Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD

25th October 2012

TITLE	**INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC) MINUTES**
EXECUTIVE SUMMARY	This report contains the Chair of IGAC's report, the draft minutes of the meeting held on 19th September 2012 and the revised terms of reference for IGAC.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Committee focused on the areas of risk to the organisation in its daily operations as well as risks to the achievement of its strategic objectives.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Not sought.
EQUALITY AND DIVERSITY ISSUES	None identified.
LEGAL ISSUES	None identified.
The Trust Board is asked to:	1. Note the minutes and heed the assurance and expressions of concern of the report; and 2. Approve the revised IGAC Terms of Reference.
Submitted by:	Heather Caudle, Associate Director of Quality on behalf of Philip Beesley, Non-Executive Director and Chair of IGAC.
Date:	17th October 2012
Decision:	For Noting

Contents

1. Chair of IGAC's report

The Integrated Governance and Assurance Committee was held on Wednesday 19th September 2012. Apologies were received from the Deputy Chief Executive and the Client Manager from Parkhill Auditors. In attendance to observe were David Dignam and Sarah Leavey from PricewaterhouseCoopers.

1. The Committee focused on three main areas:

i. The Quality, Safety and Risk Management Strategy: with particular focus on learning from the visit to Salford Royal NHS Foundation Trust.
ii. Issues of Assurance
iii. Issue of Concerns

2. The Quality, Safety and Risk Management Strategy

2.1 Report on visit to Salford Royal.

Vision: Their mission statement: Safe Clean and Personal is embedded in processes and practices throughout the Trust.

Leadership: significant improvements at Board, Corporate, Divisional and ward level. There is an exemplary model of devolved leadership where each ward has a graph of their ward-level balance score card on the wall of their staff room which is updated daily (attached).

Processes: the Trust's corporate Clinical Quality Team is designed to have more of a Quality Improvement focus rather than a Quality Assurance.

Measurement: the nursing audit cycle, where improvement and performance are linked through an accreditation scheme called the Nursing Audit Assessment Programme (NAAS).

2.2 The QSRM Strategy progress was presented which was found to be largely on track with the new structure to be fully in place by next year.

The areas where the results that have been judged to be red are:

1. Implementation of Datix Web

Datix Web was expected to be deployed Trust-wide by the 1st October 2012. However, due to resourcing constraints from the supplier and the amount of users that will require training, it is now expected that a Trust-wide go-live will be the 3rd January 2013.

2. Co-produce the Quality and Safety Half (QuASH) Days with developed KPIs for Divisions, specialties and wards.

Each Division is currently using their Quality and Safety half days, however they do not yet follow a standardised process. The executive Clinical Quality team (MD, CN, DMD, ADQ) have met each Divisional Director individually to learn about what each Division is doing.

Development of divisional dashboards is still underway and the new contract with CHKS, which started this week, provides an opportunity to help this development.

a. One key performance indicator is Mortality UTI as Primary Diagnosis, which is being carefully managed at Specialty level reported to the Clinical Outcomes Steering Group.

3. Assurance

The Integrated Governance and Assurance Committee would like to provide the following **Assurance**:

3.1 A rigorous process for formally closing SIRIs once all points in the action plan are implemented will be adopted. Follow up to ensure the action plan is embedded and effective will be monitored on a separate log and reported to IGAC.

3.2 The Trust can be assured that the issues that cut across incidents, complaints and quality risks in the divisions all have corporate action plans to address these issues.

3.3 Newly emerging issues appear to be the practice of Pre-operative nutrition, for which a SMART Trust-wide action plan will be developed and tracked centrally, to ensure the improvements are embedded and sustained.

3.4 The issues pertaining to the Radiology and Imaging issues within the Trust. These will be addressed in the pathology meeting and followed up in December IGAC. The Deputy Medical Director is leading on this.

3.5 The use of post mortems in cases of neonatal mortality. Increasingly this practice is being used to help with improving clinical effectiveness in the Trust and guidelines for when this is appropriate will be developed.

3.6 The action plan to reduce the number of pressure ulcers is robust and is comparable to action plans developed by other Trusts. The Chief nurse will monitor the numbers and grade of pressure ulcer cases to assess the effectiveness of the action plan and report to IGAC and to Board.

3.7 CQC – the Trust has done well to receive good reports from recent CQC visits and is still focusing on delivering the action plan devised in July 2012 to address outcome 21. However, IGAC is fully aware that there is no room for complacency in respect of fully meeting all essential standards.

4. Concerns

IGAC would like to bring the following **concerns** to the Board's attention:

4.1 The Board assurance Framework - The BAF was reviewed during September and the population of controls and assurances completed. There appears to be some repetition of risks: Emergency pathway; SO 3.

4.2 IGAC recommends to the Board that the previously agreed top five risks remain the same:

- Emergency pathway
- (CQUINS)
- Financial or service pressures on third party providers
- If NHS Surrey suffers unexpected financial pressures.
- Major stakeholders (and residents) apropos the Epsom transaction

4.3 The Slippage of Datix web - Implementation of Datix Web: Datix Web was expected to be deployed Trust-wide by the 1st October 2012. However, due to resourcing constraints from the supplier and the amount of users that will require training, it is now expected that a Trust-wide go-live will be the 3rd January 2013.

2. INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)
Minutes of the meeting held on
19 September 2012
14.00 -16.00hrs – Room 2, Chertsey House, St Peter's Hospital

Members Present:		
Philip Beesley	**PB**	Non-Executive Director - Chair
Andrew Liles	**AL**	Chief Executive
David Fluck	**DF**	Interim Medical Director
Mick Imrie	**MI**	Deputy Medical Director
Simon Marshall	**SM**	Director of Finance & Information
Suzanne Rankin	**SR**	Chief Nurse
Terry Price	**TP**	Non-Executive Director
In Attendance:		
Donna-Marie Jarrett	**DMJ**	Associate Director Health Informatics
Heather Caudle	**HC**	Associate Director of Quality
Jane Gear	**JG**	Head of Corporate Affairs
Marty Williams	**MW**	Head of Patient Safety
Maurice Cohen	**MC**	Patient Panel Representative
Sal Maughan	**SMA**	Head of Accreditation and Regulation
Apologies:		
Dakshita Takodra	**DT**	Client Manager (Parkhill)
Absent:		
Raj Bhamber	**RB**	Director of Workforce & Organisational Development
Valerie Bartlett	**VB**	Chief Operating Officer / Deputy Chief Executive
Claire Braithwaite	**CB**	Associate Director Performance Improvement

Minute taker: Flick Simmonds, Incident & Investigations Co-ordinator

1	**Apologies for Absence** These were noted above The Chair also welcomed Sal Maughan to the meeting.	
2	**Committee Duties and Responsibilities for Reference** The document was noted.	
3	**Minutes of the Meeting held on 20 June 2012** These were agreed as a correct record of events.	
4	**4.1 Matters Arising – Action Points – Paper 2** The completed action points were accepted. Ongoing action points as follows unless covered under another agenda item: <u>Item 17</u> – Information required was received and in the process of being pulled together, identifying how the Trust performance rates against this information. A report will be produced for December IGAC meeting. Item 7 – TP questioned the completion of the backlog of work for the National Joint Registry Data. This has now been resolved and the work to clear the backlog is on-going.	

5	**Quality, Safety and Risk Management Strategy** 5.1 KPI Update – paper 3 a. It was noted that the strategy is largely on schedule apart from the following: 2.1.4 – Implementation of Datix Web – this has slipped by 3 months and is due to commence live in three pilot areas, Acute Medicine & Emergency, Women's Health and Paediatrics and Pharmacy, from October 1st. The new go live date for the full Trust is 3rd January 2013. The slippage is due to resourcing constraints from the supplier. An exception report was submitted by HC. HC will forward the roll out plan to IGAC members and identify the confirmed start date for the whole Trust. SR expressed concern regarding the reconciliation of the paper records with the numbers reported to Board and other areas as the inputting of data is around one month behind. There is now a process in place to mitigate this. 4.1.1 - Quality and Safety Half (QuASH) days – developing KPIs for Divisions, Specialities and Wards. This has slipped as the Clinical Specialities need to develop their own process. Individual meetings with the Divisional Directors have taken place to discuss the mapping out to understand what the Divisions are doing in terms of their Quality and Safety half days. The next phase will be to visit the QuASH days b. A Terms of Reference is to be drawn up for the next phase which is the holding to account of the Divisions. c. The next milestone is the Clinical Effectiveness Performance meetings, for which the Terms of Reference are in draft. By the December IGAC meeting the timetable, ToRs and a report on the first round of meetings will be available. d. SR wished to bring attention to the 'red' on the Outcomes Dashboard which is in relation to the mortality UTI. An audit was carried out on looking at patients that did die with a UTI diagnosis exploring both clinical and coding issues.	**HC** **HC** **HC / MI**
	5.2 Dr Foster a. SM reported that the Trust's contract with Dr Foster came to an end at the beginning of August. Following a market testing exercise it has been decided that CHKS offered the best for the Trust's needs. . b. DMJ stated that the system will be switched on in the week beginning 24th September. There will be on-going training sessions to help address any risks associated with the system change as well as the change in quality indicator definitions. The Board will need to be aware of any discontinuity in data resulting from the change.	**SM/DM-J**
	5.2 Report from Salford Royal Unit a. HC and Jim Gollan (NED) visited Salford. HC gave a verbal report on the visit. The salient points were around transformation change	

	in leadership structures and capabilities at board and ward levels as well as within Nursing. b. Ashford and St. Peter's would seek to learn from Salford Royal's accredited Nursing Assessment Audit Process (NAAS), which is an assessment system based on 13 standards reviewing the environment, care and leadership on the ward. All wards are assessed and gain either a red, amber, green or blue rating. c. A programme of quarterly Best Care review meetings with the matrons and heads of nursing will be instituted, which is being planned for late October/beginning of November. HC will be giving a presentation. d. It was felt that following exploration of gathered information from other models of quality improvement, proposals of how to take this forward should be put to Board for discussion. . e. JG stated that it has already been agreed that a short update would be taken to a subsequent Board.	**HC**
6	**NHSLA Update - Paper 4** a. The Litigation Authority informed all Trusts that they will be reviewing their accreditation process from April 2013 to April 2014 and therefore will not be carrying out a full schedule of assessments during that time. b. The assessment for the Trust's CNST level 3 due in September 2013 would possibly be suspended due to potential transaction with Epsom. During this period the Litigation Authority has indicated that the respective discounts of the two 'merging' organisations will be proportionately split within the newly formed organisation. c. A meeting between HC and the Risk Management director from the NHSLA is being arranged. This meeting is for the Trust to volunteer to be a pilot site for the new standards expected to be in place from April 2014. d. TP expressed concerned that there will be no positive effect increase and therefore no gain for another year. e. It was confirmed that work is ongoing in preparation for submission for the next levels in due course and also policies from both Trusts are being reviewed. f. IGAC's recommendation is that the trust is assessed by NHSLA, 12 to 18 months after the merger of the two organisations, if the transaction proceeds.	**HC**
7	**Incidents** <u>7.1 SIRI Report</u> a. The following were noted: • There were 17 cases reported since the last Committee meeting in	

	June. • Following a discussion at the last meeting, nine cases were not closed as further information was requested by the committee. b. PB wished to discuss the following: • SIRI closure process. • The incident around a neonatal death with no post mortem analysis which would have provided essential information. • Still a high number of pressure ulcer cases even though there is an extensive action plan in place. c. SR built on previous discussions on how to close a SIRI. The next improvement in the Action Tracker Log process would be to include an indication in the report of the status of the actions of the SIs for which closure is being sought. d. SR proposed the following for SIRI closure: i. Where the action plans are green, in terms of all the process elements are completed or alternatively have an amber rating due to the audit test of effectiveness being incomplete, then these actions would be classed as closed. ii. A report would be taken to IGAC on measures of effectiveness giving an indication of the effectiveness and sustainability of the change. iii. A link could then be maintained between the cases and the measure of effectiveness. IGAC approved this proposal. e. There will be a triangulation by division with the number of new risks with the number of incidents, which will be produced for the next IGAC.	**HC**
	7.2 Action Tracker a. MW discussed the action log tracker exception report, detailing that 382 actions are now on the action log tracker, the highlighted red actions are bought to IGAC's attention with an update. • Emergency services: the development from the policy / clinical guidelines using the Marsden manual. • Surgery: the failure to act on test results. The action on misdiagnosis, code 5, still only applies to radiology and this action will now close. An update will be sent via email to the Committee. • Women, Health and Paediatrics: information still to be consulted and due to be ratified by the end of September. b. PB highlighted no outstanding concerns on the red concerns. c. TP queried, 55 actions with no rag rating and queried whether these actions are recent or part of a backlog. SR explained that the action tracker is evolutionary work and it is still a work in progress, but successful. Also that Acute Emergency Medicine, will link the	**MW**

	number of incidents/actions back to the number of risks made. d. AL stated that the action tracker is a successful device and asked about ways to improve the process. HC and SR addressed the divisional performance meetings; any highlighted red actions would then be dealt with by briefings at Divisional meetings.	**HC / SR**
	<u>7.3 External Review of Endoscopy Service</u> a. MI highlighted a case regarding one patient who was transferred to the Royal Surrey from the Trust, where the concern of the quality and care the patient received within our Trust was raised. This was then escalated into a Serious Incident to the PCT. There is to be an external review of the Trust's Endoscopy service following a serious incident in the Trust. This stemmed from the concerns that were first raised to the Trust Board in 2009. b. A wider piece of work, a formal review for gastroenterology service has been commissioned.	
8	**Clinical Governance Committee Exception Report** a. MI highlighted key concerns around sepsis and timed administration to antibiotics that lie within the piece of work from the leading improvement in patient safety (LIPS) programme. Looking at an audit which will test the time to first administration of antibiotics. This will then be reported back to the improvement team, and subsequently to the December IGAC. b. HC highlighted that the recorded attendance to mortality and morbidity shows that the M&M meetings are going ahead. However there is a lack of recording in the standardised format. This now needs clarity round the reporting of the exception report.	
9	**Safety and Risk Committee Exception Report** a. Concerns were raised about quality assurance in pathology services. TP will be chairing the pathology board meeting and will raise this matter then. The CT scan matter was performed on the wrong patient, a different error.	**TP**
10	**Care Quality Commission (CQC)** <u>10.1 Essential Standards</u> a. The overall position of the Quality Risk Profile is improved. Four standards have decreased in the risk rating, a positive move and one increase in risk to Outcome 16. The changes in individual measures from this Outcome are unclear and the Trust still awaits clarification from the CQC around this. b. Self-assessment against outcome 5 is green. Overall three standards which previously were compliant but with minor concerns are now fully complaint on self-assessment c. Outcome 17: Complaints, now the self-assessment continues to be Amber. An action plan is in place following the Parkhill internal audit review. This has been fully considered and approved by the TEC.	
	<u>10.2 CQC Action Plan Update</u>	

	a. The redesign of the internal assurance framework down to Divisional level is progressing. The aim is to report to the board in December a more structured and addressed approach within the divisions. b. The CQC action plan in relation to the December visit is now closed. The action plan referring to the 23rd of May visit is now being implemented around outcome 21. All actions on track, and are green. The compliance review on the 11th September the CQC was positive feedback.	
11	**Risk Register Reports** a. There were twelve new risks added of which there were three corporate risks. b. PB feels that the level of risks seems to be tracking at a fairly constant level; there is a sound turnover of risks; new and closed risks. PB questioned if the right risks are being added and reflected at the right level. c. MW and JG have been working closely to align the corporate risks with the BAF. d. TP questioned the uninterrupted power supply risk has still not been actioned. MI felt that this had been downgraded and was not aware that there are still ongoing issues with this. MW to discuss with Facilities to get clarification. e. Also that the non-compliance of JAG Accreditation has been on the register for more than three years and been treating it. f. MI assured MC regarding the ongoing risk of the WHO Safer Surgery Checklist. g. PB concerned about new risk 1223 – Imaging equipment no longer supported by manufacturer as equipment at end of life. It was noted that a plan is in place for investment. A case will be taken to TEC and the Board within the next month or two. It was noted that at present there are available options of equipment to cover any risk issues and although the equipment is no longer supported by the manufacturer, the equipment is still in a position to be used. h. PB requested that MW follow up on risks 1222 and 1220 as there are no progress reports for these.	**MW** **MW**
12	**Board Assurance Framework (BAF)** a. JG stated that this is the first report of the revised format of the BAF. It has been aligned in conjunction with the five Strategic Objectives, (SO) as detailed in the Corporate Business Plan 2012-2013. b. Following a review of the BAF in September it had been identified that there appears to be some repetition of risks. The Emergency Pathway is similar across the three SO's and is very relevant to all three objectives so it is advised to maintain this. c. There are two similar risks with SO3 – although both risks relate to	

	loss of market share, one is due to competition and the second to not achieving joined up health care. It was suggested to consider whether the two risks should be maintained as separate items. d. There are three risks rated as red which are linked to the need of having a robust efficiency programme. The Finance Committee regularly scrutinise these risks. e. The top five risks were highlighted. PB suggested that, due to time constraints, some members of the Committee take a look at the top five risks outside of this meeting. AL suggested that these five risks be taken to the Board for their consideration. JG to action.	**JG/GR**
13	**External Agencies and Inspections Report** a. The report was noted and discussed. b. Regarding the final JAG visit – the Trust invited JAG to undertake an inspection which provided some positive outcomes. Two key issues were identified: the booking process and moving to better computerised systems. A business case is being presented to TEC on 24.09.12 around this. Following the action by TEC this item should then be downgraded to a green rating. c. Discussion around the issue of capacity pointed to a potential resolution of these issues by Spring 2013. Once implemented the Trust would then be ready for a formal JAG accreditation inspection.	
14	**PALS, Incidents, Complaints and Claims (PICC) Report** a. The report took a Trust wide perspective with a graphical overview, qualitative and quantitative analyses supported with thematic analysis. b. The numbers on incident reporting is down but this is due to a backlog of data inputting and the receipt times of these in the Quality department. c. The top five incidents are: clinical, administration, drug errors, falls and patient documentation. The clinical incidents are predominantly pressure ulcers and administration ones includes shortage of nursing and midwifery staff, lack of beds and cancellation of surgery. d. Complaints and PALS themes are mainly around communication. e. Common themes around SIRIs (Serious Incidents Requiring Investigation) were poor documentation, lack of escalation, communication. Following a benchmarking exercise with the Strategic Health Authority is was found that the Trust is an average reporter in relation to similar sized Trusts. f. The Trust held sixty three clinical claims at the end of quarter four. Quarter one identified a 20% increase from the 2011/2012 quarter one statistics. During quarter four and quarter one there were eighteen new cases reported to the NHSLA. Nine files were closed during the same quarters.	

	g. HC welcomed the complaints audit and was optimistic regarding compliance with the action plan for this. PB requested that SR and HC look at triangulating the issues with activity and update at the next meeting. h. SR commented that there should be corporate action plans for corporate activity similar to the divisional action plans. PB and HC to discuss and report back at next meeting. i. TP requested more comparable information on the graphs –. MW to look into this for the next meeting.	**SR/HC** **PB/HC** **MW**
15	**Audit Committee Report** 15.1 – Exception Report This report was discussed and taken as read.	
16	**Finance Committee Report** 16.1 – Exception Report This report was discussed and taken as read with further updates at the next meeting.	
17	**Any Other Business** 17.1 – Dates for 2013 These were circulated with the papers and will be also sent out with the minutes.	**With Minutes**
	17.2 – ToRs Sept 2012 These are due to be approved by the Board in October. The ToRs have been updated to reflect the change of personnel and the Quality team re-structure with reference to the new Committee structure. Once the new structure is firmly in place there will be a refreshed ToR's to be in place early 2013.	
16	**Date of next meeting** Wed 12 December 2012 – Room 2 - 1400 – 1600hrs	

6 Integrated Governance and Assurance Committee (IGAC)

Terms of Reference

Authority

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any Committee or Group and all employees are directed to co-operate with any request made by the Committee.

Limits to authority

- It is not the duty of the IGAC to carry out any function that properly belongs to the Trust Board

Membership

1. Chief Executive
2. Chief Nurse (Chair of Safety and Risk Committee, soon to be the risk and scrutiny committee)
3. Deputy Chief Executive
4. Director of Finance and Information
5. Director of Workforce and Organisational Development
6. Medical Director (Chair of Clinical Governance Committee)
7. Non Executive Director (Chair)
8. Non Executive Director (Chair of Audit Committee)
9. Non Executive Director (Safety Lead)
10. Deputy Medical Director

Where the Non Executive Director who chairs the Committee also carries out the role of NED safety lead or Chair of the Audit Committee, there will only be 2 Non Executive members of the Committee and total membership will be eight.

In attendance

11. Head of Patient Safety
12. Head of Accreditation and Regulation
13. Associate Director of Informatics
14. Head of Patient Engagement and Experience
15. Associate Director of Quality (Secretary)
16. T i

Observers

1. Internal Audit

Attendance

Attendance at meetings is essential and each member is required to attend at least 3 of the 4 meetings during the year.

Quorum

The quorum necessary for transaction of business will be at least 6 of the 9 or 7 of the 10 designated members who must be in attendance. The attendees must include 1 NED, 2 Executive Directors. 1 representative from Quality and Risk must be in attendance.

Where an Executive Director cannot attend, the Deputy Director should attend as nominated deputy but will not form part of the quorum.

The Quality department attendees will deputise for each other.

Frequency and Conduct

The Committee will meet no less than four times per annum.

CHAIR

A Non Executive Director will act as Chair of the Committee. In their absence another Non Executive Director on the Committee will deputise.

SECRETARY

The Committee will be supported by the Secretary whose duties include

- Agreement of the agenda with the Chair and collation of the papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward

- Advising the Committee on pertinent areas

Papers will be circulated 1 week prior to the meeting.

Papers should be submitted to the Secretary 7 working days prior to the meeting.

Membership and terms of reference will only be changed with the approval of the Board and will be reviewed and agreed annually.

Duties

- The Integrated Governance Assurance Committee has a duty to ensure that the Trust's governance systems, behaviours and processes relating to risk management, clinical and non-clinical governance, and the achievement of organisational objectives are effective, and provide the Board with the assurance required to govern effectively.
- To ensure the identification, management and control of risk is robust and cohesive, taking action where necessary and alerting the Board to any areas of concern.
- To consider the resource implications for risk control.
- To work in association with the Audit Committee in matters of corporate governance.
- To oversee the development of the Trust's Integrated Governance and Risk Management Strategy
- To oversee the development and maintenance of the Board Assurance Framework (BAF) and management of the corporate risk register
- To act as parent Committee to the Clinical Governance Committee, and the Safety and Risk Committee

Key Responsibilities

- To monitor and review top level and significant risks identified from the Trust's Risk Register, to consider the adequacy of control mechanisms, whether identified risks are scored correctly, and to take action to ensure risks are mitigated when necessary.
- To review completed Serious Incident Requiring Investigation reports and satisfy itself that appropriate action is taken
- To oversee compliance with the Essential Standards of Quality and Safety and ensure that sufficient assurance of compliance is available to the Board
- To monitor levels of risk associated with external inspections and reviews, in particular to oversee the progress and compliance with the NHSLA Risk Management standards and to take action when necessary
- To receive exception reports from the Clinical Governance/Quality Governance Committee and the Safety and Risk and Scrutiny Committee and take action where necessary.

- To receive feedback from the Finance Committee and Audit Committee
- To receive the 6 monthly PALS, Incidents, Claims and Complaints (PICC) report
- To receive the 6 monthly summative assessment and assessment with the essential standards of quality at ward level.

Reporting Lines

The Chair will report to the Trust Board on the proceedings of the Committee and draw attention to any issues that require disclosure or require action., after each meeting

Minutes of the IGAC will be provided for the Trust Board after each meeting and a full report will be provided once a year.

Minutes of the meeting and the Corporate Risk Register will be provided to the Audit Committee for each meeting after each IGAC.

IGAC will receive an exception report from the Quality Governance Committee after each quarterly meeting.

IGAC will receive an exception report from the Safety & Risk Committee (sson to be the Risk and Scrutiny committee) after each quarterly meeting.

Monitoring

The effectiveness of the Committee and the governance processes will be monitored by the internal auditors and demonstrated via the internal annual audit reports.

Further scrutiny will be provided by the Trust Board through receipt of minutes and reports.

Approved by Trust Board : September 2012

Review: September 2013