Report from Chair of Audit Committee
Date of Committee 14 November 2024

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Minutes of the previous meeting	Minutes from the last meeting on 12 September 2024	Approved	None	n/a	n/a
Action Matrix & Matters Arising	Supply Chain Security overview of mechanisms in place to manage cyber risk related to external suppliers the Trust engages with for the provision of IT services Asset Management & Tracking Summary of work undertaken and planned for the remainder of 2024/25 regarding the management of assets and related processes	**Assured**	None	n/a	n/a
Emergency Preparedness, Resilience & Response (EPPR)	Annual review of the Trust's overall Emergency Preparedness, Resilience and Response (EPRR) plans, which have been peer-reviewed by ICB colleagues	**Assured**, noting the following: - Substantial compliance - Non-compliance only related to the Data Security & Protection Toolkit (DSPT); predicted full compliance by January 2025 - Internal and external assurance mechanisms in place including the role of the Trust Resilience Committee - Significant telephony-related risk (CRR 225) and actions to address	None	n/a	To take **assurance** from substantial compliance and **approve** for submission

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Organisational Risk	Overview of risk within the Trust including details from the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) Annual revised risk appetite statement presented for Committee approval	**Partially assured**, noting the following: - Verbal update on endoscopy capacity issues (CRR 320) and oversight mechanisms in place - Safeguarding capacity related to the Multi-Agency Safeguarding Hub (MASH) (CRR 413), newly escalated to the CRR with oversight by Q&CGC - Summary of CRR risks which require mitigations through capital expenditure Revised risk appetite statements **approved** by the Committee, noting the need for appetite to be reviewed against current levels of risk on a regular basis	Further iterations to risk reporting including greater detail on top scoring (red) risks Revisit endoscopy capacity and implementation of mitigating actions (CRR 320) in February 2025	Ongoing oversight of the following by the Quality & Clinical Governance Committee (Q&CGC): - Quality impact of/harm related to endoscopy capacity challenges (CRR 320) - Action plan to address safeguarding capacity (CRR 413)	To **note** the content of the report and take **assurance** from committee focus and discussions To consider and **approve** the revised risk appetite statement
External Audit	Verbal update from EY recognising planning for the 2024/25 audit for both the Trust and Charity	**Noted**	None	n/a	n/a
Internal Audit; Progress Report	Update on progress with annual plan including presentation of three final reports: - Electronic Patient Record (EPR) Programme Management - Capital Management, including governance - Consultant Job Planning All provided with a reasonable assurance opinion	Detailed Committee discussions related to the finalised reports **Assured**, noting the following: - Work ongoing to finalise capital management actions, recognising wide ranging implications of these - Strong engagement from the digital team for both the EPR audit and completion of actions	As per management actions set out within reports Consideration of how best to re-audit consultant job planning	n/a	To **note** the plan to consider the capital management actions in the context of the Carbon Energy Fund (CEF) project and overspend

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Internal Audit; Recommendations Follow Up Report	Update on actions and recommendations followed up since the last meeting	**Assured**, noting the following: - Suggestion to re-look at IT asset management within the next financial year		n/a	n/a
Internal Audit; Publications	Publications issued since the previous meeting and provided to the Committee for information: - Internal Audit Code of Practice - Data Security & Protection Toolkit (DSPT) 2023/24 insights and benchmarking - October 2024 Sector Update	**Noted**	None	n/a	n/a
Single Tender Waivers (STW)	Overview of STW since the last meeting including internal comparative data and those waivers considered to be avoidable and retrospective	**Assured**	Report to be revised in view of the revised procurement regulation/guidance	n/a	n/a
Losses and Special Payments	Summary of YTD losses including pharmacy and patient property	**Assured,** noting the following: - Processes related to bad debts for private patients and overseas visitors - Update on the scan for safety case	None	n/a	n/a
Minutes of Finance & Business Performance Committee	Minutes from the F&BP Committee Meeting on 19 September 2024	**Noted**	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Minutes of Quality & Clinical Governance Committee	Minutes from the Q&CG Committee Meeting on 18 September 2024	**Noted**	None	n/a	n/a
Minutes of Strategic People Committee	Draft minutes from the SPC Committee Meeting on 14 October 2024 (draft)	**Noted**	None	n/a	n/a

Emerging Risks Identified:

- No new risks identified.

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2024

Agenda item	Organisational Risk Report
Board Lead	Joanna James, Head of Corporate Governance
Type name of Author	Joanna James, Head of Corporate Governance
Attachments	Appendix 1 - Corporate Risk Register (CRR) Update Report Appendix 2 - Board Assurance Framework Report (BAF) Report
Purpose	Assurance
Previously considered	EMC 05.12.2024 Audit Committee 14.11.2024

Executive Summary

Organisational Risk
This report provides an overview of current risk within the organisation, considering both strategic and operational risks as well as the Trust's risk appetite.

At the time of writing the report, the Trust was carrying a high level of risk related to finance, people, quality and performance and estates and facilities, all above the Board's appetite for such.

Risk Appetite
A Board Seminar was held on 30 October 2024 to review the Trust risk appetite and changes have been suggested accordingly and included in this report. These will be considered for approval by the Board at the November meeting.

Corporate Risk Register
The following changes have been made to the CRR.

- Risk 413: Safeguarding (escalation).
- Risk 189: Industrial action (de-escalation).
- Risk 51: Nursing workforce (de-escalation).
- Risk 119: On-hold (de-escalation).

Board Assurance Framework
There have been no material changes to the BAF.

Executive Management Committee (EMC) Discussion
This report was considered by EMC on 5 November 2024. The Committee discussed and approved the risks for escalation and de-escalation to the CRR as above. The role of the Committee as the moderating function was highlighted and a number of other significant risks within the organisation were discussed, noting effective controls/mitigations in place may contain these risks within registers at SDU or Care Group level. Work remains underway to review risk management processes within the organisation and suggest improvements to this.

Audit Committee Discussion
This report was considered by the Audit Committee on 14 November 2024. The Committee held detailed conversations related to endoscopy capacity (CRR 320) and safeguarding capacity (CRR 413) recognising the Quality & Clinical Governance Committee held the responsibility for Board level oversight of these. A specific report was presented to and also considered in detail by the Committee related to those risks within the CRR which required capital expenditure to mitigate. Further information would be included in future reports for top scoring CRR risks. The Committee approved the changes suggested to the risk appetite statements.

Decision	The Board is requested to:

	a) Note the contents of the report and use this information to support risk-based discussions and decision making. b) Approve the suggested changes to the risk appetite statement.

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	There are a significant number of operational mapped to the Trust ambition to 'meet/exceed quality and performance standards'.
Risk: link to Board Assurance Framework (BAF)/Risk Register	This paper attempts to highlight and map risks from the Corporate Risk Register (CRR) aligned to the Trust's strategic objectives and principal risks.
Financial	Two risks from the CRR are mapped against the objective to 'deliver a financially sustainable plan'.
Compliance CQC Standards Good Governance	An effective, comprehensive process is required to be in place to identify, understand, monitor and address current and future risks to the organisation
Partnership: consultation / communication	No CRR risks have been mapped against the objective to 'work with partners and engage people'.
Equality	Specific attention to issues related to equality are considered in relation to the Trust ambition to 'reduce health inequalities' and 'deliver people priorities'.
Quality Impact Assessment [QIA] completion required?	n/a

1 Introduction

The purpose of this report is to provide a summary of current risk within the organisation considering the detail of both those risks within the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF).

2 Risks mapped to Strategic Objectives

Table 1 below lists the nine Strategic Objectives of the Trust as documented in the BHT Strategy 2025. For each objective, the risk appetite of the Board is noted, the number of high scoring operational risks within the CRR and the risk rating of the relevant Principal and CRR risks (maximum, minimum and average for the latter).

This is intended to provide a more global overview of the risk portfolio in each area. The amber and red colouring is intended to highlight those areas of most significant risk.

No.	Strategic Objective	Risk Appetite (max. 5)	Principal Risk RR*	No. of Corporate Risks mapped to Objective	Maximum RRR** (Corporate Risks)	Minimum RRR (Corporate Risks)	Average RRR - Mean (Corporate Risks)
1	Consistently meet or exceed quality and performance standards	2.5	12	7	25	9	19 Increased
2	Deliver a financially sustainable plan	2.5	12	2	16	12	14 Decreased
3	Work with partners and engage people	4	9	0	-	-	- No change
4	Ensure children get the best start in life	2.5	12	0	-	-	- No change
5 6	Use population health analytics to reduce health inequalities and improve outcomes Improve the wellbeing of communities	4	9	0	-	-	- No change
7	Deliver People priorities	2	12	2	15	8	15 Decreased
8	For buildings and facilities to be great places to work	3	16	6	20	15	19 Decreased
9	Maximise opportunities for improving, sharing good practice and learning	4	9	0	-	-	- No change
	Total number of Corporate Risks	-	-	**19**	-	-	-

Table 1. **RR – Risk Rating; **RRR – Residual Risk Rating. No change in any Principal Risk Ratings.*

3 Risk Appetite

Figure 1 overleaf displays the residual ratings for each strategic risk and the average risk ratings of corporate risks against the Trust risk appetite, demonstrating where these are aligned/misaligned.

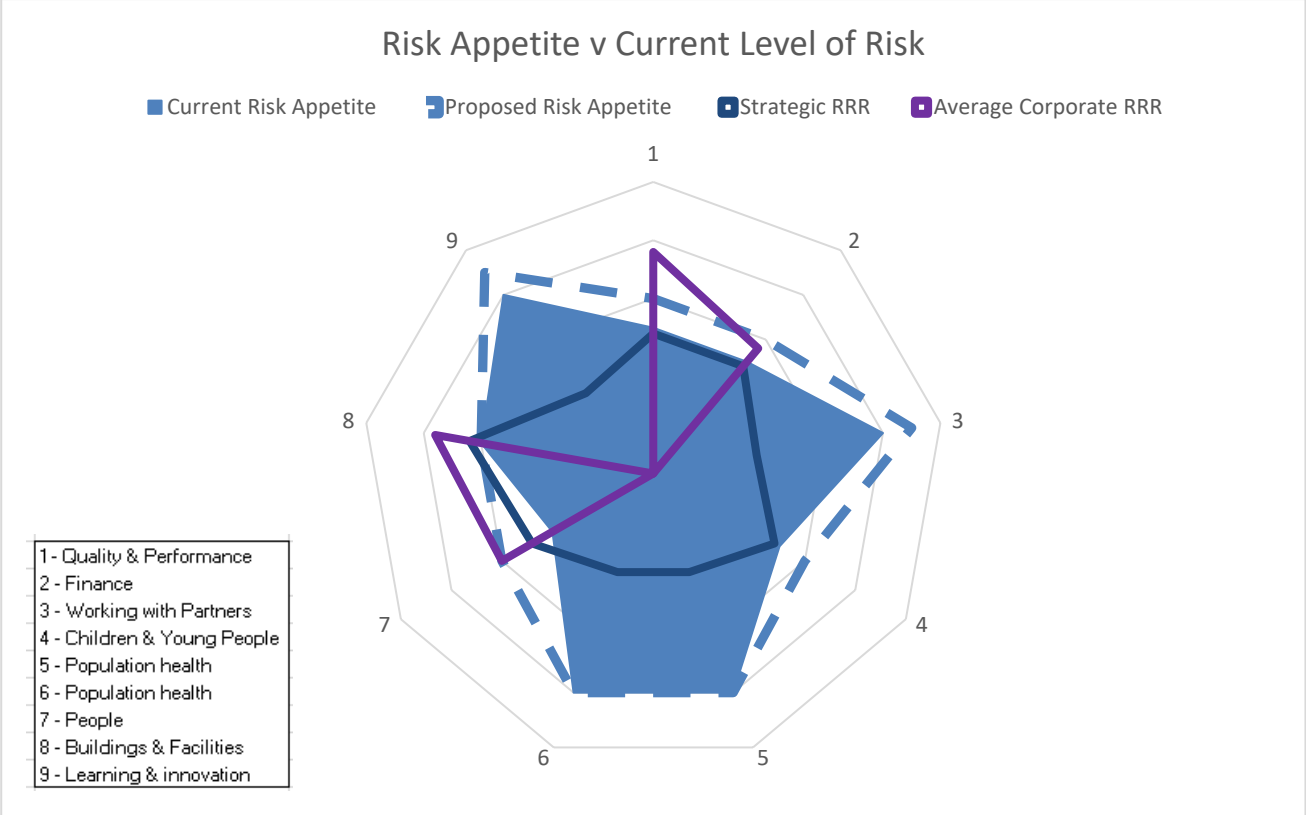

Figure 1.

The diagram indicates the Trust is currently carrying higher risk than set out in the risk appetite in relation to quality and performance, finance, people and buildings and facilities. The Trust is open to more risk in relation to working with partners, healthy communities and innovation and learning.

The Trust risk appetite statement is below, with suggested changes tracked following the Board Seminar on 30 October 2024.

> *Buckinghamshire Healthcare NHS Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners.*
>
> *The Trust has the lowest tolerance for risks that materially impact on the safety and wellbeing of our patients and colleagues and we will not accept these. We recognise that decisions about our level of exposure to risk must be taken in context but are committed to a proactive approach. We have a greater appetite for risk where we are persuaded there is potential for benefit to patient outcomes/experience, service quality and/or value for money, particularly where this relates to collaboration with external partners, integration of services and wider population health. The Trust has the greatest appetite to pursue innovation and challenge current working practices where such positive gains can be anticipated whilst operating within appropriate governance arrangements and regulatory constraints.*
>
> *Where we engage in risk strategies, we will ensure they are actively monitored and managed and would not hesitate to withdraw our exposure if benefits fail to materialise. Our risk appetite statement is dynamic and its drafting is an iterative process that reflects the challenging environment facing the Trust and the wider NHS. The Trust Board will review the risk appetite statement annually.*

In addition to the changes above, the following changes to the risk appetite for each of the strategic objectives is also proposed:

Principal Risk	Current Appetite	Proposed Appetite	Change
Failure to provide care that meets quality and performance standards	Minimal-Cautious (2-3)	Cautious (3)	⇧
Failure to deliver our annual financial plan	Minimal-Cautious (2-3)	Cautious (3)	⇧
Failure to work with partners	Open (4)	Open-Hungry (4-5)	⇧
Failure to provide care for children and young people	Minimal-Cautious (2-3)	Cautious (3)	⇧
Failure to improve population health and reduce health inequalities	Open (4)	Open (4)	n/a
Failure to deliver our people priorities	Minimal (2)	Cautious (3)	⇧
Failure to provide adequate buildings and facilities	Cautious (3)	Cautious (3)	n/a
Failure to learn, share good practice and continuously improve	Open (4)	Open-Hungry (4-5)	⇧

Table 2.

When these are plotted against current level of risk (Figure 1 – dotted line), should they be accepted by Board, the Trust will continue to carry higher risk than is set out in the risk appetite related to quality and performance and buildings and facilities. The Trust is open to more risk in relation to working with partners, children and young people and learning and innovation.

4 Risk Management

4.1 Organisation wide-risk management

Risk management processes within the organisation are acknowledged to require improvement and are currently under review with a proposal due for presentation by end November 2024 (delayed by one month).

This will include the following:

- Accurate mapping of risk across the organisation including corporate services.
- Appropriate articulation of risks with registers.
- How risk is changing across the organisation.
- Robust processes for the management of actions.
- A review of the Risk & Compliance Monitoring Group.

4.2 Board Assurance Framework (BAF)

The BAF was successfully migrated onto the web-based 4risk platform (see appendix 2 for reporting) and colleagues are independently able to update and manage risks and actions within the system. There have been no material changes since the previous report.

Feedback is welcome on the content of the report. Further work is underway to use the full functionality of this system and future reports aim to provide further detail on the effectiveness of those controls in place and the three lines of assurance supporting these.

The use of the 4action platform in the management of compliance with legislation and external reviews will allow greater links and triangulation with organisational risk.

4.3 Corporate Risk Register (CRR)

There are currently 17 risks within the CRR and appendix 1 provides details of the most recent update for all risks.

EMC were asked to consider the following risks for escalation/de-escalation to/from the CRR:

a) Risks for escalation to the CRR

- Risk 413: Safeguarding

b) Risks for de-escalation from the CRR to Corporate/Care Group registers

- Risk 189: Industrial action
- Risk 51: Nursing workforce
- Risk 119: On-hold

All of these were approved.

4.4 BOB ICB Risk Register

The Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB) risk report was last shared with EMC and Audit Committee in July 2024 and agreed to be appended to this paper on a 6 monthly paper with a summary of the content including any areas for Committee discussion. This is due again in January 2025.

5 KPI Dashboard

Table 3 below provides high level information on how risk is being managed each month.

Month	% Strategic Risks reviewed	% Operational Risks reviewed	% Actions Overdue Operational risks	Balance of assurance Internal v External	Number of new risks	Number of removed risks Closed/de-escalated from CRR	% risks with increased scores Strategic	% risks with reduced scores Strategic	% risks with static scores Strategic	% risks with increased scores Operational	% risks with reduced scores Operational	% risks with static scores Operational
May 2024	88%	57%	77%	Med	0	0	0%	0%	100%	0%	0%	100%
Jun 2024	75%	87%	25%	Med	0	0	0%	0%	100%	0%	0%	100%
Jul 2024	75%	87%	33%	Med	1	1	0%	0%	100%	0%	27%	73%
Aug 2024	75%	66%	33%	Med	0	0	0%	0%	100%	0%	0%	100%
Sep 2024	75%	42%	33%	Med	4	0	0%	0%	100%	13%	27%	60%
Oct 2024	88%	21%	43%	Med	0	0	0%	0%	100%	0%	11%	89%

Table 3.

6 Emerging Risks; Board and Committees

Table 4 below summarises those new/emerging risks identified at Board and Board Committee meetings during the months of September and October.

Month	Meeting	Risks Noted
Sept 2024	Audit	None new.
	F&BPC	None new.
	Q&CGC	- Engagement of corporate services related to improvements within the Emergency Department (ED). - Recent incidences of Never Events; further work planned to identify themes/patterns and ascertain level of future risk.
	SPC	None new.
	Public Board	None new.
	Private Board	- Related to Healthcare Support Workers (HSW) review, risk across other staff groups.
Oct 2024	F&BPC	None new.
	Q&CGC	- Wound care service provision. - Medical support for End of Life/Palliative Care Team. - System-wide neonatal bed base and potential impact on local demand and capacity.
	Public Board	None new.
	Private Board	- Procurement risk related to UEC contract.

Table 4.

Where risks are highlighted in grey, these are not currently reflected within the CRR or BAF. Table 5 below pulls together actions held by the Board and Committees where these have been set to address the identified risks.

Risk(s)	Action Details	Committee	Owner	Due Date
Engagement of corporate services related to improvements within ED	No formal action; to monitor via Care Group reporting.			
Recent incidences of Never Events; level of risk to be ascertained	Review of Never Events including historical incidents to identify themes/patterns	Q&CGC	Chief Nurse	November 2024
Related to HSW review, risk across other staff groups	Assessment of risk within other groups of colleagues	SPC	Chief People Officer	November 2024
Wound care service provision	Development of proposal to manage	Q&CGC	Chief Medical Officer	December 2024
Medical support for End of Life/Palliative Care Team	No formal action; within service level risk register, to be escalated to CRR if appropriate.			
Procurement risk related to UEC contract	No formal action. Related to implementation of Provider Selection Regime.			

Table 5.

7 Action required from the Board/Committee

The Committee is requested to:

a) Note the contents of the report and use this information to support risk-based discussions and decision making.
b) Note the suggested changes to the risk appetite statement.
c) Consider the escalation/de-escalation of risks to and from the CRR.

APPENDICES

Appendix 1: Corporate Risk Register (CRR) Update Report
Appendix 2: Board Assurance Framework (BAF) Report

Appendix 1: Corporate Risk Register Report

Risk ID	Risk Title	Risk Description	Last Update	Inherent Rating	Current Rating	Last 2 Movements	Actions
597	**Community Tissue Viability Service**	Under resourced team have approached the ICB for funding to support the service across winter months. The current service does not have the capacity to meet demand being asked particularly supporting referrals received from GP Practices and Nursing Homes. If patients in the community are not provided the necessary care and support this could lead to an increase in ED visits/Hospital admissions for wound infections/complex leg and pressure ulcers etc. 30 patients from nursing homes on the waiting list for assessments. Clinics have been put on hold for GP patients Current staffing situation of both senior TVNs leaving in March and April 24. Without suitable recruitment there is a significant risk to service provision. The team have noted a increase in staff stress and related sickness, and as a result the team are now only able to offer email advice to care homes and GP practices.	No recent update since included within the CRR	25	20	↔ ↔	Open – 1 O'due - 0
~~**189**~~	~~**Industrial Action**~~	~~The risk of industrial action in relation to the national pay awards.~~ ~~The impact on patient care and service delivery of the industrial action.~~ ~~The longer-term impact on the physical~~	~~23/09/24 07:41:09] Recommendation to close this risk, as Junior doctors have accepted the latest pay offer, following their referendum. Threat of further strike action has now been averted. The Trust will now look to implement the revised pay award accordingly.~~	~~12~~	~~8~~	~~↔↓~~	~~Open – 1 O'due – 1~~

		~~and psychological health of colleagues affected by strike action.~~					
~~51~~	~~**Nursing Workforce**~~	~~A shortage of registered and unregistered nursing staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care, the wellbeing of permanently employed colleagues and the Trust financial position.~~ ~~NOTE: Unmitigated risk score input incorrectly - this should have been 20 (not 15).~~ ~~There is an increase in the HCAs by 150 in Oct 2022 due to complexity of patient requirement and changing demographics.~~	~~21/10/24 09:54:57] This risk has been de-escalated to reflect that the Trust-wide vacancy target rate has been met and maintained; vacancies are being mitigated by temporary staffing.~~ ~~A recommendation has been made to RCMG to de-escalate this risk from the Corporate Risk Register.~~	~~15~~	~~9~~	~~↔ ↓~~	~~Open – 0~~
~~119~~	~~**On Hold Patients**~~	~~Review of data (captured in June 2022) demonstrates 116,575 "on-hold" records affecting a total of 108,458 patients. This has since reduced to 30,000 for patients with an appointment due before 31/03/23There is a potential for unmanaged clinical risk unless the status of these patients are understood and actioned appropriately.~~	~~23/07/2024 13:02:47] This is the overarching on hold risk which was originally raised due to the high number of patients on the on hold risk that had not been validated etc.~~ ~~This risk is now well controlled with all pre April 2023 patients having been validated and the number being reduced from 130,000 to 30,000 for the individual CDU's to manage.~~ ~~This aspect of the risk is now well managed and the proposal is that the risk be removed from the RR with individual CDU's managing their on holds as needs been.~~ ~~7 additional risks have been linked to this one for individual on hold risks within CDU's~~	~~20~~	~~9~~	~~↔ ↔~~	~~Open – 1 O'due – 0~~
234	**Delivery of the Financial Plan**	Trust cannot define/live within its agreed financial envelope, impacting its ability to resource/deliver clinical, operational and strategic priorities (operational/revenue risk).	09/08/2024 16:15:07] Reviewed and updated by CFO.	20	12	↔ ↔	Open – 0

655	**Consultant Microbiologist Staffing**	1 of 4 consultant Microbiologists has left the Trust in October 2023. They covered the IPC role for 1PA. We have been unable to fill the position other than with intermittent high-cost agency locums. The role of an IPC doctor has expanded over recent years and even if we do replace this post we have insufficient time in current job plans to cover the additional duties. According to RCPath IPC doctor role is 4-6PA per week. The risk is inadequate oversight of IPC aspects of bed management and facilities could increase risk of outbreaks of infectious diseases. Financial risk paying for agency locums (includes out of hours cover). Another full-time microbiology consultant is retiring mid July in 2024. They hold the Antimicrobial Stewardship lead role for 1PA. This leads to 2 microbiology consultants in the hospital and unable to continue the clinical services and on-call rota from July onwards as if the rota gaps are not filled by the locums. This will lead to only 2 consultants (1 WTE, 0.9WTE) for the BHT. The AMS and IPC lead roles are not held by the existing consultants so the duties and responsibilities of these roles are not covered. Clinical risks: 1) Limited clinical services - Cannot attend the MDTs as when there were 4 consultants, delayed response by the micro team for primary care clinical queries. This leads to delay in treatment and clinical decision making. 2) on-call frequency will stay as 1:4 as existing clinicians are not in a capacity to	24/09/2024 15:23:49] 1 x Locum fixed-term consultant - will start in BHT from 04/11/2024, so having 3 trust consultants from November onwards. One vacancy is still not filled. NHSP/bank cover for rota gaps on-going.	12	15	↔ ↔	Open - 0

		provide on-call below than 1:4. Gaps to be sort out by locum/NHSP 3) Attendance in laboratory quality and accreditation work - unable to oversee this work 4) Increase workload and stress for existing 2 consultants impacting their psychological well-being and potential burnout 5) Potential increase in errors and mistake due to increase workload and burnout 6) Clinical advisory service - Micro clinicians are unable to get back to primary care by phone/therefore only responding by email for non-urgent queries 7) Impact on laboratory and admin staff in the micro department 8) Unable to attend regular IPC meetings, but acute IPC queries will be dealt within the role A duties.					
287	**Midwifery Staffing**	A shortage of registered and unregistered midwifery staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care, the wellbeing of permanently employed colleagues and the Trust financial position	25/10/2024 11:10:56] 17 WTE midwives started in October, further 7 WTE commencing in January. projected vacancy rate will be 4.5% by January. Can be reviewed after January to ensure all in post.	15	15	↔ ↔	Open – 0
394	**Pharmacy Robotic Infrastructure**	The SMH Pharmacy dispensary has a single robot installed around 2008 with an expected life of 10 years, now 6 years past its planned service life. Robotics are essential due to limited space, allowing sufficient storage capacity for medications. Frequent faults cause service disruption, and suppliers only provide reconditioned spare parts. The robot requires replacement with a higher capacity and faster dispensing speed model, especially as it predates the workload shift from WH to SMH.	30/09/2024 11:08:48] Risk reviewed - as of 26th Sept meeting with Trust executives including operations estates and finance generally agreed in principal necessary project for funding in FY25-26. To finalise business case and undertake estates review and scoping before submission to capital estates group.	12	15	↔ ↔	Open – 0

		A workflow analysis and ergonomic improvements, along with lifecycle works as part of the PFI structure, are necessary for the refit.					
388	**Misapplication of the Mental Capacity Act (MCA) incl. Deprivation of Liberty (DoLs)**	There is a risk that people may be deprived of their liberty unlawfully which could lead to risk of liability to Trust including risk of breach of Human Rights. This could to a delay in pursuing appropriate legal avenues including application to the court of protection. This could lead to unlawful detention in hospital, increased length of stay and poor patient experience. Risk of making decisions on behalf of an adult without legal framework to do so. The safeguarding team do not have capacity to review all MCA assessments linked to Deprivation of Liberty Applications. BHT have become aware through an individual case that the Local Authority have delays in being able to review applications for Deprivation and therefore granting the appropriate application. If a patient is actively objecting the Supervisory Body (Local Authority) should assess with a Best Interest Assessment. There is a risk that colleagues will not recognise the application of the MCA for 16 & 17 year olds.	11/07/2024 – Review of risk by the Safeguarding Team.	15	15	↔ ↔	Open – 1 O'due – 0
719	**Legionella, Wycombe Hospital**	Due to asbestos being present, we are unable to remove water pipework dead legs thus increasing risk of Legionnaires. Because this affects most areas on the WH site it will require asbestos removal under controlled conditions which will impact greatly on the delivery of clinical services.	No update since included on CRR (September 2024)	16	15	↔	Open – 0
224	**Capital Resourcing**	The Trust has a significant backlog maintenance requirement, without an identified source of finance or plan to	09/08/24 13:25:21] Updated for 24/25	25	16	↔ ↔	Open – 1 O'due – 0

		address it. System (ICS) capital funding allocations are now based on historic depreciation charges, so there is no allowance for new investment, which is only possible through a separate bidding / allocation / business case process. Using the system capital allocation for new equipment / developments means there is not adequate funding for replacement of existing assets.					
575	**Lifts, Wycombe Hospital**	All passenger and goods lifts installed in the WH tower block have exceeded their service life and are now becoming obsolete, making parts increasingly difficult to source. Failures are becoming more frequent and are affecting services, particularly the movement of patients in the bed lifts. There is a significant impact on patients having to use the services that are on top floors (i.e. cancer services)	09/07/2024 13:39:02] New brakes have been installed on Lift C however the brake pads are not sufficient and need upgrading. New supplier has sourced a new brake pad system to be installed. Approx 3 weeks to installation.	20	16	↔	Open – 0
184	**Wycombe Tower, interior**	The ageing WH tower Block is showing signs of interior deterioration which is challenging to maintain in a condition that is suitable for modern healthcare provision. Asbestos is present throughout the construction including the floors, ceilings and service voids. Any remedial or improvement works are impeded by the presence of asbestos as this adds significant costs and risks to repairs and projects. Water pipework is old and has a lot of obsolete components. This is difficult to be removed under asbestos conditions which presents a legionella risk to staff and	09/07/2024 12:45:30] Improvements made to Ward 2 and small improvements made for other clinical services who continue to use the tower block. SH now left Trust awaiting new Director of Capital Planning.	25	20	↔ ↔	Open – 0

		patients. Water ingress is also common to the lower levels during periods of heavy rainfall. Electrical infrastructure is now obsolete and is difficult to maintain and does not comply with HTM 06. All Patient services could be affected by failures in the electrical infrastructure. Patient environment experience i.e., space, door widths and access are not compliant with modern healthcare standards (HBN's) and Equality Act. This compromises quality patient experience. Ventilation was not a major design requirement when the building was constructed. The current levels of ventilation are not compliant with current standards for healthcare services. As a result, patients and staff may be exposed to airborne infection and be affected by excessively high temperatures during periods of hot weather.					
711	**Infection Prevention & Control management activities**	Low staffing levels in the IPC team, microbiologists, and antimicrobial pharmacists are impacting infection prevention and management activities. IPC are working on the BCP.	No update since included on CRR (September 2024)	20	20	↔	Open – 0
415	**New Wing Theatres, Stoke Mandeville Hospital**	The New Wing Theatres block at SMH (Theatres 1-5) is nearing the end of its operational lifecycle and requires a comprehensive refurbishment within the next 12-24 months. There is a broader risk of electrical and ventilation failures across all theatres. Additionally, the heating coils and boilers are approaching the end of their service life, resulting in frequent malfunctions that cause service disruptions and downtime.	17/09/2024 08:07:35] Updated risk description and key controls.	20	20	↔ ↔	Open – 0

410	**Marlow & Main Theatres, Wycombe Hospital**	Marlow Theatres: The ventilation and overall infrastructure are outdated, requiring a full refurbishment, including the recovery space, which is inadequate. The site does not meet GPAS/RCoA guidelines or modern HTM 03-01 standards. While Theatres 1 and 3 are maintained to HTM standards, Theatre 2 cannot be brought up to these standards. Breakdowns and downtimes are becoming increasingly frequent. Wycombe Main Theatres: The Anaesthesia Rooms in Theatres 1, 2, and 3 no longer meet minimum or derogation standards, and therefore have been decommissioned presently. Anaesthesia induction is being conducted inside main theatres where HTM standards are being met. The entire suite requires a full refurbishment, including infrastructure, ventilation, and electrical systems, as it is no longer able to meet required standards, with breakdowns occurring regularly. Additionally, the ageing water supply systems across the phase 3 site presents a Legionella risk, therefore is being mitigated via point of use filters to maintain safety.	17/09/2024 08:05:57] Updated risk description and key controls.	20	20	↔ ↔	Open – 0
225	**Cyber attack; disruption**	There is a risk that the Trust is vulnerable to a cyber attack as we currently have a number of aged applications running on out-of-date Microsoft servers, networks, and telephony systems. As a result, they are no longer receiving vendor security updates. If a cyber attack were to occur, the impact would be the loss of all IT or a significant amount of IT. There could also be the potential loss of part of or all of the phones.	18/09/2024 16:18:28] As part of the Cyber project the below steps are already in place 1. The applications hosted on Windows 2008 & 2012 servers (out of support) are being worked upon to be migrated to a supported OS. The application owners are engaged and impact analysis is in place to ensure these applications operate on the new supported OS. 2. All the applications that are not	20	20	↔ ↔	Open – 0

			supported on Windows 11 devices are already identified and flagged as red to proceed with the application owner/supplier for testing and upgrades. 3. Steps are also taking in place to ensure all the Windows 10 devices are upgraded to 23H2, which is supported by Microsoft until October 2025.				
320	**Endoscopy Waiting Lists**	Endoscopy has accrued a significant backlog of patients since pre COVID. Current backlogs: Cancer 240 on PTL of which 200 are booked DM01 backlog- 722 of which 230 have been booked DM01 current- 622 of which 265 are booked Rescope – 2022/23 = 371 with 2024 =84. Total 455 of which 96 are booked Planned 2021/22- 376 of which 39 are booked 8 are awaiting genetics and 113 need vetting Planned 2023 867 – 688 need vetting (as of December 2023) (graphs attached in documents) Backlogs have been accrued primarily due to: 1. Infrastructure 2. Recruitment 3. COVID 4. New scheduling system 5. Renovation of a unit The complexity of the backlogs and the associated risks are difficult to fully define. The below captures most of these additional risks: Within the Rescope PTL Within the exclusion reports from migration of Careflow to HICSS system. Over 4,000 patients have been migrated	28/08/2024 – Review of risk by General Manager for Gastroenterology & Endoscopy.	25	25	↔ ↔	Open - 0

		over onto a new system, but many were put on exclusion reports that are still being cross checked. Lost referrals due to historical paper-based system. Issue has been flagged by General Surgery about lost requests. Unit as attempted to review any lists sent over by General Surgery, but aware more lost paper requests are possible due to high turnover of staff during the migration. Unit cannot accurately map out the wait lists from both HICSS and Medway. Unit has escalated to HICSS and is currently working with them to get a report that can be used to support cross validation Human error. Until the robotic automation system can be put in place the unit cannot ensure all patients that are entered into HICSS (via electronic request via ICE) are immediately transferred onto Careflow and therefore added to wait list for tracking Unit has flagged that potentially 180 delayed/undiagnosed cancers may sit within its backlogs so remains a high-risk area for ongoing issues due to backlogs from covid and capacity shortfalls. Due to the above demands there have been delays in surveillance appointments, which means that there have been delays in removing polyps, which have now turned into cancer. Number of patients have been diagnosed with cancer, which may have been avoidable. Issue compounded by a Backlog of patients on hold resulting in longer wait times for follow up appointments. This may result in delayed diagnosis of serious conditions, resulting in a worse prognosis. backlogs of patients are affecting multiple areas including the electronic referral system and Advice and guidance.					

		Between 3 and 5% of this cohort are anticipated to have some level of harm and this could result in approximately 180 incidents being identified over the next several months. The department will be unable to identify the extent of harm until all scopes have occurred and been reviewed.					
48	**Endoscopy Decontamination Equipment**	We have a aging decontamination plant. The AERs (automated endoscopic reprocessing systems) are coming to the end of life cycle, requiring more frequent maintenance and breakdown causing disruption to the service. Breakdowns include drainage, pumps, washers etc. Each machine has 2 chambers which are capable of washing an endoscope in each chamber. If all working we can process 4 scopes at a time. Currently we have only 1 machine in working condition. One machine is broken currently. Previously a breakdown led to a RIDDOR reportable incident in August 2024 (ID 2377). Frequent breakdowns lead to compromised washing facilities and reduced capacity for endoscopy procedures. Delays in engineer response contribute further to delays in patient care The plant room is not fit for purpose as the heat exchange is insufficient to cool resulting in the need to open the door risking exposure to aerosolised contaminate. The extract system is also insufficient and does not meet HTM 01-03 for extract in case of chemical leak. The electrical system is build on a single circuit resulting in no backup. Any modifications to meet Joint Advisory Group (JAG) and HTM compliance would	28/10/2024 14:11:16] Action updated after discussion with Endoscopy Senior Sister and Service Manager.	20	20	↔ ↔	Open – 2 O'due – 2

		result in a major refurbishment of the whole decontamination unit.					
413	**Safeguarding; demands of the Multi Agency Safeguarding Hub (MASH) activity**	There is no commissioning provision for Multi-Agency Safeguarding Hub activity. Attendance at the MASH restricts the capacity of the safeguarding team to meet other routine demands and activities across the Trust.	16/10/2024 10:19:48] Risk reviewed at Safeguarding committee (16/10/24) and members were asked to consider and approve a request to escalate this risk to the corporate risk register due to the increase in risk score and reasons associated with this. Approved for escalation by Safeguarding Committee.	15	16	↑	Open – 1 O'due – 0

Heatmap – November 2024

Consequence Likelihood	1	2	3	4	5
5			388 – Application of MCA/DOLs 287 – Midwifery Staffing 655 – Consultant Microbiologist Staffing 394 – Pharmacy Robotics Infrastructure	410 – Wycombe Theatres 415 – SMH Theatres 597 – Lack of commissioned TVN service 48 – Ageing/failing endoscopy decontamination equipment 711 – Infection prevention, control and management activities *413 – MASH demand*	320 – Risk of endoscopy waiting lists leading to delays in procedures/diagnoses
4				224 – Trust Capital 575 – Lifts, Wycombe Hospital	225 – Disruption to Trust technology caused by cyber incidents 184 – Ageing Wycombe tower block (interior)
3			~~119 – 'On hold' Patients~~ ~~51 – Nursing Workforce~~	234 – 2024/25 Financial Plan	719 – Legionella risk, Wycombe Hospital
2				~~189 – Industrial Action~~	
1					

Board Assurance Framework

Buckinghamshire Healthcare NHS Trust

Generated Date	04 Nov 2024 10:59
Risk Criteria	
Project	Risk Register

Buckinghamshire Healthcare NHS Trust

1. To consistently meet or exceed quality and performance standards

Reference	Risk Details	Causes & Effects		Inherent Priority	Controls		Actions	
		Type	Title		Summary	Assurance Details Summary	Detail	Variable Target
2301	**Principle Risk - Title**: Failure to provide care that meets quality and performance standards (elective care) **Principle Risk - Further Description** : Failure to provide care that consistently meets or exceeds performance and quality standards a) Reducing long waits **Strategic Priority** : Provide outstanding, high value care ("Outstanding Care") **Achieve by 2025** : We will see people as early as possible when they need our services, to improve outcomes **Risk Appetite**: Minimal - Cautious (2-3) **Risk Area**: Strategic **Strategic Objective**: 1. To consistently meet or exceed quality and performance standards	Cause	Limitations in capacity and capacity growth due to capital availability	Very High (4:5=20)	Optimisation of available capital investment and development of multi-year plans; prioritisation of business cases for maintenance.	Outputs of Capital Management Group (CMG)	Business Case in development - seeking capital to support endoscopy capacity	31 Dec 2024
		Cause	Variation in the productivity of clinical service lines		PFI investment		Business Case in development - seeking capital for suitable outpatient space and capacity on the Stoke Mandeville site	31 Dec 2024
		Cause	Continued backlogs from COVID-19 period		Planned care transformation programme including focus on elective productivity.	Planned care bi-monthly updates		
		Effect	Harm caused by delayed treatment		Structured harm review process across elective care and cancer.	Regular reporting on outputs of clinical harm process		
		Effect	Impact on staff resilience			Annual Mortality/Learning from Deaths reporting		
		Effect	Public dissatisfaction and poor patient experience			Annual Trust ligitation reporting		
		Effect	Clinical, operational, financial and regulatory consequences		Getting It Right First Time (GIRFT) reviews	GIRFT outputs/reporting		
		Effect	Unable to replace/restore faulty estate and equipment			Outputs of GIRFT Board		
		Effect	Failure to maximise clinical resources to reduce waiting lists and meet regulatory standards		Monitoring of productivity metrics	Monthly IPR reviewed by Board and Board Committees		
		Effect	Political mistrust/lack of confidence in management.			Productivity Reviews (Finance & Business Performance Committee)		
					Flag function on Datix			
					Processes for prioritisation and monitoring of waiting lists	Outputs of Care Group and SDU meetings		
					System wide working on Cancer and elective performance	Outputs of Elective Care Board (APC)		
						Outputs of Thames Valley Cancer Alliance (TVCA) meetings		
					External review programme (including Trust policy)	Annual reporting to Board and Board Committees		
					Monitoring of patient experience	Annual National Inpatient Surveys		
						Friends and Family Test		
2302	**Principle Risk - Title**: Failure to provide care that meets quality and performance standards (urgent care) **Principle Risk - Further Description** : Failure to provide care that consistently meets or exceeds performance and quality standards b) Providing safe emergency care. **Strategic Priority** : Provide outstanding, high value care ("Outstanding Care") **Achieve by 2025** : We will see people as early as possible when they need our services, to improve outcomes **Risk Appetite**: Minimal - Cautious (2-3) **Risk Area**: Strategic **Strategic Objective**: 1. To consistently meet or exceed quality and performance standards	Cause	Inability to control demand for services or primary/social care capacity	Very High (4:5=20)	Urgent and Emergency Care Improvement Plan and monitoring of progress against plan	Outputs of Urgent and Emergency Care Board		
		Cause	Inability to reform the urgent care pathway			Regular reporting on progress against plan for Operational Improvement Programmes		
		Cause	Inadequate infection, prevention and control due to estates infrastructure		Incident response structure; Gold, Silver, Bronze with policy in place			
		Effect	Overcrowding and extended length of stay within the Emergency Department		Place-based programmes to integrate care and redesign urgent care offer			
		Effect	Ambulance handover delays		Monitoring of Infection Prevention & Control (IPC) practices and outcomes	Regular Infection Prevention & Control Reporting		
		Effect	Negative impact on staff resilience			Results of cleaning audits		
		Effect	Clinical, operational, financial and regulatory consequences			Outputs of quarterly Infection Prevention & Control (IPC) Commitee		
		Effect	Challenging/costly to clean clinical areas effectively			Annual Infection Prevention & Control Report		
		Effect	Potential for hospital acquired infections			Outputs of adhoc Outbreak Meetings		
		Effect	Harm caused by delayed treatment		Monitoring of patient experience	Friends and Family Test		
		Effect	Political mistrust/lack of confidence in management			Annual National Inpatient Survey Results		
		Effect	Poor patient experience		External review programme (including Trust policy)	Annual reporting to Board and Board Committees		
					Daily Emergency Department Huddles including consideration of Safe Staffing	Outputs of huddles		
						Quarterly Safe Staffing Reporting		
					Monthly monitoring of performance metrics through Integrated Performance Report (IPR)	Outputs of Board and Board Committee meetings		
					Harm review processes	Annual Trust litigation reporting		
						Annual Mortality/Learning from Deaths reporting		
					Winter planning including monitoring of performance against plan	Lessons learned reporting		
						Metrics within Integrated Performance Report (IPR)		

Buckinghamshire Healthcare NHS Trust

Reference	Risk Details	Causes & Effects		Inherent Priority	Controls		Actions	
		Type	Title		Summary	Assurance Details Summary	Detail	Variable Target
2303	**Principle Risk - Title**: Failure to provide care that meets quality and performance standards (risk and governance) **Principle Risk - Further Description** : Failure to provide care that consistently meets or exceeds performance and quality standards a) Management of risk and clinical governance **Strategic Priority** : Provide outstanding, high value care ("Outstanding Care") **Achieve by 2025** : We will see people as early as possible when they need our services, to improve outcomes **Risk Appetite**: Minimal - Cautious (2-3) **Risk Area**: Strategic **Strategic Objective**: 1. To consistently meet or exceed quality and performance standards	Cause	Variation in clinical service lines	Very High (4:5=20)	Clinical Accreditation Programme	Clinical Accreditation metrics within IPR		
		Cause	Organisational governance not always being easy to navigate and enabling of change		Quality Audits via Tendable	Outputs of Care Group and SDU meetings		
		Effect	Inadequate 'ward to Board' assurance			Care Group Reviews to Quality & Clinical Governance Committee		
2304	**Principle Risk - Title**: Failure to provide care that meets quality and performance standards (maternity) **Principle Risk - Further Description** : Failure to provide care that consistently meets or exceeds performance and quality standards d) Maternity and neonatal care **Strategic Priority** : Provide outstanding, high value care ("Outstanding Care") **Achieve by 2025** : We will see people as early as possible when they need our services, to improve outcomes **Risk Appetite**: Minimal - Cautious (2-3) **Risk Area**: Strategic **Strategic Objective**: 1. To consistently meet or exceed quality and performance standards	Cause	Maternity and neonatal staffing levels	Very High (4:5=20)	EPR Programme	Monitoring of EPR Programme		
		Cause	Data quality		External review programme (including Trust policy)	Annual reporting to Board and Board Committees		
		Cause	Digital immaturity		Recruitment and retention plans			
		Cause	Antenatal pathway capacity		Monitoring of safe staffing levels	Twice yearly reporting to Trust Board		
		Cause	Size of bed base within neonatal unit and transitional care		System-wide quality and safety dashboard	Perinatal Quality Surveillance Model (PQSM) Reporting to Board and Board Committees		
		Cause	Increasing complexity of service users		Increased system-based projects	Outputs of Transformation Board		
		Cause	Health inequalities		Compliance with BirthRate Plus recommendations			
		Effect	Staff burnout creating further vacancy owing to attrition and unavailability		Oversight from Board level Maternity and Neonatal Champions			
		Effect	Potential for clinical harm		Oversight of performance against the Maternity Incentive Scheme safety actions			
		Effect	Clinical, operational, financial and regulatory consequences		Implementation of the Local Maternity and Neonatal System (LMNS) Opel classification and escalation processes	Outputs of safety huddles		
		Effect	Political mistrust/lack of confidence in management		Dedicated governance structure for maternity, gynaecology and neonates			
		Effect	Ability to plan sustainable services and manage demand and capacity		Monitoring of quality and safety KPIs within maternity services	Metrics within monthly Integrated Performance Report (IPR)		
		Effect	Negative impact on patient experience			Quarterly Maternity Safety Reports		
		Effect	Inability to meet information governance standards			Quarterly Maternity Quality Reports		
						Quarterly feedback from Healthcare Safety Investigations Body		
						Claims and litigation scorecard		
					Monitoring of patient experience	Annual Picker Survey		
						Quarterly feedback via Maternity and Neonatal Voices Partnership (MVP)		
					Monitoring of action plans through internal maternity governance structure	Relevant reports from external bodies		
						Outputs of Maternity governance meetings		

2. To deliver a financially sustainable plan and improve our benchmarking in model hospital

Reference	Risk Details	Causes & Effects		Inherent Priority	Controls		Actions	
		Type	Title		Summary	Assurance Details Summary	Detail	Variable Target
2164	**Principle Risk - Title**: Failure to deliver our annual financial plan **Principle Risk - Further Description** : Failure to deliver a financially sustainable plan and improve our benchmarking in model hospital **Strategic Priority** : Provide outstanding, high value care (Outstanding Care") **Achieve by 2025** : We will continuously improve our services and use of resources to deliver value for our residents **Risk Appetite**: Minimal - Cautious (2-3) **Risk Area**: Strategic **Strategic Objective**: 2. To deliver a financially sustainable plan and improve our benchmarking in model hospital	Cause	Fixed, no growth, envelope funding model for urgent and community care	Very High (3:5=15)	Scrutiny from CMG/EMC, Finance and Business Performance Committee, Trust Board including; in-year financial performance, variance analysis,...	Outputs of CMG/EMC/F&BPC/Trust Board.	Assurance Gap: Historic issues underpinning organisational deficit to be addressed as part of joint external review with ICB. Action: Plan to address the deficit as part of annual and medium-term planning (CFO) - Timeline to be agreed with ICB in 2024.	30 Sep 2024
		Cause	Lack of general growth funding due to Commissioner (BOB ICB) prioritisation to other areas			Monthly finance reports		
		Cause	Lack of long-term financial strategy			Monthly monitoring of CIPs		
		Cause	Structural financial challenges			Financial deep dive – to focus on Trustwide issues e.g. Patient Flow/Urgent Care Workstream, rather than Care Group specific issues.	Assurance Gap: Historic issues underpinning organisational capital deficit. Action: Need to pursue alternative external capital provision (e.g. PFI bullet payments, MES and asset sales).	30 Sep 2024
		Cause	Mismatch demand and availability of Trust level capital		Care Group & Corporate Performance Management Framework, with specific focus on financial performance and use of resources.	Output of performance reviews meetings for financial deep dives.		
		Cause	Inability to improve organisational productivity to pre-pandemic levels and above			Internal audit review of Governance & Performance Framework		
		Cause	Inflationary pressures		Reporting/challenge of performance through NHSE Regional, ICB/ICS and APC	Scrutiny of APC Reporting by Transformation Board/Trust Board..		
		Effect	Negative impact on ICS financial position			Outputs of alternate monthly APC Board meetings.		
		Effect	Reduced opportunities for service investment			Outputs of monthly System Recovery and Transformation Board		
		Effect	Block contract for locally commissioned services which does not reflect the increasing activity or cost of meeting regulatory standards.		Annual planning, budget setting in-year forecasting and monitoring processes.			
		Effect	Inability to plan resourcing long term, to deliver strategic plans and activity at required levels.		Continual engagement with NHSE and ICB regarding inherent risks and management of forecasting and budgeting processes.	Meetings between CFO and Regional NHSE representative on month end position- outputs of meeting.		
		Effect	Inability to invest in estates and digital improvements.			Outputs of fortnightly system meeting.		
		Effect	Inability to support structural shifts in activity between care settings (e.g. hospital to out-of-hospital).		Continue to seek alternative funding solutions to address the capital funding gap.	Commercial Strategy & review of performance against this.		
					Agreed 2024/25 financial plan through Trust Board and submitted / agreed with BOB ICB/NHSE.			
					Weekly Executive-led Vacancy Control Panel (VCP) and Care Group temporary staffing control meetings.	Scrutiny of weekly workforce performance by EMC		

3. To work with our partners and engage people

Reference	Risk Details	Causes & Effects		Inherent Priority	Controls		Actions	
		Type	Title		Summary	Assurance Details Summary	Detail	Variable Target
2230	**Principle Risk - Title**: Failure to work with partners **Principle Risk - Further Description** : Failure to work effectively and collaboratively with external partners **Strategic Priority** : Take a leading role in our community ("Healthy Communities") **Achieve by 2025** : - **Risk Appetite**: Open (4) **Risk Area**: Strategic **Strategic Objective**: 3. To work with our partners and engage people	Cause	Inability to work with partners to deliver new models of proactive and preventative care	Very High (4:5=20)	ICS Senior Leaders and Chairs Groups	Outputs of ICS Senior Leaders and Chairs Groups	Process in place to review clinical strategy (Place Strategy) taking a Buckinghamshire-wide strategy, including Buckinghamshire Executive Partnership (BEP) and the Voluntary, Community and Social Enterprise (VCSE) sector.	31 Jul 2024
		Cause	Failure to align with Council and Partners for Place Strategy		Integrated Programme Board	Outputs of Integrated Programme Board		
		Cause	Local uncertainty		Acute Provider Collaborative	Outputs of Acute Provider Collaborative	Development of a Delivery Group by the Buckinghamshire Executive Partnership (BEP) focussed on delivering the BEP priorities.	30 Sep 2024
		Cause	Failure to secure necessary infrastructure changes linked to Buckinghamshire growth strategy			Acute Provider Collaborative MoU		
		Cause	Not realising Trust potential as an anchor institution		Integrated Partnership Board	Outputs of Integrated Partnership Board		
		Effect	Missed opportunities to develop new models of care to improve patient experience and outcomes		Buckinghamshire Executive Partnership (BEP)	Outputs of Buckinghamshire Executive Partnership (BEP)		
		Effect	Impact on public trust/ confidence		Health and Wellbeing Strategy	Outputs of Health & Wellbeing Board		
		Effect	Services not aligned to community needs		Opportunity Bucks	Outputs of Opportunity Bucks Board		
		Effect	Duplication of services and not making full potential of public money		South 4 Pathology Network	South 4 Pathology Board MoU		
		Effect	Population health outcomes deteriorate or do not improve		Thames Valley Radiology Network	TVRN Annual Report		
		Effect	Health inequalities widen			Thames Valley Radiology Network MoU		
						Regional funding		
					Access to housing development proposals			
					Bucks Estates Group	Outputs of Bucks Estates Group		
					S106 Proforma	S106 Proforma examples		
					One Public Estate Strategy			
					Active role within the local community	PPEDI Records		

4.To ensure children get the best start in life

Buckinghamshire Healthcare NHS Trust

Reference	Risk Details	Causes & Effects		Inherent Priority	Controls		Actions	
		Type	Title		Summary	Assurance Details Summary	Detail	Variable Target
2262	**Principle Risk - Title**: Failure to provide care for children & young people **Principle Risk - Further Description** : Failure to provide consistent access to high quality care for Children and Young People (CYP) **Strategic Priority** : Taking a leading role in our community ("Healthy Communities") **Achieve by 2025** : - **Risk Appetite**: Minimal - Cautious (2-3) **Risk Area**: Strategic **Strategic Objective**: 4.To ensure children get the best start in life	Cause	Shortage of Community Paediatricians	Very High (5:5=25)	Scrutiny of CYP Community Services by relevant groups.	Outputs of relevant meetings	Estates plan for relocation of therapies at SMH	31 Mar 2025
		Cause	Waiting times for community paediatric services		Monitoring of the Special Educational Needs and Disability (SEND) Written Statement of Action (WSoA).	Internal Audit review of the SEND WSoA.		
		Cause	Space restrictions; lack of MDT appropriate clinical space within multiple sites			Outputs of Care Group Meeting		
		Cause	Ability to manage current demand whilst reducing backlog		Monthly scrutiny of performance by Commissioners.	Outputs of Commissioner meetings		
		Cause	Lack of digital solution for repeat prescriptions		Recruitment of appropriate MDT.			
		Effect	Services do not provide care in a timely manner which results in potential clinical harm and a negative patient experience		Outsourcing			
					Monitoring of CYP waiting lists	Outputs of Care Group Performance Reviews		
						Outputs of Care Group and SDU meetings		
					Management of referrals and outpatient capacity	Outputs of Care Group and SDU meetings		
					Patient Initiated Follow Up (PIFU)	Outputs of Care Group and SDU meetings		
					Clinical validation processes for waiting list management	Outputs of Care Group and SDU meetings		
					SEND identified as a priority by the Buckinghamshire Executive Partnership (BEP).			
					Pilot of MDT working model	Evaluation of MDT Working model		
					EPR Programme	Monitoring of EPR Programme		

5. To use population health analytics to reduce health inequalities and improve outcomes in major diseases, 6. To improve the wellbeing of our communities

Reference	Risk Details	Causes & Effects		Inherent Priority	Controls		Actions	
		Type	Title		Summary	Assurance Details Summary	Detail	Variable Target
2287	**Principle Risk - Title**: Failure to improve population health and reduce health inequalities **Principle Risk - Further Description** : Failure to support improvements in local population health and a reduction in health inequalities **Strategic Priority** : Take a leading role in our community ("Healthy Communities") **Achieve by 2025** : We will prevent people dying earlier than they should, with a particular focus on addressing inequalities in access and outcomes **Risk Appetite**: Open (4) **Risk Area**: Strategic **Strategic Objective**: 5. To use population health analytics to reduce health inequalities and improve outcomes in major diseases, 6. To improve the wellbeing of our communities	Cause	Inequalities in access to care and outcomes of care	High (3:4=12)	Equality & Quality Impact Assessments (EQIA)	EQIA assurance reporting	Establish Shared Care Record (SCR) working group	31 Aug 2024
		Cause	Failing to use integrated care records and data to manage population health			EQIA documents	Roll out of Health Inequalities Dashboard to Care Groups	30 Sep 2024
		Cause	Failure to take population health inequalities into account when making decisions about care delivery and the use of resources		Index of Multiple Deprivation Data		Sharing of Population Health Management (PHM) data across the leadership team	30 Sep 2024
		Cause	Not realising Trust potential as an anchor institution		Patient and Public Equality, Diversity and Inclusion (PPEDI) Group	Outputs of PPEDI Group	Development of the Shared Care Record (SCR): - to support proactive management of patients (including pre-operatively) - with a place-based approach, including additional health and social care data	30 Sep 2024
		Cause	Failure to work in an integrated way with partners			PPEDI Annual Report		
		Cause	Lack of simple access to Shared Care Record (SCR) for clinicians		Monitoring via Integrated Performance Report; use of deprivation and ethnicity reporting	Outputs of Board and Board Committees	Roll out of Connected Care for clinical services	30 Sep 2024
		Cause	Lack of consistency in application of Equality & Quality Impact Assessment (EQIA)		Reporting/benchmarking on population health management	Public Health reports	Development of new Trust clinical strategy using a place-wide approach	31 Dec 2024
		Effect	Continued growth of the health inequality gap		Use of Shared Care Record (SCR)	Shared Care Record (SCR) utilisation reports		
		Effect	Preventative health strategies and clinical services not aligned to community needs		Health and Wellbeing Strategy	Outputs of Health & Wellbeing Board		
		Effect	Some groups continue to receive less care relative to their needs		Appointment of substantive Director of Strategic Programmes Delivery			
		Effect	Some groups continue to have poor experiences, outcomes and health status		Collaborative working with partners	See Risk 2230		
		Effect	Demand for health care (particularly Urgent and Emergency Care) will increase		Health Inequalities Dashboard			
					Healthy Communities Programme	Outputs of Healthy Communities Programme		
					Tobacco dependency programme	Tobacco Dependency Service activity data		
					Homelessness Clinic	Service activity data		
					Health Inequalities Buckinghamshire Group	Outputs of Health Inequalities Leaders Buckinghamshire Group		

7. To deliver our 5 people priorities

Buckinghamshire Healthcare NHS Trust

Reference	Risk Details	Causes & Effects		Inherent Priority	Controls		Actions	
		Type	Title		Summary	Assurance Details Summary	Detail	Variable Target
2297	**Principle Risk - Title**: Failure to deliver our people priorities **Principle Risk - Further Description** : Failure to deliver our five people priorities. **Strategic Priority** : Ensure our workforce are listened to, safe and supported ("A Great Place to Work") **Achieve by 2025** : Our people will feel motivated, able to make a difference and be proud to work at BHT. We will attract and retain talented people to build high performing teams with caring and skilled people. **Risk Appetite**: Minimal (2) **Risk Area**: Strategic **Strategic Objective**: 7. To deliver our 5 people priorities	Cause	Inequal experience for BME colleagues	Very High (4:4=16)	Health & Safety Committee	Outputs of Health & Safety Committee		
		Cause	Insufficient levels of qualified, experienced staff and training opportunities			Annual Reports (incl. Health & Safety, Fire and Security)		
		Cause	Cost of living (nationally)		Trust-wide recruitment and retention plans	Monthly monitoring of vacancy rates through Integrated Performance Report (IPR)		
		Cause	Impact on morale, wellbeing and retention resulting from the pandemic, sustained operational pressures and industrial action			Outputs of Transformation Board		
		Cause	Variations in organisational culture and behaviours including staff reporting bullying and harassment		Bucks Health & Social Care Academy			
		Cause	Workforce not always feeling the organisation is safe including staff reporting incidents of violence and aggression from patients, families and service users		NHS Professionals partnership working	Outputs of contract management meetings		
		Cause	Organisation is not always inclusive and does not always treat people equally		Management of temporary staffing	Weekly workforce update to Executive Management Committee		
		Effect	Retention challenges			Regional System Programme outputs		
		Effect	High levels of temporary staffing			Internal Audit review		
		Effect	Low staff resilience and wellbeing negatively contributing to engagement, productivity, happiness at work and potentially the quality of care provided			Care Group level performance reports		
		Effect	Higher levels of bullying		BOB ICS Senior Leadership Group	Outputs of BOB ICS Senior Leadership Group		
		Effect	Negative impact on staff engagement and productivity		Comprehensive in-house cost of living support package			
		Effect	Reputational damage		Comprehensive in-house Occupational Health and Wellbeing offer			
		Effect	Consequential impact on patients' care		Staff reporting of sickness via Electronic Staff Record (ESR)	Monthly reporting of sickness absence rates through Integrated Performance Report (IPR)		
						Monthly ESR Reporting		
					Trust HR policies			
					Colleague vaccination programme including monitoring of performance against plan			
					Regular Union meetings (JMSC & JCNC)	Outputs of JMSC & JCNC		
					Staff Networks in place			
					Equality, Diversity & Inclusion (ED&I) Committee	Outputs of ED&I Committee		
					Freedom To Speak Up (FTSU) Service	Regular reporting from FTSUG		
					Violence & Aggression; weekly MDT forum	Outputs of forum		
						Colleague Story to Trust Board		
					ICS People Strategy including monitoring of performance against plan			
					Guardian of Safe Working Hours (GSWH) in place	Regular reporting from GSWH		
					Monitoring of colleague experience at work	Annual Staff Survey & Outputs		
						Outputs of Quarterly Pulse Survey		
						Annual reporting; WRES/WDES, Gender Pay Gap		
						Public Sector Equality Duty (PSED) Report (colleagues)		

8. For our buildings and facilities to be great places to work and contribute to the health and wellbeing of staff

Buckinghamshire Healthcare NHS Trust

Reference	Risk Details	Causes & Effects		Inherent Priority	Controls		Actions	
		Type	Title		Summary	Assurance Details Summary	Detail	Variable Target
2298	**Principle Risk - Title**: Failure to provide an adequate estate **Principle Risk - Further Description** : a) Failure to provide adequate buildings and facilities; estates **Strategic Priority** : Ensure our workforce are listened to, safe and supported ("A Great Place to Work") **Achieve by 2025** : - **Risk Appetite**: Cautious (3) **Risk Area**: Strategic **Strategic Objective**: 8. For our buildings and facilities to be great places to work and contribute to the health and wellbeing of staff	Cause	Lack of capital	Very High (4:4=16)	Estates and Net Zero Strategy with monitoring of progress against plan	Annual Net Zero/Carbon Footprint Audit		
		Cause	Aging estate			Outputs of oversight Committees		
		Cause	Significant backlog of estate maintenance		Prioritisation through the use of QFM			
		Effect	Low compliance with regulatory requirements		Monitoring of compliance with legislation/regulation	Annual Compliance with Legislation exercise		
		Effect	Staff leave the organisation due to feeling unsafe at work			Premises Assurance Model (PAM) reporting		
		Effect	Loss of confidence of the public			Estates Returns Information Collection (ERIC) Returns		
						Internal Audit review of Health & Safety Legislation Dashboard		
					Contract meetings with PFI contractors; hard and soft facilities management	Outputs of contract meetings		
					Accommodation Strategy with monitoring of progress against plan	Outputs of Space Committee		
					Prioritisation of capital spend through Capital Management Group and related processes	Outputs of Capital Management Group (CMG)		
					PLACE assessments	Annual reporting to Quality & Clinical Governance Committee		
					Health & Safety Committee	Outputs of Health & Safety Committee		
						Annual Reports (incl. Health & Safety, Fire and Security)		
					Use of Model Health System for benchmarking			
2299	**Principle Risk - Title**: Failure to provide adequate digital facilities **Principle Risk - Further Description** : b) Failure to provide adequate buildings and facilities; digital **Strategic Priority** : Ensure our workforce are listened to, safe and supported **Achieve by 2025** : - **Risk Appetite**: Cautious (3) **Risk Area**: Strategic **Strategic Objective**: 8. For our buildings and facilities to be great places to work and contribute to the health and wellbeing of staff	Cause	Digital immaturity leading to service disruption and preventing wider service transformation	Very High (4:4=16)	Data Security and Protection Toolkit (DSPT) Audit	Annual reporting ahead of submission (June)		
						Internal Audit review of DSPT submission		
		Cause	Lack of detailed intelligence to drive quality improvement initiatives		Extensive IT stabilisation programme and monitoring of progress against plan	Outputs of Digital Health Programme Board		
		Effect	Low compliance with regulatory requirements		EPR Programme and monitoring of progress against plan			
		Effect	Continued reliance on paper based/manual information flows		IT performance monitoring against KPIs	Outputs of local meetings and Corporate Performance Reviews		
		Effect	Lack of data limits potential improvements					
		Effect	Potential clinical harm (e.g. through lack of EPMA)					
		Effect	Lack of digital literacy amongst colleagues					
		Effect	Gaps in infrastructure and unsupported systems					

9. To maximise opportunities for improving, sharing good practice and learning

Reference	Risk Details	Causes & Effects		Inherent Priority	Controls		Actions	
		Type	Title		Summary	Assurance Details Summary	Detail	Variable Target
2300	**Principle Risk - Title**: Failure to learn, share good practice and continuously improve **Principle Risk - Further Description** : Failure to learn, share good practice and continuously improve **Strategic Priority** : Ensure our workforce are listened to, safe and supported ("A Great Place to Work") **Achieve by 2025** : - **Risk Appetite**: Open (4) **Risk Area**: Strategic **Strategic Objective**: 9. To maximise opportunities for improving, sharing good practice and learning	Cause	Gaps in learning following incidents or against best practice	High (3:4=12)	Organisational learning forums.		Explore digitised processes for trend identification and thematic analysis (Datix not yet able to support)	30 Sep 2024
		Cause	Not being an organisation where innovation and new ideas can always thrive and be easily adapted		Implementation of Patient Safety Incident Response Framework (PSIRF) - monitoring of programme plan.	Quarterly updates to Executive Management Committee and Quality & Clinical Governance Committee		
		Effect	Missed opportunities to improve patient outcomes/experience		Monthly Patient Safety Board meetings	Outputs of Patient Safety Board		
		Effect	Non-systematic approach to learning		Analysis of Datix incident reporting	Thematic analysis reports		
		Effect	Inefficiencies, processes not completed in a timely manner, erosion of desire to innovate and improve			Executive dashboards		
		Effect	Inadequate foresight of organisational risk		Research & Innovation Centre			
		Effect	Inability to transform care and clinical models in a way that is fit for the future		Regular Research & Innovation reports			

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

Date: 27 November 2024

Agenda item	EPRR Annual Report on Preparedness
Board Lead	Raghuv Bhasin as Accountable Emergency Officer
Author	Jeremy Meadows, Kaye Wallace
Appendices/Attachments	1. BHT EPRR Board Report September 2024 2. BHT EPRR Statement of Compliance 2024 3. BHT EPRR Core Standards 2024/25 Action Plan 4. Executive slide deck; assurance presentation – available in the Reading Room
Purpose	Assurance
Previously considered	Trust Resilience Committee – September 2024 Executive Management Committee – 29 October 2024 Audit Committee – 14 November 2024

Executive summary

Annually, the Trust is required to complete a self-assurance process and goes through a check-and-challenge process with BOB ICB to ensure compliance with the NHS EPRR 'Core Standards', which reflect NHS statutory duties under the Civil Contingencies Act 2004.

The Trust's rating for 2024-25 is substantially compliant with the Core Standards.

The attached documentation and subsequent evidence was scrutinised and approved by the Associate Director of Emergency Planning for BOB ICB and the Trust Emergency Planning Team.

The EPRR Annual report and results of the NHSE EPRR Core Standards Annual Assurance process for 2024/25 have also been approved at the Trust Resilience Committee held on 2nd October 2024.

The assurance process requires the approved documentation and confirmation of compliance status to be noted by the Trust's Executive Team and through the Public Board process.

Both the Executive Management Committee and Audit Committee took assurance from this report, recognising the position of substantial compliance. Where the Trust was not compliant, related to the Data Security & Protection Toolkit (DSPT), actions were in place to address this by January 2025.

Decision	The Committee is requested to review and be assured of BHT's competencies for submission to Trust Board.

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	No direct impact from this assurance process, full compliance with the assurance ensures BHT is working to the highest standard
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	No associated risks with this assurance process
Financial	No financial impact
Compliance Select an item. Select CQC standard from list.	Compliance with NHS England and NHS Improvement EPRR Annual Assurance process to fulfil Civil Contingency Act 2004
Partnership: consultation / communication	All required consultation with internal stakeholders and BOB ICS to achieve approval
Equality	No direct impact from this assurance process, full compliance with the assurance ensures BHT is working to correct standards
Quality Impact Assessment [QIA] completion required?	No

Buckinghamshire Healthcare NHS Trust

Emergency Preparedness, Resilience and Response (EPRR) Board report October 2024

Background

The Trust has duties and responsibilities in Emergency Preparedness, Resilience and Response. This report provides an update on these requirements and activities in evidence of their completion and competence.

The Civil Contingencies Act (CCA) 2004 is a statutory document detailing the UK's response to civil emergencies. The Act sets out two categories of responders. Category 1 responders have a statutory requirement to fulfil the full remit of the Act, whilst Category 2 responders have a supporting obligation.

As an acute health care provider BHT, is a designated Category 1 responder with a duty to:

- Risk Assess (prioritisation and mitigation)
- Ensure plans are in place (covering the organisation and linking with multi-agency partners)
- Warn, inform, and advise (for patients and the public)
- Co-operate in resilience planning and preparations (working with the Thames Valley Local Resilience Forum)
- Engage in Business Continuity Management (within the organisation and linking with multi-agency partners)
- Sharing information (with partner organisations and the Thames Valley Local Resilience Forum)

Assurance

Health organisations evidence their compliance with the CCA via the 'NHS EPRR Core Standards' which are created by NHS England as a set of criteria to follow and audit against. This report covers our compliance with governance, assurance, and systems working in more detailed sections below.

For 2024/2025: **The Trust expects to be Substantially Compliant with the standards.**

Governance

To ensure full compliance as a Category 1 responder, the Trust has several key items in place:

- A designated Accountable Emergency Officer (AEO), a role fulfilled by the Chief Operating Officer
- The AEO chairs the Trust Resilience Committee. This committee meets every two months and includes attendance from across all the Care Groups including senior managers and clinicians
- The Trust employs a full time Emergency Planning Lead and Emergency Planning Support Officer
- Overseen by, and reporting to, the Resilience Committee are the key workstreams. These each have a project group for each specific area in which BHT is required to have plans. These include:
  - Command and Control,
  - Major/Mass Casualties,
  - Contaminated casualties (Hazmat/CBRN),
  - Severe Weather,
  - Mass Fatalities,
  - Pandemic Influenza,
  - Evacuation,
  - Lockdown and Security,
  - Business Continuity

The Trust runs a raft of training for key staff ranging from Strategic and Tactical Leadership training for all on call Gold and Silver commanders, allied training to key staff groups and specific training for example to clinical and reception staff within the emergency department. Much of the training is mandatory for key staff groups and includes a basic EPRR e-learning module for **all** staff.

Current compliance for EPRR training as a Trust (as of 06/08/2024):

EPRR eLearning module for all staff – 89.86% of colleagues are deemed as compliant and having completed the module for 2024.

On-call Strategic and Tactical Leadership Training – 58% of colleagues who are required to undertake training are deemed as fully compliant for 2024. Further dates are planned/scheduled for the remainder of the year.

External/Internal Assurance:

To comply with the CCA 2004 the Trust is also required to host tabletop exercises, and a live exercise every three years. Periods in which a real incident is managed also suffices for the standard.

Regular table-top exercises allow for scenarios and plans to be tested and ensures adequate opportunities for all Gold and Silver Commanders and other key staff to attend.

Table-top exercises run or BHT participation in 2023/2024, since last report, include:

1) Management of Infectious Diseases Table top Exercise
2) Bucks Fire & Rescue Hospital Fire Drill Exercise (Multi-Agency Partner working)
3) Regional Exercise Holler (Major Incident communication cascade)
4) X4 Trust Generator Black Start test Exercises (Business Continuity Plans)
5) Regional Trauma Network Major Incident Table Top exercise (Major/Mass Casualties)
6) Regional Exercise Toucan (Major Incident communication cascade)
7) HazMat/CBRN Semi-Live Exercise
8) Cyber Security Table top Exercise (Business Continuity Plans)

Compliance against live exercise requirements can be achieved in the event of any live incidents' where plans have been invoked. The Trust has experienced Business Continuity issues in 2023/2024, including:

- Cath Lab outage requiring divert to other Trusts *(Sept 2023)*
- Critical Incident declared due to capacity and flow as a result of IT network issues *(Sept 2023)*
- Bleep system outage *(Nov 2023)*
- Evacuation of Cancer Care and Haematology Unit building due to electrical Fire *(Nov 2023)*
- Flood/Burst pipe Incident affecting critical clinical area *(Jan 2024)*
- Maternity Unit closure due to capacity Incident *(Feb 2024)*
- Loss of Wycombe Hospital multi-storey Car park *(Feb 2024)*
- X2 Loss of back-up generator cabling to Neonatal and Maternity building *(Apr 2024, Sept 2024)*
- Contamination of and loss of hot water at Wycombe Hospital requiring medium to long term mitigations *(Apr 2024)*
- Major Incident phoneline outage in Switchboard *(May 2024)*
- Loss of IT network as a result of water ingress to the IT Comms room *(May 2024)*
- X4 Significant heat events *(Jun 2024, Jul 2024, Aug 2024, Aug 2024)*
- External Synnovis system cyber-attack impacting on Pathology services *(Jun 2024)*
- Flood Incidents affecting Acute and Community sites *(Jul 2024, Sept 2024)*

- Ventilation issues affecting Theatres Anaesthetics room *(Jul 2024)*
- Global IT system outage affecting Primary Care EMIS systems impacting on ED attendances *(Jul 2024)*
- Security Incident following stabbing casualties presenting to CSRU at Wycombe and ED at Stoke Mandeville along with aggressive crowds *(Jul 2024)*
- Amber O Type Blood shortage Alert issued by NHS Blood and Transplant *(Jul 2024)*
- Telephony outage at Community Hospitals *(Aug 2024)*
- Telephony outage at Wycombe Hospital affecting single key critical area *(Aug 2024)*
- IT CareFlow/EPR system outage following routine planned upgrade *(Aug 2024)*
- ICE system outage following routine planned upgrade *Oct 2024)*

The above required the Incident Response policy and business continuity plans to also be invoked.

The Trust Fire Safety Officer also runs regular 'live' fire evacuation drills within the clinical areas and reports back regularly on learnings to the Trusts Resilience Committee.

In addition to the above detailed exercises undertaken and business continuity incidents, the Trust has also experienced:

- A suspected MERS case (*Feb 2024)* and two confirmed Measles cases *(Jul 2024)* where the Trusts Management of Infectious Diseases policies were enacted and debriefs from incidents were held to reflect of any learnings and updates to plans required.
- The impacts of and planning for four separate periods of Junior Doctors Industrial Action and two periods of Consultants and Junior Doctors Industrial Action covering a total of 25 days. Full Command & Control and Incident Management Teams were stood up for each of these periods to allow for co-ordinated planning and reporting on behalf of the Trust.
- Preparation for potential disruption as a result of a period of national Civil unrest.

Risk Assessments

To be compliant with the CCA 2004 the Trust is required to undertake risk assessments. This is documented on the Trust EPRR risk register and forms a standing agenda item at the Resilience Committee and each of the workstream groups. The EPRR Risks are also formally reviewed monthly by the Trust Governance Manager at the Risk and Compliance Governance meetings which the Trusts EP Lead attends. Any high-level risks are included on the Corporate Risk Register.

Whole systems

The Trust cooperates in resilience with the following in place:

- Attendance at the Local Resilience Forum (LRF) County Resilience Group chaired by the Local Authority. This group has representation from all emergency services, health, local authorities, utilities companies and voluntary sector. It meets on a regular basis to share information, review regional risks, and required actions and mitigations, and shares learning from incidents and training. It encourages joint working between the whole system partners.

- Attendance at the Local Health Resilience Partnership (LHRP) Executive Group: This is a strategic group with representation from all health partners including NHS England, UK Health Security Agency (UKHSA), Integrated Care Board (ICB) and Ambulance Service. The Acute providers are represented by their AEO. It provides a strategic plan for Health against the core standards and required actions, and links into the National NHS England Resilience Team.

- Attendance at the LHRP Business Management Group: This is the tactical (working) group at which the provider and ICB EP Leads/Officers attend. The role of the group is to ensure completion of the Strategic objectives and to raise any issues or risks to the LHRP.

NHSE EPRR Annual Assurance process:

NHSE publishes NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met. Trusts are required to provide formal assurance to NHS England on a yearly basis, which takes the form of a compliance matrix against which The Trust assesses itself. This RAG rating once approved at the Trust Resilience Committee is signed off by the AEO and is submitted to the ICB AEO and Resilience lead. The Trust is required to attend a 'confirm and challenge' meeting with the BOB ICB Emergency Planning team where the details of the ratings and compliance is discussed and agreed. Formal submission of this rating along with an overall compliance rating plus an action plan for any amber or red rated areas is submitted via the ICB to NHS England.

2024/2025 Assurance

NHSE have published the EPRR Core Standards for 2024/2025. On initial review, there are **not expected** to be any issues relating to the Core Standard requirements for this period for the Trust. Submission of the Annual Assurance Process to NHSE will be completed within the timescales requested following approval from the Trust AEO, and after completion of the confirm and challenge meeting with the BOB ICB.

The Trust expects to be Substantially Compliant with the standards.

NHS England South EPRR Assurance compliance ratings - To support a standardised approach to assessing an organisation's overall preparedness rating NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

Conclusion

Overall, the Trust is in a good position in terms of its EPRR obligations. It has been noted that as a Trust we do have a high level of 'buy in' and co-operation from senior managers, Executives and clinicians in terms of planning, training and exercising.

Buckinghamshire Healthcare NHS Trust updated EPRR Statement of Compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS Core Standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for **2024/25**, Buckinghamshire Healthcare NHS Trust was required to assess itself against these core standards. The outcome of this self-assessment in October 2024 showed that against 62 of the core standards which are applicable to the organisation, Buckinghamshire Healthcare NHS Trust:

- was fully compliant with 61 of these core standards; and
- would become fully compliant with 1 of these core standards when new Statement of Compliance for Data Protection and Security Toolkit is achieved.

Following a Confirm and Challenge meeting with BOB ICB, the overall rating for Buckinghamshire Healthcare NHS Trust is: Substantially Compliant

Raghuv Bhasin
Chief Operating Officer (Accountable Emergency Officer)
Buckinghamshire Healthcare NHS Trust
16 October 2024

NHS England South East EPRR Assurance Compliance Ratings:

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England and Improvement have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

EPRR Action Plan: Buckinghamshire Healthcare NHS Trust
Version: 1.0
October 2024

Buckinghamshire Healthcare NHS Trust has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2024/2025. This improvement plan is the result of the self-assessment exercise and sets out the actions that are required to ensure full compliance with the core standards.

This is a live document and it will be updated as actions are completed.

Core standard	Current self-assessed level of compliance (RAG rating)	Remaining actions required to be fully compliant	Action completed	Lead name	Further comments
Core Standard 49 – Business Continuity – Data Protection and Security Toolkit Statement of Compliance	Amber = Partially compliant	An improvement plan for BHT to achieve Statement of Compliance for DSP Toolkit has been developed to achieve compliance. The status of the toolkit submission has been updated to: 2024 Approaching Standard (Plan Agreed).	As of June 2024 Trust was 97% compliant. Trust Digital team working on remaining outstanding 10 items for compliance. Trust declared status as 'Approaching Standard' and a plan is in place to address remaining 3% and has been agreed by NHSE Trust, but it is likely to take more than 6 months to close out the last 3%.	Information Governance Manager & Chief Information Officer	

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Report from Chair of Strategic People Committee (SPC)
Date of Committee 11 November 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 14 October 2024	**Approved**	None	Refer to Audit Committee for noting	n/a
Actions & Matters Arising	<u>Sickness absence by reason</u> Summary of data between Aug '23-Aug '24, broken down by sickness absence reason and Care/Corporate Group and key actions in place to support colleagues <u>Correlation of absences with violence and aggression incidences</u> Summary of data from Aug '23 – August '24 including actions in place to address potentially related sickness absence	**Partially assured**, noting the following: - Poor uptake of flu (28.5%) and covid (6.4%) vaccinations - Challenging to correlate data between sickness and V&A due to methods of capturing/reporting	Ongoing efforts to understand colleagues' reluctance for vaccines	n/a	Request to proactively support the vaccination campaign
Chief People Officer (CPO) Report	Update on key people developments since the previous Committee meeting (October 2024)	**Assured**, noting the staff survey so far response rate and improved position compared to last year	None	n/a	n/a
Estates Update	Quarterly report on the work of the Health & Safety Committee during Q2 2024/25 Comprehensive update on the provision and use of lone worker devices, including body worn cameras, and actions taken to address recent issues with swipe access points	**Assured**, noting the revision of local policy to ensure such devices treated similarly to IT/telephone assets upon colleagues leaving the Trust	Use of SPC charts for data related to violence and aggression to support Committee oversight	n/a	To note the planned trial of body worn cameras underway within the Emergency Department (ED)

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Freedom to Speak Up (FTSU) Report	Quarterly report summarising activity within the FTSU service across Q2 2024/25 including key themes and mitigations in place to cover maternity leave within the service	**Assured**	None	Confirm ethnicity profile for FTSU Champion cohort, noting data within the annual report	n/a
Guardian of Safe Working Hours Report	Quarterly report summarising exception reporting activity within resident doctors across Q2 2024/25 Verbal update on processes in place to address Immediate Safety Concerns (ISCs) when raised	**Assured,** noting collaborative working to address ISCs	Triangulation of ISCs with clinical incidents reported via Datix	n/a	n/a
Employee Relations Report	Overview of employee relations cases opened and closed during Q1-2 2024/25 Comprehensive update on procurement of new IT management system and investigation/panel training conducted for colleagues	**Assured,** noting the following: - The complexity of cases - Model Hospital data concluding the number of Trust cases was below average when compared to peers - Overview of the wellbeing support available for colleagues, recognising cases can extend over a long period of time - The role of Staffside and unions more broadly and how these are engaged with any policy change	None	n/a	n/a
Sexual Safety at Work	Update on the sexual safety programme including progress toward full White Ribbon accreditation	**Assured**	Internal audit to conduct a review against the revised Worker Protection Act 2023 planned for 2025/26 (advisory only)	n/a	To note revised legislation in place from October 2024 and Trust compliance

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
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: - Progress so far against targets - Planning underway for the 'Health on the High Street Unit' within High Wycombe - Activities undertaken as part of 'Anti-Bullying' week - The launch of the 'See Me First' campaign - The need for colleagues to take personal accountability for reducing B&H and support a culture of kindness and civility, including the creation of safe spaces for colleagues to address inappropriate behaviours - The importance of managers role modelling good behaviours	None	n/a	n/a
Risk Register	Review of 'People' risks within divisional and corporate risk registers Overview of current external reviews/audits underway and planned	**Noted**, including the following: - Communication to resident doctors regarding administrative processes to support the agreed pay award - Organisational responsibility related to the payment of the award - De-escalation of the following risks from the Corporate Risk Register: a) Nursing workforce (51) b) Industrial action (189)	None	n/a	To note discussions when considering the Organisational Risk Report

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 progress with actions to address any performance issues	**Noted**	None	n/a	n/a To note when considering full IPR
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**, noting the following: - Key, proactive, developments within education - Physician Associates (PAs), recognising this as an important and valued role with strong organisational support alongside a challenging national context - Targeted support for PA wellbeing - GMC regulation of PAs due to commence from December 2024 - Potential future changes to the registration of Clinical Nurse Specialists (CNS) by the NMC - Review of study leave/training requirements more broadly including clear role profiles for statutory/mandatory training, recognising national work underway in this area	Correlation between those undertaking and completing preceptorship programmes Proactive comms to support the sharing of good news stories related to the Physician Associates role	n/a	n/a
General Medical Council (GMC) National Training Survey (NTS)	Overview of results following the 2023 annual survey including national and local themes and plans for sustainable change Comprehensive update on actions undertaken within Cardiology related to feedback in this area	**Assured**, noting the impact on Speaking Up culture within Cardiology following recent interventions	None	n/a	n/a

Item	Summary of Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
People Strategy	Draft interim strategy for 2024-2026, reflecting the national and local context, suggested priorities with drivers for these and implementation plans with key risks to delivery	**Noted**, recognising the: - Breadth of consultation - Place Strategy due for publication in 2025 with an accompanying workforce plan	Committee comments to be shared with Chief People Officer by 14 November to be incorporated into revised version Plan for re-presentation to Committee for approval in January	n/a	n/a
Committee Terms of Reference	Annual review of terms of reference for Committee consideration	**Approved**, recognising provision in place for deputies to cover for members	None	n/a	To approve
Items referred from Quality & Clinical Governance Committee	a) Governance Review of Safeguarding Policies and Practices Confirmation of Committee oversight in this area b) Maternity & Neonatal SCORE Survey Potential for use of SCORE survey elsewhere within the Trust	**Assured** noting the following: a) Update on amendments to relevant policies and clarification of Committee oversight of sexual safety legislation and violence and aggression more broadly b) Director of Midwifery to liaise with Director for Education, Inclusion & Organisational Learning recognising the variety of available tools in place and the benefits and costs of each of these	None	n/a	n/a

Emerging Risks Identified

- Sickness absence across winter months; recognising significant increase in absence related to coughs, colds and flu over recent weeks and low uptake of vaccinations.

OUTSTANDING CARE
HEALTHY COMMUNITIES
AND A GREAT PLACE TO WORK

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2024

Agenda item	Committee Terms of Reference
Board Lead	Committee Chair, Tom Roche
Type name of Author	Joanna James, Head of Corporate Governance
Attachments	SPC Committee Terms of Reference DRAFT November 2024
Purpose	Approval
Previously considered	SPC 14 October 2024 SPC 11 November 2024

Executive Summary

The attached document contains the draft terms of reference for the Strategic People Committee including the requirement for these to be reviewed on an annual basis in line with best practice. The Committee last considered and approved these in May 2023. A revised version was considered by the Committee in May 2024 and comments on these have been included in the attached version.

The terms of reference have been re-written to:

- Satisfy the requirement for an annual review.
- Align the format with that of other Board Committees.
- Incorporate recommendations from an Internal Audit review of the revised Trust Governance Framework.
- Incorporate feedback following the Committee effectiveness self-assessment review earlier in the year.

In view of this, changes have not been tracked. However, there have been no material changes to the responsibilities or workings of the Committee.

The Strategic People Committee approved these terms of reference on 11 November 2024, noting the provision for a deputy to attend in place of a non-executive or executive committee member.

Decision	The Board is requested to review and approve the terms of reference.

Relevant strategic priority

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

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	Key matters related to patient safety are delegated by the Board to the Quality & Clinical Governance Committee for consideration.
Risk: link to Board Assurance Framework (BAF)/Risk Register	A key duty of the Committee is oversight of people related risks and the terms of reference and Committee workplan sets out a requirement for regular of these.
Financial	Key Trust financial matters are delegated by the Board to the Finance & Business Performance Committee for consideration.

Compliance Select an item. **Good Governance**	A strong link has been established between good governance and patient outcomes and this is recognised widely within research as well as by the CQC well-led domain.
Partnership: consultation / communication	The terms of reference should be considered by the Committee collectively prior to amendment and/or approval. Membership and attendance is listed to ensure appropriate representation at Committee meetings. Where appropriate, the terms of reference consider the work of the Committee within the context of the local system.
Equality	The terms of reference set out the key functions of the Committee in supporting the Board in the achievement of the Trust strategic objectives including a reduction in health inequalities. The Committee also take responsibility for oversight of matters related to Equality, Diversity & Inclusion (ED&I) related to Trust colleagues.
Quality Impact Assessment [QIA] completion required?	No

Strategic People Committee

Terms of Reference

1. Purpose

The overall purpose of the Strategic People Committee is to assist the Board in the performance of their duties through developing and monitoring the implementation of workforce related strategy. This includes:

- Oversight of all aspects of workforce and organisational development arrangements of the Trust including workforce planning as it relates to both the Trust and in the context of the Buckinghamshire, Oxfordshire and Berkshire (BOB) Integrated Care System (ICS).
- Providing a forum to set the strategic direction concerning all matters related to workforce, monitoring delivery against such strategy and providing assurance to the Board to this effect.
- Oversight of Trust workforce performance and delivery against the people programmes of the Trust corporate objectives. When required, the Committee will focus on specific issues where Trust performance is deteriorating or where there are areas of concern.

2. Constitution

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

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

3. Membership

The Committee shall be appointed by the Board from amongst the non-executive and executive directors of the Trust and shall include (as a minimum):

- Two independent non-executive directors with the personal and professional characteristics necessary to be effective (this may include associate non-executive directors); at least one of whom (normally the Chair of the Committee) should be a member of the Audit Committee.
- Chief People Officer.

Committee members may appoint a deputy to represent them at a Committee meeting; both Executive and Non-Executive Directors.

A Non-Executive Director (NED) shall chair the Committee. In the event the Committee Chair is unable to attend they should make alternative arrangements for a NED member to act as Committee Chair.

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

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

The following Executive Directors will be expected to attend each meeting or send a deputy:

- Chief Medical Officer
- Chief Nurse
- Chief Operating Officer
- Chief Estates & Facilities Officer

Open invitations will be maintained for, and papers sent to:

- Director of Education & OD
- Director of Workforce & Wellbeing
- Freedom to Speak Up Guardian
- Trust Chair
- Head of Corporate Governance
- Board Affiliate(s)

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

- Director for Medical Education
- Assistant Director of HR and HR Business Partners
- Guardian of Safe Working Hours

4. Quorum

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

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

5. Meetings

The Committee shall meet at least 6 times during the year (usually bi-monthly) and at such other times as the Chair of the Committee shall require. Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chair of the Committee

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

The Committee shall follow an annual work plan reviewed by the members in advance of each financial year.

The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

In addition to the formal meetings, Committee members should consider one session of training and development each year.

6. Authority

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

The Strategic People Committee is an advisory body with no executive powers; it is not the duty of the Strategic People Committee to carry out any function that properly belongs to the Board of Directors or the Executive Management Committee. The Committee is, however, authorised by the Board to investigate any activity within its duties as set out below and to seek any information it requires from any employee, who are directed to co-operate with any request made by the Committee.

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

The Committee has the authority to seek any information it requires from any member of staff and request any member of staff to attend its meetings. All members of staff are directed to comply with such requests.

7. Duties

The Committee shall be responsible for the following duties:

I. Governance

The Committee shall provide assurance to the Board on the effectives of structures, policies, systems and processes specifically in those areas related to workforce.

The Committee will receive regular reports from the Freedom to Speak Up Guardian and Guardian of Safe Working Hours. These will have been considered by the Executive Management Committee (EMC) and provided to the Committee with a summary of any discussion. The Executive Management Committee shall receive regular reports from relevant workforce groups with escalation of workforce matters to the Committee as appropriate.

II. Compliance

The Committee shall review reports regarding compliance with external assessment and/or reporting related to workforce matters.

III. Performance

The Committee shall gain assurance on the full range of people performance metrics and delivery of annual breakthrough objectives, requesting in-depth examination of key people issues were required. Alongside this, the Committee shall consider associated risks to the delivery of Trust Objectives. The following will be used to support this function:

- Integrated Performance Report (IPR).
- Breakthrough objectives; performance reporting.
- People Directorate Risk Register.
- Corporate Risk Register (CRR).
- Board Assurance Framework (BAF).
- Minutes and/or reports from relevant stakeholder groups.
- Any other information deemed necessary and requested by the Committee.

Specific activities for the Committee within key areas are as follows:

a) Operational performance

- Detailed scrutiny of monthly, quarterly and year-to-date workforce performance and organisational development information, determining the level of assurance the Board should receive from this.
- Monitoring of staffing levels to ensure there are the right number of staff with the right skills and talent working at the Trust through recruitment and retention.
- Monitoring the productivity of the workforce.
- Monitoring delivery of annual breakthrough objectives.
- Maintain oversight of people related service delivery agreements and key contractual arrangements (where appropriate).

b) Staff engagement

- Across medical and non-medical groups, monitoring of staff engagement levels and supporting activities including talent management and succession planning and leadership and management development.

c) Wellbeing

- Monitoring and providing assurance on the delivery of Health and Wellbeing Services provided by the Trust.

d) Speaking up

- Reviewing the application of the Trust's Raising Concerns Policy and Procedure, including the work of the Freedom To Speak Up Guardian (FTSUG) and the Guardian of Safe Working Hours (GSWH).
- Scrutiny of reports and actions from the FTSUG and GSWH.

e) Education

- Critically appraising training and education across the organisation.
- Reviewing the effectiveness of training programmes delivered both internally and externally by partner and Higher Education Institutes, making recommendations for action.
- Monitoring the provision of medical education for doctors in training.

f) Health & Safety

- Oversight of health and safety matters and the provision of assurance of such to the Board, alongside the escalation of any areas of concern.
- Oversight of risk related to health and safety.

The Committee may choose to utilise deep dives to support the above for key people projects or areas of specific interest/concern.

IV. People Strategy

The Committee shall oversee the delivery of the People Strategy as well as the development and approval of any strategy related to workforce, workforce planning and organisational development. The Committee shall seek assurance that measures for success are implemented within appropriate timescales.

The Committee shall monitor, advise on and recommend to Board matters relating to the Trust's people and organisational development strategy, policies and culture as appropriate.

Alongside the above, the Committee shall maintain an awareness of developments related to workforce within the local place and system including opportunities for collaborative working and related risks.

V. Annual Review

The Committee shall set annual objectives in line with the purpose and duties of the Committee. A report on progress against these and the terms of reference shall be submitted to the Board at year end.

The Committee shall also undertake any other responsibilities as delegated by the Board. Those processes used by the Committee to gain assurance will be reviewed by the Audit Committee to determine their effectiveness. Where appropriate, the Committee will escalate areas of concern to the Board.

8. Reporting

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

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

9. Review

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

The effectiveness of the Committee will be monitored by the Audit Committee through receipt of the Committee's minutes and by the Board through receipts of such written or verbal reports that the Chair of the Committee is required to provide.

The committee shall carry out an annual review of these terms of reference, putting forward any suggested changes to the Trust Board. The Board will review and approve the terms of reference annually.

10. Support

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

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

Appendix 1

Annual Objectives

The Committee objectives for the financial year 2024/2025 are as follows, noting the assurance function of the Committee:

a) Performance
   i. Oversight of progress against Trust breakthrough objectives for 2024/25 through regular reporting:
      - ***Improve everyone's experience of working at BHT*** *by taking a zero tolerance approach to bullying and becoming best in class in the staff survey within 2 years.*
   ii. Oversight of and support for the delivery of enabling Trust strategies.
   iii. Oversight of key people risks through regular review.
b) Other functions
   i. Oversight of activities and outputs by the Freedom to Speak Up Guardian and Guardian of Safe Working Hours.
   ii. Oversight of compliance with Health & Safety Legislation.

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

Document Control

Version	Date	Author	Comments
1.0	18/1/2017	E Hollman	Developed for new Committee, approved by Committee and for Board ratification
2.0	4/1/2018	B O'Kelly	Updated to take account of system changes
3.0	28/5/2019	B O'Kelly	Updated to take account of changes to committee arrangements
4.0	29/06/2022	J James	Periodic review including change of Committee name
5.0	31/05/2023	J James	Periodic review
6.0	13/05/2024	J James	Periodic review
7.0	14/10/2024	J James	Periodic review incorporating feedback from internal audit of revised Trust Governance & Performance Framework