CCG Audit Committee
Minutes of the meeting held on Thursday 1st October 2015 at 2:00pm in The Grace Room, South Plaza

Draft Minutes

Present:	
Patsy Hudson	Chair Audit Committee
Carew Reynell	Associate Lay Member
Richard Laver	Governing Body Member
In attendance	
Nicola Dunn	Chief Finance Officer
Jenny McCall	Head of Internal Audit, Audit South West
Russ Caton	Audit Manager, Audit South West
Sarah Carr	Corporate Secretary
Sandra Bell	Local Counter Fraud Specialist
Katie Spooner	Audit Manager, KPMG
Jessica Harris	Personal Health Budgets

		Action
1	**Apologies for absence** There were no apologies for absence. Patsy Hudson and Nicola Dunn were to interview a candidate for the vacant associate lay member role. Carew Raynell offered to meet with the candidate, if successful, as part of their induction.	**SC/LP**
2	**Declarations of interest** There were no declarations of interest.	
3	**Minutes of Last Meeting & Action log** It was noted that the Governing Body would review the Governing Body Assurance Framework (GBAF) quarterly. With this the open minutes were agreed as a correct record. The closed minute was agreed as a correct record. The action log was reviewed:	

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	17/12 14(1) this action had been superseded by the amendments to the GBAF. The action was closed. 25/3 9(1) Jenny McCall had raised CCG capacity issues regarding Counter Fraud and Security Management Standards with NHS England. The matter would be discussed further with NHS Protect at a workshop. The CCG would be represented at the meeting. The action remained open 21/5 6(2) Nicola Dunn had discussed the value for money report with Grant Thornton and agreed that this matter would be picked up in the ongoing programme for the new external auditors. Carew Reynell noted that the report received from Grant Thornton had been a brief pro forma and that the Committee had asked for greater detail will an indication of areas for the Committee work programme. The action was closed 21/5 6(3) it was agreed to check that the Grant Thornton self-assessment had been circulated. The action remained open 02/07 13 (1) it was confirmed that KPMG would share the work programme with the Corporate Secretary. This action was closed 02/07 8(1) reporting arrangements for suspected fraud in primary care had been raised at the Joint Committee meeting with NHS England. Sandra Bell confirmed that matters related to fraud in General Practice should be reported to NHS Protect through the fraud and corruption line. The CCG Counter Fraud service had sought written confirmation. Richard Laver asked how GP practices would raise concerns about fraud. It was explained that this should be through the NHS England Local Counter fraud Service (LCFS). It was commented that the anti-fraud service had a low profile within primary care. It was explained that the CCG LCFS service had no remit to investigate Practice referrals. It was agreed raise to the lack of proactive work in primary care with the area Anti-Fraud Specialist Lead in Bristol. The action remained open 02/07 10(1) Nicola Dunn had sought assurance on cyber security and explained that the response would come through the CCG Strategic Informatics Group prior to Audit. The action remained open Actions 25/3 6(1), 6(4), 8(1), 16(1) 17(1), 21/3 6(1), 7(1), 02/07 3(1), 3(2), 3(3), 12(1), 13(2), 13(3) were closed	
4	**Bristol CCG Update** **VAT Audit March 2015** The HMRC VAT inspection had found that the CCG had	

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incorrectly recovered VAT on the service provided by the National Autistic Society; as a result the CCG was required to repay the VAT claim on those invoices back dated 1st April 2013 which totalled £13445 plus interest of £331.61. The CCG had demonstrated that 'reasonable care' had been taken in completing the VAT return and no penalty charges for the submission of incorrect returns were incurred. Carew Reynell welcomed this news. It was noted that the NHS and other public bodies were coming under increased scrutiny by HMRC. **NHS England Assurance Letter** The committee received the NHS England Annual Assurance Outcome for 2014/15 which had been shared with the Governing Body; Carew Reynell asked how much assurance the Governing Body could take from the letter. Nicola Dunn explained that the assurance process was based on the performance of the CCG across key domains, performance against which was reported monthly to the Governing Body. The assurance process was external confirmation of this performance and there was considerable scrutiny by NHS England. It was agreed that the Assurance Letter and the outcomes of future quarterly assurance meetings would be added to the GBAF. Richard Laver noted the comment that the lack of timely and robust activity data had impacted on QIPP monitoring. Nicola Dunn agreed that a lack of predictive and reactive analytics had been a notable problem for the CCG. A meeting had been held with the Chief Informatics Officer at the CSU who had agreed that the CCG position was not as robust as should be. There would be further work undertaken to understand how analytics could be improved. **CCG Financial Position 2015-16** Nicola Dunn gave an update on the CCG's financial position for 2015-16. It was explained that the CCG had reduced the control total surplus for 2015-16 from £6.8 million to £2 million. The CCG was formally in turn around and was required by NHS England to put in place a recovery plan. The CCG was under intense scrutiny by NHS England and detailed financial information had been provided to the Local Area Team in September. Nicola Dunn confirmed that to date the CCG had received no further feedback for the Local Area Team. Members were informed that the outline structure of the Recovery Plan had been presented to the Governing Body in closed session. It was highlighted that it was important that the overall position was understood and owned across the organisation. Each recovery project would have a named clinician. The localities would be formally notified of the CCG position once an agreed structure and process for	**S Carr**

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engagement was in place. The CCG had a recurrent deficit with the surplus provided through non recurrent measures. The CCG would need to reverse this position which would entail difficult decisions. Benchmarking data received had shown that non elective admissions were growing at a faster rate compared to the rest of England. The efficiency opportunity in non-elective admissions was potentially £11 million. Potential efficiency savings of £4.4 million related to pneumonia and respiratory admissions had been identified however these were not necessarily a cashable saving. The CCG would look at areas of potential cross subsidisation including the over investment in AWP; it was noted that recovery of this would require negotiations with other commissioners also facing difficulties. The CCG would look conduct a value for review of all services to identify further potential efficiency savings. This was a longer term programme and would require public and stakeholder engagement. Governance arrangements for recovery were outlined. Overall performance against plans would be reviewed fortnightly at the Leadership Group meetings; weekly meetings would be held with the Chief Financial Officer and individual budget holders to look at QIPP programmes, recovery plans and budgets. Members were informed that Nicola Dunn had met with the CHC lead and discussed targets. The discussion had highlighted the misunderstanding of CHC eligibility criteria. There was an educational issue and this would include GP colleagues. Richard Laver flagged that localities would raise two questions, how would the CCG get out of turn around and what specifically could localities contribute? Nicola Dunn responded that a structured approach with localities would be required. Jenny McCall commented that the position across CCGs in general was difficult. There was intense financial pressure on the NHS and this was a whole health care system issue. Nicola Dunn confirmed that she and Jill Shepherd had arranged face to face meetings with the Chief Executives and Directors of Finance of all providers to discuss the position. Richard Laver commented that the complexity of the PMS reviews that would impact on GP practices. Carew Reynell asked how the NHS England decision to place the CCG in turn around had been reached. Nicola Dunn explained that at end of March 2015 the CCG had a budget plan that contained an identified QIPP of £15 million, plans for savings opportunities and a surplus of £6.8 million. In April the CCG was asked to fund individual providers to achieve RTT targets; in its initial plans the CGG had funded this on a commissioning	

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	population basis. The new requirement necessitated that the CCG contributed a further £7 million to NBT. The CGG was also required to provide for non elective admissions at a growth rate of 3.6% rather than the 1.1 % allocated. As a result of these additional requirements the CCG had £10 million of unidentified QIPP. NHS England had expressed concern about the level of unidentified QIPP and this was reduced to £6.2 million on the basis that not all the funds contributed to NBT would be used. The CCG began a process to identify further QIPP savings, both internally and with other CCGs. Other CCGs were visited to identify approaches that could be translated to the Bristol context. A board seminar with secondary care colleagues and others was held to identify potential QIPP schemes. Budgetary reviews were undertaken and the balance sheet was reviewed to ensure that all debtors, creditors and reversals from year end were up to date. These actions were completed at the end of July. The decision was taken at this point, once all possible avenues had been explored, to raise the CCG position with NHE England. The CCG position was shared with NHS England at the beginning of August, based on the July outturn. Patsy Hudson informed members that concerns about the QIPP requirement had been raised at the Finance, Performance and Planning Committee from June when data for April became available. The situation had been a focus of discussion at the Finance, Performance and Planning Committee for the previous four months. QIPP Assurance Meetings were attended by NHS England. Carew Reynell asked when the CCG was advised of the turnaround position. It was explained that this had been in a formal letter that followed a meeting with the Local Area Team Director of Finance. The CCG's clinical leadership and staff were promptly informed and the position reported to the Governing Body. Richard Laver asked what criteria the CCG needed to achieved to move out of turn around. It was explained that the CCG needed to deliver a recurring surplus and control total. Carew Reynell sought clarification that the CCG was required to address the recurrent position in the recovery plan. This was confirmed. Patsy Hudson thanked Nicola Dunn for the update.	
5	**Financial Control Environment Assessment** The Assessment had been completed by senior CCG managers and reviewed by the Chief Financial Officer. The CCG was required to return the draft submission before the Audit Committee meeting and copies of the assessment had been	

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	circulated to members for comment. It was noted that the Chair and internal auditors had reviewed and supported the assessment before its submission. The committee was now asked to review and sign off the assessment. It was noted that NHS England was developing a financial resilience toolkit. Nicola Dunn confirmed that the requirement for self-assessment was not linked to financial performance. Richard Laver asked if the financial resilience toolkit was available. It was confirmed that had not yet been released. **The Audit Committee signed off the Financial Control Environment Assessment**	
6	**Policy review – Detailed Financial Policies** It was explained that the Governing Body had approved the detailed financial policies at the September meeting. The policies provided an important framework for CCG staff and built on the Standing Financial Instructions adopted in May 2013. The policies had been drafted by the Corporate Secretary with the procurement team and the Finance Team. Additions included a section on the virement of funds. Carew Reynell asked what the review process entailed. It was explained that a desk top review of national guidance and the Detailed Financial Policies of other organisations was conducted to identify new requirements and best practice. Nicola Dunn had signed off the final revised policies prior to their submission to the Governing Body. Sandra Bell noted the section on Counter Fraud and it was confirmed that the Local Counter Fraud Service was referenced.	
7	**Standards of Business Conduct** The paper presented was to provide assurance through describing the systems of internal control in relation to the management of conflicts of interest. Members noted that the CCG had received a letter from NHS England seeking assurance on the measures in place within all CCGs to manage their business dealings. In response to the letter the CCG reviewed its systems and processes and the Audit Committee Chair and Internal Auditor reviewed the CCG evidence of compliance. A formal response setting out the outcome of the review was sent to the local AT commissioning director. Members were informed that the CCG had approved revised Standards of Business Conduct which incorporated the CCG Gifts and hospitality policy. It was noted that there had been a complete revision of the Standards of Business Conduct. The Standards sat alongside the Counter Fraud and Working with the Pharmaceutical Industry policies. It was confirmed that all policies	

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	were placed on the CCG website. It was explained that all staff would receive the Standards of Business Conduct and Detailed Financial Policies and would be asked to confirm receipt of the policies and that they had been read. Richard Laver asked if the policies applied to General Practice. It was explained that policies applied to employees of the CCG and would apply to GPs and other Practice Staff when engaged in activities for the CCG. With regards their own business practices, GP Practices should follow good practice and could use the CCG policies as a guide. There was no national guidance for GP Practices. Carew Reynell asked if there had been any known infringements of the CCG policies. It was explained that there were no known infringements of policy and this had been part of the review conducted by Patsy Hudson and Internal Audit. The CCG had received a medical and education goods and services grant (MESGG) to fund the short term use of skilled nursing staff to rollout the HG Wells diabetes project. A single action tender had been approved in relation to the software to support the project. It was explained that Detailed Financial Policies had been waived as the provider was the sole supplier of the software required. The waiver application was presented for information. It was explained that the Chief Financial Officer had sought assurance from the CSU on a number of points in relation to the procurement; details of the matters raised and response received were included in the report. The matter of IPR was outstanding and the CCG was taking further advice. Carew Reynell sought clarification on the decision to place the contract with Ashfield and what arrangements were in place to ensure that the terms and conditions of contract were reasonable. It was agreed that Sarah Carr would raise this with the team. Nicola Dunn commented that the CSU took advice from its own procurement team which performed to a consistently high standard. **The Committee received and noted:** • **The management of conflicts of interest** • **The standards of business conduct** • **Working with the pharmaceutical industry matters** • **The waiver of detailed financial policies – single action tender**	**S Carr**
8	**Counter Fraud and Anti Bribery Policy**	

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	Sandra Bell presented the counter fraud policy. The policy was based on a standard template issued by NHS Protect and adapted to the CCG. The policy included all groups within the CCG. The policy would be discussed with the CCG Staff Council. Once adopted by the CCG the policy would be communicated to all CCG staff. There was a discussion about counter fraud and primary care and Sandra Bell agreed to share comments about counter fraud arrangements for primary care with NHS Protect. Carew Reynell questioned section 5.4.1 and the Chief Financial Officer responsibilities as set out; Nicola Dunn confirmed these were appropriate. Patsy Hudson asked about section 5.6.8 and the role of line managers. Sandra Bell confirmed that the direction was for suspected fraud to be reported to the Local Counter Fraud Service, this did not prevent staff discussing concerns with their line manager.	**S Bell**
9	**Counter Fraud report** **Statistical Taxonomy Report** Patsy Hudson asked if there was an assessment of the saving made through Counter Fraud activities. Sandra Bell explained that NHS Protect had carried out methodology exercises that had given estimates previously however this had stopped. Nicola Dunn noted that the report included functions that the CCG was not responsible for. Sandra Bell confirmed that the report covered all commissioning organisations including NHS England. It was noted that this was the first report and all comments would be shared with NHS Protect. As the report developed it would be used to inform planning for proactive counter fraud activities. Carew Reynell commented on the small number of reports that resulted in investigation and asked what the criteria for investigations were. It was explained that all referrals were assessed on a case by case basis. Members welcomed the report and agreed to receive it in future. **National Fraud Initiative** Two instances of over payment had been identified. It was noted that the CCG compared well to other organisations. Carew Reynell welcomed the CCG's position and noted that initially 400 matches had been identified. He asked if the criteria needed to be refined. It was agreed that further work could be undertaken to reduce the number of matches	
10	**Internal Audit Progress Report**	

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Russ Caton informed members that the CHC follow up review had been issued and a summary was appended to the report. Progress with the remaining internal audit work was highlighted. Nicola Dunn informed members that the plan had been amended to include an audit of the CCG Freedom of Information (FOI) function and process. It was noted that Alison Moon was the executive lead for FOI. An update on actions in response to Internal Audit recommendations was included in the report. Nine actions had passed their agreed completion date and of these six were more than two months overdue. Of these actions two were graded as act soon and four as low. Internal Audit was working with the CCG to clarify the position regarding the outstanding actions. Carew Reynell observed that it had agreed that a detailed report on outstanding actions would be presented to the Committee twice a year. It was confirmed that Russ Caton would prepare a detailed report for the next meeting.	**R Caton** **R Caton**
Attention was drawn to the section related to the CSU Service Auditor Report. Internal Auditors had attended a meeting on behalf of the CCG to confirm the process for 2015/16. The majority of the audit process was pre-determined by NHS England. The timing of audit reports had been an issue nationally in 2014/15. To address this problem in 2015/16 the intention was to produce a report in month 11 with an ongoing report to reflect the full year position.	
The matter of identifying issues related to specific CCGs had been raised. It was explained that the External Auditors would not issue CCG specific reports as the audits were based on sample tests. The CSU intended to standardise it's operations across its client base and in future service auditor reports would cover 53 CCG's. members were informed that potential this would result in all criteria being flagged. The CSU was confident that these issues would be resolved through robust controls. The CCG would receive monthly reports on monitoring. The CCG Internal Audits were concerned that future Service Auditor Reports would be less helpful.	
Currently the CCG received a detailed service auditor and had a significant input into the report. Nicola Dunn commented that it was important to understand where accountability sat between the CSU and the CCG and what issues needed to be addressed. It was important to complete a match exercise against the CSU service auditor report, highlight areas of concern and identify mitigating actions either in place or required by the CCG. Russ Caton confirmed that this was completed as part of the financial controls audit and that there was confidence that this audit would identify any issues. It was noted that the CCG contract	

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	management report was received by the CCG and that this was not standard across CCGs but was specifically requested by the CCG. The IT audit was also an addition requested by the CCG. There was a discussion regarding the CHC follow up report. It was confirmed that auditors were satisfied that that robust action had been taken to address the issues contained in the initial report. A number of actions were partially complete due to changes in plans and a number of extra recommendations had been added that had a low risk rating. Carew Reynell noted that the Care Home Programme Board was due to meet in September. It was confirmed that this had happened and a full report on Care Homes had been received by the Governing Body. Carew Reynell asked if all the audit reports relating to 2014/15 had been completed and received by the CCG. This was confirmed. **The Audit Committee received the Internal Audit Progress Report**	
11	**External Audit Progress Report and Technical Update** **CCG Outcomes Indicator Set:** The CSU would produce a CCG specific briefing. The Outcome Indicator Set would be incorporated into the planning and commissioning process and the quality premium intentions. **Safeguarding Vulnerable People in the NHS:** Patsy Hudson explained that she chaired The CCG Safeguarding group. Policies for Safeguarding Adults and Safeguarding Children were in place. It was noted that the role of the Audit Committee was to receive assurances on the CCG Safeguarding arrangements. Carew Reynell noted that positive assurance through Internal Audit reports had been received. It was confirmed that the framework had been discussed at the Quality and Governance Committee and that the framework would be added to the GBAF as a source of internal control. It was agreed to share the paper discussed at Quality and Governance with members. **Ensuring patients' health and care records are available to health and care staff:** The CCG had noted the new legal duties and Connecting Care was main mechanism for delivery. The Better Care Programme Director was working with the Local Authority regarding social care implementation. There were concerns about the progress with social care and the CCG was following this up. **NHS Standard Contract Electronic Discharge Summaries Requirements:** The CCG was aware of the requirements; 50% of provider discharge summaries were sent electronically and all	**S Carr** **S Carr**

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Practices were able to receive them. The CCG had encouraged local providers to increase the number of electronic summaries through a local CQUIN. There were differing issues at both Trusts and there would not be full delivery in 2015-16.	
Different payment approaches to support new models of care: Nicola Dunn reported that a document had been embedded in the (HEMA advice) in 15-16 UHB contract. The CCG was looking at different payment approaches. It was noted that the Committee received assurance through Internal Audit. Carew Reynell asked if the CCG was confident that the full review issues were being appropriately built into commissioning and planning processes. Nicola Dunn explained that the majority of payments were through Payment by Results and therefor currently there was little scope for different payment approaches; these however would develop.	
Assurance Operating Manual: The Finance, Performance and Planning Committee had been briefed on the new arrangements at the June meeting. It was agreed to circulate the guidance to members. Nicola Dunn explained that the CCG would conduct a regular self-assessment against the new assurance criteria	**S Carr**
E2016/17 national tariff proposals The CSU had prepared a response that had been signed off by the Chief Financial Officers	
Pharmacy: The CCG was not eligible for funding. NHS England had indicated priorities for funding which the CCG had shared with Practices. It was understood that at least five Practices had submitted bids which were supported, where possible, by the CCG. The One Care Consortium had held an event to help Practices to bid which included support from the Medicines Management Team..	
GP Patient Survey Results: These were available on line and KPMG would circulate the link. Members welcomed the information. Richard Laver commented that only 41% of respondents had rated Practices as very good; Practice surveys gave a higher percent of patients rating their Practice as very good.	**KPMG**
DH Group Manual for Accounts 2015-16: It was confirmed that Colleagues in Finance Team were working through the manual of accounts.	
Accounting for Better Care Fund: Nicola Dunn informed members that the Local Authority hosted this and managed the accounting process. The CCG had concerns as the financial management post had been vacant and no financial data was available. This had resulted in a nil return being submitted to	

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	NHS England. These concerns had been raised with the Local Authority and a recruitment process was in place. It was noted that the CCG had not received Section 75 financial data in time for the submission of the 2014-15 annual accounts. Nicola Dunn would raise this with the Local Authority. Committee members commented that given the financial position of the CCG it was vital that timely information from the Local Authority was obtained and asked that their concerns be clearly minuted. **CQC latest findings to July 2015:** Richard Laver commented on the national finding that 15% of providers were rated as safe. Members welcomed the report and the update.	**N Dunn**
12	**Deep Dive – Personal Health Budgets** Jess Harris was welcomed for this item. Richard Laver asked why the CCG had a personal health budget programme. It was explained that it was a legal responsibility to provide personal health budgets for eligible CHC patients. Jess Harris explained the background to the pilot scheme and described how the initiative supported patient choice and personalisation, allowing patients to use funding in alternative ways. Richard Laver asked if there had been an increase in costs as a result. It was explained that the pilot had shown the initiative to be cost neutral as funds had already been budgeted for. Additional costs associated with the implementation stage had been incurred however no increase in individual care costs had been seen. Patsy Hudson asked if patient outcomes had improved. Jess Harris confirmed that the pilots had found that outcomes for patients had improved. Jess Harris explained the Care Planning process. It was noted that personal health budgets were optional and depended on individual circumstances. Personal Health Budgets could not be imposed. Carew Reynell queried the governance in place to manage personal health budgets and what impact the Integrated Personal Commissioning programme (IPC) was making. It was explained that the IPC looked at a broader cohort of patients. The governance process for the CHC cohort was contained within the CCG; the broader cohort required a governance process across organisations and this was being developed through the programme. Carew Reynell asked what benefit the CCG would get from participation in south West Consortium Programme. It was explained that the Consortium provided an efficient way to share expertise across CCGs and other organisations. Developments so far had attracted additional funding across the region. Carew Reynell asked how the Governing Body was assured that the programme was well managed. It was explained that the Quality and Governance Committee received a quarterly	

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	report and an Internal Audit was planned. Jessica Harris was thanked for her attendance. Members discussed the time allowed for the deep dives and it was agreed to allocate more time for the deep dive item and place the item earlier in the agenda. It was noted that there was internal audit planned for Personal Health Budgets. It was agreed that the January deep dive would focus on Out of Area Mental Health Placements and the specific CCG QIPP programme. Jill Shepherd was the lead director and Catherine Wevill was programme lead.	**S Carr/ P Hudson** **S Carr/ P Hudson**
13	**Corporate Risk register and Assurance Framework** The Governing Body had reviewed a revised GBAF at its September meeting. The Governing Body had reaffirmed the Principal Objectives for the CCG's GBAF. A number of changes had been made to two of the risks reported on the GBAF and the sources of internal control and assurances. These had been agreed by the Governing Body. As Internal Audit reports and other sources of assurance became available these would be added to the GBAF. As an example members were informed that the 2014/15 Child Death Overview Review received by the Quality and Governance Committee would be added as a source of assurance. It was agreed to circulate the report to members. Carew Reynell commented that the Committee had agreed to use the deep dives to look at the risks reported on the GBAF and test the assurances and as assurance reports were picked up on the GBAF it would be helpful if greater detail as to assurance provided by the controls would be helpful. Patsy Hudson asked that the Risk Tracker be presented to the Committee in future. Carew Reynell commented that the information provided indicated that the Corporate Risk register was a live document within the CCG. **The Audit Committee reviewed the GBAF and whether it reflected the organisations:** • **Principal objectives** • **Principal risks** • **The controls in place** • **The assurances are reliable and as is the underlying data** • **Actions are in place to address gaps in control and assurances**	**S Carr** **S Carr** **S Carr**

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	The Audit Committee reviewed the Corporate Risk Register and whether it was robust and relevant.	
14	**Work Plan 2015/16** The suggested timetable for policy review was agreed and it was agreed to add the raising concerns policy to the timetable. The production of the annual report to the Governing Body would be added to the work plan. It was agreed to make clear on the work plan that the members would have at least one meeting annually with the Auditors independently of CCG officers.	**S Carr**
15	**Minutes of the Quality and Governance Meetings** Patsy Hudson highlighted the key issues discussed at the meetings. At the June meeting issues discussed included high cost CHC cases and the unannounced CQC visits to NBT. The July meeting included discussion about continuing concerns about the 111 service and the recruitment of staff and the Out of Area placement of mental health patients. The August meeting had included discussion about concerns regarding administrative support capacity at NBT and the number of C.Dif cases.	
16	**Minutes of the Finance, Performance and Planning Meeting** It was noted that the Committee had discussed concerns regarding the achievement of QIPP and CHC costs at the June meeting. Discussions had also included CHC high cost cases, performance against the 4 hour A&E waiting time target and the 18 week RTT target. The July meeting had included discussion about increasing concerns relating to the QIPP target. At the August meeting discussions had included performance against the 4 hour A&E waiting time target and concerns about achieving the CCG surplus.	
17	**Any Other Business** Patsy Hudson confirmed with members that in her feedback on the meeting to the Governing Body she would highlight: • The committee was well briefed on the financial situation, action taken and recovery plan • Polices such as Counter Fraud and Standards of Business Conduct should be shared as guidance with member Practices. • The Committee had concerns about the timing of the Section 75 financial information received. Jenny McCall drew attention to the following:	**S Carr**

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• Guidance on the appointment of External Auditor was now available • HFMA would publish updated guidance on managing conflicts of interest • Jenny McCall would attend a meeting of Local Authority auditors and would raise concerns about the Better Care Fund.	**J McCall**