Agenda item: 18
Enclosure no: TB2018/17

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

BOARD MEETING IN PUBLIC
31 January 2018

Details of the Paper

Title	Organisational Risk Profile
Responsible Director	Director for Governance
Purpose of the paper	To inform the Board of the organisation's top risks and how they are being managed.
Action / decision required	Confirm top risks.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)

Patient Quality	***Financial Performance***	***Operational Performance***	***Strategy***	***Workforce performance***	*New or elevated risk*
Legal	***Regulatory/ Compliance***	***Public Engagement /Reputation***	*Equality & Diversity*	***Partnership Working***	***Information Technology / Property Services***

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
This links to all the strategic objectives.

Please summarise the potential benefit or value arising from this paper:
A sound knowledge of strategic risk enables the Board to make informed decisions.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: All risks on Board Assurance Framework
	Financial Risk: All risks on Board Assurance Framework

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Well Led Domain; Outcome 17 Good Governance

Author of paper: Liz Hollman

Presenter of Paper: Liz Hollman

Other committees / groups where this paper / item has been considered:
BAF moderated by EMC 5 January 2018; CRR moderated by EMC 24 November 2017 and will be going to EMC again on the 7th February following review at the Risk and Compliance Monitoring Group on the 29th January 2018. Risk process reviewed at Audit Committee. CRR considered at Quality Committee and Finance and Business Performance Committee.

Date of Paper: 23 January 2018

RISK PROFILE

1. PURPOSE

The purpose of this paper is to inform the Board of the top organisational risks and how they are being managed.

2. BACKGROUND

The Board Assurance Framework is the key document detailing the strategic risk and how it is managed and this is reviewed four times a year. The Board Assurance Framework for 17/18 is shown in Appendix 1 and was last moderated by the Executive Management Committee on the 5th January 2018.

The Corporate Risk Register shows risks emerging from clinical divisions and corporate services and was last reviewed and moderated on the 24th November 2017.

3. TOP RISKS

The top risks emerging from the risk documents are as follows:

- Risk around the delivery of the financial plan. Key actions are in place to promote efficiency and effectiveness; to closely monitor financial delivery at all levels of the organisation; and a framework of controls is in place. There is an associated risk around the requirements of the capital programme and its delivery. In addition there is recognition of the risk associated with the Cost Improvement Programme the delivery of which is fundamental to achieving the financial plan.

- Risk to delivery of organisational objectives if we do not have the right number of staff with the right skills and talent. To address this risk there is a comprehensive recruitment plan in place to drive and improve staff retention. Further detail about this can be found in the Human Resources performance report.

- Risk to patient experience due to pressures on the urgent care pathway. Further information on this is provided in the operational performance report.

4. RECOMMENDATION

The risks are recommended to the Board for discussion and action as necessary.

Liz Hollman
Director for Governance

Agenda item: 19
Enclosure no: TB2018/18

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

BOARD COMMITTEE SUMMARY REPORT FOR AUDIT COMMITTEE

Name of Committee	Audit Committee
Committee Chair	Mr Graeme Johnston
Meeting date:	11 January 2018
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Miss Elizabeth Hollman; Dr Dipti Amin; Mrs Rachel Devonshire; Mr Keith Miller.

KEY AREAS OF DISCUSSION:

The Committee received the following:

- Report on internal controls from payroll provider, Equiniti
- NHS Net email switchover
- Summary of changes to the Board Assurance Framework and a deep dive on the assurances associated with the capital programme
- Update on whistleblowing process and Freedom to Speak Up Guardian role
- Corporate Risk Register and changes since the last review
- External audit progress report
- Internal audit progress report
- Internal audit draft plan 18/19
- Local Counter Fraud Specialist report and draft workplan for 18/19
- Updates from Board Committees
- Planning for year end and financial close
- Single tender waivers
- Losses and special payments schedule
- Quality Accounts process and timetable for 17/18

MATTERS TO BE ESCALATED TO BOARD:

There were no matters to be escalated to Board.

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

AUTHOR OF PAPER:	Liz Hollman, Director for Governance

Buckinghamshire Healthcare NHS
NHS Trust

Risk Profile – Board Assurance Framework December 2017

CONSEQUENCE / LIKELIHOOD (frequency)	(1)	(2)	(3)	(4)	(5)
(5)				BAF 3.3a Delivery of the capital programme⇔⇔🡅	
(4)				BAF 1.3a Number of cases of Clostridium difficile ⇔⇔🡅 BAF 1.3b Number of cases of MRSA bacteraemia⇔⇔🡅 BAF 2.2a Reduction in agency costs⇔⇔🡅 BAF 2.2b Right number of staff with all the right skills and talent 🡅⇔⇔ BAF 3.2a Delivery of the cost improvement plan⇔⇔⇔	BAF 1.6a Delivery of NHS Constitution standards (including A&E) ⇔⇔⇔ BAF 3.1a Delivery of the financial plan⇔⇔⇔ BAF 3.1b Cash⇔⇔⇔ BAF 3.3b Having sufficient capital for high priorty requirements in estates, IT and medical equipment⇔⇔🡅 BAF 4.3a Transformation of urgent care pathways ⇔⇔⇔
(3)				BAF 1.2a Reduction in pressure ulcers⇔⇔⇔ BAF 1.2b Reduction in falls⇔⇔⇔ BAF 2.1a Staff engagement🡅⇔⇔ BAF 2.3a Statutory and mandatory training ⇔⇔⇔ BAF 3.4a Agreed Sustainability and Transformation Plan⇔⇔ BAF 3.5 – ACS – new Q2 ⇔🡅 BAF 4.4a Working with partners to transform NHS 111 and primary care service – new Q1⇔⇔ BAF 5.1.1a Enhanced stakeholder relationships⇔⇔⇔ BAF 5.2.1a Healthy Child Programme⇔⇔⇔ BAF 7.3a Theatre service transformation – new Q1⇔⇔ BAF 9.1a Use of community estate – new Q1 ⇔⇔	
(2)			BAF 1.5a Patient engagement 🡅🡇⇔	BAF 1.4a Patient experience ⇔⇔⇔ BAF 3.4a STP – new Q2 ⇔ BAF 5.1.3a Community Hubs⇔⇔⇔ BAF 6.1a Pathology transformation- new Q1⇔⇔ BAF 6.2a Maternity Strategy – new Q1⇔⇔ BAF 7.4a Diabetes transformation ⇔⇔⇔ BAF 10.6 SDU clinical strategies – new Q1⇔⇔	BAF 1.1a HSMR ⇔⇔⇔ BAF 7.1a Musculo-skeletal pathway re-design⇔⇔⇔ BAF 7.2a Outpatient re-design – new Q1 ⇔⇔ BAF 8.3a IT interoperability ⇔⇔⇔ BAF 10.3 Culture of innovation ⇔⇔⇔
(1)				BAF 8.1a Innovation Hub – newQ1🡇⇔ BAF 10.1a Board development –newQ1⇔⇔ BAF 10.4 Relationship with GPs⇔⇔⇔	

Key: 🡅= risk score has risen; 🡇= risk score has dropped; ⇔= no change.

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
Includes Reference to Corporate Risk Register where relevant	*Focused on strategic risk.*	*The score if there were no controls in place*	*IC = internal control* *EC = external control* *Controls recorded on separate lines*	*IA = internal assurance* *EA = external assurance* *Assurances map to individual controls.*	*No assurance = red* *No external assurance = amber* *Internal and external and timely assurance = Green*	*Areas which will require action if risk score or assurance RAG are to improve.*	*This indicates the level of concern i.e. are the assurances giving us negative or positive indications.*	*This will include timescales for tracking and show where timescales have not been met.*	*Executive director lead*
High quality, safe and compassionate care in patient's homes, the community or one of our hospitals **- Sustain HSMR at 90 or below; 75% of patients meet 1 hour door to needle time presenting with sepsis in ED; 80% of fracture neck of femur patients meet 36 hour standard for emergency surgery; 75% of patients on the fragility pathway are assessed with an appropriate tool.** **- No avoidable harm in grade 3 or 4 pressure ulcers, with a further reduction in avoidable grade 2 pressure ulcers.** **- Further reduction in avoidable falls per annum** **- Meet infection control targets of zero MRSA and zero avoidable C diff. Overall C Diff. target no more than 32; reduction in gram negative infection - 10%** **- Sustain 95% Friends and Family approval rating and increase the response rate to 40%.** **- Increase the number of complaints answered within 28 days.** **- Increase patient engagement numbers by 10% across key initiatives .** **- Consistently meet the NHS Constitution standards (A&E, RTT, cancer waiting times for diagnosis and treatment)**								
	There is a risk that without continuous		16/17 mortality reduction workplan in place. (IC) Monthly Mortality Reduction Group chaired by the Medical Director. Annual review of Terms of reference. Information flows have been reviewed, suite of agreed reporting information developed.(IC) 'Dr Foster routinely providing prompt data for the workstreams and is attending the mortality reduction group (EC) Mortality Reduction Action plan. Educational programme redesigned to focus on the deteriorating patient. Further embedding of deteriorating patient work through the deteriorating patient group (IC)	HSMR and SHMI and crude mortality reported in the Quality Report to Quality Committee and Trust Board. (EA) Minutes from Mortality Reduction Group received by Quality Committee. (IA) Minutes from Quality Committee demonstrating monitoring of Floodlight Report (from October 2016) including compliance with medical review of every death. (IA) Minutes from Sepsis Group go to Mortality Reduction Group. (IA) Minutes from Deteriorating Patient Group received by Quality and Safety Group. (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 1.1a (Links to CRR34)	sustained improvement that the HSMR will not be sustained at 90 or below. (Monitored through Quality Committee)	**25**	Learning from mortality reviews shared using a variety of communication methods and embedded within the academic half day revised processes. (IC) National mortality review: ten Medical Examiner (ME) roles recruited to and training received. Mortality and Morbidity (M&M) administrator post being advertised; new mortality review system live on 1st Dec 2017. (IC) Quality Improvement nurse secondment is now in place and also Consultant Nurse, critical care and Outreach (who also has a responsibility for deteriorating patients). The cardiac arrest team are routinely providing reports on all preventable arrests to the responsible teams to discuss at the academic half day (IC)	Minutes from SDU clinical governance meetings and Divisional Boards. (IA) Minutes from Quality Committee demonstrating monitoring of Floodlight Report (from October 2016) including compliance with medical review of every death. (IA) Records of training received for MEs; arrangements in place through bereavement office re cremation certification and liaison with MEs. Rota in place for MEs and commenced December 2017. (IA)	**Green**	pace of introduction of e-Obs system	**10 (5x2)**	clarify funding flows and IT platform	Medical Directo
			Clinical audit programme for mortality. Audit programme reviewed. (IC and EC) Clinical audit lead attending mortality reduction group. (IC and EC)	Monitoring of results from audit programme. (IA) Internal audit 16/17 on clinical audit function (EA)					
BAF 1.2a	There is a risk that numbers of avoidable pressure ulcers will not fall by 25% in 17/18 as measured against the 15/16 baseline. This would result in poor patient experience, increased length of stay and potential loss of confidence in the service	**20**	Sskin bundle used for pressure ulcer prevention in every in-hospital clinical area (IC) Panel review of every healthcare acquired grade 3 or 4 pressure ulcer (IC)	Risk assessments recorded in patients record and monitored through review by ward managers, matrons, and Divisional Chief Nurses. (IA) All pressure ulcers reported as incidents and monitored through Quality and Safety Group and through Quality Report to Trust Board. (IA) Quality Board in each clinical area showing numbers of pressure ulcers in each month. (IA) Standardised Quality Round documentation (IA)	**Amber**		**12 (4x3)**	As per controls.	Chief Nurse
BAF 1.2b	There is a risk that numbers of falls with harm in 17/18 will not reduce by 25%. This would result in poor patient experience, increased length of stay and potential loss of confidence in the service (Monitored through Quality Committee)	**20**	Programme for Safe Care Bundle; Risk assessments and post falls bundle. (IC)	Monthly reporting: • Ops Board Report • Datix incident reporting • Quality Rounds monthly • Quality Improvement Plan reporting	**Green**	It is inevitable that some patients will have high risk factors which will precipitate an unexpected fall	**12 (4x3)**	Robust risk assessments shared with primary care to assess other risk factors that can impact on unexpected falls	Chief Nurse
			Working with partners across system to identify patients at risk of falls earlier. (EC) Falls summit engaging partners in joint working. (EC)						
			Falls passports to enable recognition of risk. (IC)						
			Community Fall and Bone Health service in place (IC)						

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
			Serious Incident Group dedicated to learning from falls. (IC)	Monthly reporting: • Ops Board Report • Datix incident reporting • Quality Rounds monthly • Quality Improvement Plan reporting					
BAF 1.3a (link to CRR 36)	There is a risk that the numbers of cases of Clostridium difficile will be above the limit of 32 in 17/18. In a minority of cases (10%) the numbers result from a lapse in care and this impacts on patient experience and possibly affects clinical outcomes. The majority of cases do not arise from lapses in care (90%) and arise from individual patient risk factors. (Monitored through Quality Committee)	12	Promotion of Antimicrobial Stewardship. (IC)	Antimicrobial strategy, (IA) Weekly report of numbers of cases of Clostridium difficile. (IA) Monthly reporting on numbers of cases of Clostridium difficile to Quality Committee (IA) Hand hygiene audits. (IA) Antibiotic usage audits (IA) National benchmarking. (EA) Quality Accounts audit of C diff sample (EA). Internal audit in 16/17 of infection control processes. (EA)	**Green**	It is inevitable that some patients will have high risk factors for C difficile as 10% of the population have C difficile in the bowel without being symptomatic.	**16 (4x4)**	Continued focus on identifying patients at risk, following universal precautions in infection prevention and control, and rigorous antibiotic stewardship. Deep dives taking place for every C Diff infection in the trust to ensure all actions required have e been taken	Medical Director
			Prompt submission of stool samples. (IC)	Datix reporting of delayed stool sample submission (IA)					
			Environmental improvements programme (IC)	Prioritised programme submitted to Quality Committee January 2017. (IA)					
			Clearing audit programme in place independent of contractors. (IC)	Audit results reported to the Executive Management Committee (IA)					
			Introduction of Fidaxomicin (IC)	Pharmacy stocking of Fidaxomicin					
BAF 1.3b (Link to CRR69)	There is a risk that there may be at least one case of MRSA bacteraemia in 17/18 resulting in poor patient experience and possibly affecting patient outcomes (Monitored through Quality Committee)	20	Admission screening of all emergency patients and some elective patients as required. (IC) MRSA policy sets out controls. (IC) Snapshot audits in areas identified as higher risk due to poor compliance with admission screening. (IC) Anti-microbial stewardship rounds (IC) Lessons learned reports out to clinical areas by Infection Prevention Control team. (IC)	Monitoring of admission screening Weekly report of numbers of cases of MRSA bacteraemia. Monthly reporting on numbers of cases of MRSA non-bacteraemia. (IA) Hand hygiene audits by each clinical area on a monthly basis, and using a risk based approach the Infection Prevention Control Team also carry out hand hygiene audits in clinical areas. (IA) Antibiotic usage audits (IA) National benchmarking. (EA)	**Green**	Limited assurance around consistent compliance with MRSA screening on admission. VIP and UCAM form audits show deficiencies in practice	**16 (4x4)**	Developing divisional skills to undertake internal reviews, commenced in Q2 and continuing to roll out in Q3.	Medical Director

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
			Careful use of invasive devices to minimise the risk of associated infections. (IC)	Appropriate use of visual infusion phlebitis (VIP) form and urinary catheter assessment and monitoring form (UCAM). (IA) Use of VIP and UCAM forms audited. (IA) Monitoring through Quality Rounds. (IA)					
BAF 1.4a	There is a risk that we will not know what patients are experiencing if we do not have regular feedback through the Friends and Family Test. The lack of information has the potential to impact on the quality of patient experience going forward. (Monitored through Quality Committee)	20	Programme for listening to patients; measuring activity and improving services through person-centred goals. For example, Friends and Family, "You Said, We Did", Patient Opinion website (IC)	Monthly reporting: • FFT recommendations, response rates and free text themes (IA) • You Said we Did (IA) • Complaints performance & themes to Divisional Boards & performance meetings (IA) Quarterly report to Board on 4 core patient experience measures (IA)	**Amber**	Divisional improvement plans arising from Strategy not yet in place. Lack of Trust wide IT solution to capture patient experience data in a granular and systematic nature.	**8 (4x2)**	• Procurement of Trust wide patient experience software platform • Quarterly patient experience workshops for staff • Patient experience team supporting Divisional Boards directly with improvement plans • Reforming Patient Experience Group to increase accountability	Chief Nurse
BAF 1.5a	There is a risk that if we do not increase patient engagement numbers and diversity across key initiatives that we will not be sufficiently informed by the patient voice in our development.	16	Communication and Engagement Strategy. (IC) Dedicated resource for patient engagement activities. (IC) Patient Experience Group chaired by Chief Nurse. (EC) Links to Patient Experience Strategy. (IC) Stakeholder engagement group and engagement and involvement plan in place to support community hubs pilot (IC)	At least bi-annual reports to Trust Board on patient engagement activity. (IA) Monitoring of key performance indicators for pilot programmes such as community hubs at Thame and Marlow. (EA) Communications Strategy approved by Trust Board in September 2017 (IA) Minutes of Patient Experience Group. (IA) Monitoring by Communications team of contacts with stakeholders. (IA)	**Amber**	Communication and Engagement Strategy not yet signed off by Board. (C) Workplan to achieve target through new Head of Patient Engagement and Involvement by end of September (C.)	**6 (3x2)**	Workplan by end of January to provide assurance .	Director of Communications
BAF 1.6a (Links to CRR 49, 68, 77)	There is a risk that we will not deliver the NHS Constitution Standards which directly impacts on patient experience. Specifically: 4 hour A&E performance, Referral to Treatment Times & Cancer 62 day waits. Risks: Quality - impact on patient experience Financial - link to STF Regulatory (Monitored through Finance and Business Performance Committee, F&BP)	16	Access and Performance Management Group chaired by Divisional Director for Surgery (IC)	Access and Performance Management Group minutes (IA) Operational performance dashboard reported at Divisional, Board and Committee level (IA) Internal audit of performance reporting Service Strategies (IA) Deep dives and performance reviews (IA) Deep dive presentations to Finance and Business Performance Committee (IA)	**Amber**	Operational Capacity to deliver required standards in particular specialities	**20 (5x4)**	Detailed work programme through the Urgent Care Recovery Board & A&E delivery board. Activity and capacity demand modelling completed end Q3. Unplanned care forecasting tool launched. Additional RAT space and Clinical Decision Unit space to be added in January. Theatres efficiency group and LOS project.	Chief Operating Officer
			Weekly Escalation meeting chaired by the COO (IC)	Weekly Escalation meeting minutes (IA)					
			Planned Care Board (CCG led, launched Sept 2016) (EC)	Meeting minutes (EA)					
			Strategic Transformation Committee (IC)	Strategic Transformation Committee minutes (IA)					
			Urgent Care Recovery Programme Board (internal) & Local A&E Delivery Board (health and social care system) (IC & EC)	Programme Boards action plans and minutes (EA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
2. People - A great place to work where our people have the right skills and values to deliver excellence in care **- Improve staff engagement score (upper decile nationally in the 2017/18 staff survey; improved medical engagement score).** **- Reduce total agency spend to £8million for 2017-18** **- Achieve 90% statutory and mandatory training, and appraisal completion.** **- Reduce and sustain nurse vacancy levels to 7%** **- Ensure all staff have a Personal Development Plan and undertake at least 3 days development per annum.** **- Formally assess leadership development programme and implement talent management structure to monitor output/improvement.**									

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 2.1a	There is a risk that if we do not continue to improve in staff engagement that we will not achieve the organisational improvement that we aspire to. We are currently achieving an average score against the national benchmark (Monitored through Strategic Workforce Committee)	**15**	Annual appraisal for each member of staff linking to Trust strategy and objectives and agreeing personal development plans. (IC)	Monthly reporting of completion levels. (IA) Annual Staff Survey results. (EA)	**Green**	Closing the loop on feedback Friday needs to be strengthened Values based recruitment requires further embedding.	**12 (4x3)**	Review of values based recruitment. First review report end Q4 'Review of the quality of the appraisals from electronic appraisal system (introduced in April 17) . First review report end Q4	Director of Human Resources
			Staff Survey action plan driven through Staff Survey champions (IC)	Documented monthly meetings with Staff Survey Champions. This includes an update from each Champion (IA) Quarterly staff Friends and Family test reported to Board. (EA) Each Division has a people plan and these are reviewed monthly at the HR & Workforce Group. (IA)					
			Leadership and management development programme. (IC)	Documented programme. Pre/post course briefing Individual links to personal development plans as seen in application forms. Course evaluations.					
			BHT Way programme (IC)	Presentations and feedback from each session. (IA) Staff Survey results. (EA) Quarterly staff Friends and Family test. Feedback Friday collated responses. (IA)					
			Coaching for improved performance (IC)	Pre/post course briefing. (IA) Programme evaluation. (IA) Record of 200 people doing foundation coaching course. (IA) Now on 2nd tranche of training EMCC accredited coaches. (IA)					
			Health and Wellbeing programme (IC)	Sickness absence monitoring reported to Board. (IA) Flu vaccination programme. (IA) Healthier Lifestyles Hub - activity reported to the HR & Workforce Group & Strategic Workforce Committee quarterly. (IA)					
			Values and behaviours framework in place and incorporated into appraisal framework and values based recruitment.. (IC)	Information about values rollout. (IA) Visibility of core values and behaviours on board walkabouts. (IA) Values based recruitment in place (IA) Values based appraisal in place (IA) Link with behaviours is considered in Trust policies coming up for review (IA) Competency framework for behaviours launched in Q3.					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 2.2a (Links to CRR 10, 78)	There is a risk that if we spend more than £8m on agency costs that this will impact on financial targets. Has the potential to affect NHS Improvement segmentation. (Monitored through Finance and Business Performance Committee, F&BP)	**20**	Escalated sign off by Senior Managers for all agency spend. (IC) Week-end agency signed off by Gold command. (IC) Fortnightly meetings reviewing agency usage for specific staff groups against agreed targets for the year. Remedial action taken as necessary. (IC)	Weekly reported nurse / doctor agency spend. (IA) Divisional targets monitored through deep dives. (IA) Performance trajectory and monthly targets in place for specific staff groups. (IA) Exception report on agency spend to Improving Performance Group monthly (IA)	**Green**	No interface between rostering systems and temporary staffing systems, which would allow triangulation of demand	**16 (4x4)**	Sustainability and Transformation Plan (STP) wide project has been started to look at the feasibility of efficiencies through adopting a system wide Bank. This has now been mandated by NHSI	Director of Human Resources
			All requests for admin/ clerical agency is signed off by the Director of Finance or the Director of Human Resources. (IC)	Reconciliation of agency ledger to request process confirmed monthly. (IA) Weekly review by vacancy panel. (IA)					
			Process for booking and managing locum doctors has been brought in-house to retain greater control as of November 2016. (IC)	Monthly reporting of agency spend provides an indication of how effective this change has been. (IA) Medical agency spend reviewed by Medical Director and Director of HR on a weekly basis. (IA)					
			Use of Roster-Pro for nursing. (IC) Variance and outliers against KPIs have focused action to address the issue. (IC)	Review against Roster-Pro KPIs monthly at the nurse agency meeting. (IA) Internal audit of e-rostering 16/17 (EA)					
			National Guidelines agency cap - agencies compelled to comply. (EC)	Weekly report on non-compliance to NHS Improvement. (EA)					
			Clear process for booking agency and agency usage policy. (IC)	Weekly reporting internally and to NHS Improvement. (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 2.2b Links to CRR 10, 66 and 78)	There is a risk to delivery of organisational objectives if we do not have the right number of staff with the right skills and talent. (Monitored through Strategic Workforce Committee)	**20**	Recruitment and Retention project (IC) Targeted recruitment in areas with the biggest risk and/or hard to recruit areas. (IC) Member of national retention project. (EC)	Monthly management reporting on vacancy, turnover, flexible labour. (IA) Feedback from CQC on compliance with safe staffing. (EA)	**Green**	There is a shortage of some key skills. Some staff groups are particularly difficult to recruit to. Workforce planning for the ACS/STP provides an opportunity to collaboratively re-shape workforce but limited progress so far.	**16 (4x4)**	Focused recruitment for hotspot areas Recruit Band 4 staff in challenging market and train our own, using apprenticeship pathways as appropriate Focussed work on retention workstreams, including recruitment of retention specialist funded HEE TV Explore the use of Recruitment and Retention payments. Streamlining project across STP to reduce on-boarding timescales and increase opportunities for transfer within the system	Director of Human Resources
			Recruitment process. (IC) Overseas recruitment. (IC) Fast Track process offering jobs to students. (IC) Targeted recruitment of high priority jobs. (IC) Bulk campaigns and vacancy sign off for midwives and radiographers.	Reports to Board on workforce recruitment trajectories. (IA) Audit of employment checks. (IA) Internal audit of recruitment 16/17 (EA)					
			Increased support to new starters and overseas nurses - extended preceptorship. (IC)	Records of meetings and individual support from recruitment team and preceptorship team (IA)					
			Process for receiving feedback from leavers. (IC)	Analysis of leavers forms and exit interviews. IA)					
			Strategic Workforce Committee. (IC) HR and Workforce Group. (IC)	Committee minutes. (IA)					
			Medical and Nursing revalidation processes (IC)	Revalidation reports to Quality Committee. (IA)					
			Participation in regional forums on efficient staffing. (EC)	Minutes, notes, diary entries pertaining to external meetings. (IA)					
			Monthly deep dive on workforce as part of COO performance framework for divisions failing to meet core people KPIs (IC)	Notes from performance meetings. (IA)					
			Skill mix to introduce up to 65 Band 4 posts (IC).	Workforce performance reports to Board					
			Accepted for fast follower introduction of Nursing Associates. (EC)	No. of individuals recruited onto NA programme (EA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 2.3a (Links to CRR 72, 71)	There is a risk to patient care if staff have not received statutory and mandatory training at the appropriate level and frequency. (Monitored through Strategic Workforce Committee and Quality Committee)	**25**	Statutory training matrix. (IC) Mandatory training matrix. (IC) Non compliance dealt with as a disciplinary matter. (IC)	Monthly report on statutory training compliance (12 month rolling) reported to Divisions and Board. (IA) Statutory training compliance reviewed at performance meetings. (IA) NLMS training data is locked into the system and therefore unable to alter. (EA) Revalidation for doctors and nurses requires evidence of completion	**Amber**	National Learning Management System is not user-friendly; most recent update has not provided expected improvements. There have been issues with speed of the system in July and August It is more difficult for some staff to access technology for e-learning. Data on mandatory training is not reported to Board or Divisions but is available through individual manager review and ad hoc reporting.	**12 (4x3)**	Review delivery mechanism of e-learning - including moving to alternative solutions 'Review the statutory/mandatory training matrix to confirm the suitability of each element to be in the category of stat/man training. (Q4) And that a systematic review process is also in place by the same time Improved co-ordination of mandatory training compliance and a phased implementation plan is in place.	Director of Human Resources
			Training programmes in place including e-learning and face to face training. (IC) Two day induction programme for clinical staff introduced to cover key elements of statutory training when clinicians join the organisation. (IC)	Monthly report on statutory training compliance (12 month rolling) reported to Divisions and Board. (IA) Statutory training compliance reviewed at deep dives. (IA)					
			Statutory training compliance and personal development plans are linked to appraisal. (IC) Compliance is required for revalidation of clinical staff, and to incremental pay progression. (IC)	Internal audit of Nurse revalidation 16/17 (EA)					
3. Money - Financial sustainability, making the best use of our buildings and be at the forefront of innovation and technology - Deliver a control surplus of £6.5million. - Deliver a CIP programme of 4.4% - Deliver an £16.4m capital programme to ensure safe services, progress digital Interoperability and improve our estate. Deliver year two of five year BOB Sustainability and Transformation Plan, including Buckinghamshire and BOB components.									
BAF 3.1a (link to CRR 32)	The failure to deliver the annual financial plan has the potential to jeopardise the future of the organisation. It is also a breach of the statutory duty to break even. Receipt of the Strategic Transformation Funding is dependent on achieving the financial plan trajectory on a quarterly basis. (Monitored through Finance and Business Performance Committee, F&BP)	20	Standing Orders and Standing Financial Instructions. (IC)	Financial report to Board. (IA) Monthly FIMS forms for NHSI. (EA) External audit programme. (EA) Internal audit programme (EA) Minutes of NHS I Integrated Delivery Meeting. (EA)	**Green**	Cost improvement programme not yet delivering to target. (C) Nursing and medical agency staffing still running above internal targets. (C) Risk to achievement of Q3 Strategic Transformation Fund finance and Accident and Emergency targets.	**20 (5x4)**	Continued focus on financial control and accountability at all levels of the organisation. Financial Recovery Plan in place.	Director of Finance
			Signed Service Level Agreements (EC)	Performance management against service / contractual specifications. (IA)					
			Divisional Performance Management process (IC)	Deep Dive process each month for Divisions. (IA) Internal Audit of Divisional performance in 16/17 (IA)					
			Bank and Agency reduction plan approved by Trust board in October 2015 (linked to BAF 2.2a)	Performance against NHS Improvement cap. (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 3.1b (Links to CRR 38)	There is a risk that if we do not deliver the financial plan we will not have sufficient cash to make repayments to facilities and loans. (Monitored through Finance and Business Performance Committee, F&BP)	20	Standing Orders and Standing Financial Instructions. (IC)	Financial report to Board. (IA) Monthly FIMS forms for NHSI. (EA) External audit programme. (EA) Internal audit programme (EA) Minutes of NHS I Integrated Delivery Meeting. (EA)	**Green**	Cost improvement programme not delivering to target. (C) Nursing and medical agency staffing still running above internal targets. (C) Timing of payment for over performance. ©	**20** **(5x4)**	Capital programme revised and risk assessment undertaken in Q3 on any deferrals of spend. Further work required in Q4 to provide assurance of meeting CRL. Focus on recovery of debtors and in particular Q1, Q2 over-performance from Specialised Commissioning. Drawdown in January 2018 in excess of Working Capital Facility.	Director of Finance
			Signed Service Level Agreements (EC)						
			Divisional Performance Management process (IC)	Deep Dive process each month for Divisions. (IA) Internal Audit of Divisional performance in 16/17 (IA)					
			Prioritisation of cash payments and cash forecast. (IC)	Finance report to Finance and Business Performance Committee and Board. (IA)					
			Bank and Agency reduction plan approved by Trust board in October 2015 (linked to BAF 2.2a)	Workforce report to Strategic Workforce Committee and Trust Board. (IA)					
BAF 3.2a	There is a risk to delivery of the financial plan if the Cost Improvement Plan is not achieved. This could affect future sustainability of the organisation. (Monitored through Finance and Business Performance Committee, F&BP)	**20**	Programme Management Office (PMO) Lead and PMO function in place (IC). Support from FTI through the Financial Improvement Programme is in place. (EC)	Monthly financial reporting to Board, divisions, EMC, corporate services and NHSI (IA). Transformation Board minutes. (IA) Project Initiation Documents (IA) Quality Impact Assessment process (IA) Planning and documentary evidence of CIPS. (IA)	**Green**	Year to date M8 not delivering to plan. Divisional / corporate performance against control total.	**16** **(4x4)**	Continued focus on financial control and accountability at all levels of the organisation. Financial Recovery Plan in place. Specific actions to manage risks and deliver mitigating actions.	Director of Finance
			Full governance methodology and process in place for cost improvement plans (IC).	Reports of internal and external audit (EA).					
			Performance management framework for divisions and corporate services (IC).	Financial control totals agreed for divisions and corporate services.					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 3.3a (Link to CRR 27, CRR 60, 73 and 79)	There is a risk that we will not deliver the capital programme in the most effective way, or deliver the Capital Resource Limit if the programme is not managed effectively. (Monitored through Finance and Business Performance Committee, F&BP)	**20**	Governance structures: Estates CMG; IT CMG; Medical Equipment CMG; CMG. (IC) Risk assessed prioritisation of schemes. (IC)	Internal audit of Planned, Preventative Maintenance 16/17 (EA) Meeting minutes for CMG (IA) Monthly monitoring of capital programme through F&BP	**Amber**	The monitoring of tendering, procurement and contracts needs to be strengthened to provide greater assurance. Assurance around post project reviews to be developed. Link between capital programme and 5 year strategy. Deferral of spend in 17/18 will build capital pressure on 18/19 and subsequent years.	**20 (4x5)**	PMO in place for Property Services capital programmes. 5 year Estates Strategy in development. Draft was reviewed by Trust Board in September 2017 and to be finalised by March 2018. Prioritised IT and medical equipment replacement strategy in development to inform 5 year capital plan. Assessment of risk of deferral to be completed by end of December 2017 and impact assessment on 18/19 as part of capital planning process, however potential risk of breaching CRL is still being worked on.	Director of Finance
			Business cases and tendering and procurement process. (IC)	Business cases (IA) Cycle of internal audit of procurement (EA)					
			Project management using Prince 2 type methodology. (IC)	Developing through PMO for Property Services. (IA)					
BAF 3.3b	There is a risk that the available capital budget that we will not achieve all the high priority requirements relating to the estates backlog, medical equipment backlog, and the Information Technology national, statutory and local requirements. (Monitored through Finance and Business Performance Committee for business risk and Quality Committee for clinical risk)	**20**	Prioritisation of capital projects based on risk, and risk profiling for projects that are not achievable in the 17/18 financial year. This is carried out at Capital Management Group and reviewed by Executive Management Committee. (IC) Monitoring of risk impact through the incident reporting process. (IC)	Capital Management Group minutes. (IA) Risk profiled capital bids. (IA) Incident reporting trends reports to Quality Committee. (IA)	**Amber**	Increase in capital pressures on 18/19 PFI lifecycle costs in 18/19 reduce available capital for 18/19 IT, estates and medical equipment	**20 (4x5)**	As per controls capital prioritisation process for 18/19 and identify and secure other sources of funding.	Director of Finance
BAF 3.4a	There is a risk to the future sustainability of the service unless a five year Buckinghamshire ACS Plan is achieved through the Buckinghamshire, Oxford and West Berkshire (BOB) STP. (Monitored through Finance and Business Performance Committee, F&BP)	20	Bucks ACS Partnership Board (EC) Bucks ACS Executive Group (EC)	Regular updates and reports to the Trust Board and EMC (IC), LTFM (IC) Minutes of ACS Partnership Board and Executive Group (EA)	**Green**	Formal Bucks ACS Plan to be refreshed and developed in line with March 2018 deadline and potential formal support for a Bucks ACS in 2018/19	**8 (4x2)**	Joint Planning through development of Bucks ACS plans , programme and governance mechanisms.	Director of Strategy
			BOB STP Operational Group (monthly) (EC) STP Leadership Group (Quarterly) (EC)	BOB STP Submissions (EA), NHS England feedback on STP plans (EA) Bucks ACS Plan (IA), LTFM (IA)					
BAF 3.5	There is a risk that milestones will not be achieved across the health and social care system in Buckinghamshire to deliver an Accountable Care System by April 2018.	20	Accountable Care System Partnership Board and Executive meeting in place. (EC) Delivery of NHS Constitution Standards and delivery of financial plan. (IC)	Minutes of the ACS Partnership Board. (EA) ACS Compact. (EA) Memorandum of Understanding with Provider Alliance. (EA) Memorandum of Understanding with NHS England. (EA) Floodlight performance report. (IA) Financial performance report. (IA)	**Green**		**12 (4x3)**	Engage in working with the system to improve A&E and system financial performance in-year. Deliver Bucks ACS plan including transformation in areas of population health, organisational development and integrated care	Director of Strategy

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
4. Emergency and Urgent Care **Develop emergency and urgent care services which maximise the chances of survival and good recovery** **- Expand stroke services at Wycombe Hospital to cover the East Berkshire and South Bucks population.** **- Open a 2nd Catheter Laboratory expanding our catchment area for cardiac care and repatriating Buckinghamshire patients from London Hospitals.** **- Introduce new urgent and primary care pathways for both specialist hospital care and at locality level through integration with primary care.**									
BAF 4.2a	There is a risk that the 2nd Catheter Laboratory will not be opened in a timely way to expand catchment area for cardiac care.	20	Work has commenced to prepare the 2nd Catheter laboratory to be operational from August 2017. (IC) Repatriation has already commenced using appropriate theatre space at Wycombe Hospital. (IC) Commissioners have signed off the activity levels in the business case. (IC) Staff are in place to run the 2nd Catheter Laboratory. (IC)	Activity information reported at Divisional level. (IA) Progress reports at Divisional level on work to build the laboratory. (IA)	**Amber**	None	**No risk**	Laboratory open w/c 12th November	Chief Operating Officer
BAF 4.3a (links to CRR 49)	There is a risk to the quality of patient experience and outcomes if we do not rapidly reform our urgent care pathways (Monitored through Finance and Business Performance Committee, F&BP)	25	Urgent Care Programme Board chaired by Chief Operating Officer (IC) Buckinghamshire Integrated Care Board (IC) SAFER delivery plan (IC)	Urgent Care Recovery Board minutes (IA) Care Closer to Home Programme plan (IA) Improving Flow from Wards programme (IA) Transformation Board minutes (EA)	**Green**	Workforce vacancies for nursing (c) Bed capacity and ability to deploy flexibly across 2 hospital sites (c) Variability in external supporting capacity (social care) (c)	**20 (5x4)**	Detailed work programme through the Urgent Care Recovery Board & A&E delivery board. Activity and capacity demand modelling completed end Q3. Unplanned care forecasting tool launched. Additional RAT space and Clinical Decision Unit space to be added in January. Winter funding allocations to be used to support additional community capacity in Q4 Transformation Delivery Group (integrated care plan development)	Chief Operating Officer
			STP Urgent Care Programme Board (EC) Transformation Delivery Group (EC)	Programme board annual plan / meeting minutes (EA)					
			Support from the Emergency Care Improvement Programme (ECIP)	ECIP network reports (EA)					
			Performance Management framework and Divisional Governance Structures (IC)	Performance dashboards - SDU / Division / Board (IA)					
			Support from the NHS Improving Quality 7 day working team (EC)	7 day audit results (EA)					
			Local A&E Delivery Board (health and social care system) (EC)	Work programme from delivery board (EA)					
BAF 4.4a (links to CRR 49)	There is a risk that we will not deliver an integrated urgent care system in Buckinghamshire working with partners across Thames Valley to redesign NHS111 and primary care services by April 2018	15	Weekly urgent care taskforce (led by BucksFed) (EC)	Board and FBP Committee papers on Urgent Care (IA) 24/7 Primary Care Proposal (IA)	**Green**		**12 (4x3)**	Weekly meetings and assurance in co-production phase for CCG to approve Preferred Applicant status.	Director of Strategy
			Buckinghamshire Provider Collaborative Board (EA)	Meeting of taskforce meetings and mobilisation plan for April 2018 (IA)					
			Locality 'clustering' work programme (EC)	Clustering plan delivered by primary care Federation August 17 (EA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
5. Integrated Care									
5.1 Better supported care in people's homes and community settings. - Integrate providers in Buckinghamshire into a new model of care – A Primary Acute Care System. - Implement a single point of access for all referrals into community services - Pilot community hubs in Thame and Marlow to deliver expanded diagnostic, outpatient, health and well -being and ambulatory care services for local people.									
BAF 5.1.1a	There is a risk that if we do not enhance partnerships between various stakeholders that we will not deliver the best support to patients in their homes and other community settings.	20	Urgent Care Programme Board (COO) (IC) Buckinghamshire Integrated Care Committee (IC)	Annual work programme / meeting minutes (IC)	**Amber**	Workforce vacancies for nursing (c) Variability in external supporting capacity (social care) (c)	**12 (4x3)**	Implementation of IECC division annual work plan (assured via strategic workforce committee) Engagement with third sector care providers Provider collaborative launched with focus on High Intensity User programme. 3 Integrated Team pilots to be scoped during Q4	Chief Operating Officer
			Detailed workplan through A&D delivery board/ ACS Board and STP (EC)	A&E delivery board minutes (EA)					
			ACS executive - chaired by CCG (EC)	ACS executive minutes and work plan(EA)					
BAF 5.1.3a	There is a risk that the pilot of community hubs in Thame and Marlow will not enable us to deliver the expanded diagnostic, outpatient, health and well-being and ambulatory care services for local people that we aspire to.	12	Care Closer to Home Strategy (IC), Community Hubs Implementation (IC), Additional Services and clinics opened as part of the pilot (IC)	Minutes of EMC (IA), Minutes of Community Hubs Stakeholder Group (EA), Community Hubs Implementation Plan Updates (IA)	**Amber**	Capacity for diagnostic and outpatient services to extend to community hubs; voluntary groups and Council reluctance to provide additional services	**8 (4x2)**	Continue through stakeholder group and local Gps to develop services on the community hub sites	Chief Operating Officer
5.2 Maintain and develop integrated children's services - Implement the integration of children's services in line with the new BCC service specifications for the Healthy Child Programme and integrated therapies.									
BAF 5.2.1a	There is a risk to the implementation of the Healthy Child Programme and children's therapies in line with the new Bucks CC and CCG specifications.	20	HCP and integrated therapies implementation plan - creation of community hubs and single point of access (IC) Integrated children's services stakeholder engagement event - repeated in November 17 (EC)	Annual work programme (IC) Stakeholder sign up to integration work plan - summer 17 (EC)	Amber	Issues with sustainability of community paediatrician workforce	**12 (4x3)**	Creation of new roles - specialist nursing, clinical psychology. Launch of integrated paediatric pathway with CAMHS service in January	Chief Operating Officer
			Workforce plan published autumn 17 across all children's workforce groups (IC)	Assurance of workforce plan (Strategic workforce committee) (IC)					
6. Specialist Care									

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 6.1a	There is a risk to future delivery of pathology services if we do not work in a more integrated way with other pathology providers	12	Comprehensive external independent review commissioned. (IC/EC). Working with two possible network provider partners to refine a future working model.	External review report recommendations integrated within the proposed future working models(EA). Discussions commenced with possible future partners (EA) Board update to January 2018 trust board (IA)	Green	Future model not yet defined.	**8 (4x2)**	Timescale and action framework for model development to be completed by March 2018.	Medical Director
BAF 6.2a	There is a risk that the Trust will not have capacity to cope with an increase in birth rate in the next ten years in the local catchment area	12	Bucks Local Maternity System Group of the STP looking at capacity issues across Thames Valley (EC), Maternity SDU Strategy and implementation plan (IC), Women and Children's Divisional Board (IC) , Public Health population and birth rate projections (EC)	Maternity Strategy (IC), Minutes of STP Local Maternity System (EC)	Amber	Maternity SDU strategy under development	**8 (4x2)**	Strategy to form part of Clinical Strategy for Board approval in March 2018.	Director of Strategy
7. Planned Care **Services are some of the best in the country for patient outcomes, access and efficiency** **- Introduce a new model of care for musculo-skeletal services in alliance with our partners.** **- Outpatients – transform the delivery of outpatient services** **- Theatres- transform the delivery of theatres** **- Implement a new model for Diabetes services**									
BAF 7.1a	If we do not redesign our musculo-skeletal services with our partners there is a risk the that service will be competitively tendered. If this happens and we are not successful in bidding for the tender it is possible that we would lose control of the provision of secondary care MSK services (risk to recruitment, patient care and finance) (Monitored through Finance and Business Performance Committee, F&BP)	**20**	MSK programme committee (EC) MSK Redesign Group (IC) ACS executive group (CCG) - (EC) Strategic transformation committee (IC)	Service Redesign and business case linked to new service (IA) Feedback from patients (EA) 18 week RTT performance (IA)	**Green**	Ability to design a contractual model approved by all system provider partners system agreement of contractual model and baseline values	**10 (5x2)**	Board approval Q2 of new contractual model, publication of implementation plan Q3 - delayed to Q4, seeking to secure resource	Chief Operating Officer
			Actuarial review of system MSK activity and financial long term model (EC)	Report from Actuarial review (EA)					
			Confirmed as 'most capable provider' (EC)	Contractual model agreed Q2 17/18 (EA)					
BAF 7.2a	There is a risk to the quality of the patient experience if we do not redesign the delivery of outpatient care	15	Patient Pathway Improvement Programme (IC)	Annual work plan agreed and meeting minutes (IA)	**Green**	System resource to support end to end transfer of e-referrals	**10 (5x2)**	E-referral project team in place, governance structure and 4 high impact priorities agreed, programme relaunched Q4	Chief Operating Officer
			e-referral project board (EC)	System project plan and meeting minutes (EA)					
			Patient Experience Group (IA)	Patient experience strategy and annual work plan / meeting minutes (IA)					
BAF 7.3a (Links to CRR 67)	There is a risk to patient experience, safety and productivity if we do not improve our systems, process and culture in the operating department	20	Externally support theatre productivity work stream (EC)	Monthly performance framework - reporting (IA)	**Amber**	Staffing levels in theatres - availability of senior experienced nursing	**12 (4x3)**	Specific work stream supported by COO on recruitment and retention plan for theatre nursing	Chief Operating Officer
			Theatres Management Group (IC)	Meeting minutes and annual plan (IA)					
			Theatres Quality and Safety Groups (IC)	Executive attendance at fortnightly Q&S meeting (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 7.4a	There is a risk that if we do not implement a new model for Diabetes services we will not achieve the improvements for patients that we aspire to.	12	Joint steering group in place with CCG and Fedbucks. (IC/EC) Date agreed for commencement of roll out to first two pilot practices . (IC/EC)	Steering group to oversee roll out. (IA/EA)	**Green**	Partners may not adhere to timescales	**8 (4x2)**	Regular meeting of steering group. Early escalation of changes to plan. Arrangements made for CCG lead to work within the trust regularly to liaise directly with teams	Medical Director
8. Technology and Innovation									
BAF 8.1a	There is a risk that if we do not launch a Buckinghamshire Lifesciences Innovation Hub supporting businesses we will not be able to develop their healthcare products and services in conjunction with our patients and clinicians.	16	Buckinghamshire Lifesciences Partnership Board (EC), LEP Capital Investment (EC), 2017/18 Capital Plan (IC), Business case for Innovation Hub (IC),	Minutes Buckinghamshire Lifesciences Partnership Board (EA), Business case for capital changes at SMH (IA), Memorandum of Understanding and Partnership Agreements (IA), LEP Grant Letter (EA), European Funding grant letter (EA)	**Amber**	Business case yet to be agreed, Partnership Board not established, European funding yet to be confirmed	**4 (4x1)**	Establish Partnership Board. Awaiting European Grant Funding	Director of Strategy
BAF 8.3a (link to CRR 43)	There is a risk that we will not achieve our goals around IT interoperability as a result of funding resource and operational issues. This has the potential to impact on efficiency. (Monitored through Finance and Business Performance Committee, F&BP)	20	Strategic Transformation Group Bucks MIG Project Board STP/LDR Boards Local IM&T Strategy	Internal audit on pathway reviews following Medway implementation 16/17 (EA)	**Green**	None	**10 (5x2)**	Input into the LDR through the CCGs. Review LDR's with CCG's	Director of Finance
			Review of Buckinghamshire requirements for interoperability as part of LDR/STP requirements.	Review and Submission of Local Digital Roadmap (LDR) and Sustainability and Transformation Plan (STP)					
9. Estates									
BAF 9.1a **(link to CRR 27)**	There is a risk that we will not deliver our 16/17 plans for the most efficient use of the community estate. (Monitored through Finance and Business Performance Committee, F&BP)	16	Estates Strategy (IC)	Project Initiation Documentation (IA), External support from NHSE and NHSI for property sales (EA) External advisers appointed. (EA)	Green	Capacity and capability to deliver the change required	**12 (4x3)**	Option appraisal and detail of service moves with recommendation to come to March 18 Board.	Director of Finance
			Capital Plan 2016/17 (IC)	Performance monitoring of capital plan (IA)					
			Capital Management Group (IC)	CMG minutes (IA)					
			Finance and Business Performance Committee (IC),	F&BP minutes (IA					
			Improving Productivity Group (IC)	Monthly progress plans at Improving Productivity Group (IA),					
10. Organisational Development									
BAF 10.1a	There is a risk that the Board may not achieve the highest level of performance and delivery for the organisation if they do not receive board development, including opportunities for learning, strategic discussion and self reflection.	8	Board approved development programme comprising multiple elements of learning, strategy and reflection, with external facilitation as required. (IC) 360 degree appraisal for each board member every year. (IC) Learning from board observations by external regulators such as the Care Quality Commission. (EC)	Board Programme. (IA) Appraisal documentation for each board member. (IA)	**Amber**	None	**4 (4x1)**	No additional action required.	Director for Governance

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 10.3a	There is a risk that the organisation will not meet its strategic objectives unless the staff are appropriately equipped with skills relating to transformational change and a culture of innovation is created.	15	Innovation hub development programme (EA) Supporting innovation - use of the transformation team, innovation committee (IA)	Programme agreed (EA) Internal project management / tracking of change projects (IA) Training records (IA)	**Green**	Ability to control and prioritise SI team resource	**10 (5x2)**	Creation of 'innovation hub' to fast track ideas, better deploy resource	Chief Operating Officer
BAF 10.4	There is a risk that if we do not develop relationships with local GPs we will lose referrals and market share and will not integrate care for our patients	12	Development of Bucks ACS (EA), Delivery of transformation schemes in MSK, integrated care and diabetes (EA) , Locality Executive Leadership (IA), Bucks Provider Alliance (EC), Monthly GP Education Sessions with Consultants (IA), GP Newsletter Bi- Monthly	Bucks ACS Board and Executive Minutes (EA), GP Newsletter (IA), Bucks Provider Alliance Minutes (EA),	**Green**	Regular survey of GPs views of the Trust	**4 (4x1)**	Half yearly Survey to be enacted by October 2017 in line with ACS development (yet to be completed)	Director of Strategy
BAF 10.6	There is a risk that we do not develop SDU strategies to support a comprehensive clinical strategy by April 2018	12	SDU strategy meetings (IC), SDU workshops (IC), SDU Strategy Framework (IC), SDU Workshops (IC)	SDU Strategies approved at EMC (IA), Draft Clinical Strategy approved (IA)	**Green**	SDU Strategies in development, large number of strategies to develop, capacity constraints in Divisions	**8 (4x2)**	Strategy team support, clear milestones, escalation to Divisional Directors if slippage	Director of Strategy

Agenda item: 20
Enclosure no: TB2018/19

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

BOARD MEETING IN PUBLIC
31 January 2018

Details of the Paper

Title	Board Committee Terms of Reference				
Responsible Director	Director for Governance				
Purpose of the paper	The purpose of this paper is to seek the Board's approval to changes to the Board Committee terms of reference. Each of the Board Committee Terms of Reference has been reviewed by the relevant committee and updated.				
Action / decision required (e.g., approve, support, endorse)	Decision				
IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*
ANNUAL OBJECTIVE					
Which Strategic Objective/s does this paper link to?					
Please summarise the potential benefit or value arising from this paper:					
RISK					
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: None				
	Financial Risk: None				
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY					
Which CQC standard/s does this paper relate to?	Well Led Domain; Outcome 17 Good Governance				
Author of paper: Liz Hollman					
Presenter of Paper: Liz Hollman					
Other committees / groups where this paper / item has been considered: All Board Committees have considered the changes to the Terms of Reference					
Date of Paper: 24 January 2018					

REVIEW OF BOARD COMMITTEE TERMS OF REFERENCE

1. PURPOSE

The purpose of this paper is to seek the Board's approval to changes to the Board Committee terms of reference

2. BACKGROUND

It is good practice for Board Committees to review their terms of reference on an annual basis, both to maintain focus on the specific duties of each committee, and to update where there has been development through the year which affects the way the committee functions. Each Board Committee has therefore reviewed their terms of reference in December 2017/January 2018 with the exception of the Charitable Funds Committee which will be reviewing their terms of reference later in the year.

3. TERMS OF REFERENCE AMENDMENTS

The amended Terms of Reference for the Audit Committee, Quality Committee, Finance and Business Performance Committee and Strategic Workforce Committee are shown in Appendix 1.

Each of the Terms of Reference has been reviewed at the relevant committee and has been commended to the Board for ratification.

Length of membership term for Committee members has been standardised across the Terms of Reference.

4. RECOMMENDATION

The Board is asked to ratify the amended Terms of Reference.

Liz Hollman
Director for Governance, 24 January 2018

Audit Committee
Terms of Reference

1. Purpose

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

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

2. Constitution

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

3. Membership

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

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

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

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

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

- Director of Finance
- Director for Governance
- Committee Secretary
- Representative from External Audit
- Representative from Internal Audit
- Others may be invited to attend according to the agenda.

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

4. Quorum

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

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

5. Meetings

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

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

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

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

6. Authority

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

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

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

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

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

7. Duties

The duties of the Audit Committee are as follows:

7.1 Governance, Risk Management and Internal Control

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

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

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

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

7.2 Internal Audit

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

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

7.3 Local Counter Fraud Service

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

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

7.4 External Audit

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

- Consideration of the appointment and performance of the external auditor;
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan, and ensure coordination, as appropriate, with other external auditors in the local health economy;

- Discussion with the External Auditor of their local evaluation of audit risks, their assessment of the Trust and the associated impact on the audit fee;
- Review of all External Audit reports together with the management responses;
- Agreement of the annual audit letter before submission to the Board and agreement to any work falling outside the annual audit plan; and
- The Committee will develop a policy, and monitor its implementation, on the engagement of the external auditor to supply any non-audit services to ensure the external auditor retains a high degree of independence from the Trust.

7.5 Other Assurance Functions

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

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

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

7.6 Management

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

7.7 Financial Reporting

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

- The wording in the Annual Governance Statement and other disclosures within the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies and practices;
- Unadjusted misstatements in the financial statements;
- Significant judgements in the preparation of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

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

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

8. Reporting

The minutes of all meetings shall be formally recorded and a summary submitted, together with recommendations where appropriate, to the Board of Directors.
The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

9. Review

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

10. Support

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

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

Document Control

Version	Date	Author	Comments
1.0	1 Dec 2013	E Hollman	Revised Draft for Committee Chair
1.1	17 March 2014	B Courtney	Revised draft following Audit Committee
1.2	26 March 2014	B Courtney	Board approved.
1.3	27 August 2015	N.McKechnie	Periodic review for Committee
1.4	22 December 2016	E Hollman	Periodic review for Committee
1.5	24 January 2018	E Hollman	Periodic review for Committee

Quality Committee
Terms of Reference

1. Purpose

The purpose of the Quality Committee is to provide the Board with a forum for Trust leadership and Board to meet and establish direction in relation to quality; and to provide assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

To assure the Board directly and through consultation with the Audit Committee that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health services.

To assure the Board that where risks and issues exist that may jeopardise the Trust's ability to deliver excellent quality healthcare, they are being managed in a controlled and timely way.

2. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Quality Committee ('the Committee'). The Committee has no executive powers, other than those specifically delegated in these terms of reference. The terms of reference can only be amended with the approval of the Trust Board.

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

3. Frequency of Meetings and Membership

3.1 The Committee shall normally meet formally on a bi-monthly basis and at least five times per year. In addition, the Committee shall normally meet on a bi-monthly basis and at least five times per year to undertake service quality reviews.

3.2 The Committee may also meet at such other times as the Chair of the Committee shall require. Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chair of the Committee.

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

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

3.5 Members of the committee shall be appointed by the Board. Members shall include as a minimum:

- Three Non-Executive Directors including the Chair;

- Chief Executive Officer;
- Medical Director;
- Chief Nurse (representing nursing and allied health professions);
- Chief Operating Officer.

3.6 Attendees

The following will be required to attend meetings:

- Director for Governance;
- Deputy Chief Nurse;
- Divisional Chief Nurses;
- Chief Pharmacist
- Head of Allied Health Professionals.

There is an open invitation to a Clinical Commissioning Group (CCG) Representative and a designated patient representative to attend the Committee.

Other attendees will be invited according to agenda items, include the Head of Safeguarding and the Director of Infection Prevention and Control or deputy.

When a Division presents its Divisional Service Review on quality it is expected that the Divisional Director, Divisional Chair and Divisional Chief Nurse will attend.

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

4. Quorum

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

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

5. Meetings

5.1 Meetings of the committee may be called by the secretary of the committee at the request of the committee chair.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date shall be forwarded to each member of the Committee no later than ten days before the date of the meeting. Supporting papers shall be sent to Committee members and to other

attendees, as appropriate five days ahead of the date of the meeting. The Committee shall follow an annual work plan reviewed by the members in advance of each financial year.

6. Authority

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

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

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

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

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

7. Duties

The Committee is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee. In order to fulfil its purpose the Committee will:

- Provide leadership and assurance to the Board on the effectiveness of the structures, policies, systems and processes for quality assurance, clinical, information and quality governance , specifically in the areas of:
    - Patient Safety
    - Clinical Effectiveness
    - Patient Experience
- Review the Quality Improvement Strategy to ensure continuous improvement is delivered in quality and safety.

- Review the need for a Quality Improvement Framework sitting alongside the Quality Improvement Strategy with a particular focus on quality issues and staff impact. Oversee the development of any such Quality Improvement Framework.

- Review assurance of progress with the Quality Improvement Plan and escalate to Board if there is a lack of positive assurance

- Identify annual objectives of the Committee, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Committee's terms of reference and a review of the effectiveness of the committee

- Receive assurance with regard to compliance with CQC regulations and the process for compliance with legislation at least annually
- Receive assurance on the process for review of reports arising from external reviews and review the external reviews register at least twice a year
- To examine in-depth key quality issues and thereby contribute to the development of a quality culture
- Oversee implementation of all elements of the quality improvement strategy. In particular, obtaining assurance that the measures for success are implemented within the appropriate time scales
- Gain assurance over the full range of quality performance via the quality report, quality dashboard, minutes and reports from relevant stakeholder groups and the provision of any other quality related information that the committee may request
- Review quality related risks on the Corporate Risk Register at least 4 times a year
- To oversee the development of the Quality Accounts, ensuring they reflect the views of key stakeholders and advise the Audit Committee on publication
- Undertake any other responsibilities as delegated by the Trust Board

8. Reporting

8.1 The minutes of all meetings shall be formally recorded and a report from the Committee shall be presented to the Board of Directors each month summarising the meetings of this Committee.

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

8.3 The organograms appended below demonstrate the reporting lines from the Sub Groups to Quality Committee through to the Trust Board.

9. Review

9.1 The Terms of Reference of the Committee shall be reviewed by the Board of Directors at least annually.

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

9.3 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee is required to provide.

10. Support

10.1 The Committee shall be supported administratively by the This support shall ensure:

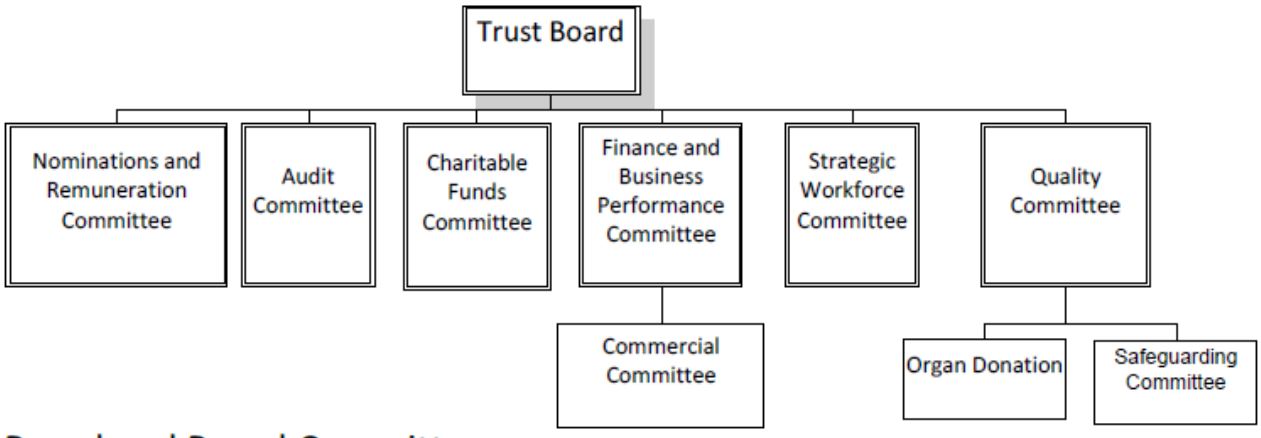
- Papers will be distributed five working days before the meeting in electronic copy. Advice to the committee on pertinent areas is provided.
- That Minutes are taken and a record of matters arising and issues to be carried forward is made.

Document Control

Version	Date	Author	Comments
1.0	1 Dec 2013	E Hollman	Draft for Committee Chair
1.1	7 Jan 2014	B H Courtney	Amended draft for Committee Chair and review by Quality Committee
1.2	7 Feb 2014	A Walker	Distributed for comment
1.3	4 Mar 2014	A Walker	Final agreed
1.4	12 Mar 2014	A Walker	Forwarded to Board
1.5	Sept 2014	A Walker	Updated • to include ACNs and Head of Allied Health on membership • allow Trust chair as non-exec member of the Committee
1.6	5 Nov 2014		Forwarded to Board
1.7	12 January 2016	E Hollman	Updated to reflect revised membership and increased numbers of meetings.
1.8	22 December 2016	E Hollman	Updated to reflect matters agreed by Committee Chairs, the planning of formal meetings and Service Reviews, and to introduce the review of the Corporate Risk Register overtly.
1.9	4/1/18	E Hollman	Updated to reflect current situation and changes to committee structures.

Appendix 1

Trust Board and Committees



Board and Board Committees

Finance and Business Performance Committee

Terms of Reference

1. Purpose

The purpose of the Finance and Business Performance Committee is to provide the Board with assurance regarding finance and operational performance. On behalf of the Trust Board, the Finance and Business Performance Committee will oversee all aspects of the financial arrangements of the Trust. It will provide the Trust Board with assurance that the financial issues of the Trust are being appropriately addressed, and will provide the Board with information and advice on key issues

The Committee will regularly review the Trust's operational performance and will, when required, focus on specific issues where the Trust's performance is deteriorating or there are issues of concern.

2. Constitution

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

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

3. Membership

3.1 The Committee shall be appointed by the Board from amongst the directors of the Trust and shall include up to five independent non-executive directors (this may include associate non-executive directors, or the Trust Chair[1])

3.2 One of the Non-Executive Director members will be appointed chair of the Committee by the Board

3.3 The Members of the committee shall be appointed by the Board. Members may appoint a deputy to represent them at a committee meeting and as a minimum shall include:

- At least three Non-Executive Directors including the Chair (one of the Non-Executive Directors should also be the Chair of the Commercial Development Committee);
- Chief Executive Officer;
- Director of Finance;
- Chief Operating Officer;
- Director of Organisational Development and Workforce Transformation;
- Director of Strategy and Business Development;

[1] This is principally an assurance and scrutiny committee. Significant matters requiring decision would be referred to the Board. There is therefore no issue with the inclusion of non-voting board members.

- Director for Governance.

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

3.5 The Chair and members of the Committee may also be members of other Committees. The Committee Chair and the Director of Finance are members of the Audit Committee.

4. Quorum

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

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

5. Meetings

5.1 The Committee shall usually meet on a monthly basis, (at least eight times per year) and at such other times as the Chairman of the Committee shall require. Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chairman of the Committee.

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

7. Authority

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

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

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

The Committee is authorised by the Board, where appropriate, to obtain external legal or other independent professional advice. This shall be authorised by the Chairman of the Committee and shall be within any budgetary constraints imposed by the Board of Directors.

The Finance and Business Performance Committee has the authority to require any member of staff to attend its meetings

8. Duties

The Finance and Business Performance Committee shall be responsible for the following duties:

Financial Matters

- To monitor, advise on and recommend to the Board matters relating to the Trust's financial strategy and policies;
- Oversee and evaluate the Trust's financial strategy to deliver the integrated business plan;
- To critically appraise the Trust's annual budgets for the Board's approval;
- Undertake detailed scrutiny of financial information at each meeting including performance against the cost improvement programme;
- Review the annual Trust Service and financial plans and financial control total: revenue, capital, working capital and key performance targets;
- Undertake detailed scrutiny of the Long Term Financial Model. Inherent within this is the work of the Model Hospital;
- Oversee the development and management and deliver of the Trust's annual capital programme;
- Review and maintain an overview of financial and service delivery agreements and key contractual arrangements;
- Oversee the management and delivery of the cost improvement programme and development of the Trust's efficiency and productivity processes;
- Review the Trust's estates strategy, the Trust's asset strategy and management and review and propose future land and property transactions; and
- Consider key financial policies e.g. investment policy, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.

Business Performance

- To monitor, advise on and recommend to the Board matters relating to the Trust's business strategy and policies;
- Oversee and evaluate the delivery of the integrated business plan;
- Review the annual Trust business plans.

Commercial Development

- To oversee the work of the Commercial Development Committee. This will be through review of the minutes of the Commercial Development Committee and the inclusion of the Chair of the Commercial Development Committee in the membership of the Finance and Business Performance Committee.

Trust Strategies to be reviewed by this committee:

- Finance;
- Operational;
- Information Management and Technology;
- Estates.

Business Cases

The Committee will review major strategic and emerging new business cases before cases are presented to Trust Board. This committee to also approve large scale business cases , those with a value in excess of £1million, In addition the Committee will review these business cases, at each milestone, to ensure project plan is on track and where there are signs of failing to provide assistance with mitigating actions. The Committee will provide assurance to Board that business cases have been considered in detail.

This committee will carry out a post project evaluation on larger business cases/projects.

Estate and Asset management

- Receive estate metric at each meeting showing risk and sustainability. Paper to include PFI, retained estate, risk on estate backlog maintenance.
- Receive paper on asset utilisation and management on a regular basis

Performance Management

- Receive assurance from the Executive Management Committee in respect of divisional performance regarding key performance indicators. This is supplemented by an annual 'deep dive' presentation by each Division on their finance and business performance;
- Review the Trust's performance reporting and support the development of appropriate performance measures, including key performance indicators around the operating framework;
- Oversee and evaluate the Trust's performance management strategy to ensure a framework is in place which allows the Trust to performance manage against its business plan.

Workforce Performance

- Workforce hard metrics to be reviewed by this committee – to include sick absence, Turnover temporary and Bank/Agency staffing figures; % appraisal and mandatory/statutory training;

Outpatient Pharmacy

- To oversee the performance of Buckinghamshire Healthcare Projects Ltd, a Wholly Owned Subsidiary delivering outpatient pharmacy services (Pharmacy@Bucks);
- The Chair of the Commercial Development Committee and the Director of Finance are Directors of Buckinghamshire Healthcare Projects Ltd and the Director for Governance is the Secretary to the company. These interests must be explicit in the minutes of any meeting where the performance of Buckinghamshire Healthcare Projects Ltd is discussed and the Chair will take a view in relation to the management of any potential conflict.

Risk

- Review finance and business related risks on the corporate risk register at least six times a year and escalate to the Board any concerns regarding the management of risk.

With respect to the duties set out above there is a clear link between this Committee and the duties of other Board Committees. The Committee Chair will refer specific matters to the Chairs of other Board Committees as appropriate and this will be recorded in the minutes of the meeting.

9. Reporting

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

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

10. Review

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

11. Support

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

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

Document Control

Version	Date	Author	Comments
1.0	1 Dec 2013	E Hollman	Draft for Committee Chair
1.1	14 July 2014	Brian Courtney	Revised draft for Committee Chair
1.2	21 September 2015	E Hollman	Revised quorum. Clarification on frequency of meetings.
1.3	6 January 2017	E Hollman	Amendments to align with other Board Committees following a meeting of all the Committee Chairs.
1.4	24 January 2018	E Hollman	Amendments following Annual Review

Strategic Workforce Committee
Terms of Reference

12. Purpose

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

On behalf of the Trust Board, the Strategic Workforce Committee will oversee all aspects of the workforce and organisational development arrangements of the Trust, including workforce planning as it relates to the Trust and in the context of the Sustainability and Transformation Plan for Buckinghamshire, Oxfordshire and West Berkshire and of the Buckinghamshire Accountable Care System.

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

13. Constitution

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

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

14. Membership

14.1 The Committee shall be appointed by the Board from amongst the directors of the Trust and shall include at least three independent Non-Executive Directors (this may include associate non-executive directors) and the Director of Organisational Development and Workforce Transformation.

14.2 A non-executive director shall chair the Committee.

14.3 Members of the committee shall be appointed by the Board. Members may appoint a deputy to represent them at a committee meeting. The membership will comprise:

- At least three Non-Executive Directors
- Chief Executive Officer
- Director of Organisational Development and Workforce Transformation
- Director of Strategy and Business Development
- Deputy Director of Human Resources
- Director for Governance
- Medical Director
- Chief Nurse or deputy
- Guardian of Safe Working
- Director of Communications

- Chief Operating Officer or representative
- Freedom to Speak Up Guardian

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

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

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

15. Quorum

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

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

16. Meetings

16.1 The Committee shall usually meet on a monthly basis. Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chairman of the Committee.

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

18. Authority

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

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

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

19. Duties

The Strategic Workforce Committee shall provide strategic oversight of the Trust's people priority of "being a great place to work where our people have the right skills and values to deliver excellence in care". The Committee shall be responsible for the following duties:

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

20. Reporting

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

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

9.2 This Committee will link closely with the Strategic Transformation Committee.

21. Review

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

22. Support

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

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

Document Control

Version	Date	Author	Comments
1.0	18/1/2017	E Hollman	Developed for new Committee, approved by Committee and for Board ratification
2.0	4/1/2018	B O'Kelly	Updated to take account of system changes
3.0			

Agenda item: 21
Enclosure number: TB2018/20

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

BOARD MEETING IN PUBLIC

31 January 2018

Details of the Paper

Title	Private Board Summary 29 November 2017
Responsible Director	Trust Chair
Purpose of the paper	The purpose of this report is to provide a summary of matters discussed at the Board in private on the 29 November 2017. The matters considered at this session of the Board were as follows: • Commercial Strategy • Shaping the Environment • Information Management & Technology Infrastructure and Digital Strategy • Outpatient Pharmacy Update • Serious Incident Report • Excluded practitioners • Purchase of Blood Products
Action / decision required	The Board is asked to note the contents of this report.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	***Strategy***	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	***Partnership Working***	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? Relates to all objectives	
Please summarise the potential benefit or value arising from this paper:	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Relates to outcome 4, Care and Welfare of Persons using our service
Author of paper: Elisabeth Ryder	
Presenter of Paper: Liz Hollman	
Other committees / groups where this paper / item has been considered: No other committee	
Date of Paper: 22 January 2018	

Agenda item: 22
Enclosure number: TB2018/21

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
31 January 2018

Details of the Paper

Title	Board Attendance Record
Responsible Director	Director for Governance
Purpose of the paper	To keep the Board informed of the attendance of Board members at Board meetings and Board committees.
Action / decision required (e.g., approve, support, endorse)	None

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	***Public Engagement /Reputation***	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE
Which Strategic Objective/s does this paper link to? Relates to all objectives
Please summarise the potential benefit or value arising from this paper:

RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Well led Domain *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Elisabeth Ryder
Presenter of Paper: Liz Hollman
Other committees / groups where this paper / item has been considered: No other committee
Date of Paper: 22 January 2018

Buckinghamshire Healthcare NHS
NHS Trust

Board Attendance Record: September 2017 to January 2018

	Strategic Workforce Committee				Finance and Business Performance Committee				Quality Committee				Trust Board Seminars		Commercial Development Committee	Charitable Funds Committee	Audit Committee		Trust Board	
	12 Sep	11 Oct	14 Nov	10 Jan	21 Sep	24 Oct	23 Nov	21 Dec	5 Sep	3 Oct	5 Dec	16 Jan	25 Oct	13 Dec	21 Nov	17 Jan	5 Oct	11 Jan	27 Sep	29 Nov
Hattie Llewelyn-Davies, Trust Chair *	x	✓	✓	x	✓	✓	✓	✓					✓	✓					✓	✓
Neil Dardis, Chief Executive *	✓	✓	✓	✓	✓	✓	✓	x	x	✓	x	✓	✓	x					✓	✓
Dipti Amin, NED*									✓	✓	✓	✓	x	✓			✓	x	✓	✓
Rachel Devonshire, NED*					✓	✓	✓	✓					x	✓	✓	x	✓	x	✓	✓
Rajiv Jaitly, NED *					✓	✓	✓	✓					✓	✓		✓	✓	✓	✓	✓
Graeme Johnston, NED * (SID)													✓	x			✓	✓	✓	✓
Tina Kenny, Medical Director *	x	✓	x	✓				✓	✓	x	✓	✓	✓	x					✓	✓
Mary Lovegrove, NED *	x	✓	✓	✓					x	✓	✓	✓	✓	✓					✓	✓
Neil Macdonald, Chief Operating Officer *					✓	✓	✓	✓	✓	x	✓	x	✓	✓					✓	x

	Strategic Workforce Committee				Finance and Business Performance Committee				Quality Committee				Trust Board Seminars		Commercial Development Committee	Charitable Funds Committee	Audit Committee		Trust Board	
	12 Sep	11 Oct	14 Nov	10 Jan	21 Sep	24 Oct	23 Nov	21 Dec	5 Sep	3 Oct	5 Dec	16 Jan	25 Oct	13 Dec	21 Nov	17 Jan	5 Oct	11 Jan	27 Sep	29 Nov
Carolyn Morrice, Chief Nurse *	✓	x	✓	x	x	✓	x	x	✓	✓	✓	✓	✓	x					✓	✓
Director of Finance * James Drury					✓	✓	✓	✓					✓	✓		✓	✓	✓	✓	✓
David Sines, Associate NED	✓	✓	✓	✓					✓	x	✓	✓	x	x					✓	✓
David Williams, Director of Strategy	✓	✓	x	✓	✓	x	✓	✓					✓	✓	✓				✓	✓
Bridget O'Kelly Director of HR	✓	✓	✓	✓	✓	✓	✓	x					✓	✓	✓		✓		✓	✓
Tom Roche Associate NED		x	x	✓	x	✓	x	x					✓	✓				✓	✓	x

NB: greyed out fields indicate committees the individual would not be expected to attend. NED = Non-Executive Director. A * indicates a voting member of the Board

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
- BME - Black and Minority Ethnic
- BMA - British Medical Association
- BMI - Body Mass Index

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
- 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
- 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
- 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
- HETV - Health Education Thames Valley
- HSE - Health and Safety Executive
- HSMR – Hospital-level Standardised Mortality Ratio
- HWB - Health and Wellbeing Board

I

M

- I&E - Income and Expenditure
- IC - Information Commissioner
- ICP - Integrated Care Pathway
- ICU - Intensive Care Unit
- IG - Information Governance
- IGT / IGTK - Information Governance Toolkit
- IM&T - Information Management and Technology
- IPR - Individual Performance Review
- ITU - Intensive Therapy Unit / Critical Care Unit
- IV - Intravenous

J

- JAG - Joint Advisory Group

K

- KPI - Key Performance Indicator

L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LHRP - Local Health Resilience Partnership
- LiA - Listening into Action
- LOS / LoS - Length of Stay
- LUCADA - Lung Cancer Audit Data

M

- M&M - Morbidity and Mortality
- MDT - Multi-Disciplinary Team
- MIU - Minor Injuries Unit
- MRI - Magnetic Resonance Imaging
- MRSA - Meticillin-Resistant Staphylococcus Aureus

N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director
- NHSE - NHS England
- NHSLA - NHS Litigation Authority
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner

- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy

P

- PACS - Picture Archiving and Communications System / Primary and Acute Care System
- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PbR - Payment by Results
- 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
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty

Q

- QA - Quality Assurance
- QI - Quality Indicator
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework

R

- RAG - Red Amber Green
- RCA - Root Cause Analysis
- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

S

- SAU - Surgical Assessment Unit
- SCAS / SCAmb - South Central Ambulance Service
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SSI(S) - Surgical Site Infections (Surveillance)

- SSNAP - Sentinel Stroke National Audit Programme
- STF – Strategic Transformation Fund
- STP - Sustainability and Transformation Plan
- SUI - Serious Untoward Incident

T

- TIA - Transient Ischaemic Attack
- TNA - Training Needs Analysis
- TPN - Total Parenteral Nutrition
- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

U

- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

V

- VfM - Value for Money
- VSM - Very Senior Manager
- VTE - Venous Thromboembolism

W

- WHO - World Health Organization
- WTE - Whole Time Equivalent

Y

- YTD - Year to Date