Agenda item: 21
Enclosure no: TB2018/088

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

BOARD MEETING IN PUBLIC
25 July 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:
Executive Management Committee; Audit Committee; Finance and Business Performance Committee; Quality and Clinical Governance Committee

Date of Paper: 17 July 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 Corporate Risk Register shows risks emerging from clinical divisions and corporate services.

These risks are reviewed throughout the organisation from Service Delivery Unit through to Board Committees and the risk level, controls and actions are reviewed.

3. BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework has been updated with the corporate objectives agreed for 2018/19.

Where there were relevant risks from the 17/18 BAF these were pulled through into the 18/19 BAF and updated.

Each Executive Director has reviewed the risks against the delivery of the corporate objectives for which they are the lead and these risks are set out in the BAF appended to this paper.

4. TOP RISKS

The top strategic and operational risks are linked and 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. The identification of transformation (cost improvement) programmes and the delivery of these schemes is a risk for 18/19.

  The limited availability of capital resource is creating risk around medical equipment replacement, maintenance of the environment, and ability to move forward with improvements in information technology.

  The Finance and Business Performance Committee monitors the assurance relating to this risk.

- 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 and retention plan in place to attract new staff and keep existing staff.

  Safe staffing is managed on a day to day basis and it is necessary to use temporary staff from bank and agency. Over-reliance on temporary staff has a quality and cost implication for the Trust.

  The Strategic Workforce Committee and the Quality and Clinical Governance Committee monitor the assurance relating to this risk.

- Risk to patient experience due to pressures on the urgent care pathway.

The mitigations to this risk and other risks around delivery of NHS Constitution standard are set out in the exception reports for the Integrated Performance Report.

The Quality and Clinical Governance Committee monitors the assurance relating to this risk.

5. RECOMMENDATION

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

Liz Hollman
Director for Governance
17 July 2018

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*
1. Quality (Medical Director and Chief Nurse) **We will offer high quality, safe and compassionate care in patients' homes, the community or one of our hospitals**									
1.1 Enhance our culture of safety **Key Focus:** **Implement a clinical accreditation scheme to improve quality of care, reduce variation and share best practice** **Quality peer review established in each ward and community area June 2018** **Launch Clinical Accreditation Programme September 2018** **75% of areas will be independently assessed by December 2018** **Minimum 3 areas will be accredited excellence in all categories March 2019**									
BAF 1.1a	There is a risk that the Quality Peer Review process established in June 2018 do not reduce variation in quality. *Board Committee with oversight: Quality and Clinical Governance*	16	Systematic self-review programme co-ordinated by the Associate Chief Nurse – patient experience and professional standards, led and driven by senior nurses, matrons and ward managers. 5 domains are completed each month linked to Care Quality Commission Key Lines of Enquiry. Perfect Ward App scores the reviews and provides immediate feedback to nursing staff in hospital and community locations. (IC)	Outputs from the Perfect Ward App (IA) Monthly reports to the Quality and Patient Safety Group and minutes from that meeting. (IA) Quarterly reports to the Quality and Clinical Governance Committee and minutes from that meeting. (IA)	**Amber**	There is an assurance gap in that we are not yet confident that all the self reviews are done in a consistent way.	**8 (4x2)**	Established baseline from the monthly reviews by September 2018 and then commence a process of clinical accreditation.	Chief Nurse
			Escalation process where trends are reported to Divisional Quality Boards for action. (IC)	Trend reports for Divisional Boards. (IA) Minutes from Divisional Board meetings where this has been discussed. (IA)					
			Programme of peer review within the organisation using an independent peer review team including external reviewers. (IC)	Peer review reports. (IA)					
			Learning and real time feedback on excellence and areas for improvement. (IC)	Outputs from the Perfect Ward App (IA) Monthly reports to the Quality and Patient Safety Group and minutes from that meeting. (IA) Quarterly reports to the Quality and Clinical Governance Committee and minutes from that meeting. (IA)					

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1.2 Listen to our Patient Voice **Key Focus:** **Work in partnership with patients to improve their experience of discharge from our care, outpatients and A&E** **Reduce number of patients waiting longer than 4 hours in A&E – monthly review** **10% reduction in outpatients cancellations (11,651 appointments) by March 2019** **95% of patients will have their discharge medication provided within our standard by March 2019** **A&E Friends and Family response rate improved by 75% and 'would recommend' rates exceed 95% by March 2019**									
BAF 1.2a	There is a risk that if we do not listen to our patients and take appropriate aciton that this will negatively impact on patient experience and care outcome. Board Committee with oversight: Quality and Clinical Governance	16	Systematic collection of Friends and Family Test information. All our services within a hospital setting are asked to provide this feedback. Systematic Quality Rounds on a monthly basis in all clinical areas and in the community. There is real time patient feedback through this mechanism. 'You said, we did' boards in hospital wards and clinical departments. Non-Executive director review of a sample of complaints each month. Chief Executive Officer and Chief Nurse see every complaint that comes to the organisation. Themes from FFT and accolades fed back at local level. Patient story at each public board meeting. Patient representaive on the Quality and Clinical Governance Committee. Patient Experience Strategy and Implementation Plan.	FFT data is reported in the Integrated Performance Report to the Board. Information including the narrative is sent to wards on a monthly basis. Patient Safety and Quality Group receives progress reports on a bi-monthly basis on the implementation plan. Summary report from Quality Rounds reported to Patient Safety and Quality Group, Executive Management Committee and Quality and Clinical Governance Committee. Healthwatch oversight of quality.	**Green**	There is no national tool for FFT for care within patients' own home.	**8 (4x2)**	Link with the work on being a 'learning organisation' to faciliate our learning from patient feedback and find a mechanism to report the assurance from this learning and action. December 2018. Commence Clinical Accreditation programme by March 2019 based on the outputs from Quality rounds. Work to improve mechanisms for capturing the feedback from patients cared for in their own homes. December 2018.	Chief Nurse
1.3 Develop as a learning organisation **Key Focus:** **Learn and share best practice to improve safety of medications and recognition of sepsis and clinical deterioration** **Implement Go Engage initiative to improve staff engagement. September 2018** **Approve a Trust –wide learning organisation framework. December 2018** **Review and revitalise the processes for learning from good practice through BHT Way. December 2018** **Implement an quality improvement skills programme for all staff March 2019**									
BAF 1.3a	There is risk that without a framework in place setting out how we will develop as a learning organisation that the quality of care and staff engagement will be impacted negatively. *Board Committee with oversight: Strategic Workforce Committee*	16	Overarching framework in place setting out a systematic set of interventions (IC)	Minutes from Executive Management Committee. (IA)	**Amber**	None currently	**9 (3x3)**	No gaps to address.	Director of Workforce and Organisational Development
			Go Engage programme introduced across the Trust (IC)	Reporting of results to EMC and Strategic Workforce Committee. (IA)					
			Quality improvement training rolled out across the Trust (IC)	No. of staff enrolled in Quality Improvement training, internal and external (IA)					
			BHT way programme in place for the year (IC)	Records of content and numbers of staff attending BHT Way (IA)					

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2. People (Director of Organisational Development and Workforce Transformation) We will be a great place to work where our people have the right skills and values to deliver excellence in care:									
2.1 Inspirational leaders developing strong teams Key Focus: Our leaders and teams are enabled to innovate and develop their services Each leader has a transformation project as part of their annual objective June 2018 15 teams enrolled in Go Engage June 2018, 15 further teams enrolled December 2018 50 leaders complete Trust Development Programme March 2019									
BAF 2.1a	There is a risk that if our leaders do not have the right skills to develop strong teams that teams will not innovate and develop their services, thus negatively impacting on patient care and staff engagement *Board Committee with oversight: Strategic Workforce Committee*	9	15 teams engaged in the Go Engage programme in both June and December (IC) Survey results as part of Go Engage programme (IC)	Outputs from Go Engage programme reported to Strategic Workforce Committee on a quarterly basis	**Green**	None currently	**6 (2x3)**	No gaps to address	Director of workforce & OD
			50 Leaders (in 3 cohorts) enrolled in Trust leadership programme during the year	Cohort numbers reported to SWC Feedback from cohorts reported to SWC					

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2.2 Attracting and retaining high calibre and engaged people **Key Focus:** **Transform our nursing workforce for the future** **Recruitment of 70% of University of Bedfordshire students in September 2018** **Recruit 25 individuals from Portugal by March 2019** **Increase internal appointments from 179 to 230 by March 2019**									
BAF 2.2a	There is a risk to us delivering all corporate objectives if we don't attract and retain high calibre and engaged people *Board Committee with oversight: Strategic Workforce Committee*	20	Trust-wide programme to transform the clinical workforce, comprising 6 elements Transform our nursing workforce for the future (IC) - Recruitment including career pathways (IC) - Education and training (IC) - Promoting excellence (including health & wellbeing) (IC) - Smart working (IC) - Temporary staffing (IC)	Outcomes of actions from the programme, reported to Executive Management Committee and Strategic Workforce Committee (IA) Nurse turnover rate (IA) Nurse vacancy rate (IA) Sickness absence rate (IA)	**Green**	Individuals may choose to apply to other employers	**16 (4x4)**	Separate recruitment plan in place. Actions include: Students final placements to areas that they have expressed an interest in working in Offer letters sent in year 2 Close support for students and line managers by recruitment and education teams	Director of workforce & OD
			Recruitment of 70% of the cohorts graduating from the University of Bedfordshire - fast track recruitment process in place (IC)	Numbers of individuals recruited (IA)					
			Recruit 29 individuals direct from Portugal Erasmus programme in place (EC)	Numbers of individuals recruited (IA) Numbers of individuals on Erasmus programme (EA)					
			Increase internal appointments to 230 during f/y 18-19 (IC)	Numbers of individuals appointed (IA)					
BAF 2.3a	There is a risk that without us pioneering new ways of working, the numbers and calibre of staff would be impacted and therefore the quality of patient care would be impacted. *Board Committee with oversight: Strategic Workforce Committee*	12	Recruiting to >100 apprenticeship posts during 2018-19 (IC) 70 Level 3 HCA apprentices - 3 x cohorts of 23 by July, November 2018, March 2019 15 nurse degree apprentices – February 19 10 young nurse degree apprentices – March 19 Nurse associate trainees – 10 recruited by August 18	Numbers of individuals recruited onto each course reported on a quarterly basis to SWC (IA)	**Amber**	Until apprenticeships are registered there is a risk to achieving these numbers Until new posts are budgeted for and recruited to there is a risk to achieving these numbers	**9 (3x3)**	Pro-active recruitment to these pathways Education team supporting senior managers	Director of workforce and OD
			Creating new roles (IC) By the end of 2018-19 20 doctors' assistants in post by the end of 2018-19 5 physicians associates in post by the end of 2018-19	Numbers of individuals recruited into each of these roles reported on a quarterly basis to SWC (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
2.3 Pioneering new ways of working across sites, services and organisations **Key Focus:** **Use apprentices to provide skilled workers for the future** **60 Level 3 by March 2019** **60 Level 5 by March 2019** **20 Level 6 by March 2019**									
BAF 2.3a	There is a risk that without us pioneering new ways of working, the numbers and calibre of staff would be impacted and therefore the quality of patient care would be impacted. *Board Committee with oversight: Strategic Workforce Committee*	12	Recruiting to >100 apprenticeship posts during 2018-19 (IC) 70 Level 3 HCA apprentices - 3 x cohorts of 23 by July, November 2018, March 2019 15 nurse degree apprentices – February 19 10 young nurse degree apprentices – March 19 Nurse associate trainees – 10 recruited by August 18	Numbers of individuals recruited onto each course reported on a quarterly basis to SWC (IA)	**Amber**	Until apprenticeships are registered there is a risk to achieving these numbers Until new posts are budgeted for and recruited to there is a risk to achieving these numbers	**9 (3x3)**	Pro-active recruitment to these pathways Education team supporting senior managers	Director of workforce and OD
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3. Money (Director of Finance) We will be financially sustainable, will make the best use of our buildings and be at the forefront of innovation and technology:									
3.1 Deliver our system control total Key Focus: Manage within agreed budget and agency cap Improvement on prior year underlying position and meeting control surplus of £9.9m including STF. Staff costs not exceeding 2018/19 budget of £250m Meet our total agency spend annual cap of £10.5m									
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 Provider Sustainability Funding is dependent on achieving the financial plan trajectory on a quarterly basis. (Monitored through Finance and Business Performance Committee, F&BP)	20	Compliance with 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) Audit Committee review of compliance with Standing Financial Instructions (waivers, losses etc.)	**Green**	Cost improvement programme not yet delivering to target. (C) Nursing and medical agency staffing still running above internal targets. (C) Delivery against Accident and Emergency trajectory. Bank and agency reduction plan has not yet been approved.	**20 (5x4)**	Continued focus on financial control and accountability at all levels of the organisation. Accident and Emergency delivery plan. Cost Improvement Programme Oversight groups established. Approval of Bank/Agency reduction plan by end of July 2018.	Director of Finance
			Signed Service Level Agreements (EC)	Performance management process against service / contractual specifications both internal and external with Buckinghamshire Clinical Commissioning Group. (IA & EA)					
			Divisional Performance Management process including monitoring, review and actions to address variances on Key Performance Indicators. (IC)	Deep Dive process each month for Divisions. (IA) Internal Audit of Divisional performance in 17/18 EIA) Income deep dive. (IA) Workforce deep dive. (IA) Run rate analysis and actions.					
			Delivery of action plan for Bank and Agency reduction.	Performance against NHS Improvement cap reviewed monthly (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 and fund capital requirements. (Monitored through Finance and Business Performance Committee, F&BP)	20	Compliance with 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 NHSI Integrated Delivery Meeting. (EA)	**Green**	Cost improvement programme not delivering to target. (C) Nursing and medical agency staffing still running above internal targets. (C)	**20** **(5x4)**	Debtor review and focus on collection.	Director of Finance
			Signed Service Level Agreements (EC)	Performance management versus contractual specification. (IA)					
			Divisional Performance Management process (IC)	Deep Dive process each month for Divisions. (IA) Internal Audit of Divisional performance in 17/18 (IA) Divisional performance monthly reviews by exception and quarterly reviews. (IA)					
			Prioritisation of cash payments and cash forecast. (IC)	Finance report which includes a section on cash forecast, debt and liquidity to Finance and Business Performance Committee and Board. (IA)					
BAF 3.1c	There is a risk that if we spend more than £10.5m on agency costs that this will impact on financial targets and could impact on NHSI segmentation *Board Committee with oversight: Finance and Business Performance Committee*	20	Escalated sign off by Senior Managers for all agency spend. (IC) Week-end agency signed off by Gold command. (IC) Monthly 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)**	Allocate system includes interface	Director of Workforce and Organisational Development
			All requests for admin/ clerical agency is signed off by the Director of Finance or the Director of Human Resources as part of the vacancy control panel (IC)	Reconciliation of agency ledger to request process confirmed monthly. (IA) Weekly review by vacancy panel. (IA)					
			Process for booking and managing locum doctors is in-house, with senior sign off. (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 workforce & OD on a weekly basis. (IA)					
			National Guidelines on bank and agency usage (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)					
			Roll-out of Allocate rostering system (led by Chief Nurse)	Monthly reporting of allocate project to EMC (IA)					

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3.2 Improve our operational productivity Key Focus: Use model hospital data to highlight areas for improvement and take actions Reduction in cost per Weighted Unit of Activity ("WAU") across all specialties. Deliver £20m transformational programme									
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).	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) Monitoring of delivery. (IA)	**Green**	Further schemes required. All schemes not rated Green or Amber.	**16 (4x4)**	Continued focus on financial control and accountability at all levels of the organisation. 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. Monthly performance meetings by exception and quarterly monitoring review process and action plans.					

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3.3 Deliver our capital plan **Key Focus:** **Manage and mitigate risks in capital backlog** **Keep within the Trust's Capital Resource Limit** **Phased disposal plan June 2018** **STP Estates bid submission June 2018** **Monthly capital risk assessment and escalation** **Maximise opportunities for external funding and replacement of medical equipment**									
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) Prioritised IT and medical equipment replacement strategy developed to inform 5 year capital plan. (IC)	Meeting minutes for CMG (IA) Monthly monitoring of capital programme through Capital Management Group and F&BP (IA) Deferral risk assessment and reported to Capital Management Group, Executive Management Committee and Finance and Business Performance Committee. (IA)	**Amber**	The monitoring of tendering, procurement and contracts needs to be strengthened to provide greater assurance. Assurance around post project reviews to be developed. Finalisation of Estates Strategy and management of implementation.	**20 (5x4)**	5 year Estates Strategy in development. Draft to be reviewed by Trust Board in March 2018. Prioritised IT and medical equipment replacement strategy in development to inform 5 year capital plan. Potential risk of breaching Capital Resource Limit is still being worked on. Steering group set up with Non-Executive Director involvement to manage process prior to Board approval. Review process, training, support from interim Transformation Director.	Director of Finance
			Business cases and tendering and procurement process. (IC)	Business cases (IA) Cycle of internal audit of procurement (EA)					
			Project management of implementation using Prince 2 type methodology. (IC)	Property Services PMO . (IA) Resourcing plan for implementation. (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 for 18/19 financial year. This is carried out at Capital Management Group and reviewed by Executive Management Committee and Finance and Business Performance Committee.. (IC) Monitoring of risk impact through the incident reporting process and updates to Capital Management Group, Executive Management Committee, Finance and Business Performance Committee and Board.. (IC) Preparation of business cases for potential external funding. (IC)	Capital Management Group minutes. (IA) Risk profiled capital bids. (IA) Incident reporting trends reports to Quality Committee. (IA) 18/19 prioritisation reviewed by Capital Management Group in February. (IA) Ongoing monthly review. (IA) Business case review process through Trust governance structure.	**Amber**	Capital allocation less than amount required.	**20 (5x4)**	Development of initiatives to increase Capital Resource Limit in 18/19 and 19/20.	Director of Finance

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4. Reducing Variation in Quality and Efficiency (Chief Operating Officer and Medical Director)									
4.1 Ensure we are meeting NHS Constitutional standards (Chief Operating Officer) Key Focus: Meeting A&E, Referral to Treatment and Cancer Access targets 4.2 Adopt best practice to reduce clinical variation to improve quality and efficiency of service (Medical Director) Key focus: Implement top two 'Getting It Right First Time' recommendations in each specialty specialties									
BAF 4.1a	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, Access to Diagnostics & 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	Weekly demand and capacity group managing access for RTT, Cancer and diagnostics. (IC) Demand Management Programme to commence with the Buckinghamshire Clinical Commissioning Group Plan for reducing non-elective and elective admissions. (EC) Escalation of all patients within 10 days of a breach to Divisional Directors and Divisional Chairs for cancer pathways. (IC)	Demand and Capacity Group minutes (IA) Weekly escalation meeting chaired by the Chief Operating Officer. (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)	**Green**	Operational Capacity to deliver required standards in particular specialities. Staffing challenges in some areas. Patient flow and length of stay.	**20 (5x4)**	Reduction in numbers of patients staying over 21 days, by December 2018. Detailed work programme through the Urgent Care Recovery Board & A&E delivery board. Unplanned care forecasting tool launched as planned. Additional RAT space to be added by Winter 2018. RTT recovery plan for specific specialities, including outsourcing. Demand management and scheduling between winter and summer and reduce cancer wait time. New Director of Planning and Performance in post. Build capacity in Accident and Emergency. Outline business case approved at Board in May 2018, progressing to full business case. Work on improved bed modelling. Implementation of improvement plan for cancer and urgent care.	Chief Operating Officer
			Planned Care Board (CCG led, launched Sept 2016) (EC)	Meeting minutes (EA)					
			Urgent Care Recovery Programme Board chaired by Chief Operating Officer and attended by the Chief Nurse and Medical Director (IC). Support from NHS Improvement on our urgent care pathway and cancer pathways. (EC)	Programme Board actions and minutes. (IA) Daily national reporting on performance. (EA)					
			Local A&E Delivery Board (health and social care system). The latter is an action focused meeting. (IC & EC)	Programme Boards action plans and minutes (EA)					

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5. Integration, Care Pathways and Models of Care (Chief Operating Officer)									
5.1 Deliver Urgent and Emergency Care Transformation **Key Focus:** **Transform services to reduce demand for Urgent and Emergency care** **Reduce demand for A&E attendances and emergency admissions in line with contract agreements** **5.2 Deliver Primary and Community Care Transformation** **Key Focus:** **Implement integrated care teams and community hubs in Buckinghamshire Communities** **Reduce demand for A&E attendances and emergency admissions in line with contract agreements** **Increase in the use of the Community Assessment and Treatment Services(CATS)**									
BAF 5.1a (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 *Board Committee with oversight: Finance and Business Performance Committee*	25	Urgent Care Programme Board chaired by Chief Operating Officer (IC) Buckinghamshire Integrated Care Board (IC) SAFER delivery plan (IC) Support from NHS Improvement on the urgent care pathway. (EC)	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 'Care-Fully' Urgent Care Programme being initiated with six key modules (Pre--Hospital, Emergency Department, Acute Medicine, Bed/Site, Inpatient Specialities, and Post-Hospital). Improvement plan development with NHS Improvement. Implement over 6 week period (timetable to be confirmed).	Chief Operating Officer
			STP Urgent Care Programme Board (EC) Operational delivery through clinical leads at project level with executive sponsors for each workstream. These are: Medical Take and Maximising the use of Ambulatory Care; Frailty Pathway; Minors Recovery Plan; Speciality response to A&E (Plastics, Surgery and Trauma and Orthopaedics); Continuation of Discharge to Assess; To Take Out medicines; Site Management; Patients with a length of stay greater than 7 days. (IC) Transformation Delivery Group (EC)	Programme board annual plan / meeting minutes (EA) Daily metrics for each workstream. (IA)					
			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) Forward planning using data from Almanac to prepare better across all services. (IC)	7 day audit results (EA)					
			Local A&E Delivery Board (health and social care system) (EC)	Work programme from delivery board (EA)					
BAF 5.1b (links to CRR 49)	There is a risk that we will not transform urgent care services in Buckinghamshire to reduce demand for A&E and emergency admissions by April 2019 *Board Committee with oversight: Finance and Business Performance Committee*	15	Bucks Urgent Care redesign and co-production framework (EC) A&E Delivery Board. (EC)	Board and FBP Committee papers on Urgent Care (IA) Service specification for newly designed urgent care service (IA) Implementation Plans for changed model of care (IA)	**Green**	Redesign and co-production framework to be developed , co-production phase from July 2018, Implementation new model of care September to April 2019	**12 (4x3)**	Begin co design from July 2018 including partnership framework and workshops - dates to be agreed	Director of Strategy
			Buckinghamshire Provider Collaborative Board (EC) Urgent Care Programme Board (IC) Contract monitoring process. (EC)	Meeting of A&E Delivery Board and mobilisation plan for April 2019 (EA) Performance dashboards for Bucks ICS (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 5.2a	There is a risk that we will not deliver the level of transformation in primary and community care that will most benefit our population with care closer to home. If we do not deliver this transformation it may have a negative impact on the urgent care pathway.	20	Local Operational Meetings – Feeding into a Governance Meeting (Partnership meeting with social services & GPS.) (EC) Stakeholder group - Community Stakeholders (EC) New Community Transformation group to be set up across the county where the HUBS and BITS will report into – This will report into the NEL FRP group and ultimately the ICS Board. This is the same process for BITS BITS x 4 at the moment have local groups that meet fortnightly that integrated meeting with the different organisations. This feeds into a mobilisation group that meets monthly. This will feed into the New Community Transformation group.	6 monthly reporting to HSAC (EA) Minutes of the NEL FRP group and Integrated Care System Partnership Board. (EA)	**Green**	This is early stages of transformation and will take time to develop.	**12 (4x3)**	• Develop the hubs model, and consider what would work for each locality • Raise awareness of hubs with public and GPs • Increase the service to at least five days per week • Consider expanding the process to self-referral • Wider range of outpatient clinics and voluntary sector • Better co-ordination of services within the hubs & signposting • Change the environment – to be more clinic-like, – better facilities for partner organisations – to be dementia, mental health a learning disabilities Phase 1 April 2018 Continue community hubs in Thame and Marlow for a further two years Phase 2 April – June 2018 Review out of hospital care model to understand scalability of services between Hubs and Integrated teams Phase 3 June 2018 - March 2019 Increase the scale of delivery of the hubs and integrated teams across the county Phase 4 April 2019 - March 2020 Integrate the out of hospital elements into the full care model	Chief Operating Officer
6. Sustainable Service Growth (Director of Strategy)									
6.1 Repatriate patients into the Trust from Buckinghamshire and surrounding areas Key Focus: Work with ICS to treat more Buckinghamshire patients and seek opportunities to expand services into new markets Increase number of patients choosing to be treated at the Trust in the following specialities: musculo-skeletal, cardiology, obstetrics, plastics, and general surgery Increase number of women choosing the Trust as a preferred place of birth 6.2 Increase non-NHS income Key Focus: Increase private patient income Expand provision in cardiology, dermatology, ophthalmology and orthopaedics in line with Commercial Strategy March 2019								
BAF 6.1a	There is a risk to the future sustainability of the service unless the Trust can attract more patients from Buckinghamshire and surrounding counties . (Monitored through Finance and Business Performance Committee, F&BP)	15	Bucks ICS Elective Programme Board (EC) Bucks ICS Executive Group (EC) , Transformation Programme (IC) , Finance and Business Performance Committee (IC) , Commercial Development Committee (IC)	Transformation Action Plan (IC), Repatriation Action Plan (IA), Outpatients Action Plan (IA), Minutes of ICS Executive group. CCG Contract Agreements on Repatriation (EA), Monthly Finance reports on Activity by Specialty (IA) Bucks ICS Operating Plan (ERA), Bucks ICS Financial Recovery Plan and Monitoring (EA), Quarterly Updates on Corporate Objectives (IA), Quarterly updates on market share analysis to FBPC (IA)	**Green**	Further development of Elective Programme Plan with CCG , Implementation of Transformation Action Plan, GP and patient Choice of Provider, Block contract restrictions, specialty targets agreed with SDUs	**12 (4x3)**	Agree clear contract variations linked to repatriation with the CCG in key specialties such as cardiology, plastics and orthopaedics, Ensure specialty targets for repatriation agreed with SDUs	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
BAF 6.2a	There is a risk that the Trust will not increase non NHS income in line with the Commercial Strategy and transformation programme target	15	Commercial Development Committee (IC), Finance and Business Performance Committee (IC), Transformation Programme (IC)	Minutes and monthly reports to the Commercial Development Committee (IA), Contract agreements with external partners (EA), Minutes and quarterly reports to the Finance and Business Performance Committee (IA), Transformation Programme Monitoring (IA), Capital Programme (IA), Communication and Engagement Implementation Plan (IA), Communication and Marketing Material (IA)	**Green**	Capital resources to support any estates changes	**12 (4x3)**	Seek external joint ventures and partnerships where appropriate to lever additional capital	Director of Strategy
7. Health and Wellbeing (Director of Organisational Development and Workforce Transformation / Chief Nurse)									
7.1 Support health and wellbeing for all staff **Key Focus:** **Programmes to combat stress and increase resilience; MSK care and targeted approaches to the flu vaccine uptake** **Reduction in number of sickness episodes due to stress and MSK episodes by 10%** **Improvement in flu vaccination uptake** **7.2 Ensure the best start in life for Buckinghamshire Children.** **Key Focus:** **Ensure children are safeguarded from harm by working with agencies such as police, social care, education and other health providers** **Safeguarding Level 1 & 2 –over 90% of the relevant staff have received training** **Timely Health Assessments for Looked After Children**									
BAF 7.1a	There is a risk that the programmes to support staff health and wellbeing will not deliver resulting in a negative impact on staff sickness levels with the potential to adversely impact on patient care. *Board Committee with oversight: Strategic Workforce Committee*	20	• Muscular Skeletal issues (MSK) - triage approach to staff MSK referrals, which helps prioritize actions that reflect the severity of the referral and offer immediate self-help advice where appropriate. Appointment of a MSK specialist within the Occupational Health and Wellbeing team to enable more proactive prevention of MSK and be more responsive when intervention required.	increase in staff responding "no" to the question "in the last 12 months have you experienced MSK problems as a result of work activities	**Amber**	Historical take up of flu vaccination is lower than 75%	**16**	Robust action plan for flu vaccination including early implementation of plan	Director of workforce & OD
			Robust staff flu vaccination programme informed by lessons learnt meeting in June for implementation from September 2018	% of staff who have taken up the flu vaccine (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
8. Innovate and Improve (Director of Strategy)									
8.1 Develop an improvement and innovation culture Key Focus: Implement a single improvement methodology that supports the adoption and spread of best practices. Launch service improvement methodology throughout the Trust by September 2018 200 additional staff trained in service improvement methodology by March 2019 8.2 Launch Buckinghamshire Life sciences Innovation Centre (BLIC) Key Focus: Establish innovation hub to support SMEs develop new products with patients and clinicians. Innovation centre at Stoke Mandeville Opened December 2018									
BAF 8.1a	There is a risk that if we do not engage and develop all colleagues in service improvement we will not improve the quality of patient care	20	Minutes of the Workforce Development Committee, Minutes of EMC (IC), Minutes of the Quality Committee (IC)	Service Improvement Training and Development Plan (IA), Communications and Engagement Plan (IA), Action Notes of Service Improvement Taskforce (IA), Monthly Team brief (IA)	**Amber**	Service Improvement Taskforce to meet, single improvement methodology to be agreed, training and development plans to be implemented, communications and marketing plan	**12 (3x4)**	Taskforce meeting in July 2018 to provide framework and action plan for service improvement launch across the Trust in September 2018	Director of Strategy/Chief Nurse
BAF 8.2a	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), 20178/19 Capital Plan (IC), Business case for Innovation Hub (IC), European funding confirmed (EC)	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)	**Green**	Full Business case yet to be agreed, Robust capital estimate.	**4 (4x1)**	Robust business case for redesign	Director of Strategy

Agenda item: 22
Enclosure no: TB2018/089

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

TRUST BOARD MEETING
25 July 2018

Title	Extension To Review Dates For Policies Reserved To The Board
Responsible Director	Director for Governance
Purpose of the paper	The purpose of this paper is to seek Board approval to extend the review date for the Risk Management Strategy and Risk Management Policy to September 2018; and to extend the review date for the Standing Orders and Standing Financial Instructions to November 2018. This request was supported by the Audit Committee in July 2018.
Action / decision required	Approval

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 relates to the delivery of all objectives.
Please summarise the potential benefit or value arising from this paper: Best outcome of review process.

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?	Good governance.

Author of paper: Liz Hollman
Presenter of Paper: Liz Hollman
Other committees / groups where this paper / item has been considered: **Audit Committee**
Date of Paper: 17 July 2018

SUPPORT FOR EXTENSION TO REVIEW DATES FOR POLICIES RESERVED TO THE BOARD

1. PURPOSE

The purpose of this paper is to seek the Board approval to extend the review date for the Risk Management Strategy and Risk Management Policy to September 2018; and to extend the review date for the Standing Orders and Standing Financial Instructions to November 2018.

This request was supported by the Audit Committee in July 2018.

2. BACKGROUND

The Risk Management Strategy and Risk Management Policy were last reviewed in May 2017 and their review date is May 2018.

The Standing Orders and Standing Financial Instructions were last reviewed in July 2016 and their review date is September 2018.

3. KEY ISSUES

There is an internal audit currently taking place on the risk process at the Trust. It would be helpful to take any recommendations into account in the review of the Risk Management Strategy and Risk Management Policy. This should be achieved by September 2018.

The review of the Standing Orders and Standing Financial Instructions is a significant piece of work. The extension to the review date will provide the time needed for the review.

There is minimal risk in extending these review dates as set out above.

4. RECOMMENDATION

The Committee is asked to support the proposal.

Liz Hollman, Director for Governance
17 July 2018

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