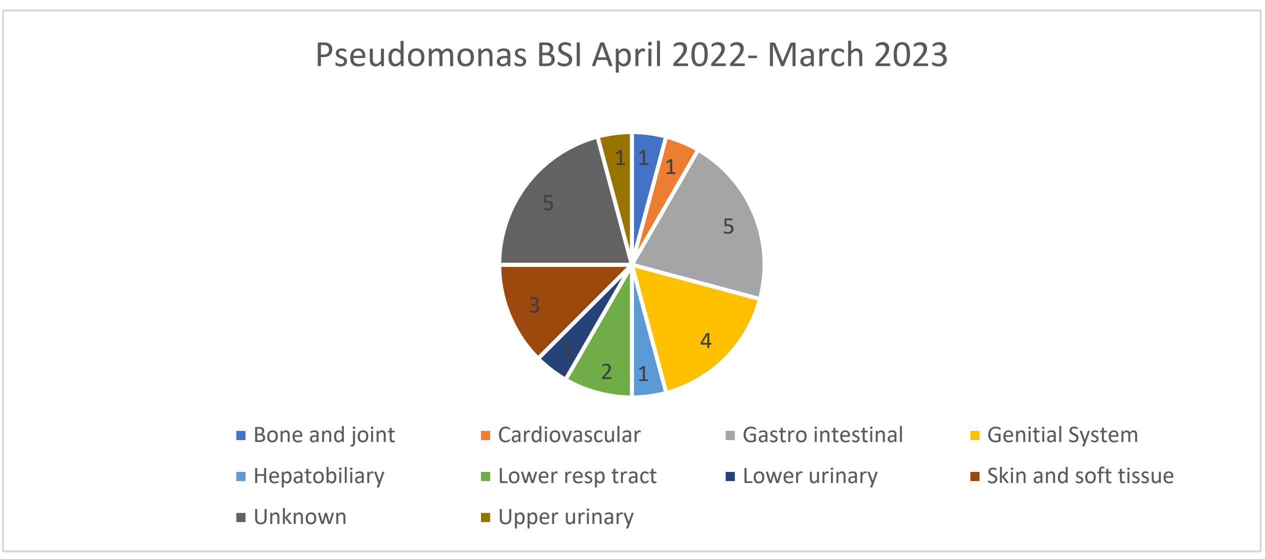


Figure 8: Klebsiella bacteraemia BSI Sources

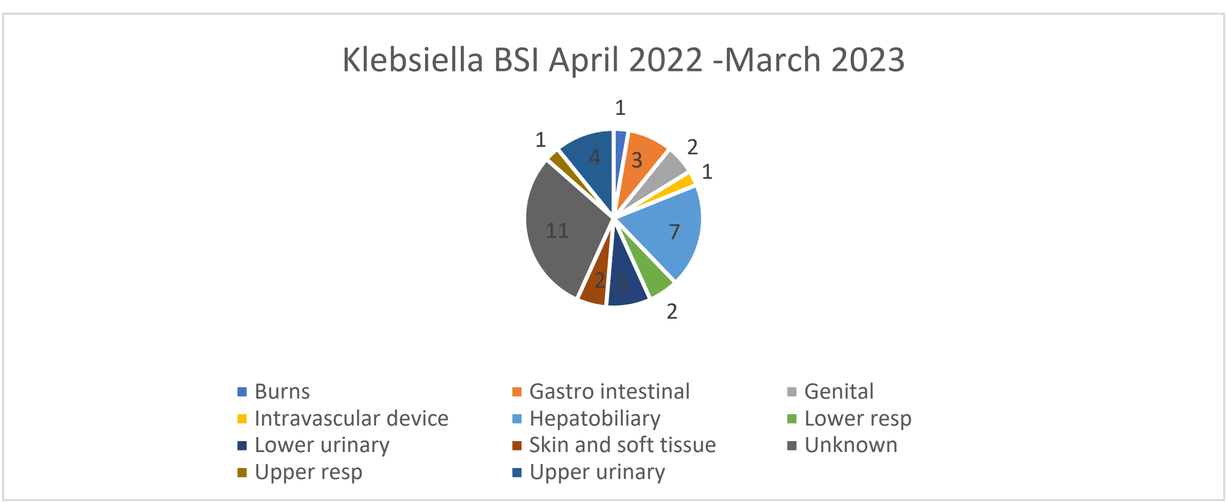
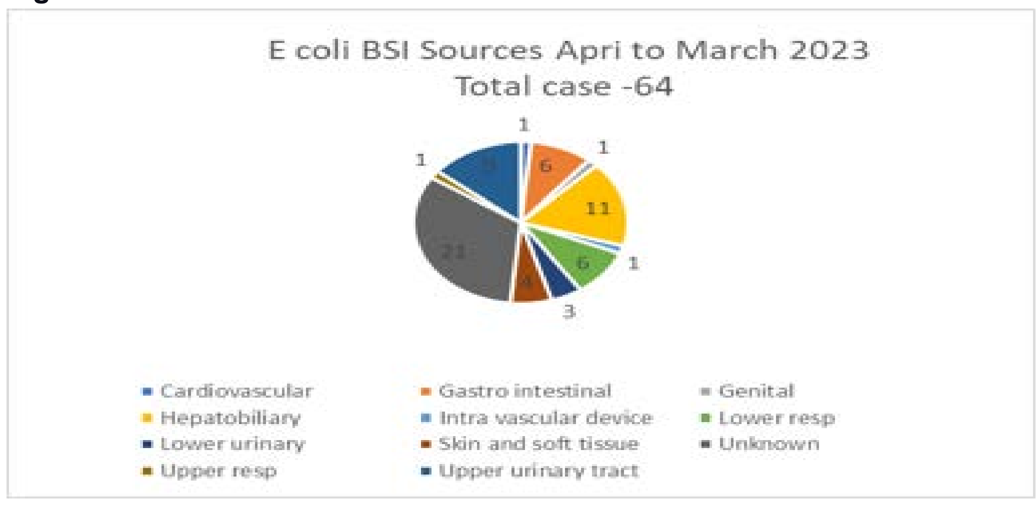


Figure 9: Escherichia Coli BSI Sources



2.5 Living With COVID-19

In May of 2022, the UK Health Security Agency (UKHSA) issued new COVID-19 guidelines to aid local decision-making on mask use and distancing as part of the reset and rebuild programme. However, in June, BHT removed masks for colleagues, patients, and visitors. Unfortunately, masks had to be reintroduced due to a significant increase in COVID cases within the community and hospital. The safe visiting guidance was updated and returned to pre-pandemic standards, while a revised infection risk screening template was introduced. Furthermore, COVID patient pathways have been adjusted to align with pre-COVID practices, and a winter planning process has been developed to guide patient placement, IPC precautions, and Personal Protective Equipment (PPE). Lateral flow testing for all colleagues was still supported, and successfully identified asymptomatic colleagues who tested positive.

2.5.1 Challenges of Living with COVID-19

The ongoing challenges of managing COVID-19 have significantly impacted the IPCT service. Although BHT has been following national guidelines for testing patients for the virus, there has been an increase in cases, particularly those acquired after admission, with an increase in probable or definite cases associated. Figure 10 shows the number of COVID cases detected through point-of-care testing and PCR using emergency and inpatient pathways and the total count. From 2022 to 2023, there were a total of 1507 cases of COVID-19. Of these cases, 966 (64.10%) were detected through screening and classified as community-onset. The remaining 541 cases, accounting for 35.8%, were nosocomial acquired. Figure 11 displays the number of COVID cases detected by NHS England Definition 2022-2023 compared to 2021-2022.

Figure 10: COVID cases categorised by NHS England definition April 22-March 23

BHT COVID Case by NHS England Definition					
22-23	Community 0-2 days after admission	Indeterminate 3-7 days after admission	Probable 8-14 days after admission	Definite 15+ days after admission	Totals
Apr-22	121	43	19	40	223
May-22	64	17	6	8	95
Jun-22	61	15	13	13	102
July -22	123	33	15	33	204
Aug-22	50	13	12	27	102
Sept-22	49	7	10	9	75
Oct-22	79	10	19	52	160
Nov -22	33	3	6	17	59
Dec- 22	46	7	13	35	101
Jan-23	50	20	26	42	**138**
Feb-23	32	33	37	40	142
March-23	36	21	16	33	**106**
Totals	**744**	**222**	**192**	**349**	**1507**

Figure 11: Total Cases of COVID-19 by NHS definition 21-23

BHT COVID Case by NHS England Definition 2021-2023					
	Community 0-2 days after admission	Indeterminate 3-7 days after admission	Probable 8-14 days after admission	Definite 15+ days after admission	Total
Total for 2022-23	744 ↑	222 ↑	192 ↑	349 ↑	1507 ↑
Total for 2021-22	731	178	94	161	1164

2.5.2 Learning from hospital-acquired COVID-19 infections in BHT

Figure 11 suggests a significant increase in patient safety incidents related to hospital-acquired COVID-19 this year compared to the previous year. This indicates that patients who require hospitalisation are still at a greater risk of contracting the virus.

Preventing the transmission of infections has been especially challenging due to delays in isolating suspected or positive cases leading to prolonged exposure to others in the ward or bay, increasing the risk of nosocomial acquisition and increasing the number of outbreaks declared see Figure 15. The IPCT continues to work with the site team to assess the level of risk posed by patients and prioritise those who require isolation in single rooms due to respiratory viruses such as COVID-19 and influenza. All infections acquired are reported on the Trust incident reporting system Datix and are reviewed based on BHT guidelines.

2.6 Influenza

In the 2022/23 flu season, there was a noticeable rise in influenza cases compared to previous years during the pandemic.

Figure 12: Influenza cases categorised by NHS England definition Nov 22-March 23

BHT Q4 FLU Case by NHS England Definition					
Month	Community-acquired	Indeterminate	Probable	Definite	Total
Nov (Partial) *	44	1	4	3	52
Dec	120	34	16	37	207
Jan-23	45	7	4	3	59
Feb-23	11	2	0	1	14
March-23	5	1	1	2	9

*Reporting began in November

Trust Vascular access device (VAD) bacteraemia's

Figure 13: BHT Yearly Vascular Access Device Bacteraemia

BHT Yearly Vascular Access Device Bacteraemia			
Year	**Central venous access devices**	**Peripheral Devices**	**YTD Total**
20 - 21	35	4	39
21 - 22	29	4	33
22 - 23	24	2	26

An RCA is carried out whenever a vascular access device infection is identified. If needed, OPAT leads a PIR with the MDT, which includes the IPC Doctor. During the process, learning and actions are identified. Divisions governance boards are responsible for reviewing the progress of the learning and actions. Any exceptions are reported to IPCC.

3. Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

3.1 Cleaning

National Standards of Cleanliness 2021

The National Standards of Healthcare Cleanliness (NSC), published in May 2021, are designed to drive improvement in healthcare organisations while allowing maximum flexibility. Adherence to these standards is mandatory and defined through the NHS Standard Contract 2022/23, with acute Trusts given a deadline of May 2022. However, BHT has yet to implement the updated NCS. To address this, BHT plans to undertake a multi-disciplinary review of the requirements using the implementation guidance provided by NHSE. This review will include a gap analysis comparing the 2007 NHS Cleaning Specification, engagement with colleagues internally and externally to apply functional risk ratings, evaluation of cleaning responsibilities, development of a cleaning policy and a trust-wide communication strategy. The standards are scheduled to be launched on April 1st, 2024, with support and approval at each implementation stage through the IPC committee.

3.2 Decontamination Group

Decontamination of reusable medical devices occurs in several areas, including the Sterile Services Department and the Endoscopy service across all sites and Urology based at Wycombe Hospital. The Sterile Services department scheduled a surveillance audit to ISO13485 with the externally approved body BSI in April 2022, with no non-conformances being raised.

The Endoscopy department undertakes monthly internal audits as part of the ongoing accreditation and quality management system. Anything raised follows the Quality Management System process of Corrective and Preventative actions. The next external accreditation audit is planned for in July 2023. Another area identified as carrying out local decontamination is the ear, nose, and throat clinics. A robust standard operating procedure, appropriate risk assessments, and training are in place. The Decontamination group meeting now includes an audit of a pre-agreed area. It will be part of the group's work plan for the upcoming year as part of continued surveillance and monitoring.

Risks

One concern that still needs to be addressed is the lack of an authorised person for decontamination within the retained estate. Current mitigation actions are in place, and the Associate Director of Estates is developing a longer-term plan to resolve this.

3.3 Water Safety Group

The Water Safety Group (WSG) reconvened in March 2023 and will continue to convene quarterly. The group follows established governance guidelines with appropriate representation and up-to-date documentation, including a Water Safety Plan and water policies. Any identified legionella and pseudomonas issues are promptly addressed through active monitoring and capital delivery processes in collaboration with our PFI partners, across the BHT estate.

3.4 Ventilation Safety Group

BHT has an appointed Authorising Engineer AE(V) for ventilation, who provides independent expert advice. We established the Ventilation Safety Group (VSG) in March 2023 to further enhance our commitment to safety. The VSG will hold quarterly meetings to ensure compliance with ventilation policies and regulations, focusing on HTM, statutory compliance, requests for change of use, matters arising from the current operational use of spaces, and examination of potential new services in BHT.

The VSG's primary objective is to ensure safe patient, colleague, and visitor spaces. To achieve this, the group will address issues related to asset and compliance data checks, technical compliance, design advice, approval of capital designs, reviewing management processes, and organisational governance arrangements. We have also prepared the necessary terms of reference and Ventilation Policy documents to guide the VSG's work and ensure our facilities' highest safety and compliance.

3.5 IPC in the Built Environment

The Trust is dedicated to expanding and improving its facilities, and the IPC team plays a crucial role in achieving this goal. The team is actively involved in refurbishments and new developments across all sites, providing valuable support and guidance throughout the planning, design, and build stages to ensure compliance with Health Building Notes (HBNs) and Health Technical Memorandums (HTMs). The team also addresses human factors by collaborating with department users, facilities, project teams, and contractors on new projects. As projects near completion, the team works with the snagging team to ensure that the finished product meets all necessary requirements and safety standards.

4. **Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance**

4.2 Antimicrobial Stewardship Group (ASG)

The Antimicrobial Stewardship Group (ASG) reports to the IPCC and Medicine Safety and Quality Group (MSQG). Its purpose is to develop and oversee the delivery of the Antimicrobial Stewardship (AMS) Programme for BHT, in line with the Government's UK five-year action plan to contain, control and mitigate the development and spread of Antimicrobial Resistance (AMR). This also

provides assurance for Criterion 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance, of the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated December 2022).

4.2 AMS Programme

The 2022/23 AMS Programme identified 4 priority areas:

1. **Reduce the use of "Watch" and "Reserve" antibiotics (Refer to Figure 14)**
   Objective: Reduce usage by 4.5% from the 2018 baseline year by March 2023 and a further 6.5% by March 2024.
   Outcome: *Not achieved* – figures suggest no significant change compared to the baseline year. Actions taken: Measures to reduce Watch and Aware drugs were implemented, following which we hope to see reductions in the use of these antibiotics over the next

2. **To minimise the harm caused by poor gentamicin prescribing.**
   Objective: To reduce gentamicin Datix incidents to ≤ 2 per quarter
   Outcome: Not achieved a Total of 9 Datix reports relating to Gentamicin prescribing and/or monitoring in 2022/2023 (but these were all in the "low" or "no harm" categories).
   Actions taken: There was a focus on safe gentamicin prescribing during World Antibiotic Awareness Week at the end of November 2022 which provided an opportunity for all prescribers to gain detailed knowledge in this area.

3. **Improve documentation of penicillin allergy and opportunities for challenge and de-labelling.**
   Objective: Improvement seen on Antimicrobial Care Bundle audits
   Outcome: Partially achieved- 51.3% of patients had the nature of the allergy documented based on 144 responses, and 53.8% of patients wore a red wristband based on 130 responses. This is baseline data which can be compared with future audit results. A de-labelling protocol has been developed which will be implemented next year.

4. **Urine Track Infection (UTI) Commissioning for Quality and Innovation (CQUIN) This is a National Quality Improvement goal.**
   Objective: To achieve ≥60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.
   Outcome: *Partially met (40-60%) There is a financial reward for meeting the targets; full payment if 60% or more is achieved; a lesser amount if the threshold of 40% is reached.*
   - **Q1 compliance: 51%**
   - **Q2 compliance: 52%**
   - **Q3 compliance: 42%**
   - **Q4 compliance: 49%** (figure to be confirmed by PHE Fingertips)

Figure 14. Usage of Watch and Aware Antibiotics 2022/23 (Regional comparison):

Highlights 2022/23

- Successful completion of the Department of Health and Social Care's Fleming-funded Commonwealth Partnerships for Antimicrobial Stewardship (CwPAMS) Extension fund to "Establish a Sustainable centre of excellence for Integrated AMS and IPC at Makerere University in Uganda"
- Three pharmacists from BHT, and one from BOB ICB, completed the Chief Pharmaceutical Officer's Global Health Fellowship.
- Continuation of the CwPAMS Health Partnership with Nottingham Trent University and Makerere University in Uganda to scale up interventions to strengthen antimicrobial stewardship in Wakiso District, Uganda. This partnership was awarded "Winner" at the Antibiotic Guardian Awards in the "Multi-Country Collaboration" award.
- A member of the antimicrobial steward's pharmacist team was shortlisted and commended for the Das Pillay Award at the Antibiotic Guardian Awards for his project: *Therapeutic Drug Monitoring (TDM) Workshops/Knowledge Cafés for Variable Dose Antibiotics during World Antimicrobial Awareness Week (WAAW) 2021.*

In collaboration with Oxford University Hospitals NHS Foundation Trust, the pharmacy team was accepted for a poster presentation at the British Society for Antimicrobial Chemotherapy Spring Conference - Using the Australian National Antimicrobial Prescribing Survey portal (to benchmark antibiotic prescribing within an Integrated Care Board a pilot point prevalence survey of two NHS trusts.

5. Criterion 4: Provide suitable, accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

5.1 Information for Service Users, Visitors and Carers

The IPC team ensures that information is up-to-date and works closely with the Communications department for accurate and wide dissemination via channels, including patient information screens, social media, and the Trust's website. The IPCT has worked with the Communications team to ensure documents are kept up to date on the Trust's intranet. The IPC team has made significant progress in updating policies and guidelines and information for patients and visitors to meet the Health and Social Care Act requirements. It is on track to achieve full compliance by the end of 2024.

6. Criterion 5: Ensure that people who have, or develop, an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people

As part of our standard operating process, assessment tools are available to reduce the risk of transmitting infection, and our admission process includes the assessment of patients for signs of infection. Our Infection Prevention Team works closely daily with wards, our site management teams, and our cleaning teams, to ensure patients with infection are rapidly identified and placed correctly and additional cleaning is in place as required. During the last year, the IPC, where needed, provided a support service seven days a week to ensure expert support was always available to maintain patient and staff safety.

6.1 Patient Alerts and Surveillance of Alert Organisms e.g., MRSA, C. difficile

The IPC team uses a manual process to monitor patient alerts which assist in detecting a patient re-admitted with an alert organism/infection. All emergency and elective admissions for MRSA are screened for infection risk. Certain alert organisms are screened on admission and transfer, e.g., MRSA and CPE.

6.2 Managing Outbreaks of Infection

During the 2022/23 period, there were a total of 51 reported outbreaks, with 43 of them being COVID outbreaks outlined in Figure 15. This indicates that COVID-19 continued to pose a significant risk during that time. However, the lack of isolation facilities remains a major challenge in accommodating patients who are identified with a risk of infection. Isolation facilities are crucial in effectively managing and containing the spread of infections. The insufficient number of isolation facilities affects BHT's ability to manage cases of infection safely, and this risk is recorded on the IPC risk register; the IPC risk register is reviewed each quarter by the IPCC. Another concern is the inadequate implementation of engineering solutions within ward settings to address infection risks. Specifically, ventilation systems lack appropriate airflow and ventilation to minimise the spread of airborne infections, thereby increasing the risk of transmission within the ward environment. The increasing demand for healthcare services in BHT has increased capacity in most areas, increasing the above-mentioned challenges. As more patients require care, effective infection control measures and adequate isolation facilities become even more critical.

The information provided highlights the importance of addressing infection prevention control challenges across all areas. It emphasises the necessity of having sufficient isolation facilities and implementing engineering solutions, such as improved ventilation systems, to reduce the risk of infection spread within BHT. With the increasing demand for services and capacity in most areas, it has become more challenging to mitigate the risk of transmission of infection. Identifying and recording potential risks on appropriate risk registers is crucial. Regular reviews of these registers by the IPCC, health and safety committee, and ventilation safety group are necessary to ensure comprehensive oversight.

Figure 15 Number of Outbreak of Infection Declared in BHT April 22-March 23

Number of Outbreak of Infection Declared in BHT April 22-March 23

	apr-22	mai-22	jun-22	jul-22	aug-22	sep-22	okt-22	nov-22	des-22	jan-23	feb-23	mar-23
Total Number of outbreaks	2	2	5	4	4	3	6	1	8	3	9	4
Total Number of Norovirus Outbreaks	0	0	0	0	0	0	0	0	0	0	1	1
Total Number of CDT Outbreak	0	1	0	0	0	0	0	0	0	0	0	0
Total Number of Flu Outbreaks	0	0	0	0	0	0	0	0	5	0	0	0
Total Number of COVID Outbreaks	2	1	5	4	4	3	6	1	3	3	8	3

6.3 Incidences

Group A Streptococcus

In Quarter 3, BHT received a notification from UKHSA regarding the high rates of invasive Group A Streptococcus (iGAS) infection, especially in children. In line with many other trusts, BHT witnessed a surge in admitted cases and an increased demand for assessment in our Paediatric Decision Unit, especially during out-of-hours care.

Viral Haemorrhagic Fever (VHF)

The IPCT has reviewed and enhanced protocols for patient care and staff support in suspected cases of VHF.

Investigation of a single potential case of Legionnaires Disease associated with Wycombe Hospital

In September, the UKHSA reported a potential single legionnaire disease (LD) case associated with Cardiac Stoke Referral Unit (CSRU) Wycombe Hospital. IPCT, with the support of the Estates and Property service teams, has investigated to identify potential sources within the environment. Routine water testing in August identified legionella in CSRU in two samples taken on 3/8/22. In line with the Trust's water safety policy, further water testing was undertaken to include all water source points across the CSRU unit. After discussion with the Consultant in Communicable Disease (CCD) UKHSA, it was agreed that the patient's probability of acquiring the Legionellae whilst attending CSRU was low. The urine sample has been sent to the reference lab, and UKHSA will inform us of the result. The case will be reviewed at the Trust's next Water Safety Group to see if there is any learning which requires additional action to be undertaken.

An investigation a single case of bloodstream infection of Listeria monocytogenes

Listeria monocytogenes were identified in the in-blood culture sample taken in January 2023. The patient died of Listeria septicaemia, being reported on part 1a of the death certificate. Therefore, the case is considered hospital-acquired, the Serious Incident process was initiated, and the UKHSA was notified.

The UKHSA led an investigation into this case which identified that the case was part of a regional outbreak, with a probable food source being the infectious agent. Further investigations are being carried out focusing on off-site production facilities of sandwich supplies. UKHSA informed NHS England of the cases and findings. A letter was circulated to all NHS providers in February via NHS Estates, which builds on the organisation implementing the national health standards for food and drink (November 2022).

Monkey Pox (Mpox)

Since the start of the Monkeypox (Mpox) virus outbreak, the Trust's Sexual Health Service (SHS), has identified five positive cases – none of which required hospital admission. A further case was identified in March 2023 following admission to Stoke Mandeville Hospital. UKHSA was notified of the result. To date, 260 first and 105-second doses Mpox vaccine have been given by the SHS. Vaccination has played a crucial role in protecting people and reducing case numbers. UKHSA recently announced that due to a sustained reduction in Mpox case numbers across England, the vaccination programme is no longer needed as an outbreak control measure and will be wound down.

6.4 Serious incidents

Four serious incidents have been related to Infection Prevention and Control (IPC). Three of these incidents involved patients acquiring COVID-19 while staying at the hospital. The Trust's Serious Incident Policy was followed, and appropriate procedures were taken to address the incidents. Each Divisional Governance Board is responsible for supervising the implementation of recommendations and actions to respond to the incidents.

6.5 Audit Programme to Ensure Key Policies are Implemented

The IPC audit programme is fundamental in monitoring and measuring IPC policies and compliance with standard infection control precautions (SICP) and Transmission based precautions (TBP). Where audit deficits are identified, areas are responsible for producing action plans to address these issues. Once the action plan has been developed, it is monitored locally via the Divisional governance arrangements to ensure action has been taken. Should any challenges hindering the completion of action plans be identified at a local level, they are escalated to the IPCC.

Hand Hygiene and Personal Protective Equipment Audit (PPE)

All clinical areas report Hand Hygiene and PPE compliance as directed by BHT hand hygiene/PPE guidance. Each area is responsible for conducting its audits and reporting them through its directorate governance structure with action plans to address non-compliance. From November, the PPE and hand hygiene audit has been split into two separate audits.

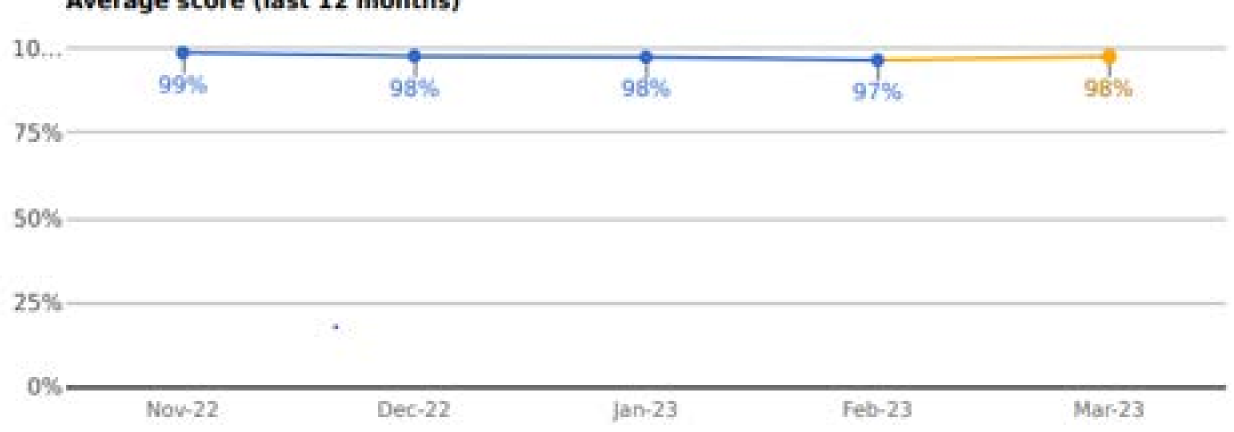
Figure 16: Audit compliance with hand hygiene and PPE audit

The average score was 99% for this period.

Hand Hygiene Audit Compliance

Since November 2022, the hand hygiene audit is now standalone; in Quarter 4, the number of audits undertaken has steadily increased, with 118 in January, 129 in February and 133 in March 2023, with an average audit score for the quarter being c. 98% Weekly hand hygiene audits are also carried out in clinical areas when there is an outbreak or Period of Increased Incidence of Infection (PII).

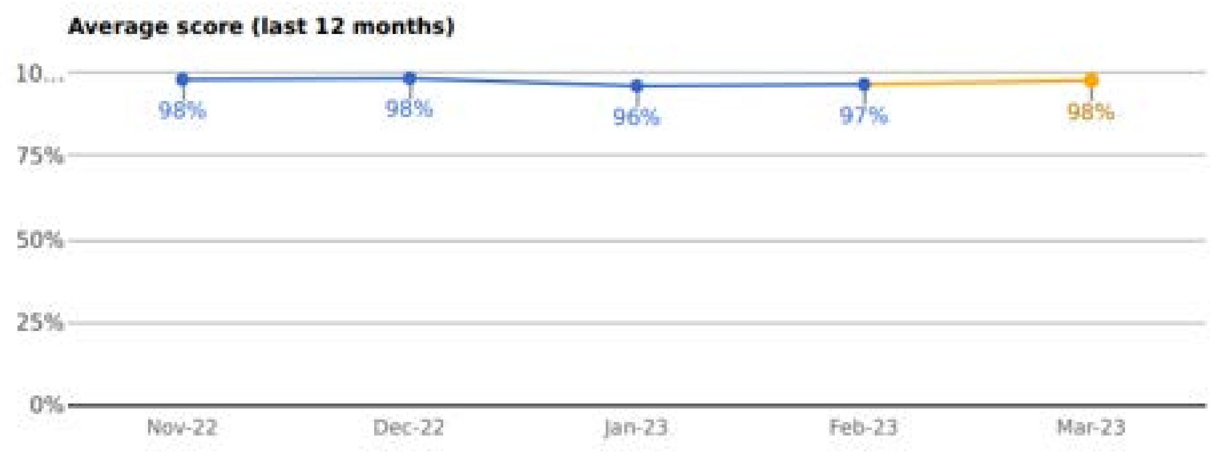
Figure 17: Average Hand Hygiene Audit Compliance



PPE Audit Compliance

Since November 2022, the PPE Audit has been standalone and used during outbreaks, PII and spot checks of practice. The average score is 98%. The IPCT has asked divisions for their assurance on the completion of this audit and what measures are in place to monitor

Figure 18: PPE Audit Compliance



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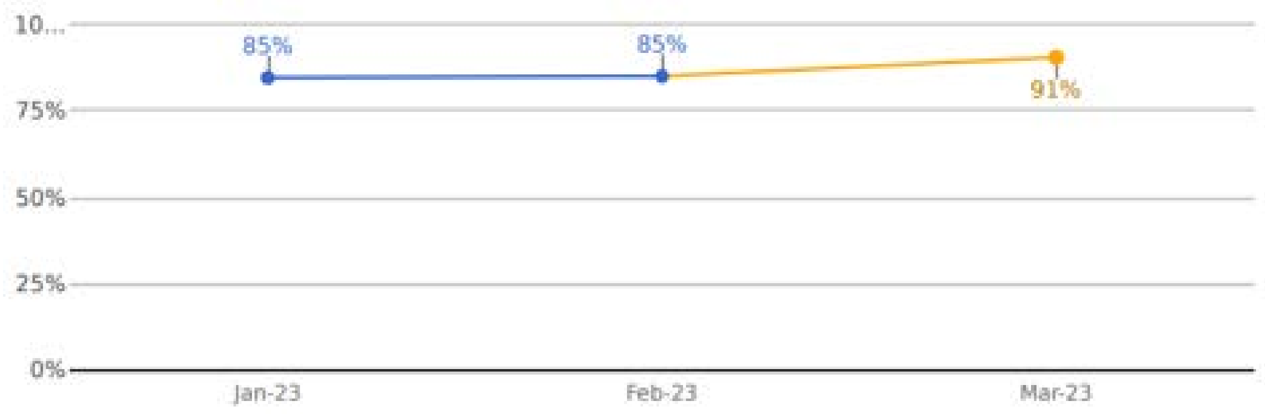
Peer-reviewed infection prevention and control audits

Peer-reviewed infection prevention and control audits and observation of standard infection prevention and control practices that form part of the Clinical Accreditation standard commenced in January 2023. The figure shows the compliance demonstrated across 17 audits carried out by IPCT. Where required, Divisional Governance and Performance groups develop and oversee action plans. If needed, areas are reaudited.

Figure 19: Ward Accreditation Audit Scores



Indwelling Urinary Cather (IDU) Ongoing Care Audit

Preventing Catheter-Associated Urinary Tract infections (CAUTI) is a critical objective for ensuring patient safety. Urinary catheters are a source of E. coli bloodstream infections, and many of these infections are suggested to be avoidable by minimising the use of indwelling urinary catheters (IDUC) or removing them as soon as possible.

The audit findings have highlighted the importance of implementing measures to reduce CAUTIs, particularly focusing on evidence-based best practices and considering the implementation of the NHS passport.

6.6 Surgical Site Infection Surveillance (SSIS)

In July 2022, UKHSA wrote to BHT as it had identified that the Trust had not participated in the mandatory data collection for monitoring surgical site infections (SSI) from 2021 to 2022. Due to a lack of resources in the IPC team, Trust will likely continue not to participate in 2023/24.

The IPCT has submitted a business case for an SSI specialist nurse and coordinator to focus on SSI monitoring and prevention in the Trust. The SSI team would work with all divisions and disciplines where surgical procedures happen across the Trust.

An SSI Prevention Policy has been developed and implemented across the organisation during 2023/24.

In Maternity, the MDT working group is still reviewing the caesarean section pathway (both elective and emergency). A repeat audit is planned for 2024. The action plan developed following a possible cluster in 2021 has been almost completed, with one outstanding action regarding skin preparation. This is ongoing and is overseen by the maternity and obstetric governance structure to improve the patient pathway and reduce the risk of SSI.

7. Criterion 6: All care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

All colleagues, including volunteers joining the Trust, must attend or undertake IPC training.
The training department monitors compliance with IPC training. Figure 16 provides compliance for IPC Mandatory training across the Trust as of the end of March 2023. Whilst the Trust has exceeded its threshold for hand hygiene, further work needs to be undertaken to ensure that the Trust achieves its threshold of 90% for overall IPC mandatory training compliance.

Figure 20: Mandatory Training Compliance as of 31/3/23

Statutory and Mandatory Compliance for Infection Prevention Control				
	Sum of Required	**Sum of Achieved**	**Sum of Non-Compliant**	**Compliance %**
Hand Hygiene - 2 Years	4515	4074	441	90.23%
Infection Prevention and Control Level 1 - 1 Year	1534	1247	287	81.29%
Infection Prevention and Control Level 2 - 1 Year	4515	3679	836	81.48%
Grand Total	**10564**	**9000**	**1564**	85.20%

7.1 Infection Prevention and Control Team/Team Development

Members of the IPCT are encouraged to undertake training within the speciality as part of development. One of the members of the IPCTs completed their master's degree in IPC this year; two colleagues further continued their master's level studies.

7.2 Link Practitioner Network

In November, the IPCT re-launched the link practitioner network with a cross-Trust study day. The theme was back to basics, and the day saw the National IPC Manual launched within the Trust. All members of the IPCT presented, and the guest speaker was Rose Gallagher, IPC lead from the Royal College of Nursing. Unfortunately, as the IPCT has remained on business continuity staffing, it has not been possible to carry out further activities during the winter period. – this is covered elsewhere in the report

8. Criterion 7: Provide or secure adequate isolation facilities.

The Trust faces challenges in assigning isolated side rooms to patients with infection risks due to the limited availability of side rooms. This has been escalated to IPCC and Health and Safety Committee.
The lack of secure and adequate isolation facilities and inadequate ventilation are on the estate's risk register. The IPCT continue to advocate for increased isolation and improved infrastructure for caring for patients with infections and protecting colleagues from infection.

9. Criterion 8: Secure adequate access to laboratory support as appropriate.

Laboratory services for BHT are located at Stoke Mandeville Hospital. The microbiology laboratory has full Clinical Pathology Accreditation (CPA). The microbiology laboratory sends a daily list of all positive samples, including sensitivities. This enables all patients to receive the appropriate treatment/antibiotic therapy and prompt isolation if required. As serology has been incorporated back into microbiology, the Trust has started applying for UKAS accreditation as a joint laboratory. Work has been ongoing to validate rapid molecular screening methods for MRSA and CPO. Laboratory-based molecular testing for Covid, Flu and RSV (as a triplex test) has been validated, and point-of-care testing using the IDnow has been introduced for Covid/Flu and RSV.

10. Criterion 9: Have and adhere to policies designed for the individual's care and provider organisations that help to prevent and control infections.

BHT has implemented the National IPC Manual. In line with the Health and Social Care Act (2008) code of practice on preventing and controlling infections (update 2022). BHT remains non-compliant with the current policy list. The IPCC oversees progress toward compliance and it is expected that BHT will be fully compliant by the end of 2024.

11. Criterion 10: Providers have a system in place to manage the occupational health needs of colleagues in relation to infection.

11.1 Immunisation COVID and Flu

The Autumn vaccination program 2022/23 for Flu and COVID-19 built on the experience and knowledge gained over the last two years. It aimed to deliver a programme that supported the offer of both the Flu & COVID vaccinations to colleagues while allowing operational and clinical choices to meet their needs.

Both vaccinations were offered to 100% of all BHT colleagues, with a final uptake of 59.5% for Flu and 57.3% coming forward for the COVID vaccination. Flu vaccinations started two weeks after winter COVID boosters due to the vaccine's availability and delivery; from that point, 38.3% of all vaccines given were co-administered and were offered consistently at every session.

Occupational Health is committed to protecting all Trust employees as part of policies and guidelines. As part of the Recruitment and Selection Policy, all colleagues are assessed for fitness for work and infection control risk. Occupational Health also supervises the Trust's policy for preventing and managing Sharps injuries and body fluid exposure incidences as part of their Infection Prevention Control remit.

As mandated by the Health and Social Care Act 2008 and Department of Health Guidelines, Occupational Health is responsible for evaluating the immunisation status of all Trust employees. We also regularly review the immunisation status of existing healthcare workers and administer necessary vaccinations following the Green Book to minimise the risk and spread of vaccine-preventable diseases. The vaccines depend on workplace risk and consist of Mantoux / BCG, Hepatitis B, Hepatitis A, Tetanus/Diphtheria/Polio, Measles/Mumps /Rubella, Typhoid and Varicella.

11.2 Exposure to bloodborne viruses

Exposure to bloodborne viruses can pose a significant threat to healthcare workers. To ensure the safety and health of these colleagues, Occupational Health works in tandem with Health and Safety Legislation to prevent, reduce, and control the risks of healthcare-associated infections and manage occupational exposure to bloodborne viruses, including post-exposure prophylaxis. The assessment and follow-up of bloodborne virus exposure incidents during departmental opening hours and emergency departments outside of hours fall under the responsibility of Occupational Health. During 2022/23, the number of exposure incidents reported to Occupational Health was 150 compared to 157 the previous year. Out of these cases, the majority occurred during a procedure on the patient before the safe needle device had been activated.

Most colleagues exposed to blood or body fluids are dealt with through testing of the source patient. Where this is not possible, follow-up blood tests are organised for six months through the Occupational Health Department.

11.3 COVID-19 Risk Assessments

COVID-19 Risk Assessments are mandated for all colleagues in the Trust. Changes to the risk from COVID have resulted in Occupational Health only being directly involved in staff who fall into the high-risk category.

11.4 Fit Mask Testing

Fit Mask Testing for clinical colleagues transferred to the Occupational Health remit in 2022. Compliance has been maintained at 90% or over, and plans have been developed to capture re-testing as advised by NHS England at two yearly intervals.

11.5 Lateral Flow Testing and Isolation

Lateral Flow testing and Isolation have had multiple changes to the advice provided to NHS colleagues. Occupational Health updated the advice at the end of 2022/23 to reflect moving away from lateral flow testing and replacing it with isolation based on symptoms only.

This report has been complied with contributions gratefully received from the IPC Team plus colleagues from Microbiology, Pharmacy, Estates and Facilities, Decontamination, occupational health, and all divisions.

Meeting: Trust Board Meeting in Public

Date: 27 September 2023

Agenda item	CQC Report - Paediatric Emergency Department June 2023
Board Lead	Karen Bonner, Chief Nurse
Author	May Parsons, Associate Chief Nurse
Appendices	Appendix 1: CQC Final Report INS2-15920326251 - RXQ02 Stoke Mandeville Hospital Appendix 2: Revised SI Policy – awaiting ratification at TPSG (available within the Reading Room)
Purpose	Information
Previously considered	Q&CGC 16.08.2023 EMC 22.08.2023

Executive summary

BHT had an unannounced inspection by the Care Quality Commission (CQC) at Paediatric Emergency Department Stoke Mandeville Hospital on 1 June 2023 focusing on safe and well-led key lines of enquiry.

This inspection was triggered by a concern which suggested an early recognition of sepsis did not always take place and investigations were not always thorough and learning robust.

The report is planned to be published on the CQC website on 11 August 2023.

Although this inspection is not rated, the CQC inspectors has identified lots of positive points during their visit including an open and positive culture which the team should be extremely proud of.

Summary of findings:

- Paediatric staff had training in key skills. Staff usually assessed risks to patients, acted on them and kept good care records.
- Leaders ran services well using reliable information systems. Staff felt respected, supported, and valued.
- The service did not always have the optimum number of staff but had procedures in place to ensure the levels were safe.

However:

- The service did not always thoroughly review and investigate incidents. This meant that areas of improvement and learning were not always identified to prevent further occurrences.
- Staff did not always use translator services when required, and there was no accessible information to inform children, young people, and their families this service was available. This meant there was a risk of breakdown in communication which could impact on understanding.
- Staff were not always clear about their roles and accountabilities when reporting incidents according to trust's own policy.

The CQC found breaches in our compliance with the treatment of disease, disorder, or injury Regulation 17 HSCA (RA) Regulations 2014 Good governance.

This report was considered by the Executive Management Committee on 22 August 2022 and by the Quality and Clinical Governance Committee on 16 August 2023. The areas of areas of good practice and the areas for improvement were noted. It was agreed that the action plan would be signed off by the Executive Management Committee.

Decision	The Board is requested to note the outcome of the CQC Inspection.		
Relevant strategic priority			
Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒

Relevant objective		
☒ Improve waiting times ☒ Improve safety ☒ Improve productivity	☒ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☒ Improve the experience of our new starters ☒ Upskill operational and clinical managers

Implications / Impact	
Patient Safety	Indicators related to patient safety and experience performance are monitored, and assurance is gained.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards
Financial	Unidentified or 'slow to respond' risks to organisational governance and Trust reputation can impact financial standing.
Compliance CQC Standards Good Governance	We act on the best information about risk, performance, and outcomes, and we share this securely with others when appropriate.
Partnership: consultation / communication	CQC
Equality	Health inequalities are avoidable, unfair and systematic differences in health and experience between different groups of people. The Trust is committed to the fair treatment of all patients and service users, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependents, sexual orientation, or any other personal characteristics. BHT is committed to reducing health inequalities, and the items which the CQC have identified as Must Do require attention for all service users.
Quality Impact Assessment [QIA] completion required?	No

1 Introduction/Position

1.1 BHT had an unannounced inspection by the Care Quality Commission (CQC) at Paediatric Emergency Department Stoke Mandeville Hospital on 1 June 2023 focusing on safe and well-led key lines of enquiry.

1.2 This inspection was triggered by a concern which suggested an early recognition of sepsis did not always take place and investigations were not always thorough and learning robust.

1.3 CQC carried out an unannounced inspection of the paediatric emergency department at Stoke Mandeville Hospital. During the inspection visit, the inspection team:

- Inspected the new paediatric emergency department, children's observation unit, resuscitation room and urgent treatment centre (UTC).
- Looked at the triage process and patient journey from the UTC.
- Looked at a sample of 12 patient records.
- Observed the daily safety huddle.
- Spoke with 10 members of staff, including nursing staff, medical staff, and leaders of the service.

As this was a focused inspection, not all key lines of enquiry were asked. CQC looked at aspects of the key questions under safe and well-led:

- Assessing and responding to patient risk, and appropriate escalation of patients.
- Record keeping.
- Staffing levels and skill mix.
- Investigation of incidents and learning from incidents.
- Management of risk.
- The provision and use of translator services.
- The culture of the service.

Following the inspection, the inspection team reviewed further service information such as policies, patient feedback, and training records.

The final report is to be published on the CQC website on 11 August 2023.

2 Problem

2.1 A concern was raised to the CQC regarding the care of their family.

2.2 Evidence provided during the enquiry for assurance did not satisfy the regulators which triggered the unannounced visit to our Paediatric department.

3 Outcome

3.1 CQC has found that:

- Paediatric staff had training in key skills. Staff usually assessed risks to patients, acted on them and kept good care records.
- Leaders ran services well using reliable information systems. Staff felt respected, supported, and valued.

- The service did not always have the optimum number of staff but had procedures in place to ensure the levels were safe.

However:

- The service did not always thoroughly review and investigate incidents. This meant that areas of improvement and learning were not always identified to prevent further occurrences.
- Staff did not always use translator services when required and there was no accessible information to inform Children, Young People and their families that this service was available. This meant there was a risk of a breakdown in communication which could impact understanding.
- Staff were not always clear about their roles and accountabilities when reporting incidents according to Trust policy.

3.2 The CQC found breaches in our compliance with the treatment of disease, disorder, or injury Regulation 17 HSCA (RA) Regulations 2014 Good governance.

3.3 Areas for improvement identified:

Must Do

The Trust must ensure there are effective systems and processes in place to ensure potential serious incidents have been correctly categorised, reviewed, thoroughly investigated and lessons shared to reduce the risk of reoccurrence.
Regulation 17 (2).

Should Do

The Trust should ensure that service users are aware that interpreters are readily available and that they are used when required and according to Trust policy.
Regulation 17

4 Actions and next steps.

4.1 CQC has determined a breach in our legal requirement to meet the Treatment of disease, disorder, or injury Regulation 17 HSCA (RA) Regulations 2014 Good governance. BHT has already taken actions to ensure that we meet regulation 17 (2) through the revision of our policies in line with our agreed processes.

4.2 As part of our response to the initial feedback, the leadership team has determined, and enacted actions detailed within our response to CQC which are now in place.

4.2.1 Must Do

1. BHT's Serious Investigations policy has been reviewed and revised as detailed in the policy changes which ensures that there are rigorous processes and systems in place to categorise, review, and investigate without bias with lessons shared for improvement and learning.

   The changes to the SI policy are:

- 6.7 The Chief Nurse is responsible for ensuring that the Board is kept informed of trends and learning from incident reporting Trust wide including incidents and Serious Incidents and ensure that:

  - Review 72 hour reports outside of Serious Incident Executive and Divisional Management (SIEDM) Panel, if i) timing of review is required earlier than Panel date, ii) capacity does not enable scheduling on next agenda iii) there is reason to not submit to Panel (Patient Safety team will use their judgement and discretion) e.g., a highly sensitive case, or involving a patient, who is an employee, or a conflict of interest for a Panel member).

- 6.27 Senior Manager/ Service Manager on duty at the time of a potential SI

Senior Manager/ Service Manager on duty at the time of a potential SI
The manager of the service/senior member of staff on duty at the time of the incident is responsible for ensuring that within 72 hours / 3 working days:

- Ensuring that immediate actions to reduce harm and risk have been taken.
- Ensuring that the senior Divisional Lead within the Division/Corporate Services are notified immediately:
- Ensuring that the following executive managers are included in a notification email for Serious Incidents of significant concern or risk, this may include escalation to:

  o Chief Nurse
  o Medical Director
  o Chief Operating Officer
  o Director of Finance

- Informing the patient's consultant/lead clinician as soon as possible if he/she was not present at the incident. If the lead clinician is absent, the duty clinician should be contacted. It is normally the responsibility of the patient's consultant or other appropriate lead clinician to inform the family about the incident, in line with the Being Open Policy (2022). If the incident occurs out-of-hours, agreement should be reached with the director on call and the duty clinician regarding who will inform the patient or next of kin. Unless a severe harm to a patient (or an incident resulting in unexpected death), has occurred, the discussion with the patient or next of kin family can be scheduled to take place in regular working hours, usually the following day.

- 9.0 REPORTING AND INVESTIGATING SERIOUS INCIDENTS

9.1.1 Process where an incident has been identified as a potential SI

1. Potential SI occurs
2. Reporter completes Datix, notifies line manager or appropriate other, and Clinical Divisional Governance Lead/team, and others as deemed relevant for support/awareness. Senior Management will receive notification for moderate

and above harms via Datix alerts, or other harm grades depending on parameters requested on Datix.

3. A call will be set within a 72 hour period (3 working days); however, discussions should be ongoing in preparation for the meeting, particularly for severe harms, unexpected deaths or Never Events.
4. Attendees on the call: where possible, at least one member of the Division Senior Leadership Team, local manager where incident occurred, Divisional Clinical Governance Lead, proportionate to the severity of the incident and current known outcome for patient.
5. If the incident requires a medical opinion all efforts should be made to get the Consultant responsible for the patient on the call or, proportionate

- 9.1.2 The witness to the incident/potential SI will:
  The Divisional Leads will in the case of potential SIs, or unexpected deaths:
  - ✓ Inform the Chief Operating Officer where appropriate to do so
  - ✓ Ensure the service manager/most senior member of staff on duty completes a brief report outlining the incident and immediate actions taken and forward it to them as the relevant Divisional Director, Divisional Chairs and Head of Nursing/Midwifery once completed within the 72 hours/ 3 working days.

- 18.0 COMMUNICATING WITH AND SUPPORTING PATIENTS, CARERS AND RELATIVES (Being Open and Duty of Candour)

  Duty of Candour must be carried out by a member of the team authorised to do so by senior Managers within the Division.

  Essentially, for any incident where there is an incident which leads to a confirmed harm which is a moderate or severe harm, or has resulted in unexpected death, (using CQC definitions) it is a requirement, contractually, and legally, that the patient and/or next of kin (or identified carer) is informed ideally within 10 working days and an expression of regret made. This should be documented. Consideration should always be given to the needs for patients, next of kin or carers who may need support from a navigator, professional interpreter/translation services provided by the trust, specialists such as Learning Disability/Autism nurse team, to enable equitable access to services, and materials provided by the service such as a clinical conversation, letters, or advice leaflets.

- APPENDIX 8: OTHER TYPES OF SERIOUS INCIDENT
  (1) Child unexpected death incident management process
  - Terms of Reference
    A draft Terms of Reference for the SI should be developed within 5 working days of the incident occurring, where possible.
  - Securing statements/reflections
    The first phase of the SI investigation should include the collection of reflections from the staff involved, ideally, where possible, particularly for severe harms or unexpected deaths, within 3 working days of the incident. It should be noted that

whilst NPSA guidance states that statements/reflections requested as part of an investigation do NOT need to be signed by the member of staff concerned, these documents would be disclosable if required for a Coroner's inquest or claim.

2. The Buckinghamshire NHS (National Health Service) Trust Child Death guideline 773 has been updated and now states that:

   All unexpected deaths are reported via the Trust Datix electronic incident reporting system. The handler will be a clinician who was not directly involved in the care. This will be the on-call paediatrician of the week (POW) for paediatric deaths, and on-call Neonatal Consultant of the week (NOW) for neonatal death. If the Consultant for the week is directly involved in a paediatric death, then the Consultant for the Children's Observation unit will review the care.

   - The Consultant will convene a joint agency response meeting. The relevant Consultant chaired the meeting in line with the above on-call paediatrician for the week (or neonatologist for the week in the event of a neonatal death).
   - A 72-hour report will be completed for all unexpected deaths of children who have received care from the trust as part of their final illness. This report will be submitted to the Serious Incident Executive and Divisional Management (SIEDM) panel. The SIEDM panel, which is an independent panel chaired by the Deputy Chief Nurse and Chief Medical Officer, reviews and determines whether a serious incident investigation is required. The 72-hour report should be completed in line with the new Trust process by the relevant on-call Consultant of the week (Appendix 1 Child Death guideline).

4.2.2 Should Do

The Trust will ensure that service users are aware that interpreters are readily available and that they are used when required and according to Trust policy.

The Big Word Telephone Interpreting Service at Buckinghamshire Healthcare Trust is available 24 hours a day. The inspection highlighted that the information about this service is not clearly visible in the Children's Emergency Department and our Children's Observation Unit. With immediate effect, information on the service has been added to the electronic information board within the Paediatric ED (Emergency Department) waiting area.

The inspection highlighted the availability of translation services was not clearly articulated in the duty of candour letter provided to families. The duty of candour letter has been updated to confirm the availability of this service should families wish to access it. All areas where children are seen have clearly visible information concerning translator services.

Whilst the service is moving to an electronic patient system, a sticker will be applied to the paper admission proforma to confirm if a translator is required. Compliance with this will be monitored monthly via the senior sister's meeting to ensure the process is embedded. In addition, the trust patient experience and involvement team

have provided a summary of interpreter requests from paediatrics with an associated action plan.

4.3 Next Steps

A report and updates on all actions will be submitted to the CQC by 1 September 2023 and an update will be provided to the board in September.

Shared learning and planned audit of improvements/change of practice to ensure that they are embedded and rolled out across the Trust, where applicable.

10 Action required from the Board/Committee

10.1 The Committee / Board is requested to:

a) The Committee is requested to discuss and note the outcome of the CQC Inspection.

APPENDICES
Appendix 1: CQC Final Report INS2-15920326251 - RXQ02 Stoke Mandeville Hospital
Appendix 2: Revised SI Policy

Buckinghamshire Healthcare NHS Trust

Stoke Mandeville Hospital

Inspection report

Mandeville Road
Aylesbury
HP21 8AL
Tel: 01296315000
www.buckinghamshirehospitals.nhs.uk

Date of inspection visit: 1 June 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Stoke Mandeville Hospital

Inspected but not rated

We did not rate the service at this inspection.

We found that:

- Paediatric staff had training in key skills. Staff usually assessed risks to patients, acted on them and kept good care records.
- Leaders ran services well using reliable information systems. Staff felt respected, supported, and valued.
- The service did not always have the optimum number of staff but had procedures in place to ensure the levels were safe.

However:

- The service did not always thoroughly review and investigate incidents. This meant that areas of improvement and learning were not always identified to prevent further occurrences.
- Staff did not always use translator services when required, and there was no accessible information to inform children, young people and their families this service was available. This meant there was a risk of breakdown in communication which could impact on understanding.
- Staff were not always clear about their roles and accountabilities when reporting incidents according to trust's own policy.

Urgent and emergency services

Inspected but not rated

Buckinghamshire Healthcare NHS Trust (BHT) provides acute hospital and community services for people living in Buckinghamshire, as well as some people living across the borders in surrounding counties. The trust has 2 acute hospitals, Stoke Mandeville Hospital which is in Aylesbury, and Wycombe Hospital which is in High Wycombe.

The trust had won a bid for £15 million of capital funding to enable them to build a new children's emergency department (ED), and to improve the maternity and gynaecology facilities at Stoke Mandeville Hospital in 2020. This had opened on 24 April 2023. The new facilities provided a children's ED and a children's observation unit (COU), which had freed up more space within the adult emergency department. It was open 24 hours a day, 7 days a week.

We carried out an unannounced focused inspection of the children's emergency department within Stoke Mandeville Hospital. We had received information of concern which suggested an early recognition of sepsis did not always take place and investigations were not always thorough and learning robust. As this was a focused inspection, we did not inspect all key questions. We looked at aspects of the key questions under safe and well led. We looked at:

- Assessing and responding to patient risk, and appropriate escalation of patients.
- Record keeping.
- Staffing levels and skill mix.
- Investigation of incidents and learning from incidents.
- Management of risk.
- The provision and use of translator services.
- The culture of the service.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills, including the highest level of life support training, to all staff and made sure everyone completed it.

Most paediatric nursing staff received and kept up-to-date with their mandatory training. Overall compliance with statutory and mandatory training was 97% in March, 96% in April and 98% in May 2023. Mandatory training is compulsory training that is deemed essential by an organisation for the safe and efficient delivery of services. Statutory training is training which is required by law or where a statutory body has instructed an organisation to provide training on the basis of a specific legislation.

Advanced Paediatric Life Support (APLS) training had been completed by 71% of paediatric nursing staff. APLS training was paused during the COVID-19 pandemic, as it was face to face training. APLS training provides the knowledge and

skills necessary for recognition and effective treatment and stabilisation of children with life threatening emergencies. Training in paediatric sepsis had been completed by 95% of paediatric nursing staff and training on the use of the Paediatric Early Warning System (PEWS) had been completed by 92% of paediatric nursing staff in May 2023. PEWS helps with early recognition of sick children and identification of any deterioration in their condition.

Paediatric medical staff received and kept up to date with their mandatory training, demonstrating 100% compliance in training in APLS, paediatric sepsis and PEWS training.

However, children were occasionally seen by general emergency department medical staff. In May 2023, 46% of all general emergency department medical staff had completed paediatric sepsis training and 56% had completed training in the use of PEWS. Junor medical staff had not completed training in APLS.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

The design of the environment followed national guidance.

The new paediatric emergency department opened in April 2023. It included a children's observation unit (COU), which had 10 rooms holding 14 bed spaces, 1 dedicated room designed for the treatment of children or young people with mental health needs and a double-bedded resuscitation unit, which was used exclusively for children. There was a dedicated entrance for babies, children and young people arriving by ambulance. The new children's emergency department was clean, bright, and spacious.

The COU was used for children and young people who did not need to be admitted to the children's ward but required a period of up to 24 hours for observation and treatment. The design of these rooms followed guidance in health building note 00-03, with ensuite bathroom facilities, and plenty of space for storage of their belongings and accompanying family members. Oxygen, medical air, and vacuum outlets were in place within each room and each bed had access to a call bell. Single rooms were used for children and young people who may be infectious. The multi-bedded rooms had privacy curtains around each bed.

The sluice room and storeroom of the department had 'Jack and Jill' access, so they could be accessed from both the children's emergency department and the COU. The department had a medicines room which was accessed using keys which had been programmed for each staff member including agency staff. This ensured traceability to who had accessed the room and at what time.

The resuscitation room contained 2 resuscitation bays and followed health building note 15-01 and guidance from the 2010 resuscitation guidance from the Resuscitation Council. There was unimpeded access to the resuscitation room from the ambulance entrance. Each resuscitation bay was large, to accommodate the numbers of staff required to care for patients, and to house all necessary equipment and medicines required to safely treat critically unwell children and young people.

Staff carried out daily safety checks of specialist equipment. We saw that daily and weekly audits had been carried out on the resus trolleys. There were 3 resus trolleys readily available within the department.

Assessing and responding to patient risk

Urgent and emergency services

Staff completed risk assessments for children and young people swiftly. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff completed risk assessments for each child or young person on arrival, using a recognised tool, and reviewed this regularly. Children attending the emergency department between the ages of 1 month and 16 years were initially assessed within the Urgent Treatment Centre (UTC). The UTC was staffed by a streaming nurse between 8am and 8pm each day within a dedicated children's waiting area. The streaming nurse was a trained paediatric nurse. They had oversight of the children and young people in the waiting room, which meant they could monitor and assess for deterioration. The streaming nurse followed the streaming pathway for children, which was based on the Manchester Triage System. The use of the Manchester Triage System ensured a consistent approach to assessment and prioritisation. This meant children and young people were seen in order of clinical priority and not in order of attendance. The streaming checklist was clearly displayed within the assessment area. This highlighted criteria for those who were required to be on the rapid paediatric pathway, which included:

- All babies under 1 month old
- Babies under 3 months of age with a body temperature of below 36 degrees Celsius or above 38 degrees Celsius.
- First febrile convulsion in children under 18 months of age.

The service's triage standard was that a face-to-face encounter should occur within 15 minutes of arrival and should take less than 5 minutes to complete. Triage consisted of a set of observations which included, but was not limited to, temperature check, respiratory rate, heart rate, blood pressure and capillary refill time (CRT). CRT is defined as the time taken for colour to return to a finger after pressure is applied to cause blanching and is widely used to assess the circulatory system in unwell children. The patient record proforma used within the UTC asked the streaming nurse to consider 'could this be sepsis?' This box was ticked if the initial observations raised concerns about a potential sepsis diagnosis. Based on this initial examination, patients were either streamed to the children's emergency department or seen within the UTC by a team of general practitioners (GPs). Those children and young people assessed as requiring urgent care were accompanied by the streaming nurse directly to the children's emergency department. The streaming nurse requested other staff within UTC to cover the paediatric waiting room while this took place. Children and young people who remained within the UTC were re-examined at regular intervals to ensure that they did not deteriorate while waiting to be seen by the GPs.

Children and young people who had been seen within 48 hours could report directly to the children's emergency department if they were returning with the same condition. Children and young people would present directly to the children's emergency department between the hours of 8pm and 8am, when the paediatric streaming nurses were not working within the UTC.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used Paediatric Early Warning System (PEWS) to aid with the early recognition of sick children and identify any deterioration in their condition. The PEWS system looked at the patient's respiratory rate, oxygen saturation, heart rate, CRT, blood pressure and temperature. In addition, the PEWS system considered a patient's AVPU score:

A - is the patient awake/sleeping normally?

V - does the patient respond to verbal stimulation?

P - does the patient respond to painful stimuli?

U - is the patient completely unresponsive?

Staff followed the PEWS escalation plan, which was documented on the PEWS chart. Observations were repeated at intervals which were indicated by the PEWS score. Staff demonstrated a good knowledge of what they would do if a patient's PEWS scores required escalating. We saw observations were repeated in line with the PEWS score in each of the 12 patient records we reviewed.

Staff told us that electronic devices were going to be introduced later in the year to record PEWS scores. The electronic devices would upload the PEWS scores automatically onto electronic white boards within the nurses' stations, so nurses could visualise which patients were most at risk of deterioration. They would also highlight when patient observations were due to be repeated. The new ePEWS system would give more emphasis to parental and clinical judgement within the scores.

The service's fever pathway - clinical assessment and management tool for children younger than 5 years old, referenced the National Institute for Health and Care Excellence (NICE) 'traffic light' system to assess a child's risk of serious illness. We saw evidence that the traffic light system was being used in patient records. A quick reference guide to the traffic light system was observed within the assessment area of UTC. It outlined the normal and high-risk ranges for respiratory rate, heart rate and blood pressure for different age ranges of children.

A sepsis screening tool was used on all patients on triage. The sepsis screening tool was an aid for staff to recognise, review, respond and reassess for signs of sepsis. The sepsis screening tool was triggered if patients presented with 2 from the following:

- Temperature below 36 degrees Celsius or over 38.5 degrees Celsius.
- Raised heart rate according to patient age.
- Raised respiratory rate according to patient age. Plus 1 from the following:
- Altered mental state: sleepy, floppy, lethargic or irritable.
- Mottled skin or prolonged CRT.
- Clinical concern indicating possible sepsis.

If the sepsis tool was triggered, the patient would be reviewed by a middle grade doctor or above. Staff told us that the sepsis screening tool would be used again if the PEWS scores changed and indicated a possible sepsis diagnosis. If sepsis was considered likely, staff followed the sepsis 6 pathway, where treatment would be delivered within 1 hour. Treatment included high flow oxygen, urine output measurements, obtaining intra-venous (IV) access, taking blood tests and blood gases, giving antibiotics and fluids.

Children were not sedated within the paediatric ED department or resus rooms. Children who required sedation were transferred to an operating theatre and the children's ward.

The service used the Southampton Oxford Retrieval Team (SORT). SORT guidelines were displayed within the resus area of the department. SORT was a collaboration between 2 paediatric intensive care units which delivered paediatric critical care to hospitals throughout the south of England.

Shift changes and handovers included all necessary key information to keep patients safe. A safety huddle was held every weekday morning which was attended by representatives from all departments within the hospital. This meeting was chaired by the chief nurse and discussed staffing levels, capacity and any significant events that had occurred during the previous day. Staffing levels were RAG rated as red, amber, or green and staff would be moved between wards when necessary.

The service used an electronic clinical patient management programme, which helped staff monitor waiting times and communicate treatment details with the patient's GP.

Staffing

The service did not always have enough nursing staff and support staff but took steps to maintain safe staffing levels. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The number of nurses and healthcare assistants did not always match the planned numbers. Between November 2022 and April 2023, 571 shifts were required to be filled by agency or bank staff across the paediatric department. The review of data showed of these 571 shifts, 15% were unfilled. The service had no incidents which related to a shortage in nursing staff in the year preceding the inspection.

The department manager could adjust staffing levels daily according to the needs of the children and young people. A specific paediatric huddle was held between the paediatric ward and ED department at 3 hourly intervals each day. This meant that the departments could adjust staffing levels to meet extra demand when required. Staff followed the service's acute bed management policy for addressing shortfalls in capacity and staffing. This included asking staff to alter shifts and seeking suitable staff from other areas within the trust. Managers requested staff familiar with the service. We saw that the same bank and agency staff were repeatedly used. The paediatric nurse who triaged patients in UTC told us that they worked 4 to 5 days per week as an agency nurse. They told us that managers made sure all bank and agency staff had a full induction and understood the service.

The Divisional Director for Women and Children's Health told us there had been a recruitment drive over the past 12 months, to ensure the service had a robust staff model in place.

Medical staffing

The trust used a flexible approach to maintain safe medical staffing levels, while steps were being taken to employ the additional medical staff required. Managers regularly reviewed staffing levels and skill mix.

Managers could access locums when they needed additional medical staff. Between November 2022 and March 2023, 89 shifts were filled by bank medical staff. Bank staff were used to cover for staff sickness, maternity leave, and strike action. The service had logged 1 incident in the year preceding the inspection which related to a shortage of doctors in the emergency department. This had resulted in a 10 hour wait for some patients.

The service had a good skill mix of medical staff on each shift. They reviewed this regularly. However, there was not a paediatric emergency medicine consultant, (PEM) as recommended by the Royal College of Paediatric and Child Health.

The Divisional Director for Integrated Medicine told us there had been a big recruitment drive as the paediatric emergency department had expanded once it had moved into the new building in April 2023. They understood that the service needed to invest in a bigger workforce to fulfil the transformation of the urgent and emergency care (UEC)

service. The service had plans to increase the paediatric medical workforce by an extra 2 consultants. They told us that the new paediatric emergency department would be more attractive for paediatric emergency medicine consultants (PEMs) to want to work at the service. The unit was staffed by paediatric consultants and registrars and junior doctors from the general emergency department were allocated to work within paediatric emergency department on rotation.

Twilight consultant cover was in place between 4pm and 10om on weekdays and 5pm and 10pm on weekends and bank holidays. This allowed for onsite senior decision making for more hours of the day. However, staff told us that this shift was not always filled.

To accomodate for the increased capacity of the new children's emergency department, additional consultant cover for the COU was introduced in January 2023. This meant that a paediatric consultant was available in the COU between 9am and 10pm on weekdays and 5pm and 10pm on weekends, when twilight cover was in place.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive. We reviewed a sample of 12 patient records. The records were clear, detailed, and demonstrated that PEWs scores and sepsis screening tools were being used appropriately and routinely. All patient records were paper based.

Trust wide audits on patient records were carried out monthly. These audits looked at various aspects of patient records, including if pain assessments and food charts had been completed, if safeguarding screening had taken place and if the records had a legible printed name after each entry. The average score for the department was 54% in October and 55% in December 2022. Improvements had been made and in January and May 2023 the audit showed 100% compliance. The department aimed to maintain these standards and to continue the monthly audit of patient records.

Sepsis and PEWS audits were completed internally within the department and the outcomes of these audits were discussed in the Children's Emergency Department/Children's Observation Unit monthly meeting. We saw the meeting minutes for March, April and May 2023 which showed compliance with using the sepsis screening tool was between 80% and 90% and compliance with using the PEWS chart correctly was between 84% and 90%.

Records were stored securely. All records were stored on the department for 3 days before being filed centrally.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers did not always fully investigate incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. They told us that incidents would be reported on the electronic incident reporting system and the divisional director of the department would be notified by email of any incidents classed as moderate or above. We saw that staff from the children's emergency department and observation unit had reported 171 incidents on the electronic incident reporting system in the year preceding the inspection. Of these incidents, 149 had been classed as no harm, 15 classed as a near miss and 7 were classed as harm occurred (6 of which were classed as low harm and 1 as moderate harm).

Urgent and emergency services

Staff did not always report serious incidents clearly and in line with trust policy. A serious incident is defined by the NHS Serious Incident Framework as "adverse events, where the consequences to patients, families, carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified." The NHS Serious Incident Framework supported NHS services to develop robust systems for reporting, investigating, and responding to serious incidents.

The trust's serious incident report form stated that the purpose of a serious incident investigation was to learn from incidents (and not to assign blame). The objectives of the serious incident investigation were to establish whether lapses occurred in care and identify any actions to reduce or eliminate any identified lapses.

Staff were directed to follow the service's paediatric, neonatal, and obstetric incident investigation flowchart. This demonstrated the steps which would be taken in the event of a possible serious incident. All incidents were to be reviewed daily by the senior nursing team, to see if they met the criteria to be a serious incident. The flowchart included a trigger list for potential paediatric serious incidents. The trigger list included, but was not limited to:

- Death of a child
- Unexpected deterioration of a patient requiring retrieval for an increased level of care
- Failure to adhere to PEWS policy and escalation.

In the year preceding our inspection, the service had reported 1 unexpected child death within the paediatric emergency department, 30 incidents which involved an unplanned transfer of care to other institutions or clinical services and 4 incidents which involved a failure to adhere to PEWS policy and escalation. From the 171 incidents, 6 had further investigation with a 72-hour report (3 of these involved a deteriorating patient which required an unplanned transfer of care) and 3 of those had been identified as serious incidents.

The service's management of child deaths guideline stated all unexpected deaths should be reported in the incident reporting system and the lead handler for these incidents should be the Sudden and Unexpected Death of a Child (SUDC) lead paediatrician. We saw that the SUDC paediatrician was not involved in the assessment of an incident following an unexpected child death. The incident report for this unexpected child death was lacking in detail, with no reasoning or explanation on why further investigations were not carried out.

It was not clear if managers investigated all incidents thoroughly. We saw from the electronic incident reporting system that an initial review of each incident was reviewed by senior staff members. The record included a description of the incident and any actions taken or lessons learnt following the incident. Some entries were clear and concise, with enough detail to support an informed decision. Most entries were clear and concise, with enough detail to support an informed decision. However, for some of the incidents which met the criteria for consideration as a serious incident, it was unclear from the records if they had been correctly identifed as not requiring further investigation.

The NHS England Serious Incident Framework states, "Whilst a serious outcome (such as the death of a patient who was not expected to die) can provide a trigger for identifying serious incidents, outcome alone is not always enough to delineate what counts as a serious incident. The NHS strives to achieve the very best outcomes, but this may not always be achievable. Upsetting outcomes are not always the result of error, acts and/or omissions in care. However, this should be established through thorough investigation and action to mitigate future risks should be determined".

Urgent and emergency services

The NHS England Serious Incident Framework states that where it is not clear whether an incident fulfils the definition of a serious incident, providers must engage in open and honest discussions to agree the proportionate response. If a serious incident is declared, but further investigation demonstrates there were no acts or omissions of care which contributed to the outcome, the incident can be downgraded.

The NHS England Serious Incident Framework also states, 'Those involved in the investigation process must not be involved in the direct care of those patients affected nor should they work directly with those involved in the delivery of that care. Those working within the same team may have a shared perception of appropriate/safe care that is influenced by the culture and environment in which they work. As a result, they may fail to challenge the 'status quo' which is critical for identifying system weaknesses and opportunities for learning.' The decisions to not further investigate potential serious incidents with a 72-hour report were made by the senior management team in the paediatric emergency department.

Staff understood the duty of candour. They were open, transparent, and gave patients and families a full explanation if and when things went wrong. The duty of candour requires registered providers and registered managers to act in an open and transparent way with people receiving care or treatment from them and includes specific requirements for certain situations known as 'notifiable safety incidents.' A notifiable safety incident must meet all 3 of the following criteria:

- It must have been unintended or unexpected.
- It must have occurred during the provision of an activity we regulate.
- In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

Formal duty of candour was not required if the incident was classed as no harm, low harm or near miss, but there was an expectation for the paediatrics team to discuss and support families following all incidents. Formal duty of candour was required if the incident had required a 72-hour report, even if the incident had been downgraded and was not classed as a serious incident. We saw that duty of candour had been formally completed in 3 incidents in the year preceding the inspection. There was no evidence that formal duty of candour had occurred for the other 3 incidents which had a 72-hour report.

Staff received feedback from investigation of incidents. There was evidence that changes had been made in response to some of the incidents reported. Where improvements were identified, actions taken to address these improvements were documented in the incident reporting system. For example, we saw that on 3 occasions, action was taken to remind staff on the importance of clear and correct documentation. This included an incident where the PEWS chart had not been completed correctly, but this had not impacted on care as the patient was escalated immediately when triaged. The junior doctor involved in this incident was informed about the importance of completing the PEWS chart correctly.

An online communications channel had been developed when the service had moved into the new unit. We saw that changes to process were communicated to staff through this communications channel. Following an incident, staff were reminded to wear red aprons when making and using medicines. The purpose of the red apron was to notify other staff that they were not to be distracted.

We saw an email which was sent to all staff at the beginning of April 2023. This reminded staff to ensure that the correct PEWS chart was used according to the patient's age. The matron planned to complete spot checks to ensure that this was happening in the future.

Urgent and emergency services

Staff met to discuss the feedback and look at improvements to patient care. Incidents and complaints were discussed at monthly PDU meetings, and service delivery unit (SDU) clinical governance meetings.

Managers debriefed and supported staff after any serious incident. Staff told us that they received support following incidents.

The trust was working towards implementing the Patient Safety Incident Response Framework (PSIRF) in Autumn 2024. This was a new approach to responding to patient safety incidents and would replace the Serious Incident Framework. PSIRF would support the development and maintenance of an effective patient safety incident response system, which would have 4 aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approached to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The paediatric emergency department sat under the Division of Integrated Medicine but was staffed by paediatric nurses from the Division of Women's and Children's Health. The Children's Observational Unit (COU) was located next to the paediatric emergency department and sat under the Division of Women's and Children's Health. Leaders were aware that as the paediatric emergency department was cross divisional, and had recently moved into a new separate building, there needed to be strong links between the 2 departments. The Divisional Director of Integrated Medicine said the arrangement could feel fragmented, as the department was staffed by paediatric nurses who sat under the Division of Women and Children and Sexual Health. The service had appointed a lead clinician who linked the 2 departments. The 2 emergency departments held 3 hourly safety meetings during the day, where capacity and demand, waiting times and safety issues were discussed, so both departments were aware of the current pressures on the service.

The nursing leadership team for the paediatric emergency department was overseen by the Head of Nursing for Acute Paediatrics. They oversaw the Acute Lead Nurse for Paediatrics, the Matron for Paediatrics, the Team Lead for the department and 15 deputy sisters or charge nurses. Staff told us the Acute Lead for Paediatrics, Matron for Paediatrics, and the team leaders were accessible and visible. Staff would raise concerns and escalate through the named manager of the day. The service had a named paediatric consultant of the week, who also managed any issues arising in the department.

Vision and Strategy

Urgent and emergency services

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust had received £15 million of funding in 2020, which was part of a £28 million package of funding to upgrade emergency departments in a bid to reduce overcrowding within emergency departments nationally. The opening of the new unit in April 2023 had a positive impact for both paediatric emergency medicine and the general emergency department, as it had freed up more space.

The Divisional Director for Integrated Medicine told us about the trust's ongoing plans to transform the Urgent and Emergency Care (UEC) service, which were in line with the NHS's UEC Recovery Plan and the NHS Long Term Plan, which was published in January 2019. This included measures to provide an urgent care service, through the Urgent Treatment Centre (UTC) 24 hours a day, 7 days a week. The UTC was crucial to stream patients arriving at the emergency department to the most appropriate pathway, which in turn relieved the pressure on the emergency departments. The Divisional Director for Integrated Medicine told us there were 5 pillars of work ongoing, which included measures on working with other community services, such as pharmacies, focusing efforts on reducing the length of stay in hospital, admission avoidance whenever possible and implementing same day emergency care (SDEC) services, to allow for rapid assessment, diagnosis, and treatment of patients. The UEC programme was still in development, but the UTC was scheduled to be open 24 hours a day from July 2023.

The Head of Nursing for Acute Paediatrics told us they attended the emergency care transformation meetings and had an input into the transformation.

Culture

Most staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear. The service did not always make sure that all people could communicate effectively.

The service participated in a national annual staff survey. The survey provided essential information to the trust about staff experience, which could be compared to other NHS trusts across England.

Staff from the Women and Children and Sexual Health Division of the trust gave a response rate of 57% in 2022. Generally, staff from the division gave scores in line with the whole trust, which was above the national average. Scores were on a scale of 0-10, with a higher score being more positive than a lower score. The whole division gave higher positive scores relating to compassion and inclusivity, feeling recognised and rewarded, and teamwork, compared to the whole trust. The division scored lower compared to the whole trust in parameters about flexible working, supporting a work-life balance and experiencing negative experiences.

However, staff from the Paediatric Division Unit (PDU) gave lower than average scores compared to other staff in the division. This included:

- Score of 4.17 in response to being recognised and rewarded for their work (compared to an average score of 6 across the whole trust).
- Score of 6.14 in response to the service being compassionate and inclusive (compared to an average score of 7.4 across the whole trust).

Urgent and emergency services

Paediatric medical staff scored 7.86 for compassion and inclusivity, compared to 7.4 across the whole trust and 6.68 for being recognised and rewarded, compared to an average score of 6 across the trust.

The Interim Divisional Director for Women and Children's Health told us they had seen an improvement in staff morale since moving to the new unit.

Staff told us doctors within the paediatric emergency department were approachable, and they felt part of a team. They detailed how they could escalate patients to their medical colleagues if they had any concerns. If a paediatric doctor was unavailable, they would escalate to their matron or the nurse in charge.

Junior doctors from the adult emergency department had rotations within the paediatric emergency department. A buddy system was in place, so they were supported.

Staff told us that they had input into the planning of the new unit, and they felt listened to and valued.

Between May 2022 and May 2023, the paediatric service had used interpreters 26 times (this covered the whole paediatric department, including the ward and community services). Interpreters had been arranged for Ukrainian, Polish, Punjabi, and Cantonese languages. The service had arranged British Sign Language interpreters twice within this period. One member of staff told us interpreter services were available 24 hours a day and 7 days a week. We did not see any information within the paediatric emergency department, children's observation unit (COU) or urgent treatment centre (UTC) which informed children, young people, and their families of the availability of interpreter services. The failure to provide an interpreter when required can affect patient experience and health outcomes and could result in children young people and their families feeling they had not been listened to. Trust guidelines encouraged staff to involve an interpreter, who was not a family member, when English was not understood or spoken well. A review of records demonstrated there had been some occasions when families may have benefited from an interpreter, but one had not been called.

Governance

Leaders operated effective governance processes. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The paediatric emergency department was an extension of the general emergency department. We saw meeting minutes between the emergency department and the paediatric decision unit (PDU) held in May 2023. Staff discussed the opening of the new paediatric emergency department and when children should be transferred to the children's observation unit (COU). Matrons from each department met twice a month to discuss any concerns or issues. The Head of Nursing for Acute Paediatric Medicine told us that the monthly quality and safety report from the general emergency department covered an assessment of incidents recorded by the paediatric emergency department.

Staff from the paediatric emergency department were expected to attend at least 4 paediatric decision unit (PDU) meetings per year. These meetings discussed feedback from incidents reported for the previous month, staffing and recruitment, and outcomes from audits.

Meeting minutes for the monthly paediatric clinical governance meetings were clear and comprehensive. These meetings covered incidents, learning points, paediatric deaths, the risk register, safeguarding concerns, complaints, and audits. Outcomes from the morbidity and mortality (M&M) meetings and Child Death Overview Panel (CDOP) were also discussed within these meetings. The paediatric mortality and morbidity (M&M) meetings gave a summary of each case and identified learning points and actions.

The Service Delivery Unit (SDU) clinical governance meeting for the emergency department included updates from the paediatric department. The meeting discussed incidents and complaints, learning, audits, and performance across the whole emergency department.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively.

Clinical and internal audit processes generally had a positive impact on quality governance, with clear evidence of action to resolve concerns. We saw the minutes of a PDU meeting held in May 2023 which discussed that the department had scored 80% in a sepsis audit, and 90% in a PEWS audit. Staff were reminded of the importance of completing the sepsis screening tool and to initial and outline the frequency of observations on the PEWS chart. Similar results for these audits were discussed in previous meeting minutes for March and April 2023.

We did not see any evidence the trust had clear processes in place to assure themselves that policies and guidelines relating to incident reporting and management were being followed and that incidents were being correctly categorised and investigated.

The trust's policy for the management of incidents and serious incidents outlined the immediate actions to be taken when an incident had been identified as a potential serious incident. The recommended actions included a conference call within a 48-hour period to include a member of the Division Senior Team, local manager where the incident occurred and the Divisional Clinical Governance Lead.

We saw evidence of a 48-hour report for a potential serious incident (SI) which was completed following a historic event. The decision rationale to not progress this case as a serious incident was documented and explained clearly within the report. We did not see any evidence of 48-hour reports for any of the incidents reported within the year preceding the inspection, including those which were included on the potential serious incident trigger list.

The trust had completed a serious incident and complaints, including lessons learnt audit in April 2023. However, this only looked at incidents once they had been declared a serious incident. It did not give assurances whether all incidents had been appropriately classified and investigated.

The service's policy for the management of incidents and serious incidents stated that the effectiveness of this policy was monitored through an annual audit of 20 incidents from each division, to check compliance with the policy. This audit was to be led by the Patient Safety Manager and the outcome would be reported to the Quality and Patient Safety Group. The service did not provide us with evidence that an audit of incidents within the paediatric emergency department had taken place. This meant that the service could not provide assurances that all incidents reported on the incident reporting system had been graded correctly, all learning points identified, and measures put in place to reduce the likelihood of a similar incident happening again.

Engagement

Urgent and emergency services

Leaders actively and openly engaged with staff and patients to plan and manage services.

Key messages were communicated to staff in monthly Big 4 Safety Messages. The Big 4 Safety Message in April 2023 reminded staff that a failure to record information accurately in clinical records can result in reduced quality of care and actual harm to patients. We saw that these communications were used to remind staff of the paediatric resuscitation guidelines which stipulated that blood pressure must be completed manually if 2 consecutive high readings were obtained or if blood pressure was very low.

The Matron for Paediatrics had set up a team communications channel in April 2023 to coincide with the move into the new building. This provided a route for easy communication to all members of the children's emergency department nursing team. We saw the Big 4 Safety messages were communicated to all staff through this communications channel. Staff were also informed of any changes to process. We saw a communication which informed nursing staff that all ambulance handovers were to be taken by the nurse in charge for observations to be completed. This was a change in the usual process which had been implemented because of an incident. This message was posted on the communications channel and sent by email to all staff, to ensure everyone had received it. Changes were also discussed within staff huddles.

Prior to the development of the team communications channel, staff were kept updated on any changes through emails.

The service's Clinical Governance newsletter in August 2022 focused on learning from recent incidents and complaints. The newsletter stated that 'it is only by reporting incidents that we can learn from them and improve our service.'

Patients were encouraged to give feedback on the service both directly to the service through the Friends and Family Test or through a confidential service which was independent to Buckinghamshire Healthcare NHS Trust. We saw feedback from patients who had used the service between December 2022 and June 2023. Feedback was mostly complementary about staff. Examples of feedback included, 'Every member of staff was friendly, helpful and compassionate,' and 'both nurses and doctors were lovely despite how busy they were.' More recent complements were seen about the new building, including ''The new building was very nice, loved the solo room space and bathroom' and 'The new facilities are amazing, and it's made our journey much more comfortable as its peaceful and less chaotic.' Negative feedback included a theme around wait times and some people complained about having to be triaged in UTC before being sent to paediatric ED. Feedback was discussed within the SDU clinical governance meeting.

Formal complaints were directed to the Patient Advice and Liaison Service (PALS). We saw evidence of formal complaints from the paediatric emergency department being responded to by the Chief Medical Officer, the Chief Nurse and the Chief Executive of the trust following an investigation into the complaint. The responses included apologies and measures that had been put in place to reduce the risk of a recurrence. For example, the service had produced a patient advice leaflet to ensure that clinical staff gave consistent information following a complaint.

Areas for improvement

MUSTS

The trust must ensure there are effective systems and processes in place to ensure potential serious incidents have been correctly categorised, reviewed, thoroughly investigated and lessons shared to reduce the risk of reoccurrence. Regulation 17 (2).

Urgent and emergency services

SHOULDS

The trust should ensure that service users are aware that interpreters are readily available and that they are used when required and according to trust policy. Regulation 17

Our inspection team

We carried out an unannounced focused inspection of the paediatric emergency department at Stoke Mandeville Hospital. During the inspection visit, the inspection team:

- Inspected the new paediatric emergency department, children's observation unit, resuscitation room and urgent treatment centre (UTC).
- Looked at the triage process and patient journey from the UTC.
- Looked at a sample of 12 patient records.
- Observed the daily safety huddle.
- Spoke with 10 members of staff, including nursing staff, medical staff, and leaders of the service.

Following the inspection, the inspection team reviewed further service information such as policies, patient feedback, and training records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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