Board Meeting Papers Consent Agenda (Pack B)

Meeting Date:

13th June 2023

	CONSENT AGENDA ITEMS 13 – 21 inclusive (Pack B Papers)	Presenter	Time
13	**Consent Agenda Cover Report** To inform the Board of the items covered under this section of the agenda and arrangements for their approval.	Donna Cairns Paper	5 mins
14	**Equality, Diversity & Inclusion Policy** For formal ratification by Board, as the designated approval route for this policy, following approval by the Executive Committee.	Sheridan Flavin Paper	
15	**Risk Management Policy** For formal ratification by Board, as the designated approval route for this policy, following consultation with the Audit, Assurance & Risk Committee, and approval by the Executive Committee.	Mary Lewis Paper	
16	**Quarterly Summary Report from the Audit, Assurance & Risk Committee** To receive the quarterly report for assurance on key discussions, actions and decisions from recent meetings and to approve the revised Title and Terms of Reference for the Committee. **16.1** – AARC Terms of Reference	Lorna Harrison Paper	
17	**Quarterly Summary Report from the People Committee** To receive the quarterly report for assurance on key discussions, actions and decisions from recent meetings and to approve Terms of Reference for the Committee. **17.1** – People Committee Terms of Reference	Anil Patil Paper	
18	**Quarterly Summary Report from the Finance, Estates, Environment & Digital Committee** To receive the quarterly report for assurance on key discussions, actions and decisions from recent meetings.	Simon MacSorley Paper	
19	**Quarterly Summary Report from the Performance Committee** To receive an update report for assurance on key discussions, actions and decisions from recent meetings.	Barbara Brown Paper	
20	**Quarterly Summary Report from the Quality & Outcomes Committee** To receive the quarterly report for assurance on key discussions, actions and decisions from recent meetings.	Paul May Paper	
21	**Quarterly Professional Council Summary** To present to the Board with a summary of the Quarter 3 activities and decisions from meetings of the Professional Council	Mary Lewis/ Kathryn Bateman Paper	

Board Cover Report

Date	13th June 2023	**Agenda item**	13 - Consent Agenda Covering Items 14 - 21
Title	Consent Agenda Cover Paper		
Author	Donna Cairns, Head of Corporate Governance		
Presented by	Amanda Cheesley	**Version**	1
For	Approval/decision ☒ Debate ☐ Assurance ☒ Information ☒		

Purpose of the report

To set out the items on the Consent Agenda including:

- The recommendations for the Board to approve or ratify from the enclosed reports
- To present summary reports detailed within the Consent Agenda, received for information and/or assurance that are also attached.

Why is this report coming to the Board

E.g. is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

To ensure the effective use of the Board's time, matters which require Board's ratification or updates for Board to note have been brought together under the Consent Agenda. Any matters which do require discussion in reaching a decision will be listed separately on the agenda for consideration.

Related Risk No. (If applicable)	N/A

How has this report been developed

Including the lead director, those involved in preparing the report and the sources of information relied on

The papers brought under this item for ratification/approval and the papers to note have been agreed with the Chair and the Chief Executive and provided electronically in advance for comment or question to Members of the Board.

What is the process the report has been through internally

i.e. which teams or groups have reviewed the report or the information that informs it

The individual papers have been provided electronically in advance for comment or query to Members of the Board.

If there are any matters Board members wish to query or comment on, please send your comments to the Chair in advance of the meeting. If there are any matters of escalation these will be outlined and brought to a future meeting for further consideration.

Summary and Key Issues Highlighted by these teams, including mitigations

Please highlight in summary the key messages from this report, including matters of escalation from Committees or other Teams, significant issues, risks and actions to address them

Not Applicable

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

The Board is asked to approve the following recommendations from each report:

14. Equality, Diversity & Inclusion Policy

The Board is asked to ratify the policy and accompanying documents that have been approved by the Executive Committee

15. Risk Management Policy

The Board is asked to ratify of the Risk Management Policy and Procedure document"

16. Quarterly Summary Report from the Audit, Assurance & Risk Committee

Board is asked:

- To approve the Terms of Reference for the Committee to add Risk to the title
- To note the updates provided from the meeting on 8th February and 30th May 2023.

17. Quarterly Summary Report from the People Committee

Board is asked:

- To approve the Terms of Reference for the Committee
- To note the following:.
    - The Committee will continue to seek assurance that there are sufficient resources against delivery and achievement of plans.
    - The Committee are cognisant of any risks associated with the delivery of programmes and plans

The Board is asked to note the following papers provided for assurance:

18. Quarterly Summary Report from the Finance, Estates, Environment & Digital Committee

For the Board to note the written record of assurance following the assurance of the FEED Committee provided verbally at the Board meeting on 11th April 2023 when the budget for 2023/24 was approved.

19. Quarterly Summary Report from the Performance Committee

For the Board to note the written record of assurance following recent meetings of the Performance Committee.

20. Quarterly Summary Report from the Quality & Outcomes Committee

Board is asked:

- To note the contents of this report.
- To receive future progress updates on quality at next Board.
- To note that the Committee will receive an update regarding Children In Care at their meeting in June 2023

21. Quarterly Professional Council Summary

The Board is asked to note the activities of Professional Council, there are no decisions required or options for consideration.

Board Report

Date	13th June 2023	**Agenda item**	Consent Agenda Item 14
Title	Equality, Diversity and Inclusion (EDI) Policy		
Author	Dan J Whalley – Interim EDI Consultant		
Presented by	Dan J Whalley – Interim EDI Consultant and Sheridan Flavin, interim Chief People Officer	**Version**	
For	Approval/decision ☒ Debate ☐ Assurance ☐ Information ☐		

Purpose of the report

To provide an updated EDI Policy and Equality and Health Inequality Impact Assessment (EHIIA) toolkit for approval.

These documents provide and update and effective way for Sirona to continue demonstrating its compliance with the Equality Act 2010

Why is this report coming to the Board

E.g. is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

The EDI policy and EHIIA toolkit are key documents setting out effective processes for Sirona to meet its statutory responsibilities under the Equality Act 2010.

The policy is reserved to Board for ratification.

Related Risk No. (If applicable)	

How has this report been developed

Including the lead director, those involved in preparing the report and the sources of information relied on

The EDI policy has been updated to ensure it meets the current statutory requirements under the Equality Act 2010, utilising EHRC guidance and taking good practice examples from other health service providers.

The EHIIA toolkit has been developed, again utilising EHRC guidance to support compliance with the Equality Act 2010, as well as utilising the BNSSG-wide toolkit the ICB and partners developed.

The EDI policy and EHIIA toolkit has had input from the Quality, Community Development and EDI teams in Sirona, as well as being circulated and discussed with staff network leads to gain their insight, with appropriate amendments being taken into consideration.

What is the process the report has been through internally

i.e. which teams or groups have reviewed the report or the information that informs it

The policy and toolkit were presented to and approved by the Executive Committee on May 2023, subject to the following amendment: The EHIIA Toolkit has been updated to link and refer effectively to the establishment of the Impact Assessment Panel and associated policy that outlines the governance processes.

Summary and Key Issues Highlighted by these teams, including mitigations

Please highlight in summary the key messages from this report, including matters of escalation from Committees or other Teams, significant issues, risks and actions to address them

Adoption of these documents will improve the organisation's ability to demonstrate compliance with the Equality Act 2010.

In terms of risk, implementation of a new toolkit (EHIIA) always creates demand for subject matter expert (SME) support for staff to fully understand how to use it effectively. Current capacity of the Community Development & EDI resources is limited. Community Development and EDI are working together to mitigate this risk as much as practicable.

The EDI Policy and the EHIIA Template are attached as Appendices 1 and 2. The Toolkit contains further guidance and resources to support staff completing the impact assessment. If Board members wish to see the guidance, please contact the corporate governance team or Dan Whalley. Once the policy is approved all the resources will be available on Workplace.

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

The Board is asked to ratify the policy and accompanying documents that have been approved by the Executive Committee

Equality & Diversity Policy

Version:	4
Name of originator/author:	Organisational Development Team Communities Team
Name of executive lead:	Sheridan Flavin, Interim Chief People Officer
Date ratified:	June 2023
Review date:	June 2025

Applicable to

This policy sets out the Sirona commitment to equality, diversity and inclusion. This policy applies to:

- All employees, bank workers, contract and casual workers, volunteers, students, learners on placement and apprentices for Sirona.
- All patients, their representatives, and families across the Bristol, North Somerset and South Gloucestershire (BNSSG) communities in which we provide services and support.
- All services, our partners, sub-contractors and suppliers
- All purchasing and procurement

This document can only be considered valid when viewed via Sirona's intranet site. If this document is printed into hard copy or saved to another location you must check that the version number on your copy matches that of the one on-line. The document applies equally to full and part time employees, bank and agency staff.

Executive Summary

We commit to placing equality and inclusion at the centre of our organisation. We value diversity of experience and perspective and will ensure that we set the highest standards for our communities, our workforce, our students, volunteers and any visitors to any of our services.

Implementation

At Sirona, we are committed to providing an environment free from discrimination, bullying, harassment or victimisation, where everyone feels welcomes, supported, safe and valued. We will:

- Ensure that the services we provide do not discriminate against any groups by conducting Equality Analysis, utilsiing our Equality and Health Inequalities Impact Assessment (EHIIA) toolkit (Attached to the policy);
- Provide culturally sensitive services which are relevant and accessible to all our service users and take into account different needs;
- Advance equality of opportunity and embrace diversity by ensuring that equality and diversity is reflected within our service delivery, employment practices, procurement process and involvement;
- Promote good relations between people from different groups by celebrating diversity within our communities;
- Publicise our approach to equality, diversity and inclusion widely and positively;
- Identify, correct and prevent any form of discrimination, harassment or victimisation;
- Comply with the requirements of all relevant legislation to make sure that our services and facilities are fully accessible for all patients and employees;
- Act promptly to all reports of discrimination, victimisation and harassment.

Consultation Process

Key individuals involved in developing the document

Name	Designation
Dan Whalley Caroline James	Interim EDI Consultant Community Development and Equalities

Circulated to the following individuals/groups for consultation

Name of Individual & designation	Date approved
Network Representatives, including; Sirona - Our Voice, The Global Majority Sirona Network, the Sirona LGBT Network and Sirona Disabled and Long-term Conditions Network	February 2023

Details of approval by Lead Director

Director	Designation	Date approved
Sheridan Flavin	Interim Chief People Officer	May 2023

Circulated to the following Committee for Ratification

Name of Committee(s)	Date ratified
Executive Committee Board	May 2023 June 2023

Version Control

Version	Updated By	Updated On	Summary of changes from previous version
2	F Spence	26/07/22	Approved by Julie Sharma -CEO(Acting)
3	D Whalley	10/05/23	Approved by Sheridan Flavin – Interim CPO
4	D Whalley	01/06/23	Incorporating feedback from Exec Committee

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1. Introduction

Sirona's mission of One You, One Sirona and One System recognises and values the uniqueness and diverse needs of all individuals. Our aim is to provide an environment in which everyone feels their needs are being met whilst also harnessing the differences that people bring so we can all be stronger together. We are passionate about fair and equitable access to services and to employment and career progression opportunities. We will ensure protection from discrimination, victimisation and harassment in line with the Equality Act 2010 especially, although not exclusively, across the nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. We acknowledge that socio-economic status and other factors can also result in a range of disparities across our communities and workforce and we will be cognisant of these in all of our considerations.

We believe:

- Equality is not about treating everyone the same; in fact it is about ensuring that the equality of opportunity is offered to all by taking into account different needs and capabilities.
- Diversity is about recognising and valuing differences regardless of someone's gender, age, disability, gender reassignment, race, religion/belief, sex, sexual orientation and marital or other status or characteristics.

1.2. Equality Act 2010

As an organisation, we are required to comply with equality and diversity legislative framework. The Equality Act 2010 standardises the legal protections available to all people with identities across the 9 protected characteristics. It harmonises the definitions and concepts of discrimination, harassment and victimisation, and strengthening enforcement powers.
The Equality Act established a Public Sector Equality Duty (PSED) which requires all organisations and functions who are funded from public funds to meet certain obligations. As a provider of public services, Sirona must meet the obligations of the PSED.
This includes, in the exercise of its functions, having due regard to the need to:

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between people who share a protected characteristic and those who do not.

The Act explains due regard for advancing equality involves:

- Removing or minimising disadvantages experienced by people due to their protected characteristics;
- Taking steps to meet the needs of people from protected characteristics groups where these are different from other people; and
- Encouraging people from protected characteristic groups to participate in public life or in other activities where their participation is disproportionally low.

2) Definitions:

For the purpose of this policy, the following definitions shall apply:

“Equality” is about providing an equal opportunity to all by taking into account different needs and capabilities.

“Diversity” involves recognising and valuing the differences and individual contribution that people make and treating them fairly and with respect.

“Discrimination” consists of conduct or words or practices which disadvantages or advantages people because of certain characteristics.

“Disability” includes people with physical or sensory disability, learning difficulties, mental illness, or who are living with HIV or AIDS.

“Victimisation” occurs when an individual is treated in a way that is detrimental because they have or intend to make a complaint about being discriminated against or harassed. This would also apply if they have or intend to act as a witness or give evidence in support of another person(s) relating to a complaint about discrimination or harassment.

“Harassment “ is related to unwanted conduct related to a protected characteristic under the Equality Act 2010 (other than marriage and civil partnership, and pregnancy and maternity) that has the purpose of violating a person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person; or is reasonably considered by that person to have the effect of violating his or her dignity or of creating an intimidating, hostile, degrading, humiliating or offensive environment for him or her, even if this effect was not intended by the person responsible for the conduct.

“Third Party Harassment” is harassment of an employee related to a protected characteristic under the Equality Act 2010 (other than marriage and civil partnership, and pregnancy and maternity) by third parties, for example patients or employees from a partner organisation.

3) ROLES AND RESPONSIBILITIES:

This policy applies to all functions, services we provide and activities undertaken by Sirona whether directly or on our behalf. This policy therefore specifically demonstrates our commitments to; delivering services, employment, procurement and partnership/involvement.

Overall this policy will contribute to embed the equality and diversity strategy of Sirona. Sirona aims to deliver the highest standards of service, employment, and patient care.
In relation to our service delivery we will:

- Provide information about our services that is clear, accurate and accessible to all by ensuring that the information adheres to Sirona’s Minimum Standards Framework and is available in alternative formats and languages in line with our Accessible Information Policy (AIS) Translation and Interpretation Policy;

- Work in partnership with our contracted language providers, DA Languages and Sign Solutions to ensure our patients whose first language is not English or who require British Sign Language (BSL) for an interpreter service on request;
- Ensure that our website is accessible, comprehensive and offers a range of mechanisms to meet the needs of users;
- Ensure that our staff have access to information that may assist them in delivering services to meet individual needs;
- Ensure that all our services and premises are accessible by service users;
- Offer a comprehensive and accessible complaint procedure.
- Provide on-going opportunities for our staff members to learn about cultural awareness

Sirona aims to have an effective, efficient workforce, valuing equality, diversity and inclusion.

In relation to employment we will:

- Welcome and encourage applications from diverse communities and adopt clear and fair recruitment and selection processes;
- Support the recruitment of board members, management and staff which reflect the ethnicity and diversity of the population of our area and where required, apply positive action;
- Make reasonable adjustments in the workplace to minimise the barriers to employment faced by disabled people;
- Ensure that we offer our employees a working environment that is supportive, accommodating and free from bullying, harassment and victimisation.
    - If you have any concerns on the grounds of discrimination, please raise with your line manager in first instance or speak to HR on a confidential basis or your trade union representative;
    - You can also seek confidential support and guidance via our Freedom To Speak Up Guardians (sirona.freedomtospeakup@nhs.net)

- Provide staff with clear guidance on complaints, disciplinary and dismissal and grievance procedures through policies and procedures;
- Deliver equality and diversity training for all employees, board members and Members with regular refresher training as and when requested;
- Ensure that our workforce has access to wellbeing resources, including culturally sensitive services that recognise the diverse needs of our workforce;
- Take into account, recognise and build on staff ideas and suggestions for developing and improving our services;
- Promote opportunities for staff members from protected characteristics to meet with a view to gaining mutual support and to ensure a collective voice is embedded across Sirona as a vehicle for change
- Adopt fair employment opportunities, operating non-discriminatory practices and promoting equal access to staff training and development.

Sirona aims to provide high quality health care support to those in need.

In relation to procurement we will:

- Integrate equality and diversity within our procurement processes to ensure equal and fair access;

- Ensure that partners meet and share our expectation in relation to equality and diversity and work with us in achieving the overall high standards for our services

Sirona aims to work in partnership with others to make sure that we help build sustainable communities.

In relation to partnership working and co-production we will:

- Develop inclusive consultation mechanisms with our patients, staff and stakeholders to ensure that our plans and policies do not discriminate against any particular group;
- Encourage the involvement of diverse communities in decision making and service development;
- Share information, experience and examples of good practice in relation to equality and diversity;
- Ensure all suppliers, contractors and consultants providing service to or on behalf of Sirona has an Equality and Diversity policy in place and adhere to our practices.

4) Procedure

- All staff and board members will receive training to ensure that they are fully aware of their responsibilities and have the necessary skills and ability to comply within a supportive environment;
- All strategies, policies, procedures, plans and publications adopted by Sirona in the areas of service delivery, governance, employment, partnerships, involvement and procurement will be subject to the principles of this policy;
- Sirona will continue to develop a robust system for undertaking and publishing Equality Impact Assessments in relation to all the work we do.
- Sirona will challenge any unacceptable behaviour and discrimination by our employees, board members, contractors, partner organisations and service users; and take action to ensure that any incidents of discrimination, victimisation or harassment are addressed where preventative action has proven unsuccessful;
- Sirona aims to actively reduce disability discrimination so that people with impairments are not disadvantaged by physical barriers in our premises or restricted by attitudinal barriers in society;
- Sirona will make reasonable adjustments to job roles and working conditions to support people at work and will develop a programme of positive action to redress under representation as identified;
- Sirona values the importance of complaints, compliments and comments and will treat them all seriously, ensuring an accessible service is promoted and provided;

5) Monitoring compliance

The Executive Committee, chaired by Sirona's Chief Executive, alongside the Sirona Senior Leadership Team (SLT), supported by the internal EDI staff, will oversee the successful implementation of the policy and any identified actions.

This policy will be reviewed by the lead for equality and diversity at least biannually or following a change of legislation or statutory guidance.

References

- The Equality Act Equality Act | Equality and Human Rights Commission (equalityhumanrights.com)
- Home - Equally Ours Equality Policy, research and communications website.
- Home | The Health Foundation Independent research based charity aimed at supporting fairer health and care outcomes for people living in the UK.
- NHS England » Accessible Information Standard Information and resources to support NHS and Adult Care organisations in delivering accessible information and services to people with additional communication needs.
- Health Equity in England: The Marmot Review 10 Years On - IHE (instituteofhealthequity.org) Research that addresses the wider determinants of health and the impact of life expectancy.
- NHS Long Term Plan » The NHS Long Term Plan
- www.runnymedetrust.org Runnymede is the UK's leading independent race equality think tank.
- Home page - NHS - Race and Health ObservatoryNHS – Race and Health Observatory (nhsrho.org) An independent Policy and Research Resource focused on improving race equality targets across the UK.
- LGBT Foundation - Monitoring Sexual Orientation and Trans Status Policy and research support to ensure equity for LGBT + communities across the UK.
- The Disability Equality Commission - Disability Equality Commission Chair - bristol.gov.uk A new Disability Equality Commission in Bristol to support the views and experiences of disabled people.

Appendix 1

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:** This policy does not affect one or more groups less or more favourably than others on the basis of the 9 protected characteristics. This policy document sets out the active commitments of Sirona, as an employer and provider of services, in relation to equality, diversity and inclusion. Where groups may be affected differently to others, this would be in order to provide equity and/or remove or mitigate barriers those groups may experience.		
	• Race		
	• Ethnic origins (including gypsies and travellers)		
	• Nationality		
	• Gender (including gender reassignment)		
	• Culture		
	• Religion or belief		
	• Sexual orientation		
	• Age		
	• Disability – learning disabilities, physical disability, sensory impairment and mental health problems		
2.	**Is there any evidence that some groups are affected differently?**		

3.	**If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?**
4.	**Is the impact of the document/guidance likely to be negative?**
5.	**If so, can the impact be avoided?**
6.	**What alternative is there to achieving the document/guidance without the impact?**
7.	**Can we reduce the impact by taking different action?**

Equality & Health Inequality Impact Assessment

Other documents required to complete the Equality Impact Assessment:

- **Equality & Health Inequality Impact Assessment Guidance** – Read this first
- **Equality & Health Inequality Impact Assessment Resources**

Please make sure you read the guidance and resources before completing this template.

Title of proposal:				Date:
☐ Policy	☐ Strategy	☐ Service	☐ Function	☐ Other (*please state)*
			HEAT in progress/ completed ☐	Has an EHIIA been previously undertaken? Yes ☐ No ☐
Reason for EHIIA	New Activity ☐	Change to existing activity ☐	Review ☐	Other ☐
Lead person(s) completing this assessment:				
Lead person job title(s) and service area:				

Step 1: Outline
Give a brief description of the proposal context, purpose, aims and objectives. Describe the intended outcomes and benefits and who these might impact. Include whether it is a new proposal or a change to an existing one and the key decision that will be informed by the EHIIA (e.g. proceed with the policy/proposal or not).

Step 2: Assess Impact

Health Inequalities (HI)

Health inequalities are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient.

Groups of people who may face health inequalities include:

- Carers
- Care leavers
- People who experience homelessness
- Offenders in prison/on probation, ex-offenders
- People with addictions and substance misuse problems
- People on low incomes
- People with poor literacy
- People from deprived areas
- People who experience digital exclusion
- People living in remote, rural and island locations
- People in the Armed Forces / Veterans
- People newly arrived in the country as asylum seekers or refugees
- People from Gypsy, Roma or Travelling communities (GRT)

2.1 What health inequalities have or might emerge from your proposal?

Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below.
You can also consider completing the HEAT tool to support summarising key issues, this can help to systematically evaluate HI:

2.2 Could the proposal have a positive or negative impact on any of the protected characteristic groups or other relevant groups?

Although some of your conclusions will be widely known and accepted (e.g. need for accessible information), your analysis should include evidence to support your statements to aid the decision-maker.

EHIIA Resources - Sirona V6.docx

Evidence might include insights from your engagement, focus groups, stakeholder meeting notes, surveys, research papers, national directives, reports, expert opinion, etc.
If there is insufficient evidence, state this and include an action to find out more in the action plan in Step 3.

In addition to having due regard for the Equality Act 2010 Public Sector Equality Duty to:

- eliminate unlawful discrimination
- advance equality and
- foster good relationships between protected groups

you must also have due regard to the principles of the Armed Forces Act 2021, removing disadvantages and making special provisions if needed to ensure services and employment opportunities are accessible.

Positive Impact:				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage & Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the **benefits** including benefits to any of the protected characteristic groups plus health inequality groups (such as digital inclusion). Include your evidence here. Also include intersectional impact where possible:				
Negative Impact				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage & Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the **negative** impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Include your evidence here. Also, include how discrimination may impact on multiple levels on an individual (intersectionality): (You can share further details and mitigations below in 2.3)				

No Effect
Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if 'not applicable':

2.3 Outline any negative impacts of the proposal on people based on their protected characteristics or other relevant groups. Consider how you might level the 'playing field' for all people:		
Protected Characteristic(s) or other relevant groups	**Details of negative impact** **(e.g. access to service, health outcome, experience, workforce exclusion)**	**Identify any mitigations that would help to reduce or eliminate the negative impact**

Step 3: Action Plan

3.1: What actions will you take to mitigate the negative impact outlined above?

Action	Timeframe	Success Measure	Lead

3.2 How and when will you review the action plan (include specific dates)?

Step 4: Summary

4.1 What are the main conclusions of this equality and health inequalities impact assessment?

Share a brief summary of the positive impact the proposal will make and any negative impact and mitigations e.g. what steps you have taken to improve accessibility.
Explain how the EHIIA has informed, influenced or changed the proposal.
Select a recommendation for the decision maker in **4.3** and include the rationale for the decision below.

4.2 Outline how the proposal will support our Public Sector Equality Duty:

To eliminate discrimination, harassment and victimisation.	Positive	☐
	Negative	☐
	No effect	☐
Please describe:		
To advance equality of opportunity between people who share a protected characteristic and those who do not.	Positive	☐
	Negative	☐
	No effect	☐
Please describe:		

To foster good relations between people who share a protected characteristic and those who do not	Positive	☐
	Negative	☐
	No effect	☐
Please describe:		
4.3 Select a recommended course of action (include your rationale above in section 4.1):		
Outcome 1: Proceed – the assessment is that the programme/ activity is/will be robust		☐
Outcome 2: Proceed with adjustments – this involves taking steps to remove any barriers or discrimination, better advance equality and/or foster good relations.		☐
Outcome 3: Continue with caution – there is potential for adverse impact with mitigation in place (justification to be clearly set out).		☐
Outcome 4: Stop and rethink - there are adverse effects which cannot be prevented/mitigated.		☐

Submit your completed template to the Partnerships and Communities team for review:

- sarah.prendergast3@nhs.net
- caroline.james7@nhs.net

Step 5: Review

Partnerships and Communities team Feedback	
Name:	Date:

Partnerships and Communities Team Assessment							
1	Has evidence been analysed (quantitative/qualitative data)	Yes	☐	No	☐		
2	Have Health Inequalities been considered	Yes	☐	No	☐		
3	Are actions resulting in improved access, experience, and outcomes?	Yes	☐	No	☐	N/A	☐
4	Compliant with the Public Sector Equality Duty	Yes	☐	No	☐		

*All Equality, Health Inequality Impact Assessments will be reviewed by the **Impact Assessment Panel (IAP)** to obtain Director-level sign-off to meet legislative requirements.*

Panel Feedback (this document has been reviewed by the Communities and Inclusion Team and/or trained manager/project lead)

IAP Panel name:	
IAP Panel signature:	
Date:	

Recommended course of action:	
Outcome 1: Proceed – the assessment is that the programme/ activity is/will be robust	☐
Outcome 2: Proceed with adjustments – this involves taking steps to remove any barriers, better advance equality and/or foster good relations.	☐
Outcome 3: Continue with caution – there is potential for adverse impact with mitigation in place (justification to be clearly set out).	☐
Outcome 4: Stop and rethink - there are adverse effects which cannot be prevented/mitigated.	☐

Board Report

Date	13th June 2023	**Agenda item**	Consent Agenda Item 15
Title	Risk Management Policy and Procedure		
Author	Sandra Farmer head of Clinical Governance		
Presented by	Mary Lewis CNO	**Version**	1
For	Approval/decision ☒ Debate ☐ Assurance ☐ Information ☐		

Purpose of the report

To request ratification of the Risk Management Policy and Procedure following revision of the policy to reflect changes to the Sirona governance structure.

Why is this report coming to the Board

E.g. is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

Ratification of this policy is reserved to the Board.

Related Risk No. (If applicable)	

How has this report been developed

Including the lead director, those involved in preparing the report and the sources of information relied on

In consultation with Chief Nursing Officer, Risk Management Team and including recommendations from Audit, Assurance and Risk Committee and the Executive Committee.

What is the process the report has been through internally

i.e. which teams or groups have reviewed the report or the information that informs it

Review of Policy amendments by

- Audit, Assurance and Risk Committee
- Executive Committee

Summary and Key Issues Highlighted by these teams, including mitigations

Please highlight in summary the key messages from this report, including matters of escalation from Committees or other Teams, significant issues, risks and actions to address them

The amended risk policy was presented to Audit, Assurance and Risk Committee in February 2023, the amendments were approved with the request that Executive Committee confirm the allocation of risks by category to each of the committees.

Two papers were presented to Executive Committee in February and April where the risk categories to be allocated to each committee was agreed. In addition there was a request by the Executive Committee to map the allocation of risk by category to an SLT lead by portfolio responsibility rather than line management reporting routes. The final draft of the risk policy was presented to Audit, Assurance and Risk Committee on 30th May 2023 where the amendments to the policy listed below were approved.

- Change name of key individuals involved in developing the policy
- Section 4.2 **Update** names of committees
- Section 4.2 **Additional** committees
- Section 4.3 **Update** titles for executive titles. Addition of Chief Digital and Information Officer. Removal of Director of Transformation
- Section 4.3.1.1 **Update** *Chief Officers: have delegated authority for the management of all risks within their own portfolios including the development, maintenance, and monitoring of their identified risks on the on-line risk register. Directors will be assigned as Director-lead for specific risk categories as outlined in this policy and will be responsible for ensuring their consideration at appropriate subject matter groups in line with the groups' terms of reference.*
- Section 7.1 **Minor change** to describe the Ulysses Risk Management Module
- Section 7.2.3 **Small addition** to describe the responsibility more fully for the management of corporate level risks
- Section 7.2.3 **Update** Table 2 to show subject matter groups reporting to committees as approved by Executive Committee
- Section 7.2.3 **Addition** Table 3 Additional information to reallocate risk categories to Executive Lead by portfolio rather than along line management reporting structures.
- Section 7.2.3 **Addition** *Risks can by exception, at the request of a Chief Officer or a Committee be allocated outside of this framework but only if the change is approved by the Executive Committee*.
- Section 7.2.3 Table 2 Recommendation to remove category Service User Care and Treatment and change risks in this category to Patient Safety/Clinical quality as insufficient distinction between the two risk types.
- Section 7.2.6 **Minor change** to procedure for the closure of risks
- Section 7.2.7 **Minor change** to procedure for controlled risks

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

The Board is asked to ratify of the Risk Management Policy and Procedure document.

Risk Management Policy and Procedure

Version:	6.1
Name of originator/author:	Sandra Farmer Head of Clinical Governance
Name of executive lead:	Mary Lewis Director of Nursing
Date ratified:	March 2021
Review date:	March 2024

Applicable to
All staff

Executive Summary
This Policy details how Sirona manages risk. It outlines the procedures to identify, manage and report risks to ensure a consistent and systematic approach across the organisation.

Implementation
Cascade by managers.

Key points for implementation:

- ensure all managers and staff are aware the policy and their responsibilities
- managers to ensure there is an open culture within their team(s) to enable staff to identify and communicate risks
- managers to identify a suitable local forum for the discussion of risks and risk management issues within their team(s)/service(s)

This document can only be considered valid when viewed via Sirona's intranet site. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one on-line. The document applies equally to full and part time employees, bank and agency staff.

Consultation Process

Key individuals involved in developing the document

Name	Designation
Sandra Farmer	Head of Clinical Governance
Carole Morgan	Joint Lead for Risk Management
Sarah Leggett	Joint Lead for Risk Management
Rose Daly	Joint Lead for Risk Management

Version 5.2 - Circulated to the following individuals/groups for consultation

Name of Individual & designation		Date approved
Janet Rowse	Chief Executive	
Mary Lewis	Director of Nursing	
Simon Knighton	Chair of the Board	
Paul May	Non-executive Director	
Amanda Cheesley	Non-executive Director	
Lorna Harrison	Non-executive Director	
Clive Bassett	Director of Finance	
Simon MacSorley	Non-executive Director	
Rachel Corrigan	Senior Project Manager	
Donna Cairns	Head of Corporate Governance	
Nura Aabe	Associate Non-executive Director	
Clare-Jane Hopkinson	Health & Safety Co-ordinator	
	Executive Committee Members	23/02/2023
	Executive Committee Members	26/04/2023

Circulated to the following Committee for Approval

Name of Committee(s)	Date Approved
Audit & Assurance Committee	22/02/2021
Audit, Assurance and Risk Committee	08/02/2023
Audit, Assurance and Risk Committee	30/05/2023

Circulated to the following Committee for Ratification

Name of Committee(s)	Date ratified
Board	02/03/2021

Version Control

Version	Updated By	Updated On	Summary of changes from previous version
4	Sarah Leggett	March 2020	Policy reviewed and streamlined. The changes do not materially affect the content of the policy.
5	Sandra Farmer Carole Morgan Sarah Leggett	February 2021	Policy reviewed and updated to reflect new governance and locality structures within Sirona and a review of the risk register.
6	Sandra Farmer Carole Morgan Rose Daly	January 2023	Policy reviewed to reflect changes to the governance structure, key individual titles, SLT Lead

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1. RISK MANAGEMENT

Risk management is the term applied to the use of a logical and systematic method of identifying, analysing, evaluating, controlling, monitoring and communicating risks associated with any activity, process or function necessary to the achievement of Sirona's objectives. It can also be described as a method of minimising loss and maximising opportunity.

Sirona has a statutory responsibility to service users, the public and its staff to ensure that it has effective processes, policies and people in place to deliver its objectives and to control any risks that it may face in achieving these objectives.

2. DEFINITIONS

Risk Management - the assessment, analysis and management of risks. It is simply recognising which events (hazards) may lead to harm in the future and minimising their likelihood (how often?) and consequences (how bad?)

Risk - a risk is an event or condition that if it happened may impact on or have a negative effect on quality, safety, performance or organisational reputation.

Issue – An issue is something which has happened and is impacting on quality, safety, performance or organisational reputation. This may be reported as an adverse event but will not be added as a risk to the risk register.

Risk Appetite – the amount of risk an organisation is willing to take on or is prepared to accept in pursuing its strategic objectives. The risk appetite may vary dependent upon the specific type of risk, current circumstances, and context.

Risk Register – a document used as a risk management tool and to fulfil regulatory compliance. It acts as a repository for all risks identified and includes information about the nature of the risk, responsible persons, mitigation measures in place and actions to be taken to reduce risk. Risks are scored initially (before control measures are in place) and at subsequent reviews using the approved risk scoring matrix.

Initial Risk Score – risk scoring before any controls are applied.

Current Risk Score – risk scoring with controls applied.

Target Risk Score (lowest possible risk level) **-** the actual or anticipated level of risk remaining once all identified controls and actions have been put in place and are working effectively.

Risk Level – the level at which the risk is managed according to Sirona's definitions (i.e., corporate or local - see section 7.2.2)

Tolerated Risk - Decision taken not to implement any initial or additional controls / actions. This decision is usually taken either because the management of the risk is outside Sirona's control or because the cost of implementing the controls will exceed benefits of risk reduction.

Controlled Risk – A risk is controlled when it reaches its target risk score and all actions have been implemented. The risk will be recategorised as "controlled" and remain open with a monitoring schedule agreed to ensure the risk remains controlled

Closed Risk - Risks are categorised as closed when the risk has been eliminated.

3. AIM AND PURPOSE

The aim of risk management is not to remove all risk but to recognise that some level of risk will always exist and that these risks must be managed. Taking risks in a controlled manner is fundamental to innovation and developing a positive culture.

This Policy details how Sirona manages risk; the aim of which is to promote a consistent and systematic approach to the identification and management of risk throughout the organisation.

Sirona will provide a safe environment for its staff and the provision of safe and effective care to its service users by identifying risks and taking the appropriate action to address them. This will typically be either to eliminate the risk entirely, or to reduce it to an acceptable level.

4. RESPONSIBILITY FOR RISK

Risk management is seen as an integral part of management and professional/clinical practice. Every individual within Sirona is therefore responsible for identifying and managing risk. The following section summarises the responsibilities of the Board committees, individuals and risk specialists in relation to risk

4.1 The Role of the Board

The Board: is responsible for:

- ensuring that within Sirona there are effective systems for identifying and managing all risks
- setting the risk appetite
- monitor risks with a risk score of 15 or above
- reviewing the assurance provided by way of the regular committee reports presented to the Board and challenging any information provided that does not give adequate assurance.

4.2 Committees reporting to the Board with Overall Responsibility for Monitoring Risks

The committees reporting to the Board are responsible for the monitoring of risks for which it is identified as the monitoring committee within Sirona's governance structure and the committee's terms of reference. Some risks may fit with more than one committee and in this case the risk owner for the risk should use discretion to ascertain the most appropriate monitoring committee. As part of their monitoring of risks, and if deemed necessary, committees can recommend that a risk is transferred to a more appropriate committee for monitoring. Committees should receive assurance that risks are being managed by way of regular reports and should challenge any information provided that does not give adequate assurance. The committees are:

4.2.1 Executive Committee: the Executive members of SLT are responsible for establishing and embedding a risk management structure to help deliver its responsibility for implementing risk management systems across the organisation and for monitoring risks in line with its terms of reference.

4.2.2 Audit, Assurance and Risk Committee: is responsible for reviewing the processes in place across the organisation to identify and manage risks and for monitoring risks in line with its terms of reference.

4.2.3 Quality & Outcomes Committee: is responsible for ensuring that controls are in place and operating efficiently and effectively to identify and manage risks that affect service users and staff and for monitoring risks in line with its terms of reference.

4.2.4 People Committee: is responsible for providing assurance on all aspects of workforce and organisation development.

4.2.5 Performance Committee: is responsible for monitoring and overseeing the performance of Sirona and overseeing the delivery of strategic, operational, and activity plans, performance and strategies.

4.2.6 Finance, Estates, Environment and Digital Committee: is responsible for monitoring and overseeing a framework for optimising the deployment of all resources available to Sirona to enable it to meet its business and financial objectives.

4.2.7 Equality, Diversity and Inclusion Steering Committee: is responsible for providing strategic direction for delivery of Sirona's Equality, Diversity & Inclusion Strategy, in compliance with wider legislative and regulatory requirements.

4.2.8 Other groups with a responsibility for subject matter risks: As outlined in the Governance structure, the Subject Matter Groups reporting into the committees of the Board will receive risk reports based on their area of expertise. They will provide advice and guidance to the risk owners and note any trends and areas of concern. Relevant information about subject matter risks will be included in reports to their monitoring committee. The chart under section 7.2.3 of this policy (Reviewing and Monitoring Risks) identifies the types of risk and links to the subject matter groups. These responsibilities will be reflected in the Group's terms of reference.

4.3 Individuals with Specific Responsibility in Relation to Risk

The following members of staff have specific responsibilities and accountability for risk, as part of their existing roles:

4.3.1 Chief Executive: has overall accountability to the Board for risk management and the Board Assurance Framework (BAF). Operationally, the Chief Executive has delegated responsibility for implementation of risk management as outlined below:

4.3.1.1 Chief Officers: have delegated authority for the management of all risks within their own portfolios including the development, maintenance, and monitoring of their identified risks on the on-line risk register. Directors will be assigned as Director-lead for specific risk categories as outlined in this policy and will be responsible for ensuring their consideration at appropriate subject matter groups in line with the groups' terms of reference.

4.3.1.2 Chief Finance Officer: has delegated authority for financial governance; risk and assurance, security management and counter fraud and Information Governance

4.3.1.3 Chief Nursing Officer: has delegated authority for overseeing the organisational risk management process, clinical governance, risk and assurance. In addition, holds the statutory roles for: Health and Safety, Infection Prevention & Control and Safeguarding.

4.3.1.4 Chief Operations Officer: has delegated authority for Emergency Planning inc EPRR

4.3.1.5 Chief Digital Officer; has the delegated authority for the oversight of digital risks.

4.3.1.6 Chief Medical Officer holds the statutory role of Caldicott Guardian and Responsible Officer and Chair of the Professional Council. The Professional Council has delegated authority to manage clinical risk-based decision making.

4.3.1.7 Chief Allied Health Professionals Officer : holds the statutory role of Chief Clinical Information Officer.

4.3.1.8 CQC Registered Managers and Senior Managers (inc Associate Directors): are responsible for ensuring compliance with the CQC Regulations and compliance with the Risk Management Policy. In addition, they are required to:

- ensure that risks are discussed and monitored in an appropriate forum;
- develop and implement work-plans to ensure risks are identified and managed;
- ensure that risks are entered onto the on-line risk register and are reviewed to ensure timely and systematic risk management and communication of risk;
- ensure risks are escalated in line with the Risk Management Policy (see Section 7.2.2).

4.3.1.9 All Sirona staff, including contractors and staff employed through bank / agency

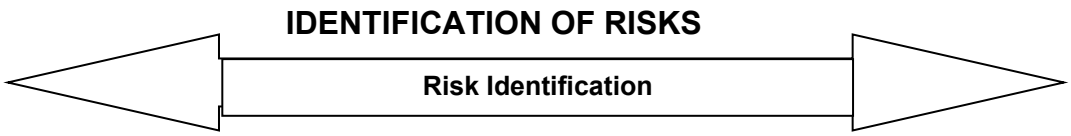
All staff are required to actively identify, assess, report and contribute to the control and management of risk. This will promote and ensure adherence to safe working practices and to ensure that the services provided by Sirona have safety and quality as paramount requirements. All staff are responsible for complying with the requirements of the Risk Management Policy and to assist the risk management process by:

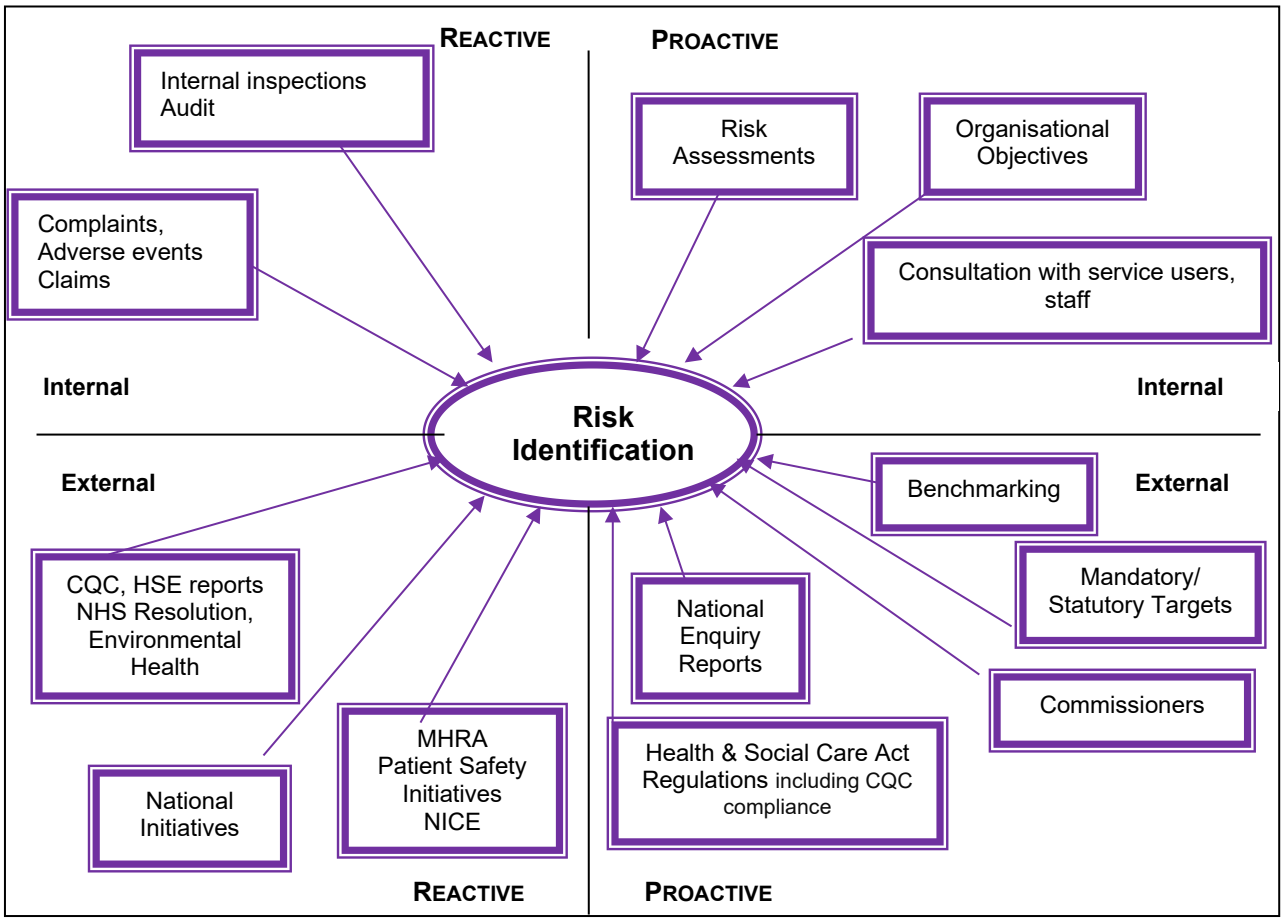
- completing an on-line adverse event report form every time an adverse event or potential adverse event (including near miss) occurs (refer to Sirona's Adverse Event Reporting Policy);
- following all procedural documents i.e. policies, procedures, guidelines
- identifying and communicating concerns, issues or risks through their line management structure in order that these can be fully assessed and actions identified as appropriate. Where risks cannot immediately be managed to an acceptable level the risk must be entered onto the on-line Risk Register by a senior member of the team.

4.4 Risk Specialists: The Chief Nursing Officer, Head of Clinical Governance and the Leads for Risk Management are responsible for developing, overseeing and supporting the risk management processes across Sirona and acting as a central reference point for risk management.
The Risk Team will review all new risks added to the Register and will discuss with the risk owner if any points of clarification are needed. Any action will be agreed between the Risk Team and the risk owner.

5. RISK IDENTIFICATION

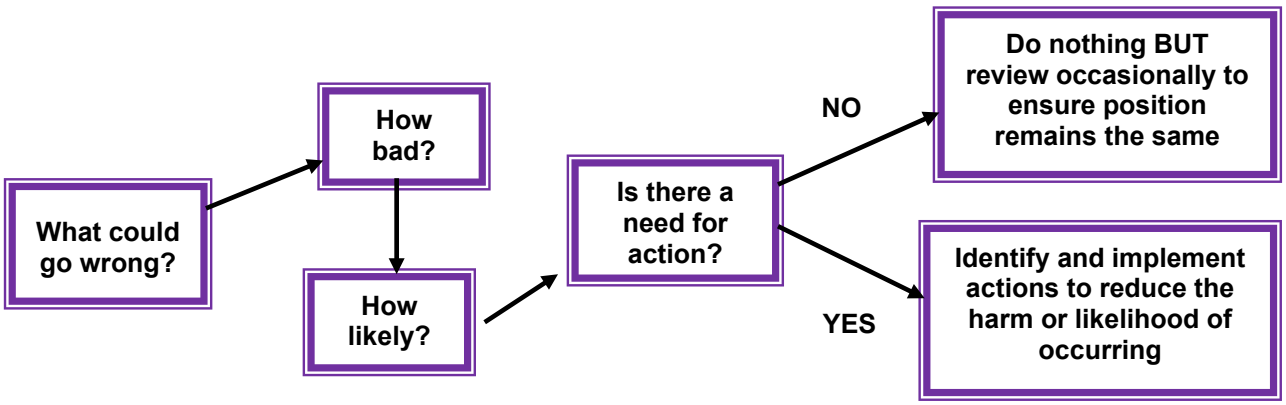
Risks can be identified through a variety of proactive and reactive internal and external indicators. Examples of the potential indicators of risk are shown in the diagram below:





6. RISK ASSESSMENT

6.1 What is a risk assessment? A risk assessment seeks to answer four simple questions:



6.2 Recording the Risk

The risk **must** be added to the on-line risk register. Although teams are expected to complete their own risk assessments, assistance can be sought from the risk leads within the Quality & Safety Team.

N.B

- Risk assessments relating to individual service users must not be entered onto the Risk Register and must instead be filed in the service user's care plan and shared as appropriate.

- Health and Safety risk assessments e.g. for manual handling, COSHH; driving at work; first aid; Display Screen Equipment (DSE); security; lone working; fire etc should be completed as required and held within the team or service. The assessment templates are available on workplace.

6.3 Risk Scoring

Sirona uses a standard 5 x 5 risk scoring matrix for guidance on assessing the likelihood and severity/impact of the risk (Appendix A). Risk scores are not intended to be precise mathematical measures of risk but are a useful tool to help in the prioritisation of actions to reduce and manage the risk.

6.4 How to manage the risk

The options to manage the risk are often referred to as the 4 Ts:

Treat The most usual action is to take direct action to reduce the level of risk to an acceptable level. Current 'on-going' controls / actions are continually monitored, and actions identified which once implemented will reduce the level of risk to an acceptable level.

Tolerate Decision taken not to implement any initial or additional controls / actions. This decision is usually taken either because the management of the risk is outside Sirona's control or because the cost of implementing the control will exceed benefits of risk reduction. When deciding on this management strategy care needs to be taken to ensure consequences of the defined risk are fully considered, e.g. potential breach of legislation, reputational loss. Current 'on-going' controls / actions (established 'routine' controls) will need to be monitored and reviewed on an ongoing basis. The decision to tolerate a risk is taken by the relevant monitoring committee with escalation of any areas of concern to the Board.

Transfer It may be that the risk can be transferred to another organisation by way of a contractual agreement or shared with partner organisations. In some instances, a risk may be covered by insurance either totally or in part (e.g. legal liability, property, motor vehicle). However, it must be remembered that responsibility for statutory functions cannot be fully transferred, and the reputational implications of risks need to be managed.

Terminate The risk may be so serious that adding controls or modifications do not reduce the risk to an acceptable level. At this stage withdrawal from the activity should be considered. The decision to stop or withdraw from the activity will be taken by SLT and reported to the Board.

Early consideration must be given to the cost/benefit of the course of action to be adopted to manage the risk. To implement a solution which brings with it a level of cost which outweighs or is disproportionate to the benefits of the reduction in the level of risk is a poor use of resources.

The cost/benefit analysis applied during the risk management process assists the decision-making process. Risk owners need to be satisfied that the risks and opportunities related to proposals are fully considered. It is therefore important that all those involved in the decision-making process have consciously analysed the proposals put forward to manage the risk and have access to all relevant information required to make the decision.

In addition to the risk owner obtaining a level of assurance that the proposal and the implementation of recommendations has been subject to a robust risk assessment, it is also an important principle of good governance that decisions taken can be subjected to effective scrutiny (Accountability).

Risk owners can be held accountable for decisions both internally and externally (Regulatory inspectors, service users and members of the public). The regulatory inspectors will want to see that the decision and the information used to make the decision is documented and accessible, i.e. the decision is 'informed' and 'transparent' and also to ensure that the treatment of a risk does not in itself generate another risk.

6.5 Communication of Risk with Third Parties

If a risk is identified which is shared with, or wholly relates to another organisation the risk must be discussed and shared with that organisation BEFORE the risk is placed on the Risk Register. Advice on the method of communicating and sharing the risk must be sought from the appropriate Director. The third party must not be named in the Register and the risk must not be entered onto the Register without the knowledge of the third-party organisation.

7. RISK REGISTERS AND THE MANAGEMENT OF RISK

7.1 Risk Register

Sirona has a single electronic risk register held on the Ulysses Risk Management Module which is set up to produce risk reports that can be customised to meet the needs of the end user e.g. Board, Committees, Groups, Teams etc.

Services are required to enter risks onto the Register to assist their team in the management of their risks. It also enables Sirona to identify risks that are affecting more than one team/service which may in itself increase the risk score and require corporate rather than local action to be taken to manage and reduce the level of risk.

7.2 Management of Risk

7.2.1 Authority for the Management of Risk

All managers have the delegated authority to manage any level of risk locally within the resources available to them (see table below). This will include putting controls in place as a result of risks identified from risk identification processes such as risk assessment, complaints, adverse events and claims. Where the manager does not have delegated authority and/or resources to adequately control or manage the risk the advice of their line manager, senior manager or director should be sought and a decision made on whether the risk should be escalated to the corporate level.

7.2.2 Risk Level:

The following table sets out where the risk will be managed:

Table 1

RISK LEVEL	Allocate risk level according to guidance below:
LOCAL Level (Operational or corporate teams)	Risks that meet one or more of the following criteria • Only affect a service or team (operational or corporate team) • has a risk score of 10 or less • are within the manager's delegated authority and/or budgetary limits and financial resources

***CORPORATE Level**	Risks that meet **one or more** of the following criteria: • have a risk score of 12 or more • affect a number of teams, services, localities (operational or corporate teams) • affect the whole organisation • require senior ownership and /or support from SLT to mitigate the risk NB: Corporate level risks continue to be managed by the identified risk owner

*Corporate level relates to the level of risk and not the corporate teams of the organisation

7.2.3 **Review and Monitoring of Risks**

All risks added to the risk register will be allocated a risk type, this will determine the subject matter group to receive monitoring reports and the relevant monitoring committee. This will ensure robust review and monitoring of the risk takes place. The SLT lead is selected by the risk owner and should be the director responsible for their service.

Subject matter groups will review risks of the type relating to their individual remits. Committees will receive regular reports of all risks for which they have been allocated as the monitoring committee. Committees will report regularly to the Board on risks falling within their remits and must escalate to the Board any risks causing concerns via their reports to the Board. The Board will receive regular reports of all risks scoring 15 or above in addition to receiving regular reports from its committees.

Local: Local (Operational or Corporate Team and service) risks are monitored through the systems put in place by their senior manager for monitoring quality, performance, issues and risks.
Each senior manager is responsible for ensuring their risks are reviewed and updated in line with the timescales set out in the Risk Management Policy.
Corporate Risks: these risks have a score of 12 or above, should be managed in the same way as Local risks described above but in addition are reported to and monitored by the relevant committee (as set out in table 2 below). In addition to the allocated monitoring committee risks scoring 15 or above will also be included in a bespoke report to the Board.

When a corporate risk is added consideration needs to be given to an appropriate cascade of information to ensure that actions required are implemented at all relevant levels.

Subject-Specific Risks: are reported to the Subject Matter Groups reporting to the committees. Table 2 below outlines the risk types, the Subject Matter groups and the monitoring committees in place at the time the policy is issued.

Table 2: Risk Type by Subject Matter Group

Quality and Outcomes Committee **Executive Lead** **Chief Nursing Officer**	**Risk Category**	**Subject Matter Group**
	Clinical Records	Clinical Records Management Group
	Health, Safety & Security	Corporate Health, Safety & Security Committee
	Infection Prevention & Control	Infection Prevention & Control Group
	Medical Devices	Medical Devices Group
	Medicines Management	Medicines Optimisation Management Group
	Patient Safety / Clinical Quality	Clinical Governance Forum (name to be confirmed)
	Research and Development	Research & Development Group
	Safeguarding	Safeguarding Children & Adults at Risk Forum
	Regulation & Compliance – CQC	Clinical Governance Forum (name to be confirmed)

Audit, Assurance and Risk Committee **Executive Lead Chief Finance Officer**	**Risk Category**	**Subject Matter Group**
	Information Governance	Digital Steering Group
	Regulation & Compliance – not CQC	Dependent on area of risk

People Committee **Executive Lead Chief People Officer**	**Risk Category**	**Subject Matter Group**
	Staff Wellbeing	People & Development Group
	Workforce	People & Development Group
	Learning & Development	People & Development Group

Finance, Environment, Estates and Digital Committee Executive Leads Chief Finance Officer and Chief Digital Information Officer	**Risk Category**	**Subject Matter Group**
	Accommodation	Accommodation Group
	Digital (IM&T)	Digital Steering Group
	Business / **Finance**	**Finance** SLT

Equality and Diversity Steering Committee Executive Lead Chief People Officer	Risk Category	Subject Matter Group
	Equality & Diversity *	Equality, Diversity & Inclusion Steering Group

*** Proposed to report to Exec Committee until ED&I Steering Committee established**

Performance Executive Lead Chief Operations Officer	Risk Category	Subject Matter Group
	Capacity & Demand - Operations	Operational Delivery Group or Operational Governance Group
	Performance	Operational Delivery Group or Operational Governance Group

Executive Committee Chief Executive	Risk Category	Subject Matter Group
	Business / Finance*	**Business** SLT
	Capacity & Demand – Corporate	Dependent on area of risk
	Contracts	SLT
	Engagement / Stakeholder Relationships *	SLT *
	EPRR / Business Continuity	EPRR / Business Continuity Group
	Programme, Planning & Projects	Programme & Planning Steering Group
	Equality and Diversity**	Equality, Diversity and Inclusion Steering Group

***Proposed until alternate group identified**
**** Proposed until ED&I Steering Committee established**

Table 3 Executive Leads for specific risk categories

Risk Category	Director Lead
Research	Chief Allied Health Professions Officer
Medical Devices	Chief Allied Health Professions Officer
Clinical Records	Chief Allied Health Professions Officer
Engagement / Stakeholder Relationships	Chief Allied Health Professions Officer
Infection Prevention & Control	Chief Nursing Officer
Health, Safety & Security	Chief Nursing Officer
Safeguarding	Chief Nursing Officer

Medicines Management	Chief Medical Officer
Patient Safety / Clinical Quality	Chief Nursing Officer
Regulation & Compliance – CQC	Chief Nursing Officer
Equality and Diversity	Patient Chief Medical Officer Staff Chief People Officer
Learning & Development	Chief People Officer
Staff Wellbeing	Chief People Officer
Workforce	Chief People Officer
Regulation & Compliance – not CQC	Depending on subject
Information Governance	Chief Digital Information Officer
Digital (IM&T)	Chief Digital Information Officer
Accommodation	Chief Finance Officer
Business / Finance	Chief Finance Officer
Programme, Planning & Projects	Chief Finance Officer
Capacity & Demand – Corporate	Dependent on area
Contracts	Chief Operations Officer
Performance	Chief Operations Officer
Capacity & Demand - Operations	Chief Operations Officer
EPRR / Business Continuity	Chief Operations Officer

Risks can by exception, at the request of a Chief Officer or a Committee be allocated outside of this framework but only if the change is approved by the Executive Committee.

7.2.4 Timeframe for Reviewing Risks

The table below outlines the frequency of review of all risks on the register, dependent on their risk score:

Table 3

Risk Level	Risk Score	Risk Level Description	Frequency Review AT LEAST
High	**16-25**	Unacceptable level of risk exposure that requires immediate corrective action; to be monitored by Board.	Monthly
	15	Unacceptable level of risk exposure that requires measures to be put in place to reduce exposure; to be monitored by the Board	Monthly
Significant	**12**	Unacceptable level of risk exposure that requires measures to be put in place to reduce exposure.	Monthly
	10	Unacceptable level of risk exposure that requires measures to be put in place to reduce exposure	Quarterly
	8-9	Unacceptable level of risk exposure that requires measures to be put in place to reduce exposure	Quarterly
Moderate	**4-6**	Acceptable level of risk exposure subject to regular active monitoring measures	Quarterly
Low	**1-3**	Acceptable level of risk subject to regular passive monitoring measures at management level	6 monthly
Tolerated Risks		Decision taken not to implement any initial or additional controls / actions. This decision can only be taken by the relevant monitoring committee	To be determined by monitoring committee

Risks at Target Risk Score	A risk is controlled when it reaches its target risk score and all actions have been implemented.	To be determined by monitoring committee

7.2.5 Email notifications

The on-line risk register will send automated email notifications to advise of new risks and when actions are required.

7.2.6 Closure of Risks:

Only risks that have been eliminated and or no longer exist can be closed. This situation usually only occurs when the procedure is no longer performed, the service no longer delivered or when control measures or actions taken have eliminated the risk completely. Risks that have been closed since the last report will be included in the next reports to Board and committees so that the closure can be reviewed, discussed or challenged.

7.2.7 Controlled Risks (see section 7.2.2):

7.2.7.1 **Local Risks:** The decision that a risk is controlled when it reaches its target score and all actions have been implemented will be agreed with the risk owner and senior manager. The risk will be categorised as "controlled", remain open in a subsection of the electronic Risk Register.

7.2.7.2 **Corporate Risks**: The decision that a corporate risk is now controlled will be agreed by the risk's monitoring committee and will be included in the committees' reports submitted to the Board.

8. LINKS TO PROCEDURAL DOCUMENTS

Board Assurance Framework

Governance Framework and Structure

Terms of Reference of the Board, Committees of the Board and the Subject Matter Groups

Risk Guidance Documents

APPENDIX A

SIRONA - RISK SCORING MATRIX

Impact score (severity of potential harm by risk type)

Risk Type	1 Negligible	2 Minor	3 Moderate	4 Severe	5 Catastrophic
Patient Experience	• Unsatisfactory patient experience not directly related to patient care • Peripheral element of treatment or service sub-optimal • Informal complaint / inquiry	• Unsatisfactory patient experience – readily resolvable • Overall treatment or service sub-optimal • Formal complaint • Local resolution	• Mismanagement of patient care • Repeated failure to meet internal standards • Formal complaint • Local resolution (with potential to go to independent review)	• Serious mismanagement of patient care • Multiple complaints / independent review	• Totally unacceptable level or quality of treatment or service • Inquest / Ombudsman inquiry
Patient and Staff Safety - Impact on the Individual (physical or psychological)	• Minimal injury requiring nominal intervention or treatment • Reputation concerns - Rumours	• Low harm injury or illness requiring minor or short-term intervention • Minor implications for patient safety if unresolved • Local media interest – short term	• Moderate injury requiring professional intervention • Major patient/staff safety implications if effective controls and mitigations are not put in place. • Local media interest– long term	• Severe injury leading to long-term incapacity / disability • Mismanagement of patient care with long-term effects • Non-compliance with national standards with significant risk to patients if unresolved • PHSO involved	• Incident leading to death • Multiple permanent injuries or irreversible health effects • Gross failure of patient safety if controls and mitigations put in place are ineffective • National media 3 days or more • MP concerns (questions in House)
Workforce / Staffing / Training and Competence	• Short-term low staffing level temporarily reduces service quality for <1 day	• Ongoing low staffing level reduces service quality •	• Late delivery of key objective / service due to lack of staff • Minor error due to lack of, training, or effective training or capacity to attend • Ongoing unsafe staffing level	• Uncertain delivery of key objective / service due to lack of staff • Serious error due to lack of training, or effective training or capacity to attend training	• Non-delivery of key objective / service due to lack of staff • Loss of key staff • Very high staff turnover • Serious Clinical error resulting in serious patient harm/death due to insufficient training
Performance, Business Objectives, Projects	• Interim and recoverable position • Negligible reduction in scope or quality • Insignificant cost increase	• Partial failure to deliver service/business/project objectives • Minor delay in delivery • Minor reduction in quality / scope	• Some key objectives met • Definite reduction in quality / scope • Significant delay expected in delivery • Definite escalating risk of non-recovery of situation	• Majority of key objectives not met • Irrecoverable schedule slippage that will have a critical impact on project success	• Strategic Organisational objectives not met • Unable to deliver project/objectives
Business Continuity, EPRR	• Loss / interruption of >1 hour	• Loss / interruption of >8 hours	• Loss / interruption of >1 day	• Loss / interruption of >1 week	• Permanent loss of service or facility

Risk Type	1 Negligible	2 Minor	3 Moderate	4 Severe	5 Catastrophic
Finance including Claims	• No or minimal impact on cash flow • Complaint unlikely • Litigation risk remote	• Readily resolvable impact on cash flow • £375k - £750k (0.25% - 0.5% of organisational annual budget) • Complaint possible • Litigation unlikely	• Individual supplier put Trust 'on hold' • £750k - £1,125k (0.5% - 0.75% of organisational annual budget) • Complaint expected • Litigation possible	• Purchasers failing to pay on time • Uncertain delivery of key objectives • £1,125k - £1.5m (0.75% - 1% of organisational annual budget) • Litigation expected	• Failure to meet specification or slippage • Non delivery of key objective • £1.5m or above (1% or organisational annual budget)
IM&T	• Information system issue affecting a single individual or very small team • No impact on patient safety	• Information system issue affecting one service? • Poor functionality of organisation-wide system, readily resolvable and not impacting on service delivery • Smaller number of staff affected with some impact on service delivery	• Information system issue affecting one directorate • Poor functionality of organisation-wide system impacting on service delivery but readily resolvable • Smaller number of staff affected with service delivery and some patient safety implications	• Information system issue affecting more than one directorate. • Poor functionality of organisation-wide system impacting on service delivery but not readily resolvable • Smaller number of staff affected with major impact on service delivery and patient safety	• Complete failure of organisation-wide information system that directly impacts on service delivery
Regulation and Compliance including all statutory, corporate responsibilities, Information Governance	• No or minimal impact or breach of guidance / statutory duty • Minor recommendations • Reputation concerns - Rumours •	• Non-compliance with standards • Reduced rating • Recommendations given • Local media interest – short term •	• Single breach in statutory duty • Challenging external recommendation • Improvement notice • Local media interest– long term •	• Enforcement action • Multiple challenging recommendations • Improvement notices • Critical report • National media interest - <3 days • PHSO involved	• Prosecution • Multiple breaches in statutory duty • Complete systems change required • Severely critical report • Multiple permanent injuries or irreversible health effects • National media 3 days or more • MP concerns (questions in House)
Regulation and Compliance - CQC	• No or minimal impact or breach of guidance / statutory duty • Minor recommendations • Reputation concerns - Rumours	• Non-compliance with standards • Reduced rating • Recommendations given • Local media interest – short term	• Single breach in statutory duty • Challenging external recommendation • Improvement notice • Local media interest– long term	• Enforcement action • Multiple challenging recommendations • Improvement notices • PHSO involved	• Prosecution • Multiple breaches in statutory duty • Complete systems change required • Severely critical report • National media 3 days or more • MP concerns (questions in House)

Risk Type	1 Negligible	2 Minor	3 Moderate	4 Severe	5 Catastrophic
Health, Safety and Security	• No time off work	• Requiring time off work for <3 days	• Requiring time off work for 4-14 days • RIDDOR / MHRA / agency reportable incident	• Requiring time off work for >14 days	• Multiple permanent injuries or irreversible health effects

Likelihood Score - consider which measure below (frequency or probability) works best for the risk that is being assessed

Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
Frequency 1 (Very useful for recurring events such as incidents. Commonly used measure for patient safety and patient experience risks)	Not expected to occur for years	Expected to occur at least annually	Expected to occur between quarterly and monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability 2 (will it happen or not?) (Very useful for one-off or infrequent events such as delivery of a project)	<0.1 per cent	0.1 – 1 per cent	1.1 – 10 per cent	11 – 50 per cent	>50 per cent

Risk Score (= impact x likelihood)

Likelihood Score → **Impact/Severity Score ↓**	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic	5	10	15	20	25
4 Severe	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Grade

Risk Score	Risk Grade
1 - 3	Low Risk
4 - 6	Moderate Risk
8 - 12	Significant Risk
15-25	High Risk

Appendix B - Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travelers)	No	
	• Nationality	No	
	• Gender (including gender reassignment)	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	
	• Disability – learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?**		N/A
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**		N/A
6.	**What alternative is there to achieving the document/guidance without the impact?**		N/A
7.	**Can we reduce the impact by taking different action?**	No	

Board Report

Date	13th June 2023	**Agenda item**	Consent Agenda Item 16
Title	Audit, Assurance & Risk Committee Summary Report of meetings on 8th February & 30th May 2023		
Author	Rachel Corrigan, Corporate Governance Manager		
Presented by	Lorna Harrison – AARC Chair	**Version**	1
For	Approval/decision ☒ Debate ☐ Assurance ☒ Information ☒		

Purpose of the report

This report is to inform the Board of the key items discussed at the Audit and Assurance Committee meeting held in February and May, and to give assurance on the matters within the Committee's remit.

Why is this report coming to the Board

The Audit & Assurance Committee are delegated by the Board to provide independent scrutiny and objective challenge on Sirona's financial and internal controls and provide this report to the Board for assurance.

Related Risk No. (If applicable)	

How has this report been developed

Information has been gathered to inform this report from representative coporate services and external providers of contracted auditing services.

What is the process the report has been through internally

This report has been prepared as a summary of items and discussions undertaken by the Audit & Assurance Committee at their meetings in February and May as noted within the minutes of those meetings.

Summary and Key Issues Highlighted by these teams, including mitigations

Please highlight in summary the key messages from this report, including matters of escalation from Committees or other Teams, significant issues, risks and actions to address them

As per the verbal briefing provided to the Board on 14th February on the key points of the Committee's meeting on 8th February, the following confirmation of that briefing is provided for reference:

External Audit Plan – This was received, setting out the roles and responsibilities for the preparation of the 2022/23 financial statements, with formal presentation and approval of the Annual Statements scheduled for August 2023. Committee were assured by the content of the plan and arrangements in place with the Finance Team to deliver to the agreed timeframe.

Annual Information Governance Report – received for assurance as the designated monitoring committee for this function. Information was provided on training compliance, number of breaches, mitigation of risks and plans to move towards digitalisation of all records. A review of IG policies is planned, with an update on progress of review scheduled for the May meeting. There were no issues to escalate.

Risk Management

- received the revised risk management policy for consultation ahead of review by the Executive Committee to obtain agreement on the risk monitoring groups
- reviewed the risks assigned to the AAC as the monitoring committee and was assured by the activity regarding mitigations
- received a report on the work to embed the Risk Management Process across the organisation, including a new training suite, updated induction pack for new starters and dedicated support in the management of risk

Conflicts of Interest, Gifts & Hospitality - assured by the report on the management of conflicts of interest.

Policy Reviews - Received an update on the status of policies and assured by the improved levels of compliance of policies within review period and plans surrounding those coming due for review.

Terms of Reference - Agreement reached on the addition of Risk to the title of this committee and recommendation to take to Board for formal approval.

Internal Audit Arrangements –

- Received a progress report from Internal Auditors on the status of the IA plan and agreed to remove the audit surrounding EDI data in light of other reviews on this subject being undertaken as part of the wider EDI agenda
- In reviewing detailed recommendation reports for IA's undertaken around Financial Sustainability, AAC identified a training need for some members surrounding financial awareness training
- Received the quarterly Cyber Security Report and received assurance on the measures in place to keep us safe in this area within the scope of this audit
- Received the draft internal audit plan for the 2023/24 period and agreed to six throughout the reporting period with an aim to complete five
- Local Counter Fraud Report received and no notable concerns for Sirona
- An outline plan to procure Internal Auditor services was received and supported by the Committee to be progressed with a view to new contract commencing in Jan 24

At the Committee meeting on 30th May, which was held in person, the Committee was concerned about the high number of policies coming due for review within the next period, in terms of staff capacity to meet review deadlines. The Committee requested the matter be raised with the Executive Team to ensure that action would be taken to make progress in this area. Policy Status reports are received at every quarterly meeting for on-going monitoring of the situation.

The Committee was also concerned that many risks and actions related to risks were not being updated on time. Assurance was given that long standing high scoring risks would be reviewed in detail by the Risk Team and reported on at the next committee meeting on 2nd August.

A summary of the other items considered by the Committee is provided below. There were no issues or matters of concern to highlight from these areas of business, however a recent Cyber Security Risk had identified shortcomings within the recent Internal Audit and an internal review of how Internal Audits were scoped is to be arranged.

Companies House Reporting
Confirmation on arrangements was noted as:

- Registration of directors brought to Committee's attention and the numbers of Exec vs NED registered, this would be re-visited once the Chief People Officer has been appointed
- Articles of Association to be reviewed and once completed they will need to be filed with Companies House. Work is planned with a small working group from Members to review the Membership constitution, which may have further impact of the Articles.
- Sirona Care Services information to be considered for future Board agenda to ensure clear understanding of why established, with further thought needed on retaining this as a potential business model for the future.

- The Corporate Governance team operate checklists for completion when a NED's term of office ends and as part of a new NED's induction, and maintain a Compliance timetable for the annual cycle of activity, including submission of accounts/annual reports.
- The Corporate Governance team co-ordinates with HR and the CEO to support the updates for Executive Directors when required.

Policy Reviews

- Committee assured that reporting will continue as quarterly. It was confirmed that consideration is given to staggering review dates to reduce the impact on the capacity to review.

Insurance Renewal Arrangements

- New broker arrangements now in place, with better terms on coverage and improved costings.
- Review meetings planned and Committee assured that Cyber Security is a specific area of focus

Review of Delegations of Authority Policy

- Committee advised that whilst due for review, there would be a short delay whilst the 2023-24 Budget and Business Plan are embedded; that a small task and finish group would consider any changes and return the updated policy to the August meeting.

Risk Management

- Committee supported proposed amendments to the Risk Management Policy and that the policy be taken for approval to the Board.
- Received detailed quarterly report on the management of risk and status of those risks assigned to the AARC as the monitoring committee.
- The committee was assured by the continued efforts surrounding the training and management of risk but sought further assurance on the management of those risks remaining on the register of two years or longer and it was agreed that those with scores of 16+ with this criteria would be brought to the August meeting for an in depth review.
- Committee Chairs' specific request is for all committees to prioritise the review of their assigned risks, as there seems to be a lack of review and/or some questions around scoring etc. focussing on the highest scoring risks assigned to them.

Internal Audit Arrangements

- Remaining 2022-23 findings report on the EPRR internal audit scheduled for August
- Regarding the timing of the BAF/Risk Management audit, consideration to be given to deferring by a month or two due to the clash with external audit activities and resulting reduced capacity within the Finance Team.
- Clarity sought on the scope of recent Cyber Security audit, with agreement to review scoping of internal audits
- Counter Fraud Plan received, and actions associated with the plan supported.

AOB

- The absence of a Fixed Asset Register was raised as a concern and, due to other Finance priorities detailed above, a detailed plan on the implementation of a Fixed Asset Register was requested for the November meeting, to include timelines and cost implications.

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

Board is asked to:

- To approve the Terms of Reference for the Committee to add Risk to the title.
- To note the updates provided from the meetings on 8th February and 30th May 2023.

Terms of Reference

Audit, ~~&~~ Assurance & Risk Committee

Version Control:

Version	Date	Author	Owner	Status (Active or Dissolved)	Review Date
V3.2	Nov 2022	Rachel Corrigan	Lorna Harrison	Active – Board Ratification Feb 2023	November 2023

Approval Process:

These Terms of Reference must be approved by those people identified as members of the group and signed off by the Director or Committee to which this group reports.

Name	Position	Signature	Date
Amanda Cheesley	Chair of the Board		

Principle Function *(consider the decision making, assurance and delivery aims for the group)*
The overarching purpose of the Audit, ~~and~~ Assurance & Risk Committee, on behalf of the Board, is to: • Provide the Board with an independent and objective review on Sirona's financial and non-financial systems, financial and non-financial information and compliance with laws, guidance and regulations • Delegated to review and recommend to the Board for approval, the Financial Statement and Annual Accounts • Provide assurance to the Board on the effectiveness of governance systems and processes, risk management and internal control; internal and external audit, counter fraud and security management and financial reporting • Approving internal and external audit plans, reviewing progress against these and receive assurance on actions taken in response to audit reports • Reviewing key assurance documents such as Quality Accounts, Governance Framework, Quality Assurance Framework

Purpose
The Committee should carry out the duties below: **1. Financial reporting** 1.1. The Committee shall monitor the integrity of the financial statements of the Company, including its annual reports, interim management statements, and any other formal announcement relating to its financial performance, reviewing significant financial

reporting issues and judgements which they contain. The Committee shall also review summary financial statements.

1.2. The Committee shall review and challenge where necessary:

1.2.1. the consistency of, and any changes to, accounting policies both on a year on year basis and across the Company

1.2.2. the methods used to account for significant or unusual transactions where different approaches are possible

1.2.3. whether the Company has followed appropriate accounting standards and made appropriate estimates and judgments, taking into account the views of the external auditor

1.2.4. the clarity of disclosure in the Company's financial reports and the context in which statements are made; and

1.2.5. all material information presented with the financial statements, such as the operating and financial review and the corporate governance statement (insofar as it relates to the audit and risk management);

2. Assurance: internal controls, risk management systems and policies

The Committee shall:

a) to consider the entries on the corporate risk register which are assigned to the Committee and any risks that are escalated to them by the Subject Matter Groups, ensuring that the risks are appropriately prioritised and adequately controlled and that assurance is given to the Board that those risks are being appropriately managed. The Committee will include in each report to the Board a summary of the risks considered and details of any significant concerns as appropriate.

b) keep under review the effectiveness of the Company's internal controls and risk management systems; and in particular:

I. review the adequacy of all risk and control related disclosure statements (in particular the Statement of Internal Control and declaration of compliance with Care Quality Commission), together with any accompanying Internal Audit statement, external audit opinion or appropriate independent assurances, prior to endorsement by the Board.

II. the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

III. the appropriate policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements

IV. Review register of Policies to be assured that internal controls in relation to policy reviews and updates are compliant.

c) review and approve the statements to be included in the annual report concerning internal controls and risk management

d) In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3. Whistle blowing and fraud

3.1 The Committee shall:

a) review the Company's arrangements for its employees to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action;

b) review the Company's procedures for detecting fraud

c) review the Company's systems and controls for the prevention of bribery and receive reports on non-compliance

4. Internal Audit

4.1 The Committee shall consider annually whether there is a need for an internal audit function and make a recommendation to the Board accordingly and where such function exists will:

a) oversee the selection process for internal auditors where the function is outsourced

b) monitor and review the effectiveness of the Company's internal audit function in the context of the Company's overall risk management system

c) consider and approve the remit of the internal audit function and ensure it has adequate resources and appropriate access to information to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee shall also ensure the function has adequate standing and is free from management or other restrictions

d) review and assess the annual internal audit plan

e) review promptly all reports on the Company from the internal auditors

f) give consideration to the major findings of the internal audit work and review and monitor management's responsiveness to the findings and recommendations of the internal auditor; and

5. External Audit

The Committee shall:

5.1 Consider and make recommendations to the Members, in relation to the appointment, re-appointment and removal of the Company's external auditor. The Committee shall oversee the selection process for new auditors and if an auditor resigns the Committee shall investigate the issues leading to this and decide whether any action is required

5.2 Oversee the relationship with the external auditor including (but not limited to):

a) approval of their remuneration, whether fees for audit or non-audit services and that the level of fees is appropriate to enable an adequate audit to be conducted

b) approval of their terms of engagement, including any engagement letter issued at the start of each audit and the scope of the audit

c) assessing annually their independence and objectivity taking into account relevant UK professional and regulatory requirements and the relationship with the auditor as a whole, including the provision of any non-audit services

d) satisfying itself that there are no relationships (such as family, employment, investment, financial or business) between the auditor and the Company (other than in the ordinary course of business)

e) agreeing with the Board a policy on the employment of former employees of the Company's auditor

f) monitor the implementation of this policy by monitoring the auditor's compliance with relevant ethical and professional guidance on the rotation of audit partners, the level of fees paid by the Company compared to the overall fee income of the firm, office and partner and other related requirements

g) assessing annually their qualifications, expertise and resources and the effectiveness of the audit process which shall include a report from the external auditor on their own internal quality procedures

h) seeking to ensure co-ordination with the activities of the internal audit function, where this function is in place

5.3 meet regularly with the external auditor. The Committee shall meet the external auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit

5.4 review and approve the annual audit plan and ensure that it is consistent with the scope of the audit engagement

5.5 review the findings of the audit with the external auditor. This shall include but not be limited to, the following:

a) a discussion of any major issues which arose during the audit

b) any accounting and audit judgements

c) level of errors identified during the audit

5.6 review the effectiveness of the audit

5.7 review any representation letter(s) requested by the external auditor before they are signed by management

5.8 review the management letter and management's response to the auditor's findings and recommendations

5.9 develop and implement a policy on the supply of non-audit services by the external auditor, taking into account any relevant ethical guidance on the matter

Governance *(should include the groups delegated authority and reporting requirements)*

Reporting Responsibilities

The Chair shall report formally, by way of a Chair Summary Report, to the Board on the Committee's proceedings after each meeting on all matters within its duties and responsibilities

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

The Committee shall compile a report on its activities to be included in the Company's annual report.

Authority

The Committee has delegated authority by the Board to:

- seek any information it requires from any employee of the Company in order to perform its duties
- obtain, at the Company's expense, outside legal or other professional advice on any matter within its terms of reference
- call any employee to be questioned at a meeting of the Committee as and when required
- have the right to publish in the Company's annual report details of any issues that cannot be resolved between the Committee and the Board.

Monitoring Effectiveness and Review of Terms of Reference

To monitor the effectiveness of the Committee an annual retrospective review of its work programme will be undertaken to confirm whether the Committee has met the requirements as set out in the Terms of Reference for the preceding year. The Committee shall also review its constitution and terms of reference annually to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Committee's review of its effectiveness will be included in an end of year report to the Board summarising the work of Committee throughout the year.

Other Matters

The Committee shall:

a) have access to sufficient resources in order to carry out its duties, including access to the Company Secretariat for assistance as required

b) be provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members

c) be responsible for co-ordination of the internal and external auditors

d) oversee any investigation of activities which are within its terms of reference

Meeting of Company Members

The Chair of the Committee shall, by invitation, attend any meeting of Company Members prepared to respond to any question from the Members on the Committee's activities

Membership

Members of the Committee shall be appointed by the Board. The Committee shall be made up of all Non-Executive Directors.

The Board shall appoint the Committee Chairman who shall be an independent non-executive director with a financial background. In the absence of the Committee Chairman and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the

meeting.

All members of the Committee shall be independent non-executive directors at least one of whom shall have recent and relevant financial experience.

The Chairman of the Board shall not be a member of the Committee.

Only members of the Committee have the right to attend Committee meetings, although, the Director of Finance shall normally attend meetings and the internal auditors will also be invited to attend meetings.

The Committee reserves the right to extend an invite to individuals to attend all or part of any meeting as and when appropriate.

The external auditors will be invited to attend meetings of the Committee at least once a year at which meeting Executive Board members may be excluded for all or part of the meeting.

Roles and Duties: *(Consider Reporting and Communication of outcomes or decisions)*

Chair:

- Planning agendas with members including timings, and who leads each item.
- Agreeing the purpose of items being brought to the meeting against the principal functions and whether they are for information, discussion or decision.
- Working with nominated secretariat to ensure agendas and papers are sent out in 7 days advance.
- Keeping the meeting to time and the agenda.
- Setting the scene for each item and clarifying the objective.
- Allowing full participation of all members and freedom of expression
- Identifying and communicating key messages regarding decisions, risks etc. regularly to the Board

Meeting Arrangements and Support *(To include frequency and timing of meetings)*

Secretariat

The Secretary to the Board or their nominee shall act as the secretary of the Committee.

Committee Arrangements

The Committee will meet at least four times a year at appropriate times in the reporting and audit cycle. The Secretary to the Board will liaise with the Chair to set the meeting dates for the year and these will be communicated to the members at the beginning of each financial year.

At the discretion of the Committee Chair an extraordinary meeting can be arranged for specific purposes.

The agenda and papers will be sent to the Committee members at least five working days before the meeting. Relevant papers will also be sent to attendees of the meeting. It is the responsibility of the person producing the paper to ensure their paper is with the Committee's secretariat at least six working days before the meeting.
Any papers received after this date will only be included on the agenda with the agreement of the Committee Chair.

All authors of papers will be required to attend to present their paper(s) and respond to any questions raised.

Minutes of Meetings

The Secretary to the Board, or their nominee, shall minute the proceedings and resolutions of all meetings of the Committee, including recording the names of those present and in attendance and the recording of any agreed actions or decisions.

The Chair shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.

Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

QUORACY (*the minimum representatives from the organisation required for the group to make any decisions)*

The quorum necessary for the transaction of business shall be 3 members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

GDPR PRIVACY NOTICE

In line with the General Data Protection Regulations (GDPR) and the Data Protection Act (DPA 2018) Sirona care & health is registered as a Data Controller. As an attendee of this meeting, you can find out how your personal data is processed by visiting our website www.sirona-cic.org.uk.

Video Conferencing
If the meeting is to be recorded then the Chair of that meeting will make it clear to all attendees that this will be happening and outline any plans for the recordings and/or transcripts (e.g. sharing with all attendees).
Any implications for attendees as a result of turning on their camera in order to participate in a video conference call or meeting will be explained at the start of the meeting, including if their image will become available to everyone in attendance.

Attendees may choose to participate via audio only, especially for Safeguarding, confidential or meetings of a sensitive nature.

Depending on how personal accounts are set up by external attendees, their name, email, etc. may be available to other attendees, and it is essential to ensure that they are informed that what they say may be recorded.

Clarity must be provided by the Chair at the beginning of the meeting in regards to the retention of any recordings gathered during the meeting, including screen sharing or discussions of a Safeguarding, confidential or sensitive nature.

Meeting participants should be informed that when meetings on MS Teams are recorded, the resulting video file is stored on the NHSmail cloud for all in the NHSmail population, i.e. nationally available to the NHS Mail network.
This means that the following elements **should not be included** in recordings of MS Teams conference meetings or calls:

- patient identifiable information
- sensitive business information
- confidential corporate information

STANDING AGENDA & FORWARD PLANNING

See following examples

Sirona care & health

AUDIT & ASSURANCE COMMITTEE				
Date:				
Time				
Venue:				
AGENDA				
OPENING BUSINESS				
1.	**Apologies from Committee members**:			
	Unable to attend:			
2.	**Declaration of Interest** Those present are asked to declare if they have any direct or indirect interest in any way in the proposed transactions to be considered at the meeting		Chair Verbal	5 mins
3.	**Minutes from Previous Meeting** To approve the minutes of the meeting held on:		Chair Paper	
4.	**Action List and Matters Arising** Update on actions arising from previous meetings		Chair Paper	
	CORPORATE GOVERNANCE / RISK /ASSURANCE ITEMS			
5.				
	INTERNAL & EXTERNAL AUDIT ITEMS			
6.				
	REGULATORY ITEMS			
7.				
	CLOSING BUSINESS			
8.	**Closing Summary** To agree decisions and actions for the minutes and quarterly Board report **Next meeting** To discuss and agree items to be presented at the next meeting.		Chair	Verbal
9.	DATES FOR NEXT AND FUTURE MEETINGS:			

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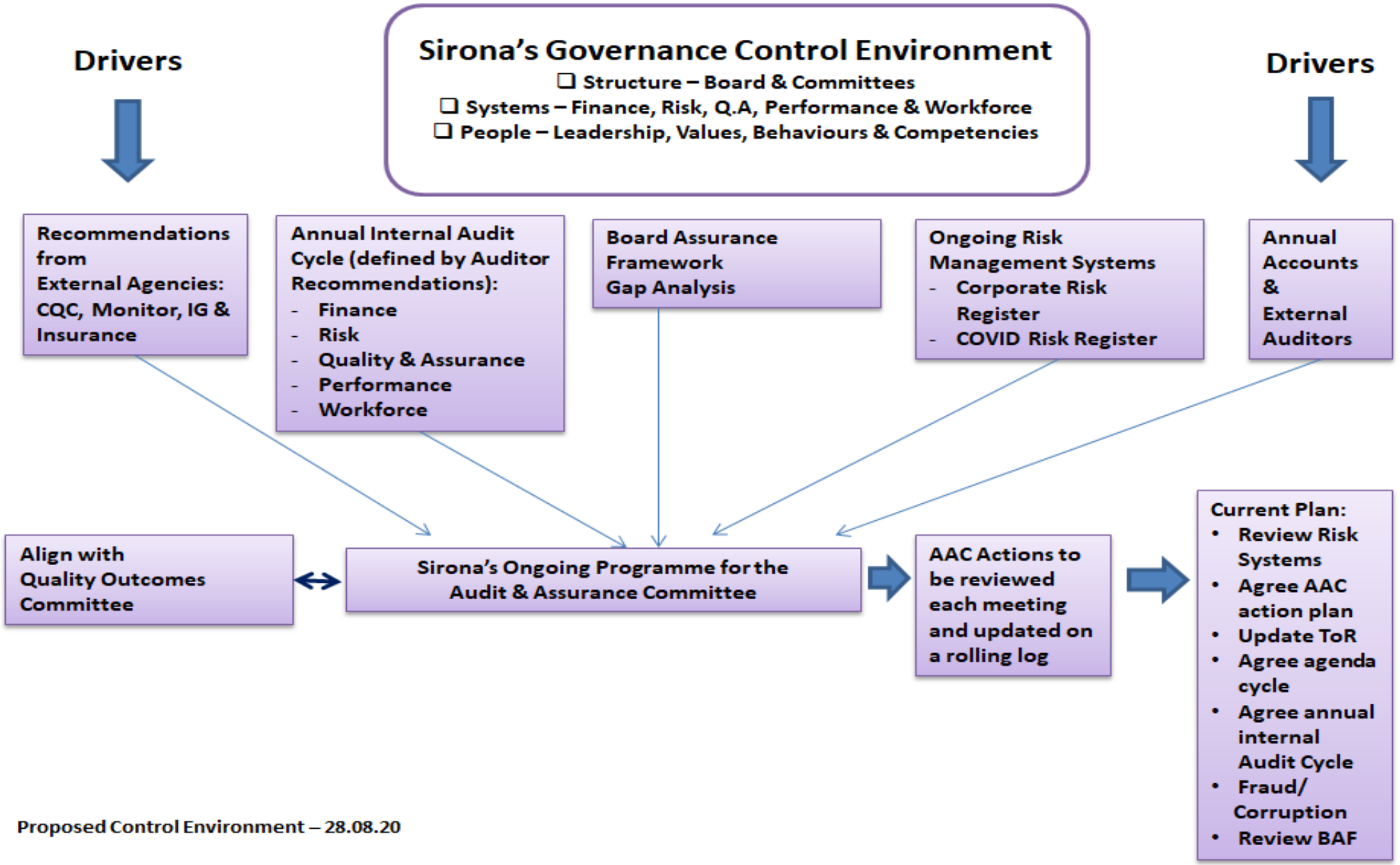
Appendix 1 – A & A Terms of Reference



Proposed Control Environment – 28.08.20

Board Report

Date	13th June 2023	**Agenda item**	Consent Agenda Item 17
Title	People Committee Summary Report		
Author	Tayo Gaji, Corporate Governance Administration Manager		
Presented by	Anil Patil	**Version**	1.0
For	Approval/decision ☒ Debate ☐ Assurance ☒ Information ☒		

Purpose of the report

To inform the Board of the key items discussed at People Committee meeting on 29th March 2023 and 24th May 2023 to give assurance on the matters within the Committee's remit.

Why is this report coming to the Board

E.g. is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

The Committee is delegated by the Board to provide independent scrutiny and objective challenge on Sirona's People Strategy and Workforce Agenda, and to provide this report to the Board for assurance.

Related Risk No. (If applicable)	

How has this report been developed

Including the lead director, those involved in preparing the report and the sources of information relied on

The papers considered by the Committee were prepared by key staff of the People Directorate led by the Interim Chief People Officer (Sheridan Flavin).

What is the process the report has been through internally

i.e. which teams or groups have reviewed the report or the information that informs it

The Committee considered all the reports presented at both of its meeting held on 29th March 2023 and 24th May 2023.

Summary and Key Issues Highlighted by these teams, including mitigations

Please highlight in summary the key messages from this report, including matters of escalation from Committees or other Teams, significant issues, risks and actions to address them

- The key areas discussed at the Committee meeting held on 29th March 2023 include:

Terms of Reference

Consideration of the ToR defining membership, attendance, quoracy and general governance consideration for the effectiveness and management of Committee meetings and recommendation to take to Board for formal approval.

People Strategy

An update to the rewrite of the People strategy in a concise and accessible format was given. There is a plan to socialise it within the organisation and staff consultations have commenced. Feedback from ALDs, staff networks, Exec Co. etc. will further inform the strategy.

Staff Survey

Assurance was received surrounding priorities and actions in response to the key themes identified within the results of the 2022 Staff Survey. Further progress reports will be provided throughout the year.

Workforce Dashboards & Development of KPIs

With the implementation of a workforce dashboard, the Committee were assured that managers will in future be able to make evidence-based workforce decisions. The workforce dashboard pulls data primarily from the Electronic Staff Record (ESR) and data from e-rostering platform.

E-rostering

Progress report provided to inform the Committee of the status of this crucial staffing management tool, which commenced in April 2021 and linked to safer staffing & agency controls, additionally, it was reported that the rollout will continue across defined services, and this is fully supported by the Executive Committee. The Executive Committee has approved the following:

(a) The expansion plan and associated costs.
(b) To support and champion the E-rostering as an organisational priority – commitment.
(c) To agree the ring-fencing of the E-rostering team resource to deliver the roll-out commitment.

The key issues discussed at the Committee meeting held on 24th May 2023 include:

Staff Retention

Assurance was received on the number of measures now in place and planned to improve our staff retention rates. Some of the initiatives we have introduced to reduce staff turnover include the Itchy Feet service, Exit Interviews, OneYou Retention Initiative Package and addressing concerns raised within the Staff Survey.

Staff Wellbeing

A presentation of our data around staff wellbeing (including Sickness absence data (ESR, March 2023), NHS Staff Survey (2022), Risk Register (Ulysses, May 2022), EAP Report (Health Assured, March 2023), Workforce wellbeing questionnaire (July 2022) and health checks clinic results) was presented at the meeting highlighting our initiatives to support and improve staff wellbeing, which will continue to be an area of focus for the Committee.

People & Development Group

A report on the formation, standard agenda items and the Terms of Reference for the People & Development Group was considered by the Committee. The P & D Group is a monthly forum where the people & development leads (consisting of associate directors, heads of functions etc) meet to discuss current issues, address concerns and ratify/amend policies.

Freedom to Speak Up

Following the recent changes to our policy, a comprehensive update on the activities of the group was reported to the Committee providing assurance.

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

The Board is asked to:

- To approve the Terms of Reference for the Committee

And to note the following.

- The Committee will continue to seek assurance that there are sufficient resources against delivery and achievement of plans.
- The Committee are cognisant of any risks associated with the delivery of programmes and plans.

This paper is to provide a written record of that assurance for the Board to note, together with the other matters considered.

Terms of Reference
People Committee

Version Control:

Version	Date	Author	Owner	Status (Active or Dissolved)	Review Date
1	March 2023	Sheridan Flavin Interim Chief People Officer	Anil Patil, Chair of People Committee	Active	March 2024

Approval Process:

These Terms of Reference must be approved by those people identified as members of the group and signed off by the Directorate Executive or Committee to which this group reports.

Name	Position	Signature	Date
Amanda Cheesley	Chair of the Board of Directors		

Purpose ***(the why and how)***
The People Committee is as a formal Committee to the Sirona Board, responsible for providing assurance to the Board on the quality and impact on all aspects of workforce and organisation development. This includes assurances around the delivery of the NHS People Plan, NHS People Promise and the Sirona People Strategy - ensuring that Sirona achieves the objective of being *'a great and inspiring place to work'*.

Principal Function ***(consider the decision making, assurance and delivery aims for the group)***
The Committee is the primary Board Committee for providing assurance and raising any concerns to the Sirona Board about delivery of the Sirona People Strategy and organisational priorities in relation to the workforce. The Committee will provide the Sirona Board with an independent and objective review of, and assurances in relation to: • Workforce & Organisational Development (OD) risks recorded on the Board Assurance Framework (BAF). • The development and delivery of a People Strategy that supports the delivery of the corporate objectives. • The creation and delivery of a clear workforce plan aligned to Sirona's business plan and financial envelope to provide assurance that the Sirona has adequate staff with the necessary skills and competencies to meet the current and future needs of the people accessing our services. • Oversight on the delivery of appropriate plans to ensure that we have the right people, in the right job, with the right skills, at the right place, at the right time and for the right cost. • The effectiveness of our internal communication strategy and staff engagement plans.

- The effective monitoring and regular reporting of our workforce performance and sustainability indicators and KPI's, including but not limited to, sickness absence, staff turnover/retention, learning & development, appraisal, mandatory training, employee relations, people practices and bank and agency usage and expenditure - monitoring any necessary corrective plans and actions.
- As part of the above, monitoring and reviewing employee engagement and experience, reviewing staff surveys (national & pulse surveys and colleague feedback) and delivery plans to achieve a highly motivated and engaged workforce.
- The effectiveness of recruitment and retention processes to ensure that Sirona has the people to deliver its strategy.
- The effectiveness of arrangements to understand and improve health and wellbeing of the workforce.
- The effective identification and mitigation of workforce and organisational development risks within the supporting infrastructure of the Board Assurance Framework and Risk Register.
- The effectiveness of learning, development, training, and education of the workforce in all professions, including clinical workforce development and continuous professional development.
- Leadership and management development, including talent management and succession planning.
- National reports and best practice relating to workforce and organisational development.
- Receive assurance on the HR aspects of any external/internal compliance reviews that have raised concerns at Board and/or Executive Team.
- Development of effective and compassionate people practices and a just and learning culture.
- Other people related activity and priorities as requested by the Board.
- Signpost to the appropriate channels for those items not under the remit of the Committee's Principal Functions

The Committee will formally ratify new or significantly updated People & Development policies (as listed within the policy governance framework) that have been through the appropriate consultation and approval routes.

Governance *(should include the groups delegated authority and reporting requirements)*

The Committee will be supported in executing its responsibilities through People & Development Group.

Risk Monitoring

To consider the entries on the corporate risk register which are assigned to the Committee and any risks that are escalated to them by the Subject Matter Groups, ensuring that the risks are appropriately prioritised and adequately controlled and that assurance is given to the Board that those risks are being appropriately managed. The Committee will include in each report to the Board a summary of the risks considered and details of any significant concerns as appropriate.

Reporting Responsibilities

The Chair shall report formally, by way of a Summary Report, to the Board on the Committee's proceedings after each meeting on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

The Committee shall compile a report on its activities to be included in the Company's annual report.

Authority

The Committee has delegated authority by the Board to:

- seek any information it requires from any employee of the Company in order to perform its duties
- obtain, at the Company's expense, outside legal or other professional advice on any matter within its terms of reference

- to invite any member of staff to attend to speak to the Committee and all members of staff are required to cooperate with any request made by the committee have the right to publish in the Company's annual report details of any issues that cannot be resolved between the Committee and the Board.

The Committee shall:

- have access to sufficient resources to carry out its duties, including access to the Company Secretariat for assistance as required
- be provided with appropriate and timely training as required
- oversee any investigation of activities which are within its terms of reference

Monitoring Effectiveness and Review of Terms of Reference

To monitor the effectiveness of the Committee an annual retrospective review of its work programme will be undertaken to confirm whether the Committee has met the requirements as set out in the Terms of Reference for the preceding year. The Committee shall also review its constitution and terms of reference annually to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Committee's review of its effectiveness will be included in an end of year report to the Board summarising the work of Committee throughout the year.

Sub-Groups

The following operational/sub-group minutes will be shared with the Committee to provide a high-level summary of matters from these groups:

- People & Development Group
  The purpose of People and Development Group is to steer and co-ordinate the creation and delivery of workforce strategies, plans, systems and processes.

Distinction between Committees responsibilities

It is important to ensure the Committee remits are clear to avoid duplication and overlap between the Quality & Outcomes, Equality, Diversity & Inclusion and Professional Council Committees. The following table summarises the distinctions. For more information, the full Terms of Reference for each can be reviewed.

Responsibilities covered by other Committees or groups:	People Committee responsibilities cover:
• Health & Safety – Quality & Outcomes Committee • Equality & Diversity within Sirona – EDI Committee • Health Inequalities - EDI Committee • Competency Frameworks – Professional Council	• People & Development Strategy (and related programmes of work) • Annual Workforce Report • Colleague Experience inc. Staff Survey • Freedom To Speak Up • Safer Staffing Monitoring

The Committee will act to minimise any possible areas of overlap between these Committees through regular discussion between the Chairs of Quality & Outcomes, Equality, Diversity & Inclusion, Professional Council, and Performance Committees.

The Chair of the Committee shall, by invitation, attend any meeting of Company Members prepared to respond to any question from the Members on the Committee's activities

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Committee Members	
Name	**Job Title**
Core Members *(expected to attend all meetings or send a deputy)*	
Anil Patil	Non-Executive Director (Chair)
Simon MacSorley	Non-Executive Director
Sheridan Flavin	(Interim) Chief People Officer
Mary Lewis	Chief Nursing Officer
Kathryn Bateman	Chief Medical Officer
Penny Agent	Chief Therapy & Allied Health Professionals Officer
Ceridwen Massey	Chief Operating Officer
Kelly Thompson/ Victoria Kennedy-Hall	Chair of Our Voice
Sarah Osborne	(Interim) Deputy Chief People Officer
Standing Invitation	**Job Title**
Amanda Cheesley	Chair of the Board of Directors
Julie Sharma	Interim Chief Executive Officer

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Roles and Duties: *(Consider Reporting and Communication of outcomes or decisions)*

The Committee will be chaired by a Non-Executive Director. In the absence of the Chair, another NED colleague will be nominated.

The administration of the meeting will be the responsibility of the Corporate Governance Team who will arrange to take minutes of the meeting and provide appropriate support to the Chair and committee members.

The People Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair.

Chair (Name or Role):

- Develop and plan agendas with the Chief People Officer and a member of the corporate governance team
- Agreeing the purpose of items being brought to the meeting against the key functions and whether they are for information, discussion, or decision.
- Keeping the meeting to time and the agenda.
- Setting the scene for each item and clarifying the objective.
- Allowing full participation of all members and freedom of expression, ensuring that the meeting etiquette is understood (i.e., use of commentary box or raised hands if using video MS Teams)
- Identifying and communicating key messages regarding decisions, risks etc.

Everyone:

- Exemplify good meeting behaviors
- To be an active participant within the meeting
- To proactively seek feedback from their teams/service on the content of the meetings and bring this back to the group members
- Talk to colleagues outside of / in advance of meetings about key issues and items.
- Provide constructive challenge and support to peers in the deliver to their objectives
- Highlight opportunities and potential risks as they emerge.

Corporate Governance Team: (administration support)

- In consultation with the Committee Chair and the Chief People Officer, develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Committee chair with support from the Chief \People Officer.
- Ensuring agendas and papers are sent out at least 7 days in advance.
- Taking the minutes and keeping a record of maters arising and issues to be carried forward
- Advising the committee members of scheduled agenda items on forthcoming meetings
- Agreeing the action schedule with the Chair and ensuring circulation
- Maintaining a record of attendance and sharing this on an annual basis.

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All members must declare any actual or potential conflicts of interest relevant to the work of the People Committee, which shall be recorded in the minutes accordingly.

Committee members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.

If any member is unable to attend a meeting, they are to designate another suitable person to attend as an alternate in their place.

In addition to members of the People Committee, the following people may be invited to attend and contribute to discussions, but have no voting rights nor contribute to the quorum:

- Other Directors
- Associate Directors
- People & Development Senior Leadership Team
- Other organisational managers and colleagues will be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

Meeting Arrangements and Support *(To include frequency and timing of meetings)*

The Committee will initially meet bi-monthly for approximately two hours and these meetings will be set in advance as part of the planning of the Board and Committee meetings annual calendar.

Additional meetings shall be called at the request of the Chair.

Quoracy **(*the minimum representatives from the organisation required for the group to make any decisions)***

A quorum shall be at least 1 Executive Director, 1 non-Executive Directors and one other members (minimum 3 in total)

Communications **(*briefings, comms planning, decision and/or outcome cascades and comms risks i.e. reputational)***

The minutes of Committee meetings shall be formally recorded and will be shared with the members following agreement by the Chair.

Messages from the Committee that need to be shared with the wider organisation will be passed on to the Communication Team.

GDPR

Privacy Notice for attendees

In line with the General Data Protection Regulations (GDPR) and the Data Protection Act (DPA 2018) Sirona care & health is registered as a Data Controller. As an attendee of this meeting, you can find out how your personal data is processed by visiting our website www.sirona-cic.org.uk.

Individual's Rights

In accordance with the Data Protection Act 2018 individuals have rights, including a right of access to personal data that is held about them. Therefore, if the meeting is intending to discuss and record information about individuals (data subjects), then the above Act of legislation will apply.

Notification of recording, (including Video Conferencing)

If the meeting is to be recorded then all those attending the meeting must be notified in advance of the intention to record proceedings.
Any objections to recording must be considered by the Chair and the Chair will ultimately decide whether the recording is appropriate in light of any objection.
The Chair of the meeting will make it clear to all attendees if recording will be happening and outline our plans for the recordings and/or transcripts (e.g. sharing with all attendees).

Any implications for attendees as a result of turning on their camera in order to participate in a video conference call or meeting will be explained at the start of the meeting, including if their image will become available to everyone in attendance.

Attendees may choose to participate via audio only, especially for Safeguarding, confidential or meetings of a sensitive nature.

Depending on how personal accounts are set up by external attendees, their name, email, etc. may be available to other attendees, and it is essential to ensure that they are informed that what they say may be recorded.

Clarity must be provided by the Chair at the beginning of the meeting in regards to the retention of any recordings gathered during the meeting, including screen sharing or discussions of a Safeguarding, confidential or sensitive nature.

Meeting participants should be informed that when meetings on MS Teams are recorded, the resulting video file is stored on the NHSmail cloud for all in the NHSmail population, i.e. nationally available to the NHS Mail network.
This means that the following elements **should not be included** in external MS Teams conference meetings or calls:

- patient identifiable information
- sensitive business information
- confidential corporate information

Standing Agenda Items

For example:

- Welcome & Apologies
- Minutes and/or actions from the previous meeting
- Update on Strategic Plans
- Workforce Dashboard
- Regulatory Reporting
- Review of Issues and Risks
- Communications - messages/decisions for sharing with Wendy Best

Board Report

Date	30th May 2023	**Agenda item**	Consent Agenda Item 18
Title	Finance, Estate, Environmental and Digital Committee Summary		
Author	Tayo Gaji, Corporate Governance Administration Manager		
Presented by	N/A	**Version**	1
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☒		

Purpose of the report

To inform the Board of the key items discussed at the Finance, Estates, Environmental and Digital (FEED) Committee meetings on 29th March 2023 and on 6th April 2023 and to give assurance on the matters within the Committee's remit.

Why is this report coming to the Board

E.g. is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

The Committee is delegated by the Board to provide independent scrutiny and objective challenge on Sirona's financial performance and to provide this report to the Board for assurance.

Related Risk No. (If applicable)	

How has this report been developed

Including the lead director, those involved in preparing the report and the sources of information relied on

The Budget Reports to the Committee were prepared by the Chief Finance Officer (Clive Bassett).
The 2023/24 budget was presented to the Committee for scrutiny and assurance.

What is the process the report has been through internally

i.e. which teams or groups have reviewed the report or the information that informs it

The Committee considered the 2023/24 budget at its meeting held on 29th March 2023.

Prior to the meeting, the Executive Team had reviewed the 2023/24 budget at its meeting of 16th February 2023. A further scrutiny of the 2023/24 budget by the Executive Team took place on 30th March 2023.

A second meeting to consider the 2023/24 budget in management accounting format was held by the Committee on 6th April 2023.

Summary and Key Issues Highlighted by these teams, including mitigations

Please highlight in summary the key messages from this report, including matters of escalation from Committees or other Teams, significant issues, risks and actions to address them

29th March Meeting

The Committee reviewed and scrutinised the proposed 2023/24 budget and thereafter made the following recommendations:

1) The Committee supported the recommended budget and savings proposals as outlined in the 2023/24 budget report subject to the provision of the budget in management accounting reporting format at its next meeting on 6th March 2023.

2) The Committee supported the availability of up to £2m of reserves for non-recurrent pressures during the financial year

3) The Committee agreed that any requests for recurrent investments will require business cases (proportionate in detail to the value of the scheme) and will need to demonstrate that they can be recurrently funded.

4) That good practice be recognised in confirming that all service developments and reviews should consider how Cost Improvement Programmes will be delivered as part of the implementation of the scheme.

The Committee received the 2023/24 budget reports for assurance.

6th April Meeting

Again, the Committee scrutinised and considered the proposed 2023/24 budget in the management accounting reporting format and supported the following recommendations:

(a) the Committee agreed that it has scrutinised the information & the 2023/24 budget adequately recognising that there is still work to be done and has assurance that the finance team will work within the established framework and the principle of a balanced budget.

(b) the Committee approved the recommendation of increasing the additional investment from £2m to £4m in terms of the non-recurrent investment without any changes to the delegated authority and overarching governance principles.

Other notable updates were considered by the Committee, and these include:

(a) New HQ project:
The Project structure is in place and due diligence is being conducted pending satisfactory agreement of Heads of Terms negotiations. The Committee delegated the responsibility of reviewing the H/Q lease agreement to the Chair (Simon MacSorley).

(b) Woodlands Projects
A new site to serve as a locality hub in South Gloucester is currently under fit out. We expect to have teams moving in at the end of May which will give up two other sites.

(c) Throgmorton
We have been asked to vacate, with very little notice by Bristol City Council as they are disposing off the building. We had to rehome the teams in existing estate and also find additional clinic space at Whitchurch health centre with the support of the ICB.

(d) Weston Rugby Football Club

We will be taking a sublease from NHS Property Services who are the head lease holder in the purpose build, state-of-the-art community provision, combining three providers on this central site. Future developments here will include a diagnostics hub and we will be able to take full advantage of that additional facility.

We will be able to dispose of some very poor estate and move clinical teams out of Castlewood when this is completed in 2025.

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

The Board received the assurance of the FEED Committee provided verbally at the Board meeting on 11th April 2023 and the budget for 2023/24 was approved by the Board.

This paper is to provide a written record of that assurance for the Board to note, together with the other matters considered.

Board Cover Report

Date	13th June 2023	**Agenda item**	Consent Agenda Item 19
Title	Performance Committee Summary		
Author	Tayo Gaji, Corporate Governance Administration Manager		
Presented by	Barbara Brown	**Version**	1
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☒		

Purpose of the report

To inform the Board of the key items discussed at the Performance Committee meeting on 17th April 2023 and to give assurance on the matters within the Committee's remit.

Why is this report coming to the Board

E.g. is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

The Committee is delegated by the Board to provide independent scrutiny and objective challenge on Sirona's operational performance and to provide this report to the Board for assurance.

Related Risk No. (If applicable)	

How has this report been developed

Including the lead director, those involved in preparing the report and the sources of information relied on

The Committee had a deep dive on Children in Care services. The presentation was prepared by the Interim Deputy Director of Operations with input from business intelligence, and children's performance leads.

What is the process the report has been through internally

i.e. which teams or groups have reviewed the report or the information that informs it

The Performance Committee reviewed and considered the presentation provided to the meeting on 17th April 2023.

Invitation to the deep dive (meeting) was extended to the Quality & Outcomes Committee in view of their oversight functions in accordance with its Terms of Reference. A joint scrutiny of our Children in Care services was done by the Performance Committee and the Quality & Outcomes Committee at the meeting with recommendations made to improve the service.

An offer remains extended by Directors, to Committee members, to submit any further comments or queries once the presentation has been read more fully.

Summary and Key Issues Highlighted by these teams, including mitigations

Please highlight in summary the key messages from this report, including matters of escalation from Committees or other Teams, significant issues, risks, and actions to address them

The Committee received the presentation on Children in Care Services performance for assurance. The presentation discussed the statutory context regulating Children in Care services and our performance, identifying key actions & next steps towards achieving our corporate goals and improving our services. The key summary of the presentation include:

Key Summary of the Children in Care Deep Dive

- Initial Health Assessment Completion performance data for our Children in Care indicate high percentages occurring outside of the 20-working day framework.
- Challenges include multiple referral processes across BNSSG, incomplete partner referral information, lack of structured provision across paediatric services, backlog issues and unscheduled demand from unaccompanied asylum-seeking children.
- A time-scaled action plan has been developed to address some of the challenges, as well as a review of job-planning with consultant paediatricians.
- The action plan performance will be monitored from Q1 which the aim of monthly improvement which will be reviewed in November 2023.
- The immediate aim is the achievement of Sirona's statutory requirements for Children in Care.

Notable Key Areas of Concern

- To consider if there are risks surrounding the timelines to achieving the action plan in the Children in Care presentation.
- To consider Key Performance Indicators to support charting measurable improvement for Sirona's contractual arrangements for Children in Care.
- To understand the ongoing impact of systems level arrangements (and performance) on Sirona's ability to meet its contractual obligations both internally and externally: and plan to manage relationships accordingly

Future Agenda Items
Standing Reports for Adults, Specialist Services and Children's Services
Standing Closing Report on the Reset Programme Performance
Dedicated Deep Dives as identified in performance reporting

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

This paper is to provide a written record of that assurance for the Board to note, together with the other matters considered.

Board Report

Date	13.06.2023	**Agenda item**	Consent Agenda Item 20
Title	Q4 Quality Report		
Author	Paul May Chair of Quality and Outcomes Committee / Mary Lewis Chief Nursing Officer		
Presented by	Paul May/Mary Lewis	**Version**	
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☒		

Purpose of the report

To provide Board with a Q4 Quality update following the Quality and Outcomes Committee held on 28.02.2023, 28.03.2023,and 25.04.2023.

Why is this report coming to the Board

E.g. is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

Quality reporting is a contractual requirement and provides assurance that Sirona is meeting the CQC fundamental standards of care.

Related Risk No. (If applicable)	

How has this report been developed

Including the lead director, those involved in preparing the report and the sources of information relied on

Papers presented at the Quality and Outcomes committee and discussion that took place during the meeting. Papers have been produced using the quality and safety data held within Ulysses.

What is the process the report has been through internally

i.e. which teams or groups have reviewed the report or the information that informs it

Quality and Outcomes Committee and subgroups that report to it.

Summary and Key Issues Highlighted by these teams, including mitigations

Please highlight in summary the key messages from this report, including matters of escalation from Committees or other Teams, significant issues, risks and actions to address them

Q4 Quality data has shown positive improvements and some key issues summarised below

- A further reduction in serious incidents during Q4 compared with Q3 - a continuing downward trend.
- An increase in complaints received - thought to be linked to the new Customer Care processes introduced during Feb 2023 which categorises data differently. Reporting and management of complaints is now more streamlined.
- Continued increase in compliments during Q4.
- Dip in Duty of Candour compliance indicating further training is required to support staff to see sustained improvement in compliance.
- Level 2 Hand Hygiene was not compliant during Q4 - IPC team is supporting staff to complete.
- Level 3 safeguarding training compliance is improving steadily.
- Adverse event reporting has improved slightly compared with Q3.
- Top three cause groups remain – medication, pressure injuries and treatment and procedure.
- A deep dive was undertaken into medication incidents during Jan 2023 highlighting insulin related incidents being most prevalent.
- Quality Improvement projects planned for 23/24 will seek to address these areas.

- The **Vexatious and Habitual Complainants Policy** was approved by the Committee at the February meeting.

- The **Medicines Optimisation Group** Quarter 3 report was received at the March meeting.

- The **End of Life Group** Quarter 3 report was received at the March meeting.

- The **Health Safety and Security** Quarter 3 report was received at the March meeting.

- **The Clinical Records Group** Quarter 3 was received at the March meeting.

- The **Bi Annual Safer Staffing Report** was noted as the agreed reporting route is now the People Committee.

- A Presentation on the new **Patient Safety Framework (PSIRF)** was received by the Committee at the March meeting.

- **Infection Prevention and Control Board Assurance Framework (BAF)** – the updated BAF was approved by the Committee at the March meeting. The April meeting noted the positive development of in-house staff in the IPC Team.

- An update about the progress of the **Quality Priorities Q4** was received at the April meeting. There will be some of the priorities which will not be completed within the year allocated. These will be monitored to completion during 23/24.

- The **Quality Account and Priorities 2023/24 Report** was received at the April meeting. The production of the Quality Account 22/23 is on track to meet publication deadline with the new priorities for 23/24 having been agreed.

- The **Nice Guidance Quarter 4 Report** was received at the April meeting.

- An update about **CQUIN** progress to Q4 was received at the April meeting.

- An update about the **Annual Clinical Audit Programme 2022/2023** was received at the April meeting – plans for 2023/2024 will be shared at the May meeting.

- **Risk -** Work is continuing on updating the Risk Management Policy, with a second paper outlining suggested changes for discussion being presented to the Executive Committee. Once the final agreement is confirmed the Risk Team will begin to work on making the required changes to the risk management module.

- Changes to the **Terms of Reference** to reflect both organisational changes and to ensure outcome quality improvements are more robust have been approved.

- Robust update of key operational and clinical issues and assurance was given from Chief Operations Officer and Chief Nursing Officer. The April meeting noted an update about changes to Sirona processes around autism; further updates will come to future Committee meetings.

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

To note the contents of this report.
To receive future progress updates on quality at next Board.
To note that the Committee will receive an update regarding Children In Care at their meeting in June 2023.

Board Report

Professional Council

Date	13th June 2023	**Agenda item**	Consent Agenda Item 21
Title	Professional Council Summary Report		
Author	Kathryn Bateman, Chief Medical Officer		
Presented by	Kathryn Bateman	**Version**	0.1
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☒		

Purpose of the report

To provide the Board with an overview of the activities of Professional Council Feb – May 2023

Why is this report coming to the Board

E.g. is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

This report is presented as a regular update from Professional Council, as described within the Corporate governance scheme of reporting.

Related Risk No. (If applicable)	

How has this report been developed

Including the lead director, those involved in preparing the report and the sources of information relied on

This report is prepared by the Chief Medical Office, Chair of Professional Council as a culmination of the minutes and actions at the meetings.

Professional Council meets monthly. The agenda items considered by Professional Council span a variety of clinical issues. Also included are discussions on potential Quality Improvement and audit projects.
A folder is on Glasscubes for papers, minutes and action logs for the meeting, accessible to group members.
Submissions for the agenda include a cover sheet to summarise the reasons for bringing the item to Professional Council, along with a note of any associated risks and anticipated Equality Impacts.
On occasion updates of policies are signed off between meetings and any such decisions are noted in the minutes.

What is the process the report has been through internally

i.e. which teams or groups have reviewed the report or the information that informs it

The report is a summary report and as such has not been considered by other groups.

Summary and Key Issues Highlighted by these teams, including mitigations

Please highlight in summary the key messages from this report, including matters of escalation from Committees or other Teams, significant issues, risks and actions to address them

The following summarises policies reviewed and approved, papers and discussions that were undertaken by Professional Council Feb- May 2023. Relevant policies have also been through Medicines Optimisation Committee.

EOL Pilot – update on planned pilot of an end of life telephone assessment. Aimed to improve and enable experience and clinical skills, also help with recruitment and retention. Is agreed to take this forward with the support of South Bristol Locality.

Transfer of UCR Incidents Using Secure Email/Telephone
A pilot has been provided in February 2023 transferring cases from the ambulance call stack directly into Sirona before receiving a clinical triage to clinically triage internally and improve speed of patients receiving care. It will initially be funded by the ICC as part of the urgent care funding.

Remote Therapy Assessment Parkinsons SOP
Remote Therapy Assessment is a new approach to managing waiting lists and now started to observe benefits to waiting list to staff and to patient being able to access their interventions more quickly. The planned therapy waiting list has reduced significantly and positive feedback from staff, Now being rolled out across other localities with the support of the D2A programme. Will collate feedback and a survey has been built on Ulysses for monitoring, so can learn and adapt.

SBAR – Pocket Masks Community Resuscitation
Professional Council happy to support pocket masks, allowing staff the option noting the mixed guidance on their use, safety and efficacy.

AOB
Future Terms of Reference (TOR) of Professional Council
Professional Council was set up during height of covid pandemic as a rapid discussion and clinical decision-making forum for new policies related to covid. It is recognised that the role has changed and the future TOR of Professional Council is being reviewed, in light of this. The proposal is to focus on multi-professional clinical discussion for new or emerging areas, developments, or proposed projects, especially cross-organisational and/or where guidance or multiple stakeholder involvement is recommended. Feedback has been received from Council members and group set up to review.

Policies received:

- NHS@Home Anaphylaxis Risk assessments
- Transcibing Policy
- PGD SOP respiratory@home for Acute Respiratory Advanced Care Practitioners.
- Outbreak Policy
- Carbapenemase-Producing Enterobacteriaceae Policy

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

The Board is asked to note the activities of Professional Council, there are no decisions required or options for consideration.