Meeting: Trust Board Meeting in Public

Date: 30 October 2024

Agenda item	Place & System Partnership Working Report
Board Lead	Neil Macdonald, Chief Executive
Author	Chloe Powell, CEO Business Manager
Appendices	Appendix 1 – Buckinghamshire Clinical Interface Group Annual Report
Purpose	Information
Previously considered	None

Executive summary

This report provides a summary of key developments in health with partners in Buckinghamshire ('Place') and within the Buckinghamshire, Oxfordshire & Berkshire West Integrated Care System (BOB ICS; 'System') during the last quarter.

Of particular note since the last report, are the developments in the Acute Provider Collaborative, the challenging System financial position and work ongoing towards reaching a sustainable forward plan, and publication of the BOB Integrated Care Board Operating Model.

Decision	The Board is requested to **note** the contents of this report.

Relevant strategic priority

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

Relevant objective

☐ Improve waiting times in ED ☒ Improve elective waiting times ☐ Improve safety through clinical accreditation	☐ Give children living in most deprived communities the best start in life ☐ Outpatient blood pressure checks	☐ Zero tolerance to bullying

Implications / Impact

Patient Safety	Strong relationships with partners delivering health and care services are important for the safety and experience of patients in our Trust.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 3: Failure to work effectively and collaboratively with external partners
Financial	Our Trust financial position is a component of the System financial plan. The Trust also makes financial contributions to the Acute Provider Collaborative.
Compliance	Good governance with partners is fundamental to the well-led domain of the CQC framework.
Partnership: consultation / communication	Significant partnership working is involved in working at Place and System. Work is ongoing to communicate internally about partnership activities external to the Trust.
Equality	A common theme for place and system strategic priorities is improving outcomes for those experiencing the poorest.
Quality Impact Assessment [QIA] completion required?	Not required for this report

1.0 Introduction

1.1 This is a quarterly report updating the Board on key developments and activities in partnership with health and care organisations in the county of Buckinghamshire ('Place') and in the wider Buckinghamshire, Oxfordshire & Berkshire West Integrated Care System (BOB ICS; 'System').

1.2 Of particular note since the last report, are the developments in the Acute Provider Collaborative, challenging System financial position and work ongoing towards reaching a sustainable forward plan, and publication of the BOB Integrated Care Board Operating Model.

2.0 System

2.1 Following a period of consultation and engagement, the **BOB Integrated Care Board (ICB)** has published its Operating Model, which sets out how the organisation is structured to deliver its objectives. Slides 18 and 19 may be of particular interest in the context of this report, as they set out how the ICB will be structured to support place partnerships and leadership.

2.2 Since the last iteration of this report, the BOB ICB has met once on 17 September 2024, reviewing standing items covering performance, quality, and finance. In the Chief Executive Report, an update on the contractual and financial position has been provided, noting the System deficit of £61.5m at Month 4, which is in excess of the £60m deficit plan agreed at the start of the year. As such the System has entered the NHS England Investigation and Intervention regime, as mentioned in my CEO Report to Trust Board last month. A System Financial Recovery Plan has now been submitted to NHS England for consideration. I would take this opportunity to thank BHT colleagues for their hard work and input into these activities over recent weeks.

2.3 The BOB ICB also received an update from Berkshire West Place. The Board may be interested to read of similar ambitions to our own goals, including their Community Wellness Outreach service, and developing Integrated Neighbourhood Teams.

2.4 The **Acute Provider Collaborative (APC)** has made notable progress in the last quarter.

a. Within the clinical services programme, the focus for 2024/25 is on osteoporosis, rheumatology and bariatric surgery. Work is in progress to establish a system-wide Fracture Liaison Service, aimed at improving patient care and outcomes, as well as saving costs across primary, secondary and social care.
b. The Elective Care Board is overseeing a programme of mutual aid to support elimination of patients waiting 65 weeks or longer for their care. At the end of September, there were over 700 patients waiting more than 65 weeks for treatment at Oxford University Hospitals NHS Foundation Trust.
c. The Corporate Services programme is looking at options for scaling and consolidating corporate services, and a workshop held in August helped to identify three main areas of focus (people services, procurement, digital/information management and technology) and a roadmap to implementation.
d. A fourth programme has also been established to identify and deliver opportunities of financial productivity improvement across the collaborative and which Jon Evans (Chief Finance Officer) will lead.
e. Following the publication of the BOB ICB Operating Model, individuals from the BOB ICB Planned Care team will transition to the APC transformation and programme team to support progress across the aforementioned workstreams.

2.5 The **BOB System Recovery and Transformation Board (SRTB)** continues to meet monthly, discussing the system financial performance, investigation and intervention programme, and workforce. The table below shows the financial position of the System at Month 6 (inclusive of deficit support funding):

Surplus / (Deficit) - Financial Position M6	Plan YTD £'m	Actual YTD £'m	Variance YTD £'m	Variance YTD %	Plan 24/25 £'m
Berkshire Healthcare NHS Foundation Trust	1.4	1.4	0.0	0.0%	1.9
Buckinghamshire Healthcare NHS Trust	(6.0)	(6.7)	(0.8)	(0.2%)	(0.7)
Oxford Health NHS Foundation Trust	(1.0)	(0.8)	0.2	0.1%	(0.1)
Oxford University Hospitals NHS Foundation Trust	(17.1)	(25.8)	(8.7)	(1.1%)	(0.2)
Royal Berkshire NHS Foundation Trust	(0.3)	(6.5)	(6.1)	(2.0%)	(0.4)
Provider Total	**(23.0)**	**(38.3)**	**(15.3)**		**0.5**
Buckinghamshire, Oxfordshire And Berkshire West ICB	(0.2)	(2.3)	(2.1)	(0.1%)	(0.5)
ICS Total	**(23.2)**	**(40.6)**	**(17.4)**		**0.0**

2.6 In September, a workshop was held to reflect on the 2024/25 planning round and use it to inform an agreed approach to planning for 2025/26. The following Principles have been agreed:

BOB System Planning Principles 2025/2026
What we will do:
1. **Our organising principle** – Our overarching approach will be to use the 2025/2026 planning round to move the system towards breakeven while seeking to improve quality and performance against the core national operational standards. We recognise that this will require us to work together to prioritise and identify key trade-offs or difficult decisions to take as a system. 2. **Focus on the longer-term** – The route towards system sustainability will require us to transform the way we work, investing our resources differently, embracing digital technologies and population health management at scale and delivering the left shift through investing more in prevention, primary and community services. We will hold this longer-term view alongside the decisions we need to make this year, ensuring that we do not cut across it and instead seeking to identify opportunities to invest in longer term sustainability and transformation. 3. **Commissioning more strategically –** We want to move towards a more strategic, equitable and pathway driven approach to commissioning to shape our services around the outcomes that will have the most impact on our population's health and wellbeing. We also recognise that the path towards longer-term system sustainability will be achieved through greater levels of service transformation, reconfiguration and may need to include the cessation of services where appropriate. We will therefore need to surface difficult commissioning decisions based on evidence and identify these as early as possible in the process.

How we will do it:
4. **National guidance –** We plan to follow national guidance as outlined by NHS England, allocating mandated and named funds towards intended areas. On non-mandated areas or where there is discretion or a need to review this position, the SPLG will work together to identify options and make a recommendation to the System Recovery and Transformation Board. 5. **Baselines** – We want to better understand the underlying baseline across the system both by organisation and sector. We will commission the CFOs to agree the best approach towards this, building on their discussions so far. We will also ensure we build a broader evidence base on system demand, capacity and resource allocation, as referred in *Point 7* below. 6. **Efficiency** – We want to move away from flat efficiency assumptions and approaches which do not necessarily make sense across organisations or sectors. We will develop a stronger technical efficiency approach during planning this year, reflecting differing organisational starting positions, Investigation & Intervention outputs, productivity benchmarking and other tools. We will need a stronger assessment, backed by evidence, of the maximum amount of productivity improvement we can individually and collectively deliver. Again, this will be supported by the work referenced below. 7. **Evidence-based decision making** – We want our planning decisions to be grounded in evidence about what is best for our population and ensures the best use of our resources. The ICB is commissioning analysis to provide a robust analytical baseline focused on: • *Allocative efficiency* – making sure we are investing in the services which will have the greatest impact on population health for the resource invested. Developing a 5-year projection on population growth and need, activity and spend. • *Technical efficiency* – identify opportunities for increased productivity and savings across pathways and models of care; corporate infrastructure; estates; workforce and procurement. • This work needs to inform a more strategic and prioritised system discussion about capital recognising the need to balance strategic, operational, clinical safety and risk and population growth aspects.

2.7 We are a partner organisation of the **Health Innovation Oxford & Thames Valley**, which has published its report for the first quarter of 2024/25 – this and future quarterly reports can be found on their website, here.

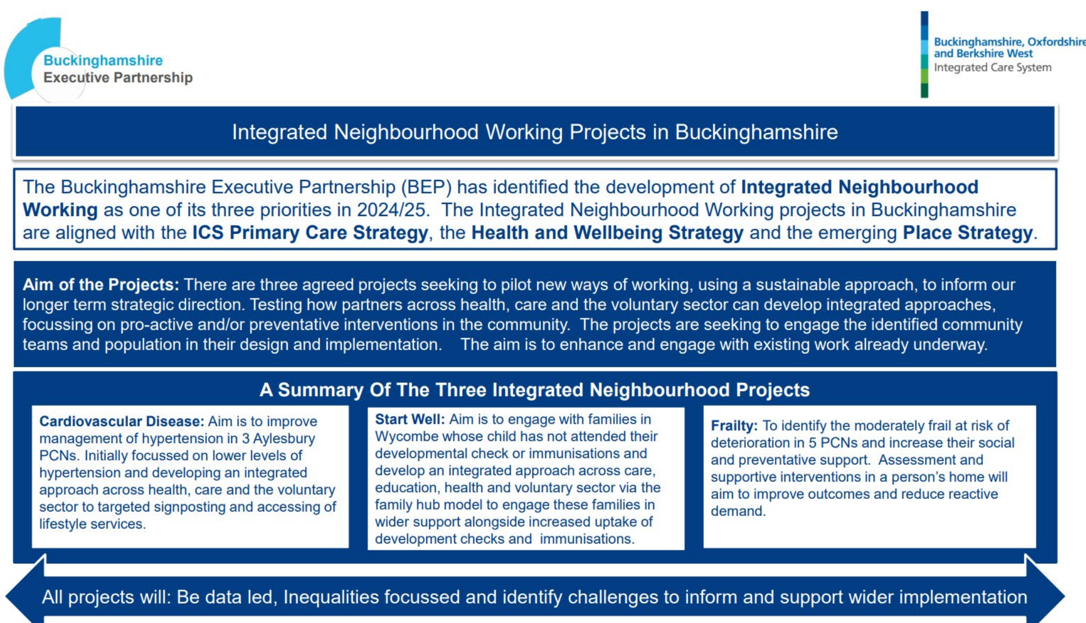
3.0 Place

3.1 The **Buckinghamshire Executive Partnership (BEP)** continues to meet bimonthly, chaired by Neil Macdonald (Chief Executive) and attended by Executive-level partners from the Council, primary care, and mental health. In response to the BOB ICB Operating Model consultation, the BEP once again reiterated to the BOB ICB to agree a programme of delegation of funding to Place due to concerns about reduced support for Place-based activities.

3.2 Across its last two meetings, the BEP has considered progress against its three priorities.

- **Special Education Needs & Disabilities (SEND):** good progress has been made in reducing waits for patients in community therapies and community paediatrics; however, there is more to do to support an increasing need for Education, Health and Care Plans which is currently exceeding available capacity. A local area SEND strategy is in development.

- **Joining Up Care:** the average number of patients in hospital with no criteria to reside (i.e. are medically well enough to be discharged) was improving, however there has been a noticeable increase in numbers of patients on 'Pathway 1' since August. A formal review of Pathway 1 process, demand and capacity has been completed and will be reviewed by the Partnership in December.
- **Integrated Neighbourhood Working and Health Inequalities:** three projects across the county are being developed with focus areas of cardiovascular disease, starting well, and frailty informed by local health data (see below):



3.3 Significant work is underway with colleagues in primary care and appended to this report is the **Buckinghamshire Clinical Interface Group** Annual Report (*Appendix 1*). This clinical group brings together representatives of primary and secondary care, as well as Place and System partners. Its purpose is "to come together and understand each other's pressures and is an opportunity to collaboratively develop solutions, with patients and service users at the forefront of decision making". The report demonstrates where working together has already seen benefits for patient experience and sets out ongoing work and future plans.

3.4 At its August meeting, the **Buckinghamshire Health & Wellbeing Board** considered updates from the public health team on the Joint Strategic Needs Assessment, a draft Pharmaceutical Needs Assessment 2025–28, and the Tobacco Control Strategy 2024–29, and a report on mental health inequalities from Oxford Health NHS Foundation Trust. It also considered updates against standing items of joint Local Health & Wellbeing Strategy dashboard, Healthwatch Bucks, BEP, BOB ICB, and the Bedfordshire, Luton and Milton Keynes Integrated Care Board. In September, in addition to these regular updates, it reviewed the Buckinghamshire Suicide Prevention Action Plan 2024–28, and Buckinghamshire Winter Plan and report on virtual wards. The Buckinghamshire Council Director of Public Health's report on Buckinghamshire's future health and wellbeing may be of particular interest to the Board. All papers and recordings of the meeting webcasts are available online here.

3.5 The **Buckinghamshire Growth Board** has met twice since the last report, discussing new government policy direction, growth initiatives from partner organisations, economic strategy, Buckinghamshire devolution deal, Bucks Business First, and the Growth Board financial position.

4.0 Conclusion

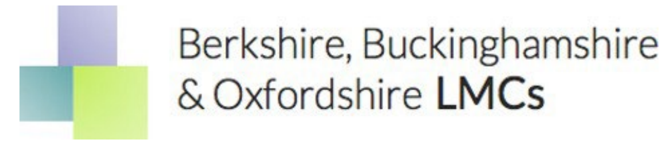
4.1 The Board is asked to **note** this update.

Appendix 1 – Buckinghamshire Clinical Interface Group Annual Report

Buckinghamshire Clinical Interface Group

Annual report

September 2024



Introduction

Place based collaborative approach to system issues

In July 2021, Buckinghamshire became the first in the Buckinghamshire Oxfordshire and Berkshire West Integrated Care system (BOB ICS) to establish an interface group, bringing together representatives from the then Buckinghamshire Clinical Commissioning Group with senior clinicians from Buckinghamshire Healthcare NHS Trust (BHT) and the Local Medical Committee (LMC).

The group has evolved, with current membership reflecting developments within the system, to include representation from the GP Provider Alliance and the BOB Integrated Care Board (BOB ICB), Primary Care and Buckinghamshire Place Based teams, with continued representation from the LMC and leaders of BHT acute and community teams.

The Interface Group provides an opportunity for colleagues from across the health system in Buckinghamshire to come together and understand each other's pressures and is an opportunity to collaboratively develop solutions, with patients and service users at the forefront of decision making.

The Academy of Medical Royal Colleges released the General Practice and Secondary Care Working Better Together report 2023 which set out a number of recommendations for systems to improve interface working.

The Buckinghamshire Interface Group is aligned to the recommendations in the report.

The Interface Group

The interface group has developed a systematic approach to working through issues raised, taking into account system challenges, developments and priorities, whilst considering implications of improvements to the patient journey and care.

Actions taken will follow one of three routes:

1. Following discussion and information sharing within the group, agreement on and delivery of action(s) for a considered solution.
2. A working group is set up to collaboratively address the issues and identify improvements to pathway, guidelines, and processes.
3. The issue is directed to another more appropriate group within the ICS for resolution.

'We would like to thank all members of the Interface Group for their commitment to constructive challenge and problem solving.

We have demonstrated how working together for the benefit of patients and residents in Buckinghamshire is delivering better outcomes, experiences and a more supportive environment which recognises and appreciates the pressure and challenges that all parts of the system face.'

Dr George Gavriel, Director, Bucks GP Provider Alliance

Dr Becky Mallard-Smith, Medical Director, Berkshire, Buckinghamshire & Oxfordshire LMCs

Dr Andrew McLaren, Chief Medical Officer, Buckinghamshire Healthcare NHS Trust

Achievements over the past year:

- ✓ Identifying gaps in service provision that were putting undue pressure on primary and/or secondary care and collaborating on appropriate solutions.
- ✓ Addressing discharge and outpatient prescribing issues between primary and secondary care.
- ✓ Development and publication of guidance for primary care to aid with referrals and interpretation of gastroenterology results.
- ✓ Collaborative development of the pathway and communication for targeted lung health checks.
- ✓ Collaborative working to support the pathway for acne referrals.
- ✓ Support for dermatology demand and service delivery, resulting in significant improvements in waiting times.
- ✓ Sharing development of new community models – such as ambulatory blood pressure monitoring via local pharmacies.
- ✓ Support on shared care management of children with ADHD, preventing development of a two-tier system in access to medication.
- ✓ Ensuring the key contractual delivery of the Acute Trust contract was embedded for the areas stated to support General Practice.
- ✓ Oversight of referral pathways and associated proformas to support good quality referrals.

Buckinghamshire Interface Success Stories

Improvements to the Gastroenterology Pathway

Following concerns from primary care around patient waiting times, delayed responses to GPs seeking advice and bounce back of referrals to primary care, it was identified that improvements were needed to streamline and clarify pathways.

To address this, collaborative work between primary and secondary care developed the platform GPs use to order diagnostic tests to enable them to request appropriate gastroenterology tests. Alongside this, primary care referral guidance for gastroenterology services was developed to support referrals into the service.

These improvements to the pathway have resulted in more accurate and better quality referrals into secondary care and a more streamlined pathway for patients.

Development of the Acne Referral Pathway

In 2023 The Medicines and Healthcare Products Regulatory Agency updated the guidance around isotretinoin treatment for acne. This had significant implications for both primary and secondary care on the management of patients being considered for treatment.

Meetings were held between dermatology consultants from each of the BOB acute trusts as well as GP and LMC representatives to develop a local pathway to support patients.

The outcome of discussion was agreement to jointly develop a local referral proforma which can be used by GPs to refer patients into secondary care.
The proforma will ensure the new guidance is followed and patients experience a smooth pathway and are not delayed at the interface between services.

Improvements to the Lower Gastrointestinal Suspected Cancer Pathway

Following updates to the cancer waiting time standards in October 2023 and concerns from the BHT Lower Gastrointestinal clinical team regarding referrals to the BHT service, it was agreed that work was needed to clarify the pathway and requirements for urgent referrals.

BHT, the ICB, and the LMC have collaborated to update and improve the referral proforma used by GPs when referring patients into the service.

Education events were also delivered by clinical colleagues to reinforce the importance of the changes and how this will contribute to faster diagnosis of cancer patients.

Referrals into the service were audited prior to the implementation of the change and will be repeated to see if these changes have improved the quality of referrals and supported faster diagnosis.

Buckinghamshire Interface Success Stories

Shared Care Management – Children with ADHD

Working with social prescribers in 6 Primary Care Networks (PCNs) across Buckinghamshire covering 45% of our population, the BHT Community Paediatrics service is leading on a pilot that aims to support children awaiting assessment for ADHD and autism.

A working group has been set up to deliver training to social prescribers, so they are able to extend their role support families and children.

Participating PCNs can refer their patients to the social prescribers who can signpost to local support services. Over100 families have been contacted and offered support to date.

This work is being evaluated by the University of Bedfordshire to assess the impact on primary and secondary care, as well as the experiences of families.

Targeted Lung Health Checks

Lung cancer is the most common cause of death from cancer in the UK both in men and women. The Targeted Lung Health check (TLHC) is a programme which is being rolled out nationally. The aim of The TLHC is to identify people aged 55-74 at increased risk of lung cancer and to pick up lung cancers at an earlier stage which may potentially be curable.

The programme, started in Buckinghamshire in May 2024, supports GPs to identify patients at risk who are then contacted and investigated with a low dose CT scan. The launch was after extensive collaboration between several teams across the county.

The ICB worked closely with BHT to support with data collection from shared care records, a joined-up communication plan to ensure a safe manageable roll out and joint meetings with primary care colleagues to increase awareness and to ensure full support if patients question the letters they receive.

With input from respiratory clinicians, ICB clinical GPs and the LMC, a fully endorsed guidance document has also been produced regarding incidental findings. The guidance addresses the concerns raised by both primary and secondary and will be communicated to the wider teams.

Midwifery Prescribing

BHT have undertaken a training programme for midwives to allow them to dispense certain medications for the women they see.

Midwives have not historically been able to issue prescriptions for pregnant women under their care and require doctors to prescribe medication. This can be challenging when working out of community locations where midwives may not have access to a doctor to sign off prescriptions. They must often defer prescribing to the women's GP, which can be both inconvenient for the patient and create a delay to commencing treatment.

The training programme addresses this problem and plans are in place to increase the number of midwives who can dispense as well as the range of mediations they can prescribe. Midwife prescribing gives faster access to medication for pregnant women and is more convenient when out in the community.

Closing the Gaps in Bucks Services

The Buckinghamshire Interface Group Identified a number of services where there were gaps in provision. Below are some of the key gaps and the solutions put in place.

Locally Commissioned Services

Gaps in provision were identified for several diagnostic pathways including ECG, phlebotomy and the respiratory diagnostics spirometry and fractional exhaled nitric oxide.

These were investigated to understand the extent of the gap in provision and then escalated through the ICB for resolution.

The outcome of this has resulted in Locally Commissioned Services (LCSs) to support provision of these diagnostics within primary care.

Community Services

The group identified gaps in provision in women's services for pessaries and long-acting reversible contraception (LARC) where this is required for gynaecological indication without contraceptive need.

This was discussed within the interface group and escalated through the ICB for a solution.

As a result, the Buckinghamshire Intermediate Gynaecology Service is being developed to expand provision of pessaries to women in Buckinghamshire.
A LCS is being explored to provide LARC for gynaecological indication within primary care.

Development of Hub Services

The secondary care dermatology service has been experiencing pressure due to increased in demand on services.

The Interface Group has supported through discussion and understanding of the challenges and working through solutions with the dermatology team.
It was identified that providing photographic images of dermatological presentations with referrals into secondary care would support faster and more accurate triage into the appropriate service.

To enable this process, BHT have introduced a teledermatology hub in Buckinghamshire, which patients attend for photographic images to be taken.

This service supports faster flow through the pathway and allows for appropriate allocation of resources according to clinical need.

Embedded areas of support for Secondary Care

Improved communication

Improved communication channels between primary and secondary care.

Increased understanding

Increased understanding and awareness in primary care of secondary care services and the pathways into these, supporting more accurate and higher quality referrals.

Supporting services

Primary care awareness where services are under pressure, taking a collaborative approach to supporting these services to make improvements to pathways.

Building relationships

Building relationships between primary and community services to work towards more joined up care.

Supporting pathways

Support for the urgent lung cancer pathway with GPs requesting diagnostics ahead of patients being seen at their first outpatient appointment, resulting in a faster treatment pathway.

Increased awareness

Increased awareness of frailty services, supporting primary care with advice on management and referral into the most appropriate service for patients.

Collaboration

Collaboration with primary care on projects to maximise benefits on patient care, through shared understanding and agreed and defined roles.

Embedded Areas of Support for General Practice

BHT has embedded the following 11 principles and ways of working to support general practice

Principal 1

If onward referrals are needed for the patient in relation to their initial presentation the Acute consultant should facilitate this.

Principal 2

Discharge summaries to be received by the GP within 24 hrs and have clear directions on any necessary follow up which is realistic to General Practice.

Principal 3

General Practice should be informed of cross organisational transfers of their patients.

Principal 4

Outpatient letters to be received within 7 working days.

Principal 5

Issue medication following an Inpatient episode (2 weeks is generally the accepted amount)

Principal 6

If medication is required following an outpatient appointment a minimum of two weeks is supplied.

Principal 7

Where a shared care protocol exists, the service user's GP should confirm willingness to accept transfer of care, for the SCP to be initiated.

Principal 8

Follow local prescribing guidelines for all medications.

Principal 9

Issue medical certificates if indicated for both in patient stays and outpatient visits for the total duration of need.

Principal 10

Establishment of a clear GP Liaison pathway to support patients directly contacting the hospital for information on their ongoing care which does not go via GP.

Principal 11

Not to discharge patients automatically following a DNA episode

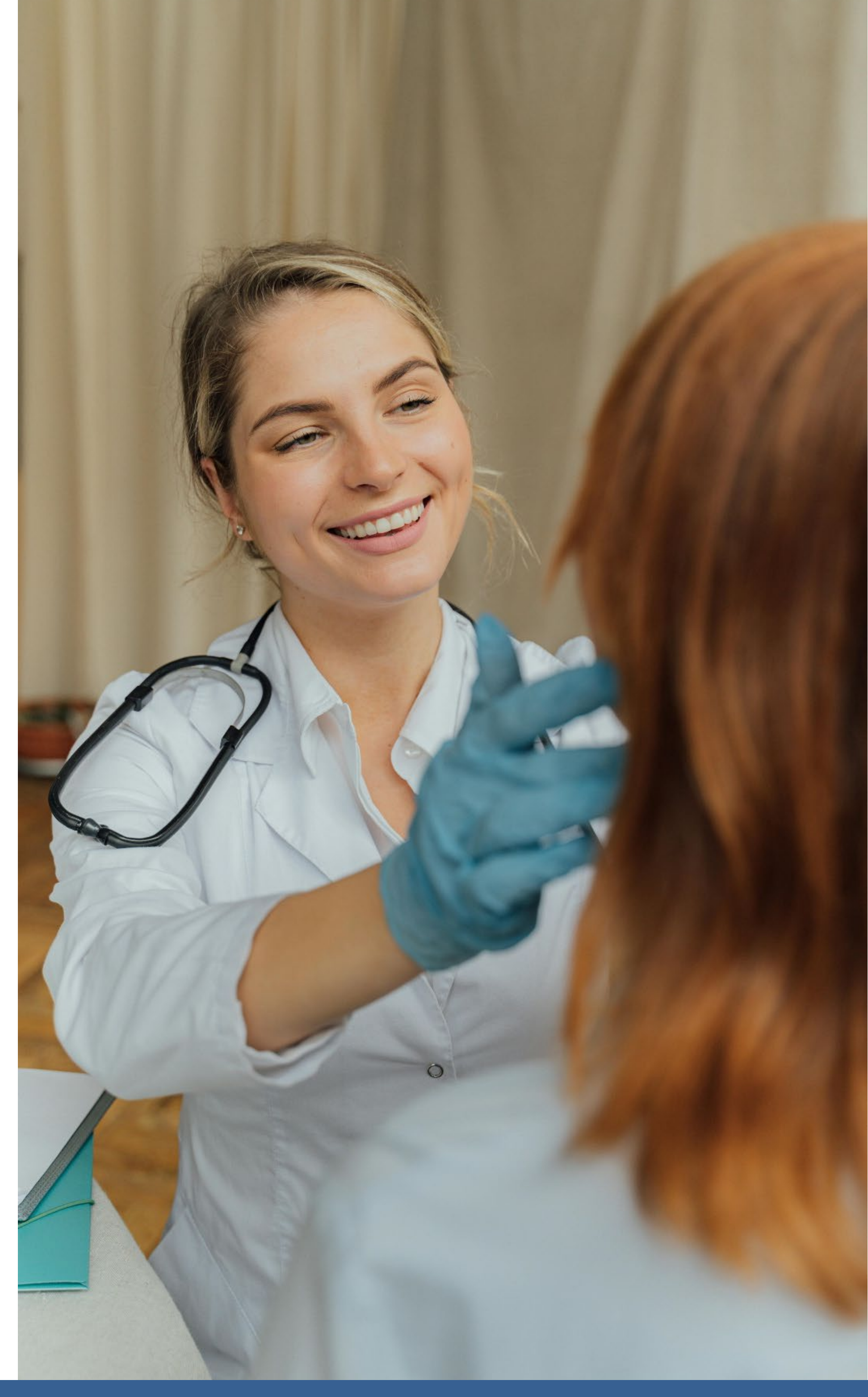
What next?

The Buckinghamshire Interface Group has demonstrated that collaborative working has created a supportive environment between colleagues in the Buckinghamshire system and provides an ongoing forum for sharing of important areas of communication.

To build on the good work to date and to maximise the impact of the group, a workshop was held in November 2023 to review, take stock and develop strategic priorities whilst continuing to work through challenges that arise within the system.

The workshop also highlighted the need to improve communication of interface work and outputs across Buckinghamshire. The group will therefore be sharing regular updates across the system through establish communications routes with the aim of raising awareness, sharing of news and engaging with those in the Buckinghamshire system.

A page has also been created on the BOB ICB SharePoint where key documents and updates are available: [Buckinghamshire Interface SharePoint]



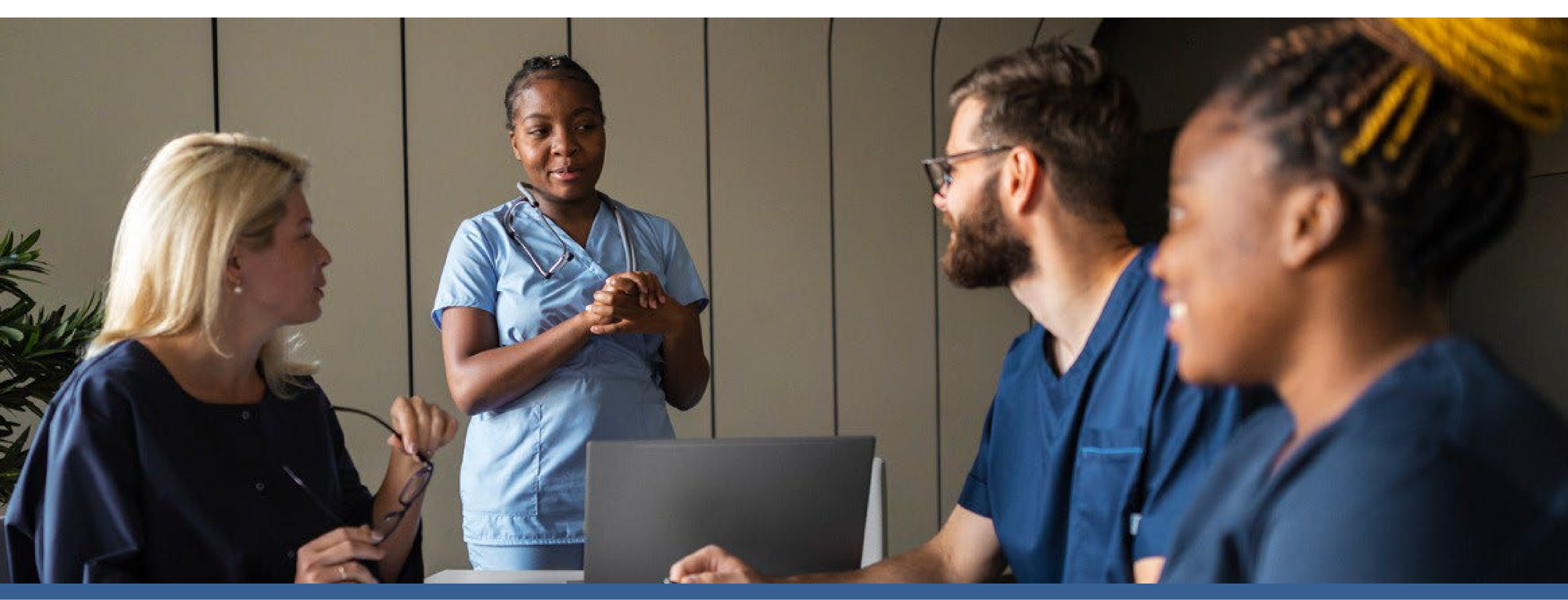
Can the Buckinghamshire Interface Group help you?

The Buckinghamshire Interface Group is established as the place for primary and secondary care to raise any challenges they are facing. It is a forum where system partners can share and discuss information, actions can be considered and agreed, and broader approaches developed.

The Group is recognised as a place where communications can be brought for sharing and refinement before release. The Interface Group has an agreed membership but welcomes clinicians and subject matter experts to join meetings and contribute to discussions.

We encourage and invite you to consider bringing matters to the group to help support a holistic and collaborative solution to challenges or developments you are considering.

Please contact us via our central email box: bobicb.interface@nhs.net



Report from Chair of Quality and Clinical Governance Committee (Q&CGC)
Date of Committee 16 October 2024

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the Q&CG meeting on 18 September 2024	Minutes **approved**	None	Refer to Audit Committee for noting	n/a
Actions & Matters Arising Governance Review of Safeguarding Policies & Practices	Recommendation to clarify the process for recording fact-finding phases of an investigation when concerns are raised regarding colleagues	**Assured** Action closed based on update provided by the Assistant Director, HR	None	Refer to Strategic People Committee for oversight of this action including the inclusion of changes to the Managing Violence & Aggression Policy	n/a
Integrated Performance Report (IPR)	Monthly reporting on Trust quality metrics and actions/progress with actions to address negative variance Data related to September 2024	**Assured**, noting: - Common cause variation seen across all metrics including perinatal mortality with all cases being considered individually - Implementation of PSIRF and the need to consider best reporting methods, focusing on themes, triangulation and organisation/system wide learning (most likely outside of the IPR) - Feedback provided to support changes to PSIRF training for further cohorts	Additional narrative to be added to the report related to the validation of pressure ulcer data Information regarding colposcopy surveillance and harm review to be presented to the Committee	n/a	To note Committee discussions when considering the full report

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Surgery & Critical Care Group	Summary of activities and performance metrics related to the quality and safety of services delivered within surgery and critical care for Q2 2024/25	**Assured**, with Committee discussion related to: - Management of actions related to complaints - Optimal methods of engaging effectively with patients - Challenges with the provision of wound care, noting ICB plan awaited by end of the year - System-wide collaboration to reduce the prevalence of Never Events - The need to focus on QI projects with the most impact on key areas of risk - Update on external reviews - Further monitoring and oversight in place at system-level for paediatric audiology services	None	n/a	n/a
Perinatal Quality Surveillance Model (PQSM)	Overview of maternity issues aligning with NHS England guidance and NHS Resolution standards for Q2 2024/25	**Assured**, noting the following: - Reduction in midwifery vacancy rate due to recruitment of students following placements - The benefits of the maternity Electronic Patient Record (EPR) related to off-site visibility of fetal monitoring results - Plans for oversight and flagging of specific maternity results	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Maternity & Neonatal SCORE Survey	Summary of key finds from NHS England (NHSE) SCORE survey, conducted as part of the NHSE Perinatal Culture and Leadership Programme, and key short, medium and long-term actions in place and/or planned	**Assured**, noting the following: - Differences between the SCORE survey and the national staff survey - Funding provided by NHS England for completion within maternity services but potential benefits in other areas, recognising limitations related to cost, response rate and survey fatigue - Comprehensive set of actions in place	Report back to the Committee on the impact of actions following the publication of Staff Survey heatmaps in early 2025	Ongoing oversight of work planned by Strategic People Committee – to consider any other areas where application of the survey may be beneficial	n/a
Pressure Ulcer Report	Overview of incidences of pressure ulcers during August 2024 with an update on the quality improvement action plan in place	**Assured**, noting the following: - Plans for the roll out of pressure relieving mattresses across the full organisation with appropriate phasing to support finances - Changes in the validation of pressure ulcers with narrative to be provided related to this within the IPR - Good reporting culture - The need to identify community acquired pressure hotspots	None	n/a	n/a
CQC Action / Improvement Plan	Update on progress with action plans following CQC inspections since February 2022 and position with CQC inquiries during the last quarter	**Assured**	Additional narrative to be provided to support the closure of enquiries to the CQC	n/a	To note Committee discussions Full report considered by Board twice yearly

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Dementia Recommendations	Following the publication Health and Adult Social Care (HASC) Rapid Review of the Dementia Journey in Buckinghamshire, update on actions taken to address two key recommendations related to personalisation of dementia care through 'This is Me' and collaborative work with Buckinghamshire Council to develop 'Big Conversation' events	**Assured**, noting the progress against recommendations	Report back to the Committee on the implementation and uptake of the Carers Passport in 12 months	n/a	n/a
End of Life Care Strategy	Update on progress against the End of Life Care Strategy 2021-2024 and initial proposals for the 2025-28 strategy	**Assured**, noting the following: - Increase in referrals from acute areas with work ongoing to reduce admissions - Plans for the next strategy including key objectives and how these are articulated - The potential impact of the roll out of the ReSPECT document which combines the Treatment Escalation Plan (TEP) and decisions related to resuscitation	None	n/a	n/a
Maternity Incentive Scheme	Overview of compliance with Safety Action 4 of the Maternity Incentive Scheme (MIS)	**Assured**, noting the following: - Minimal use of locums within maternity services - Increase in acuity within the neonatal unit	None	n/a	To note full compliance

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Deteriorating Patient Group (DPG) Annual Report	Overview of work completed against the 2023/24 plan by the DPG, plan for work for 2024/25 and a summary of the work specifically undertaken by the Critical Care Outreach Team (CCOT)	**Assured**, recognising the challenges encountered by colleagues in this area	Explore whether further support could be provided to teams	n/a	n/a
Urgent & Emergency Care (UEC) Patient Survey Results currently under embargo	Summary of results of survey conducted in February 2024 including both areas of good performance and areas for improvement	Initial results **discussed** by the Committee	Action plan currently under consideration including wider comms when permitted	n/a	n/a
Patient Story	Summary of feedback from clients of the Community Head Injury Service following receipt of Cognitive Group Therapy	**Noted**, including benefits of group work more broadly across a range of health conditions	None	n/a	To note and discuss at November Board meeting
Organ & Tissue Donation Annual Report	Overview of performance related to organ and tissue donation during 2023/24	**Noted**	None	n/a	To note
Special Educational Needs & Disability (SEND) Strategy	Five-year strategy for children and young people with special educational needs and disability	**Noted**, including the aspirational nature of the strategy and potential challenges in delivering relating to the size of the local team	None	n/a	To note and discuss
Patient Experience Board Minutes	Minutes of the meeting held on 19 September 2024	**Noted**	None	n/a	n/a
Clinical Effectiveness Board Minutes	Minutes of the meeting held on 31 July 2024	**Noted**	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Patient Safety Board Minutes	Minutes of the meeting held on 22 August 2024	**Noted**, reflecting on inconsistent attendance from all Care Groups	None	n/a	n/a
Committee Workplan	Committee schedule of work for the full financial year 2024/25 Draft agenda for the November meeting	**Noted**	None	n/a	n/a
AOB	Integrated Care Board (ICB) Quality Visit Positive feedback received following visit to ED	**Noted**	None	n/a	n/a

Emerging Risks noted:

- Wound care service provision.
- Medical support for the End of Life/Palliative Care Team.
- Capacity challenges within the neonatal bed base across the system and potential impact on local demand.

Report from Chair of Strategic People Committee (SPC) – *not quorate, no decisions made*
Date of Committee 14 October 2024

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes from the Strategic Workforce Committee meeting on 08 July 2024	**Approved**	None	Refer to Audit Committee for noting	n/a
Actions & Matters Arising	Slides presented on reasons for sickness absence and correlation with incidences of violence and aggression across areas of work	**Partially assured**	Consider whether any groups of colleagues are disproportionately experiencing violence and aggression and triangulate with raising concerns data	Committee to reconsider at November meeting with Director of Workforce & Wellbeing present	n/a
Chief People Officer (CPO) Report	Update on key people developments since the previous Committee meeting (July 2024)	**Assured**, through updates on the following: - Industrial action and resident doctors - Work to improve sexual safety within the workplace - Celebrations including recent staff awards and the Trust open day	None	n/a	n/a
Transformation Objectives – Bullying & Harassment	Overview of progress against the 2024/25 breakthrough objective related to the reduction of bullying and harassment within the organisation and the aim to be best in class within 2 years	**Assured**, noting the following: - Importance of focus on positive language; 'Civility & Kindness' interventions - Launch of reporting tool - Overview of upcoming interventions to support further progress	Triangulation with data related to raising concerns/speaking up and colleague well-being. Consider use of AI to support theming, particularly when considering narrative comments from surveys	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Staff Survey Communications 2024	Based on lessons learned from 2023, overview of the approach to the 2024 staff survey	**Assured**, noting the following: - Addition of specific local questions - Progress so far; 20% response rate compared to 16% at this point in 2023 - Communications plan including both organisation-wide initiatives and those locally within teams - Ongoing lobbying nationally for the inclusion of a specific ethnic group for Filipino colleagues in the staff survey demographic options		n/a	n/a
Freedom To Speak Up Guardian (FTSUG) Report	Quarterly report summarising FTSU activity and themes within Q1 2024/25 and initial analysis of staff survey results	**Assured**, noting the following: - Recent successes including the Appreciative Inquiry conference and focus on civility, the Speaking Up Champion thank you event and the effective management of estates concerns - Involvement of the FTSUG within the PSIRF core group to support the development of psychological safety - Active analysis of data from specific National Training Survey questions (for medics), considering sample size as part of this work - The ability to share the work of the FTSU service more widely, whilst maintaining confidentiality - Methods of communication in place to share information and messages with colleagues	None	n/a	n/a Board to consider mid-year and annual report

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Guardian of Safe Working Hours (GSWH) Report	Quarterly report summarising exception reporting activity within resident doctors across Q1 2024/25	**Assured**, noting the following: - Work planned to understand any barriers in place in reporting for individuals with specific protected characteristics - Resident Doctors Forum (RDF) in place and functioning well - Changes to the national resident doctor contract – exception reporting requirements. Noting current proactive work by the Trust in this area - Reporting channels including Immediate Safety Concerns (ISC) and clinical incidents via Datix, and the importance of theming - Improvement work ongoing within the Cardiac and Stroke Receiving Unit (CSRU)	None	n/a	n/a Board to consider annual report
Colleague Voice	Introduction to the in-house physiotherapy service, working within Occupational Health, to support colleague health and wellbeing both proactively and reactively Positive feedback shared from a colleague who had received physiotherapy from the team	**Assured**, commending the proactive work by the team to maintain colleagues' health and wellbeing, noting the following: - This is a substantive service, which was put in place following a business case - Ongoing horizon scanning by the team to ensure the service continues to develop proactively	None	n/a	To note and discuss (next colleague story due at Board in January 2025)

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Integrated Care Report (IPR) **People Metrics**	Monthly reporting on Trust people metrics and actions/progress with actions to address any performance issues.	**Noted**	None	n/a	n/a Full IPR considered by Trust Board on a monthly basis.
Education Report	Quarterly summary of actions related to the provision of education to colleagues against the requirements of NHS England and the Apprenticeship Levy	**Assured**, recognising the following: - Equity in delivery of education/ funding for courses across groups of colleagues - The importance of effective line management in talent management and supporting colleagues' professional development - Use of charitable funds for education across the organisation - Retention of students within midwifery, celebration of success in this area - Ongoing risk related to lack of funding to support pre-registration apprenticeships noting Bucks Skills Board are lobbying upwards in this area	None	n/a	n/a
Committee Terms of Reference	Annual review of terms of reference for Committee consideration	**Noted** – not approved due to the Committee not being quorate	To reconsider at the November meeting	n/a	n/a
Corporate Performance Review	Summary of the Corporate Performance Review for the People Directorate, Sept 2024	**Noted**	n/a	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Risk Register	Review of 'People' risks within divisional and corporate risk registers.	**Assured**, noting the plan to de-escalate the two risks within the corporate risk register related to nursing workforce and industrial action	None	n/a	Take assurance from Committee discussions when considering the full Organisational Risk Report
Annual Workforce Equalities Report 2023/24	Details on how the Trust meets the annual Public Sector Equality Duty (PSED) obligations for colleagues during 2023/24 including an overview of the following: - Workforce Race Equality Standards (WRES) - Workforce Disability Equality Standards (WDES) - Gender Pay Gap (GPG) Summary of key objectives for 2024-2026 including compliance with the NHS EDI Improvement Plan	**Assured**, noting the following: - Amendments to the report following discussion by the Executive Management Committee (EMC) and Trust Board - Requirements of the Employment Rights Bill. - The recent Board ED&I seminar	Ensure processes support fair and equitable recruitment and talent management across the organisation	n/a	Reviewed by Trust Board September 2024
Improving the Working Lives of Doctors in Training	Further to a letter from NHS England in April 2024, an overview of Trust compliance with prescribed actions.	**Assured**, noting the Trust's areas of full and partial compliance with actions to address gaps **Noted** plan to submit final return confirming non-compliance with provision of work schedules 8-weeks in advance and plan to re-test processes in 4 months	To confirm the percentage of doctors who received personalised work template Re-review compliance with actions in February 2025	n/a	To note details of submission

Emerging Risks Identified

- No new/emerging risks identified during the meeting.

Meeting: Trust Board Meeting in Public

Date: 30 October 2024

Agenda item	Integrated Performance Report (IPR)
Board Lead	Raghuv Bhasin, Chief Operating Officer
Author	Wendy Joyce, Director of Performance & Planning
Appendices	IPR September 2024
Purpose	Assurance
Previously considered	EMC 29.10.2024 F&BPC 29.10.2024 Q&CGC 15.10.2024 (quality metrics)

Executive summary

The Integrated Performance and Quality Report provides a monthly update on Trust performance based on the latest information available. The document also includes reporting on actions being taken to address performance issues.

Page 3 of the report provides an executive summary for the month with information on the use of Statistical Process Control (SPC) charts on pages 4-6.

Decision	The Committee is requested to take assurance from the report

Relevant strategic priority

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

Relevant objective

☒ Improve waiting times in ED ☒ Improve elective waiting times ☒ Improve safety through clinical accreditation	☒ Give children living in most deprived communities the best start in life ☒ Outpatient blood pressure checks	☒ Zero tolerance to bullying

Implications / Impact

Patient Safety	The Integrated Performance Report reflects the full suite of performance measures for the Trust. The quality and safety measures are discussed in detail at the Quality Committee.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards
Financial	The productivity metrics in the IPR are key to the financial sustainability of the Trust
Compliance	Public and Board accountability
Partnership: consultation / communication	The IPR reflects programmes run in partnership with ICB and Place partners.
Equality	The IPR contains a focus, through our Healthy Communities metrics, on reducing health inequalities
Quality Impact Assessment [QIA] completion required?	Not required

Integrated Performance & Quality Report

September 2024

CQC rating (July 2022) - GOOD

Introduction & Contents

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

Outstanding Care

Provide outstanding cost effective care

Operational Standards

- Access and performance
  - Waiting Lists
  - ED Performance
  - Ambulance Handovers
  - Urgent 2 hour response
  - Cancer
  - Diagnostics
  - Activity
- Productivity
  - Length of stay
  - Theatres
  - Outpatients

Quality and Safety

- Incidents
- Infection Control
- Patient Safety
- Patient Experience
- Maternity

Healthy Communities

Taking a lead role in our community

- Health and Development Reviews
- Very Brief Advice training for smoking cessation
- Smoking in pregnancy
- Acute and community waits

A Great Place to Work

Ensuring our people are listened to, safe and supported

- Vacancy rates
- Turnover
- Sickness
- Training

Report changes this month

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

Added

Attendance rates for Health and Development Review ASQ3

Removed

Changed

Attendance rates for Health and Development Review renamed to Attendance rates for Health and Development Review ASQSE

Executive Summary

The IPR for September presents a mixed picture in terms of delivery of the Trust's objectives. Urgent care performance declined as the Trust, as with the rest of the NHS, saw significant increases in the number of admissions needed with the increase in respiratory viruses in adult and paediatric patients. Whilst performance did decline it was improved compared to September 2023 and 2022.

The Trust just missed the ambition to have zero acute patients waiting more than 65 weeks at the end of September with 12 patients. This is however a very significant reduction in long waiting patients overall and the Trust continues to improve it's RTT performance and reduce the overall size of its waiting list in parallel. The success in these areas is highlighted by the improving benchmarking against other South East Trusts for elective care metrics. Cancer performance declined as expected due to imbalances with demand and capacity experienced over the summer. A recovery trajectory is in place and the Trust is currently on track to return to the 28-day standard by the end of November.

Performance remains stable on our quality and workforce metrics with PSIRF continuing to embed in the organisation and a increase in focus as part of our bullying and harassment breakthrough objective on (1) managing violence and aggression; (2) sexual safety; and (3) racism.

Our productivity metrics show maintenance of the improved position on length of stay and our reductions in temporary staffing spend.

SPC Charts

Metrics are represented by Statistical Process Control (SPC) charts, with target and latest month's performance highlighted.

These SPC charts are based on three years' worth of data to show the post Covid period (where back data is available).

SPC charts are used to monitor whether there is any real change in the reported results.

The two limit lines (grey dotted lines) around the central average (grey solid line) show the range of expected variation in reported results based on what has been observed before. New results that fall within that range should not be taken as representing anything different from the norm. i.e. nothing has changed.

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

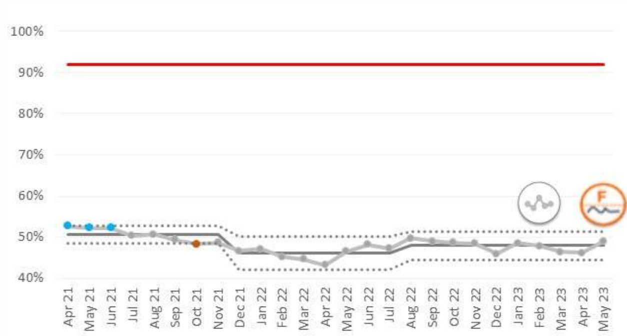
In these charts, where it looks like there has been some kind of change in the variability or average result in the reported data, the limits and the central line have been adjusted to indicate when it appears - statistically - that the change happened. This should be a prompt for users of the chart to look for factors which may have effected the change in the reported data. These may have been changes in the way things were done or external factors e.g. bad weather causing more accidents and therefore an increase in demand/change in case mix.

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

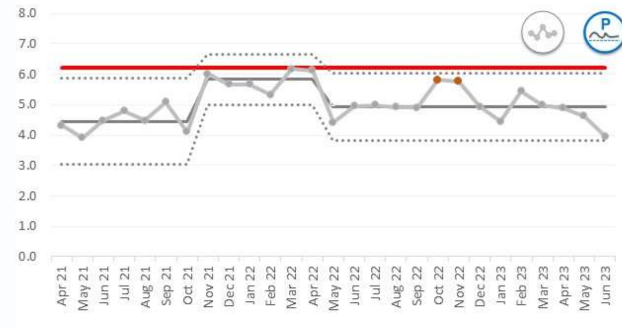
Either way, users of the charts should take care not to directly attribute causal factors to changes in the charts without further investigation.

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

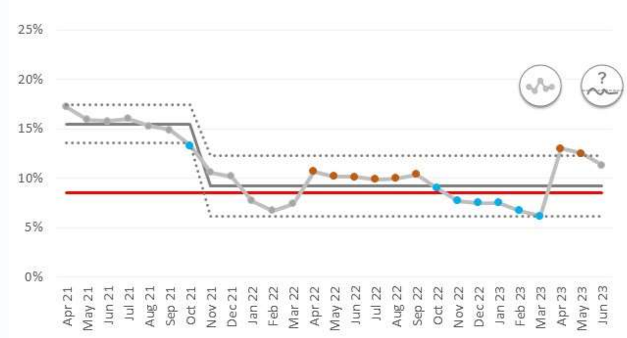
Target line is above the upper limit for this indicator (higher is better) showing that it will not be achieved consistently without a change to the process.



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



Target line is between the control limits for this indicator (lower is better) showing that the process will hit or miss the target without a change.



Key to variation and assurance icons

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

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

Key to matrix

Assurance

Variation/Performance

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

Overall Performance Summary

Variation/Performance

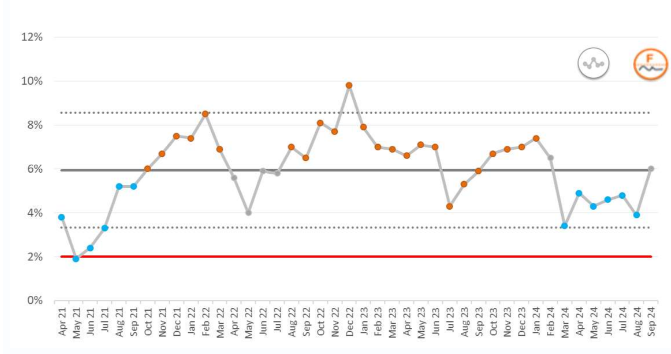
	Assurance: P	Assurance: ?	Assurance: F	Assurance: (none)
H		CWT - FDS general standard	NHSE productivity	
L		Nursing and midwifery vacancy rate	Acute open pathway 65 week breaches Diagnostic compliance	Bed days lost for patients without Criteria to Reside Acute open pathway 52 week breaches Median acute waiting time adults & paeds Community waiting list 65 week breaches Community waiting list 52 week breaches Median community waiting time paeds
Common cause	Urgent 2 hour response Trust overall vacancy rate Statutory & Mandatory training HSMR	ED 4 hour performance Ambulance handovers within 30 mins Hospital at home utilisation Theatre utilisation CWT - 62 day general standard Incidents that are low/no harm Falls per 1,000 bed days Clostridioides difficile Complaints response rate Perinatal mortality Term admissions to neonatal unit Pre term birth rate Maternity smoking at time of booking Maternity smoking at delivery Attendance rates for Health and Development Review ASQSE Level of achievement for Health and Development Review	12 hour waits in ED Acute open pathway RTT performance CWT - 31 day general standard Theatre cases per 4 hours planned time Outpatient DNA rate Attendance rates for Health and Development Review ASQ3	Conversion rate to admission Discharges by 2pm Urgent community response referrals Patients without Criteria to Reside Acute waiting list size New OP activity Average LOS community hospitals 14 day LOS - acute & community 14 day LOS - acute Community contacts - District Nursing Community contacts - Community Therapies Incidents reported Pressure ulcers per 1,000 bed days Complaints received
H	Turnover rate			Median community waiting time adults
L		Daycase rate		

	Assurance: P	Assurance: ?	Assurance: F	Assurance: (none)
Up				Cancer referrals Elective activity WTEs in the trust Substantive staffing
Down				Community waiting list size Temporary staffing
(none)				Acute open pathway 65 week risks Elective activity against plan New OP activity against plan Substantive staffing against plan Temporary staffing against plan Staff completing VBA training for smoking cessation

Breakthrough objectives

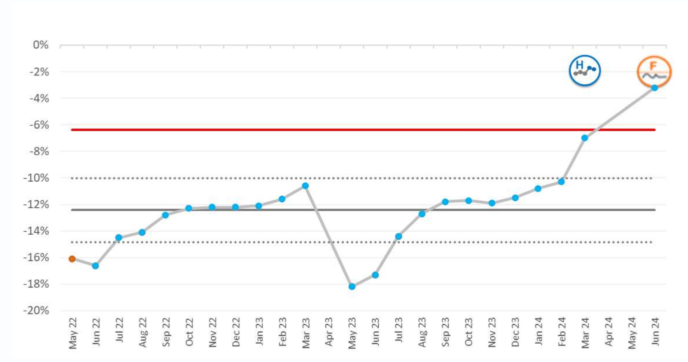
12 hour waits in ED

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



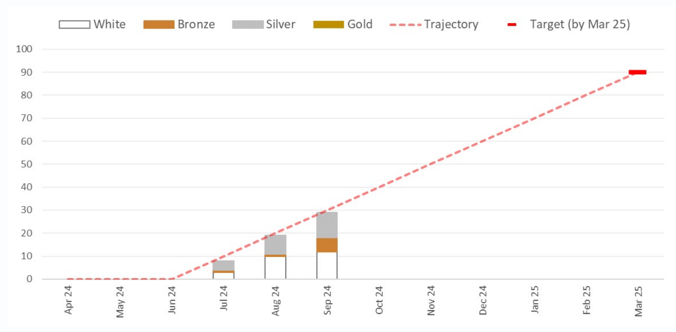
NHS Productivity measure

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



Clinical accreditation

The cumulative total number of accreditations awarded in month. Reset for 2024-25 year.

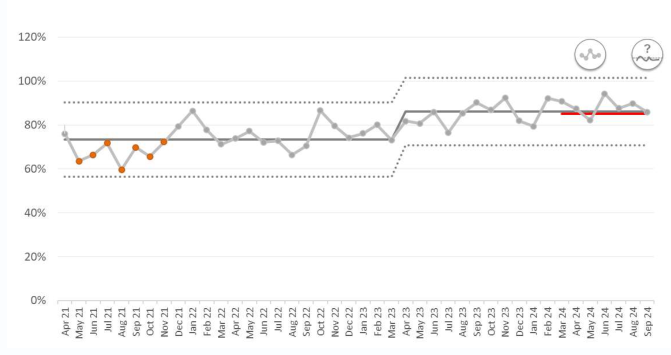


Behaviour

Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse from managers.

School readiness

Percentage of children in opportunity Bucks wards that attend 12-month health and development review by the time they're 15 months.



BP checks

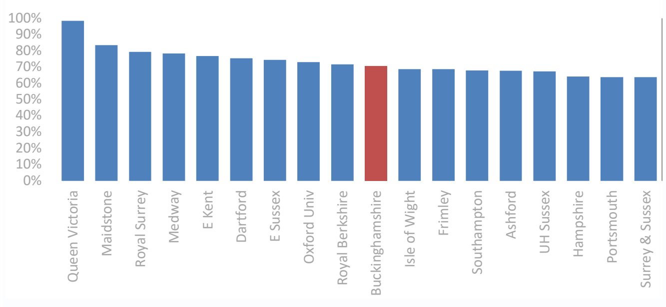
The percentage of face to face, acute, adult outpatients having their blood pressure taken.

Chart for BP checks

Benchmarking Summary for South-East Region

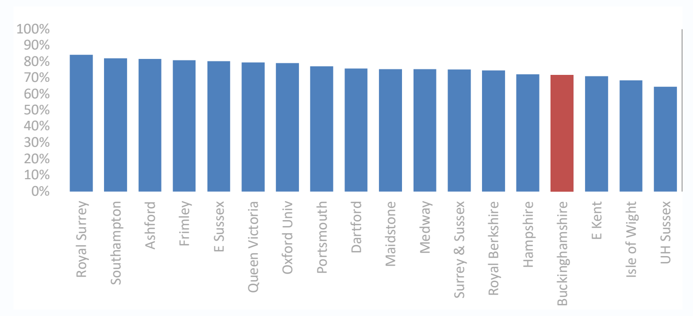
ED 4 hour performance

South East A&E 4 hour performance benchmarking - Sep-24



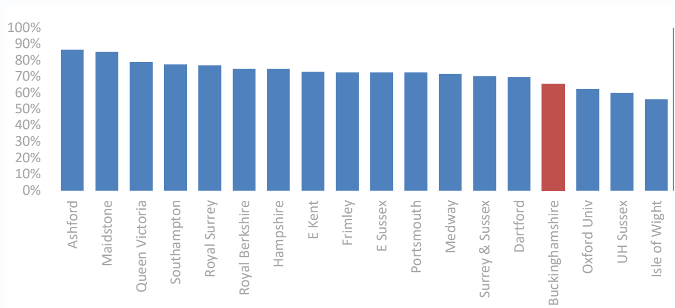
Faster diagnosis standard cancer

South East region faster diagnosis standard cancer benchmarking - Aug-24



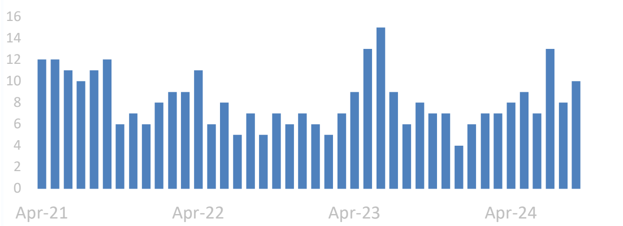
62 day wait cancer

South East region 62 day wait cancer benchmarking - Aug-24



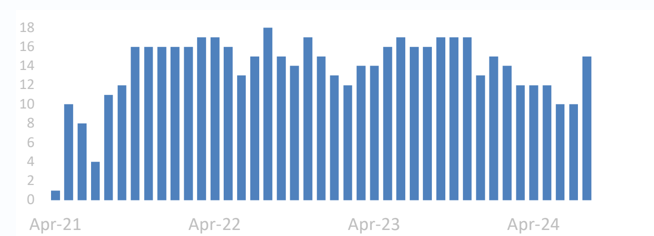
ED 4 hour performance ranking

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



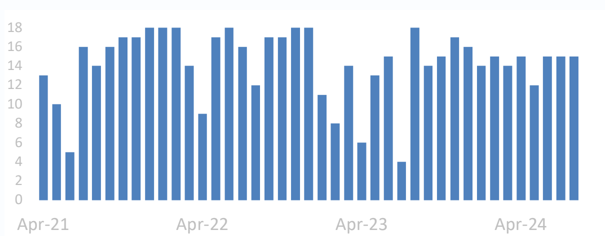
Faster diagnosis standard cancer

South East region faster diagnosis standard cancer benchmarking - historic rankings out of 18



62 day wait cancer ranking

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



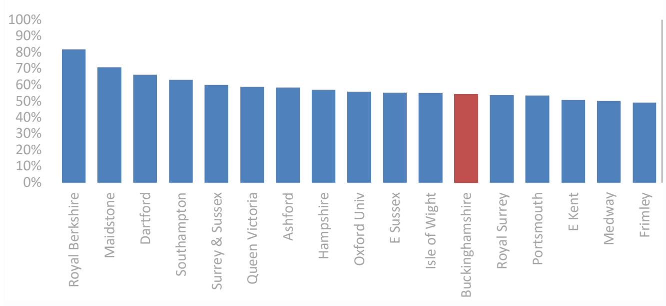
Frimley Health & Portsmouth Hospitals do not report 4 Hour performance as they are part of the Clinical Services Review.

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

Benchmarking Summary for South-East Region

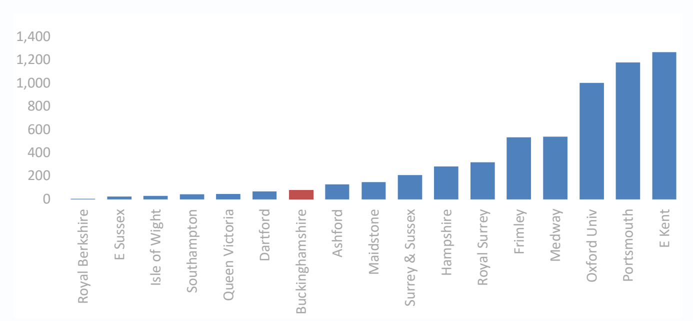
RTT performance

South East RTT performance benchmarking - Aug-24



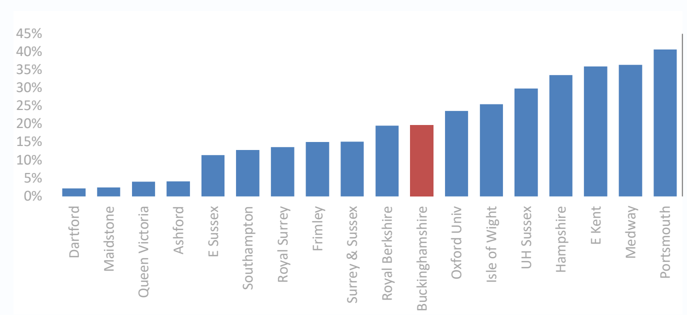
65 week waits

South East over 65 week waits benchmarking - Aug-24



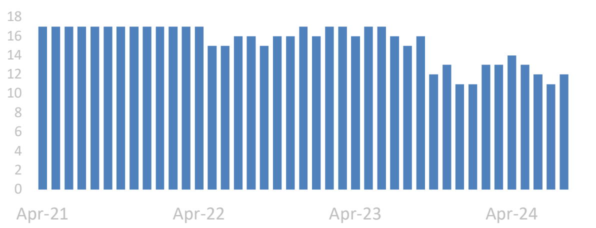
Diagnostic performance

South East diagnostic performance benchmarking - Aug-24



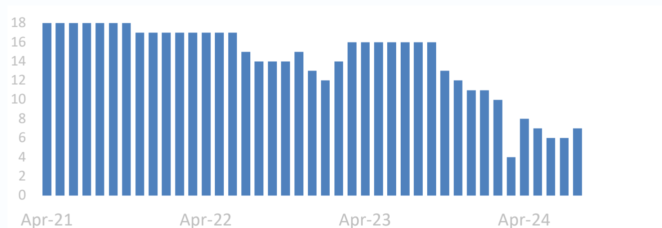
RTT performance ranking

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



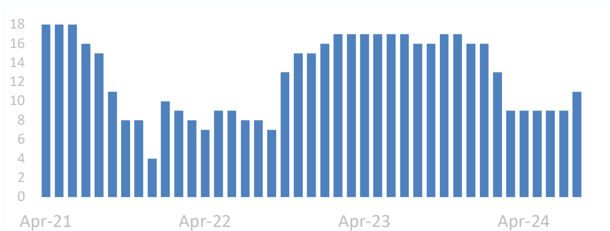
65 week waits ranking

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



Diagnostic performance ranking

South East diagnostic performance benchmarking - historic rankings out of 18



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

Access & Performance

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Breakthrough objective								
12 hour waits in ED	Sep 24	6.0%	2.0%			5.9%	3.3%	8.6%
Driver metrics								
Conversion rate to admission	Sep 24	9.4%	-			10.8%	8.7%	12.9%
ED 4 hour performance	Sep 24	70.7%	78.0%			72.2%	66.4%	78.1%
Discharges by 2pm	Sep 24	27.8%	-			25.5%	21.6%	29.4%
Urgent & emergency care								
Ambulance handovers within 30 mins	Sep 24	85.4%	95.0%			85.5%	75.6%	95.4%
Urgent 2 hour response - community	Sep 24	92.0%	70.0%			91.8%	86.5%	97.2%
Urgent community response referrals	Sep 24	328	-			374	278	470
Patients without Criteria to Reside	Sep 24	69	-			74	50	99
Bed days lost for patients without Criteria to Reside	Sep 24	2050	-			2450	2065	2836
Hospital at home utilisation	26 Sep 24	83.3%	80.0%			82.8%	63.5%	102.1%

12 hour waits in ED

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

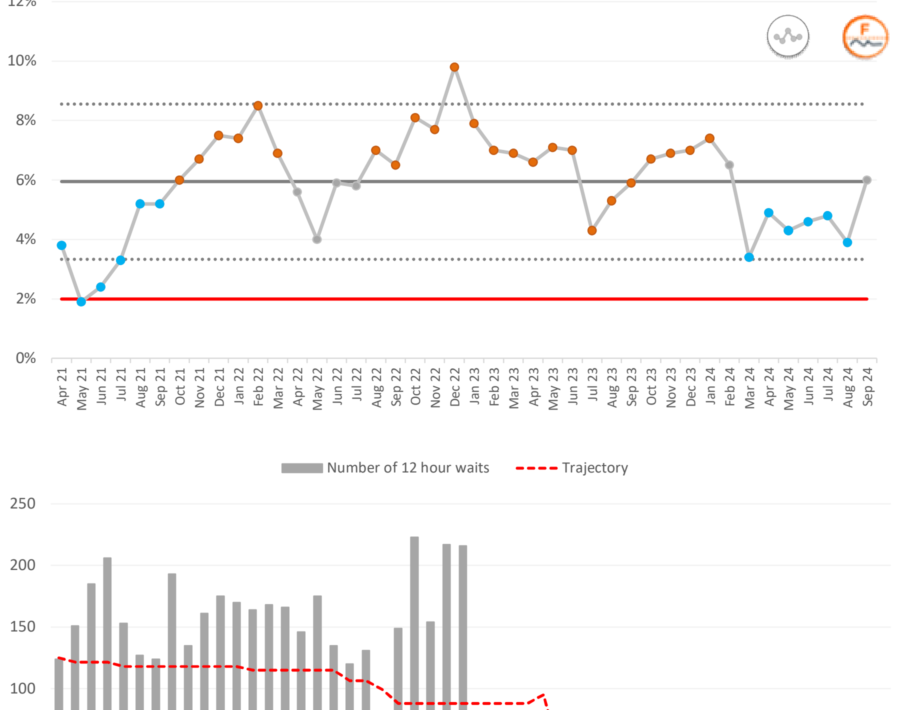
Target: In March 2025 no more than 2% of patients spend more than 12 hours in Stoke Mandeville ED

Owner: Chief Operating Officer
Committee: Finance and Business Performance

How we are performing

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

Sep-24	Variance Type	Target	Achievement
6.0%	Common cause variation	2.0%	Incapable process - likely to consistently fail to meet the target

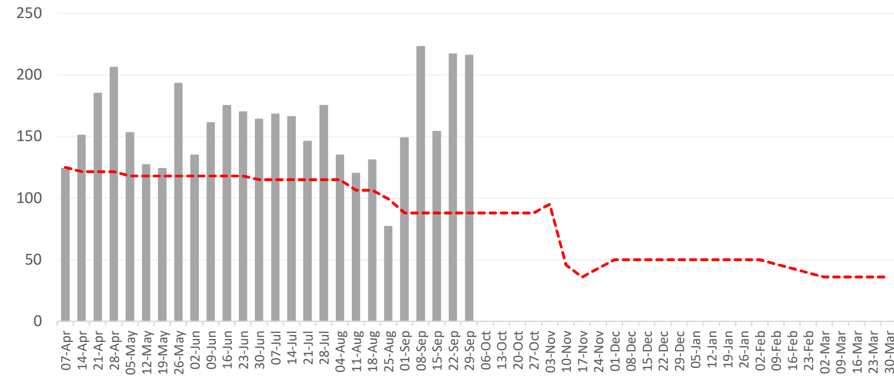


Drivers of performance

Lack of bed capacity on the Stoke site
Long ED waiting times through the night mean late referrals to specialties
Inappropriate admissions overnight due to fewer senior decision makers and alternatives to admission
Minimal number of discharges in the mornings leads to congestion in the Department
Lack of effective & consistent use of our pathways.

Actions to maintain or improve performance

Planned stocktake in September against all performance indicators with focus alongside the ED team in October to drive down waits in that Department.
We remain on track for the new ward opening in November 2024 and are introducing changes to ways of working ahead of the physical estate changes such as extended consultant hours in our Acute Medical Unit and an expansion of the criteria of patients who can be referred to frailty services. These changes were introduced at the end of August/start of September.



Risks and mitigations

Limited control over patient attendances. **Mitigation** - we continue to work with Buckinghamshire Place pathways on alternative pathways and redirection pathways through the Buckinghamshire Place Board. This has result in the continued investment in the Primary Care Clinical Assessment Service for 2024/25.
Constraints on out of hospital care funding in the NHS and social care may inhibit reduction of non-criteria to reside patients. **Mitigation** - we are working closely with system partners to improve discharge processes and manage capacity collectively.
Winter pressures will bring increased demand. **Mitigation** - we are planning now for increased capacity with Olympic Lodge and increased integration of our community services to support admission avoidance.
Delay in ward opening until November 24.

Driver metrics

Buckinghamshire Healthcare NHS Trust

Conversion rate to admission

Number of patients admitted to a General & Acute (G&A) bed (directly or indirectly) from Stoke Mandeville ED over total number of type 1 ED attendances during the month.

Sep-24	Variance Type	Target	Achievement
9.4%	Common cause variation	-	N/A

SM SDEC opens

ED 4 hour performance

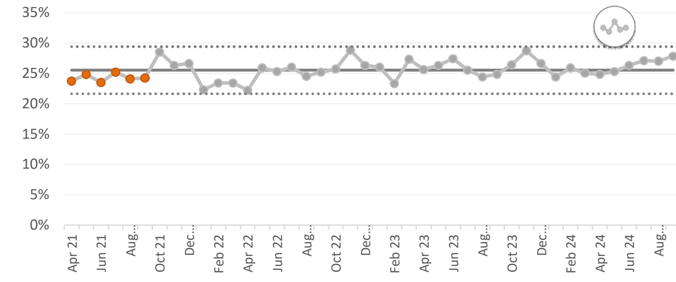
The percentage of patients spending 4 hours or less in ED from arrival to departure over all types of in month departures from ED.

Sep-24	Variance Type	Target	Achievement
70.7%	Common cause variation	78%	Unreliable process - may or may not meet the target consistently

Discharges by 2pm

Proportion of inpatients discharged between 5am - 2pm of all discharges. Excludes maternities, deceased, purely elective wards and patients not staying over midnight.

Aug-24	Variance Type	Target	Achievement
27.0%	Common cause variation	-	N/A



How we are performing

Conversion rate to admission: This metric is experiencing common cause variation i.e. no significant change.

ED 4 hour performance: This metric is experiencing common cause variation i.e. no significant change.
The target lies just below the upper control limit and so is very unlikely be achieved unless something changes in the process.

Discharges by 2pm: This metric is experiencing common cause variation i.e. no significant change.

Drivers of performance

Expansion of SDEC hours has faciltated this reduction in admissions.
Challenges in consistently delivering high performance at the Stoke Mandeville Urgent Treatment Centre.

Increased waiting times in ED in the evenings and then overnight which are challenging to recover during the day.
Inconsistent processes across wards can lead to late discharges including lack of clarity on the key steps needed for a discharge.

Delays due to length process to write TTOs (drug prescriptions) for patients

Actions to maintain or improve performance

Increased use of CDU improving 4 hours performance in A&E

Review of UTC leadership to be concluded in June.
New middle grade rota in ED from August to move more colleagues later in the day

New ED clinical leads driving focus on clinician productivity. Impact expected in August.

New electronic whiteboards to facilitate Board Rounds and clarify next discharge steps rollout started and to be completed by end September.

Expanded discharge lounge with ability for patients to move there without a TTOs to go live in November
Multi Agency Discharge Event (MADE) in September.

Risks and mitigations

Limited control over patient attendances, however we continue to work with ICB on alternative pathways and redirection pathways through the UEC programme.

Cultural changes to working practices can take time to be accepted and embed and this is being supported through an external provider.

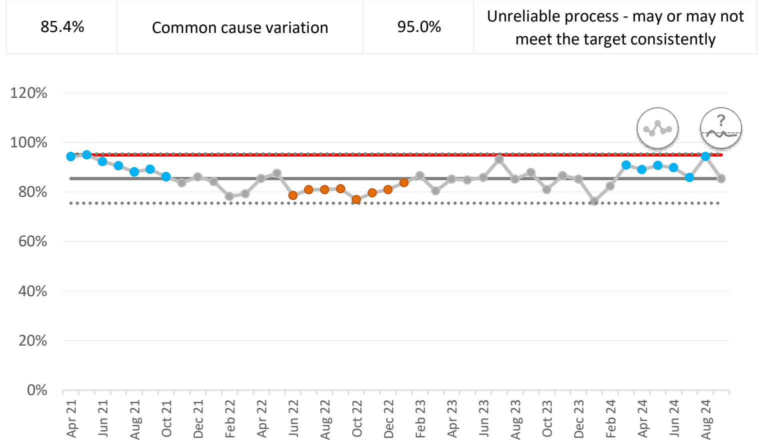
There have been a number of previous attempts to implement new ward round processes including digital input. Learning has been taken from these attempts and a more deliberate, phased and better resourced approach is in place to ensure success.

Ambulance handovers within 30 mins

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

Sep-24	Variance Type	Target	Achievement
85.4%	Common cause variation	95.0%	Unreliable process - may or may not meet the target consistently

This metric is experiencing common cause variation i.e. no significant change. The target lies just below the upper control limit and so is very unlikely be achieved unless something changes in the process.

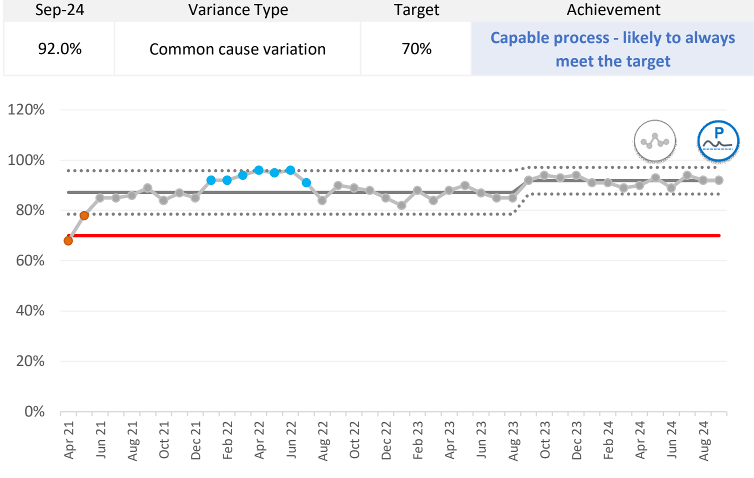


Urgent 2 hour response - community

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

Sep-24	Variance Type	Target	Achievement
92.0%	Common cause variation	70%	Capable process - likely to always meet the target

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

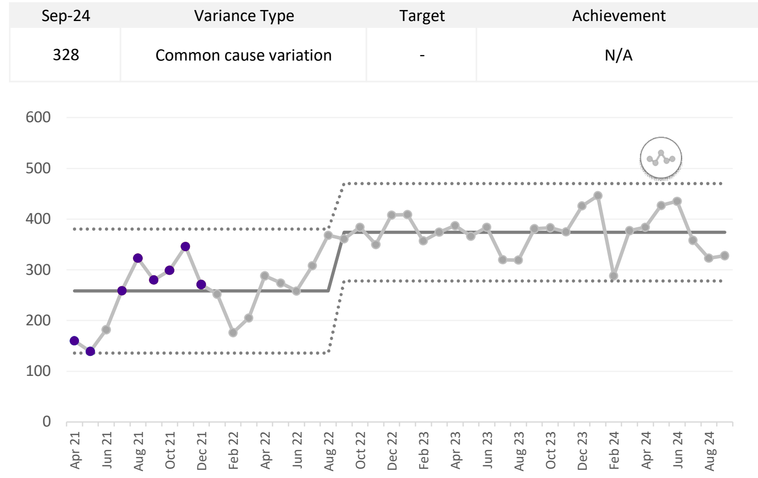


Urgent community response referrals

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

Sep-24	Variance Type	Target	Achievement
328	Common cause variation	-	N/A

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

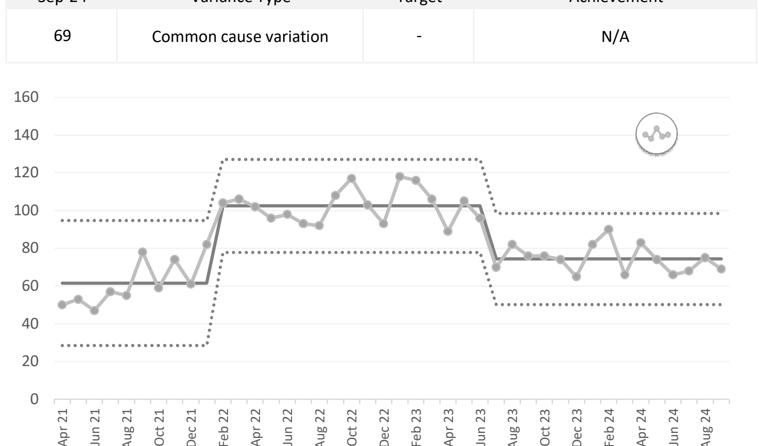


Patients without Criteria to Reside

The number of patients in hospital who do not meet the criteria to reside. Snapshot taken at month end.

Sep-24	Variance Type	Target	Achievement
69	Common cause variation	-	N/A

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

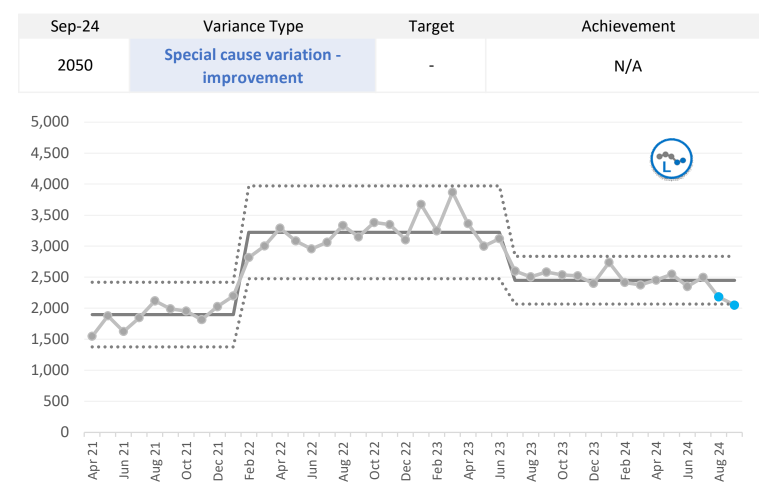


Bed days lost for patients without Criteria to Reside

The number of bed days lost during the month for patients who did not meet the criteria to reside but were not discharged.

Sep-24	Variance Type	Target	Achievement
2050	Special cause variation - improvement	-	N/A

This metric is experiencing special cause variation of an improving nature with the last two out of three data points falling close to the lower control limit.



Hospital at home utilisation

Bucks Hospital at Home current patients using the service divided by number of open beds. Fortnightly snapshot.

26-Sep-24	Variance Type	Capacity	Achievement
83.3%	Common cause variation	80.0%	Unreliable process - may or may not meet the target consistently

This metric is experiencing common cause variation i.e. no significant change.
However the target lies within the current control limits and so the metric will consistently hit or miss the target.

Access & Performance

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Planned care								
Acute open pathway RTT performance	Aug 24	54.2%	92.0%			53.9%	52.2%	55.5%
Acute waiting list size	Aug 24	47401	-			48263	46083	50443
Acute open pathway 65 week breaches	Aug 24	78	-			802	531	1073
Acute open pathway 65 week risks	Sep 24	12	0			-	-	-
Acute open pathway 52 week breaches	Aug 24	1688	-			3040	2311	3769
Median waiting time for acute waiting list for adults (days)	Aug 24	115	-			118	109	126
Median waiting time for acute waiting list for paediatrics (days)	Aug 24	100	-			122	110	133
Community waiting list size	Sep 24	7814	-			8485	8041	8928
Community waiting list 65 week breaches	Sep 24	807	-			981	851	1111
Community waiting list 52 week breaches	Sep 24	1022	-			8485	8041	8928
Median waiting time for community waiting list for adults (days)	Sep 24	74	-			981	851	1111
Median waiting time for community waiting list for paediatrics (days)	Sep 24	138	-			1344	1188	1501

Access & Performance

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Planned care continued								
Diagnostic compliance	Aug 24	19.8%	5.0%			34.8%	26.4%	43.2%
CWT 28 Day General Faster Diagnosis Standard	Aug 24	71.7%	75.0%			68.9%	57.3%	80.4%
CWT 31 Day General Treatment Standard	Aug 24	81.3%	96.0%			82.0%	73.8%	90.1%
CWT 62 Day General Treatment Standard	Aug 24	65.6%	70.0%			62.8%	46.6%	79.0%
Cancer referrals	Aug 24	2292	-			2246	1688	2803
Elective activity	Sep 24	4461	-			4070	3255	4886
Elective activity against plan	Sep 24	-0.3%	0.0%			-	-	-
New outpatient activity	Sep 24	18858	-			18956	14387	23526
New outpatient activity against plan	Sep 24	-3.1%	0.0%			-	-	-

Acute open pathway RTT performance

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

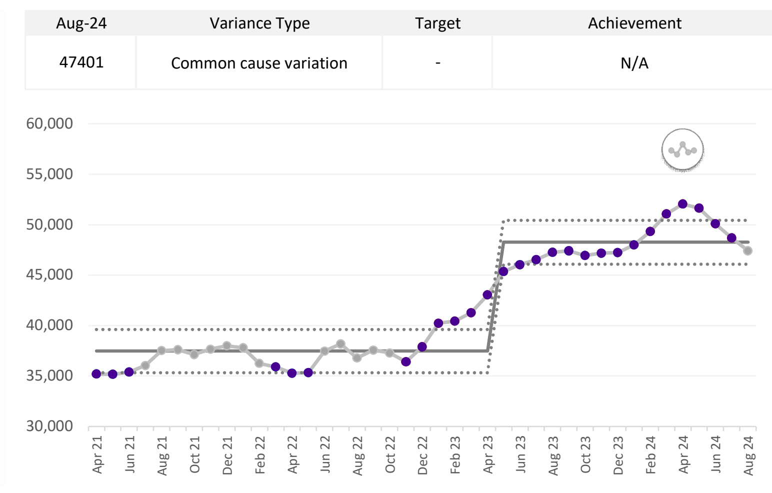
Aug-24	Variance Type	Target	Achievement
54.2%	Common cause variation	92.0%	Incapable process - likely to consistently fail to meet the target

This metric is experiencing common cause variation i.e. no significant change.
However the target still lies above the upper control limit and is unlikely to be acheived without a change in the process.

Acute waiting list size

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

Aug-24	Variance Type	Target	Achievement
47401	Common cause variation	-	N/A



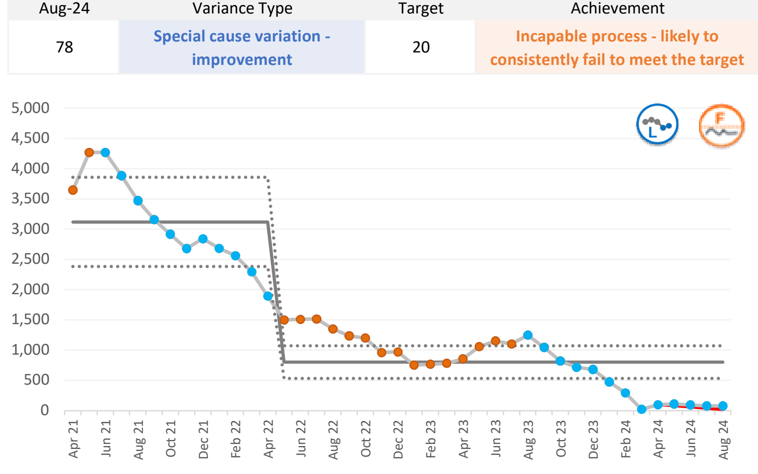
This metric is experiencing common cause variation i.e. no significant change.

As activity levels rise in 24/25 we are able to treat more patients and the total number waiting reduces. We aim to continue this in 25/26 and monitor progress against each speciality

Acute open pathway 65 week breaches

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

Aug-24	Variance Type	Target	Achievement
78	Special cause variation - improvement	20	Incapable process - likely to consistently fail to meet the target

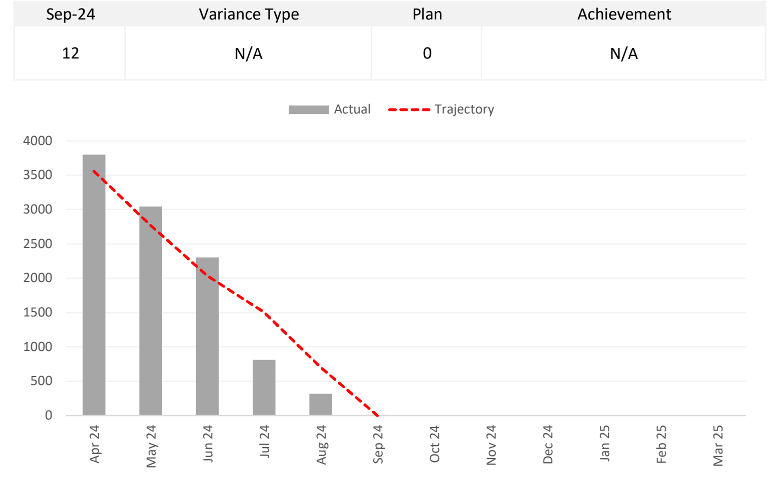


This metric is experiencing special cause variation with an improving nature with the last eight data points falling below the lower control limit.

Acute open pathway 65 week risks

The number of patients who will breach 65 week waiting time by September 2024.

Sep-24	Variance Type	Plan	Achievement
12	N/A	0	N/A



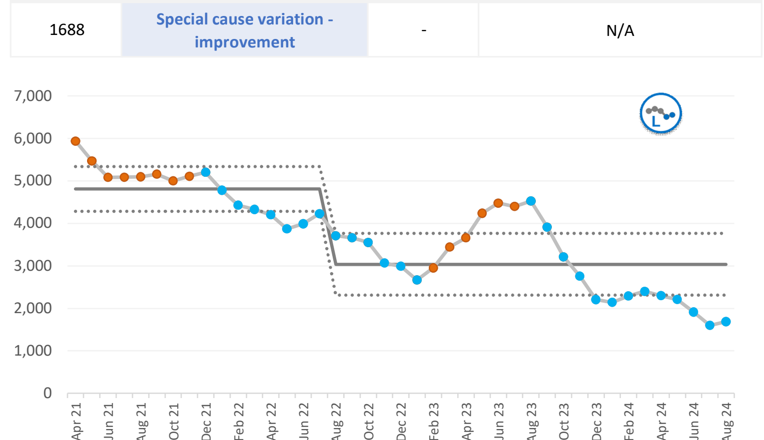
BHT finished the end of September with 12 patients waiting 65 weeks or more for their treatment. Some were due to patient choice with a small number due to complexity and equipment issues.

Acute open pathway 52 week breaches

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

Aug-24	Variance Type	Target	Achievement
1688	Special cause variation - improvement	-	N/A

This metric is experiencing special cause variation of an improving nature with the last five data points falling below the lower control limit.

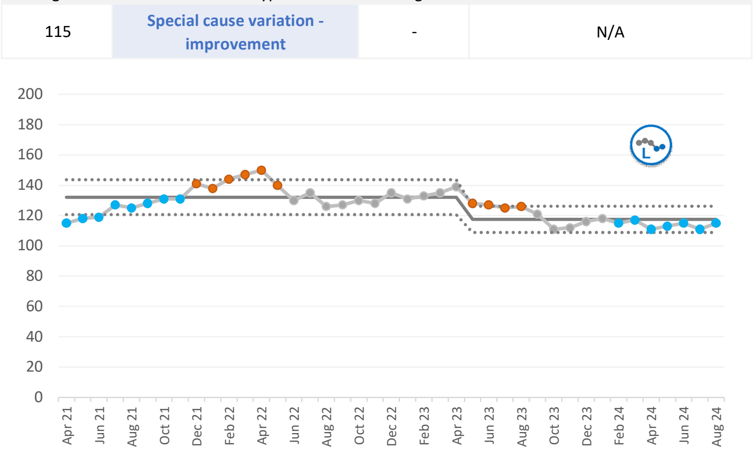


Median waiting time for acute waiting list for adults (days)

Median waiting time in days between referral and month end snapshot for adult patients on the acute waiting list. Patients are aged 16 years and over.

Aug-24	Variance Type	Target	Achievement
115	Special cause variation - improvement	-	N/A

This metric is experiencing special cause variation of an improving nature with the last seven data points falling below the central line.

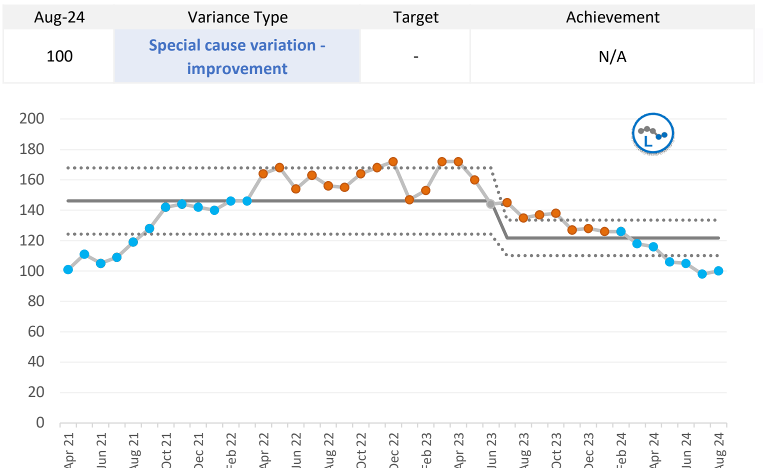


Median waiting time for acute waiting list for paediatrics (days)

Median waiting time in days between referral and month end snapshot for paediatric patients on the acute waiting list. Patients are aged under 16 years.

Aug-24	Variance Type	Target	Achievement
100	Special cause variation - improvement	-	N/A

This metric is experiencing special cause variation of an improving nature with the last four data points falling below the lower control limit.

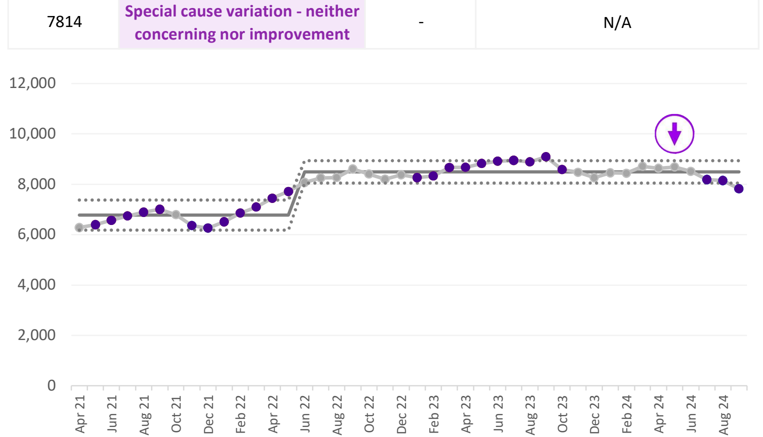


Community waiting list size

Number of patients waiting on the community waiting list at the end of the month. Excludes universal referrals (i.e. health visitors, school nurses, looked after children, and family nurse partnership) and includes community paediatrics under 18 week pathway rules.

Sep-24	Variance Type	Target	Achievement
7814	Special cause variation - neither concerning nor improvement	-	N/A

This metric is experiencing special cause variation of neither an improving nor a concerning nature with the last data point falling below the lower control limit.

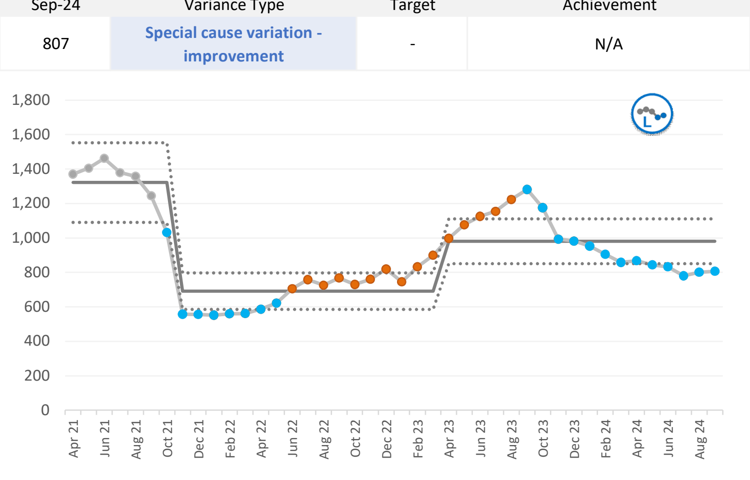


Community waiting list 65 week breaches

Number of patients waiting over 65 weeks on the community waiting list at the end of the month. Excludes universal referrals (i.e. health visitors, school nurses, looked after children, and family nurse partnership) and includes community paediatrics under 18 week pathway rules.

Sep-24	Variance Type	Target	Achievement
807	Special cause variation - improvement	-	N/A

This metric is experiencing special cause variation of an improving nature with the last four data points falling below the lower control limit.

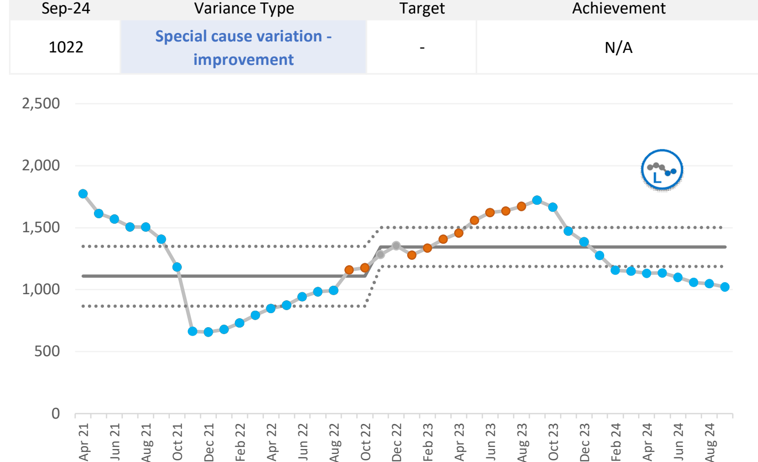


Community waiting list 52 week breaches

Number of patients waiting over 52 weeks on the community waiting list at the end of the month. Excludes universal referrals (i.e. health visitors, school nurses, looked after children, and family nurse partnership) and includes community paediatrics under 18 week pathway rules.

Sep-24	Variance Type	Target	Achievement
1022	Special cause variation - improvement	-	N/A

This metric is experiencing special cause variation of an improving nature with the last eight data points falling below the lower control limit.

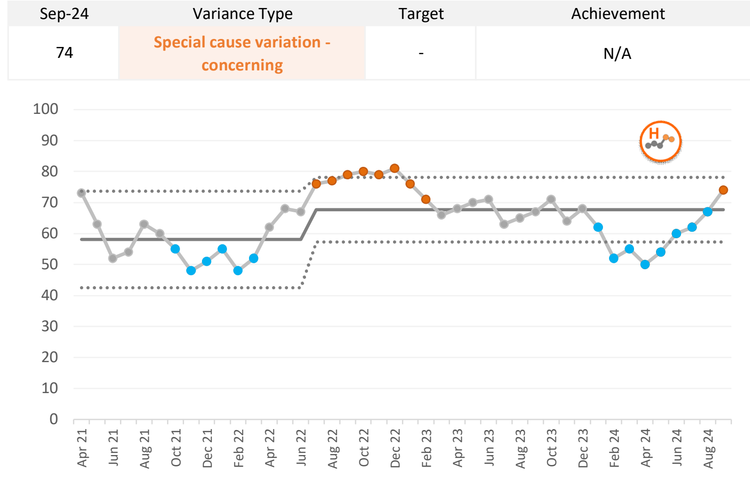


Median waiting time for community waiting list for adults (days)

Median waiting time in days between referral and month end snapshot for adult patients on the community waiting list. Patients are aged 16 years and over. Excludes universal referrals (as above) and includes community paediatrics under 18 week pathway rules.

Sep-24	Variance Type	Target	Achievement
74	Special cause variation - concerning	-	N/A

This metric is experiencing special cause variation of a concerning nature with a run of six points in an upward trend.

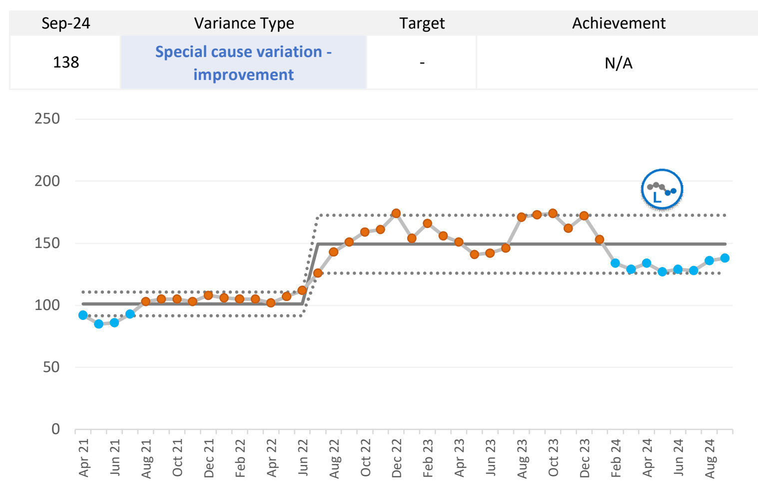


Median waiting time for community waiting list for paediatrics (days)

Median waiting time in days between referral and month end snapshot for paediatric patients on the community waiting list. Patients are aged under 16 years. Excludes universal referrals (as above) and includes community paediatrics under 18 week pathway rules.

Sep-24	Variance Type	Target	Achievement
138	Special cause variation - improvement	-	N/A

This metric is experiencing special cause variation of an improving nature with the last eight data points falling below the central line.

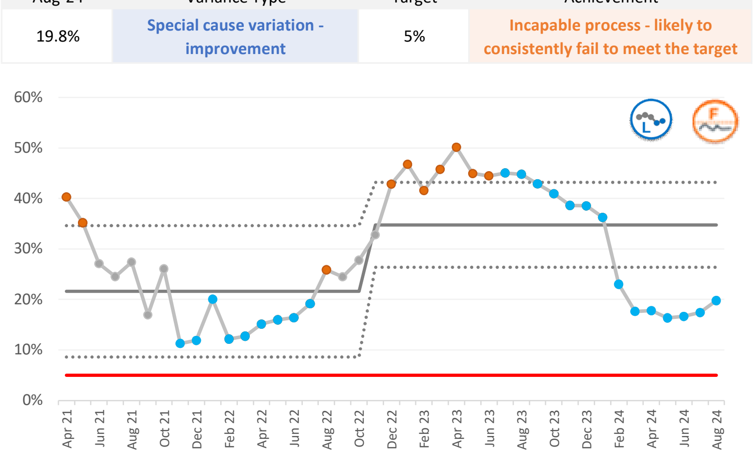


Diagnostic compliance

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

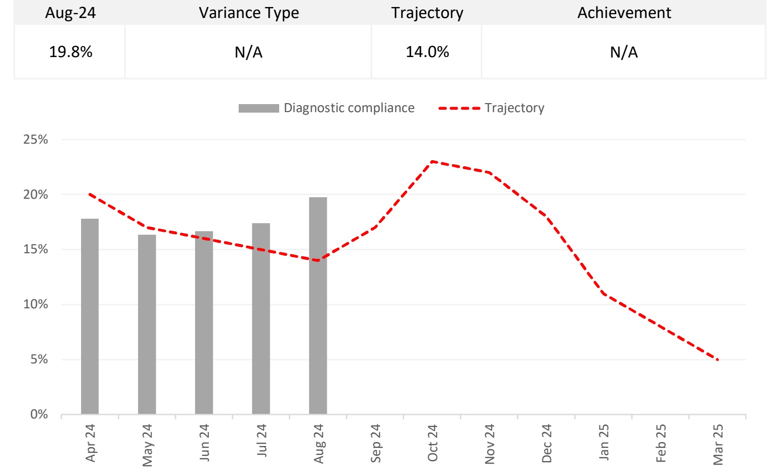
Aug-24	Variance Type	Target	Achievement
19.8%	Special cause variation - improvement	5%	Incapable process - likely to consistently fail to meet the target

This metric is experiencing special cause variation of an improving nature with the latest seven data points falling below the lower control limit.
The target still lies below the current control limits and so cannot be achieved unless something changes in the process.



Diagnostic trajectory

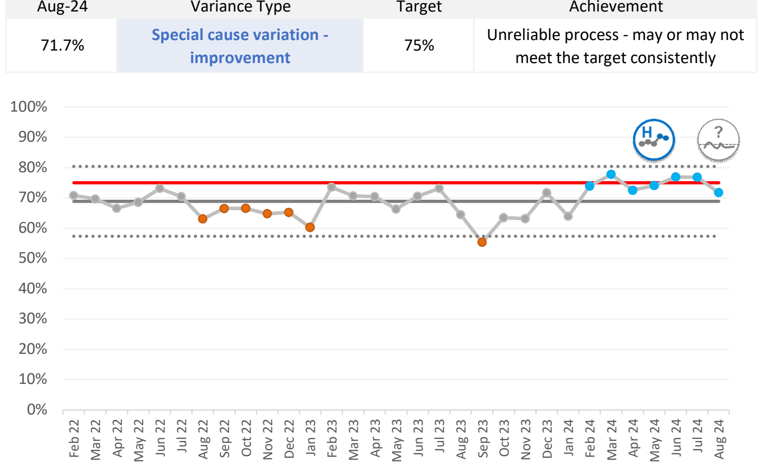
Aug-24	Variance Type	Trajectory	Achievement
19.8%	N/A	14.0%	N/A



CWT 28 Day General Faster Diagnosis Standard

Maximum four weeks (28 days) from receipt of urgent GP (or other referrer) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to the point at which the patient is told they have cancer, or cancer is definitively excluded.

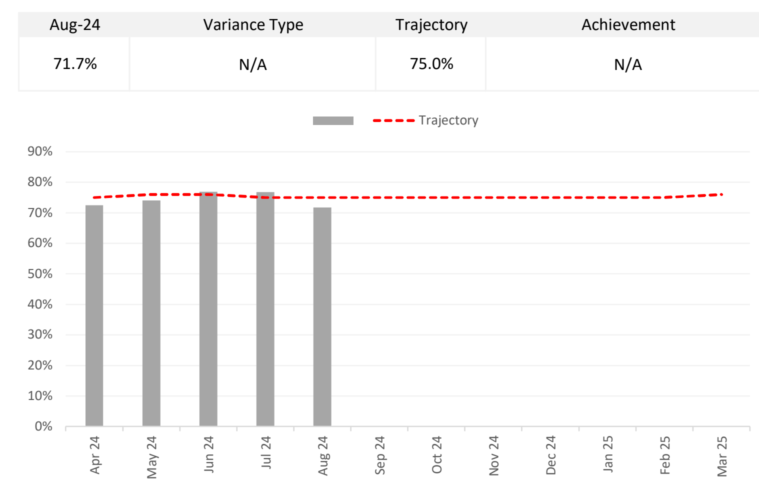
Aug-24	Variance Type	Target	Achievement
71.7%	Special cause variation - improvement	75%	Unreliable process - may or may not meet the target consistently



This metric is experiencing special cause variation of an improving nature with the latest seven data points falling above the central line. The target lies within the current control limits, but just below the upper control limit and so the target is unlikely be achieved unless something changes in the process.

CWT 28 Day trajectory

Aug-24	Variance Type	Trajectory	Achievement
71.7%	N/A	75.0%	N/A



Performance has dropped due to:
Skin - due to the seasonal variation in demand. Skin introduced teledermatology and AI in June and as a result there have been a demand for face to face appointments. Polling has been >14 days for both urgent suspected cancer appointments and teledermatology.
Gynae – OPH capacity
NSS – due to the number of further information requested to GPs and tests results.
Path delays across tumour sites

CWT 31 Day General Treatment Standard

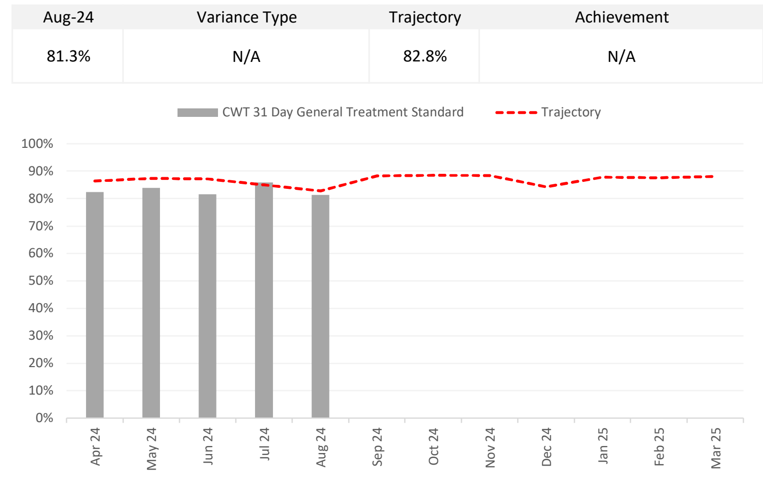
Maximum 31 days from Decision To Treat/Earliest Clinically Appropriate Date to Treatment of cancer. Percentage of patients receiving a first definitive treatment or subsequent treatment for cancer within 31 days in the reporting period over all patients receiving treatment.

Aug-24	Variance Type	Target	Achievement
81.3%	Common cause variation	96%	Incapable process - likely to consistently fail to meet the target

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

CWT 31 Day trajectory

Aug-24	Variance Type	Trajectory	Achievement
81.3%	N/A	82.8%	N/A

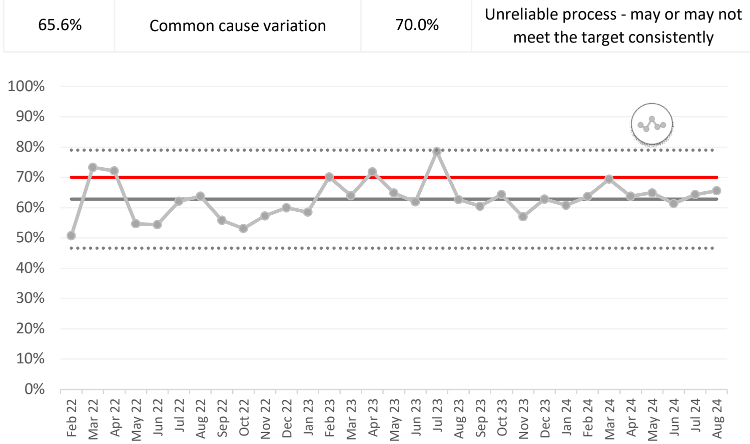


Performance has dropped due to:
Urology: complex pathways, PET PSMA delays and workforce capacity for theatre sessions, oncology capacity
Lung: Delays in molecular results and PET CT
Gynae: elective capacity
Breast: complex pathways, patients' choice and chemo delays
CTVC: delays in reporting
Pre op delays

CWT 62 Day General Treatment Standard

Maximum 62-day from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer, breast symptomatic referral, urgent screening referral or consultant upgrade to First Definitive Treatment of cancer

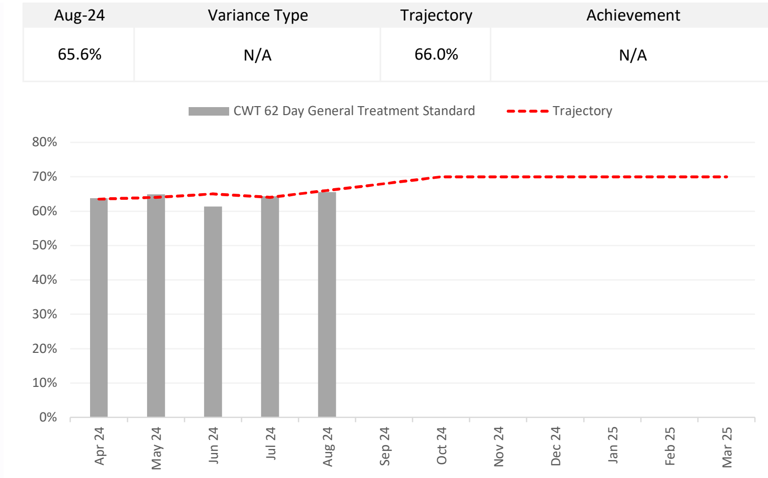
Aug-24	Variance Type	Target	Achievement
65.6%	Common cause variation	70.0%	Unreliable process - may or may not meet the target consistently



This metric is experiencing common cause variation i.e. no significant change.
The target lies within the current control limits and so the metric will consistently hit or miss the target.

CWT 62 day trajectory

Aug-24	Variance Type	Trajectory	Achievement
65.6%	N/A	66.0%	N/A



Performance has dropped due to:
Urology: complex pathways, PET PSMA delays and workforce capacity for theatre sessions, oncology capacity
Lung: Delays in molecular results and PET CT
Gynae: elective capacity
Breast: complex pathways, patients' choice and chemo delays
CTVC: delays in reporting
Pre op delays

Cancer referrals

Number of patients referrred each month on a cancer pathway.

Aug-24	Variance Type	Target	Achievement
2292	**Special cause variation - neither concerning nor improvement**	-	N/A

3,500
3,000
2,500
2,000
1,500
1,000
500
0
Apr 21 Jun 21 Aug 21 Oct 21 Dec 21 Feb 22 Apr 22 Jun 22 Aug 22 Oct 22 Dec 22 Feb 23 Apr 23 Jun 23 Aug 23 Oct 23 Dec 23 Feb 24 Apr 24 Jun 24 Aug 24

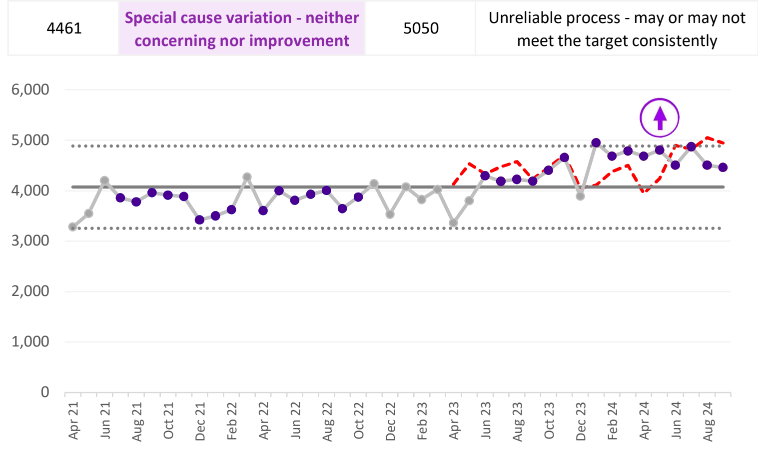
This metric is experiencing special cause variation of neither an improving nor a concerning nature with the last eight data points falling above the central line.

Cancer Performance Mitigations:
Urology: Surgeon started in Oct will increase capacity in robotic surgeries from Jan 2025.
Lung: PET CT to be commenced from Amersham from Jan 2025 will potentially reduce waiting time
Gynae: Locum started in Oct will increase capacity for theatre cases
Breast: review and monitor complex pathways. Chemo requests escalated on a regular basis.
CTVC: started using outsourcing company from Sept and showing improvement and reduction of backlog
Pre – op: Written note on e-TCI card that patient is on USC pathway

Elective activity

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

Sep-24	Variance Type	Plan	Achievement
4461	Special cause variation - neither concerning nor improvement	5050	Unreliable process - may or may not meet the target consistently

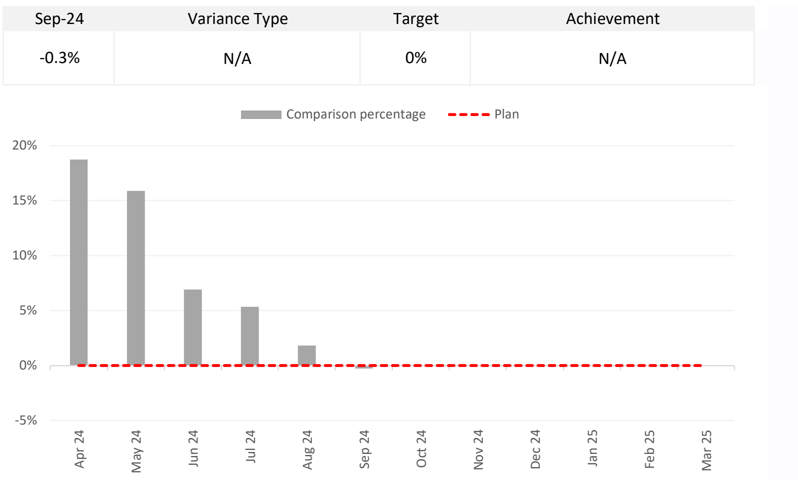


This metric is experiencing special cause variation of neither an improving nor a concerning nature with the last nine data points falling above the central line.

Elective activity against plan

The year to date number of elective inpatient and day case admissions over year to date plan for the same period. For financial year 2024/25.

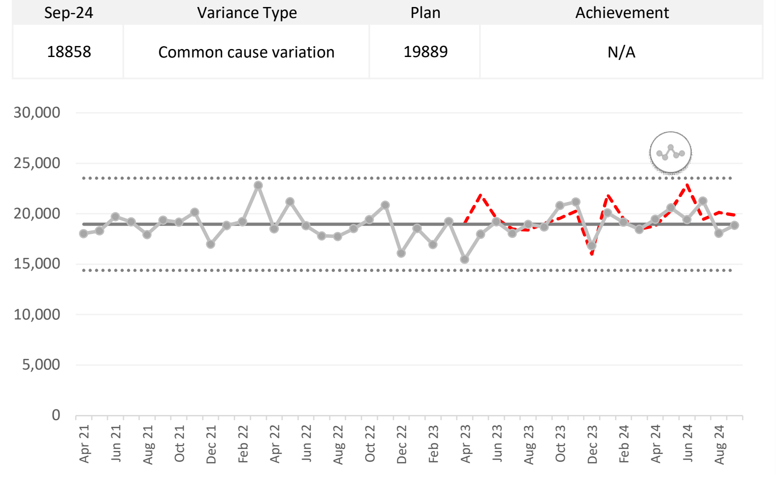
Sep-24	Variance Type	Target	Achievement
-0.3%	N/A	0%	N/A



New outpatient activity

Total number of new outpatient attendances during the month.

Sep-24	Variance Type	Plan	Achievement
18858	Common cause variation	19889	N/A



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

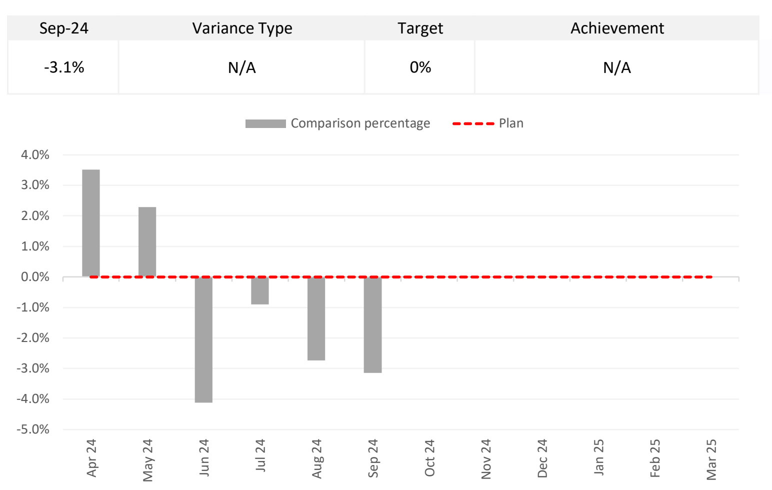
Investigation into a lower than expected activity rate for new outpatients has evidenced that we are delivering more outpatient procedures than previously and this is improving the patient pathway. We will therefore be including this activity against the year plan.

We also understand delays in not completing the 'cashing up'process for our outpatient activity in a timely manner is leading to exclusion from our monthly reporting. We have agreed a plan to ensure this is corrected.

New outpatient activity against plan

The year to date number of new outpatient attendances over year to date plan for the same period. For financial year 2024/25.

Sep-24	Variance Type	Target	Achievement
-3.1%	N/A	0%	N/A



Clinical accreditation

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Breakthrough objective								
Clinical accreditation	Sep 24	29	-			-	-	-
Driver metrics								
Incidents that are low/no harm	Sep 24	98.3%	98.0%		?	98.3%	96.9%	99.8%
Complaints responded to within 25 days	Aug 24	83.0%	85.0%		?	78.0%	49.6%	106.4%
Falls per 1,000 bed days	Sep 24	5.4	6.2		?	4.9	3.6	6.3
Quality & safety								
Incidents reported	Sep 24	1324	-			1224	960	1488
Pressure ulcers per 1,000 days	Aug 24	2.54	-			2.90	1.44	4.37
HSMR	Jun 24	92.5	100.0		P	91.4	87.4	95.4
Clostridioides difficile	Sep 24	7	4		?	4	-3	10
Complaints received	Sep 24	46	-			41	11	72
Perinatal mortality (over 24 weeks)	Sep 24	1	0		?	1	-2	5
Term admissions to the neonatal unit	Sep 24	1.7%	5.0%		?	4.3%	0.8%	7.7%
Overall preterm birth rate	Sep 24	6.1%	6.0%		?	5.9%	2.0%	9.9%

Clinical accreditation

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Patient Safety Incident Response Framework								
After Action Reviews	Sep 24	14	-			-	-	-
Multi Disciplinary Team reviews	Sep 24	5	-			-	-	-
Patient Safety Incident Investigations	Sep 24	3	-			-	-	-

Clinical accreditation

Definition: The cumulative total number of accreditations awarded by month end and the cumulative total number of areas in the trust with a silver (or higher) accreditation at month end. (Resetting baseline to zero in April 2024.)

Target: All acute areas undergo clinical accreditation and at least 40% achieve a silver award

Owner: Chief Nursing Officer
Committee: Quality and Clinical Governance

How we are performing

In September, we successfully completed 10 assessments, comprising 7 reassessments and 3 new assessments. Additionally, a mandatory question set assessment was conducted for areas that were scored as "white" during the July evaluation.

Drivers of performance

Our performance continues to be influenced by several key factors:
Adherence to Core Quality and Safety Standards: Ensuring that all wards and departments follow established quality and safety protocols and regulatory and legislative Standards.
Consistent Governance: Maintaining oversight through Care Group quality governance systems, including regular audits, reviews, and accountability measures.
Focus on High Behavioural Standards and Empowerment: Upholding professionalism, teamwork, and ethical conduct while fostering an environment where colleagues feel safe and empowered to voice any concerns without fear of reprisal.
Culture of Continuous Improvement: Encouraging every team member to actively seek and implement improvements in processes and workflows.
Data-Driven Decision-Making: Utilizing comprehensive data analytics to monitor key performance metrics, such as patient outcomes and compliance rates, enabling informed decisions that drive continuous quality and safety improvements.

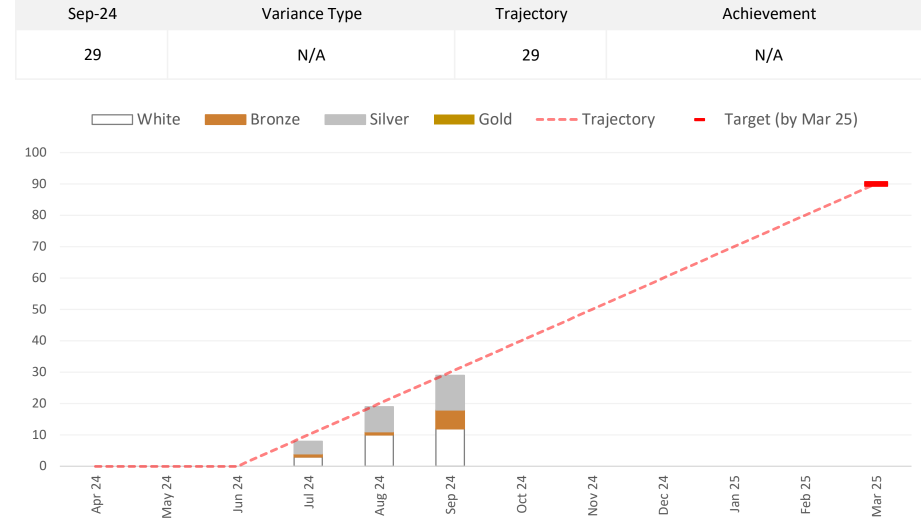
Actions to maintain or improve performance

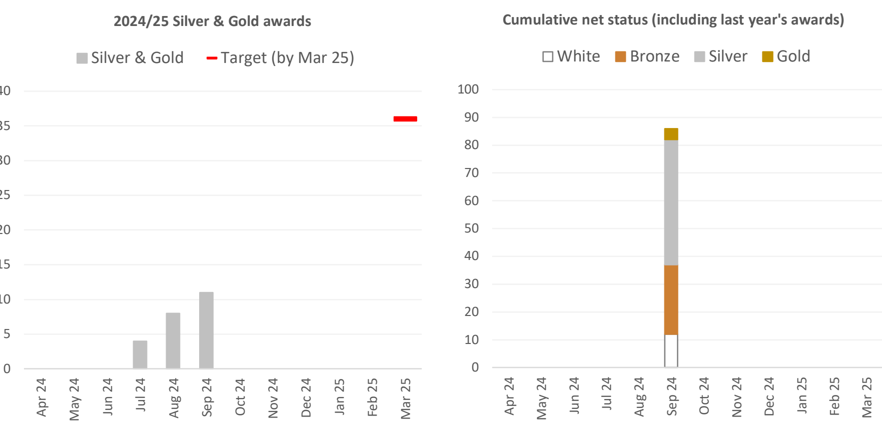
The Cycle 2 accreditation programme is proceeding on schedule, with three areas being accredited weekly. To support this process, nursing and midwifery leadership teams across Care Groups and corporate are actively involved in conducting the accreditation assessments as per the established rota.
At the end of each month, an impact assessment will be conducted, identifying areas for potential improvement based on the assessment results. This targeted approach will ensure that any gaps or weaknesses are addressed promptly.

Risks and mitigations

Resourcing Challenges: The programme faces challenges due to financial constraints affecting resource allocation.
Mitigation: The Transformation Team is currently reviewing resource allocation to explore additional support options for the programme. Additional resource to the team in line with the trust governance and patient safety consultation outcome.

Sep-24	Variance Type	Trajectory	Achievement
29	N/A	29	N/A





Incidents that are low/no harm

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

Sep-24	Variance Type	Target	Achievement
98.3%	Common cause variation	98%	Unreliable process - may or may not meet the target consistently

Complaints responded to within 25 days

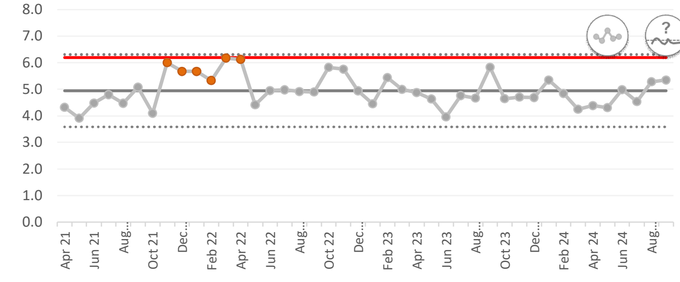
Percentage of complaints responded to within 25 days of receipt. Reporting suspended until July 21 due to Covid.

Aug-24	Variance Type	Target	Achievement
83.0%	Common cause variation	85%	Unreliable process - may or may not meet the target consistently

Falls per 1,000 bed days

Rate of inpatient falls incidents reported per 1,000 inpatient bed days.

Sep-24	Variance Type	Target	Achievement
5.4	Common cause variation	6.2	Unreliable process - may or may not meet the target consistently



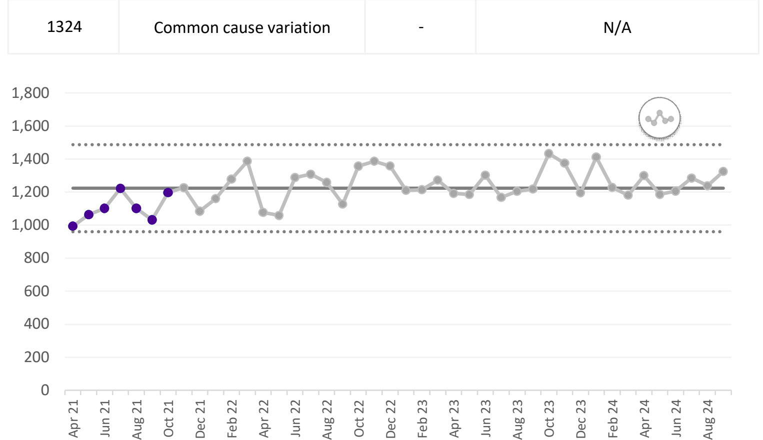
How we are performing	Drivers of performance	Actions to maintain or improve performance	Risks and mitigations
Incidents that are low/no harm: This metric is experiencing common cause variation i.e. no significant change. The target lies within the current control limits and so the metric will consistently hit or miss the target.	Implementation of Patient Safety Incident Response Framework (PSIRF) promoting incidents reporting for learning	Continue to embed PSIRF principle as a learning organisation and promote psychological safety and Just culture. Weekly Patient Safety Forum attended by Care Groups for shared learning and triangulation of data with complaints, PALS contacts, claims, and litigation. PSIRF training provided by NHS England accredited training provider.	Cultural transformation in line with transition from serious incident framework (SIF) to PSIRF. Mitigation: NHSE accredited training on Creating a Just Learning Culture. Senior leadership behavioural framework Recruitment of patient safety investigators and family liaison officer.
Complaints responded to within 25 days: This metric is experiencing common cause variation i.e. no significant change. The target lies within the current control limits and so the metric will consistently hit or miss the target.	Usage of Quail (AI enabled complaints dashboard) for better oversight and tracking of complaints performance, themes, and action monitoring.	Complaints performance oversight through Care Groups monthly governance meeting, Patient Experience Board and Care Group performance review.	Embedding the usage of the complaints tool -Quail in specialty and Care Group governance meeting to identify themes and quality improvement development. Short term sickness leading to staffing shortfall for 1:1 specialling for patients at high risk of fall.
Falls per 1,000 bed days: This metric is experiencing common cause variation i.e. no significant change. The target lies within the current control limits however it is close to the upper control limit and so the metric is likely to acheive the target most of the time unless there is a change to the process.	Harm Free Care Group theming of incidents by Care Group and subsequent development of local and trust wide quality improvement plan.	Theming of incidents and learning responses presentation by Care Groups to the Patient Safety Forum and Harm Free Care Group meetings.	Safety huddle and staffing redeployment based on patients' acuity and dependency. Enhanced Care Supervision policy in place.

Incidents reported

Total number of incidents reported on DATIX during the month.

Sep-24	Variance Type	Target	Achievement
1324	Common cause variation	-	N/A

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



Pressure ulcers per 1,000 days

Rate of pressure ulcer incidents reported per 1,000 inpatient bed days. Includes all pressure ulcer categories.

Aug-24	Variance Type	Target	Achievement
2.54	Common cause variation	-	N/A

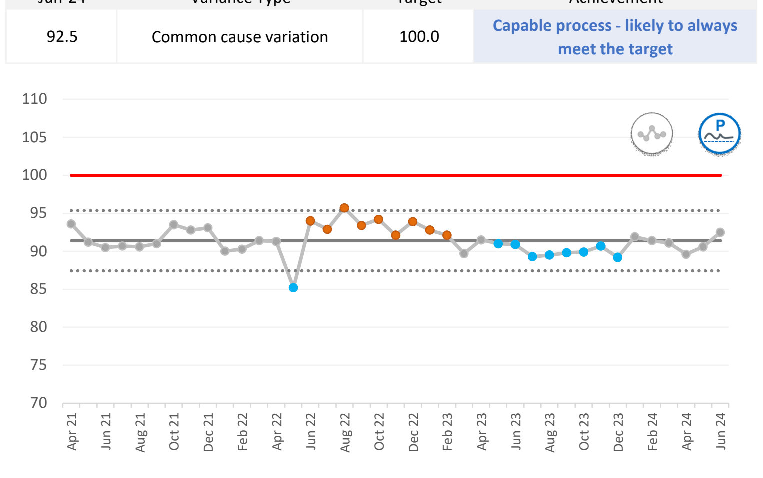
This metric is experiencing common cause variation i.e. no significant change.

HSMR

Hospital Standardised Mortality Ratio (rolling 12 months).

Jun-24	Variance Type	Target	Achievement
92.5	Common cause variation	100.0	Capable process - likely to always meet the target

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



Clostridioides difficile

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

Sep-24	Variance Type	Target	Achievement
7	Common cause variation	4	Unreliable process - may or may not meet the target consistently

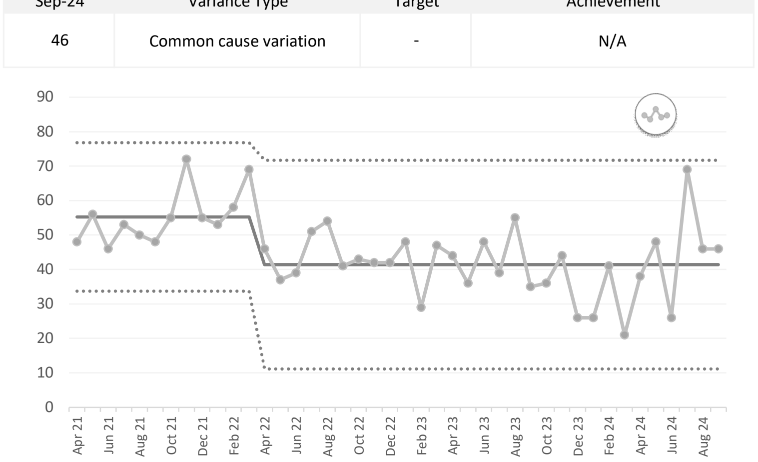
This metric is experiencing common cause variation i.e. no significant change.
The target lies within the current control limits and so the metric will consistently hit or miss the target.

Complaints received

Number of complaints received during the month.

Sep-24	Variance Type	Target	Achievement
46	Common cause variation	-	N/A

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

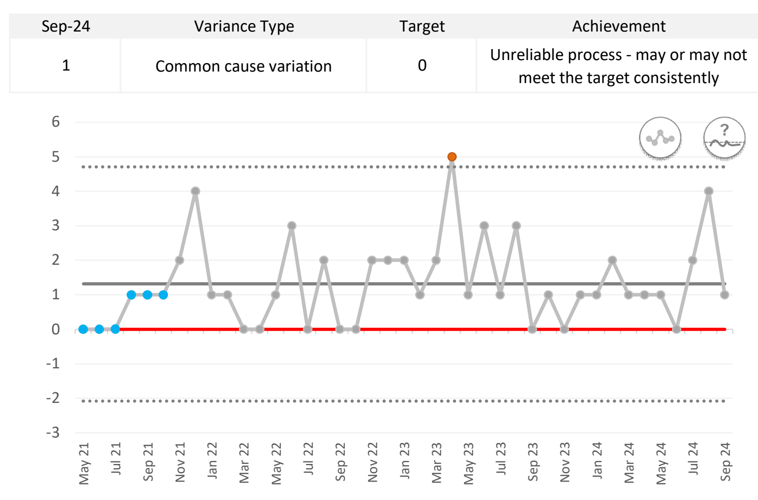


Perinatal mortality (over 24 weeks)

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

Sep-24	Variance Type	Target	Achievement
1	Common cause variation	0	Unreliable process - may or may not meet the target consistently

This metric is experiencing common cause variation i.e. no significant change.
The target lies within the current control limits and so the metric will consistently hit or miss the target.



Term admissions to the neonatal unit

Percentage of admissions to neonatal unit >37 weeks gestation (over all admissions to the neonatal unit in month).

Sep-24	Variance Type	Target	Achievement
1.7%	Common cause variation	5%	Unreliable process - may or may not meet the target consistently

This metric is experiencing common cause variation i.e. no significant change.
The target lies within the current control limits and so the metric will consistently hit or miss the target.

Overall preterm birth rate

Percentage of birth that occur <37 weeks gestation (over all births in month).

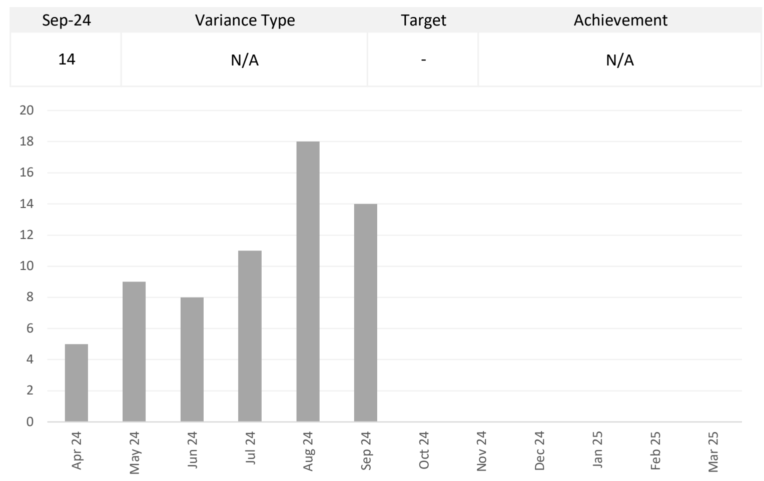
Sep-24	Variance Type	Target	Achievement
6.1%	Common cause variation	6%	Unreliable process - may or may not meet the target consistently

This metric is experiencing common cause variation i.e. no significant change.
The target lies within the current control limits and so the metric will consistently hit or miss the target.

After Action Reviews

Number of After Action Reviews (AAR) underway.

Sep-24	Variance Type	Target	Achievement
14	N/A	-	N/A

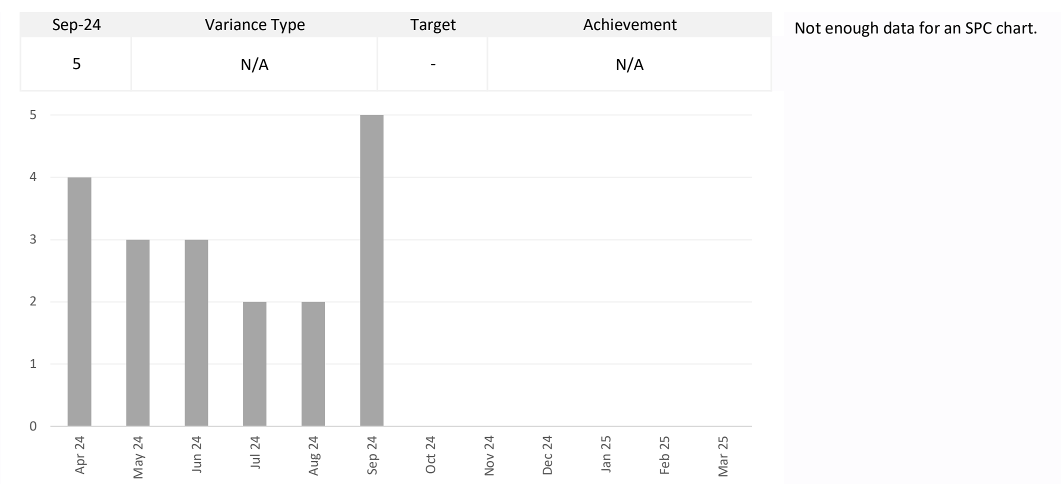


Not enough data for an SPC chart.

Multi Disciplinary Team reviews

Number of Multi Disciplinary Team (MDT) reviews underway.

Sep-24	Variance Type	Target	Achievement
5	N/A	-	N/A

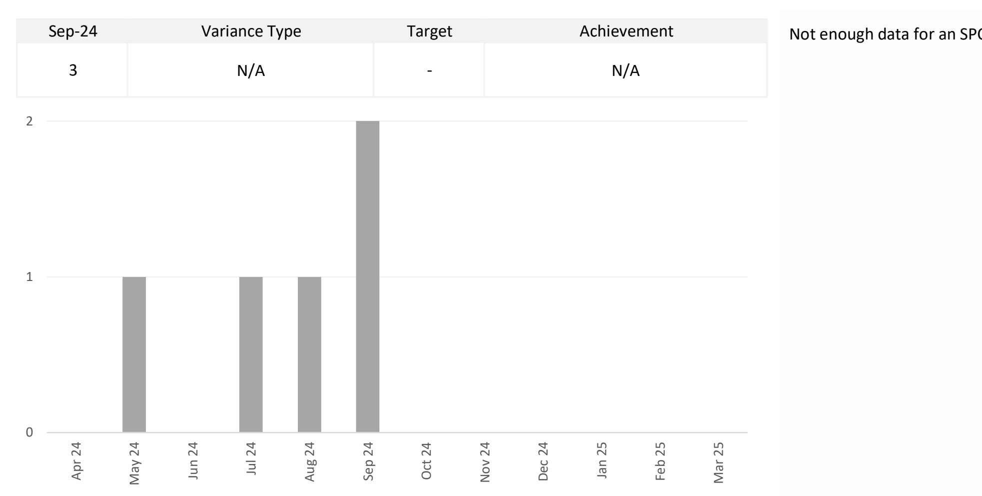


Not enough data for an SPC chart.

Patient Safety Incident Investigations

Number of Patient Safety Incident Investigations (PSII) underway.

Sep-24	Variance Type	Target	Achievement
3	N/A	-	N/A



Not enough data for an SPC chart.

Healthy Communities

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Breakthrough objectives								
Attendance rates for Health and Development Review	Sep 24	86.0%	85.0%			86.3%	71.3%	101.3%
Number of blood pressure checks at outpatient appointments			-					
Driver metrics								
Expected level of achievement with Health and Development Review ASQSE	Sep 24	91.7%	90.0%			93.3%	81.7%	104.9%
Expected level of achievement with Health and Development Review ASQ3	Sep 24	83.7%	90.0%			79.4%	69.5%	89.4%
Healthy communities								
Staff completing very brief advice training for smoking cessation	Sep 24	67.1%	75.0%			-	-	-
Maternity smoking at time of booking	Sep 24	5.2%	5.0%			5.7%	0.9%	10.5%
Maternity smoking at time of delivery	Sep 24	3.5%	5.0%			4.2%	1.5%	6.8%

Attendance rates for Health and Development Review

Definition: Percentage of children from opportunity Bucks that attend 12-month Health and development review by the time they're 15 months (over all children from opportunity Bucks who turn 15 months old during the reporting month.)

Target: Deliver at least 85% by the end of 2024/25

Owner: Chief Digital and Transformation Officer
Committee: Finance and Business Performance

Sep-24	Variance Type	Target	Achievement
86.0%	Common cause variation	85%	Unreliable process - may or may not meet the target consistently

How we are performing

From the data, there appears to have been a step change in April 2023 with the last thirteen data points falling above the central line so the limits have been recalculated at this point.
This metric is experiencing common cause variation i.e. no significant change.
The target lies within the current control limits and so the metric will consistently hit or miss the target.

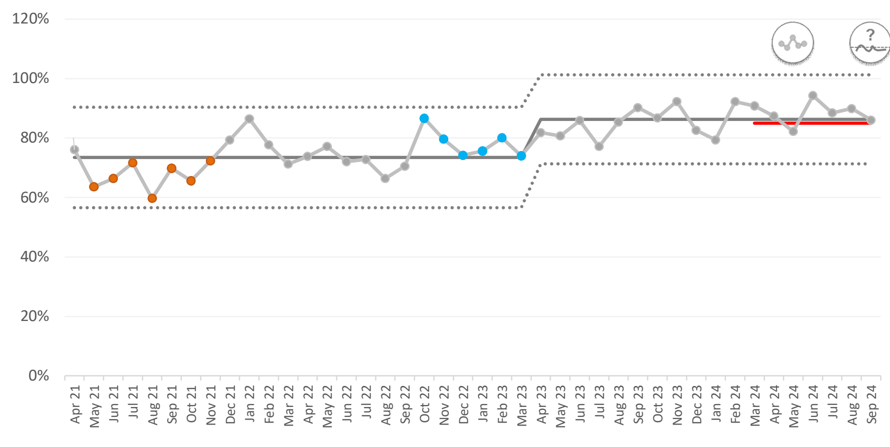
Drivers of performance

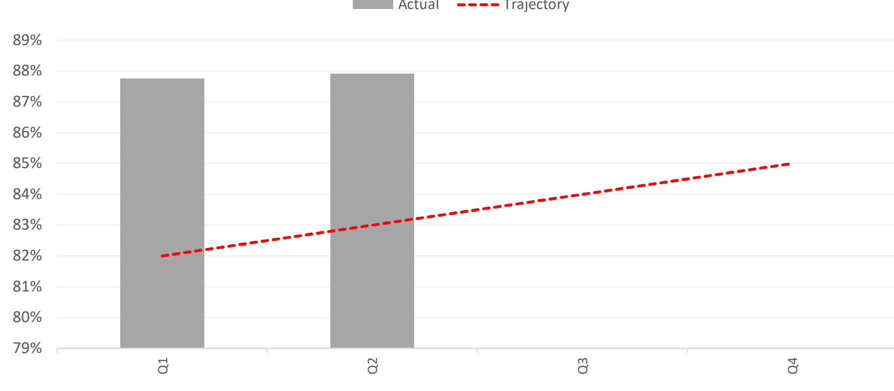
Invitations to appointments being sent earlier
Implementation of locality-based appointments
Implementation of virtual clinics as an option for some parents.
Enhanced communications e.g. updated website; stickers for parent held child records (red books), posters.
Enhanced information on children and young people websites
A promotional video has been produced for health and developmental reviews

Actions to maintain or improve performance

HVs to ask parents what would help them attend when following up on "was not brought's"
Running a parent forum in October 2024 to further understand what could help increase uptake.

Risks and mitigations





Number of blood pressure checks at outpatient appointments

Definition: The percentage of adult outpatients having their blood pressure taken at an face to face outpatient appointment (over all adult face to face outpatient appointments during the reporting month.)

Target: Deliver at least 75% by the end of 2024/25

Owner: Chief Medical Officer
Committee: Finance and Business Performance

Sep-24	Variance Type	Target	Achievement

How we are performing

The Breast Unit (initial pilot area) showed 74% of patients had a blood pressure taken and record in their notes in September (from an audit), increasing from 62% in the initial pilot phase.
Blood pressure monitors have been rolled out too:
- Main outpatients in Amersham, SMH and Wycombe

Drivers of performance

An Evolve form has been developed to capture the patients results and enable automatic reporting from October's data
Communications plan has been rolled out including: care groups, team brief, leadership briefing, BHT today and information available on CAKE
Colleagues have also been encouraged to use the blood pressure machines to 'know their numbers'. Anecdotal feedback has identified that colleagues have identified they have high blood pressure from using the machines and have now started medication to reduce their blood pressure

Actions to maintain or improve performance

Roll out final patient-operated blood pressure monitors in therapies and dermatology departments by 14th October
Reporting data weekly by care group from 18th October
Update trajectory by 31st October
Auto-generate sending GP letters from the evolve in quarter 4

Risks and mitigations

There is resistance to using blood pressure machines due to concerns about additional work load and creating bottle necks - This is being monitored with clinical leads at weekly project meetings.
The 75% target is not met due to delays in the roll out of blood pressure monitors: weekly monitoring will begin from 11th October and will be shared with care groups to enable targeted actions to be put in place using a PDSA approach.

Expected level of achievement with Health and Development Review ASQSE

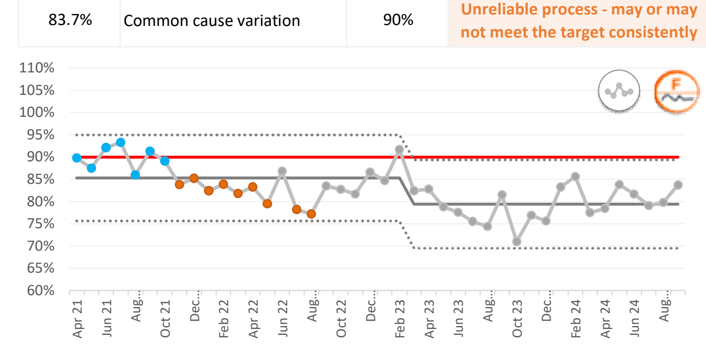
Percentage of children attending the 12-month HDR who achieve the expected level or above for all areas on ASQ-SE (over all children with a review in month.) Children from from opportunity Bucks only

Sep-24	Variance Type	Target	Achievement
91.7%	Common cause variation	90%	Unreliable process - may or may not meet the target consistently

Expected level of achievement with Health and Development Review ASQ3

Percentage of children attending the 12-month HDR who achieve the expected level or above for all areas on ASQ3 (over all children with a review in month.) Children from from opportunity Bucks only.

Sep-24	Variance Type	Target	Achievement
83.7%	Common cause variation	90%	Unreliable process - may or may not meet the target consistently



ASQ-SE: Ages & Stages Questionnaires - Social Emotional:
Screens children in seven areas of social-emotional development—self-regulation, compliance, social-communication, adaptive functioning, autonomy, affect, and interaction with people.

ASQ3: Ages & Stages Questionnaires 3:
Screens children in the five areas of communication, gross motor, fine motor, problem solving, and personal-social.

How we are performing

Expected level of achievement with HDR ASQ-SE: This metric is experiencing common cause variation i.e. no significant change. The target lies within the current control limits and so the metric will consistently hit or miss the target.

Expected level of achievement with HDR ASQ3: This metric is experiencing common cause variation i.e. no significant change. The target lies above the current control limit and is unlikely to be acheived without a change in the process.

Drivers of performance

Have run information sessions with locally authority, family hubs and health visitors to support more integrated working and consistency of messages

Communication through team and leadership brief confirming the importance of smoking cessation conversations and the training.
Care group specific comms form clinical advocates in each area
Stoptober stalls and awareness

Actions to maintain or improve performance

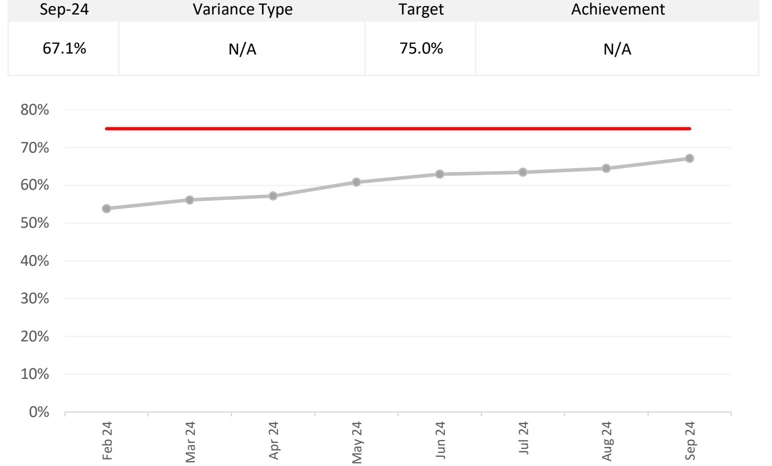
Risks and mitigations

Staff completing very brief advice training for smoking cessation

The percentage of patient facing staff have completed Very Brief Advice (VBA) training for smoking cessation.
Data collection commenced February 2024.

Sep-24	Variance Type	Target	Achievement
67.1%	N/A	75.0%	N/A

Not enough data for an SPC chart.

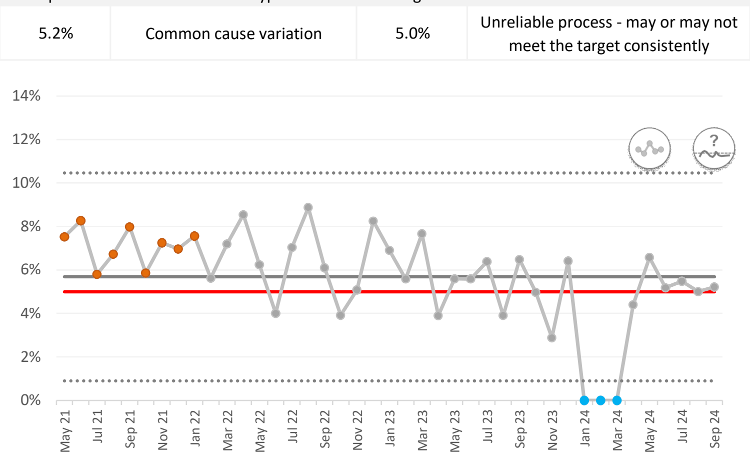


Maternity smoking at time of booking

Percentage of overall women who book in month who are current smokers.

Sep-24	Variance Type	Target	Achievement
5.2%	Common cause variation	5.0%	Unreliable process - may or may not meet the target consistently

This metric is experiencing common cause variation i.e. no significant change.
The target lies within the current control limits and so the metric will consistently hit or miss the target.



Maternity smoking at time of delivery

Percentage of overall women who deliver in month who are current smokers.

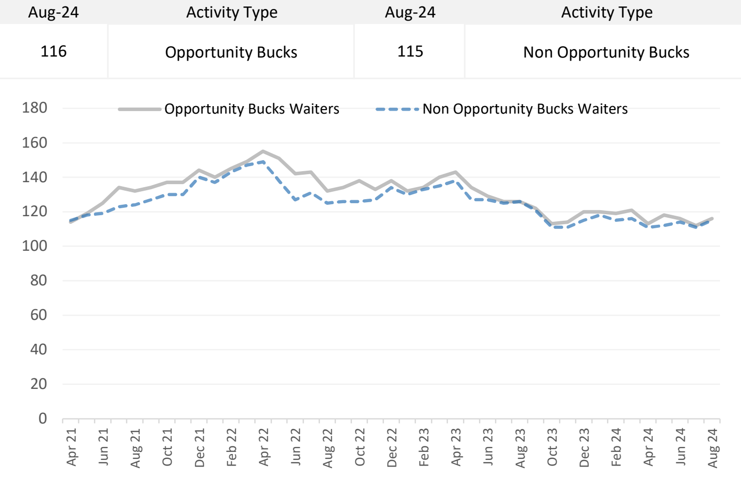
Sep-24	Variance Type	Target	Achievement
3.5%	Common cause variation	5.0%	Unreliable process - may or may not meet the target consistently

From the data, there appears to have been a step change in August 2023 so the limits have been recalculated at this point.
This metric is now experiencing common cause variation i.e. no significant change.
However the target still lies within the current control limits and so the metric will consistently hit or miss the target.

Median waiting time for acute waiting list for adults (days)

Median waiting time in days between referral and month end snapshot for adult patients on the acute waiting list. Patients are aged 16 years and over split by Opportunity Bucks and Non Opportunity Bucks patients.

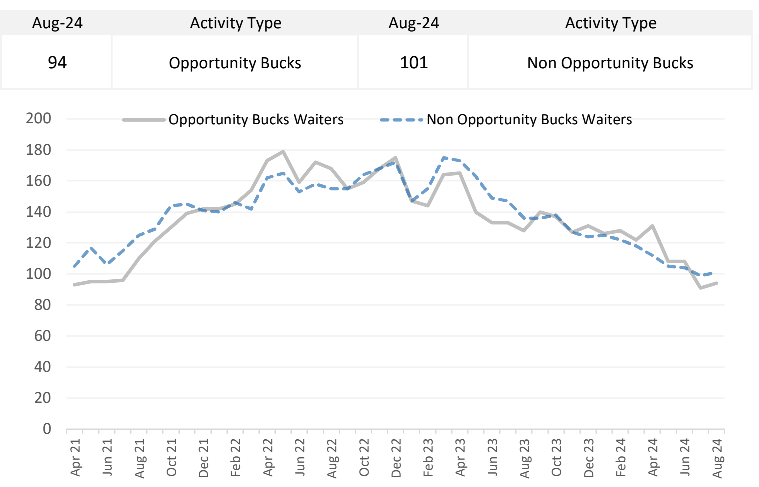
Aug-24	Activity Type	Aug-24	Activity Type
116	Opportunity Bucks	115	Non Opportunity Bucks



Median waiting time for acute waiting list for paediatrics (days)

Median waiting time in days between referral and month end snapshot for adult patients on the acute waiting list. Patients are aged under 16 years split by Opportunity Bucks and Non Opportunity Bucks patients.

Aug-24	Activity Type	Aug-24	Activity Type
94	Opportunity Bucks	101	Non Opportunity Bucks



Median waiting time for community waiting list for adults (days)

Median waiting time in days between referral and month end snapshot for adult patients on the community waiting list. Patients aged 16 years and over split by Opportunity Bucks and Non Opportunity Bucks. Excludes universal referrals and includes Community Paediatrics.

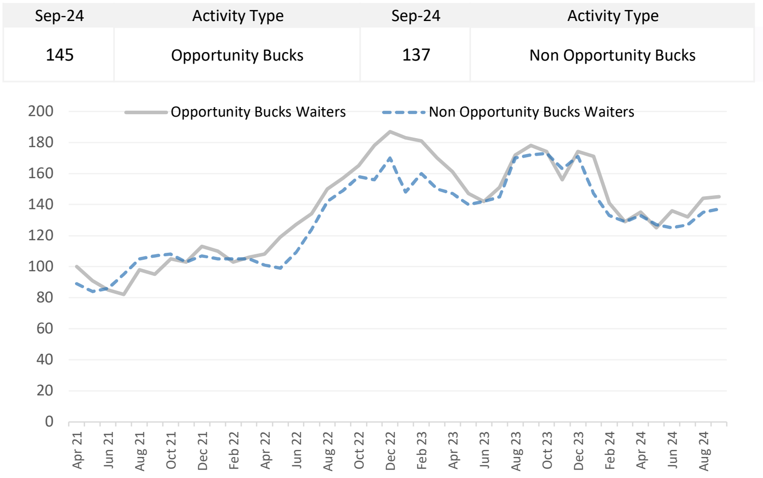
Sep-24	Activity Type	Sep-24	Activity Type
82	Opportunity Bucks	71	Non Opportunity Bucks

Opportunity Bucks Waiters
Non Opportunity Bucks Waiters
120
100
80
60
40
20
0
Apr 21
Jun 21
Aug 21
Oct 21
Dec 21
Feb 22
Apr 22
Jun 22
Aug 22
Oct 22
Dec 22
Feb 23
Apr 23
Jun 23
Aug 23
Oct 23
Dec 23
Feb 24
Apr 24
Jun 24
Aug 24

Median waiting time for community waiting list for paediatrics (days)

Median waiting time in days between referral and month end snapshot for paediatric patients on the community waiting list. Patients aged under 16 years split by Opportunity Bucks and Non Opportunity Bucks. Excludes universal referrals and includes Community Paediatrics.

Sep-24	Activity Type	Sep-24	Activity Type
145	Opportunity Bucks	137	Non Opportunity Bucks



Great place to work

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Breakthrough objective								
Staff experiencing bullying from managers	2023	9.4%	8.4%			10.5% (avg)	5.8% (best)	16.9% (worst)
Staff experiencing bullying from other colleagues	2023	17.7%	15.7%			19.3% (avg)	12.3% (best)	26.1% (worst)
Great place to work								
Trust overall vacancy rate	Sep 24	7.3%	10.0%			7.4%	5.2%	9.7%
Nursing and midwifery vacancy rate	Sep 24	6.5%	10.0%			8.4%	5.9%	10.8%
Turnover	Sep 24	11.6%	12.0%			11.1%	10.4%	11.7%
Sickness	Aug 24	3.6%	3.5%			3.8%	3.2%	4.5%
Statutory and Mandatory training	Sep 24	92.4%	90.0%			91.6%	90.3%	92.9%

Behaviours

Definition: Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse out of those who answered the question: In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers/other colleagues?

Target: No more than 8.4% of staff experiencing bullying from managers and 15.7% of staff experiencing bullying from colleagues by December

Owner: Chief People Officer
Committee: Strategic People

How we are performing

% of colleagues reporting bullying by managers = 9%
% of colleagues reporting bullying by colleagues = 17%
Next data point:
2024 National Staff Survey results available January 2025

Drivers of performance

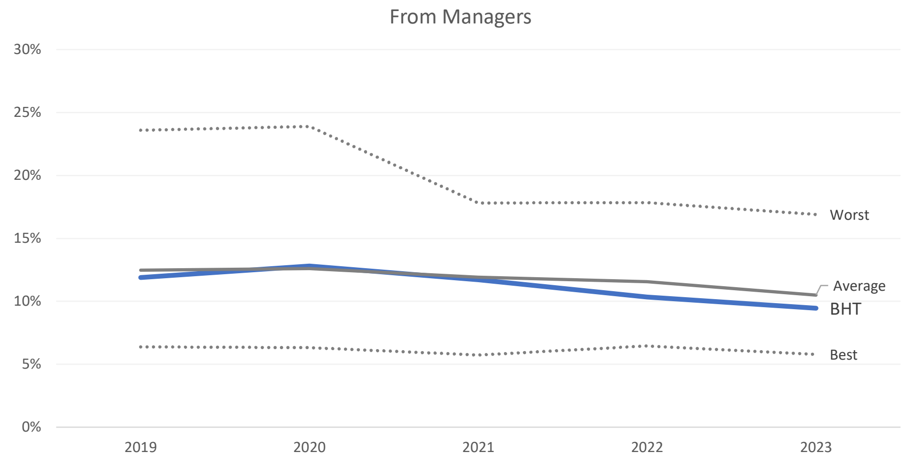
Lead indicators include appraisal compliance, sickness rates, vacancy rates, no. of excellence reports, no. numbers of managers completing Trust Peaks Programmes.
Lag indicators include number of incidents reported, employee relation cases, National Staff Survey results.

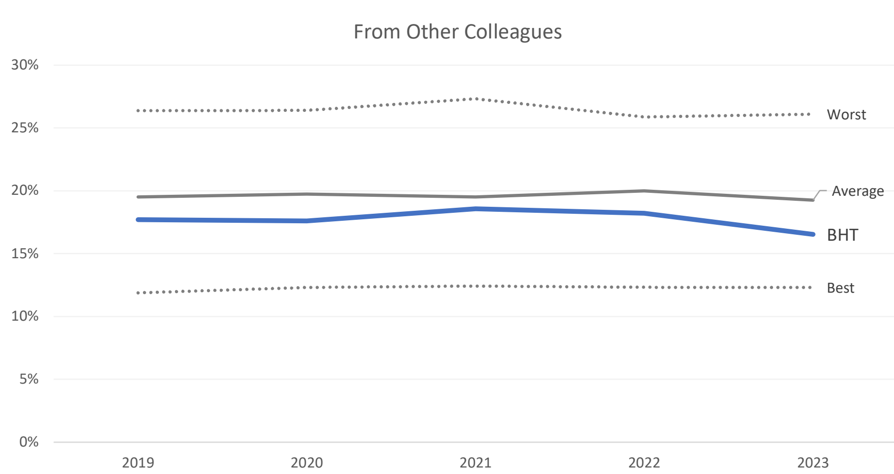
Actions to maintain or improve performance

Actions / Interventions	When	Impact
Behaviour framework Incorporate into Managers induction	17 July	Awareness
Behaviour framework fully embedded into Peaks	30 July	Operationalisation
A new kindness award added to Staff awards	30 July	Recognition
Difficult conversation training for Managers– supporting managers to approach and facilitate conversations about B&H.	12 Aug	Instruction / operationalisation
Develop TED civility module for teams(including intro to Civility)	12 Aug	Instruction / operationalisation
Senior Leadership Forum bite sixed session (psychological safety)	20 Aug	Instruction
PSIRF just culture training for senior leaders	9-20 Sept	Awareness
B&H webinar (part 1 – 2 pilots completed)	23 Sept	Awareness
Deploy a new reporting tool for behaviours	23 Sept	Monitoring
Appreciative enquiry conference	24 Sept	Learning from best practice
NQPS data point 1 analysed	30 Sept	Data analysis
Launch the interventions (BHT today, BHT Buzz, Our BHT App)	30 Sept	Awareness
Launch the BHT behaviour reporting tool	30 Sept	Monitoring

Risks and mitigations

Engagement with 'Introduction to Civility' sessions. Mitigation – monthly train the manager sessions and support provided as required, with all resources available on CAKE
Resources to respond to incidents raised through reporting tool. Mitigation – key personnel identified across People Directorate with access to tool and time allocated to respond.
Operational pressures reducing engagement and rollout. Mitigation – Frequent & clear Comms campaign, links to other initiatives.

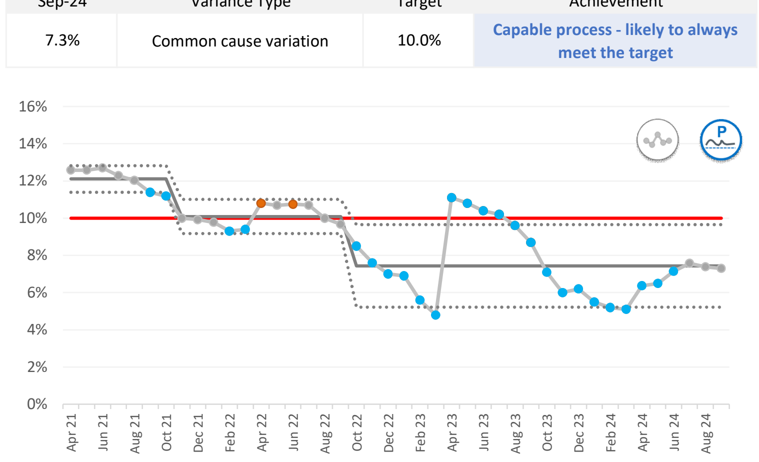




Trust overall vacancy rate

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

Sep-24	Variance Type	Target	Achievement
7.3%	Common cause variation	10.0%	Capable process - likely to always meet the target



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

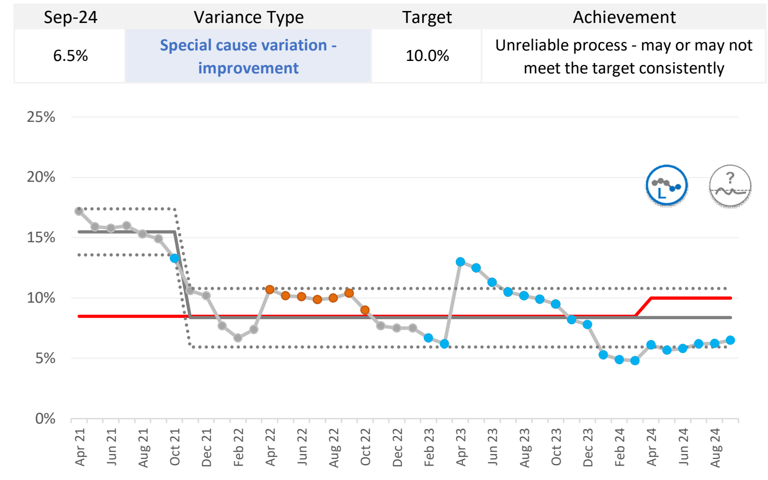
We continue to be below (better) than the 10% threshold.

We have seen further improvements in our time to hire.

Nursing and midwifery vacancy rate

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

Sep-24	Variance Type	Target	Achievement
6.5%	Special cause variation - improvement	10.0%	Unreliable process - may or may not meet the target consistently



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

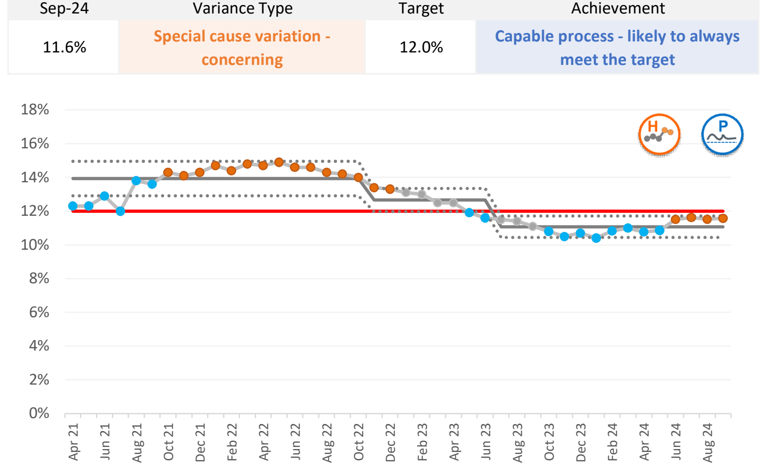
Nursing and Midwifery vacancy rate remains stable and below (better than) the threshold.

We have focused on onboarding our student nursing and midwifery graduates who join us across September and October.

Turnover

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

Sep-24	Variance Type	Target	Achievement
11.6%	Special cause variation - concerning	12.0%	Capable process - likely to always meet the target



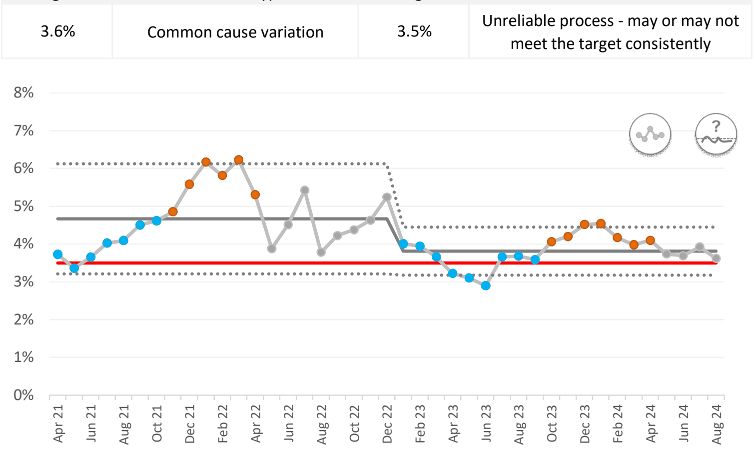
This metric is experiencing special cause variation of a concerning nature with the last two out of three data points falling close to the upper control limit.
The target lies above the current control limits and will be consistently achieved unless something changes in the process.

Turnover continues to be stable and below (better than) threshold.
Main leaver reasons continue to be relocation and retirement (2 colleagues retired and returned in September).
This was followed by those leaving citing work life balance and leaving to undertake further education/training and work life balance.
We continue to work on retention initiatives to support our colleagues to work and retire flexibly.

Sickness

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

Aug-24	Variance Type	Target	Achievement
3.6%	Common cause variation	3.5%	Unreliable process - may or may not meet the target consistently



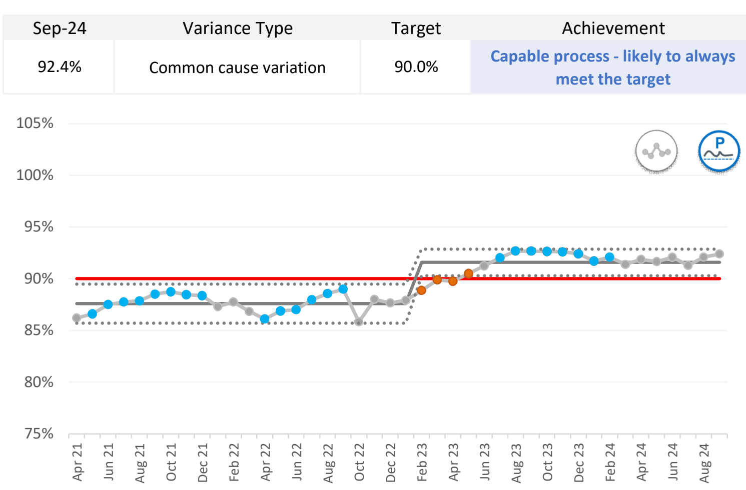
This metric is experiencing common cause variation i.e. no significant change.
The target lies within the current control limits and so the metric will consistently hit or miss the target.

Overall sickness has reduced by 0.3% primarily due to a significant reduction in overall sickness absence of 1.1% between July and August in Surgery & Critical Care, care group.
All other care groups sickness levels have remained relatively stable.
Deep dives with each of the care groups continue. These, together with additional Health Summits for all hot spot areas will be initiated in this quarter. We will monitor data for impact of these initiatives.

Statutory and Mandatory training

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

Sep-24	Variance Type	Target	Achievement
92.4%	Common cause variation	90.0%	Capable process - likely to always meet the target



This metric is experiencing common cause variation i.e. no significant change.
The target lies just below the current control limits so is likely to be consistently achieved unless something changes in the process.

We have seen a small increase in compliance since Aug. This is due to Safeguarding L3 post launching the e-learning/video making it more accessible for colleagues.

Oliver McGowan training (not included in the overall figures above) has also increased, with compliance now at 68.57%

Productivity

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Breakthrough objective								
Overall NHSE measure of productivity	Jun 24	-3.2%	-6.4%			-12.4%	-14.8%	-10.0%
Driver metrics								
14 day length of stay - acute & community	Sep 24	199	-			195	160	231
Theatre cases per 4 hours planned time	Sep 24	2.5	2.8			2.4	2.3	2.6
WTEs in the Trust	Sep 24	6286.2	6676.0			6194.5	6108.9	6280.2
Productivity								
14 day length of stay - acute	Sep 24	146	-			154	123	185
Average LOS - community hospitals	Sep 24	15.4	-			19.6	12.9	26.3
Theatre utilisation	Sep 24	85.0%	85.0%			84.8%	82.8%	86.8%
Daycase rate	Sep 24	82.0%	85.0%			84.1%	81.1%	87.1%
Face to face contacts delivered by Community Therapy	Sep 24	454.8	-			440.6	225.2	656.0
Face to face contacts delivered by District Nursing	Sep 24	3725.1	-			3631.6	3259.6	4003.6
Outpatient DNA rate	Sep 24	7.2%	5.0%			7.1%	6.2%	8.0%

Productivity

KPI	Latest month	Measure	Plan	Variation	Assurance	Mean	Lower process limit	Upper process limit

Productivity continued

KPI	Latest month	Measure	Plan	Variation	Assurance	Mean	Lower process limit	Upper process limit
Temporary staffing levels (spend £)	Sep 24	3001659.44	-			4109276.26	2967909.38	5250643.14
Substantive staffing	Sep 24	6286.2	6348.0			6194.5	6108.9	6280.2
Substantive staffing against plan	Sep 24	-1.2%	-			-	-	-
Temporary staffing	Sep 24	481.2	337.0			582.9	498.6	667.3
Temporary staffing against plan	Sep 24	17.7%	-			-	-	-

Overall NHSE measure of productivity

Definition: Comparison between the cost base and weighted activity provided in our acute settings in 23/24, against equivalent periods in 19/20. Year to date figures.

Target: 5% improvement on 2023/24 productivity position

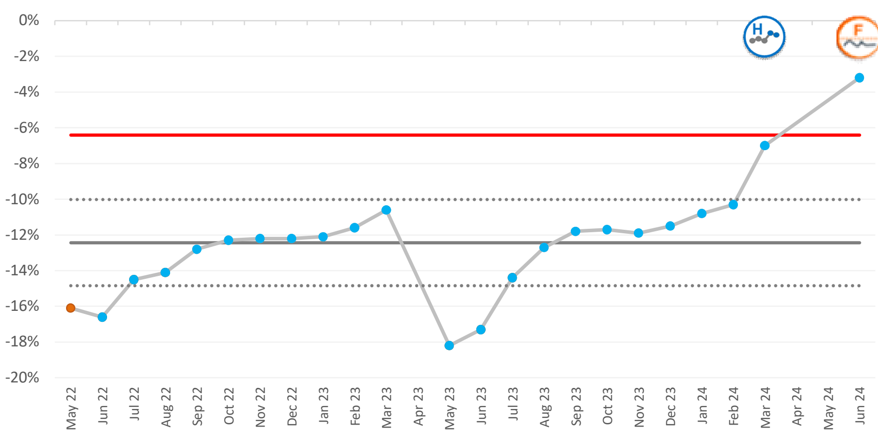
Owner: Chief Finance Officer
Committee: Finance and Business Performance

Jun-24	Variance Type	Target	Achievement
-3.2%	Special cause variation - improvement	-6.4%	Incapable process - likely to consistently fail to meet the target

How we are performing

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

NHSE have not provided figures for April and May 2024. July data not available due to querying Data Quality from NHSE productivity report.



Drivers of performance

Elective activity in the first part of 2024/25 coupled with reduced pay spend, and continued focus on length of stay have maintained this productivity improvement.

Actions to maintain or improve performance

Theatre utilisation and average case per list is being managed on a weekly basis with improvement targets at individual team level for both of these metrics.
Theatre maintenance work last year should minimise downtimes due to estates issues.
Temporary staffing and workforce controls continue with weekly oversight through EMC.
The rollout of new electronic patient whiteboards has started which will further support improved flow and reductions in length of stay.
Key productivity metrics for each Care Group monitored monthly with a breakdown of the NHSE productivity metric by Care Group in development.

Risks and mitigations

Our limited capital allocation may prevent the volume of remedial work needed to maintain theatres. Mitigation: We are developing a prospective maintenance plan across operations and estates to minimise risks.
Financial constraints may hinder recruitment to key roles to support high volume activity through theatres. Mitigation: We are ensuring that where there is a clear productivity benefit from recruitment, supported through the control process.
Clinical variation within teams may inhibit the delivery of consistently high cases per list and/or increase in outpatient clinic activity. Mitigation: Productivity improvement is being supported through our cross-cutting Planned Care programme; including a focus on Further Faster, a national GIRFT programme to deliver rapid clinical transformation with the aim of reducing 52-week waits.

Buckinghamshire Healthcare NHS Trust

14 day length of stay - acute & community

Count of patients in beds over 14 days in either Stoke Mandeville or Wycombe hospitals (excluding Spinal) or community beds (Chartridge, Waterside and Buckingham wards). Month end snapshot.

Sep-24	Variance Type	Target	Achievement
199	Common cause variation	-	N/A

Theatre cases per 4 hours planned time

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

Sep-24	Variance Type	Target	Achievement
2.5	Common cause variation	2.8	Incapable process - likely to consistently fail to meet the target

WTEs in the Trust

Snapshot at month end of substantive Whole Time Equivalent (WTE) staff in post. Excludes bank and agency.

Sep-24	Variance Type	Establishment	Achievement
6286.2	Special cause variation - neither concerning nor improvement	6676.0	N/A

How we are performing

14 day LOS - acute & community: This metric is experiencing common cause variation i.e. no significant change.

Theatre cases per 4 hours planned time: This metric is experiencing common cause variation i.e. no significant change. However the target lies above the current control limits and so cannot be achieved unless something changes in the process.

WTEs in the Trust: This metric is experiencing special cause variation of neither an improving nor a concerning nature with the last two out of three data points falling close to the upper control limit.

Drivers of performance

LOS
Numbers of patients who do not meet the criteria to reside
Early identification of discharges and clarity on discharge processes
Effective escalation process for our longest staying patients

Theatres Cases Per list
Booking density levels at 100%+
Starting on time and standby patients in case of last minute cancellations
Standardising of lists make-up to ensure higher volumes

WTE
Control over temporary staffing and substantive recruitment

Actions to maintain or improve performance

LOS
Continued rollout of Patient Flow digital whiteboards following early adopter wards
Escalation meetings with Bucks Council to resolve patients with no criteria to reside
MADE events to create flow and develop learning
Expansion of Discharge Lounge
Roll out of criteria led discharge

Theatres Cases Per list
Individual SDU by SDU plans developed and agreed for standardisation of lists
Increases in booking density and improved theatre booking, prompt start and standby patient lists

WTE
Continued weekly scrutiny of WTE levels and temporary staffing spend
Action plan to address rise in Bank usage
Continued development of Care Group pay plans

Risks and mitigations

LOS
Financial constraints across the system may inhibit the efficient flow of patients. Mitigation - transparent review of data with partners and clear escalation processes.

Theatres Cases Per list
Culture change needed amongst a wide range of teams and with individuals across the MDT setup. Mitigation - investment in new leadership roles in the Wycombe Elective Centre to help drive change and shape culture.

WTE
WTE and pay savings are challenging to make. Mitigation - detailed planning with support from the People team underway across all areas. Focus on key areas for consideration of restructures and rotas to deliver more efficiently. Programme launched to drive improvements and help support management of sickness.

14 day length of stay - acute

Count of patients in a bed at either Stoke Mandeville or Wycombe hospitals at the end of the month who have a total length of stay of more than 14 days. Excludes Spinal patients.

Sep-24	Variance Type	Target	Achievement
146	Common cause variation	-	N/A

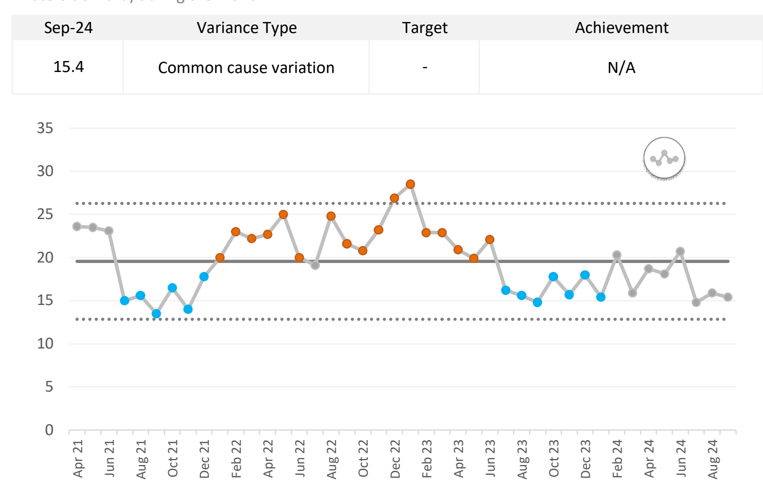
This metric is experiencing common cause variation i.e. no significant change.

Average LOS - community hospitals

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

Sep-24	Variance Type	Target	Achievement
15.4	Common cause variation	-	N/A

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



Theatre utilisation

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

Sep-24	Variance Type	Target	Achievement
85.0%	Common cause variation	85%	Unreliable process - may or may not meet the target consistently

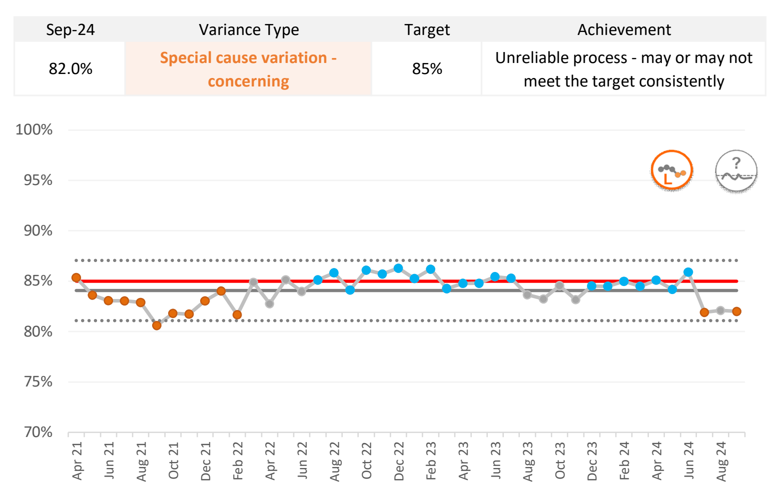
From the data, there appears to have been a step change in July 2023 so the limits have been recalculated at this point.
This metric is now experiencing common cause variation i.e. no significant change.
However the target lies within the current control limits and so the metric will consistently hit or miss the target.

Daycase rate

The percentage of elective patients booked to have a procedure as a day case in month over all elective procedures booked in month.

Sep-24	Variance Type	Target	Achievement
82.0%	Special cause variation - concerning	85%	Unreliable process - may or may not meet the target consistently

This metric is experiencing special cause variation of a concerning nature with the last two out of three data points falling close to the lower control limit.
The target lies within the current control limits and so the metric will consistently hit or miss the target.

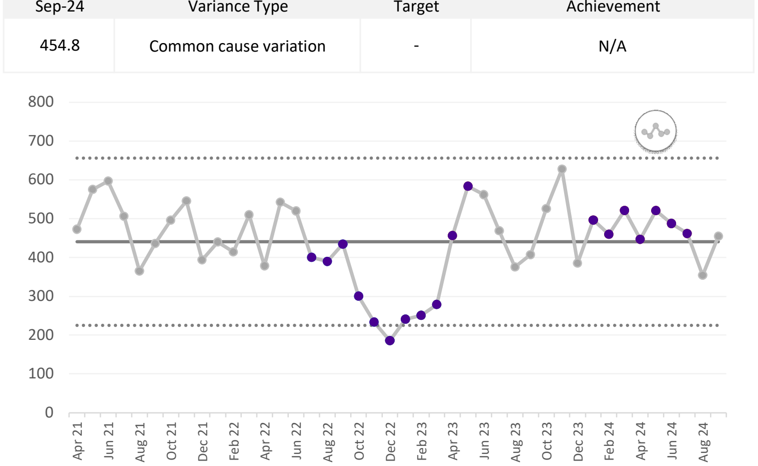


Face to face contacts delivered by Community Therapy

The total number of face to face contacts during the reporting month delivered by Community Therapy (Physiotherapy and Occupational Therapy) per 100,000 of the population.

Sep-24	Variance Type	Target	Achievement
454.8	Common cause variation	-	N/A

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



Face to face contacts delivered by District Nursing

The total number of face to face contacts during the reporting month delivered by Community/District Nursing services per 100,000 of the population. (Excluding Health Visiting and Specialist Nursing.)

Sep-24	Variance Type	Target	Achievement
3725.1	Common cause variation	-	N/A

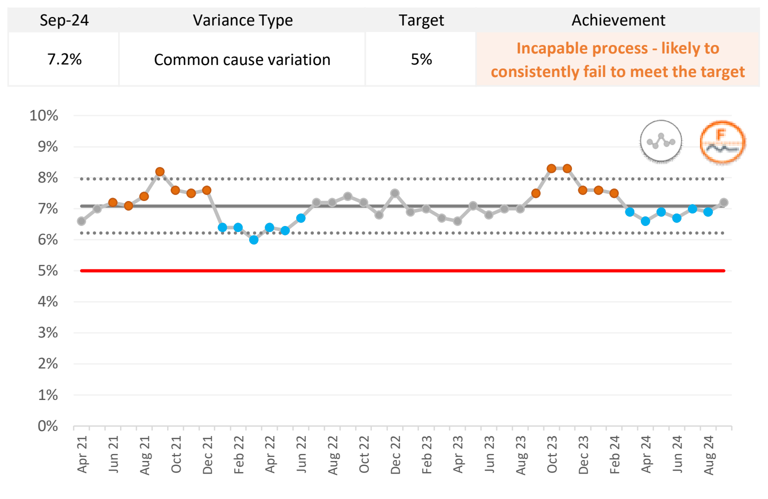
This metric is now experiencing common cause variation i.e. no significant change.

Outpatient DNA rate

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

Sep-24	Variance Type	Target	Achievement
7.2%	Common cause variation	5%	Incapable process - likely to consistently fail to meet the target

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

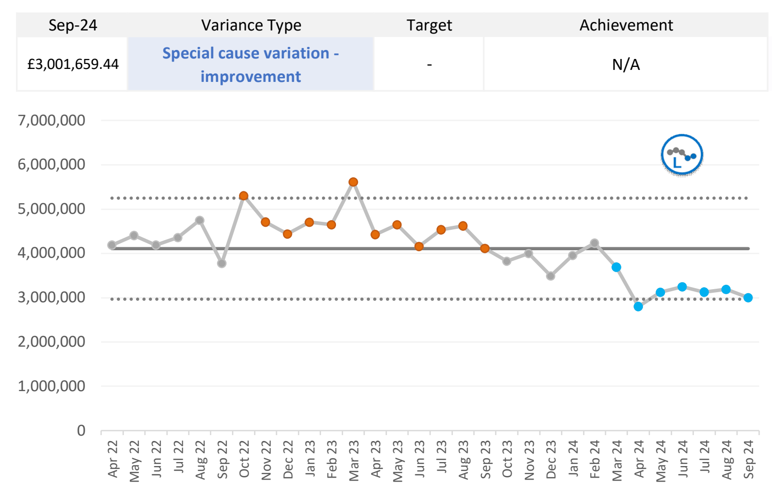


Temporary staffing levels (spend £)

Temporary staffing spend. Includes bank and agency staff.

Sep-24	Variance Type	Target	Achievement
£3,001,659.44	Special cause variation - improvement	-	N/A

This metric is experiencing special cause variation of an improving nature with the last two out of three data points falling close to the lower limit and the last seven data points falling below the central line.



Substantive staffing

Snapshot at month end of substantive Whole Time Equivalent (WTE) staff in post.

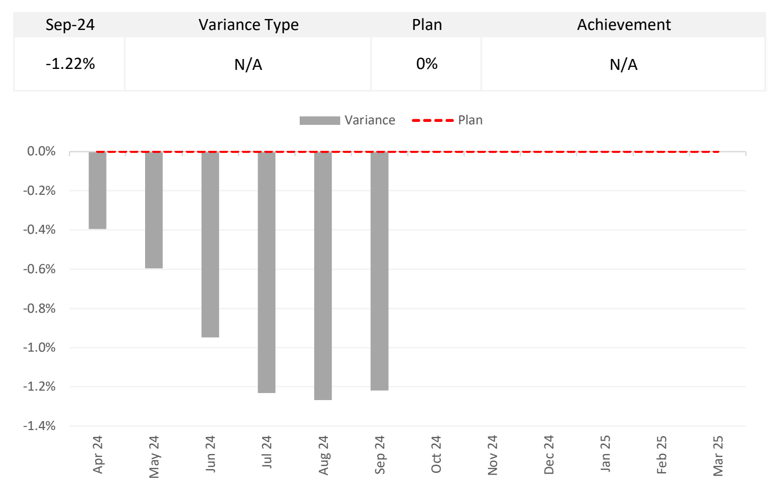
Sep-24	Variance Type	Plan	Achievement
6286.2	Special cause variation - neither concerning nor improvement	6348.0	N/A

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

Substantive staffing against plan

Snapshot at month end of substantive Whole Time Equivalent (WTE) staff in post over year to date plan for the same period. For the financial year 2024/25.

Sep-24	Variance Type	Plan	Achievement
-1.22%	N/A	0%	N/A



Temporary staffing

Snapshot at month end of bank and agency Whole Time Equivalent (WTE) staff in post.

Sep-24	Variance Type	Plan	Achievement
481.2	Common cause variation	347.0	N/A

This metric is experiencing special cause variation of neither an improving nor a concerning nature with the last two data points falling below the lower control limit.

Temporary staffing against plan

Snapshot at month end of bank and agency Whole Time Equivalent (WTE) staff in post over year to date plan for the same period. For the financial year 2024/25.

Sep-24	Variance Type	Plan	Achievement
17.69%	N/A	0%	N/A