PACK B

Board

12th September 2023

Meeting in Public

Consent Agenda

Board Report

Date	12 September 2023	**Agenda item**	15 – Consent Agenda
Title	Consent Agenda Cover Paper		
Author	Donna Cairns, Head of Corporate Governance		
Presented by	Amanda Cheesley	**Version**	1
For	Approval/decision ☒ Debate ☐ Assurance ☒ Information ☐		
Assurance Rating	High/Significant ☐ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☒		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom	Assurance ratings are provided on each report within the consent agenda pack, where applicable.		

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board

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

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.

Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?

What sources of information have been relied on? How has assurance been built up through the organisation?
Provide links to relevant evidence sources relied upon in this report.

Detailed on each paper within the Consent Agenda pack.

What is the process the report has been through internally

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 to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them
Alert the Board to of areas where assurance is not sufficient.
Advise the Board of steps taken to address areas where assurance needs to be improved. (please ref relevant section of the report, where more information can be found).

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:

16. Minutes

The Board is asked to approve as a true record the minutes of the meeting in public held on 13th June 2023 and the following minutes of decisions made by written procedure:

16.1 New HQ Heads of Terms
16.2 ICB Nomination
16.3 Continence Product Procurement
16.4 Appointment of Chief People and Culture Officer

17. Delegated Authority Policy

The Board is asked to approve the revised Delegated Authority Policy.

18. Modern Slavery Statement

The Board is requested to:

1. approve the attached statement for filing with the regulatory body and publication on the Sirona website
2. Note and support the activities detailed as part of our forward plans within the 2023/24 statement

19. Medical Staff Revalidation Report

The Board is asked to note and approve the Annual Board Report and Statement of Compliance.

20. Quality & Outcomes Committee Recommended Annual Reports: Infection Prevention & Control Annual Report & Health, Safety & Security Annual Report

The Board is asked to approve the Infection Prevention & Control Annual Report and the Health, Safety & Security Annual Report.

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

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

For the Board to note the written record of assurance following recent meetings of the Audit, Assurance & Risk Committee. The Annual Report & Financial Statements were recommended to Board for approval (paper at item 11 on the Board agenda) and the Committee also recommended the Delegated Authority Policy to Board to approve (paper at Item 17).

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

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

23. Quarterly Summary Report from the People Committee

For the Board to note the written record of assurance following the recent meetings of the People Committee, and to note the high/significant level of assurance, assessed on the basis the committee reports, meeting minutes and other supporting documents e.g. workforce risks on the risk register.

24. Quarterly Summary Report from the Performance Committee

For the Board to note the written record of assurance following recent meetings of the Performance Committee. The Committee recommends the Board accept the partial assurance offered with mitigations on the basis that appropriate timelines with agreed milestones for monitoring and review of acceptable progress are provided to next Performance Committee in line with Executive Committee recommendations.

25. Quarterly Professional Council Summary

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

Date	13th June 2023 – 2pm – 5pm
Location	Virtual via MS Teams

Attendees

The following Board attendance was noted:

Attendees		**Present**	**Apologies**
Amanda Cheesley	Chair	✓	
Paul May	Non-Executive Director	✓	
Lorna Harrison	Non- Executive Director	✓	
Simon MacSorley	Non-Executive Director	✓	
Barbara Brown	Non-Executive Director		✓
Anil Patil	Non-Executive Director	✓	
Julie Sharma	Interim Executive Officer	✓	
Clive Bassett	Chief Finance Officer	✓	
Ceridwen Massey	Chief of Operations	✓	
Julian Fleming	Chief of Digital Strategy & Delivery	✓	
Sheridan Flavin	Interim Chief People Officer	✓	
Mary Lewis	Chief Nursing Officer	✓	
Penny Agent	Chief Therapy and Allied Health Professions Officer	✓	
Kathryn Bateman	Chief Medical Officer	✓	

In attendance

Donna Cairns	Head of Corporate Governance
Rachel Corrigan	Corporate Governance Manager (Minute Taker)
Sue Porto	Chief Executive Officer Designate (Observer)
Presenters:	
Andrew Edmondson & Suzanne Golding-Ellis	Item 2 - Our People Story
Becca Wright	Item 10 - Staff Survey Action Plan

Chair	Lorna Harrison

Item	Notes	ACTIONS
1	**Apologies:** Due to difficulties in connectivity for Amanda Cheesley, Donna Cairns opened the meeting and Lorna Harrison Chaired, noting apologies for Claire Valsler and Barbara Brown. Note: although unable to chair the meeting, Amanda was able to be present remotely and to hear the discussion and engage via the Chat function which was then fed into the meeting accordingly.	
2	**Our People Story – Staff Story** **Integrated Care Making a Difference** Sheridan introduced Andy Edmondson to the meeting to share his experience and learning of a patient safety incident. Andy shared his background and career development pathway then outlined the patient visit and subsequent identification of perianal abscess. He then described the next steps and actions undertaken, to further assessment by clinicians and eventual hospitalisation of the patient for intensive treatment, where his stay lasted six weeks. Patient needed nine operations to correct the damage caused by the wound. Andy described how the patient journey was documented and the actions undertaken. A root cause analysis was undertaken and the clinical outcome for patient was good, with the wound being caught in time to avoid critical or terminal outcome. The triage from SPA was outlined and the subsequent 72 hour review, due to the severity of the patient's condition. Escalations in treatment for this patient proved successful and findings for Andy included the improved communications between internal and external agencies and that the review had been constructive in terms of learning and guidance and not critical. Missed opportunities for earlier identification and interventions have been identified as part of the learning. Andy described how Sirona had reviewed its documentation templates to develop a uniform suite, which had aided the safe transfer of patients via the ambulance service and onwards to hospital. This includes the current pilot on the Healthy IO app, which is being trialled for improved Wound Care. An interview to review Sirona's Duty of Candour in relation to this incident was undertaken with the patient. Suzanne Golding Ellis also joined to support the presentation of this incident management. She commended Andy for his quick assessment and actions undertaken to address the patients wound. Board acknowledged that the RCA had identified clear learning and that this demonstrates a learning rather than blame culture within Sirona. **Action: Glossary of abbreviations and acronyms to be shared with minutes – Mary**	
3	**Declarations of Interest** None other than that previously recorded for Board by Paul May as a Councillor in BANES Council	

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4	**Approval of Board Minutes – Meeting in public February 2023** The minutes of the meeting in public held on 14th February were reviewed and approved as an accurate record.	
5	**Chair and Non-Executive Directors' Report** **CEO Update** As Director appointments must be made by the Board in accordance with our Articles of Association. The Board had previously approved the appointment subject to fit and proper person checks being completed and with the start date of 5th June as CEO designate before commencing in post officially on 17th July. As the outgoing Interim CEO, sincere thanks were extended to Julie Sharma for her service to both Sirona and the wider Healthcare system ahead of her retirement at the end of July. The Board noted the update on Sue Porto's appointment as CEO, and transition arrangements in place, welcoming her to the Board at the meeting on 13th June as part of her induction.	

6	**Executive Committee Report**
	The report was taken as read with the following highlights:
	- Funding for the one-off payment made centrally to NHS bodies following the national pay review was not extended to CICs or Social Enterprises. Sirona however was able to extend this payment to staff due to our strong financial position
	  o In response to the query raised surrounding Sirona's response to the non-funding of this payment and our plans to address, it was shared that specific discussions with commissioners in relation to the impact to targeted savings are ongoing, as are those with Social Enterprise UK to address the funding shortfall.
	  o Concerns expressed regarding setting a precedent of self-funding one off payments, whilst recurring payment funding is included.
	  o Other funding schemes to only NHS bodies are also being given consideration
	- Focus on the continued development of Equality, Diversity, and Inclusion plans
	- Considerable achievements noted and celebrated within the Annual Quality Account
	- Continue to focus attention on long waiters, especially in MSK and Podiatry services, including more scrutiny in the data to ensure mitigation can be put in place to address known issues
	- Identification within Children's Services of additional measures needed to address particular issues, with a detailed plan now in development
	- Reviewing training targets and focusing efforts into ensuring continued compliance against targets are achieved
	- Acknowledgement of the processes in place to meet reporting targets – such as Duty of Candour as detailed in the Our People staff story
	- Assurance surrounding the transition from interim to substantive Chief Executive
	One huge achievement absent from the report is around our approach to COVID and Flu Vaccinations. NHS England national statistics show that Sirona are rated 4th nationwide in the staff uptake for flu and are top, at 75.7%, for COVID vaccinations, this was applauded by the Board	

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	Report received for assurance.	
7	**Risk Register** Mary reported on the work undertaken to review the Risk Management Policy, and how the monitoring committees detailed within provide the scrutiny and challenge on those risks assigned to them. The movement of the current risk scores was illustrated within the report and Board notified that only four risks remain overdue for review. A number of new risks have been added, including the consolidating of some risks into a new single risk. **Risk 430** – Social Care Staffing, Community Learning Disability Service - escalated to the ICB **Risk 429** – Safeguarding Children – out to recruitment for Safeguarding Nursing Posts and we can fill all advertised positions and awaiting start dates. Anticipate new way of working can be begin in 4-6 weeks For IT and Cyber Risks, Julian was invited to provide Board with an update on these risks. He provided assurance that all of the risks assigned to Digital are being reviewed in detail and that there is a newly formed Cyber Risk Group within the ICB, which ensures more strategic thinking across the system, being proactive rather than reactive. In response to whether comparisons against other system providers is made on the number of risks, it was queried whether the Board should be concerned that we have a high number of risks; Mary reported that recent process reviews and training is ensuring that risk is being appropriately managed, and that Sirona scrutinise these risks through the appropriate committees of the Board. Ceridwen made mention of the work being undertaken by the Risk Team to support operational colleagues through training and how appreciated this has been by operational teams; she added that there is still work to be done in terms of long-standing high scoring risk. Sheridan added that we should also be ensuring that the correct actions to address risks are taken and recognise that actions sometimes maintain a score rather than improving it. Recognition that not all mitigations will reduce score and that we will have some high scoring risks that are tolerated. **Action: Chairs of Committees requested to undertake a Deep Dive of those high scoring risks assigned to their committee** Report received for assurance.	
8	**People's Council Report** In Claire's absence, Penny presented the prepared report drafted for the Board. Key discussions of the group were shared, including planned initiatives to improve and diversify membership and participation. With only a limited number of active members, work is underway to widen membership and increase diversity. Specific areas of focus by the group have included: • Discharge to Assess Programme – Presentation on the various pathways and work on supporting leaflets for this pathway • Customer care – Changes to process shared and feedback from the group helped shape some of the changes • Autism assessment – Presentation by the AD for Children's Services following recent public spotlight on this service.	

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	• Green agenda – Sirona's plans and ambitions and how the council can support this Acknowledging the challenges in membership, the group have proposed tiering of membership to enable differing levels of participation, along with the development of their workplan. Links to Experience & Engagement review and Peoples Council have been fundamental in helping with the shaping of our People Engagement strategy. Report received for assurance.	
9	**Business and Financial Plan** Report taken as read and builds on earlier Board discussions, currently in draft and will be reviewed in full by the FEED Committee on Thursday 15th June with a view to recommending to the Board for approval either by Written Procedure or delegating authority to the Chair and CEO following review by FEED. Clive provided a recap on the development of this years' plan, including the recent RESET Programme and the focussed work on the five workstreams to support the development of this plan. In the background, there are now five strands of work, using the Hoshin Kanri methodology to progress and track the delivery of these objectives. FEED received recommendations on the investments to achieve improvements and supported the approval of the Budget Plan to the Board. The Scheme of Delegations of Authority will ensure that Business Cases and improvement plans are appropriately considered and have clear aims towards services and cost savings. Plan ensures focus for the coming year but maintains a level of flexibility to meet any changes in business. Mary added that the work in developing this plan has been collaborative with senior leadership team and has ensured that our key objectives have been given their consideration. In terms of the costs associated with delivering this plan, Lorna was keen to establish whether there would be any cost saving initiatives included. Clive provided assurance that any savings would be tracked against this plan as part of the ongoing review of finance. Board was advised that improvements in service delivery through prioritisation will realise cost savings, as evidenced in improved efficiencies. In response to queries about the longer-term view for the remainder of our 10-year contract, it was shared that there is work ongoing to specifically support this, such as the Safer Staffing Programme. This in turn supports the longer-term financial plan with the aim to take forward a three year rather than one year plan. Board understood that not all savings would be realised directly by Sirona but would within the wider system, such as hospital admissions. Assurance was provided that the Audit, Assurance and Risk Committee would receive the proposed revision to the Reserves Policy in August. Noting that the current version of the Business Plan was still in draft, the governance for signing off the final Business Plan was discussed. As the plan dated back to April, it needed to be agreed whether Julie or Sue's name, or both, were included in the plan. The plan and investment proposals would be subject to further scrutiny by the FEED Committee and all Board Members were invited to make further comments.	

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	It was proposed that the final Business Plan be signed off by written procedure by the Board and to aim to conclude this by the end of June if possible, however this could be extended to allow sufficient time for the scrutiny and input required. **Action: Comments and queries to be raised directly to Julie and Clive for consideration as soon as possible - ALL** **Action: Timeframe for review and approval to be agreed, along with consideration to the named CEO, due to the transition between Julie to Sue and the plan start date of April 2023 – CLIVE/JULIE** **Action: Approval route agreed as Decision by Written Procedure by Board based on FEED recommendation – SIMON/ Corporate Governance** **Action: Performance Committee and others will monitor their assigned areas of the plan for their focus, with FEED monitoring the overall progress and financial aspects of the plan.**	

10.	**NHS Staff Survey Action Plan Update**
	
	Sheridan introduced the report and welcomed Becca Wright to the meeting to provide further detail and assurance to the Board on activities, highlights from the report included:
	
	- High level results presented to Board on 28.02.23 & leadership team on 08.03.23
	- Presentations prepared for each Directorate to help develop engagement plans
	- OD Team meeting with HR and Comms to ensure teams are appropriately supported
	- Data gathered around EDI, Bank Team and AHP's
	- April Pulse Survey run and planning to run further topical pulse survey's each quarter
	- Developing support information for managers
	- Comms for 'you said, we listened, and together we did' shared via staff social media, Workplace
	- EDI, staff networks reviewing data –
	  o Long Term Conditions/Disability working with team
	  o Ethnicity, linked to PDR process. All colleagues have access to career progression
	  o Improved leadership and management training
	  o Sexual Orientation, looking at flexible working options, need to support
	  o Religion, ensuring all religions have equal opportunities
	  o Promotion of awareness and support surrounding violence and aggression
	
	Positive feedback from engagement sessions and the development of action plans. This is helping to develop trust within teams, appraisals are completed, and development and career progression is considered.
	
	Seven key themes of the action plan were explained and detailed below:
	
	• Appraisals – Reviewing the PDR Process – both short and long-term review
	• Team Effectiveness – Scoped out evidence-based tools – TED, Pack Types and Rate My Shift
	• Staff Retention - #OneYou phases 1 & 2 – Promoting 1:1 career clinic's
	• Level of Pay – National pay award agreed and will be paid in June pay run
	Launched Wagestream – access to wages early
	• Burnout/Stress – Launched stress risk assessment template for individuals, teams and organisation
	Burnout & Stress support package developed for managers and teams	

- Capacity and Demand – Set up capacity and demand working group as part of the RESET programme

  Recommendations will be made to enable capacity and demand reporting
- Violence from Service Users – Violence and aggression reduction group in place/ interventions discussed for Urgent Care Centres

  Action cards and posters have been created to promote zero tolerance

Timetable for Next Steps:

Timeline	Actions
June	Triangulation of data – OD and HRBPs working together to triangulate data where possible for teams to include – e.g. NHS Staff Survey response rates and results, absence, vacancies, turnover, wellbeing champions in teams
June	Launch of first quarterly "You Said, Together We Did" comms in June, next addition due out in September
June	Further support for burnout and stress is being developed linking in with UHBW
Ongoing	HRBPs continuing to work with managers to develop action plans with teams
June	NHS Staff Survey provider comparison and decision for the NHS Staff Survey 2023
July	Q2 Pulse Survey live in July
Sept	Preparing for roll out of NHS Staff Survey 2023
Sept	People Promise animation video
Oct	NHS Staff Survey 2023 launch

Consideration was suggested in how we could include the activities detailed within our Business Plan.

In reply to benchmarking survey results against other organisations, it was confirmed that we are able to do this.

Board were assured by the report and work to develop robust action plans.

11. **Equality & Diversity Update**

Further to the regulatory and governance update to the Board in May, Dan Whalley was welcomed to the meeting to make the presentation.

Board members were informed about the activity undertaken since December 2022 and future plans, which included:

- The conclusion of an EDI survey being undertaken by Diverse Matters, with recommendations from due for Board consideration later in the summer.
- Our own staff survey seeking feedback about our colleagues' own experiences.
- Development of an EDI programme, chaired by Sarah Prendergast, pulling together all the strands of activity.

The achievements for 2022 and 2023 to date were shared, along with plans for the remainder of 2023 and into 2024, demonstrating the renewed emphasis in addressing all aspects of EDI with supporting documentation and evidence.

It was confirmed that there is representation from our Disability Network on the Accessible Information Group.

Board were assured by the progress made surrounding EDI and expressed a renewed confidence in this programme, acknowledging how specialist skills and knowledge is helping inform the actions to support this work.

12. **Quality Account 2023**

Mary advised that there is a requirement to publish our account by 30th June and the version being considered by the Board has been informed by work with staff and patient

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	groups and scrutinised by the Quality and Outcomes Committee, who recommend Board approval, and is now awaiting stakeholder/ partner statements for inclusion within the annual report. Thanks were extended to the Quality and Safety Team, notably Jo Hudson and Coron Wybrow along with Comms colleagues in the development and presentation of this years' account. **ACTION: The final version will be published in accordance with requirements and the link to the website document shared with Board members.** **DECISION: Recommendation to approve by the Board was fully supported**	
13.	**Consent Agenda Cover paper** All papers detailed below were approved under Consent Agenda arrangements.	
14.	**Equality, Diversity & Inclusion Policy** Considered and approved.	
15.	**Risk Management Policy** Considered and approved.	
16.	**Quarterly Summary Report from the Audit, Assurance & Risk Committee** Report noted for information and assurance. **16.1 – AARC Terms of Reference** Revision ratified and approved as the latest version.	
17.	**Quarterly Summary Report from the People Committee** Report noted for information and assurance. **17.1 – People Committee Terms of Reference** Approved as the latest version.	
18.	**Quarterly Summary Report from the Finance, Estates, Environment & Digital Committee** Report noted for information and assurance.	
19.	**Quarterly Summary Report from the Performance Committee** Report noted for information and assurance.	
20.	**Quarterly Summary Report from the Quality & Outcomes Committee** Report noted for information and assurance.	
21.	**Quarterly Professional Council Summary** Report noted for information and assurance.	
22.	**Any Other Business and Close** It was noted that there were no questions received in advance of the meeting from the public for consideration and response by the Board. Chairs summary noted as: - Great People Story, demonstrating the learning culture - Assurance on the recruitment process and subsequent appointment to CEO - Assurance Reporting from the Executive Committee - Discussion on Business Plan and agreement on approval routes - Action plans for Staff Survey	

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	- Update on the EDI Initiative Board recognised and shared their appreciation of the leadership and work undertaken by Julie during her interim position as CEO. Meeting brought to a close.	

Next meeting date	Tuesday 12th September, meeting in public

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Minute of Decision by
Written Procedure – Sirona Board

Date of Decisions	20th June 2023
Recipient of Directors' Responses	Donna Cairns, Head of Corporate Governance

Confirmation of votes

VOTING COMPANY DIRECTORS		**IN FAVOUR**	**AGAINST**
Amanda Cheesley	Chair	✓	
Barbara Brown	Non-Executive Director		
Lorna Harrison	Non-Executive Director		
Simon MacSorley	Non-Executive Director	✓	
Paul May	Non-Executive Director	✓	
Anil Patil	Non-Executive Director	✓	
Julie Sharma	Interim Chief Executive	✓	
Clive Bassett	Chief Finance Officer	✓	
Mary Lewis	Chief Nursing Officer	✓	
Ceridwen Massey	Chief Operating Officer		
OTHER BOARD MEMBERS			
Penny Agent	Chief Therapies and AHP Officer	✓	
Kathryn Bateman	Chief Medical Officer	✓	
Sheridan Flavin	Interim Chief People Officer	✓	
Julian Fleming	Chief Digital & Information Officer		

Item	Decision
1.	**Approval to sign off Heads of Terms on new Sirona Headquarters** The Board approved the following: 1. the signing of the Heads of Terms for the proposed lease of space from South Gloucester Council at Badminton Road, Yate, by the Chief Finance Officer. 2. delegation to the Chief Finance Officer to sign the final lease, in accordance with these Heads of Terms, once finalised. **REASON FOR DECISION** Details of the proposal were set out in Board report circulated by email on 16th June 2023. The proposal was reviewed and agreed by the CFO, following review by the Chair of the Finance, Estates, Environment and Digital Committee, on behalf of the Committee, who supported the recommendation.

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Minute of Decision by
Written Procedure – Sirona Board

Date of Decisions	30th June 2023
Recipient of Directors' Responses	Donna Cairns, Head of Corporate Governance

Confirmation of votes

VOTING COMPANY DIRECTORS		**IN FAVOUR**	**AGAINST**
Amanda Cheesley	Chair	✓	
Barbara Brown	Non-Executive Director	✓	
Lorna Harrison	Non-Executive Director	✓	
Simon MacSorley	Non-Executive Director		
Paul May	Non-Executive Director	✓	
Anil Patil	Non-Executive Director		
Julie Sharma	Interim Chief Executive	✓	
Clive Bassett	Chief Finance Officer	✓	
Mary Lewis	Chief Nursing Officer	✓	
Ceridwen Massey	Chief Operating Officer	✓	
OTHER BOARD MEMBERS			
Penny Agent	Chief Therapies and AHP Officer	✓	
Kathryn Bateman	Chief Medical Officer	✓	
Sheridan Flavin	Interim Chief People Officer	✓	
Julian Fleming	Chief Digital & Information Officer		

Item	Decision
1.	**SIRONA NOMINATION TO INTEGRATED CARE BOARD (ICB)** The Board approved the nomination of Sue Porto, as Chief Executive for Sirona, to take the seat as the 'Other' partner member (providing the perspective of Adult and Children's Community Health Services) on the Integrated Care Board (ICB) effective from 17th July 2023. **REASON FOR DECISION** As a provider of Adult and Children's Community Health Services within BNSSG ICB's area, Sirona care & health is eligible under the Health and Care Act to nominate an individual to be the 'Other' Partner Member on the Board. This individual will provide the ICB Board with the perspectives of adult and children's community health services and ensure that insights and the perspectives of all parts of the geography of BNSSG area are provided. The nominated individual must be the Chief Executive or hold a relevant Executive Level role, therefore Sue Porto was recommended for appointment. **ACTION**: Sue Porto to sign the nomination form to be submitted to the ICB. **ACTION**: Head of Corporate Governance to submit the nomination to the ICB on behalf of the Board.

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Minute of Decision by
Written Procedure – Sirona Board

Date of Decisions	28th July 2023
Recipient of Directors' Responses	Rachel Corrigan, Corporate Governance Manager

Confirmation of votes

VOTING COMPANY DIRECTORS		**IN FAVOUR**	**AGAINST**
Amanda Cheesley	Chair	✓	
Barbara Brown	Non-Executive Director	✓	
Lorna Harrison	Non-Executive Director	✓	
Simon MacSorley	Non-Executive Director		
Paul May	Non-Executive Director	✓	
Anil Patil	Non-Executive Director		
Sue Porto	Chief Executive		
Julie Sharma	Interim Chief Executive	✓	
Clive Bassett	Chief Finance Officer	✓	
Mary Lewis	Chief Nursing Officer	✓	
Ceridwen Massey	Chief Operating Officer		
OTHER BOARD MEMBERS			
Penny Agent	Chief Therapies and AHP Officer	✓	
Kathryn Bateman	Chief Medical Officer		
Sheridan Flavin	Interim Chief People Officer	✓	
Julian Fleming	Chief Digital & Information Officer		

Item	Decision
1.	**Approval to sign new Contract for Continence Product Provider** The Board approved the following: 1. the signing of the contract with Ontex, as a direct award for 3 years with a break clause at 18 months. 2. delegation to the Chief Finance Officer and Chief Operating Officer to sign the contract, with onward contract monitoring by the Clinical Operational Lead for the Bladder and Bowel Service and Deputy Finance Officer **REASON FOR DECISION** Details of the recommendation to award were set out in an SBAR circulated by email to Board on 25th July 2023. The decision is based on the conclusion of a robust procurement process and on recommendation by the Sirona procurement panel for this contract award.

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Minute of Decision by
Written Procedure – Sirona Board

Date of Decisions	24th August 2023
Recipient of Directors' Responses	Donna Cairns, Head of Corporate Governance

Confirmation of votes

VOTING COMPANY DIRECTORS		**IN FAVOUR**	**AGAINST**
Amanda Cheesley	Chair	✓	
Barbara Brown	Non-Executive Director	✓	
Lorna Harrison	Non-Executive Director		
Simon MacSorley	Non-Executive Director	✓	
Paul May	Non-Executive Director		
Anil Patil	Non-Executive Director	✓	
Sue Porto	Chief Executive	✓	
Clive Bassett	Chief Finance Officer	✓	
Mary Lewis	Chief Nursing Officer	✓	
Ceridwen Massey	Chief Operating Officer	✓	
OTHER BOARD MEMBERS			
Penny Agent	Chief Therapies and AHP Officer	✓	
Kathryn Bateman	Chief Medical Officer	✓	
Sheridan Flavin	Interim Chief People Officer		
Julian Fleming	Chief Digital & Information Officer	✓	

Item	Decision
1.	**APPOINTMENT OF CHIEF PEOPLE & CULTURE OFFICER** The Board approved the appointment of Dr Sonya Wallbank to the post of Chief People and Culture Officer, subject fit and proper person tests; start date to be confirmed by the Chief Executive. **REASON FOR DECISION** The appointment followed a formal, rigorous and transparent recruitment and selection procedure, detailed in the report of the Interim Chief Executive. The appointment is subject to the satisfactory completion of the required fit and proper persons checks, being undertaken by the recruitment team. Remuneration for the role was agreed by the Remuneration Committee.

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Board Report

Date	12th September 2023	**Agenda item**	Consent Agenda Item 17
Title	**Delegated Authority Policy/Scheme of Delegation Review**		
Author	Donna Cairns, Head of Corporate Governance		
Presented by	Donna Cairns/Clive Bassett	**Version**	1
For	Approval/decision ☒ Debate ☐ Assurance ☐ Information ☐		
Assurance Rating	High/Significant ☐ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☒		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom			

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board

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

To present to the Board the review of the Delegated Authority Policy (containing the scheme of delegation) for approval. The policy is reserved to Board for ratification. The new Scheme of Delegation/Delegated Authority Policy was approved in March 2022 and is due for review annually as good practice, normally part of the budget setting. This has been delayed due to the development of the financial and business plan.

Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?

What sources of information have been relied on? How has assurance been built up through the organisation?
Provide links to relevant evidence sources relied upon in this report.

This year's review includes only minor amendments, following discussion with the Chief Finance Officer, Chief Operating Officer and SLT. The Leadership engagement group also provided feedback on their understanding and confidence in exercising their delegated authority and this identified that whilst most people knew the limits of their financial authority there were some gaps in confidence and knowledge of governance routes and decision-making processes. Further work will take place in the next review to support the embedding of the policy further.

What is the process the report has been through internally

Which teams or groups have reviewed the report or the information that informs it

Review by SLT and approved by Executive Committee. Audit, Assurance & Risk Committee also reviewed the report and recommended the policy to Board to ratify.

Summary and Key Issues to be highlighted
Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them *Alert the Board to of areas where assurance is not sufficient.* *Advise the Board of steps taken to address areas where assurance needs to be improved. (please ref relevant section of the report, where more information can be found).*
This report proposes an extension of the existing policy, with some minor amendments to update job titles and reflect changes in groups and committees. Amendments are shown in tracked changes on the attachments except for the spreadsheet where this is not possible. Changes to the spreadsheet at Appendix 3 are only to the job titles. A wider review to support implementation of the policy will take place with the Operational Governance Group and alongside the development of the governance to support the business and financial planning processes. The policy review at this point is limited to minor amendments to support the extension of the existing authority levels. More substantial changes or work required can be fed into the further review that will take place up to March 2024 as outlined below.
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 approve the revised Delegated Authority Policy.

Background

The original work to develop the new scheme of delegation/delegated authority policy stemmed from a series of leadership engagement events in 2021 that identified the need to empower senior leaders to be taking more decisions and to increase the thresholds for financial authorities. A working group worked on the development of the new policy which came to Board in March 2022. A training day was held in March 2022 to support embedding the policy however more work was needed at that point on how recording of decisions would take place. A training package on LMS was developed building on this training day and was shared with all senior leaders to complete.

Amendments to the Policy

Minor amendments to the policy and delegation scheme have been made as the current levels are proposed to be extended. The sections that need revising now in order to roll over the policy are:

- Updating job titles
- Updating Committees in the matters reserved to Board and Committees
- Flowchart and policy referencing the Leadership Delivery Team – amended to Operational Governance Group.

Further Review to Support Implementation

A further review is planned to have a more inclusive discussion on the implementation of the policy, how to support senior managers in using their delegated authority and empowering them to act, where escalation is not necessary.

Corporate Governance and Finance leads will work with the Operational Governance Group to review the delegation scheme now it's been in place over a year and to identify how to support the implementation/embedding the principles and any further amendments needed.

This also needs to align to the new procedures supporting business and financial planning development.

Delegations of Authority Policy

Version:	~~V1~~v2
Name of originator/author:	~~Janet Rowse~~~~Sue Porto~~Donna Cairns
Name of executive lead:	~~Janet Rowse~~Sue Porto
Date ratified:	~~March 2022~~September 2023
Review date:	~~March 2023~~~~September~~ March 2024

N.B. Please check you are referring to the latest version, however the policy remains valid even if the review date has passed, until a new version is approved.

Applicable to

Directors, Associate Directors and Heads of Service to whom the Board delegate responsibility for defined functions.

Executive Summary

In recognition of the expanded scope of the Company and the need for processes that support agile decision making, this document sets out the principles for decision making to support devolved leadership. It includes the principles, a flow chart outlining the decision making mechanisms and a financial scheme of delegation.

Implementation

There will be a mandatory series of workshops outlining the role and responsibilities being devolved and the expectations of those from whom and to whom responsibility is delegated. Delegated authority should not be exercised by those who have not attended.

This document can only be considered valid when viewed via ~~Sirona's intranet site~~Sirona's Workplace 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 ~~(Members of the August Group)~~

Name	Designation
Those involved in original policy development	
Janet Rowse	CEO
Clive Bassett	Director of Finance
Linda Frankland	Deputy Director of Finance
Ceridwen Massey	Acting Director of Operations
Amanda Cheesley	Chair
Mike Richards	Director of Therapies and AHPs
Andrew Hunt	Head of IT
Nikki Carr	AD ICE
Wendy Best	Head of Communications
Lorraine McMullen	AD Children's
Donna Cairns	Head of Corporate Governance
Angela Glenn	Personal Assistant to CEO and Chair

Circulated to the following individuals/groups for consultation

Name of Individual & designation	Date approved
Audit, ~~&~~ Assurance & Risk Committee (02.08.23)	
Executive Committee (27.07.23)	
SLT (13.7.23)	

Details of approval by Lead Director

Director	Designation	Date approved
~~Janet Rowse~~Sue Porto	Chief Executive	

Circulated to the following Committee for Ratification

Name of Committee(s)	Date ratified
Executive Committee	
Audit, ~~&~~ Assurance & Risk Committee	
Board	

Version Control

Version	Updated By	Updated On	Summary of changes from previous version

v2	Donna Cairns	July 2023	Updates to ~~named directors~~ Job Titles of Directors etc. Revision to Provision for System Wide Working Update to named groups – Operational Governance Group and Programme & Project Steering Group

Contents

Consultation Process 2

Contents 4

1. Introduction 5

2. Principles for decision making 5

3. Delegation of authority 5

4. Acting in the interests of Sirona and the community as a whole 8

5. Process of decision making 8

6. Compliance with Strategic and Policy Framework 9

7. Emergency Powers and Urgent Decisions 9

8. Delegated Authority During Absences 9

9. Sub-delegation 9

10. Monitoring compliance 10

11. Links to procedural documents 10

Annex 1 11

Appendix 1a Matters reserved to Members

Appendix 1b Matters reserved to the Board and Committees

Appendix 2a Scheme of delegation

Appendix 2b Scheme of delegation financial thresholds

Appendix 3 Decision flow chart

1. Introduction

The Articles of the Company set out that the Board of Directors may make arrangements for the exercise, on their behalf, of any of its functions by a committee, sub-committee, or by a Director or other officer of Sirona.

This Delegated Authority Policy sets out the delegations of authority, approved by the Board for operation within Sirona. The policy describes how decisions are to be made, where they are made and who makes them. Types of decisions that are reserved for Members and/or the Board are clearly identified, and the policy ensures that arrangements are in place that enable responsibility for other decisions to be clearly delegated to executive management.

The development of this policy is intended to ensure greater agility in decision making and more locally sensitive use of resources through a devolved leadership model supported by a revised scheme of delegation.

This policy represents a new way of working within the company. We are implementing it at the same time as the six place-based Integrated Partnerships (ICPs) in BNSSG and the new system wide Integrated Care Board (ICB) are also establishing themselves and determining their new ways of working. The policy will be subject to ongoing review and amendment.

2. Principles for decision making

The delegations are designed to facilitate devolved decision making and personal accountability, in accordance with the following principles:

- **Subsidiarity**: to encourage decisions to be made as close as possible to those affected by them, by those with the right expertise at the right level.
- **Inclusivity**: ensuring engagement and consultation take place where appropriate during decision-making processes.
- **Simplicity**: to keep the decision-making process as simple as possible in order to allow those staff who have delegated powers sufficient scope to be agile and to innovate and enhance the quality of services within a cost-effective framework.
- **Transparency**: to ensure that decisions and policy is formed within a transparent and open framework.
- **Accountability:** the above principles need to be operated within a clear framework which aligns freedom to make decisions and the accountability for actions which stem from it.

3. Delegation of authority

Functions reserved for the Membership or the Board and delegated to Committees

Matters reserved for the Members are set out at Appendix 1a and Matters reserved for the Board at Appendix 1b, as derived from the Articles, the

Governance Framework, the Members Agreement and the Board Terms of Reference.

The functions of the Board that have been delegated to Committees are also set out in Appendix 1b, derived from the approved Committee Terms of Reference.

Scheme of Delegation - Functions delegated to Directors and Managers

The Scheme of Delegation attached at Appendix 2a sets out the decisions delegated to Directors, Managers and Authorised Signatories. Appendix 2b sets out the associated financial limits within such delegation may be undertaken.

Limitations on all delegations

This scheme does **not** delegate to Directors or Managers:-

a) Any matter reserved to the Members or the Board or any matter within the terms of reference of a Committee or sub-Committee
b) Any matter expressly withdrawn from delegation by this scheme.

In each case the delegated authority to Directors and Managers **excludes**

a) the taking of decisions which are not in accordance with the Strategy, Governance Framework or corporate policies
b) the approval or revision of service or business plans
c) the approval or revision of service standards
d) the approval of budgets

The financial delegations in themselves give no power to act. The power to act up to the limits prescribed, derives from approved annual plans and budgets and, where applicable, authorised capital and revenue business cases. These financial authorities form part of the Sirona's overall financial control process. Each Directorate will develop and agree with the Strategic Leadership Team (SLT) an annual plan, which governs workforce, facilities and financial resources.

The Scheme of Delegation (Appendix 2b) sets out the limits applicable to Directors in delegating their authority.

Sirona care & health CIC operates a framework of delegated authority in relation to non-pay expenditure which operates in tandem with the company's Purchase Order Procedure.

Nominated budget managers are delegated the management of a budget to permit the performance of a defined range of activities. Each delegation is accompanied by a clear definition of:

- The amount of the budget
- Individual and group responsibilities
- Planned levels of service
- Provision of monthly reports comparing actual expenditure against budgets

Each budget holder is responsible for ensuring that:

- Any permanent reduction in income or overspending of expenditure is not incurred without prior consent at the level indicated within the Schedule of Delegation set out in Appendix 2b.
- The amount provided in the budget is not used in whole or in part for any purpose other than that specifically authorised.
- New posts and new appointments, even those within budget and or fixed term, cannot be created without discussion with the relevant HR and Finance Business Partner and sign off by the relevant Director and the Finance Director. At all times, those considering the creation of new posts will be mindful of the wider financial and workforce context across BNSSG and the strategic direction being set by the System wide People Steering Group. At times of financial constraint, approval will be required from SLT prior to Director of Finance sign off.

All projects are bound by these Schemes of Delegation even where funded partly or wholly from third party funds. Approval for business cases and subsequent approval to commit expenditure must be in strict accordance with the detailed Scheme of Delegation.

Provision for system-wide working

Delegated limits to authority also apply to decisions made as part of system-wide working, ~~Healthier Together or~~ the Integrated Care System (ICS). Over time it is envisaged that certain funds will be formally delegated to the ICB or to ICPs to manage or direct. In the interim, application of resource, even within delegated limits, which is intended for the furtherance of system-wide or place-based goals which have not been signed off in the Sirona annual business planning and budget setting exercise, must be signed off by the relevant Director before resource is diverted from its original purpose. It is expected that this will take place in a planned manner ~~within the Business Meetings of the Senior Leadership Team~~with the Executive Committee ~~and in consultation with~~or the ~~Leadership Delivery Team~~Operational Governance Group.

Single Tender Actions

All expenditure above £20,000 on any of the following must be subject to a formal tender process. The only exceptions will be with the express permission of the Chief Executive and the Chief Finance Officer, ~~Director~~ who can approve single tender actions up to £50,000.

- Supply of goods, materials and manufactured articles
- The rendering of services
- The design, construction and maintenance of building works

4. Acting in the interests of Sirona and the community as a whole

It is vital that each Directorate and Locality recognises that it is an integral part of Sirona and does not therefore act as an independent business or service but as an important part of the corporate whole. Whilst the Scheme of Delegation enables and encourages operating as autonomous localities or directorates, within our corporate strategy and policy framework each Locality and Directorate will be expected to use the authority given to them in the best interests of the organisation and our communities overall.

Subject to compliance with corporate strategies, policies and procedures, each Directorate and Locality will have a defined level of freedom to manage their own affairs based on their performance but Sirona will retain the option of corporate intervention to address any concerns as they arise.

In certain circumstances, it may also be necessary to set aside the usual devolution arrangements in order to manage specific issues and problems. It is anticipated that these will be exceptional and linked to an accountability framework. Equally, it is impossible to define every aspect of responsibility within such a document in a manner which is robust enough to cope with every eventuality; where an issue crosses over the portfolio of more than one Director, in these cases Directors are expected to formally agree the split in responsibility or to escalate the matter to the Chief Executive to determine.

5. Process of decision making

The flow chart at Appendix 3 shows how a decision may be made. There are a number of Sirona committees which form a key part of this process and which are intended to support those with delegated authority to make sound decisions:

~~**Leadership Delivery Team [working title]**~~**Operational Governance Group** – Senior managers from operational and corporate services working collaboratively to ensure coherence in the way decisions are taken and to reach agreements where decisions affect more than one department or Locality.

~~**Senior Leadership Team &**~~ **Executive Committee** – Executive Directors working individually and collectively – a source of advice for those with devolved accountability but also a point of reference should decisions need to be escalated

Professional Council – senior clinicians providing clinical advice and guidance to Board and to SLT

Programme & ~~Planning~~ Project Steering Group – ~~advising managers on issueswhere there may be a significant impact regarding public consultation, equality impact or commercial competition.~~ a forum for review of proposals for new programmes and projects, including considering potential impacts that need to be assessed as part of the decision-making process

6. Compliance with Strategic and Policy Framework

This document cannot be read in isolation, it sits alongside other documents to create a management framework for Sirona. Critical documents linked to the Scheme of Delegation are the Articles of Association, Governance Framework, the Performance Management Framework, and the suite of corporate and clinical policies. All such documents are readily available to all staff on the intranet site.

All those exercising authority delegated in Directorates and Localities must ensure that they use their delegated authority in a manner that is consistent and compliant with the requirements of these frameworks and policies. It will be the responsibility of each Director to ensure that staff delegated by them to exercise decision making powers are capable and competent to do so. Powers of delegation will be rescinded if the Board of Directors are not satisfied that they are being exercised in accordance with and within the spirit of this document.

7. Emergency Powers and Urgent Decisions

In an emergency or when an urgent decision is required, the powers which the Board has reserved to itself may be exercised by the Chief Executive following consultation with the Chair of the Board, after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board for formal ratification.

8. Delegated Authority During Absences

In the absence of a director or manager to whom powers have been delegated, those powers shall be exercised by that director or manager's superior unless alternative arrangements have been approved by the Chief Executive or existing delegations are in place to another director or manager. If the Chief Executive is not available in the timescale within which a decision is required, powers not specifically delegated by him/her may be exercised by their nominated deputy.

9. Sub-delegation

Directors and managers with delegated powers may authorise another manager to exercise those powers. Such authorisations must be in writing and may be subject to limitations and conditions. The Director or manager with the delegated powers must keep a register of all authorisations granted. Sub-delegation is a transfer of authority but not of accountability. This means that the person sub-delegating the authority will remain accountable for the use of that authority.

Although Directors can delegate functions they remain responsible for and accountable to the Board for the exercise of their delegated authority. On

occasions they may still decide to take decisions themselves. Managers may decide to refer delegated powers back to the Executive Director. The Board can also decide to reserve a particular decision to themselves.

10. Monitoring compliance

Compliance with this policy will be overseen by the Audit ~~and~~ Assurance & Risk Committee who may call in decisions in order to assure themselves that the policy is being adhered to. Day to day compliance will be ensured through the Operational Governance Group, ~~Leadership Delivery Team and the~~ Senior Leadership Team and Executive Committee~~.~~

11. Links to procedural documents

This document cannot be read in isolation, it sits alongside other documents to create a management framework for Sirona. Critical documents linked to the Scheme of Delegation are the Articles of Association, Governance Framework, the Performance Management Framework, and the suite of corporate and clinical policies. All such documents are readily available to all staff on the intranet site.

Annex 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:**	No	
	• 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?**	No	
3.	**If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?**	None Identified	
4.	**Is the impact of the document/guidance likely to be negative?**	No	
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?**		

Scheme of Delegation – Appendix 1a

Matters Reserved to Members

The central role of Members in Sirona as a community interest company is to ensure that the company's activities are wholly carried out for the benefit of the community they serve and that its assets are also used wholly for this purpose.

The Board is accountable to the Members of Sirona for its management of the Company. Members play an important role in scrutinising the Board's performance against the company's strategy and delivery of activities in accordance with its community objectives.

The role of a Member is similar to that of a shareholder in a public limited company, save that a Member has no financial interest in the Company. Members perform this corporate governance role by receiving regular reports on the Company's performance and participating in members' meetings and in general meetings of the Company.

This document sets down those powers reserved for the Members (including powers as required by law and those matters delegated to Members by the Board).
Where a Special Resolution or special procedure is required other than an Ordinary Resolution, this is indicated in brackets after the matter.

Matters Reserved for Members

1. Altering the Articles of Association (other than the Company Objects) *(Special Resolution)*
2. Altering the Company Objects *(Special Resolution following the agreement of the Board, signed by all Company Directors)*
3. Change of Company Name *(Special Resolution)*
4. Appointment of External Auditors
5. Removal of External Auditors from office *(Ordinary Resolution following special notice – may not be passed by written resolution)*
6. Transactions between Sirona and a Director(s) requiring approval of members - for example substantial property transactions (over £100k or 10% of the company's asset value); loans; payments for loss of office
7. Removal of a Director *(Ordinary Resolution following special notice – may not be passed by written resolution)*
8. Pass a resolution for voluntary winding up of the company and appoint a liquidator
9. Receiving the Annual Report and Financial Statements before deadline for filing

Matters Delegated by the Board to Members

1. Setting the rate of remuneration for Chair *(following recommendation by the Nominations Committee)*
2. Setting the rate of remuneration for the Non-Executive Directors *(delegated by Members to the Nominations Committee)*

Note: Not all functions required by law to be reserved to Members are applicable to Sirona's current circumstances; however they are listed here for completeness.

Scheme of Delegation – Appendix 1b

Matters Reserved to Board & Committees

The Board has collective responsibility for the long-term success of Sirona. The Board's role is to provide entrepreneurial leadership of Sirona within a framework of prudent and effective controls which enables risk and outcomes to be assessed and managed.

The Board sets Sirona's values and standards and ensures that its obligations to the community and others are understood and met. Subject to the articles of association (the "Articles"), the Board sets Sirona's strategy and approves plans presented by management for the achievement of the strategic objectives it has set.

The Board determines the nature and extent of the significant risks it is willing to take in achieving its strategic objectives and is responsible for ensuring maintenance of sound risk management and internal control systems.

Implementation of the strategy set by the Board and the management and day-to-day running of Sirona is delegated to the Chief Executive Officer (supported by the Executive/Senior Leadership Team) with the exception of the matters reserved to the Board listed below and, as set out in the Articles, the matters reserved to the Members. The Executive Team are responsible for ensuring timely and balanced information is presented to the Board to enable it to make decisions effectively and to provide assurance. Collectively, the team is responsible for providing the systems, processes and evidence of governance and ensuring that these are reviewed, maintained and any gaps closed and that this is reflected in the regular updating of the Board Assurance Framework reported to the Board.

This document sets down those powers reserved for the full board of directors of Sirona (the "Board") and not delegated to the Company's executive directors. The Board may, however, appoint committees as it thinks fit to exercise certain of its powers. Specific areas of delegation are set out in the Terms of Reference for the Remuneration Committee, the Quality and Outcomes Committee, the Audit and Assurance Committee, ~~.~~ the Finance, Estates, Environment and Digital Committee, the Performance Committee and the People Committee.

Matters Reserved to Board

1. Strategy, Business Plans and Budgets

1.1. Setting the vision and values of the organisation, its purpose and the difference it intends the organisation to make and contributing to the vision and values of the wider ~~health and care system~~Integrated Care System ~~(Healthier Together)~~.

1.2. To develop and articulate a clear "vision" for the organisation. This will be a formally agreed statement of the organisation's purpose and intended outcomes which can be used as the basis for the Organisation's overall strategy, planning and other decisions. The vision for the Organisation will be developed within the context of Sirona's role within an integrated care system.

1.3. Setting strategy – the planned means by which the organisation will deliver its planned vision and that of ~~Healthier Together~~Integrated Care System.

1.4. To set the organisation's strategic aims and review these annually taking into consideration the views of its stakeholders and partners, ensuring that the necessary financial and human resources are in place for the organisation to meet its priorities and objectives and, then, periodically reviewing progress and management of performance.

1.5. To set the values and standards of conduct and ensure that its obligations to its staff are understood, clearly communicated and met.

1.6. Approval of change of company objects, signed by all Company Directors, subject also to a Special Resolution of the Members

1.7. Approval of the Annual Budget

1.8. Approval of the annual Business Plan

2. Assurance/Accountability

2.1. Receiving assurance that the organisation is delivering the strategy to plan, manages risk to itself and others, works within the law, delivers safe, quality services and has a proper control on resources of all kinds and for which it is accountable.

2.2. To be collectively responsible for ensuring the quality and safety of services, education, training and research delivered by Sirona and applying the principles and standards of clinical governance set out by the Department of Health & Social Care (DHSC), NHS England, NHS Improvement, the Care Quality Commission (CQC), the Social Care Institute for Excellence and the National Institute for Health and Care Excellence.

2.3. Approval of the Performance Management Framework

3. Governance, Reporting and Internal Control

3.1. Approval of the Governance Framework and amendments as required from time to time.

3.2. Authorisation of a conflict of interest

3.3. Confirmation of Board Register of Interests Annually

3.4. Preparation and Approval of Annual Accounts (Financial Statements) and Annual Report including Community Interest Report.

3.5. Receipt and Approval of the annual Social Impact Report

3.6. Receipt and Approval of the annual Quality Account

3.7. Decision to purchase and maintain indemnity insurance

3.8. Complete and publish self-certifications to demonstrate compliance with NHS Improvement Licence Conditions

3.9. Approval of Modern Slavery Statement annually

3.10. Approval of Gender Pay Gap Report

3.11. Receipt of Workforce Race Equality Standard (WRES) Report

3.12. Approval of creation/participation in subsidiary companies and collaborative ventures

4. Finance, Contracts and Capital

4.1. Approval of contractual and financial decisions in accordance with the thresholds set out within the delegation scheme.

4.2. Transfers to Sirona Foundation

5. Policy Ratification

Ratification of the following policies:

5.1. Communications Policy

5.2. Customer Care Policy

5.3. Emergency Preparedness, Responsiveness and Resilience Policy

5.4. Equality and Diversity Policy

5.5. Health and Safety Policy

5.6. Reserves Policy

5.7. Investment Policy

5.8. Delegated Authority Policy

5.9. Development and Management of Policies (Policy on Policies)

5.10. Risk Management Policy

5.11. Whistle Blowing - Raising Concerns Policy

5.12. Intellectual Property policy

6. Board Membership; Appointments and Other Procedures

6.1. Changes to the structure, size and composition of the Board

6.2. Appointment of Directors

6.3. Approval of continuation in office of directors seeking re-election

6.4. Removal of a Director

6.5. Appointment of Chair

6.6. Nomination of Director to Chair in Chair's Absence

6.7. Determining the level of quorum

6.8. Agreeing the membership and Chairs of the Board Committees

6.9. Agreeing the NED roles and responsibility, such as champion roles

7. Delegation of Authority and Committees

7.1. Delegation of Directors Powers (including delegation, removal and alteration of any delegated powers and the setting of any terms and conditions for the exercise of delegated powers)

7.2. Establishment of Committees exercising Board functions

7.3. Approval of the Terms of Reference for Committees directly accountable to Board, including approval of amendments required from time to time.

8. Membership Appointments and Other Procedures

8.1. Appointment of Members

8.2. Removal of a Member

8.3. Call a Member meeting

8.4. Nominate a Non-Executive Director to Chair a Members Meeting in Chair's absence

8.5. Determine manner for authentication of proxy notices for Members general meetings if not by signature

8.6. Determine manner for authentication of documents agreeing resolutions in writing if not by signature

9. Other

9.1. Ratification of urgent decisions by the Chief Executive made following consultation with the Chair after having consulted at least two Non-Executive Directors.

9.2. Review and confirmation of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) (Medical revalidation).

10. Remuneration

10.1. Determine Directors Remuneration is a function of the Board as stated in the Articles, delegated as follows:

10.1.1. Chair and Non-Executive Directors Remuneration is delegated to the Membership. The Members have delegated the setting of the Non-Executive Directors Remuneration to the Nominations Committee (of the Members).

10.1.2. Executive Director Remuneration policy is delegated to the Remuneration Committee

Functions of the Board delegated to Committees

The Board has agreed the terms of reference for the following Committees exercising functions of the Board:

- Audit and Assurance Committee
- Quality and Outcomes Committee
- Finance, Estates, Environmental and Digital Committee
- Performance Committee
- People Committee
- Remuneration Committee

Save for the specific matters listed below, the majority of the functions of the Committees are advisory capacity on behalf of the Board or the making of recommendations to the Board on matters requiring Board approval. This does not preclude the Board delegating a specific task or matter to any committee by resolution of the Board.

Audit & Assurance Committee

A1. Approving internal and external audit plans, reviewing progress against these and receive assurance on actions taken in response to audit reports

A2. 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

A3. Oversee the relationship with the external auditor including (but not limited to):

A3.1. 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

A3.2. approval of their terms of engagement, including any engagement letter issued at the start of each audit and the scope of the audit

A3.3. 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

A3.4. 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

A3.5. review and approve the annual audit plan and ensure that it is consistent with the scope of the audit engagement

A4. Approval of policies as set out in the Policy on the Development and Management of Policies

Quality & Outcomes Committee

Q1. Support the Board to meet its legal and statutory requirements, its quality and safety objectives, and to meet national standards, including the CQC requirements for Registration.

Q2. Approval of the submission of monitoring information as required in accordance with the Quality Schedule

Q3. Monitor associated risks to quality and safety.

Q4. Investigate or have investigated any activity within its terms of reference

Q5. Approval of policies as set out in the Policy on the Development and Management of Policies

Finance, Estates, Environment & Digital Committee

F1. Finance

- Development of the Budget and medium- and long-term financial strategy (including rolling 3 year forecast) – *Recommending to the Board*
- Budget monitoring - financial performance of Income statement, Balance Sheet and Cashflow, cost improvement programmes – trends and exceptions from management accounts - *Assurance to the Board*
- Advise the Board with respect to making significant financial decisions/ approval of business cases and service plans – *Assurance/Recommendations to the Board*
- Effective management & investment of cash and reserves in line with company policy - *Decision Making / Assurance to the Board*
- Management of year end surplus - *Recommending to the Board*
- Review of finance policies including but not limited to Reserves Policy, Treasury Management Policy, Investment Policy - *Recommending to Board*
- Ensure health and social inequalities are taken into account in financial decision-making

F2. Digital

- Development/review of Digital Strategy – *Recommending to the Board*
- Performance against Digital Strategy Action Plan – *Assurance to the Board*

F3. Estates

- Development/review of Estates Strategy – *Recommending to the Board*
- Performance against Estates Strategy Action Plan – *Assurance to the Board*
- Estates Compliance – by Exception – *Assurance to the Board*

- Hybrid Working Strategy – consideration of Environment issues rather than People issues (May fall under Estates Strategy?) – *Assurance to the Board*

F4. Environmental Sustainability

- Net Zero Strategy Review – *Recommending to the Board*
- Performance against Net Zero Strategy – *Assurance to the Board*
- Statutory carbon reporting

People Committee

P1. 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.

P2. 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.

~~Finance and~~ Performance Committee

~~Q6.~~

~~Q7.~~ PERF 1. **To review and provide assurance on:~~Functions to be determined on approval of Terms of Reference.~~**

- Operational Performance – against plans, contractual commitments and targets, including any mitigations plans necessary to achieve target, providing assurance that appropriate measures are in place to address under and over-performance and, where appropriate any plans for corrective action
- The Operational Planning Process covering the development and submission of the annual plan
- Strategic Priorities and Plans as requested by the Board
- The robustness of data systems and data collection/management processes – reporting by exception rather than regular monitoring reports.
- The Performance Management Framework on an annual basis (Structures and processes for effective planning, management and improvement of performance)

Remuneration Committee

R1. Determine and agree with the Board the framework or broad policy for the remuneration of the company's Chief Executive, the Executive Directors, and such other members of the Executive Management Team as it is designated to consider, (excluding any senior manager on Agenda For Change or clinical contracts).

	Notes	AUTHORITY DELEGATED TO:																
		Board	SLT (Executive Committee)	Remuneration Committee	Chief Executive	Deputy CEO†	Chief Medical Officer	Chief Nursing Officer	Chief Therapies & Allied Health Professionals Officer	Chief Oerating Officer	Chief Finance Officer	Deputy Chief Finance Officer	Chief Digital & Information Officer	Chief People & Culture Officer	Associate Director Governance or Head of Corporate Governance	Associate Directors/ Heads of Service	Delegated Budget Manager	Line Manager
		† Deputy CEO may exercise any of the functions/responsibilities of the Chief Executive when the Chief Executive is absent or unable to act ✓ A tick on its own indicates that any authorised person may make this decision or carry out this function. It does not need to be a formal joint decision, however this is still subject to the usual rules on consultation and inclusivity in decision-making. ✓+ A tick and a plus symbol indicate that a joint decision is required ✓+* A tick, plus and an asterisk indicates where there are alternative people who can join the decision; for example, either the Chief Finance Officer or the Deputy Chief Finance Officer is required to be party to the joint decision, but not both. N.B. - Authority for approvals includes authorisation for variation or extensions to contracts, agreements etc. - Associate Directors/Heads of Services include any budget holders who report directly to Directors																
BUSINESS PLANNING, BUDGET SETTING, AND MONITORING																		
1.1	Agreeing Annual Budget (including budgetary allocations, savings and efficiency targets)	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1.2	Agreeing Performance Management Framework	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1.3	Monitoring of Budgetary Performance	-	-	-	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-
1.4	Agreeing Performance Management Action	✓	✓	-	✓	-	-	-	-	✓	-	-	-	-	-	-	-	-
COMPLIANCE WITH BUDGETARY ALLOCATION LIMITS																		
2.1	For the totality of the company	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2.2	At Directorate level	-	-	-	-	✓	✓	✓	✓	✓	✓	-	✓	✓	-	-	-	-
2.3	At Divisional Level	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-
2.4	At individual budget level	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-
2.5	For all central income budgets	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
2.6	For all centralised budgets not otherwise allocated to a Director	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
2.7	Removing or suspending delegated authority	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	-	-
MANAGEMENT OF REVENUE BUDGETS																		
3.1	Transfers between Directorate allocations	-	-	-	✓+	-	-	-	-	-	✓+	-	-	-	-	-	-	-
3.2	Transfers of budgets between Operational Divisions which do not impact on contracted service requirements	-	-	-	-	-	-	-	-	✓+	✓+	-	-	-	-	-	-	-
3.3	Transfers of budgets within areas of responsibility that do not impact on the contracted service requirements	-	-	-	✓	✓	✓	✓	✓	✓	✓+ *	✓+ *	✓	✓	-	✓	✓	-
3.4	Transfers of budgets which will lead to a change in the contracted service requirements	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3.5	Utilisation of budget allocation under-spends (in accordance with corporate policy)	-	-	-	✓	✓	✓	✓	✓	✓	✓+ *	✓+ *	✓	✓	-	✓	-	-
3.6	Carry forward of savings across financial years	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
STAFFING AND PAY																		
4.1	Agree control measures limiting the delegated authority of others	-	-	-	✓	-	-	-	-	-	✓	-	-	✓	-	-	-	-
4.2	Setting Director and other VSM Remuneration	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.3	Approving remuneration levels within VSM range for Executives based on experience and performance	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
4.4	Approving interim engagements as Executives or Consultants over £50k total cost	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.5	Approving Redundancy or severance payments (Executive Directors)	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.6	Approving Redundancy or severance payments	-	✓+	-	-	-	-	-	-	-	-	✓+	✓+	✓+	-	-	-	-
4.7	Approving arrangements for additional payments for recruitment and retention	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.8	Approving local agreements over and above statutory requirements	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.9	Approving local agreements outside nationally set contracts and terms and conditions	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.10	Approving pay rates for non substantive engagements including bank and extra contractual duty rates	-	✓+	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.11	Approval of TUPE and/or other transfers of staff (in or out of Sirona)	-	✓	-	-	-	-	-	-	-	-	-	-	✓+	-	-	-	-
4.12	Approving changes to team structures or service requirements that are likely to result in redundancies, changes to contracts of employment or down-grading of roles	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.13	Authority to alter funded establishments within their area of delegated control where this does not impact or set precedent in another similar service (within agreed funded establishment)	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	-	-
4.14	Authority to alter funded establishments within their area of delegated control where a proposal in one area will potentially impact on another service (within agreed funded establishment)	-	✓+	-	-	-	-	-	-	-	✓+ *	✓+ *	-	-	-	-	-	-
4.15	Approving interim engagements (agency and bank) within their area of delegated control (within agreed budgets)	-	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-
4.16	Approving interim engagements (agency and bank) within their area of delegated control (outside of agreed budgets)	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.17	Approving engagements of consultants within their area of delegated control	-	✓+	-	-	-	-	-	-	-	✓+ *	✓+ *	-	-	-	-	-	-
4.18	Authority to recruit to funded establishments within their area of delegated control	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-
4.19	Authority to agree regrading or incremental progression within their area of delegated responsibility provided this will not set precedent in another similar service (within agreed budgets)	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-
4.20	Authority to agree regrading that may set precedent in another service	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.21	Authority to authorise overtime, time off in lieu, or other exceptional items	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
4.22	Authority to complete payroll data forms affecting pay, new starters, variations and leavers.	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
4.23	Authority to authorise time sheets	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
4.24	Authority to authorise travel and subsistence expenditure (within delegated limits)	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
CONTRACTUAL ARRANGEMENTS AND NON-PAY EXPENDITURE																		
5.1	Approving Main Service Contracts (CCG/ICS/Local authority) as part of the budget and business plan	✓	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
5.2	Approving contracts or service agreements for provision of Clinical Services (provided by or provided to Sirona)as part of budget and business plan	see financial thresholds table																
5.3	Approving contracts or service agreements for provision of other Services including property (provided by or provided to Sirona) as part of budget and business plan	-	-	-	-	-	-	-	-	-	✓+ *	✓+ *	-	-	-	-	-	-

		AUTHORITY DELEGATED TO:																
		Board	SLT (Executive Committee)	Remuneration Committee	Chief Executive	Deputy CEO†	Chief Medical Officer	Chief Nursing Officer	Chief Therapies & Allied Health Professionals Officer	Chief Oerating Officer	Chief Finance Officer	Deputy Chief Finance Officer	Chief Digital & Information Officer	Chief People & Culture Officer	Associate Director Governance or Head of Corporate Governance	Associate Directors/ Heads of Service	Delegated Budget Manager	Line Manager
5.4	Approval of new contracts not part of current budget and business plan	see financial thresholds table																
5.5	Authorising expenditure within approved budgets	see financial thresholds table																
5.6	External Fees (income generation and other patient related services)	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	-	-
5.7	Instigating legal action in any dispute with other parties in relation to our core contracts	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5.8	Instigating legal action in any contractual dispute with a supplier/third party- Above £50k	-	✓	-	-	-	-	-	-	-	✓+ *	✓+ *	-	-	-	-	-	-
5.9	Instigating legal action in any contractual dispute with a supplier/third party- below £50k	-	-	-	✓	✓	✓	✓	✓	✓	✓+ *	✓+ *	✓	✓	-	-	-	-
5.10	Authorised Signatories for approved Contracts	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	-
5.11	Approval for waiving procurement policy for quotations and tenders below £50k	-	-	-	✓+	-	-	-	-	-	✓+ *	✓+ *	-	-	-	-	-	-
AGREEMENTS AND LICENCES																		
6.1	Use of borrowing as financing mechanism	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
6.2	Extensions to existing property leases.	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	-	-
6.3	Establishing or terminating leases with total rental value up to £500k	-	✓	-	-	-	-	-	-	-	✓+	-	-	-	-	-	-	-
6.4	Establishing or terminating leases with total rental value over £500k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
6.5	Entering into Property licences, leases or hire agreements – existing or renewal	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓ (AD Estates Only)	-	-
6.6	Loans, mortgages, guarantees and indemnities	✓	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
CONDEMNING AND DISPOSAL (obsolete, redundant, irreparable items (excluding land & buildings))																		
7.1	Condemning plant and equipment with current/estimated value below £5k	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-
7.2	Condemning plant and equipment with current/estimated value above £5k	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	-	-
7.3	Sale or transfer of plant and equipment (subject to estimated income of less than £5k per sale)	-	-	-	-	-	-	-	-	✓	✓	✓	-	-	-	-	-	-
7.4	Sale or transfer of plant and equipment (subject to estimated income exceeding £5k per sale)	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	-	-

		AUTHORITY DELEGATED TO:																
		Board	SLT (Executive Committee)	Remuneration Committee	Chief Executive	Deputy CEO†	Chief Medical Officer	Chief Nursing Officer	Chief Therapies & Allied Health Professionals Officer	Chief Oerating Officer	Chief Finance Officer	Deputy Chief Finance Officer	Chief Digital & Information Officer	Chief People & Culture Officer	Associate Director Governance or Head of Corporate Governance	Associate Directors/ Heads of Service	Delegated Budget Manager	Line Manager
WRITE-OFFS AND COMPENSATION PAYMENTS																		
8.1	Write offs for losses, bad debts, damage etc. where recovery is not viable below	see financial thresholds table																
8.2	Compensation payments made under legal obligation; Extra contractual payments to contractor; or Ex-Gratia Payments below £50k	-	-	-	✓+	-	-	-	-	-	✓+	-	-	-	-	-	-	-
8.3	Compensation payments made under legal obligation; Extra contractual payments to contractor; or Ex-Gratia Payments above £50k	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
INVESTMENT OF FUNDS																		
9.1	Maintenance/Operation of Bank Accounts	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	-	-
INSURANCE POLICIES																		
10.1	Agreement of insurance Policies and associated expenditure (premiums)	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
INTELLECTUAL PROPERTY																		
11.1	Approval of licence agreements	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	-	-
11.2	Material changes to IP policy	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
11.3	Inventor reward in IP policy	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
REPORTING OF INCIDENTS TO THE POLICE																		
12.1	Fraud	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	-	-
12.2	Other incidents (except in the case of emergencies when any staff member may call the police but the director on call must be informed immediately)	-	-	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	-	-	-

		AUTHORITY DELEGATED TO:																
		Board	SLT (Executive Committee)	Remuneration Committee	Chief Executive	Deputy CEO†	Chief Medical Officer	Chief Nursing Officer	Chief Therapies & Allied Health Professionals Officer	Chief Oerating Officer	Chief Finance Officer	Deputy Chief Finance Officer	Chief Digital & Information Officer	Chief People & Culture Officer	Associate Director Governance or Head of Corporate Governance	Associate Directors/ Heads of Service	Delegated Budget Manager	Line Manager
GOVERNANCE / RISK MANAGEMENT																		
13.1	Responsible for ensuring effective governance / risk management arrangements in place	✓	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
13.2	Responsible for ensuring policies / procedures & meeting structures are in place	✓	-	-	✓	✓	-	-	-	-	-	-	-	-	✓	-	-	-
13.3	Responsible for ensuring governance is 'owned by all'	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
MANAGEMENT OF INCIDENTS / SUIs, COMPLAINTS / CONCERNS AND CLAIMS																		
14.1	Overall responsibility for sufficient systems and processes to report and respond to incidents / SUIs	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-
14.2	Responsibility for ensuring incidents/SUIs are investigated thoroughly and in a timely manner	-	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
14.3	Responsibility to ensure appropriate remedial action is taken / lessons learnt are shared	-	✓	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	✓	✓	✓
14.4	Overall responsibility for ensuring that all complaints and concerns are dealt with effectively	-	-	-	✓	-	-	✓	-	-	-	-	-	-	-	-	-	-
14.5	Responsibility for ensuring complaints are investigated thoroughly and within agreed timescales	-	✓	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	✓	✓	✓
14.6	Responsibility for ensuring appropriate remedial action on complaints is taken / lessons learnt are shared	-	✓	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	✓	✓	✓
14.7	Responsibility for ensuring that claims are dealt within accordance with agreed procedures and timescales	-	-	-	-	-	-	-	-	-	✓	-	-	-	✓	-	-	-
14.8	Responsibility for ensuring the provision of timely information to enable Sirona to respond effectively to claims	-	✓	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	✓	✓	✓
14.9	Responsibility for ensuring appropriate remedial action on claims is taken / lessons learnt are shared	-	✓	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	✓	✓	✓
14.10	Engagement of solicitors	-	-	-	✓+ *	✓+ *	-	✓+ *	-	✓+ *	✓	-	-	✓+ *	✓+	-	-	-
COMPLIANCE WITH ALL STATUTORY LEGISLATION AND HEALTH AND SAFETY REQUIREMENTS																		
15.1	Review of Fire Precautions (Nominated Fire Officer)	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-
15.2	Responsible for ensuring adequate H&S processes are in place	-	-	-	✓	-	-	✓	-	-	-	-	-	-	-	-	-	-
15.3	Responsible for ensuring staff awareness and compliance	-	✓	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	✓	-	✓
15.4	Responsible for identification of designated leads to co-ordinate health & safety arrangements at local level	-	✓	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	✓	-	-
15.5	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
15.6	Review of Medicines Inspectorate regulations	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-
15.7	Compliance with the Information Governance Legislation	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-
15.8	Infectious Diseases and Notifiable Outbreaks	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-
AUTHORISATION OF NEW DRUGS (including research projects and clinical trails)																		
16.1	Drugs Approved by Medicines & Therapeutic Committee	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-
16.2	Research/clinical trials - Ethical Approval	-	-	-	-	-	✓	✓	✓	-	-	-	-	-	-	-	-	-
16.3	Research/clinical trials - Funding	-	-	-	-	-	✓	✓	✓	-	-	-	-	-	-	-	-	-
16.4	Authorisation of Research Projects	-	-	-	-	-	✓	✓	✓	-	-	-	-	-	-	-	-	-
16.5	Authorisation of Clinical Trials	-	-	-	-	-	✓	✓	✓	-	-	-	-	-	-	-	-	-

		AUTHORITY DELEGATED TO:																
		Board	SLT (Executive Committee)	Remuneration Committee	Chief Executive	Deputy CEO†	Chief Medical Officer	Chief Nursing Officer	Chief Therapies & Allied Health Professionals Officer	Chief Oerating Officer	Chief Finance Officer	Deputy Chief Finance Officer	Chief Digital & Information Officer	Chief People & Culture Officer	Associate Director Governance or Head of Corporate Governance	Associate Directors/ Heads of Service	Delegated Budget Manager	Line Manager
RETENTION OF RECORDS																		
17.1	Clinical	-	-	-	-	-	-	-	✓	✓	-	-	✓	-	-	-	-	-
17.2	Financial records	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
17.3	Other (as appropriate)	-	✓	-	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	-	-
17.4	Caldicott Guardian	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-
17.5	Clinical Audit and Quality	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-
IMPLEMENTATION OF NICE GUIDANCE																		
18.1	Overall responsibility for ensuring arrangements are in place for the Trust to implement NICE guidance	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-
18.2	Ensuring operational arrangements are in place to ensure implementation of NICE guidance	-	✓	-	✓	-	✓	✓	-	✓	-	-	-	-	-	✓	-	-
18.3	Responsible for escalating proposed deviations in accordance with the NICE Implementation Policy	-	✓	-	✓	-	✓	✓	-	✓	-	-	-	-	-	✓	-	-
MISCELLANEOUS DELEGATED AUTHORITY																		
19.1	The keeping of Declaration of Interests Register	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-
19.2	The keeping of the Hospitality & Gifts Register	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-
19.3	Compliance with requirements of the Civil Contingencies Act	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-
19.4	Maintenance of a Register of members	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-

Appendix 2b
Delegation Scheme Financial Thresholds

It should be emphasised that the financial delegations in themselves give no power to act. The power to act up to the limits prescribed, derives from approved annual plans and budgets and, where applicable, authorised capital and revenue business cases. These financial authorities form part of the Sirona's overall financial control process. Each Directorate develops and agrees with the Strategic Leadership Team (SLT) an annual plan, which governs workforce, facilities and financial resources.

	Board[1] £	**Chief Executive & Chief Finance Officer[2]**	**Directors (Chief Officers)**	**Associate Directors[3]**	**Senior Budget managers[4]**	**Budget managers**
Approval of Expenditure and Issue of Purchase Orders within approved Budgets	>500k	500,000	100,000	25,000	5,000	2,000
Approval of Expenditure and Issue of Purchase Orders and approval of new contracts outside of approved Budgets	>100k	100,000	10,000			
Approval of supply contracts provided to Sirona within approved Budgets *	>500k	500,000	100,000	25,000	5,000	2,000
Approval of supply contracts provided by Sirona within approved Budgets *	>500k	500,000	100,000	25,000		
Budget Transfers within area of responsibility	>500k	500,000	100,000	25,000	5,000	2,000
Write off of bad debts*	>100k	100,000	50,000	5,000		

1. Where it is impracticable to wait until the next Board meeting for a decision, the procedure for written decisions outside of meetings may be used. In emergencies, the Chief Executive is empowered to act on the Board's behalf in accordance with the Scheme of Delegation.

2. A joint decision of the Chief Executive & Chief Finance Officer is required.

3. includes budget holders who report directly to Directors

4. includes budget holders who report to Associate Directors (or equivalent)

*In all circumstances in consultation with the Chief Finance Officer or the Deputy Chief Finance Officer.

Appendix 3: Devolved Decision Making Flowchart

Decision to be reviewed by Operational Governance Group

Does the decision significantly affect more than one locality/Directorate?

Yes

No

Is the decision reserved for Executives?

Yes

No

Is the decision likely to have significant public interest?

Yes

No

Is the decision outside of budget/business plan/ or differ from core deliverables/outcomes?

Yes

No

- Does the issue challenge organisational vision or values?
- Is the issue outside the agreed organisational business plan on which the annual budgets have been based?
- Is it beyond your delegated financial limit?
- Is it politically very sensitive?
- Does it raise regulatory issues?

Consider Implications

Decision to be taken by Operational Governance Group or escalated to SLT if outside delegated authority

Decision can be taken within Delegated authority

Can be completed in any order but all prior to decision

Implications	Minor Impact	Significant Impact
Clinical or Quality / safety (QIA)	Complete Quality Impact Assessment – submit to Impact Assessment Panel	
Financial	Consult financial business partner	Executive Committee
Workforce	Consult HR business partner	Chief People & Culture Officer or Executive Committee
Estates	Estate team / Head of Estates	Chief Finance Officer or Executive Committee
Digital/BI/Information Governance	Digital Team / Head of BI / Information Governance Lead	Chief Digital & Information Officer or Digital Steering group
Engagement/ communications	Head of Communications	Programme and Projects Steering Group
Equality Impact (EIA)	Complete Equality & Health Inequalities Impact Assessment – submit to Impact Assessment Panel	

Board Report

Date	12 September 2023	**Agenda item**	Consent Agenda Item 18
Title	**Annual Modern Slavery & Human Trafficking Statement**		
Author	Rachel Corrigan – Corporate Governance Manager		
Presented by	Clive Bassett CFO	**Version**	1.0
For	Approval/decision ☒ Debate ☐ Assurance ☐ Information ☐		
Assurance Rating	High/Significant ☒ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☐		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom			

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board

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

To present the draft annual statement setting out our commitment to the elimination of slavery and trafficking from our supply chains and our business.

We are required by Section 54 of the Modern Slavery and Human Trafficking Act 2015, to publish this annual statement which must be approved by the Board. The regulatory deadline for publication is the end of September (6 months after our financial year-end).

Related Risk No. (If applicable)	Non-compliance of meeting regulatory reporting deadlines leading to penalties

How has the assurance provided in this report been obtained?

What sources of information have been relied on? How has assurance been built up through the organisation?
Provide links to relevant evidence sources relied upon in this report.

The 2022 statement preparation incorporated an in-depth review of our systems and processes to develop a forward plan for the coming year, activities for 2023 have continued to plan, and there have been no further updates or requirements to the regulation which we need to address.

What is the process the report has been through internally

Which teams or groups have reviewed the report or the information that informs it

Members of the Finance Team, Corporate Governance Team and People & Development Team have worked collaboratively on the action plans towards the development of this statement.

Safeguarding Policies and Training have previously been considered in the preparation of action plans and the published statement.

The paper has been to the Executive Committee and is recommended for approval.

Summary and Key Issues to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them
Alert the Committee to of areas where assurance is not sufficient.
Advise the Committee of steps taken to address areas where assurance needs to be improved. (please ref relevant section of the report, where more information can be found).

By approving this statement and publishing by the 30th September, we will maintain compliance with the requirements of the Modern Slavery Act.

Key Activities to note from this year:

- Considered policies where Modern Slavery & Human Trafficking may have an impact, and these are in the process of being updated to include cross referencing to safeguarding policies and a clause relating to MS & HT, as policies reach their diarised review date.
- Developed a standard template to use for suppliers to evidence their own MS & HT arrangements.
- Employee welfare arrangements have also been considered, with the introduction of a new occupational health service provider in February 2023 and the expansion of our internal Wellbeing Champions network and strengthening of our Staff Network Groups.
- Undertaken a total overhaul of our Whistleblowing/ Raising Concerns Policy, bringing together previous policies on Raising a Concern and Whistleblowing in Nov 2022
  (In July 2022, NHS England updated the national Freedom to Speak Up policy for the NHS, providing the minimum standard for local Freedom to Speak Up policies across the NHS. This means that those who work in the NHS know how to speak up and what will happen when they do)
- Continued to promote our Freedom to Speak Up arrangements and undertake thematic reviews on a regular basis
- Appointed Clive Bassett, Chief Finance Officer, as the accountable Executive

It has been noted that due to a change in legislation for NHS organisations, a blanket statement has been issued by NHS England covering all NHS bodies, although as a CIC and Social Enterprise, despite delivering NHS services, we are still required to produce our own statement.

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

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

The Board is requested to:

- approve the attached statement for filing with the regulatory body and publication on the Sirona website
- Note and support the activities detailed as part of our forward plans within the 2023/24 statement

NB Amendments to the statement have been proposed by the Chair of the People Committee, Anil Patil. These add to rather than amend the statement. The updated statement will be circulated to the Board as soon as possible.

Modern Slavery and Human Trafficking Statement for reporting year 2022/203 as required by the Modern Slavery and Human Trafficking Act 2015.

Definition of Offences

Slavery, Servitude and Forced or Compulsory Labour

A person commits an offence if:

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude, or
- The person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour.

Human Trafficking

A person commits an offence if:

- The person arranges or facilitates the travel of another person (victim) with a view to being exploited.
- It is irrelevant whether the victim consents to travel and whether or not the victim is an adult or a child.

Exploitation

A person is exploited if one or more of the following issues are identified in relation to the victim:

- Slavery, servitude, forced or compulsory labour.
- Sexual exploitation
- Removal of organs
- Securing services by force, threats and deception
- Securing services from children, young people and vulnerable persons.

DRAFT

Modern Slavery and Human Trafficking Statement

Sirona care & health is a social enterprise delivering publicly funded NHS healthcare services for adult and children in the Bristol, North Somerset, and South Gloucestershire (BNSSG) region. We provide over 50 different services, and we employ up to 4,000 highly skilled staff to deliver these services.

We strive to make a positive social impact across our areas of provision, and we are committed to making a long-term difference to the many different social and cultural communities we serve, which includes a key strategic objective to focus on people from all backgrounds within the diverse neighbourhoods of our communities as detailed within the Sirona Vision of Improved Outcomes for All.

In accordance with the Modern Slavery Act 2015, Sirona care & health CIC makes the following statement regarding the steps it is taking in the financial year 2022/2023 to ensure that Modern Slavery i.e. slavery and human trafficking, is not taking place in any part of its own business or any of its supply chains.

Sirona is committed to ensuring that there is no Modern Slavery or Human Trafficking in our supply chains or in any part of our business.

We are committed to social and environmental responsibility and have zero tolerance for Modern Slavery and Human Trafficking. Any identified concerns regarding Modern Slavery and Human Trafficking are escalated as part of the organisations safeguarding protocols, working in conjunction with our partner agencies.

Training and Policies in relation to slavery and human trafficking

- Human trafficking and modern slavery guidance is covered within Sirona's safeguarding mandatory training from Levels 1-3 for Children and Levels 1-2 for Adult's
- The response to human trafficking and modern slavery concerns are coordinated under the safeguarding adult and/or safeguarding children process. The Police are the lead agency (a national framework is in place to assist in the formal identification and help to coordinate the referral of victims to appropriate services, known as the National Referral Mechanism).
- The referral process for adults/ children at risk and links to both Sirona Safeguarding Adults (Local Safeguarding Adults Board) are located on the safeguarding section of the Sirona website.
- Sirona has systems and policies in place to encourage the reporting of concerns and the protection of whistle blowers and in addition has dedicated named adult and children's safeguarding leads plus numerous dedicated Freedom to Speak Up Guardians.
- Sirona takes a unified corporate approach to the development, management, and approval of policies to make sure that the information is presented in a standard format, can be easily accessed by staff and that the drafting, ratification and review process is clear to all.

- A review is undertaken of all safeguarding referrals via the Sirona incident reporting system and presentation of data is shared at the Quality and Outcomes Board Sub-Committee and Safeguarding Committee.

- Sirona Employment Checks are in line with National NHS Employment Check Standards (which include identification, right to work, qualification and registration and reference checks)

- In addition, Sirona requires all external agency engagements to be made via framework approved supplier who are audited centrally and required to confirm that all staff have been checked for their right to work, identification, qualification and registration in line with NHS employment check standards commensurate to NHS processes.

Sirona staff

Training

- Undertake safeguarding training appropriate to their roles and responsibilities, which includes Modern Slavery & Human Trafficking, and which are refreshed as part of Sirona's mandatory training compliance framework.
- All staff receive a comprehensive induction programme which includes information on, and guidance regarding, slavery and human trafficking.
- Relevant staff are required to familiarise themselves with policies within their areas – i.e. HR

Working with Suppliers & Procurement

- Top 30 suppliers have been checked against the national modern slavery registry to provide assurance that they comply with the requirements of the regulation with any that are not registered written to requesting that this be evidenced. A further exercise to ensure all suppliers provide evidence of compliance has taken place and the Procurement Policy revised to provide additional rigor.
- We seek to procure goods and services through frameworks endorsed by the Cabinet Office and Department of Health and Social Care in accordance with the Public Contracts Regulations 2015. We use suppliers such as NHS Supply Chain and Crown Commercial Services for the majority of our purchases of equipment and utilities which adhere to the code of conduct on forced labour. 69% of our expenditure in 2022/23 was with NHS or government bodies.
- All members of the procurement team are required to undertake safeguarding training at a level appropriate to their roles and responsibilities.

Activities undertaken in 2022/2023

- Accountable Officer appointed to lead on the preparation of Modern Slavery & Human Trafficking Statements, namely Chief Finance Officer
- Identified policies due for review to and commenced a programme to revise them to reference to Modern Slavery and Human Trafficking.
- Instigated a process to ensure all new suppliers are asked about their compliance with the Modern Slavery & Human Trafficking Act 2015 as part of the revision of our Procurement Policy.
- Undertaken a total overhaul of our Whistleblowing/ Raising Concerns Policy, bringing together previous policies on Raising a Concern and Whistleblowing in Nov 2022
- Reviewed employee welfare arrangements, and introduced a new occupational health service provider in February 2023
- Expanded our internal Wellbeing Champions network and strengthened our Staff Network Groups.

Planned activities for 2023/2024

- Continue to review and revise policies we identify that need to include reference to Modern Slavery and Human Trafficking.
- Socialise the revised Procurement Policy with all staff and ensure that we adhere to the requirements stipulated within it.
- Share our action plans with procurement leads across the BNSSG Integrated Care system.
- Use our internal communications mechanisms to raise awareness of modern slavery among staff, including via our People Committee and established Staff Network Groups.
- Review policies and our website in line with requirements set out within the Modern Slavery & Human Trafficking Act 2015

We will continue to review our policies and procedures to ensure we can identify and address any issues associated with modern slavery and human trafficking. We are committed to identifying, preventing, and mitigating any potential or actual risks and will expect all of our staff, our partners, and our contractors to implement and enforce effective systems and controls to ensure that slavery and human trafficking is not taking place anywhere in our organisation or in our supply chains.

We will expect all our Suppliers and Contractors to provide, upon request, evidence to demonstrate compliance with the law and reserve the right to terminate contracts where they are unable to do so within a reasonable timescale.

The Sirona Board believes that the organisation is following good practice in implementing steps to prevent modern slavery and human trafficking

Sue Porto
Chief Executive Officer
DATE TBC

Reviewed and approved by the Board of Directors – 12th September 2023

Board Report

Date	12 September 2023	**Agenda item**	Consent Agenda - 19
Title	**A Framework of Quality Assurance for Responsible Officers and Revalidation Annex D – Annual Board Report and Statement of Compliance**		
Author	Roy Sharma, Responsible Officer. ADDIT: Kathryn Bateman, Chief Medical Officer		
Presented by	Kathryn Bateman	**Version**	
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☒		
Assurance Rating	High/Significant ☐ Medium/Partial ☒ Low/No Assurance ☐ Not applicable ☐		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom	This is an updated submission from July 2023, as the current vacant Medical Revalidation support officer role, or equivalent, has impacted on RO role. This is essential for the statutory functions of the RO and related processes and this area is being urgently addressed. Review of processes and policies underway to give partial triangulation of information. Work is being undertaken to ensure robustness of the structures underpinning the appraisal and revalidation processes, including working with partner organisations. Full assurance remains regarding the full revalidation status of our doctors.		

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board	
E.g., is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?	
Regulatory. Submission to NHSE	
Related Risk No. (If applicable)	Pending

How has the assurance provided in this report been obtained?
What sources of information have been relied on? How has assurance been built up through the organisation? *Provide links to relevant evidence sources relied upon in this report.*
Current Responsible Officer, HR dept, Customer Care Discussions with Employment Liaison Officer, GMC.

What is the process the report has been through internally
Which teams or groups have reviewed the report or the information that informs it

R. Sharma. Responsible Officer
Executive Committee, August 2023.

Summary and Key Issues to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them
Alert the Board to of areas where assurance is not sufficient.
Advise the Board of steps taken to address areas where assurance needs to be improved. (please ref relevant section of the report, where more information can be found).

The RO can give Full assurance regarding the full revalidation status of our doctors.

The currently vacant Medical Revalidation support officer role, or equivalent, has impacted on RO role. This is essential for the statutory functions of the RO and related processes and this area is being urgently addressed.

Review of processes and policies is underway to give more robust triangulation of information. Work is being undertaken to ensure the structures underpinning the appraisal and revalidation processes are in place and fully supported. This will be part of the Medical Revalidation HR support role.

The CMO will be taking on the RO role from October and is currently recruiting a deputy CMO. Once in place, the deputy will undertake training to be designated RO.

One further note, this has been a year of change for Sirona, with new CMO commencing April 2023, plus changes across the Exec Board. The current RO has been in post since 2019 and will be retiring end October 2023 and will hand on the RO role to the CMO/Deputy CMO. We would like to formally acknowledge and thank the current RO for their work during this time and supporting the handover.

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?

For information and approval of updated version.
Note and support for the required resources for the Medical Directorate RO role.

2022-23

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance

Service provided by Sirona care & health

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction: 3
Designated Body Annual Board Report 5
Section 1 – General 5
Section 2 – Effective Appraisal 6
Section 3 – Recommendations to the GMC 9
Section 4 – Medical governance 9
Section 5 – Employment Checks 11
Section 6 – Summary of comments, and overall conclusion 12
Section 7 – Statement of Compliance 12

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

  The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance,

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

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and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of **Sirona care & health CIC** can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

   Date of AOA submission: July 2023

   Action from last year: Continued use of Fourteen Fish (FF) appraisal system.

   Comments: We have sufficient cycles on the F Fish system to give a good snapshot of the progress of appraisees and appraisers

   Action for next year: Continue to monitor Appraisal and Revalidation dates. Continue to ensure staff meet their dates. Attempt to prompt those with missing sections to complete them in time.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Action from last year: The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer.

   Comments: The Chief Medical Officer (CMO) has undertaken RO training and will take on the role in October 2023. A deputy post is currently out for recruitment who will assist with RO role/act as delegate, once in post and trained. The Current RO will be retiring towards the year end.

   Action for next year: Ensure on-going training and support for new RO and facilitate a smooth transition from current post-holder including the oversight of appraisal and revalidation. Ensure CMO linked in to NHSE and system partners to assist effective function of RO role.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes - ** - Please see the update at the end of this document

   Action from last year: Administrative and secretarial support has been arranged, although current postholder within HR has recently left; currently out to advert with HR team for 'Revalidation Support Officer'. Time is allocated to attend Regional RO meetings.

   Comments: The ROAG (Responsible Officer's Advisory Group) will need review by the new Medical Director and succeeding RO. This will be a fluid process.

   Action for next year: Decide on the essential parts of the ROAG.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Doctors with a prescribed connection are monitored via the GMC Connect system. Any newly joining practitioners are added as advised. HR advise the revalidation team of the appointments of any new doctors. Comments: We can also check this connection through the Fourteen Fish appraisal system and the HR spreadsheet Action for next year: Remain up to date with this process

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The Appraisal and Revalidation policy together with the Remediation policy will be reviewed and presented to the Board this year. Comments: Due for review 2024. Action for next year: The review of Appraisal and Revalidation policy is an annual process, alongside Remediation. New RO to work with Revalidation Support Admin to ensure clear policies and structures to support this.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Peer review in progress Comments: Peer review is to be done this year between the appraisers using anonymised appraisal outputs, recently anonymised by HR but known to the RO. Action for next year: This process should be evaluated and continued if useful.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: The arrival of new doctors is flagged by the HR department. Should they have a prescribed connection, they enter the appraisal system, keeping their previous annual date. If not, they are supported and offered performance review discussions. They can use these when appraised by their Designated Body. Comments: There is a spreadsheet created and maintained by HR with the details of our employed doctors. Reviews have been incomplete this year. Action for next year: Annual performance review systems will be reviewed by the RO/CMO and a more robust system will be introduced.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. The appraisal year is dictated by the GMC and runs from 1st April to 31st March. Doctors with Appraisal anniversary dates in the months of March and April who are either late or too early with their appraisals can fall into the wrong year. For this reason, with the agreement of the Appraisees, March dates have been moved to January or February and April dates to June.

Action from last year: Move March anniversary dates to January/February and April dates to June to help maintain the correct appraisal year.

Comments: This has been done.

Action for next year: Continue to check manually that Appraisal and Revalidation dates are maintained accurately. New RO/CMO to consider SOP to ensure clear processes.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: There is an automated reminder sent to Doctors every month, starting three months before an appraisal is due. Should there be a problem with sickness or Maternity leave, appraisals are rearranged and the anniversary may be revised. Issues outside these parameters need individual consideration.

Comments: There were no unapproved delayed appraisals in the last 12 months. The system reports one approved delayed. This is a Doctor who joined us after their appraisal date but had already left their previous Designated Body so could not have one with them. This is authorised by the RO

Action for next year: The postponement of an Appraisal for "workload reasons" should raise a flag of worry for the RO and for Sirona. With time in every Consultant's week allocated to Appraisal work, it is potentially a sign of a clinician not coping when no adequate appraisal work has been delivered in time for an annual assessment. This aspect will be kept under review.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: The policy is up to date.

Comments: Due to update in 2024

Action for next year: Updates will be included and taken to the Board for approval as the Appraisal and Revalidation procedures evolve.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: We have 4 trained Appraisers for 29 Medical staff with a prescribed connection. Two joined in year and were already appraised.

Comments: The process of postponing an appraisal for workload reasons has been rare this year.

Action for next year: Maintain a review of the situation.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Maintain the annual training programme with NHS England. Assess random appraiser outputs with a QA system

Comments: Appraisers need to do 5 to 8 appraisals a year. For our appraisee numbers, this is about right. This year one appraiser did not meet the required standards and has stepped down. A replacement is now in place

Action for next year: The RO will continue to apply the Quality Assurance system to a random selection of appraiser outputs. These will also be done by the appraisal team on anonymised appraisal outputs – for training and as a consistency check. The RO will continue to monitor the training status of appraisers. It is recognised that given the scale of the organisation and the relatively low number of medical staff, even anonymised outputs are, in some cases, identifiable by the peer review group. The need for strict confidentiality is consistently emphasised.

6. The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: F Fish has made reporting more straightforward

Comments: The Board is updated annually on the completed appraisals, those subject to agreed delay and (if any) those with unauthorised delays

Action for next year: The system is regularly checked for those coming within three months and reminders are sent every 4 weeks.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting

Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: The in-house system is working well

Comments: The RO team use Fourteen Fish and GMC Connect within Sirona. There were 4 Revalidations due and all 4 were given a positive recommendation. These included the 2 which were deferred from last year

Action for next year: Continue as above

1. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: The process has worked with no problems

Comments: F Fish links directly with GMC Connect. We have had no deferrals this year

Action for next year: The current Sirona RO is performing this role. As per the Remediation Policy, the first step is to discuss issues with the Doctor concerned and next the GMC's ELO prior to completing any recommendations.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Staff at induction are introduced to the Sirona values of "Taking it Personally". This should impinge on everybody's roles and performance. We also look at complaints, clinical incidents, medication incidents and believe we have a non-threatening, supportive environment for whistle blowers or those who just need to ask.

Comments: For medical staff, we can ask for information from adverse events, complaints, performance management including waiting times, audit and appraisal. There are issues with obtaining robust BI data and the organisation is addressing this.

Action for next year: This is to be maintained in line with our open speaking-up culture where concerns can be raised without prejudice. CMO and Exec Board have started 'Integrated Reviews' to support effective Clinical Governance with all services. Board is completing a review and re-structuring of Clinical Governance structures and, as part of this, CMO has started Medical Directors Forum for Doctors, and will be chairing revised Professional Council to support Doctors and clinical teams.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

Comments: Requests are made to AskHR, any relevant information is passed to the doctors so they can be discussed at their appraisal

Action for next year: The RO (with the Medical Director) co-ordinates such issues at appraisal time and if/when they arise. The action taken will involve a response from the doctor concerned a review and change in behaviour, or, should the circumstances dictate, more robust action.

New RO/CMO to consider role of ROAG and 'triangulation' of data to assist in the above.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Fitness to practise issues are raised immediately with the clinician concerned and investigated as needed. The Senior Leadership Team is made aware of these issues and the developments. If needed the GMC and the legal department become involved.

Comments: In early April 2022, we were made aware of serious issues in the past history of a senior Physician working for Sirona. (see 4).

Action for next year: Continue to monitor reports from HR and other sources for potential issues. Work with Customer Care to ensure effective triangulation of information.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: All significant events are assessed and investigated. We have had 29 doctors with a connection. Complaints and incidents are logged by the Quality and Governance team through the Ulysses system. Further information comes through the Customer Care team and from the Clinic Administration lead.

Comments: Following receipt of information, with extensive detail in support, from an anonymous source raising concerns around one of our doctors, a team was convened the next working day in line with the Maintaining High Professional Standards guidance and a senior doctor was excluded pending investigation. Full advice from GMC and NHS Resolution was sought. Since then the GMC has placed them on an interim suspension and their employment with Sirona has now terminated (June 2023).

Action for next year: The implications of the Patterson Report continue to direct that we look at the whole range of practice for every doctor with a connection and assist other

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Designated Bodies by performing an annual mini-appraisal for those doctors formally appraised elsewhere. Not all such doctors have had a mini appraisal and new systems will need to be developed to make this a more robust process.

A Lessons Learned review is being undertaken to identify the learning from the incident above and any improvements we need to make to our processes.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: The RO is a Sirona employee

Comments: The MD and RO work together to assure the safe and competent performance of Sirona's Medical staff. There are meetings with the Clinical Governance and HR teams to discuss issues. A report on incidents and complaints is requested prior to each appraisal and the RO assesses these with revalidation in mind

Action for next year: Performance review interviews need to held at least annually with these doctors – preferably by their service manager. The RO is made aware of those staff with a connection to other appraisal systems so any appropriate issues can be shared. It is envisaged that the new CMO (Medical Director) will take on the role of RO in the year 2023/24

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Appraisal and revalidation remain in house with a small number of appraisals being carried out by NHS England.

Comments: These areas are addressed at induction training for new MDs and ROs. The HR department has a policy covering issues of bias and discrimination using the GMC guidance as a template. NHS England have appraised some of our appraisers to give them a different perspective on appraisal.

Action for next year: The policy will be reviewed and updated as needed

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: A newly employed doctor must give Sirona HR sight of their original qualification and right to reside/Nationality documents.

Comments: All checks are completed via our recruitment team – these are DBS, references, and checks via GMC register.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: Sirona cannot assume that previous organisations have undertaken these checks completely and will ensure checks are made for all new medical staff. We specifically need to ascertain if they may have a criminal record in another jurisdiction or have had their licence to practice compromised in another jurisdiction. They must confirm these aspects at their start with Sirona. Lessons learned from the exclusion incident will need to be applied to recruitment policies and procedures.

Section 6 – Summary of comments, and overall conclusion

- **General review of last year's actions:** The Board received the paper detailing the changes and reviews of the appraisal and revalidation system at the September meeting. No significant problem areas were highlighted following this.
- **Actions still outstanding:**
- **Current Issues:** Maintaining appraiser training. Sirona staff can now access NHS England S&W training. Sirona is responsible for advising our appraisers of these sessions and monitoring their attendance.
- **New Actions:** For newly appointed medical staff, an in-depth check of their qualifications and previous record will be undertaken. Original documentation needs to be seen and recorded. Review the role and set up of ROAG. Ensure robust triangulation of data with Customer Care, HR and BI data. Ensure policies and SOP in place to support Revalidation Support officer, once in post, and RO.

Overall conclusion: Changes to the appraisal and revalidation system for 2022/23 are complete. Sirona dealt with 27 doctors needing appraisal and revalidation. Two joined us in year and had already been appraised. The appraisal system information is available on-line to the RO, appraisers and appraisees. This has made the process easier for appraisees and appraisers, with tasks for the RO's clerical support being streamlined. Processes are in place to assure the quality of these systems and that the doctors are safe to practice.

We continue to review the outputs from the Patterson Report and its implications for the appraisal and revalidation processes. This is being done by the Medical Director and Responsible Officer to assure Sirona's governance processes for the future.

Completed by: Dr S R Sharma RO Medical Appraisal and Revalidation

Sirona care & health CIC 16th June 2023

Section 7 – Statement of Compliance:

The Board of Sirona care & health has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)

Signed on behalf of the designated body (pending review by the Board in September 2023)

Official name of designated body: **Sirona care & health CIC**

Name: Julie Sharma

Signed:

Role: Interim Chief Executive

Date: 3 July 2023

Update to Q3 P5:

3.The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes - ** - Please see the update at the end of this document

Action from last year: Administrative and secretarial support has been arranged, although current postholder within HR has recently left; currently out to advert with HR team for 'Revalidation Support Officer'. Time is allocated to attend Regional RO meetings.

Comments: The ROAG (Responsible Officer's Advisory Group) will need review by the new Medical Director and succeeding RO. This will be a fluid process.

Action for next year: Decide on the essential parts of the ROAG.

Current postholder within HR has recently left and there is limited capacity to provide consistent and responsive cover, to support the RO with administrative and HR functions. the proposed support personnel for the Responsible Officer have been changed and one has been reallocated to other tasks within Sirona. This has impacted the role of the RO particularly regarding time requirement, difficulties with triangulating information, and risk of missing key information or actions. The current HR support role description has been revised to ensure fully reflects the role requirements and is due to go out to advert imminently. Their role will be to support CMO/RO and Medical HR team in the review and implementation of additional or updated policies and processes, as below. The Medical Director will be able to address these points when this section is reviewed by the Sirona Board. This action is essential to ensure that robust systems are in place to support the role of the Responsible Officer.

Ensure staffing /resources in place, as above.

Dr S R Sharma R.O. Sirona 15/08/2023

Sirona Infection Prevention & Control Annual Report 2022-2023

Presented by Suzanne Golding-Ellis Head of IPC & Patient Safety

IPC Team Highlights

- There have been zero cases of MRSA or MSSA Bloodstream Infections (BSI) reported by Sirona.
- There were five reportable cases of *Clostridioides difficile* Infections (CDI) in 2022/23, no cases were attributable to Sirona care. Improved Healthcare associated infections surveillance system implemented
- There was a total of nine COVID-19 outbreaks reported. Themes included: Possible transmission from visitors as public testing guidance changed, need for staff to not attend work when unwell, mask guidance changes prior to outbreak. IPC supported units to manage outbreaks and reduce on-going transmission risk
- Submission of Hand Hygiene audits was stable with an overall increase across the year 2022-2023 from the previous year. Improved audit data extraction set up. Bare below the elbows concerns.
- 3 x IPC team members completed IPC Diploma of higher education

IPC Team Highlights

- There was a total of 208 Infection Prevention and Control adverse events reported with the three highest categories being Covid-19, Outbreaks and Sharps/Needlestick injury/near miss. IPC completed annual sharps report.

- IPC team have supported the Haven service with recommendations to improve IPC measures and practice in asylum seeker hotels across BNSSG

- During 2022-2023 the IPC team in conjunction with Sirona Health and Safety team completed an environmental audit at every clinical base accessed by Sirona services. Themes: Poor cleaning standards, 'I am clean' stickers not routinely used, stock on floor and poor storage capacity.

- IPC Mandatory training Level 1 was fully compliant during 2022/23, Level 2 was only achieved for 5 months of the year.

- Improved IPC comms: IPC workplace developed and live, IPC link practitioner group bi-monthly with speakers from TB and long COVID teams, Development of education for staff on safer sharps, hand hygiene, IPC dashboard.

Looking Forward to 2023-2024

- IPC policy alignment with National IPC manual and system approach
- Bringing IPC in line with PSIRF
- Implementation of National IPC education framework
- Improving staff adherence to bare below the elbows
- IPC sustainability project and involvement with regional approach
- Improvement to adherence to safer sharps and reduced sharps incidents and near misses
- Improved IPC link practitioner network and meetings
- Improved cleaning audit data
- BI dashboard development for further audit results

Annual Infection Prevention and Control report 2022/2023

Date	22 August 2023	Agenda item	9
Title	Annual Infection Prevention & Control Report 2022/2023		
Author	Caroline Laing /Suzanne Golding-Ellis / Infection Control Team		
Presented by	Suzanne Golding-Ellis	Version	V1.2
For	Approval/decision Debate Assurance √ Information √		

Purpose of the report

The purpose of this report is to provide assurance to Sirona Care and Health (Sirona), the Quality Outcomes Committee and the public for the reporting period April 2022 to March 2023 regarding compliance with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance.

Sirona continue their commitment to improve performance in IPC practice. Compliance with the Health & Social Care Act is judged against 10 criteria and monitored by the Care Quality Commission on how it complies with Cleanliness and Infection Prevention and Control requirements detailed in the legislation.

Why is this report coming to the Board

Infection Prevention and Control is a regulatory requirement and this report will provide assurance to the Committee that Sirona is compliant with regulations.

Related Risk No. (If applicable)	N/A

How has this report been developed

The report is prepared annually by the IPC Team with oversight from the Chief Nursing Officer.

What is the process the report has been through internally

The report has been reviewed by the Infection Prevention and Control Team and the Infection Prevention and Control Group.

Summary and Key Issues Highlighted by these teams, including mitigations

The key issues raised through the consideration of this report are:

- There have been zero cases of MRSA or MSSA Bloodstream Infections (BSI) reported by Sirona.
- There were five reportable cases of *Clostridioides difficile* Infections (CDI) in 2022/23. The Sirona IPC team have formed a collaborative approach with North Bristol Trust (NBT) and University Hospitals Bristol and Weston (UHBW) to share completed CDI post infection reviews and identify shared learning across the system.
- There was a total of nine Covid-19 outbreaks reported.
- There was a total of 208 Infection Prevention and Control adverse events reported with the three highest categories being Covid-19, Outbreaks and Sharps/Needlestick injury/near miss.
- During 2022-2023 the IPC team in conjunction with Sirona Health and Safety team completed an environmental audit at every clinical base accessed by Sirona services.
- IPC Mandatory training Level 1 was fully compliant during 2022/23, Level 2 was only achieved for 5 months of the year.
- Submission of Hand Hygiene audits was stable with an overall increase across the year 2022-2023 from the previous year.

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

N.B. For Papers Requiring Decisions – Not required for Assurance reports

Resource implications (financial/staffing/other resources)

None at this time

Quality considerations

There is a robust annual Infection Prevention and Control work programme in place and is key to the ongoing quality and safety of patients, staff and public.

1. Purpose

The Chief Nursing Officer reports on infection prevention and control activities within Sirona. This report provides assurance for the reporting period April 2022 to March 2023.

This report covers Infection Prevention and Control (IPC) across Sirona. The publication of this report is a requirement to demonstrate good governance, adherence to company values and public accountability by complying with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance and compliance with Schedule 2 of the agreed NHS Contract – The Infection Prevention and Control Services across BNSSG Integrated Care Board.

The purpose of this report is to provide assurance that the organisation implements successful prevention and control of infection as a key factor in the delivery of high quality and safe care of our patients, and in the safety and wellbeing of our staff. All staff members understand that good infection prevention and control is essential to ensure that we provide safe and effective care. This report provides evidence of governance and accountability, and compliance with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance and compliance with Schedule 2 of the NHS contract.

- A zero-tolerance approach continues to be taken by Sirona towards all avoidable Healthcare Associated Infections (HCAI).
- We have demonstrated progress against our work programme for the year and compliance with the ten criteria against which registered providers will be judged in demonstrating how they comply with the registration requirement for cleanliness and infection control.
- The IPC Group (IPCG) oversees the organisation's governance arrangements for IPC, supports improvements in practice and internally regulates our response to audits and inspections.
- The IPCG reports into the Quality Outcomes Committee.

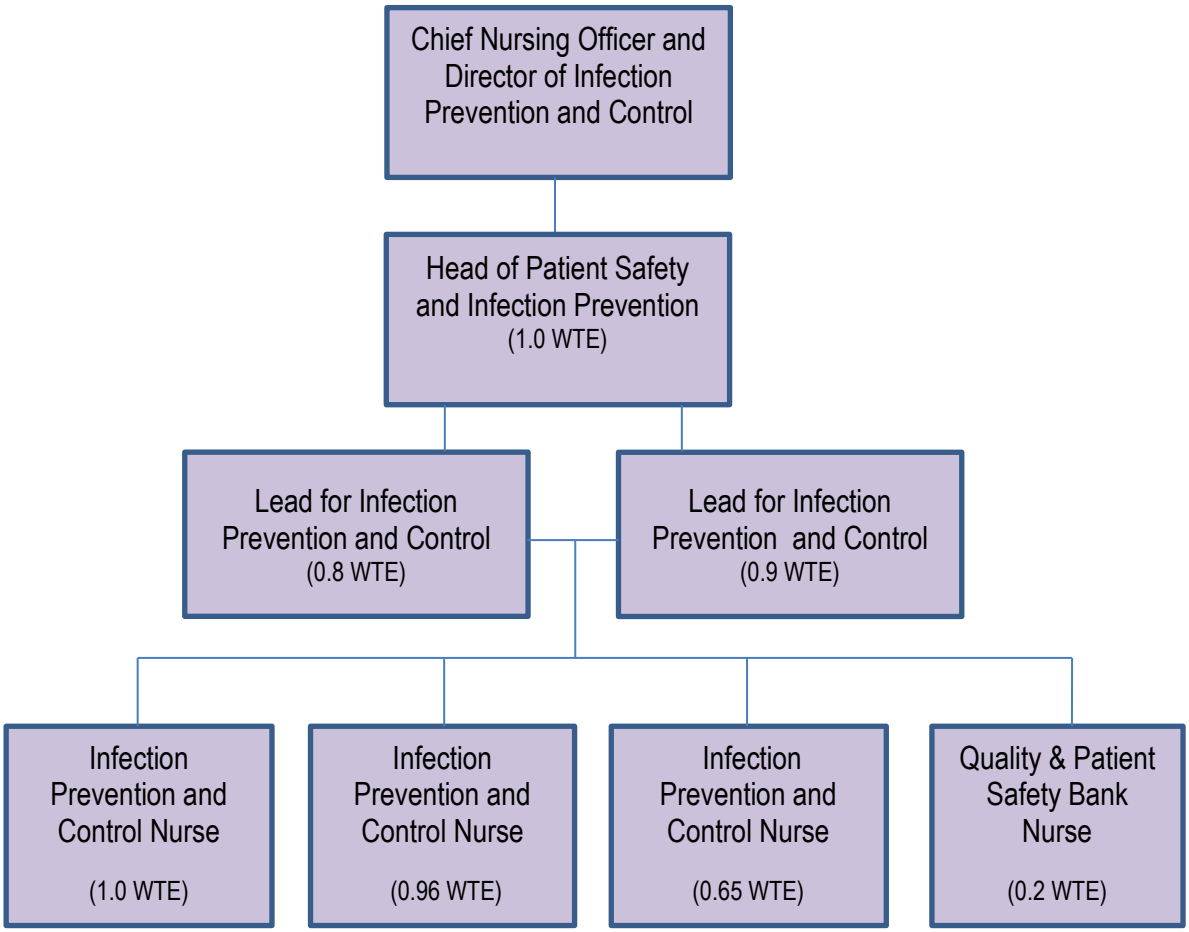
Compliance Criterion	What the registered provider will need to demonstrate against the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance.
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing / medical care in a timely fashion.
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	The provision or ability to secure adequate isolation facilities.

8 The ability to secure adequate access to laboratory support as appropriate.

9 That they have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

10 That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

2. The Sirona Infection Prevention and Control Team (IPC Team)



3. Infection Prevention and Control Work Programme

The Annual IPC Work Programme was initially formulated in April 2020 to co-ordinate and monitor the work of the IPC Team and committees in preventing and controlling infection through education, audit, surveillance, risk assessment, quality improvement and development of policies and procedures. The programme was formulated in line with both national and local priorities and a requirement of the Health and Social Care Act and extends throughout healthcare, health protection and health promotion. Delivery of the work programme is monitored by the Infection Prevention and Control group (IPCG), an assurance group reporting to the Quality and Outcomes Committee (QOC).

The Work Programme is a live document and continues to be updated with new guidance, legislation, and work streams.

The IPC Team also draws on support from the UK Health Security Agency (UKHSA), formerly Public Health England and Occupational Health specialists and works closely with Sirona Medicines Optimisation, Health and Safety, Security and Facilities Teams.

We continue to raise the profile of Infection Prevention and Control and to reinforce that IPC is everyone`s responsibility across the organisation to improve patient experience and outcomes by reducing Healthcare Associated Infections.

New National guidance issued in 2022/23

National Infection Prevention and control Manual for England V2 (June,2022)

Health & Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance (updated December 2022)

Guidance on High consequence infectious disease (updated January, 2023)

Infection Prevention and Control Education Framework (March 2023)

4. Infection Prevention and Control Group (IPCG)

The IPCG is a multi-professional group that provides assurance to the QOC of Sirona care & Health, Community Interest Company (CIC), and that the Company is taking sufficient measures, as outlined in Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

The IPCG meets quarterly and is authorised by the QOC to oversee the delivery of care quality standards across the Company, ensuring that risk and safety issues are identified and regularly monitored, and that actions are taken to protect staff, patients/service users and the public.

All four meetings held in 2022/23 were held through Microsoft Teams.

REQUIRED REPRESENTATIVE AT IPCG
Chief Nursing Officer and Director of Infection Prevention and Control
Head of Patient Safety and Infection Control
IPC Team Lead Nurses for Infection Prevention and Control
Infection Prevention and Control Nurse
Infection Prevention and Control Nurse
Infection Prevention and Control Nurse
Quality & Patient Safety Bank Nurse
North Bristol locality representative

REQUIRED REPRESENTATIVE AT IPCG
Bristol ICE locality representative
Bristol South locality representative
North Somerset Weston and Woodspring representative
South Gloucestershire locality representative
Specialist Services representative
Children's Services representative
Lifetime Services representative
EPRR representative
Inpatient unit representative
MIU/Walk-in Centre representative
Learning Disability service representative
Medical Devices Group representative
Medicines Management representative
Estates and Facilities representative
Health and Safety representative
Learning and Development representative
UHBW representative (adhoc)
NBT representative (adhoc)
Minute taker

5. Infection Prevention and Control Link Practitioner Group (IPC LPG)

The organisation has an IPC Link Practitioner Group which meets bi-monthly. The role of the Infection Prevention and Control Link Practitioner is to act as a resource for their team and to liaise with the IPC Team. They will act under the supervision of the Infection Prevention & Control Team as a role model for colleagues.

The link practitioners from across the organisation who form part of this group are responsible for attending the meetings and disseminating information back to their teams and services, to take every opportunity to update and extend their knowledge of infection control, to challenge any breaches in infection control practices and identify protected time with their line manager to facilitate this.

The IPC team continue to vary the day of the meeting to ensure a wider audience can attend which has proved successful. Key themes emerging from adverse events, audits and observations have been addressed at the meetings including bare below the elbow for clinical staff, the importance of hand hygiene, sharps safety, waste management and cleaning standards. Other discussions included the overuse of PPE (particularly glove use) and winter preparedness covering topics such as influenza, norovirus, COVID-19 and Respiratory Syncytial Virus (RSV). A peer sharps review was also undertaken by the IPCLPG to inform best practice. The IPC LPG are reminded of the requirement for hand hygiene audit completion within their teams and to undertake IPC statutory mandatory training on Learning Management System. In order to provide varied topical educational link meetings, the IPC team have organised two speakers at the IPC LPG. The Tuberculosis (TB) specialist nurse provided a presentation from the TB service and the Clinical and Operational Lead for Long COVID-19 presented

details of the Long Covid service. The IPC team received positive feedback from the IPC LPG and aim to continue with this format.

This year saw the introduction of the IPC workplace group. All link practitioners are invited to be members and the IPC team post up to date guidance, alerts, bug of the month and training opportunities to ensure communication remains our priority.

Plans for 2023/24

Following the National Education Framework for IPC we aim to deliver educational sessions for link practitioners in each locality and service and review IPC mandatory training. The IPC team are currently undertaking an audit with our links to establish staff views and the best way to proceed with this plan.

The IPC team will provide presentations on health care associated infections and a focus on 'bare below the elbow', hand hygiene, cleaning standards and sharps safety. The IPC team will continue to promote hand hygiene audits to be carried out monthly and for link practitioners to promote teams to undertake these audits.

Occupational health and Antimicrobial Resistance will be presented by a representative to the IPC LPG meetings in the coming year.

6. Healthcare Associated Infection (HCAI) Surveillance

The NICE quality standard QS113 (2016) covers preventing and controlling infections in hospitals and other secondary settings that develop because of treatment or being in a healthcare setting. Sirona comply with this standard which includes monitoring, responsibilities, and policies to reduce the risk of infection.

As part of the UK Public Health reforms Public Health England transferred its health protection functions to the UK Health Security Agency (UKHSA) in April 2021 and mandatory surveillance now falls under the remit of UKHSA.

The following organisms are subject to mandatory reporting.

Methicillin Resistant Staphylococcus aureus (MRSA) bloodstream infections

MRSA is a type of bacteria that is resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. All MRSA bloodstream infections are reported nationally and are assigned as being related to an organisation following a local process of post infection review.

All Sirona inpatient facilities had a system in place for screening all patient admissions for MRSA and to determine if patients are MRSA positive on admission to aid surveillance and reduce the risk of an outbreak of MRSA infection.

Screening rates are reported quarterly in the IPC quarterly report. During Q2 South Bristol rehabilitation unit wards 100 and 200 did not achieve 100% in their admission screens due to the swabs not being taken within 48 hours of admission, which led to results not being received within 48 hours. The unit has relied heavily on agency staff. The unit leads have worked with staff to increase compliance and adverse events have been completed on Ulysses relating to this. During Q3 and Q4 compliance from South Bristol Rehabilitation Unit has increased.

There have been no MRSA bacteraemia cases attributed to care delivered by Sirona in 2022/23

Methicillin Sensitive Staphylococcus aureus (MSSA) bloodstream infections

MSSA is a type of bacteria which lives harmlessly on the skin and in the nose, it usually only causes a problem if it gets inside the body. The same reporting and investigation for MSSA bloodstream infections, is required as for MRSA infections.

No cases reported have been attributable to Sirona care during 2022/23

Minimise rates of *Clostridiodes difficile* infection (CDI)

Clostridiodes *difficile* (CDI) is a type of bacteria that can cause a bowel infection. The bacteria are found in the digestive system of about 1 in 30 healthy adults and other bacteria found in the bowel normally keep it under control. Some antibiotics can interfere with the balance of bacteria in the bowel which can cause the bacteria to multiply and produce toxins. The infection most commonly affects people who have recently been treated with antibiotics. It can spread easily to others.

There have been five reportable cases of CDI through the period 2022/23.

There was one reportable infection of CDI in Q1. Following further investigation, it was believed this case was community acquired following a course of anti-biotics prescribed by the GP.

There were two reportable infections of CDI in Q2. One infection was at Skylark rehabilitation unit. Following further investigation, it was believed this case was hospital acquired following multiple courses of antibiotics. One infection was at Elton rehabilitation unit and was acquired at the acute trust. The service user had tested positive for CDI whilst an inpatient at Weston hospital.

During Q3 there were two reportable infections of CDI. One infection was at South Bristol rehabilitation unit and one infection was at Elton rehabilitation unit. Both cases were acquired at the acute trust prior to transfer to a Sirona rehabilitation unit.

No cases reported were attributable to Sirona care in 2022/23 and the rehabilitation units were supported by the IPC team with implementing transmission-based precautions and compliance with the CDI policy.

The Sirona IPC team have formed a collaborative approach with North Bristol Trust (NBT) and University Hospitals Bristol and Weston (UHBW) to share completed CDI post infection reviews and identify shared learning across the system. The group meets monthly to review acute based case reviews with a view to complete community case reviews throughout 2023/24.

Minimise rates of gram-negative bloodstream infections (GNBSI)

Urinary tract infections and catheter-associated urinary tract infections are reported as a leading cause of Escherichia coli (E. coli) and GNBSI. E. coli colonises the gut as part of the natural flora and does not usually cause any problems whilst living in the gut, however it is easy for people to infect themselves with E. coli if they have open channels such as catheters for the bacteria to enter. The NHS long term plan supports a 50% reduction in GNBSI by 2024/25.

The National Health Service England/Improvement (NHSI) Plan and the South West Infection Prevention Control Work programme includes a reduction in avoidable GNBSI. The national programmes include the Hydration Project and Urinary Tract Infection Collaborative.

The Bladder and Bowel Team set up a Sirona UR- in- control group in April 2021 (All things urinary catheter). This group is led by the Bladder and Bowel Team and is supported by the IPC Team.

The purpose of this group is to provide assurance to the Senior Leadership Team establishing and monitoring safe effective urinary catheter management and practice and to ensure that learning and evidence is shared across the organisation with the aim of improving harm free care. The role of the group will be to review associated policies, catheter knowledge, training, audits and incident themes ensuring that the BNSSG catheter passport is given to all appropriate patients, reduce E.coli infections, emergency admissions to the Trust and to make recommendations for change in practice where appropriate.

The last UR- in- control group was held in February 2023. The previous meeting was held in March 2022 due to capacity within the bladder and bowel service. The group will now be meeting quarterly. The bladder and bowel service are going to be completing baseline audits of catheters across Sirona and have resumed monitoring catheter related adverse events.

The minutes for this group report into the quarterly IPCG meeting.

Klebsiella species

Klebsiella is a bacteria normally found in the human intestines, where they do not cause disease. Increasingly these bacteria have developed antimicrobial resistance, mostly recently to Carbapenems, a class of antibiotics usually reserved for known or suspected multi-drug resistant bacterial infections. Klebsiella Gram- negative bacteraemia can cause different types of HCAI including pneumonia, blood stream infections and wound infections.

No cases reported have been attributed to Sirona during 2022/23.

Pseudomonas aeruginosa

Pseudomonas is a type of bacteria that is commonly found in the environment, like soil and water. Of the many different types and one that often causes infections in humans is called Pseudomonas aeruginosa which can cause infections in the blood, lungs (pneumonia) or other parts of the body following surgery. The bacteria can become multidrug-resistant.

No cases reported have been attributed to Sirona during 2022/23.

Carbapenemase Producing Enterobacteriaceae (CPE).

Out of the many different types of bacteria CPEs are a group of bacteria that usually live harmlessly in the gut of humans or animals but have become resistant to multiple antibiotics. As with *E. coli*, they can cause infections of the urinary tract, and the bloodstream. Due to the serious nature of these bacteria, it is now a requirement to report patients that are admitted to a hospital setting, or who have these bacteria identified in specimens sent to the microbiology laboratory.

There has been one reported case of CPE during 2022/23 at South Bristol Rehabilitation Unit which was not attributed to Sirona.

Respiratory infections including COVID-19

During Q3 2022/23 there were two cases of influenza. One case was transferred to South Bristol rehabilitation unit from the acute setting with the known infection status. The second case was identified in Skylark. At the time of diagnosis, the IPC team were not informed by the unit staff and when the IPC team became aware the patient had been discharged. The IPC team have improved their HCAI surveillance process by having access to the rehabilitation unit's handover documentation and this is checked daily as part of the IPC teams clinical on call duty.

7. COVID -19 Outbreaks

On 1st April 2022 national government guidance changed and public testing for COVID-19 was no longer free of charge, this meant that visitors to Sirona rehabilitation units were no longer required to test. The consequence for these settings was that a patient could test positive and the cause of the transmission may not be identified.

In June 2022 government guidance changed to support the wearing of masks to return to pre-pandemic measures, meaning that masks would only be required in healthcare settings if patients had a suspected or

confirmed respiratory illness, during an outbreak or where there were severely immunosuppressed patients. Sirona initially adopted this change across all settings, however with an increase in community prevalence and positive cases in rehabilitation facilities, reverted to the wearing of masks as routine in patient facing areas. This continued until March 6th, 2023, when Sirona mask guidance changed to align with the Government guidance, except in place-based urgent care settings where the risk of unknown infectious status was believed to be increased. Sirona guidance continues to support the use of masks as a personal preference or when a patient or colleague request staff wear one, or whilst caring for suspected and confirmed respiratory illness patients and in the event of a respiratory outbreak.

In line with system partners, investigation and management of COVID-19 outbreaks adopted a lighter approach, with SIRI's not being routinely required in the event of an outbreak, because learning points had been saturated throughout the pandemic. Detailed documentation completed by the IPC team, that identified possible transmission causes and highlighted IPC improvement needs and shared with the service managers where there had been outbreaks. The IPC team continued to support the full investigation into the possible causes of outbreaks and COVID-19 transmission, provide on-going advice to Sirona services and provide training to staff in IPC measures relevant to the findings.

Throughout the year, Sirona encountered 9 outbreaks of COVID-19 in various locations involving both patients and staff. The IPC team supported the rehabilitation unit leads to ensure close monitoring and management. The table below details the COVID-19 outbreaks in Sirona during 2022-2023:

Quarter	Date	Location	Cases	Type	Details and Key Points
Q1	March/April 2022	South Bristol Rehabilitation Unit (Wards 100 and 200)	13 patients, 21 staff members 2 outbreaks later linked as patient declined testing, however information omitted from SBRU staff to IPC team initially	Patient and Staff Outbreak	• hand hygiene audit improvements- IPC training provided • use of disposable wash bowls instead of shared reusable bowls • Improved use of 'I am clean' labels required on wards • Improvements required when providing IPC team with information
Q2	July 2022	South Bristol Rehabilitation Unit, Ward 100	5 patients	Patient Outbreak	• Possible transmission from visitors • missed routine admission test • masks not routinely worn 2 weeks prior to outbreak as per government guidance

Q2	July 2022	Elton Rehabilitation Unit	4 patients, 6 staff members	Patient and Staff Outbreak	• Agency staff not testing prior to shift- agency informed of correct testing procedures for Sirona shifts • masks not routinely worn 2 weeks prior to outbreak as per government guidance
Q2	July 2022	South Bristol Rehabilitation Unit, Ward 200	3 patients	Patient Outbreak	• Visitors informed staff of subsequent positive tests • asymptomatic cases detected through routine whole ward testing • Staff co-horted once outbreak identified • masks not routinely worn 2 weeks prior to outbreak as per government guidance
Q2	July 2022	Skylark	8 patients	Patient Outbreak	• Patients linked along the same corridor • Visitors informed staff of subsequent positive tests • Patient with dementia wandering with intent between rooms • staff co-horted along corridors • masks not routinely worn 2 weeks prior to outbreak as per government guidance
Q2	August 2022	Elton Rehabilitation Unit	2 patients, 2 staff members	Patient and Staff Outbreak	• Staff member not wearing mask- education about current Sirona mask wearing procedure given • 72 hour report completed by unit manager

Q3	December 2022	Warmley INT base	9 staff members	Staff Outbreak	• Linked to an out-of-work event • Restriction to base implemented until deep clean undertaken • Reiteration staff to not attend work when unwell • Masks in office reintroduced
Q3	December 2022	Long covid service	6 staff members	Staff Outbreak	• Linked to a team training event • Reiteration staff to not attend work when unwell
Q4	February 2023	Elton	3 patients	Patient Outbreak	• Close contact in day room

Sirona IPC team's commitment to managing and preventing COVID-19 outbreaks through enhanced infection prevention measures, timely response, and continuous improvement will remain a top priority in the coming year.

8. Serious incidents requiring investigation (SIRI)

Serious Incidents (SI) in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

There were no Infection Prevention & Control SI`s reported during the period April 2022 – March 2023.

9. Adverse Events relating to IPC

An adverse event is anything that has caused a loss of some kind; loss can include personal injury, reputation loss, financial loss or a negative impact on service user experience. Adverse events are reported on-line on a system called Ulysses (Safeguard system). Adverse events could involve staff, service users, and visitors or could be a security issue or problems with a service. When anything happens that could cause Sirona or an individual a loss, it must be reported. Near misses must also be reported. Near misses are the times when something has nearly happened but didn't.

The reporting of adverse events, including near misses, is important to Sirona to ensure that the organisation can learn from what has gone wrong and prevent such incidents reoccurring. Anyone can report an adverse event. At the end of each quarter an adverse event report is produced with statistics of the departments reported events. Staff may be asked to be involved in the investigation of the 'root cause' of an adverse event.

Sirona care & health has a 'fair blame' culture which means that staff will not be blamed for reporting that they have been involved with an adverse event or near miss, unless it is proven that the act is repeated, illegal, malicious or that gross misconduct was involved. The Infection control team report on any adverse events that relate to IPC, within the organisation, in both the IPC quarterly and annual report.

The IPC categories for reporting adverse events are:

- Cleaning Environment
- Cleaning: Equipment
- Clinical Waste
- COVID 19 related
- Outbreak patient (this category includes potential for outbreak)
- Personal Protective Equipment (PPE)
- Reportable Healthcare associated infection HCAI)
- Sharps boxes
- Sharps/Needlestick injury or near miss

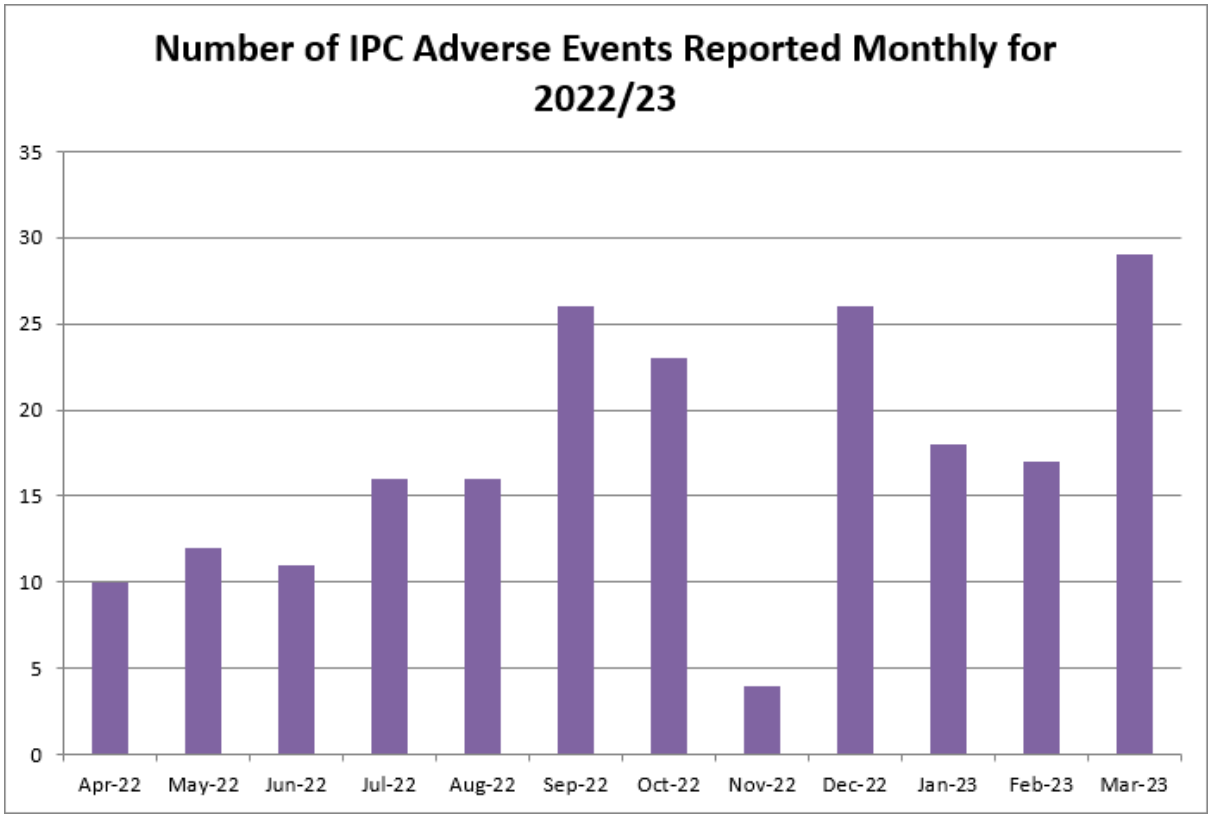
All adverse events have been actioned appropriately by the Quality & Patient Safety Team.

Table showing the number of IPC Adverse Incidents reported by month in 2022/23

Total number of adverse events reported by month in Q1	
April	10
May	12
June	11
Total	33
Total number of adverse events reported by month in Q2	
July	16
August	16
September	26
Total	58
Total number of adverse events reported by month in Q3	
October	23
November	4
December	26

Total	53
Total number of adverse events reported by month in Q4	
January	18
February	17
March	29
Total	64
Annual Total	**208**

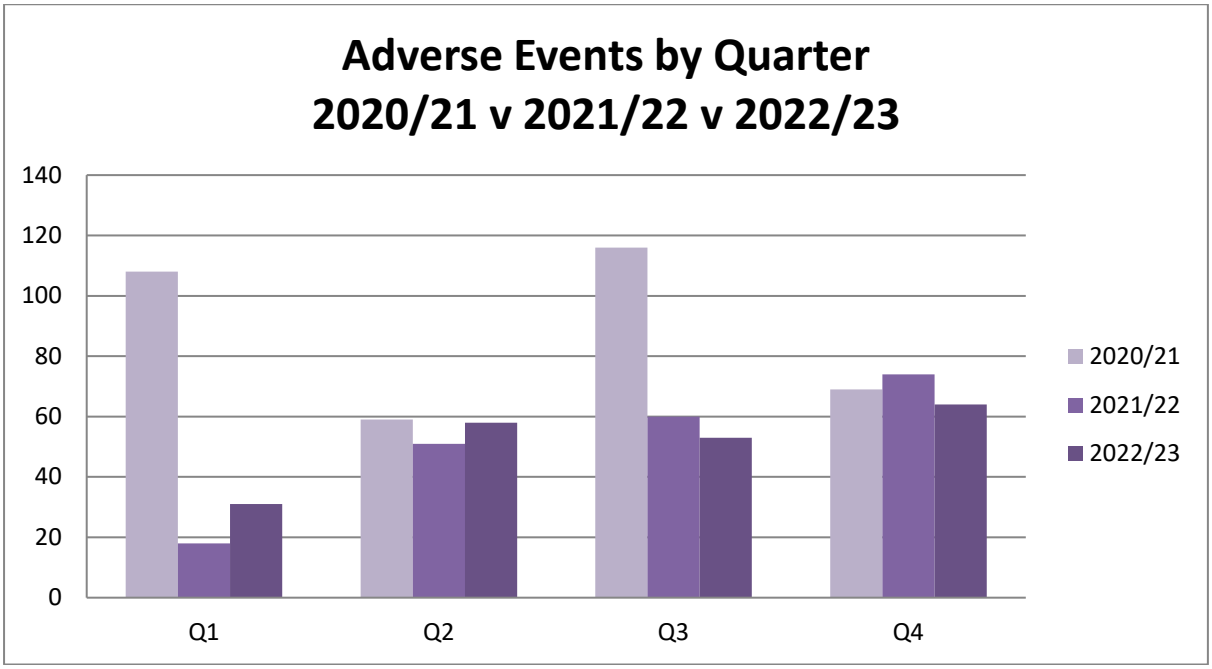
Graph below showing the number of IPC Adverse Events reported monthly 2022/23



There were a total of 208 adverse events relating to IPC reported between Aprill 2022 and March 2023 in comparison to a total of 203 reported in 2021/22.

There were just four adverse events reported in November 2022. This was investigated and there was no evidence found as to why there was low reporting during this month. Quarter 3 remains comparable to the overall IPC AE reporting for both this year and last year.

Graph below showing a comparison of IPC Adverse Events reported quarterly in 2020/21, 2021/22 and 2022/23



When the IPC team review and report on the adverse events the data is triangulated by categories, locality and complaints and any other themes which are identified. (There were no IPC complaints reported in 2022/23)

Table showing the highest four categories reported each quarter

	Covid 19	Outbreak	Sharps/Needlestick	Cleaning
Q1	8	7	8	
Q2	13	16	8	8
Q3	15	16	11	
Q4	23	6	15	
TOTAL	59	45	42	8

The highest adverse events reported during 2022/23 were reported in the categories COVID-19 related, Outbreak Patient and Sharps/Needlestick injury or near miss and cleaning.

There were 59 AE reported in the COVID 19 category and 45 reported in the outbreak category, 38 of these AE were Covid 19 related and 7 related to *Clostridioides* difficile (2), Norovirus (2), Diarrhoea and Vomiting (2) and one MRSA which was mis- reported as it was a routine admission swab not an outbreak.

The Government launched an independent Public Inquiry (PI) in 2022 into the Government and public sector response to the COVID-19 pandemic. A Task and Finish Group was set up within Sirona in March 2022, made up of senior operational and corporate managers whose role had been identified as material to the way in which the organisation responded to the pandemic.

Workstream leads were identified and tasked with the following actions:-

- Identify key events, decisions and people involved.
- Identify documents/data which record events/support decisions.
- Complete public inquiry summary document, including recording gaps in evidence.
- Place a copy of documents/data in PI filing structure on Glass cubes (under evidence and relevant workstream) or record where the documents are held on the public inquiry summary document.

This has now been completed by Sirona.

Sharps was the third highest AE category reported. There has been an increase in the number of sharp related incidents over 2022/23 compared to 2021/22. The increase in incidents may be due to services resuming across the organisation due to living with COVID-19, an increase in sharp procedures, or increased reporting. There was a total of 13 sharp incidents where the sharp was not disposed of in a safe or timely manner.

There is insignificant change to the number of incidents reported by locality when comparing the data to the previous year. South Gloucestershire continues to have the greatest number of sharp-related incidents. This may be due to staff in this locality carrying out a higher number of sharp procedures. Other factors which may have influenced the number of incidents across each locality include staff fatigue, poor lighting or lack of equipment in a patient's home, the use of agency staff and staff behavior's.

The sharps procedure which has seen the highest number of incidents is insulin administration related. This was the same in the previous year. Staff exposure to non-safe insulin needles remains evident through the incidents reported. This may be due to staff assisting patients who usually self-administer their insulin or a lack of safety needles in the patient's own home/place of residence. Staff will now carry insulin safety needle supplies in their stock.

Safer Sharps Annual Report

06. Annual Sharps report 2022-23 V2.d

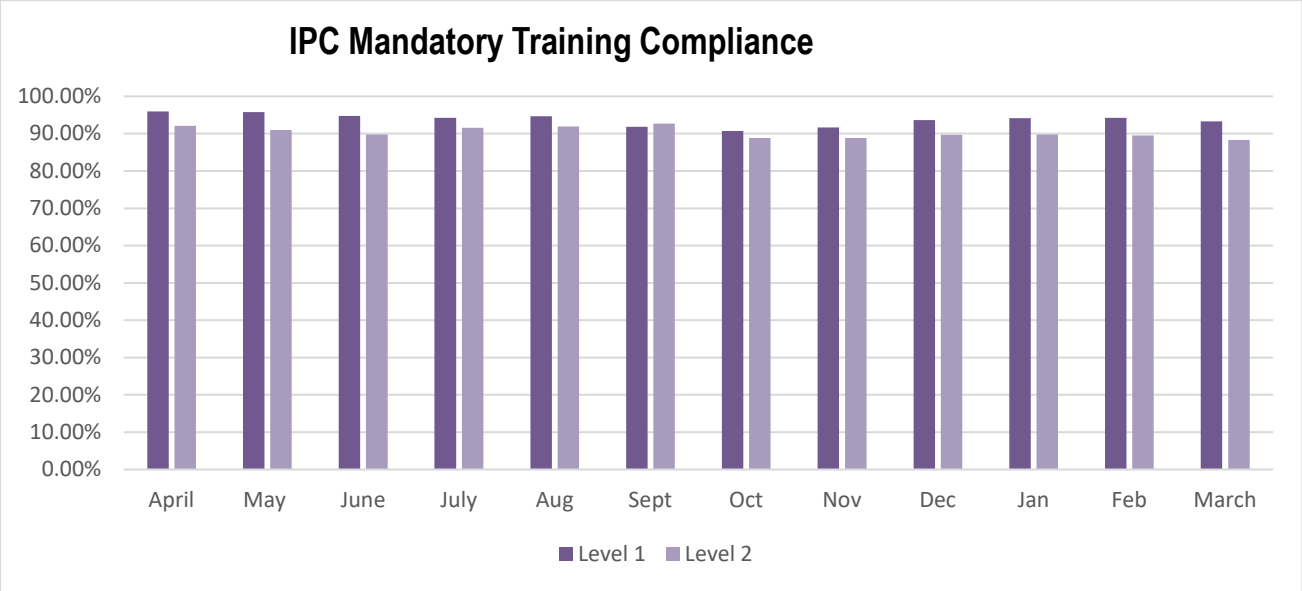
10. Complaints

There have been no IPC complaints reported to Sirona in 2022/23

11 Statutory Mandatory IPC Training and Education

The compliance for Level 1 and Level 2 IPC training is 90%. IPC Statutory mandatory training compliance has improved during 2022/23.

Graph demonstrates IPC Mandatory Training Compliance Level 1 and Level 2 for April 2022 to March 2023.



As shown in the graph above:

In Q1 level 1 IPC mandatory training was achieved in Q1. The 90% standard for level 2 IPC training was achieved in April and May but not June.

In Q2 level 1 and level 2 compliance were achieved.

In Q3, Level 1 compliance was achieved but fell just below 90% for Level 2.

In Q4, Level 1 compliance was achieved but fell just below 90% for Level 2

A contributing factor to this may be the organisations' OPEL 4 status and increased sickness and capacity issues across the organisation.

The IPC team send monthly reminders across the organisation using Workplace. The team also take the opportunity during face-to-face visits, site visits and locality meetings to remind and encourage teams to complete their training. This is added as a standing agenda item at the link practitioner group meetings. During the IPC Group meetings each locality complete an IPC highlight report which identifies localities which need to improve their compliance with IPC mandatory training. The IPC team respond via reminder emails to the IPC link practitioners for their teams to complete mandatory training and post the same message to staff on Workplace.

Educational Sessions

The IPC team have developed new ways of communicating with the operational teams. With the launch of the Workplace page- titled 'Infection Prevention and Control Group' the team have improved visibility across the organisation and used this platform to share a wide range of IPC information. The team have regularly posted IPC resources and updates to communicate effectively with Sirona staff about current IPC issues including, prevalence of infections, norovirus, PPE use including glove awareness week and details of access to training modules for clinicians. The information is also emailed to the link practitioners to cascade to their teams.

The IPC nurses have developed and recorded educational Webinars titled 'Hand Hygiene', 'Safer use of sharps' and 'winter preparedness' which has been shared on Workplace and is made available on the IPC knowledge and skills library Workplace page.

The IPC team produce a series of educational posters called 'bug of the month' which are sent out to the link practitioners to disseminate to their teams. During 2022/23 these included *legionella*, *norovirus, (TB), headlice, diptheria* and *klebsiella* and a video of 'vomiting Larry' to demonstrate the transmission of infection.

The IPC team have visited the Integrated Nursing Teams (INT) community bases and rehabilitation units to provide face to face training on safe handling and disposal of sharps, hand hygiene and winter preparedness. The nurses also use the glow box to assist with monitoring hand hygiene standards and uniform standards of bare below the elbow. This allows an opportunity to discuss any IPC related issues with the clinical teams. Unfortunately, due to capacity many INT staff have cancelled training sessions.

IPC have commenced in- team educational sessions. Each IPC team member identifies a health care associated infection and provides a presentation to the team. The first learning session in March focused on the bacteria Klebsiella. The team used this time to discuss how this infection would be managed in a clinical setting. This method of teaching was well received by the team and will continue throughout the year and the presentations are used to share with the IPC link practitioners.

On June 7th and 8th 2022, the IPC Conference in Exeter was hosted by the Southwest Infection Control Network in partnership with UKHSA and Gloucester Hospitals. This two day event was attended by the IPC Team and was a great learning opportunity with presentations including microbiology, shared decision, health care associated infections and hydration projects.

October 16-22nd 2022 was National IPC week, and the IPC team of nurses took this opportunity to set up a stand in Castlewood, Yate Minor Injuries and South Bristol Community Hospital with IPC posters and patient information leaflets. This improved the visibility of the IPC team and provided an opportunity for Sirona staff and the public to meet the team and ask questions and raise issues. This proved a great success.

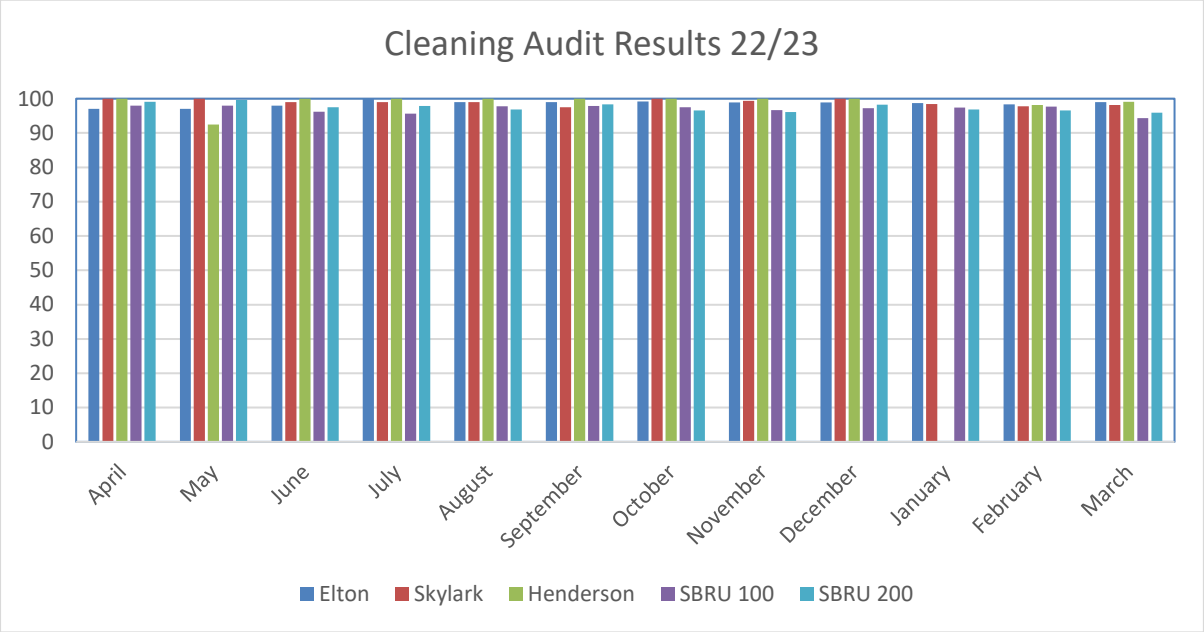
November 18-24th 2022 was World Antimicrobial Awareness Week (WAAW). The IPC team attended various antimicrobial awareness webinars which the team also promoted on the IPC Workplace group. Sirona staff were encouraged to become antibiotic guardians and help reduce the burden of antibiotic resistance.

12 Cleaning

Compliance Criterion 2: The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Environmental cleaning in all healthcare environments is vital to reduce the spread and transmission of infections.

Monthly cleaning audits are completed by all the Sirona rehabilitation units and the results are reported to the IPC team who monitor the cleaning scores monthly. If the scores are below the national standard of 95% an action plan is put in place until improvement is seen in a timely fashion.



Cleaning audits are completed on Henderson and Skylark units by the Unit Managers. The Hotel Service Manager completes cleaning audits on Elton unit. South Bristol Community Hospital are audited by the UHBW audit teams and results are sent to IPC monthly.

During Quarter 1 2022, the Sirona cleaning audit was drafted and trialled in Elton Unit (North Somerset). Other units completed their own cleaning audits. Henderson unit was the only unit to score below the passing rate of 95% in May with a score of 92.5%. This was later improved in June.

During Quarter 2 2022, the cleaning audit was being built on the Ulysses system. Henderson, Skylark and Elton all completed the Sirona audit on a word document which was sent to the IPC team each month. UHBW audit scores highlighted that ward 200 at South Bristol Community Hospital scored below the passing rate with a score of 91.25%, this was highlighted to the team and the cleaning audit score improved the next month.

In Quarter 3 2022 the Ulysses audit was built and trialled by the Elton unit team. The plan was to use the Ulysses audit for units from Quarter 4.
All units completed cleaning audits during Quarter 3 and all scored above the required pass rate.

From Quarter 4 all units were able to complete their cleaning audits on Ulysses. Henderson did not submit an audit via Ulysses in January, when contacted the IPC team did not receive a response. Therefore, monthly reminders are now sent to units to ensure audits are completed. Unit 100 at South Bristol Community Hospital also were below the passing score of 95% with a score of 94.36%. This was discussed at the Cleaning and Environmental Group and improvements made, the unit scored above the pass rate in the next month.

The IPC team had issues receiving audit scores from Ulysses at the beginning of Quarter 4. This resulted in units not being aware of their cleaning scores after completing the audit. After further discussed with the Sirona Audits team and Ulysses, IPC now receive monthly audit reports from Ulysses which shows individual audit scores.

Percentages are still manually calculated from the audit scores, an action to take forward in 2023/24 is to improve this process and will be achieved through a Quality Improvement project by a member of the IPC team.

All Sirona services with external cleaning contacts send audit results directly to the Estates team, this is updated to the Cleaning Dashboard and monitored. If scores are below the Functional Risk rating, then IPC and Estates

will carry out a joint visit to the site. The site will also be discussed at the Cleaning and Environmental Standards Group.

The Cleaning and Environmental Standards Group was commenced in February 2022 and meets monthly. This group is a multi-professional group that will provide assurance to the IPCG and the QOC that Sirona is taking sufficient measures to minimise the risk of individuals acquiring infections during their care or treatment and are compliant with the current standards, and by September 2022 the new NHS Cleaning Standards. The group shall report to the IPCG and QOC through both the quarterly and annual report.

The Cleaning and Environmental Standards Group meet monthly to discuss the cleaning standards action plan and review cleaning adverse events.

Ongoing discussions and actions are being carried out by the Cleaning and Environmental Standards Group for the sites Knowle West Healthy Living Centre and North Somerset Minor Injury Unit.
Knowle West Healthy Living Centre was highlighted with concerns regarding the standard of cleaning in 2022. Ongoing site visits and audits have been carried out during this time. This site was added to the risk register in 2022. Quarterly visits are now being carried out at the site from the IPC and Estates team. Since then the standard of cleaning has improved, the site remains on the risk register until further improvements are made. Visits continue quarterly.

Ongoing site visits and discussions in the Cleaning and Environmental group are also being carried out for North Somerset Minor Injury Unit. Standard of cleanliness of this site has also been highlighted with concerns. Further site visits and discussions are due to be carried out during Quarter 1 of 2023.

The Cleaning and Environmental Standards group have met their achievements planned in the last annual report from 2021/2022.

- The Sirona Cleaning Policy has been updated in line with the National Standards of Healthcare Cleanliness 2021 and is available on the Sirona Workplace website for all Sirona staff and services to access.
- A cleaning audit has been developed and is now used monthly by Skylark, Henderson and Elton Rehabilitation units. The audit tool is also used for spot check cleaning audits in all Sirona services.
- Commitment to Cleanliness Charters have been devised and are visible in buildings where Sirona services are carried out.
- Functional Risk Ratings have been applied to all Sirona healthcare environments by the Estates team. This has further been developed into a dashboard to monitor all cleaning audit results across Sirona.
- Staff in Sirona are aware of new guidance and the cleaning responsibilities. This has been shared via Workplace, the cleaning policy and in IPC Link Practitioner Meetings.
- Star ratings have been implemented alongside Commitment to Cleanliness Charters across Sirona to ensure the patient and public are aware of cleaning standards.
- IPC team complete Environmental Audits annually at all Sirona bases and ensure Commitment to Cleanliness Charters and 5 star ratings are in place. This is highlighted to the Estates team if not completed.

During the year 2023/2024 the Cleaning and Environmental Standards group will continue to meet regularly to discuss any cleaning concerns at Sirona bases and give updates on cleaning audits and their results.
Bases with ongoing cleaning concerns will continue to be monitored by IPC and Estates visits and updates at the Cleaning and Environmental Standards Group.
A quality improvement project will be started in 2023 by IPC to improve the audit process on Ulysses.

13. Environmental Audits

During 2022-2023 the IPC team in conjunction with Sirona Health and Safety team completed an environmental audit at every clinical base accessed by Sirona services to identify IPC concerns and issues in the environment. This audit covers:

- IPC standard precautions equipment availability
- Cleanliness of the environment, equipment, and stores
- Cleaning schedules and stores

The IPC team complete a percentage score of compliance and complete an action plan which is shared with the relevant stakeholder's dependent on the issue that needs rectifying. This would include service Managers, IPC link practitioners, Sirona Estates and Facilities team and the wider IPCG ensuring that locality leads are made aware of concerns on the sites their services access. Re-audits, where required, take place three to six monthly.

Below is a table that shows examples of the most common themes identified during these audits and the actions advised by the IPC team alert to which colleagues have responsibility to resolve.

IPC Environmental Concern	Recommended Action
General issues with cleanliness and condition of the building. This includes, high level dust, cleaners not storing their equipment appropriately, flushing and cleaning schedules not available or not completed and	Report to Estates team who manage cleaning contracts. Joint visit with Estates and cleaning contract where re-audit shows no improvement Add to Bi-monthly cleaning standards group agenda for multidisciplinary team to discuss and IPC & Estate heads to review if site should be added to the risk register
'I am clean' stickers not in use to prove that reusable equipment has been decontaminated	Action sent to service manager and link practitioner to prompt staff to use. IPC team can provide NHS supplies codes if team not aware
Storeroom stock in cardboard boxes on the floor so that stock is at risk of contamination from spill and leaks	Action sent to service manager and IPC link practitioner to advise use of plastic leak proof lidded containers where there is no wall mounted option to store stock. IPC team can provide NHS supplies codes if team not aware.
Sharps boxes not closed and/or labelled correctly, single use scissors left on shelving in storerooms	Action sent to service manager and IPC link practitioner to advise staff on the safe handling of sharps policy. IPC team have developed and made safer sharps posters available. IPC team offer safer handling of sharps training to team

The IPC team plan to continue their joint audits of these sites with the H&S team throughout 2023-2024 as it has proved a successful joint approach and the disciplines can support operational teams in managing their environments safely.

14. Hand Hygiene

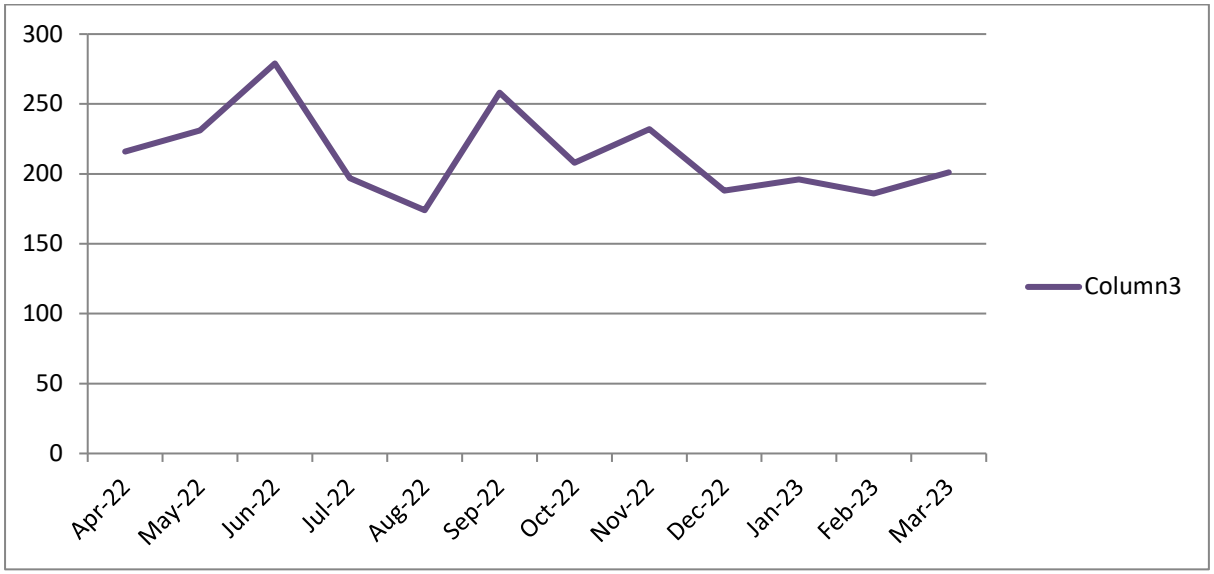
Hand Hygiene Annual Audit report 2022/23

Within Sirona care and Health, Hand Hygiene audits must be carried out by clinical teams monthly.

Hand hygiene is an essential part of Infection Prevention and Control. Hand hygiene can be related to all compliance criteria in the code of practice and must be followed to ensure staff and patient safety.

This graph evidences the total amount of Hand hygiene audits submitted by clinical staff across all of Sirona's services between April 2022 and March 2023.

Hand hygiene audits are submitted through the Ulysses system.



The above graph details hand hygiene audit returns throughout Sirona.

Submission of Hand Hygiene audits was stable with an overall increase across the year 2022-2023 from the previous year.

Quarter 1 2022-2023 showed an increase that peaked towards the end of the quarter that was followed by a decrease at the start of Quarter 2. The increase was likely down to communications from the IPC team which included reminders to link practitioners in online meetings, posts on Sirona's intranet- Workplace as well as direct face to face meetings with teams following the gradual step down of COVID-19 precautions. The decrease that followed was likely due to the unprecedented demand on operational teams across the organisation, with reduced capacity across all specialities and Sirona remaining in Opel 4 throughout this quarter.

Towards the end of Quarter 2 moving into Quarter 3 2022-2023 a steady increase was observed which likely correlated to an increase in staffing capacity and IPC communications.

Quarter 3 saw a slight rise and fall in submissions with no clear cause for this identified and although the number of submissions did not reach that seen at the start of the Quarter 1, submission numbers plateaued in Quarter 4 at an overall higher rate of return than the previous year.

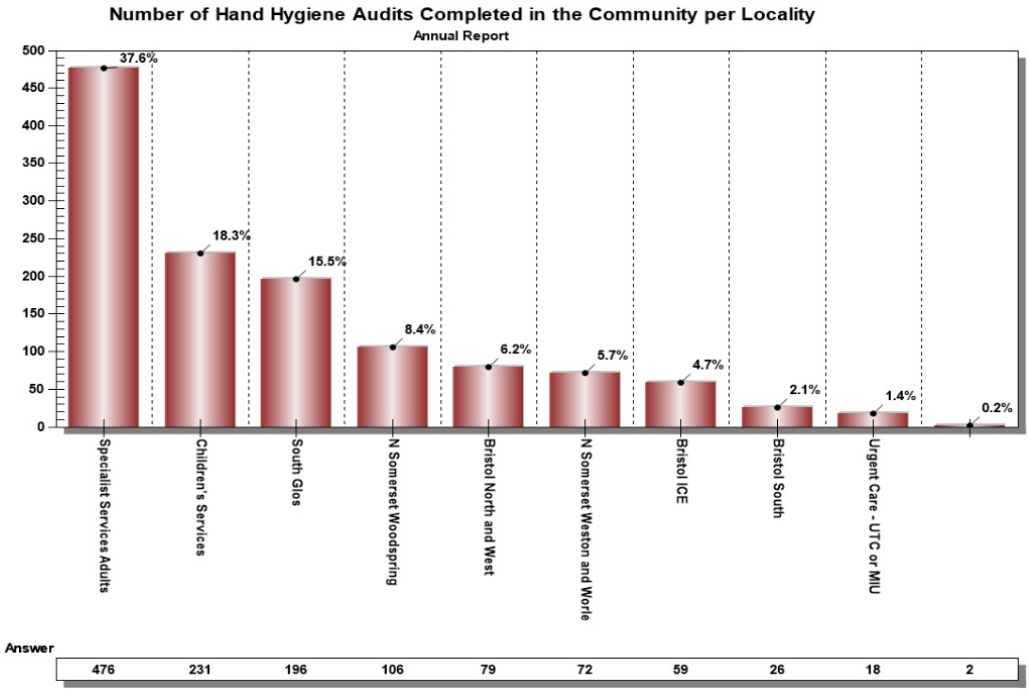
Throughout the year 2022-2023 Hand Hygiene audits remained a priority on the IPC link practitioner meetings and following the appointment of a new IPC nurse in July 2022 the localities were divided amongst the team so that each locality was provided with a named IPC nurse. This meant that more focus could be given to the areas where audit returns were lower than expected. Face to face training was also re-instated post pandemic and the Hand Hygiene training delivered to staff contained a section relating directly to the completion of these audits.

In November 2022 the IPC team launched their own group IPC page on Sirona's intranet- Workplace. The page quickly gained traction and to date has over 130 members. Link practitioners are added to this group, and it is open for any staff across the organisation to join. Hand hygiene audit reminders are posted here at regular intervals throughout the year and the IPC team are able to see how many staff members have viewed the posts, though there is not currently a way to gauge its overall effectiveness.

Following the appointment of a lead for Ulysses in Quarter 1 development work of the Ulysses system was undertaken and an IPC dashboard created. This has enabled the IPC team and Associate Directors a more in-depth insight of the audit results which is now presented in graph format alongside the total number of audits completed in the monthly hand hygiene reports across localities.
The key area identified as a concern was compliance with 'Bare Below Elbow (BBE)'. The IPC team has increased reminders about the rationale and importance of complying with this practice and in the coming year plan to roll out 'in person' BBE training, posters and regular reminders. A member of the IPC team is also planning a quality improvement project focusing on this notable area for improvement.

The Save Lives "Clean your hands" global campaign is celebrated annually on the 5th of May (World Hand Hygiene Day) and aims to bring people together in support of hand hygiene improvement around the world. In 2022 the theme was recognising that we can add to a facility's climate or culture of safety and quality through cleaning our hands but also that a strong quality and safety culture will encourage people to clean hands at the right times and with the right products.
For this campaign the IPC team shared communications with link practitioners and opened discussion amongst operational teams around the importance of excellent hand hygiene standards.

The graph below details the number of Hand Hygiene audits completed per locality.



15. Antimicrobial Stewardship (AS)

The organisation has an antimicrobial stewardship lead and program including education work plan to provide appropriate training linked to themes identified.

Antimicrobial stewardship is defined as an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness (NICE, 2015).

Standards

- Antibiotic prescribing for inpatient beds adheres to the Start Smart – Then Focus Antimicrobial Stewardship toolkit for English Hospitals (PHE 2015) and includes:
  - Compliance with prescribing guidelines (or appropriate documentation of non-compliance)
  - Appropriate course length
  - Documentation of clinical indication included on the drug chart
- Evidence that results are fed back to prescribers.
- Work towards meeting nationally set targets on reduction of broad-spectrum antibiotics (Cephalosporin's, quinolones and co-amoxiclav) by March 2023.
- Collaborate across BNSSG system on antimicrobial stewardship
- Oversee systemwide antimicrobial stewardship projects

Threshold: 75% compliance with audit standards, aiming for 95% compliance. *(Green >94%; Amber 75-94%; Red <75%)*

In cases where results are less than 95%, an action plan is created for the unit manager/sister to review, and implement any changes recommended prior to the next audit.

Locations:

- Elton Rehabilitation Unit
- Skylark Rehabilitation Unit
- Henderson Rehabilitation Unit
- South Bristol Rehabilitation Unit
- Clevedon Minor Injury Unit (MIU)
- Yate Minor Injury Unit (MIU)

Audit results

Unit	Q1 22/23			Q2 22/23			Q3 22/23			Q4 22/23		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Elton	97%	100%	96%	96%	100%	100%	100%	100%	91%	100%	100%	None
Henderson	100%	100%	100%	97%	98%	96%	94%	100%	94%	91%	94%	100%
Skylark	98%	100%	91%	91%	96%	94%	100%	97%	95%	94%	97%	93%
Ward 100 (SBRU)	100%	98%	100%	100%	93%	100%	100%	94%	100%	88%	93%	91%
Ward 200 (SBRU)	100%	100%	100%	100%	100%	100%	100%	98%	98%	100%	100%	98%
Clevedon MIU	98%			96%			98%			97%		
Yate MIU	100%			100%			100%			99%		

RED = < 75%; AMBER = 75 – 94%; GREEN = >94%

Areas of good practice

All audited prescriptions had a completed allergy status, a stop/review date, prescribed according to the patients clinical indication (except one).

Areas of non-compliance with audit standards:

- Course length exceeds BNSSG guidelines without microbiologist recommendation
- Choice of antimicrobial does not match BNSSG guidelines and no sensitivities to guide choice.
- Indication not documented clearly documented
- Not completing all appropriate investigations prior to commencing antimicrobial
- Results of investigations not reviewed and treatment amended as appropriate.

Antimicrobial Resistance (AMR) Training

Antimicrobial resistance (AMR) e-learning is available on LMS for staff to complete. With continued pressures on capacity of the workforce and considerable statutory and mandatory training for individuals to complete, this training has not been made mandatory for all clinicians. The Antimicrobial Stewardship Lead promoted this training with the Infection Prevention & Control group, Independent prescribers, and during World Antimicrobial Awareness Week in November 2022.

Quarter	Number of staff completing training
1	34
2	13
3	7
4	5
Total	59

Only a small number of staff have completed this training and of these 11 are members of the pharmacy team and they carry out the majority of the audits and are already well aware of the compliance standards. Uptake of training has been quite poor throughout the course of the year and therefore we have revisited how we can increase uptake by clinicians with the support of Learning and Development making a change to LMS in 23/24.

16. Policies

Criterion 9: That they have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

In order to achieve compliance with the registration requirements relating to infection prevention (including cleanliness), registered providers are expected to demonstrate that they have in place policies and procedures to meet each relevant criterion listed in the Health and Social Care Act.

The National Infection Prevention and Control Manual for England was published in September 2022. This is an evidence-based practice manual for use by all those involved in care provision in England and to be adopted as

mandatory guidance in NHS settings. The Sirona IPC team have reviewed policies in line with this guidance throughout 2022/2023.

There were 11 IPC policies reviewed / formulated and ratified in 2022/23

- Isolation Policy
- Decontamination Policy
- Care of the Deceased Policy
- Toy Cleaning Policy
- Tuberculosis Policy
- Linen Policy
- Standard Precautions Policy
- Overarching Infection Prevention and Control Policy
- Cleaning Policy
- Outbreak Policy
- Carbapenemase Producing Enterobacteriaceae Policy

17. Legionella and Water Quality

Duties under the Health & Safety at Work Act 1974 apply to the risks from exposure of legionella bacteria that may arise from work activities. The governance and assurance standards that influence safe healthcare estates and facilities include HCAI Code of Practice and CQC standards.

Water safety is reviewed at the Health & Safety (H&S) Committee for assurance. A Water Safety Policy is in place. Water safety assessments are undertaken by Sirona at all sites where they have maintenance responsibilities and at the hydrotherapy pool. At all other sites this remains the landlord's responsibility. The landlords provide evidence of a water assessment and a date this took place in a report submitted to Sirona.

Legionella bacteria are found naturally in freshwater environments. The bacteria can become a health concern when they grow and spread in human made building water systems. Legionella can spread in droplets small enough for people to breathe in. Less commonly people can get sick when water accidently goes into the lungs whilst drinking.

As part of the IPC work programme the organisation requires assurance that tap water is safe in all premises.

Water safety is reviewed by the Water safety group in CHP and at the Health & Safety (H&S) Committee for assurance. A Water Safety Policy is in place. Water safety assessments are undertaken by Sirona at all sites where they have maintenance responsibilities and at the hydrotherapy pool. At all other sites this remains the landlord's responsibility. The landlords provide evidence of a water assessment and a date this took place, this information is collated by the Estates team and held within the compliance dashboard which is shared at the quarterly H&S meetings.

The management of water flushing and tap temperatures data is collated quarterly by Sirona.

There have been no legionella/water related incidents during this reporting period.

The Estates, Health & Safety and IPC Teams now conduct regular environmental audit visits which will include reviewing the water flushing records.

18. Decontamination of Medical Devices

The timely decontamination, in an appropriate safe place, of equipment is important to reduce the spread of infection, keeping staff and patients free from harm. Decontamination issues are a standing item at the Medical Devices Meeting. This meeting is attended by a member of the IPC team.

The IPC team review any new medical devices that are purchased by staff to make sure that they can be decontaminated appropriately and safely.

19. Emergency Preparedness, Resilience and Response
Seasonal Immunisations 2022-23

The staff immunisation service is responsible for the vaccinating of all Sirona staff for various immunisation campaigns, currently these are the seasonal flu and autumn Covid-19 boosters. The service makes up part of the integrated immunisation service and had an influenza Commissioning for Quality and Innovation (CQUIN) goal of 70-90%.

Sirona care & health recognises the importance of frontline healthcare workers (FHCW) protecting their patients, colleagues, families, and themselves against flu and covid by being vaccinated. As a provider of NHS funded care, Sirona is responsible for the management and oversight of the flu vaccination programme for Sirona FCHW and the duties laid out by Department of Health & Social Care / Public Health England National Flu Immunisation Programme 2022/23, namely:

- Management and oversight of a flu vaccination campaign or alternative infection control measures for their frontline staff
- Ensure access to flu vaccination and maximize uptake among those eligible to receive it.

The covid vaccinations were provided by the Mass Vaccination Programme in collaboration with Sirona.

Approach

To provide the organisation with assurance of preparedness for seasonal influenza Sirona applied a formal governance structure consisting of a Strategic Immunisation Group chaired by the Chief Nursing Officer who is the designated Director of Infection Prevention and Control (DIPC) and Executive Lead for the programme. The BNSSG Head of Specialist Services for Children & Sirona Integrated Immunisations and the All Age Immunisations Lead led the programme.

An Operational Immunisation Group worked alongside, consisting of representatives from Quality & Governance, Communications, Learning & Development, Medicines Optimisation, Human Resources and Operational Leads. The Operational Group was established to co-ordinate campaign activity across Sirona and provide the Strategic Group with assurance of completeness of operational planning. Operational planning focused on the establishment clinics throughout Bristol, North Somerset, and South Gloucestershire.

Analysis of the lessons learnt from the 2021-22 flu season resulted in a business case being submitted to secure funding to recruit a separate team to administer the vaccines rather than using the existing teams. This also included the recruitment of a project lead with administrative support.

The aim of the separate staff vaccination team was to reduce the pressure on current operational teams who had been used in the past and have challenges with workforce capacity. The staff flu clinics were held across each locality with flexibility to attend other locations depending on need and staff feedback. There were varied appointment times and drop-in appointments available in order that staff from any area could flexibly access any clinic. Sites were rotated and operated at different times to support different working patterns including evenings and weekends.

Uptake

During the 2022/23 season Sirona has continued to achieve a higher uptake than the average amongst the other providers across BNSSG, achieving 80% uptake in flu and 76% in covid.

Sirona used the Vaccination Track system to record vaccinations and worked closely with Bank and ESR to remove any inactive staff members.

Communications

The seasonal immunisation team worked closely with the communications team meeting weekly to review specific target areas, ensuring that the most effective method was used. Film clips were used which had been produced by the BNSSG Integrated Care Board, highlighting key staff from Sirona to increase uptake and to ensure consistency of messaging. There was a focus on the incorporation of representation from a variety of ethnicities. Through the BNSSG System Flu Meetings, Sirona collaborated to ensure that the communication plans aligned to ensure that their insights and experience supported effective engagement of our staff.

Next steps

The Operational Immunisation Group met in early March to summarise the campaign, discuss lessons learnt, and begin to scope for the 23/24 season. The team will also be reviewing all meetings Terms of Reference, to confirm time scales for next year which has been submitted to the Head of Service for strategic support and oversight.

The team are looking how to engage better with new starters and are collaborating with the Learning and Development team to include an induction presentation outlining the importance of seasonal vaccinations. How these are offered, how to get a vaccine and record them which is planned to be available from April 2023.
A draft timeline has been produced to be used for future planning and a lessons learnt created which will be reviewed and with an action plan for 2023/24.

20.Sepsis

Sepsis is a life threatening reaction to an infection. It happens when your immune system overreacts to an infection and starts to damage your body`s own tissues and organs. As part of Sirona local quality requirements, we are required to ensure a continued focus on the early recognition and management of sepsis, which includes the adoption of the NICE guidance sepsis; recognition, diagnosis and early management (NG51).

To ensure continued compliance, improvement and innovation in response to Sepsis recognition and escalation, Sirona continues to have a Deteriorating Patient group (DPG) which meets every four weeks. The group is chaired by the Lead for Patient Safety and has representation from across Sirona. As part of this group, training compliance in Vital signs, NEWS 2 and Sepsis are being monitored and later this year, the training in all three of these areas is going to become mandatory for clinicians. The sessions will also be delivered face to face, as opposed to eLearning, which has not been the case since prior to COVID.

Since January 2023, Sirona has offered Systematic Assessment for Early Response (SAFER) training to all registered clinicians, to provide staff with additional knowledge and skill in recognising deteriorating patients. This is to build upon existing training and tools that staff already have available for NEWS 2 and sepsis on both EMIS and paper based formats. With the support of our communications team, a pocket sized NEWS 2 reminder tool is being developed, alongside the proposal to allow staff to download the NEWS 2 national app on their work smart phones. This is to ensure as much support and information is available to staff as possible. Later this year SAFER for non-registered clinicians is hoped to be made available.

A NEWS 2 audit tool, which encompasses Sepsis, has been developed and is now available for teams to complete on Ulysses and is part of the annual audit calendar. The results from this will be shared with the DPG for wider learning and actions will form part of the wider Deteriorating Patient workplan. This audit tool was developed as part of the Quality Improvement Community Collaborative which the Lead for Patient Safety

attended over the course of six months, with the aim to share best practice and knowledge about deteriorating patients and has now built up a network of clinicians across the country.

Representatives from the DPG continue to be active members of the West of England Academic Health Science Network (WEAHSN) which enables Sirona to have insight into priorities across our region.

Achievements for 2022/23

- Fully established IPC team – recruitment and retainment of IPC nurses.
- Provision of educational presentations to operational teams.
- Health and safety matrix working to complete environmental audits at all clinical bases accessed by Sirona staff.
- Implementation of improved HCAI surveillance process.
- Development of IPC link practitioners, Link Practioner Group, and improved meeting format.
- 3 IPC nurses successfully completed IPC Diploma.
- New member of staff has commenced the IPC Postgraduate Certificate in Infection Control.
- Increased IPC presence at clinical sites and links with operational teams established.
- Developing Sirona guidelines to align with national living with COVID-19 advice whilst keeping staff and patients safe.
- IPC Policies reviewed as required.
- Improved Hand Hygiene audit and data analysis return.
- Evidence based IPC advice provided to Sirona staff.
- National IPC manual promoted amongst Sirona staff.
- Attendance at required meetings.
- Development of IPC incident dashboard
- Improvement to educational resources on Workplace
- IPC workplace page developed and live.
- Completion of Board Assurance Framework
- Improved IPCG locality assurance document
- IPC nurse wellbeing champion development
- IPC Lead nurses attendance at locality meetings for Quality and Safety representation
- Ways of Working charted development and implementation
- IPC induction video recorded for new starters.
- Sirona IPC attendance and arrangement of education sessions at shared learning platform
- Updated Performance Development Review paperwork to ensure IPC is included in annual reviews for all staff.
- IPC audit schedule presentation at quality webinar
- Attendance at BNSSG strategic cell and presentation of Sirona IPC learnings during pandemic
- Support to The Haven to develop scabies Standard Operating Procedure

Priorities for 2023/24

- Completion of IPC PG Cert for one IPC nurse.
- Completion of RCN IPC accreditation for one IPC nurse.

- Implementation of National IPC Education Framework.
- Quality improvement link practitioner project.
- Quality improvement sharps safety begins with you project.
- Quality improvement Bare below the elbows project.
- Quality improvement appropriate glove use project.
- Quality improvement cleaning audit project.
- Align IPC policies with national IPC manual and acute system partners.
- Development of IPC Business Intelligence dashboard.
- Improve IPC support for specialist services and children's services.
- Complete IPC decontamination and safer sharps audits across Sirona with detailed data and interpretation.
- Attendance at regional IPC conferences
- Post infection reviews on-site IPC support in rehabilitation units.
- Further implementation of Ways of Working(WOW) charter at new headquarters.
- IPC team Healthcare Associated Infection education development.
- Locality face to face IPC link group meetings.
- Continue to provide evidence-based IPC advice and guidance to all staff.
- Attendance at required meetings.
- To attend IPC&M Governance Response Group.
- Improve IPCG locality representation and completion of assurance reports.
- Continue to Progress collaborative working with H&S and Estates team.

Report to: Corporate Health, Safety and Security Group

Date	2 May 2023	**Agenda item**	9
Title	**ANNUAL HEALTH, SAFETY & SECURITY REPORT 2022/23**		
Author	Andrew Smith, Head of Health & Safety and Security		
Lead Director	Mary Lewis, Director of Nursing	**Date signed off**	12 June 2023
Presented by	Andrew Smith	**Version**	1
For	Approval/decision ☐ Debate ☐ Assurance Y Information Y		

Aims/Summary

To provide an update on key Health, Safety & Security activities in 2022-23 to the Corporate Health, Safety and Security Group. To be provided also to the Quality and Outcomes committee.

Options and decisions

N/A

Resource implications (financial/staffing/other resources)

N/A

Quality considerations

N/A

Paper/information previously considered by	Date
N/A	

1. Aim / Purpose

To provide an update to the Corporate Health, Safety and Security Committee on key headlines from events and activities from April 2022 to March 2023. Please note this paper will be submitted to the May 2023 Quality & Outcomes Committee and will be accompanied with the HS&S Quarter 4 report.

2. Key Risks

Violence and Aggression and Lone Working

Violence and aggression towards Sirona staff remains a significant risks to colleagues, especially those working in patient facing roles. Reports of Violence and Aggression regularly made up 40% of all HS&S Adverse events reported on Ulysses in 2022-23. In response, the H&S team have consistently put considerable time into addressing this issue, providing support to individuals/teams and focusing on workstreams to reduce the frequency and severity of incidents of violence and aggression.

In 2022-23 a Violence and Aggression working group was set up to bring greater operational steer and ownership to a number of workstreams to address violence and aggression. See Appendix A.

A short project with the aim to reduce the frustrations from patients and visitors at Outpatient sites took place in Q2-3. The project took inspiration from the Design Council's paper on 'Reducing Violence and Aggression in A&E – Through A Better Experience' with some of the principles of the ideal patient experience applied to Sirona sites. This project included an audit of a number of sites across BNSSG carried out by the H&S team, looking at the patients experience through arrival, check in, and waiting. Findings were presented in a paper to the V&A working group and H&S Committee with recommendations including review of signage at all out-patient sites. From this the Communications team produced simple corporate signage to replace much of the temporary or missing signs at Sirona sites.

During Q4 the H&S team were regularly supported by the Communications team to promote the work of the Violence and aggression working group and bring greater awareness in the organisation of how this risk to staff is being addressed within the organisation.

Slips, Trips and Falls

Slip, Trip, Falls continue to be a risk to staff, especially those working in the community setting. This is evident in the fact that 6 of the 7 RIDDOR incidents reported in 2022-23 concerned a slip, trip or fall. Taking care working in the community during winter months was a topic of focus for one Monthly Message shared on Workplace.
The risk of slips, trips, falls on Sirona sites is managed well with vigilance of staff and defect reporting as well as issues picked up on the H&S audits of physical sites.

Manual Handling

Manual handling injuries continue to be one of the highest causes of lost time as a result of a health and safety adverse events. In 2022/23 the following measures were taken in addition to the training programme which L&D deliver:

- Manual Handling risk assessment update – complex patients and record of demonstration
- Hydrotherapy Standard and SOP for Soundwell Hydrotherapy pool
- Regular updates between H&S and L&D MH trainers 2 way learning
- Involvement in developing role for Lead MH trainer

It is hoped that in 22/23 a Lead for MH will be appointed who can bring a focus and expertise to help us further build on Sirona's training and policies for MH.

Needlestick / Sharps

The management of Sharps is led by the IPC team with significant joint working. An annual report on the management of sharps is available from the IPC team. In 2022/23 there has been:

- Comms which stressed the importance of sufficient investigation and learning form incidents and near misses.
- New Occupational Health contract, ensuring improved links with the OH link Nurse regarding processes for staff following needlestick/sharps incident.

Staff Wellbeing/Stress

The Wellbeing team, HR and the Health and Safety team jointly oversee stress and in 2022/23 developed a number of risk assessment templates to support the organisation. In 2023/24 it is hoped these assessment tools can be used effectively to address specific issues in the organisation. They include both:

- Organisation wide risk assessment for Stress
- RA templates for Service/Teams
- RA template for Individuals

Security

- Security adverse events are overseen by the HS&S Committee and reviewed as they are reported through Ulysses. There were 63 Security and 90 Estates related adverse events in 2022/23. Security adverse events were up 20 from the previous year.
- Some of the physical environment security events are the responsibility of the Landlord and where this is the case we will notify the landlord and request action is taken. Separate security assessments will be undertaken where there are repeated cases. Many of the security related incidents overlap with V&A or lone working events and are therefore captured in that category.

3. Risk Register 2022-2023

Organisational Risks

Risk Number	Risk title:	Responsible manager:	Current Risk Score
13	Documentation of Fire Compliance	Andrew Smith	10
121	Bespoke fire safety training at individual sites	Andrew Smith	10
446	Violence and Aggression whilst providing healthcare services	Andrew Smith	9
122	Lack of Fire Wardens at bases	Andrew Smith	8
297	Lone working	Andrew Smith	8

Actions

One risk register entry has been closed during the year as a result of measures taken to address Estates compliance. The five that remain can be seen above. The latest updates are as follows:

Fire Safety and Training. Fire risk assessments are now up to date. We are working with the L&D team to provide fire warden training. The Health and Safety team are also producing essential information packs for sites to up skill all staff around fire safety at sites.

Fire Safety Compliance. The programme of fire risk assessments across the Estate has been completed. However, there are numerous actions relating to the findings from the assessments.

Lone Working and Violence and Aggression. Face to face training is due to commence when the L&D budget is approved. There is ongoing work in other areas as overseen by the violence reduction working group. It is expected that a lone worker APP will be rolled out in the near future.

Other Health and Safety risks on the Risk Register (see below):
There are 6 risks on the risk register relating to Health and Safety all of which have actions in progress and owners overseeing them. There are no obvious trends within these risks although five relate to issues at our MIUs or inpatient units.

Team/ Service Risks

Risk Number	Risk Title	Responsible Manager	Current Risk Score
549	Violence and aggression at Yate MIU	Ashleigh Taylor	15
338	SBRU - Buildings	Alexander Young	10
520	Soundwell Hydropool	Neil Gadd	9
43	Patients with limited mobility are at risk of injury or death in the event of an uncontained fire at North Somerset Community Hospital	Nicola Woodland	5
39	Potential misuse of alcohol hand rub when accessible in public areas risk of ingestion, eye exposure, and irritation	Nicola Woodland	4
41	There is a risk of serious/life threatening fall down the stairs at Elton Rehab Unit.	Nicola Woodland	4

4. HS&S Activity in 2022-2023

HS&S Team

2022/23 has seen stability in the team with ongoing development activities taking place. CJ Hopkinson will take maternity leave from June 2023 so there has been activity and training relating to cover for her role.
Cover for this maternity leave is currently being advertised.

Policy/Standards
The process of consolidating policies has been completed and no new policies or HS&S Standards were ratified in 2022/23. Existing Standards and Policies can be found on the HS&S Intranet page.

Meeting Activity

HS&S Committee
In 2022-23 the Health, Safety and Security committee met every quarter with representation from operational and corporate teams. This year saw inclusion of additional agenda on Water Safety following conclusion of the main meeting.

Violence and Aggression Working group
In 2022/23 a Violence and Aggression working group was set up and has been meeting every 6 weeks. This group consists of operational managers and representation from corporate teams such as Comms, Health & Wellbeing and Training and Development. One of the main objectives of the group, to increase operational involvement in the management of this subject has been somewhat successful, however operational input is regularly from the same teams/managers concerned with this subject. Outstanding actions form the Lone Working task and finishing group (including lone worker communication systems) were picked up in the V&S working group.

Other meetings the H&S team are involved in are:

- IPC
- Estates
- Medical Devices
- Hybrid
- Health & Wellbeing
- Ulysses Governance
- Security

Building Compliance

During 2022-23, the HS&S Team continued to monitor health and safety related compliance across the Estate with reports to each HS&S Committee providing updates. In light of improved picture of safety related compliance across the estate, risk 120 was closed on the risk register in Q4 after recommendation to the HS&S Committee. From Q4, the HS&S team handed over oversight of building compliance data to the Estates team with continued assurance provided to the HS&S committee in way of a report.

Workplace and Comms

The HS&S Workplace pages have been regularly reviewed and updated throughout 2022-23. With the ability to edit these pages within the team, updates and changes to guidance and document have been timely. This included a update to the moving and handling resources, including a full directory of Factsheets covering a range of moving and handling patient techniques and use of specific equipment.

A H&S communications plan was implemented this year. This included regular scheduled 'Messages' focusing on specific risks to staff safety, for example Slips, Trips, Falls and Display Screen Equipment. These messaged were shared on Workplace with encouragement to print and display the messages at work bases. The communications plan also involved regular scheduled 'Managers Challenges' which were directed to the Band 6 and above managers group. These challenges prompted managers to consider how they could improve management of specific risks, for example, how the risks to new and expectant mothers or young persons was managed in the team/service or how to better support members of the team post incident of abuse. Lastly the plan involved reactionary communication, such as in response to new trends in adverse event reporting data or to inform of updates to documentation or new guidance. A separate paper on the full H&S Communication Plan is to be presented at the Q4 HSS Committee.

Risk Assessor Training

The H&S team have continued to deliver Health & Safety risk assessors and delivered this via Microsoft teams to small groups of staff. The aim of this training is to equip delegates with the knowledge and skills to carry out suitable and sufficient health and safety risk assessments.
Around a dozen Sirona members of staff have now completed this training in 2022/23.

5. Monitoring Of Sirona's Health, Safety and Security Performance

Adverse Event Data

In 2022-23 there were 1111 HS&S adverse events reported on Ulysses an increase of 15% on those reported in 2021-22. The increasing trend in reporting has continued for the 3 years of the adults contract. It is notable that as with 2020-21 and 2021-22, there are fewer incidents reported in Quarters 1 and 4 each year. See Appendix B Graph 2.

HS&S adverse events made up 12.8% of the total 8653 adverse events reported on Ulysses in 2022-23.

Due to changes in how data was captured at the start of 2021, only some themes are comparable to the previous year. See Appendix B, Graph 2.

Violence and Aggression is notable as 349 incidents in this category were reported in 2022-23, an increase of 117 from 2021-22. There are several potential reasons for this increase, including the restoration of services meaning more direct contact with patients, system wide pressures impacting on service delivery and potential delays in receiving care/treatment, service user (including family/carers) expectations on services and frustrations from the public with ongoing covid safety measures in healthcare settings.
There is much written about the increase in violence and aggression experienced by public facing services over the past two years and it is therefore understood that some aspects of this rise are not within the scope of Sirona. Still the Violence reduction and prevention workstreams and focused attention in the area in 2022-23 has provided much opportunity to learn and develop how this risk to staff is managed in Sirona.

Infection Control adverse events primarily reported as affecting Staff reduced in 2022-23, down 17% from the previous year. Many of these incidents were Covid-19 related, including environmental cleaning which is similar in proportion of this type in 2022-23. It is notable that There were 34 Needlestick and Sharps adverse events reported, which is a similar picture to the previous year when 32 of these events were reported. In all cases staff have been supported, sharps contamination procedures followed including referral to Occupational Health and investigations taken place.

RIDDOR

During 2022-23 there were 7 reports made to the HSE under the Reporting of Injuries, Disease and Dangerous Occurances Regulations (RIDDOR) . See Appendix C – RIDDOR data.

Active Performance Managing

- Building Compliance Checks continue to provide reassurance that Sirona workplaces are safe and healthy workplaces. A separate quarterly report goes to the CHSSC detailing compliance levels and actions being taken to provide this assurance in our leased sites.
- HS&S Audits of Sessional spaces continued throughout 2022-23 across many of Sirona's sessional spaces.
- HS&S Audits of physical sites also took place in collaboration with IPC colleagues at Clinical sites. All sites where we have a presence throughout the week were visited in 2022/23.

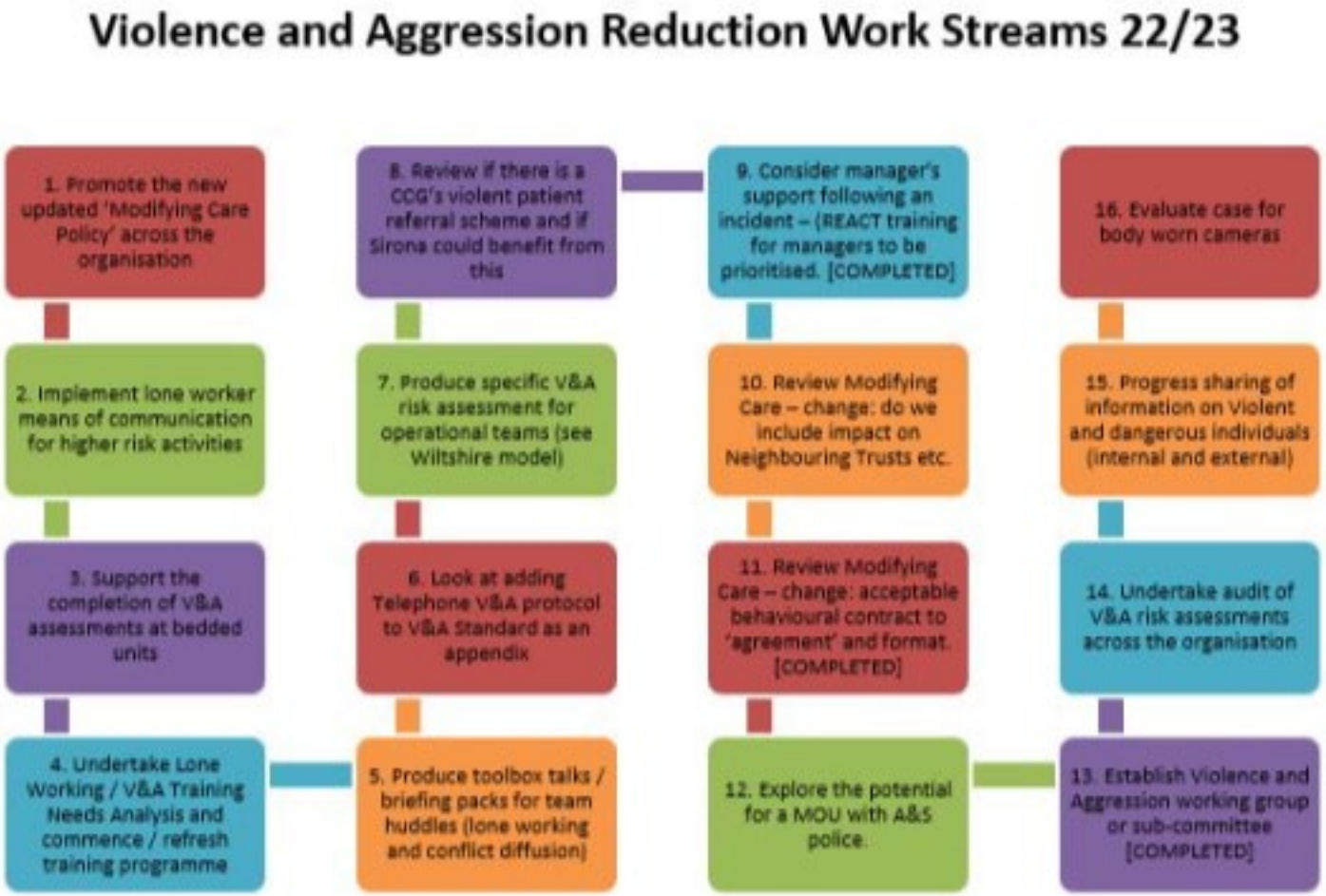
6. Looking ahead to 2023-2024

In 2023/24 we seek to further embed a healthy and strong safety culture. Specific actions will include:

- Completing the workplan for 23/24 (maintain policies, facilitate H&S meetings, analyse trends, and maintain reporting protocols etc.)
- Maintain and develop comms programme to address issues / opportunities (e.g. results from staff survey indicate work to be done to improve safety culture and adverse event reporting) and improve the organisations awareness of safety issues and requirements.
- Undertake H&S physical site audits and sessional site audits. These have jointly been undertaken with IPC and have been helpful in establishing consistent standards across the Sirona Estate. This work will continue.
- The H&S team will seek to have a team member trained in training (via a trainer qualification). This will provide the ability for us to deliver in-house training.
- The H&S team will review e-learning modules on Fire and Health Safety & Welfare to ensure they reflect good practice and legislative requirements.

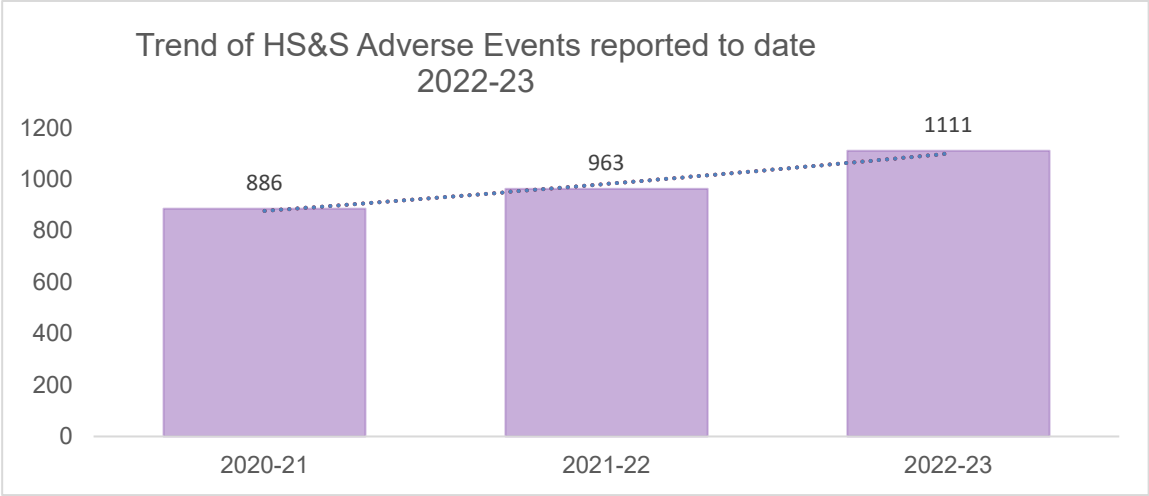
- Develop and roll out an operational desktop H&S audit. This is likely to be outside of the Ulysses development project due to the need to prioritise this work this year.
- The H&S team will promote the use of Actions on Ulysses for management of incidents / H&S input and assurance seeking. This will form part of the Ulysses development project.
- The H&S team will continue to lead and promote the Violence Reduction Strategy, V&A Reduction Workstreams and the V&A Working group in 2023/24.

Appendix A –Violence Reduction Strategy



Appendix B - Adverse Event Data

Graph 1



Graph 2

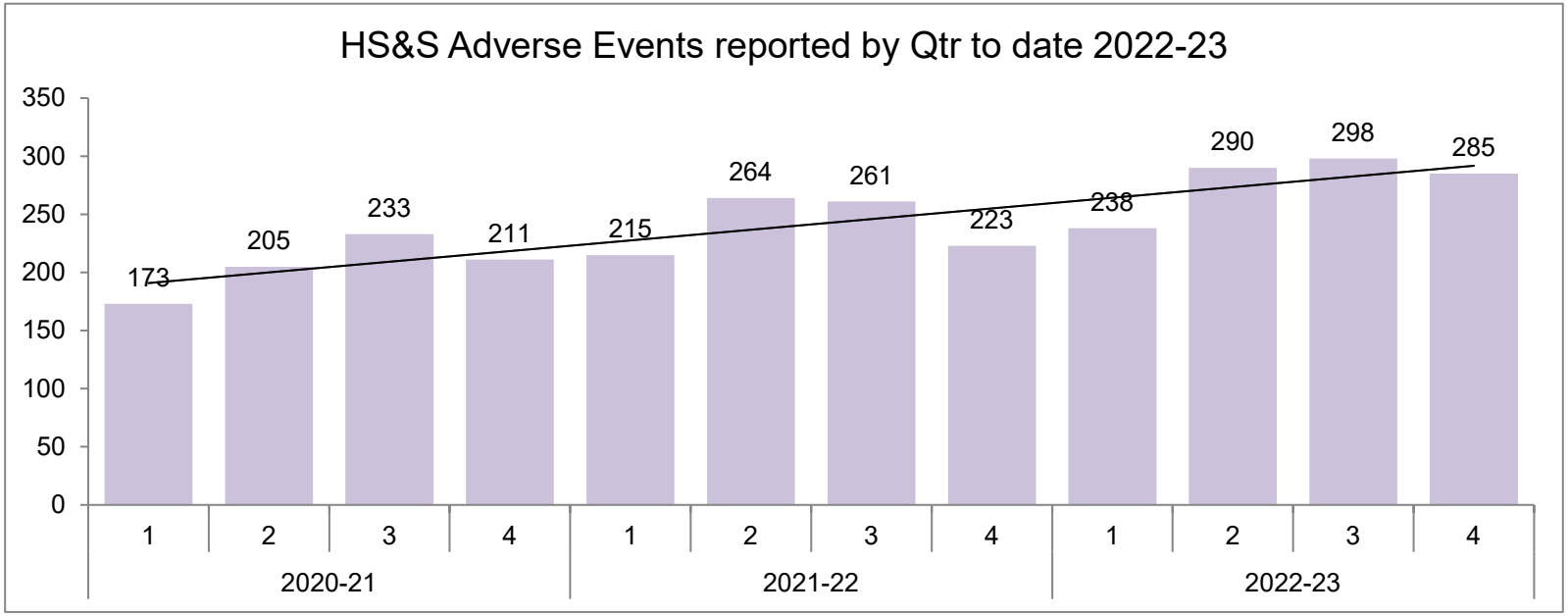
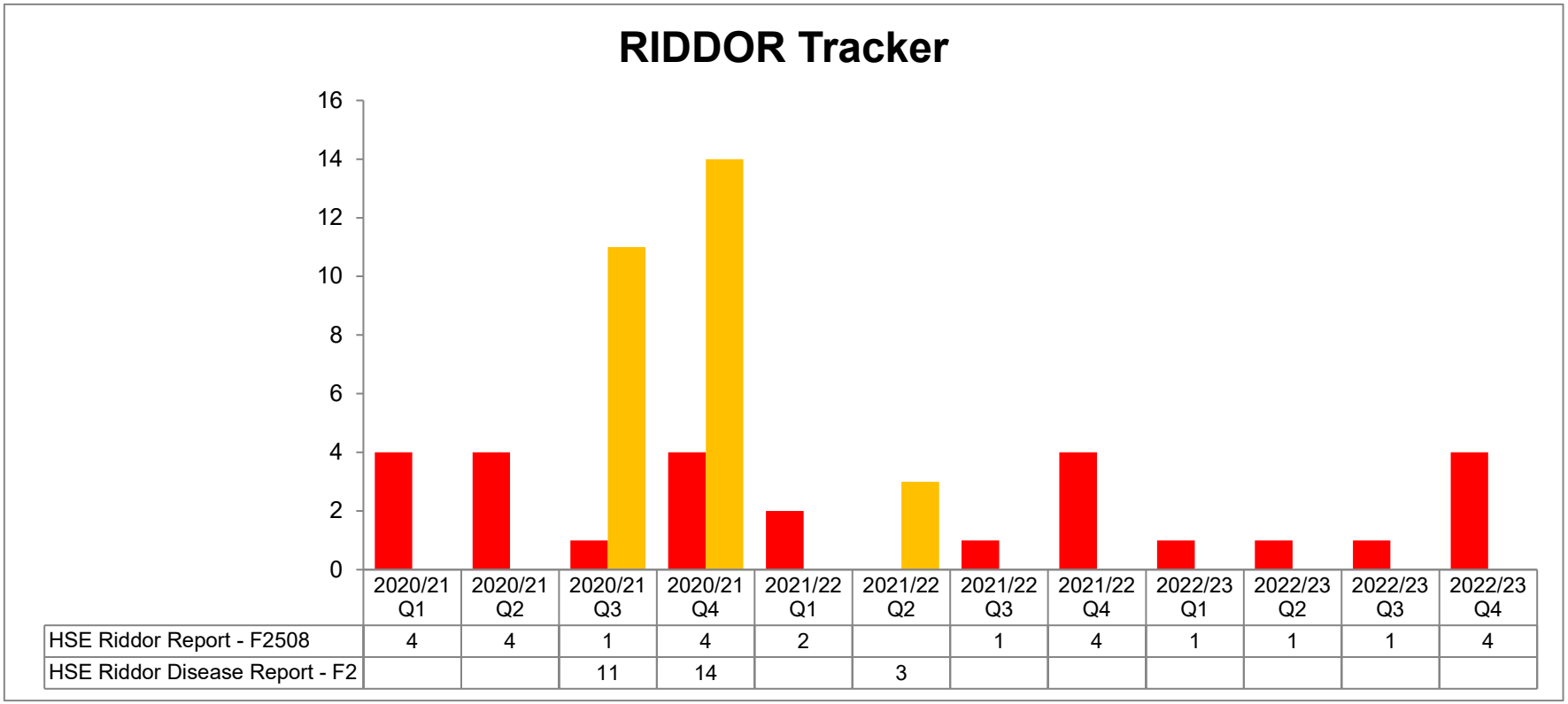


Table 1

Adverse Event Themes reported in 2022-23 compared with 2021-22				
Adverse Event Cause Groups	2021-22	2022-23	Comparison with 2020-21	% Increase from 2021-22
Assault / Violence and Aggression	349	361	+12	3%
Staffing Issues	184	194	+10	5%
Infection Control	152	187	+35	23%
Staff Injury/Ill Health/Well Being	111	131	+20	18%
Estates/Utilities	47	90	+43	91%
Security	43	63	+20	47%
Manual Handling	53	55	+2	4%
Driving For Work	16	15	-1	6%
Fire	8	15	+7	87%
Grand Total	963	1111		

Appendix C – RIDDOR data



Adverse Event Type	Number of RIDDOR reported in 2022-23
Burns / Scald	1
Slip/ Trip/ Fall - Staff	6
Grand Total	**7**

Board Report

Date	12 September 2023	**Agenda item**	Consent Agenda Item 21
Title	Chair's Summary Report – Audit, Assurance & Risk Committee		
Author	Lorna Harrison (Supported by Corporate Governance)		
Presented by	Lorna Harrison	**Version**	1.0
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☐		
Assurance Rating	High/Significant ☐ Medium/Partial ☒ Low/No Assurance ☐ Not applicable ☐		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom	Partial Assurance noted for this reporting period due to the policy review status decline, and the risk process and deep dive - where issues were found. Significant Assurance sought for next report for both Policy Reviews and Risk due in November.		

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board

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

This report is to inform the Board of the key items discussed at the Audit, Assurance and Risk Committee meeting held on August 1st, and to give assurance on the matters within the Committee's remit.

Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?

What sources of information have been relied on? How has assurance been built up through the organisation?
Provide links to relevant evidence sources relied upon in this report.

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

What is the process the report has been through internally

Which teams or groups have reviewed the report or the information that informs it

This report has been prepared as a summary of items and discussions undertaken by the Audit, Assurance & Risk Committee at their meeting in August and as noted within the minutes of that meeting.

Summary and Key Issues to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them. Alert the Board to areas where assurance is not sufficient. Advise the Board of steps taken to address areas where assurance needs to be improved.
(If appending a report, please ref relevant section of the report, where more information can be found).

External Audit Financial Statements – Committee received the draft annual financial statements. Clive took us through in detail to ensure members were fully aware of the content and their responsibilities as Directors. Members of the SLT joined for this.
Bishop Fleming gave an overview of their audit opinion which was positive and complimented the finance team on their support during the audit.
Financial statements recommended to the board for approval

Annual Write Offs – Report received, and assurance provided on the status of Write Offs with no notable exceptions.

Financial Reserves Policy – Reviewed in line with the current Policy Review Process, the Committee noted the assets, leases and contractual arrangements factored in and were supportive of a review of the longer-term financial plan and incorporating the reserves. It is planned that a paper relating to the longer view will be brought to the Committee in November.

Scheme of Authority of Delegations Policy – Noted that there were only minor changes to the policy for this review period and were supportive of recommendation to the Board for approval.

Status of Policy Reviews – Committee received the report outlining the current status of reviews, noting that the risk level has moved to 12 due to an increase in overdue reviews and sought further assurance within the next reporting period.

Annual Claims Update – Committee were provided with a status update on this year's activities to date and expect to receive a full formal report at the November meeting.

Risk Reporting – the regular quarterly report was received and reviewed, and Committee were assured by the additional work undertaken by the Risk Team surrounding a Deep Dive into Risk 430, a long-standing high scoring risk. The Risk Team felt the review was worthwhile and learnings were noted from it to improve the process. The committee commented that the risk needs further review to check the score and actions, to confirm it is a risk not an issue.

Internal Audit Plans – KPMG reported that audits are proceeding to plan, although sought support from the Committee to progress actions arising from previous audits with Sirona colleagues. This was agreed to be shared with Executive colleagues to action.

The Business Continuity Audit Findings Report was considered, and partial assurance was received based on the report recommendations. A high level of assurance was provided that business critical systems would take priority.

Local Counter Fraud – Report received with no notable areas of concern to report.

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?

1. Committee recommends the approval of the Financial Statements to the Board for filing
2. Committee recommends the approval of the revised Scheme of Authority of Delegations Policy

Date	12 September 2023	**Agenda item**	Consent Agenda Item 22
Title	Chair's Summary Report – Finance, Estates, Environment & Digital Committee		
Author	Simon MacSorley (Supported by Corporate Governance)		
Presented by	Simon MacSorley	**Version**	1.0
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☐		
Assurance Rating	High/Significant ☒ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☐		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom			

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board

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

This report is to inform the Board of the key items discussed at the FEED Committee meeting held on August 2nd, and to give assurance on the matters within the Committee's remit.

Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?

What sources of information have been relied on? How has assurance been built up through the organisation?
Provide links to relevant evidence sources relied upon in this report.

Information has been gathered to inform this report from representative corporate services and directorates.

What is the process the report has been through internally

Which teams or groups have reviewed the report or the information that informs it

This report has been prepared as a summary of items and discussions undertaken by the FEED Committee at their meeting of 2nd August and as noted within the minutes of that meeting.

Summary and Key Issues to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them. Alert the Board to areas where assurance is not sufficient.

Advise the Board of steps taken to address areas where assurance needs to be improved.
(If appending a report, please ref relevant section of the report, where more information can be found).

Business & Financial Plans - Committee approved the amendments to the Business & Financial Plans following a delegation of her powers by the Board at the meeting of 11th July 23 authorising the Committee to review, scrutinise and approve the amendments.

Financial Reporting - Committee received a comprehensive presentation of the Financial Accounts as at June 23, with ample opportunity to query, challenge and seek assurance surrounding the content of the financial report.

Digital Report - Report received for information, and assurance provided around our digital activities in addressing our IT challenges including IT operations, Business Intelligence, Clinical Systems Transformation and Information Governance. The Committee recommended the Terms of Reference of the Digital Steering Committee for approval by the Executive Committee.

Update on Estates & Environmental Sustainability - Committee received a comprehensive presentation of the draft Sustainability and Environmental Strategy, with ample opportunity to query, challenge and seek assurance surrounding the content of the report. The Committee approved the draft strategy in principle subject to the provision of the reporting framework to the Committee.

Risk Reporting - The report was received and reviewed, and Committee was assured that most of the high scoring risks have been dealt with by the Digital directorate and their corresponding risk rating has been significantly reduced. Committee were assured by the level of information within the report.

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?

Committee provided its assurance to the Board on the reports considered at the meeting.

Date	12 September 2023	**Agenda item**	Consent Agenda Item 21
Title	Chair's Summary Report – People Committee		
Author	Anil Patil (Supported by Corporate Governance)		
Presented by	Anil Patil	**Version**	1.0
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☐		
Assurance Rating	High/Significant ☒ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☐		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom			

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board

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

This report is to inform the Board of the key items discussed at the People Committee meeting held on 17th July, and to give assurance on the matters within the Committee's remit.

Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?

What sources of information have been relied on? How has assurance been built up through the organisation?
Provide links to relevant evidence sources relied upon in this report.

Information has been gathered to inform this report from representative corporate services and directorates.

What is the process the report has been through internally

Which teams or groups have reviewed the report or the information that informs it

This report has been prepared as a summary of items and discussions undertaken by the People Committee at their meeting of 17th July and as noted within the minutes of that meeting.

Summary and Key Issues to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them. Alert the Board to areas where assurance is not sufficient.

Advise the Board of steps taken to address areas where assurance needs to be improved.
(If appending a report, please ref relevant section of the report, where more information can be found).

The July meeting was chaired by Simon MacSorley in the absence of Anil Patil. This report is composed by the Corporate Governance Team with review by Anil Patil as the Committee Chair based on the meeting papers and minutes.

People Strategy - The draft People strategy document linked to regional & national strategies and incorporates Sirona's mission statements - of *One You, One Sirona, One System* was presented to the Committee. The Committee generally supported the direction of the strategy, making recommendations for further review.

Staff Survey – Q1 Pulse Survey - Committee received a comprehensive presentation of the survey, with ample opportunity to query, challenge and seek assurance surrounding the content of the NHS People Pulse Survey Results. Committee were in full support and received the survey results for assurance.

Workforce Dashboard & KPI Development - Report received for information only, and the Committee noted that the governance & assurance framework for the Workforce Dashboard & KPI Development should be presented to Exec Committee for scrutiny.

Forward Planner – Committee received the Forward Planner for information and encouraged Committee members to share their thought on topics they want covered by the Committee not yet on the Forward Planner.

Risk Reporting - The report was received and reviewed, and Committee was assured that the high scoring risks have been addressed through the People & Development Group and there has been a significant reduction in the risk associated with the high-volume invoicing for Thornbury Nursing services. Committee were assured by the level of information within the report.

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

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

To note the high/significant level of assurance, assessed on the basis the committee reports, meeting minutes and other supporting documents e.g. workforce risks on the risk register.

Performance Committee Board Report

Date	12 September 2023	**Agenda item**	Consent Agenda Item 24
Title	Chair's Summary Report – Performance Committee		
Author	Barbara Brown (Supported by Corporate Governance)		
Presented by	Barbara Brown	**Version**	1.0
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☐		
Assurance Rating	High/Significant ☐ Medium/Partial ☒ Low/No Assurance ☐ Not applicable ☐		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom	Partial Assurance noted for this reporting period due to the outline of mitigations which are showing incremental improvement. It should be noted that the operational framework includes Sirona performance within a systemic process which shows reliance upon external stakeholder behaviour/performance. External relational and joint mitigations are also being developed.		

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board

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

This report is to inform the Board of the key items discussed at the Performance Committee meeting held on August 21st, and to give assurance on the matters within the Committee's remit.

Related Risk No. (If applicable)	340, 528, 54, 213, 377, 22, 428, 429

How has the assurance provided in this report been obtained?

What sources of information have been relied on? How has assurance been built up through the organisation?
Provide links to relevant evidence sources relied upon in this report.

Information has been gathered to inform this report from representative corporate services, Operational Directorate through the lead Executive for Performance and Operations and Head of Children's Services.

What is the process the report has been through internally

Which teams or groups have reviewed the report or the information that informs it

This report has been prepared as a summary of items and discussions undertaken by the Performance Committee at their meeting in August and as noted within the minutes of that meeting.

Summary and Key Issues to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them
Alert the Board to of areas where assurance is not sufficient.
Advise the Board of steps taken to address areas where assurance needs to be improved. (please ref relevant section of the report, where more information can be found).

Adult Specialist Services and Quarter 1 Operation Performance Reporting

1. Waiting Lists are biggest challenge for specialist services with particular reference to the podiatry 104 week wait: Service are validating anyone waiting over 104, 78 and 65 weeks to confirm if they are: Low/medium risk, data errors, live high-risk patient awaiting first appointments; initiation of a project to focus on key areas of high waiting lists, with project initiation document awaiting validation for progress 8/23.
2. System pressure has led to a significant backlog of referrals in Heart Failure driven in part by changes to referral pathways through the acutes. Improving access is being addressed through the system wider working group.
3. The Haven service continues to see increasing demand with an 87.6% increase in referrals through the quarter. This increase has been recognised through the ICB with additional funding being awarded to the service until March 2024 with consideration of implications beyond this timeline.
4. Within NHS@Home a significant risk to delivery of the operation plan target of 160 beds by September remains with performance sitting at 101 beds against a trajectory of 130. Revised development options will be presented to system partners towards a joint staffing model.

Children's Services Quarter 1 Performance Reporting

1. **Children In Care** There have been improvements in performance in compliance against CIC. Performance for Initial Health Assessments and Review Health Assessments remains significantly under required targets. Capacity for CIC is being prioritised and pathway improvement opportunities have been identified.
2. **Educational Health and Care Needs Assessment** – Compliance with EHCNA has improved over the quarter but not achieving target. Work is underway by the service to align delivery following EMIS migration.
3. **Public Health Nursing –** Compliance against the delivery of New Birth Visits not achieving the required targets. There remains a significant risk in the delivery of the public health nursing due to current levels of funding. Discussions are ongoing to resolve the situation with South Gloucestershire Public Health teams.
4. **Waiting Times –** Significant concern remains around the delivery of waiting time requirements. The waiting lists for both community paediatrics and ASD continue to grow as demand exceeds capacity. Proposals are being developed for management of the waiting time challenge looking at pathway delivery, waiting list review processes and harm reviews.

Areas of Concern:

The main risk identified to delivery of national responsiveness, as well as statutory, mandatory and contractual standards are:

- Capacity and demand modelling and clarity around clinic availability for all services and increasing demand for services.
- Referral / demand pressures from system partners due to changes in the way of working or lack of clear understanding of capability within the community. (The move to one EMIS will support development in these areas).
- Workforce and vacancies across a number of services, coupled with a drive to reduce the use of agency across services, with specific gaps in Public Health Nursing in South Gloucestershire
- Clarity in delivery of core elements of the services across the Children's services.

RESET The reset closing report was presented. The committee accepted the report dependent upon a lessons learnt process that will first be referred back to the Executive Committee for process.

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?

1. Committee recommends the Board accept the partial assurance offered with mitigations on the basis that appropriate timelines with agreed milestones for monitoring and review of acceptable progress are provided to next Performance Committee in line with Executive Committee recommendations.

Board Report

Professional Council

Date	29/08/2023	**Agenda item**	Consent Agenda Item
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 Jun - Aug 2023 – Please note there was no meeting held in July.

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 Jun - Aug 2023. Relevant policies have also been through Medicines Optimisation Committee.

- **Quality Improvement Project to improve outcomes in frail older adults with Diabetes**
  The Diabetes Nutrition Services is supporting the INT around work for diabetes and insulin and looking at ways around the insulin pathway supporting people. Advances in digital technology to support self-care predominantly with diabetes and advances of moving away from the clinicians on call to having something worn on the body that works with interstitial fluid to scan with continuous monitory and intermittent scanning monitoring for the house bound population requiring third party insulin. Advances in digital technology to support self-care predominantly with diabetes and advances of moving away from the clinicians on call to having something worn on the body that works with interstitial fluid to scan with continuous monitory and intermittent scanning monitoring for the house bound population requiring third party insulin.
- **Adult Learning Disability Health Service Care Programme Approach (CPA) and Care Co-ordination**
  CPA and Care coordination SOP for people in the service with learning disabilities will have a responsible clinician to be under a consultant, LD Psychiatrist they will need as part of being under CPA to have an identified care coordinator. CPA is care programme approach and it is about risk management strategy, particularly for people coming under the Mental Health Act and back into the Community.
- **Quality Improvement Project to improve outcomes in Pulmonary Rehabilitation**
  Already approved so this is a trial we were approached to engage with our rehab team back in April to support exercise buddies to support our adherence at Pulmonary Rehab Grade. It allows us to engage in a research project and is funded within the project so no cost to Sirona and should improve our outcomes and support us to meet the standards for accreditation.
- **Terms of Reference – Specialist Link Practitioners**
  For information and interest only. Sue and Specialist Services have developed a standard term of reference for relaunching specialist LINC practitioners within the INT.
- **Revised ToR Professional Council:** approved in principle. Pending integration into wider revised clinical governance structure.

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.