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

Trust Board
30th June 2011

TITLE	**Integrated Governance and Assurance Committee Minutes**
SUMMARY	The Committee discussed the Corporate Risk Register, Board Assurance Framework and received exception reports from CGC, Safety and Risk, Audit and Finance Committees. In addition the meetings looked at Meeting held on 6th April 2011 (minutes attached) Annual Plan Self Certification NHSLA Update Review of Statutory and Mandatory Training Provision for ASPH Meeting held on 8th June 2011(draft minutes attached) Progress with NHSLA action plan and next steps CQC Quality Risk Profile and the performance Accelerator tool Quality Governance (Monitor) Action plan update
ASSURANCE (Risk) / IMPLICATIONS	The minutes provide assurance all aspects of the organisation's risks are being discussed.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	None identified
EQUALITY AND DIVERSITY ISSUES	None identified
LEGAL ISSUES	None identified
The Trust Board is asked to:	Note the minutes.
Submitted by:	Suzanne Rankin, Chief Nurse on behalf of Philip Beesley, NED Chair
Date:	23rd June 2011
Decision:	For Noting

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

INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)
Minutes of the meeting held on
6 April 2011
1400-1600 – The Lecture Theatre, Ramp, St Peter's Hospital

Present:		
Philip Beesley	PB	Non Executive Director (Chair)
Terry Price	TP	Non Executive Director (Chair of Audit Committee)
Valerie Bartlett	VB	Deputy Chief Executive
Mike Baxter	MB	Medical Director
Suzanne Rankin	SR	Chief Nurse
Jane Gear	JG	Head of Corporate Affairs
Raj Bhamber	RB	Director of Workforce & Organisational Development
Ben Endersby	BE	Internal Auditor (CVDFK)
Donna-Marie Jarrett	DMJ	Associate Director Health Informatics
Jill Down	JD	Head of Customer Affairs
Marty Williams	MW	Clinical Risk Manager
John Headley	JH	Finance Director
Apologies:		
Andrew Liles	AL	Chief Executive
Sarah Johnston	SJ	Head of Quality & Integrated Governance
Maurice Cohen	MC	Patient Panel Representative

Minutes: Marion Phillips (PA to Suzanne Rankin)

1.	**Apologies and Committee Duties and Responsibilities** These were noted.	Action
2	**Minutes of the Meeting held on 9th February 2011** The minutes were agreed as a true record with no amendments.	
3	**Matters Arising – Action Points** The completed and ongoing action points were accepted. **Re: Item 4.5** PB advised that the list of policies have been sent to AL but VB requested that these should also be distributed to all other executive directors. . **Item: 5.8 Non compliance with Climate Change** PB commented on the challenge to meet the targets. VB advised that there has been a successful audit which has generated action points	MW to send to Executive Directors

	which are being addressed but that further work is required. **<u>Item: 5.9</u> Risk related to Strategic Objectives** PB asked for an update to this outstanding item and MB reported back that this has been considered by AL and MB and at this time this is not considered to be a risk.	VB
4	**<u>Monitor</u>** **5.1 Quality Self Certificate** 1. SR referred to the papers presented outlining the assurance evidence for submission as part of the Monitor Annual Plan. Further detail is available but would not need to be submitted as part of the Quality Self Certification to Monitor. 2. JG advised that as part of the FT Application Process the Trust had completed the full Quality Assurance Governance Assessment. An action plan had been generated and was being progressed. The initial assessment documentation had subsequently been updated and additions have been made to the paper with regard to Ward Quality Indicators and Dashboards as well as Essential Care Spot Checks and Care Rounds. 3. PB confirmed that the Committee must be assured that the work meets all the Monitor requirements. 4. RB advised that Page 5 section 3 is workforce related and needs to read 12, 13 and 14. **Decision:** 1. IGAC content with Quality Self Certification. It is to be presented at the May Trust Board for sign off. 2. The action plan generated following the Monitor Quality Review (as part of the authorisation process) to be presented at the next IGAC meeting to give assurance that actions have been implemented. **5.2 Annual Plan Self Certification** 1. JG introduced the Authorisation Checklist Document which demonstrated high level pieces of assurance against each element. 2. PB sought assurance regarding the Mandatory Education and Training element. RB advised that this refers to the mandatory training required of junior doctors and nurses and will form part of the Review of Statutory and Mandatory Training Provision to be discussed later in the meeting. 3. TP advised that the private income figure is required. JG agreed to update. **Decision:** IGAC approved Annual Plan Self Certification for presentation to Trust Board.	SR/JG SR JG

6	**NHSLA Update** MW advised that the Trust has now had formal notification that it is compliant with the NHSLA Risk Management Standards at Level 2. Five criterion have been identified as failing to meet compliance and work is underway to address this shortfall. SR advised that the Trust was commended on the evidence of good clinical practice in many areas but that in some cases the NHSLA could not clearly see the connection back to clear policy and process. This should form part of the debrief and subsequent action plan and report which should be presented to the Executive Team and TEC. A debrief session will be organised for all contributors to the assessment process to identify lessons learned, agree the responsive action plan and develop the forward plan to achieve NHSLA Level 3. The Trust's NHSLA Assessor recommends a 24 month period of reflection and preparation before applying for Level 3. MW advised the Committee that a full review of all policies and practices would be undertaken to strengthen the approach to achievement of NHSLA Level 3. SR acknowledged the NHSLA view that Safeguarding Vulnerable Adult Training was not sufficiently robust. This has been raised as a Corporate Risk and will be considered by TEC when they meet in May 2011 alongside a treatment/mitigation plan. **Review of Statutory and Mandatory Training Provision for ASPH** RB tabled a paper outlining work commissioned in partnership with Epsom & St. Helier NHS Trust to review statutory and mandatory training provision and effectiveness within the Trust leading to identification of areas for improvement and subsequent Board assurance. The review aims: 1. to give clarity on what is deemed Statutory and Mandatory Training in line with NHSLA requirements 2. to review training provision in terms of demand and capacity 3. to review processes for recording and reporting of training data and offer recommendations to ensure systems are robust and accurate 4. to review current monitoring arrangements of compliance with statutory and mandatory training and to offer recommendations on how to strengthen these through relevant reporting lines and clarification of stakeholders and their roles and responsibilities 5. to review existing statutory and mandatory training policy and to offer recommendations to ensure it is compliant with NHSLA Level 2 criterion and fit for purpose as a foundation to NHSLA Level 3. A written report with recommendations will be provided to the Director of Workforce & OD by end of April 2011. 1. JH advised that March Insurance were currently reviewing the current NHSLA provision and approach.	SR MW SR

	2. TP noted that appraisal and personal development is not mentioned in statutory and mandatory training review outlined. RB advised that this will be picked up within the review. 3. PB concluded that there is more work to do in response to the NHSLA report and requested that a more detailed analysis be presented at the next IGAC meeting.	
7	**<u>7.1 SUI Report</u>** SUI Report was received and discussed in detail. **1. Code 5 Issues** (SUIs relating to missed diagnosis due to insufficiently robust responses to Code 5 alerts generated by Radiology) MB reassured the Committee that an interim process had been put in place whilst an IT solution to manage Code 5 alerts was sought. DMJ confirmed that an internal IT solution had been developed and that testing was underway. It is anticipated that the solution would be ready to deploy late April – early May. MW advised that the SHA have commended the Trust on their SUI report and action plans. **2. 3 Patients with CDiff** – full RCAs completed and a "cluster" not apparent. **Decision:** IGAC agreed to close this SUI. **3. SUI Number 121286 (death immediately following discharge).** MW advised the Coroner investigation 30 March concluded patient died from natural causes. PCT have closed this SUI. The SHA have asked for further information relating to attendance of the Consultant at the "bedside". This information to be supplied to the SHA. **Decision:** Subject to a satisfactory response from the SHA IGAC authorise closure of this SUI. MW to reply to SHA. **4. Maternity SUIs** Closed by PCT. **Decision:** SR and MB to review to ensure that no elements were preventable and that appropriate action and learning has been captured and implemented. IGAC to be advised of outcome at next meeting prior to agreeing closure.	MW SR/MB/MW
	<u>7.2 Trend Analysis of Maternity SUIs</u> Paper presented that reviewed 3 SUIs that occurred from Jan 2010 to present date. Two themes were apparent; effective use of the escalation policy and interpretation of the Cardiotocograph monitoring (CTG) by staff. The report provides details of the incidents and	

	subsequent actions. IGAC expressed thanks for the submission of the paper. 1. SR noted that the themes were consistent with those identified in maternity SUIs at other Trusts which indicates that work is still to be done to improve in these areas, but that ASPH issues were not "unusual" 2. VB very good to have this report and helpful and confident that the issues are being addressed. **Decisions:** • Action plan to be reviewed and reported upon to IGAC – SR new HoM on appointment • Identify what Obstetric Team training solutions are available - SR • Ensure that CTG equipment is fit for purpose – Head of Midwifery to give assurance • Identify what the timeline is to achieve 100% CTG training for staff and what the supportive rolling programme must be – Head of Midwifery • Escalation processes to be reviewed and effective use monitored and reported as part of the Division's report to CGC – Head of Midwifery	SR/HoM SR HoM HoM HoM
8.	**<u>Clinical Governance Exception Report</u>** The exception report was tabled and discussed. MB advised that the clinical governance report structure has been streamlined and that this has worked extremely well and the format had proved a useful basis for discussions at the CGC. The format will continue to be refined to ensure it is fit for purpose. MB gave assurance that no concerns were noted.	
9.	**<u>Safety & Risk Exception Report</u>** The Safety and Risk exception report was tabled and discussed. 1. SR expressed concerns that SRC was poorly attended by senior clinicians and that there is a lot of duplication of subject matter between CGC and SRC. 2. PB advised that there is a need to have both CGC and SRC separately but that work to minimise duplication of reports should be conducted. **Decision:** SR to review the SRC structure and function and to report progress at next IGAC.	SR
10.	**<u>Care Quality Commission Report</u>** The Care Quality Commission Report was tabled and discussed. 1. SR advised that the paper tabled was not the final version	

	submitted to Trust Board. The content was largely the same but that some minor amendments to the TB submission had been made. The TB Paper was available at the Trust website. 2. The CQC QRP for February 11 shows no area increasing of risk or non compliance. There is one area of a reduction in risk of non-compliance. 3. SR advised that the QRP is a tool used by CQC to drive their decision making with regard to inspection visits. It should not be used to provide Trust assurance on the Essential Standards of Care. The Trust must continue to use triangulation of other assurance elements to provide assurance alongside the QRP; quality domain in balanced score card, ward quality indicators, Performance Accelerator Tool, PALS and Complaints, SUIs and incidents. The QRP triangulation output will be presented to Board quarterly. 4. PB asked SR to confirm the risk status for the Trust. SR advised that risk existed within a number of Essential Standard domains such as Safeguarding and that work was underway to embed use of the Performance Accelerator Tool to improve assurance and develop action plans to mitigate risks identified. 5. MB reminded IGAC that the CQC could come and visit unannounced at anytime but that the Trust's approach should be to secure and maintain standards at all times – not as preparation for any potential inspection. Patient care and safety is paramount and is the outcome we are seeking. 6. RB suggested that the CQC Essential Standards and owners be mapped to existing sub-committees so that is clear where each Standard is reviewed and subsequent action agreed and monitored. **Decision:** 1. Performance Accelerator assessment to be presented at next IGAC. Format to ease and enable understanding of the intelligence and assurance it gives. 2. IGAC to consider at next meeting routine for presentation of this information in the future.	 SR IGAC
11.	**<u>Risk Register Reports</u>** MW presented the Risk Register Report and confirmed: • 14 new risks added to Risk Registers since the February meeting • of which 13 were local, 1 was corporate with 2 further corporate risks pending to be considered at TEC in May. These risks relate to readmission rates and safeguarding adults processes. 1. TP noted that there had been a lot of work completed to reduce and mitigate risks and could be seen by the reduction in high risks.	

	2. VB asked IGAC if there ought to be a refresh of the Corporate Risk Register and commented that many of the risks noted on the CRR and the BAF where registered some time ago 3. JG advised that the BAF strategic objective risks could be cross referenced on the CRR. **Decision:** A refresh of the CRR to be presented at the next IGAC meeting.	SR/JG
12	**<u>BAF</u>** 1. PB advised that this is not due for major review. The risks included in the 2011/12 Corporate Plan were included in the updated BAF. BAF Risk 1.1 - Trust does not meet trust national priorities and therefore Monitors Compliance Framework. VB confirmed this risk remains "extreme". BAF Risk 1.9 – VB confirmed that this risk should remain on the register pending embedding of Same Sex Accommodation approach. SR to broaden to include Privacy and Dignity. **Decision:** IGAC agreed to recommend removal of the following risks to Trust Board: 1. Data Quality 2. Informatics strategy	SR JG
13	**<u>External Reports Inspection Reports</u>** 1. Registration for CQC: this is currently rated amber. SR advised that following the recent PHSO Report it is likely that as the Trust was identified within the report a CQC Inspection visit would take place although the CQC QRP was not reflecting this. A note to reflect this concern and the amber rating should be added to the report. 2. Other comments/actions: • NHSLA should now be rated green - MW • JAG visit to remain amber • Adult Safeguarding Baseline Survey – SR to review • Information Governance Toolkit – additional training required • The issue of a press report relating to a 2010 Kitchen Inspection was raised. The report had not resulted in formal action and had not therefore been included in the Register. It is important that implementation of actions was monitored. The Trust Risk Management Strategy identifies the requirements regarding the reporting of external reviews to IGAC and may need updating or review. **Decision:** PB requested that a cover sheet to be presented with the External Inspection and Report Paper to ensure IGAC understand the purpose of the paper, what it's telling IGAC and what IGAC should focus on in terms of response and actions. This should be done to improve the	MW MW SR/VA JH MW

	governance.	
14	**Audit Committee Exception Report** The Audit Committee Exception report was received and noted. 1. TP advised that: • Internal Audit report on Information Governance Toolkit review identified that progress had been made and that Level 2 was achieved. • Outpatient Audit good - data quality was better than average. • Timetable for the Annual Report and Accounts, Statutory Accounts and Quality Account were on track.	
15	**Finance Committee** The Finance Committee Exception report was received and noted. JH gave an update: • 2011/2012 Budget approved by the Board – all acute providers are in a challenging situation with the introduction *of* penalties around readmissions. • Trust signed up to a savings plan *(*CIP*) of* £12m, which is a lot bigger than previous years. The percentage of CIPS to income for 2011/12 is 5.5 %, which is exactly the same (or less) than many other acute trust. It will be very important that IGAC maintains strong risk and clinical management and governance. CIPS have to be achieved without impacting on patient safety. Keep a watchful eye on our CIPS but not to the detriment of patient safety.	ALL
16	**AOB** PB informed the Committee that he was proposing to hold future meetings on a quarterly basis. These need to be aligned with the Audit Committee. There will be a six month trial. PB suggested the next meeting to be held in July. **Decision:** JG to review schedule of meetings.	JG

Date of next meeting: Wednesday 8th June 2011 – Lecture Theatre, the Ramp 2-4 pm.

INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)
Minutes of the meeting held on
8 June 2011
1400-1600hrs – The Lecture Theatre, Ramp, St Peter's Hospital

Present:		
Valerie Bartlett	VB	Deputy Chief Executive
Mike Baxter	MB	Medical Director
Philip Beesley	PB	Non Executive Director (Chair)
Raj Bhamber	RB	Director of Workforce & Organisational Development
Maurice Cohen	MC	Patient Panel Representative
Ben Endersby	BE	Internal Auditor (CVDFK)
Jane Gear	JG	Head of Corporate Affairs
Donna-Marie Jarrett	DMJ	Associate Director Health Informatics
Terry Price	TP	Non Executive Director (Chair of Audit Committee)
Suzanne Rankin	SR	Chief Nurse
Marty Williams	MW	Head of Patient Safety
Apologies:		
John Headley	JH	Finance Director
Jill Down	JD	Acting Head of Quality
Andrew Liles	AL	Chief Executive

Minutes: Anu Sehdev, Quality Team Administration Manager

1	**Committee Duties and Responsibilities for Reference** The document was noted.	
2	**Minutes of the Meeting held on 6 April 2011** The minutes were agreed as a true record except for item 9.2 where it read 'IGAC' it should read 'Safety & Risk Committee (SRC)' and item 9 (Safety and Risk Exception Report) should read "duplication between SRC and CGC".	
3	**Matters Arising – Action Points** The completed and ongoing action points were accepted. <u>Item 4.5 List of Policies</u> MW advised further work was required before circulating a status report on policies to the Executive Directors. This work would be undertaken as a matter of urgency by the Quality Department in liaison with Simon Leathers, Trust Web Content Manager. Update to be sent by end of July. <u>Item: 5 Annual Plan Self Certification</u> JG advised that this was now complete. <u>Item: 7.2 SUI Report</u> This related to a maternity case where consideration had been given to whether earlier intervention by the obstetric team should have taken place. SR advised that further information had been provided and confirmed the action plan could now be closed. SR advised the Royal College of Obstetricians & Gynaecologists was about to launch a package of Multi Disciplinary Team (MDT) training in July. SR would report back at the next meeting on whether the Trust could make use of this tool.	MW SR

	SR has been assured that all equipment has either been recently updated or new equipment has been procured in Maternity. SR advised the group that the department would be looking at undertaking simulations or drills in order to test escalation procedures and this process would be managed by the new Head of Midwifery. SR to report back at the next meeting.	SR
4	**NHSLA** <u>4.1 Summary Report</u> A debrief session to look at learning would be taking place on 6 July. <u>4.2 Review of TOR</u> MW discussed the TOR for IGAC as an action following the NHSLA assessment. Members agreed the suggested changes on reporting lines and frequency of reporting of the CGC and Safety and Risk Committee, which they did. It was agreed that a further review of the TOR would be undertaken by JG to include changes to membership as agreed by the Trust Board. <u>4.3 Review of Statutory Mandatory Training Provision</u> An External Consultancy had undertaken a review of the Trust's policy on Learning and Development, including statutory and mandatory training. An action plan had been agreed to take forward the recommendations from the review. The Committee was requested to note the paper at this stage. It was agreed to receive a report back in December, with exception reporting before hand on major concerns. Discussion took place about the Trust going for Level 3. MW informed the group that the NHSLA assessor had suggested a minimum of 2 years to complete the work required going forward for Level 3. It was generally agreed that this would be dependent on a robust action plan and strong project management. RB confirmed mandatory training records would be in reasonable shape by December 2011 and the Trust would be in a good position to register an excellent year's training record by 2012. TEC would make a decision around September 2011. SR to update the group at the next meeting.	JG&MW RB SR
5	**SUI Report** SUI Report was received and discussed in detail. 5 new cases had arisen since the previous meeting. MW requested the Committee consider closure of 4 cases: 7, 10, 11 and 12 for which confirmation of closure from the PCT and SHA had been received. **Decision:** The Committee agreed to close these cases. The Committee discussed the importance of ensuring improvements and learning had been embedded through dealing with SUIs. Consideration was given to an audit of particular themes, ie misdiagnosis, to test the robustness and effectiveness of the actions implemented. SR advised that she and MW were currently developing an IT tracker system which would incorporate many layers, ie case, theme and division. SR confirmed she would update the Committee at the next meeting as well as the Trust Board meeting in July.	SR

	The Committee confirmed the importance of recording areas of diversity to include ethnicity, gender, age and disability. MW suggested this could be incorporated in the TOR for investigations going forward. SR had informed the Committee that the Trust were in liaison with the CQC ensuring our processes for reporting, recording and learning from incidents were robust. MW advised the Committee that she scrutinised all grade 3 – 5 incidents to ensure what has been written is correct and a robust process is followed. SR advised she and MW would revisit case 10 as the update was not relevant to the action, ie an audit of consultant ward rounds should be conducted with the ward sister in attendance. The Committee noted the Report.	SR&MW
6	**Clinical Governance Committee Exception Report** The exception report was tabled and discussed. MB advised the meeting was continuing to develop and divisions were clearly focused and engaged. Divisions had asked for an exception report back from IGAC. The Committee discussed the increase in the caesarean section rate. Individual consultant practice was being examined and the Division was asked to feedback at the next CGC meeting in July. MB would report back at the next meeting. MB advised the Committee that the Clinical Effectiveness Audit Group (CEAG) was currently being reviewed, especially where it sits in relation to the Clinical Governance Committee.	MB
7	**Safety and Risk Exception Report** The Safety and Risk exception report was tabled and discussed. The issue of duplication of reporting and the discussion taking place at Safety and Risk and Clinical Governance was discussed. SR advised that mapping exercise was being undertaken looking at the workings of the each group in order to reduce duplication. PB advised he would endeavour to attend this exercise and SR would report back at the next meeting. The backlog of incident logging was discussed and MW advised that the Team had reduced this considerably and would continue to address it. However, there was also an issue with backlogs and batching with divisions. The Committee noted that going forward Datix Web would improve the situation considerably. As the cost of installing Datix Web had risen only slightly it was not necessary to return to TEC with an updated business case. MW would update the Committee at the next meeting.	SR MW
8	**Care Quality Commission (CQC)** The Care Quality Commission Report was tabled and discussed.	

	The CQC Quality Risk Profile (QRP) for April 2011 shows no area increasing in risk of non-compliance. There is one area of a reduction in risk of non-compliance. SR highlighted the importance of understanding practice and triangulating evidence. Good progress had been made in reviewing evidence. SR would continue to check clinician and nurses' understanding of each standard. SR advised that 3 reports relating to hospitals failing outcome 1 and 5 in a review recently conducted by the CQC had been shared. These reports highlighted the importance of staff understanding what is the required outcome for CQC standards. SR advised that on the whole there was evidence of very good practice around the Trust but highlighted the need to improve provisions for hand-washing for inpatients before mealtimes. SR advised of the setting up of a peer review tool whereby staff visited other areas of the hospital and scored them on meeting the standards. A recent peer review of Holly Ward had been favourable. Although it was important that the Performance Accelerator was regularly unloaded, this was primarily a tool for depositing information and evidence so it could be readily available if required. SR confirmed she would monitor the process of uploading evidence against the 16 standards on the Performance Accelerator database. The Committee agreed that the report was a useful summary of risks but that the Performance Accelerator reference in the final column was not required going forward. **Decision:** The Committee agreed that 2 areas of focus would be Safeguarding Adults and Mandatory training. In future the report should highlight significant areas of risk. Work had been undertaken to show where standards have reporting links to a sub committee and JG agreed to forward this information to SR.	SR JG
9	**Monitor Submission - Quality Action Plan** As part of the FT application the Trust had completed the Quality Governance Self Assessment. At the end of this an action plan had been developed to take forward three aspects rated amber/green. As part of the annual plan certification process as an authorised FT the Board needed to self certify its compliance with the Quality Governance Framework. An updated action plan was tabled which showed the actions taken post authorisation. The Committee noted the position.	
10	**Risk Register Reports** MW presented the Risk Register Report and confirmed:	

	• 10 new risks had been added to the risk register since the April meeting, of which 2 were corporate risks approved by the Trust Executive Committee (TEC). MW was working up a further 2 risks which she would be forwarding to TEC for the June meeting for consideration. VB reiterated the need to "spring clean" the risk register to ensure old risks no longer valid were removed. Discussion took place around the possibility of starting afresh but the Committee agreed this would entail a lot of work. **Decision:** MW and SR agreed to undertake a review of the Risk Register over the summer and to report back at the next meeting.	MW& SR
11	**Board Assurance Framework (BAF)** JG presented the BAF report circulated with the agenda. It was noted that some areas need updating and this would be done prior to the Board meeting. PB highlighted page 19 - Government Policy, and Committee agreed to increase the risk from 9 to 12 (increased likelihood) due to the uncertainty caused by the pause in the Bill. RB queried whether risk 8 – Non-compliance with Equality, Diversity and Human Rights legislation was still required and that Statutory Training would now need to be included. JG agreed to check whether this was still included in the SIC and then liaise with RB.	JG JG & RB
12	**External Reports and Inspections Report** The External Reports and Inspections Report was tabled and discussed. It was agreed that the report was more meaningful and clearly identified the progress made. It was agreed to confirm whether there was a benefit from colour rating and if it was requested a definition of Red, Amber and Green be placed on the front page. The report would continue to be developed.	MW&SR
13	**Audit Committee** 13.1 Exception Report The Exception Report was received and noted. 13.2 Draft Internal Audit Plan TP advised that all committees were to have sight of the plan. As IGAC had some involvement the Trust Board has requested it look at the operational audits. VB suggested focusing on whether the PMO was working. TP would meet with JH to discuss further including whether this could be managed within the audit plan resources.	TP
14	**Finance Committee Exception Report** The Exception Report was received and noted.	

	JH highlighted a concern about the loss of £0.7m for the first month of the financial quarter and how performance would need to be strong in months 2 and 3 to obtain a Financial Risk Rating of 3 according to Monitor. JH advised the Trust was closing the gap on CIPs and had met with the divisions.	
15	**Draft Annual IGAC Report to Trust Board** PB proposed reporting annually and not 6 monthly as previously done. **Decision:** The Committee agreed to report annually with exception reports when necessary.	
16	**Any Other Business** <u>16.1 Neck of Femur</u> PB highlighted the recent KPMG report which included concerns around robustness of reporting on # neck of femur. MB had met with the Divisional Director and agreed to ensure all reporting mechanisms in place were robust. This would be monitored at clinical Governance Committee. SR would bring the report incorporating the management response to the next meeting. <u>16.2 Progress</u> PB commended the Committee on how it had improved over the last few meetings in gaining a good grasp of issues.	MB SR

Date of next meetings: **Thur 8 September 2011 – Board Room 1400 – 1600hrs**
Wed 7 December 2011 – Lecture Theatre 1400 – 1600hrs

NB: 3 August and 5 October meetings cancelled