NHS
Wakefield
Clinical Commissioning Group

PROBITY COMMITTEE

26 NOVEMBER 2019
3:00 PM, ROOM 5a, WHITE ROSE HOUSE

AGENDA

No.	Agenda Item	Lead officer
1.	Apologies for Absence – Dr Greg Connor and Anna Hartley	**Richard Hindley**
2.	Declarations of Interest	**Richard Hindley**
3.	i) Minutes of the meeting held on 24 September 2019 ii) Action sheet from the meeting held on 24 September 2019	**Richard Hindley**
4.	Matters arising	**Richard Handley**
5.	**Co-Commissioning**	
5(i)	Contract Variation	**Dominic Blaydon**
5(ii)	WPPC mid-year Performance Report	**Natalie Knowles**
6.	**Governance**	
6.(i)	Terms of Reference	**Amrit Reyat**
7.	Matters to be referred to other committees or Governing Body	**Richard Hindley**
8	Any Other Business The Committee is recommended to make the following resolution: *"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1970)".*	
9	Date and Time of Next Meeting 28 January 2010, 10:00am, The Boardroom, White Rose House	

NHS Wakefield Clinical Commissioning Group

PROBITY COMMITTEE

Minutes of the Meeting held on 24 September 2019

Present:	Mel Brown	Programme Commissioning Director – Integrated Care
	Dr Greg Connor	Executive Clinical Advisor
	Diane Hampshire	Registered Nurse
	Stephen Hardy	Lay Member (Deputy Chair)
	Richard Hindley	Lay Member (Chair)
	Mr Hany Lotfallah	Secondary Care Specialist
	Jonathan Webb	Chief Finance Officer
In Attendance:	Dominic Blaydon	Associate Director for Commissioning and Integrated Primary Care
	Hilary Craig	Acting Head of Primary Care Co-Commissioning
	Natalie Knowles	Primary Care Support Manager (item 58 only)
	Anna Ladd	NHS England Representative
	Amrit Reyat	Governance and Board Secretary
	Richard Sloan, MBE	Healthwatch representative
	Pam Vaines	Minute Taker

19/050 Apologies

Apologies were received from Suzannah Cookson, Anna Hartley, Cllr Faith Heptinstall, Karen Parkin, Chris Skelton, Ruth Unwin and Richard Watkinson

19/051 Declarations of Interest

There were no declarations of interest made.

19/052 (a) Minutes of the meeting held on 21 May 2019

The minutes from the meeting held on 21 May 2019 were agreed as an accurate record subject to clarification on item 19/034 that patient transport was one of several factors, not the only issue, taken into consideration in the closure of Wrenthorpe branch surgery.

(b) Action sheet from the meeting held on 21 May 2019

The action sheet was noted.

19/053 Matters Arising

There were no matters arising discussed.

19/054 Primary Care Strategy Update

Dominic Blaydon delivered a presentation to support the paper.

The Primary Care Strategy was approved six months ago. The strategy update demonstrated significant progress against the priorities of the plan.

Priority 1: Supporting General Practice Resilience. The joint working relationship between Conexus and the Resilience Academy has been established. Training programmes have been developed, including social prescribing. A workforce analysis exercise for general practice in Wakefield has taken place.

Priority 2: Primary Care Home. Wakefield practices have been divided into seven Primary Care Homes, (also known as Primary Care Networks) all have which have leadership teams in place. Robust governance arrangements are being developed. Partners and patients are actively engaged. Work is underway to provide support for care homes and to develop the new pharmacy model.

Priority 3: Personalisation. A Social prescribing model has been defined and agreed and is being extending into networks. Memorandums of Understanding have been signed off between Live Wall and the Primary Care Homes (PCH).

Priority 4: Access to specialist services. It was noted that this priority is complex and is currently in the early stages of development. Work has begun to align the Connecting Care Hubs and primary care. Discussions are taking place with the Local Authority to align children's services and Early Health Hubs with Primary Care Homes.

Two workshops have taken place involving practice nurses and district and community nurses to discuss service delivery and closer working relationships. The next workshop has been arranged for early October 2019.

Dominic Blaydon identified the Resilience Academy, Conexus, Connecting Care Hubs, Public Health and The Network Contract as key enablers for this work.

Stephen Hardy sought clarity regarding the progress since May 2019 towards involving patent groups in the governance of the Primary Care Homes, in line with national guidance. Dominic Blaydon commented that a Network Patient Participation Group (PPG) had raised this issue recently and NHS Wakefield CCG acknowledged that more work needed to be carried out in this area. The Probity Committee will be informed of future developments.

Dr Connor acknowledged that patient groups had regularly been involved in other aspects of Primary Care development; however governance arrangements had only recently begun.

Mel Brown explained that the legal aspects involved in establishing PCHs had been the main priority. This aspect had been finalised at the end of June and work had then been commenced to progress patient involvement in the governance of

PCHs. The process has to be mindful of commercial and financial sensitivities whilst ensuring that patient involvement is meaningful. Stephen Hardy suggested that this concern could be addressed though a conflict of interest process.

Richard Hindley commented on the success of developing and implementing the Primary Care Strategy. He asked whether there had been any early indications of the challenges now faced.

Dr Connor commented that the Wakefield's general practices had been making progress in this direction for some time as networks, federations and vanguards. However, the scale of this change had been substantial and general practice was now taking on greater health and care system responsibilities through the NHS Long Term plan although individual practices and networks of practices remain fragile. NHS Wakefield CCG will continue to support the required changes. New guidance from NHS England continues to be provided and followed.

Dominic Blaydon commented that the impact of governance on partner organisations had been greater than anticipated. In view of the evolving nature of the Networks, care has been taken not to overload the system. Development of the system will continue to be monitored.

It was **RESOLVED** that:
The Probity Committee noted the progress made on implementation of the Primary Care Strategy.

19/055 Primary Care Networks Update

Hilary Craig explained the paper was to provide assurance that the additional registration information submitted by the seven Primary Care Networks (PCNs) was compliant with the requirements of the Network Contract Directed Enhanced Service (DES) which was approved in May 2019.

Hilary Craig confirmed that all PCNs had carried out and submitted baseline assessments. All extended hours and DES requirements were met and PCNs have confirmed compliance by 30 June 2019. Relevant data sharing agreements are in place.

This work was carried out using locally developed templates as NHS England did not publish their guidance until August. National templates have now been shared with all practices.

Mel Brown thanked the team for carrying out this significant piece of work within a tight timescale and shared with the Committee that NHS Wakefield CCG's approach to developing Primary Care Networks was presented to Kings Fund and has also been shared by NHS England. The primary care team are developing Primary Care Home case studies to be shared with NHS England and a stakeholder event has been delivered in April 2019 to demonstrate the work undertaken. The event is expected to have approximately 70 attendees at the stakeholder discussion.

Jonathan Webb commented on the mapping of workforce and asked whether the

issue of the innovative funding of roles such as clinical pharmacists could become a risk to NHS Wakefield CCG in future.

Dr Connor responded that this was a complex area and that NHS England guidance was evolving. Areas which had piloted workforce changes, such as clinical pharmacists, are currently locked into current funding and skillmix arrangements and this will need to evolve too.

The Committee were reminded that the clinical pharmacy in clinical practice posts were initially for a two year contract which was not attractive to all potential employees. As staff have moved from these roles, it has not always been possible to fill vacancies and now that all the Networks aim to have staff in this post, it may be necessary to consider other staffing options. One option may be to consider whole time equivalent at district level not network level. Dr Connor raised concerns that staffing gaps could impact on the ability of Practices to recruit to other roles. Further guidance regarding the governance of this role has been sought.

Dominic Blaydon assured the Committee that lessons had been learned and will be applied to the roll-out of other schemes, such as physiotherapy.

Anna Ladd provided assurance that NHS England recognised the need to look at rotational models when rolling-out to other schemes which worked at scale not just places.

Jonathan Webb commented that as an organisation involved in the development of new scheme, there were concerns regarding a potential loss of funding when schemes move to a national scale. Anna Ladd stated that NHS England are aware of the concerns.

It was **RESOLVED** that:

i. The Probity Committee received assurance in regards to the implementation of the Network Contract Directed Enhanced Service (DES) including;
    a. Noting the completion of Full Network DES Agreement – inclusive of the development of the Network Agreement schedules 1-7
    b. Noting the workforce base line survey for the 5 additional roles has been completed and submitted within the NHSE timescales
    c. Confirming the Network coverage of required Network Extended Hours and that all Network DES contract requirements will be fulfilled by the network and signatory members.

ii. The Probity Committee noted the interim arrangements in regards to the data sharing agreement until the national data sharing template is available.

19/056 Wrenthorpe Branch Closure – Assurance Report

Dominic Blaydon reminded the Committee that the closure of Wrenthorpe Branch in September 2019 had been made in view of the difficulties the Practice faced in providing an equitable service across the two sites, the clinical risks faced and the physical restrictions regarding the Wrenthorpe building.

The Practice had agreed to provide patient transport to assist local residents to access the main Practice. In May 2019 the Practice made a formal request to cancel the transport scheme in view of the low uptake by patients.

Dominic Blaydon assured the Committee that there had been no indication of any issues following the branch closure or the cancellation of the transport scheme. Following the branch closure the Practice has taken part in the national patient satisfaction review and the overall level of satisfaction with the practice has increased. The review also showed an improvement of the ease of telephone and appointment access. The Patient Participation Group had also recognised the improved situation regarding home visits.

Mel Brown reminded the Committee that the decision to approve the branch closure was based on a number of factors including increased clinical support to enable more patient appointments to be made available. The Practice now has more GPs and AWPs in place. Feedback from patients regarding the AWP model of home visits has been positive. Transport was one of the factors considered.

The Overview and Scrutiny Committee (OSC) had considered the matter in June and September 2019. NHS Wakefield CCG had agreed that OSC can signpost any local elected member queries directly to them. OSC agreed to close the matter.

Richard Sloan asked whether the Practice list had changed since the branch closure and was assured that the changes were small in relation to the practice size. (An increase of 100 patients out of a 13,000 list)

Diane Hampshire commented that the branch closure discussion had been a good and thorough piece of work with a lot of appropriate scrutiny.

It was **RESOLVED** that:

i. The Probity Committee considered the queries and views of Wakefield's Adult Services, Public Health and NHS Overview and Scrutiny Committee
ii. The Probity Committee considered the additional information provided by the practice
iii. The Probity Committee considered collectively all the information outlined in this report to progress from a decision in principle to full sign off from the committee for the cessation of the patient transport service at the practice.

19/057 GP Care Wakefield Update - Presentation

Dr Omar Alisha and Trisha Lang from Conexus Healthcare attended the Committee to provide an update to the GP Care Wakefield scheme.

The scheme supports the GP extended primary care opening hours across Wakefield and supplements the 111 service, allowing patients to access GP services at evenings and weekends for 'one off' health related issues.

Patients using the scheme will receive advice from a local clinician who has full access to their primary care medical records. Face to face appointments with a GP or ANP are available at Trinity Medical Centre and at Pontefract General Hospital.

(Provided by Conexus and Local Care Direct respectively).

The scheme allows GPs and 111 to arrange out of hours appointments and for patients calling the scheme to be given an appointment with their GP practice where appropriate.

Patients can ring their own practice and are automatically diverted to call centre run by nurses who have access to patient record. The scheme is designed for same day appointments for routine care for conditions not requiring continuity of care. The scheme has recently been extended to offer health checks and blood tests.

The clinical advisors have had 32,000 telephone conversations with patients. Feedback has been very positive with 99% of people who completed feedback cards indicating that they are likely or extremely likely to recommend the service.

GP Care Wakefield is the first out of hours service to be reviewed by the CQC and obtained an outcome of 'Good'. The scheme was the HSJ workforce efficiency winner in 2018.

The team will focus on improving marketing to increase usage of the scheme in future, including a 'talk before you walk' publicity campaign.

In response to questions from Committee Members, Dr Alisha explained that the scheme allows GP practices to manage their same-day demand and ensure a more seamless service for patients and this allows better planning of routine capacity in general practices for problems requiring continuity of care.

It is not clear how many A&E attendances have been prevented by the use of the scheme but Conexus do hold data to show how many patients are referred back to their GP. This information will be shared with the Primary Care Team.

Jonathan Webb commented that the GP Care Wakefield scheme is a valuable service but that work is still required to ensure that the various out of hours schemes work together to the benefit of local people and that the various access routes are clearly understood by local people.

Mel Brown thanked Dr Alisha and Trish Lang for their presentation and congratulated them on the CQC results which have rated the provider as Good.

It was **RESOLVED** that:

i. The Probity Committee noted the contents of the presentation

19/058 Annual General Practice Network Assurance Visits

Natalie Knowles explained that annual practice visits are a mechanism for engaging with practice and for NHS Wakefield CCG to gather information and address issues.

The meetings had previously been held at GP level; however this year they have been held with Networks to offer practices the opportunity to engage with each

other as well as the CCG to share learning across Networks. Representatives from the Medicines Optimisation team now take part in the visits.

Areas of discussion at the Annual Assurance Visits include quality, patient experience, friends and family results and feedback from the Quality Intelligence Group (QIG). Discussions include learning disabilities, lessons learned, immunisations, the Wakefield Practice Premium Contract, Primary Care Homes and prescribing issues.

Any issues or concerns will now be raised separately with a practice and will not form part of the annual assurance visits. Dr Connor advised that resilience and staffing issues would not be discussed; however practices will continue to be held accountable.

Stephen Hardy questioned whether holding the visits at Network level would allow peer pressure to increase standards, for example around health-checks for people with learning disabilities. Natalie Knowles confirmed that this was the expectation and one of the aims of the visits.

Jonathan Webb commented that the Memorandum of Understanding may need to be changed to reflect the current situation and ensure mutual accountability. He cautioned that the time management of the visits would be vital.

It was **RESOLVED** that:

i. The Probity Committee received the annual practice assurance meeting proposal for 2019/20
ii. The Probity Committee received a further report on the practice visits undertaken in 2019/20

19/059 Matters to be referred to other committees or Governing Body

The following papers are to be referred to other Committees:

i. The minutes of this meeting to be shared with the Governing Body.
ii. Primary Care Strategy and Primary Care Network reports will be shared with the Senior Leadership Team.

19/060 Any Other Business

No items were raised.

19/061 Date and Time of Next Meeting

Tuesday 26 November 2019, 3pm, Seminar Room, White Rose House

Agenda item: 3ii

NHS Wakefield Clinical Commissioning Group

ACTION POINTS FROM PROBITY COMMITTEE
HELD ON 24 SEPTEMBER 2019

Minute No	Topic	Action required	Who	Date for completion	Progress
	No actions identified				

NHS Wakefield Clinical Commissioning Group

Title of meeting:	**Probity Committee**	**Agenda Item:**	**5i**
Date of Meeting:	**26 November 2019**	**Public/Private Section:**	
		Public	✓
		Private	
Paper Title:	**Contract Variations**	N/A	
Purpose (this paper is for):	Decision		Discussion		Assurance	✓	Information	✓

Report Author and Job Title:	**Hilary Craig, GP Practice Manager Consultant**
Responsible Clinical Lead:	**Dr Greg Connor, Executive Clinical Lead**
Responsible Governing Board Executive Lead:	**Mel Brown, Commissioning Director for Integrated Care**

Recommendation (s):

It is recommended that Probity Committee

- Note the contents of this report

Executive Summary:
The paper is to notify the Probity Committee of a change in arrangements for signing of GP GMS/PMS Contract variations with effect from 1 November 2019. Contract variations will now be signed by Mel Brown; Commissioning Director for Integrated Care at Wakefield CCG.

Link to overarching principles from the strategic plan:

Reduction in hospital admissions where appropriate leading to reinvesting in prevention	
New Accountable Care Systems to deliver new models of care	
Collective prevention resource across the health and social care sector and wider social determinant partners	
Expanded Health and Wellbeing board membership to represent wider determinants	
A strong ambitious co-owned strategy for ensuring safe and healthy futures for children	
A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health	
Transforming to become a sustainable financial economy	
Organising ourselves to deliver for our patients	✓

Outcome of Integrated Impact Assessment completed (IIA)	Not applicable.
Outline public engagement – clinical, stakeholder and public/patient:	Not applicable.
Management of Conflicts of Interest:	Not applicable.
Assurance departments/ organisations who will be affected have been consulted:	Not applicable.
Previously presented at committee / governing body:	Not applicable.
Reference document(s) / enclosures:	Not applicable.
Risk Assessment:	Not applicable.
Finance/ resource implications:	To be determined depending on national changes to GP contracts

NHS WAKEFIELD CCG

PROBITY COMMITTEE

GP CONTRACT VARIATIONS

Purpose

The purpose of this report is to notify the Probity Committee of a change in arrangements for signing of GP GMS/PMS Contract variations. Responsibility for this process will transfer from NHS England to Wakefield CCG.

Background

Wakefield CCG will be responsible for signing GP GMS/PMS Contract Variations with effect from the 1st November 2019. Contract variations will now be signed by the Mel Brown; Commissioning Director for Integrated Care.

This aligns with the legal guidance for CCGs with delegated responsibility for Primary Medical Services. Practices will complete the NPL3 form and submit to PCSE. An email will be sent to NHS England to notify the change to the practice partnership. This will then be sent to the Primary Care Team at the CCG to manage the application process.

Variations to contracts fall broadly within four categories:

1) changes due to legislation of regulatory changes;
2) changes due to the contracting party;
3) changes to services; or
4) changes to the payment arrangements.

The Primary Care Team will be responsible for verifying that contract variations comply with guidance set out in the Primary Medical Policy and Guidance Manual; and for providing assurance to the Commissioning Director for Integrated Care, prior to signature.

An application process to vary a GMS/ PMS contract has been developed and is attached.

Recommendations

It is recommended that the Probity Committee;

- Note the contents of this report

Hilary Craig
GP Practice Manager Consultant
11 November 2019

NHS Wakefield Clinical Commissioning Group

Title of meeting:	**Probity Committee**	**Agenda Item:**	**5ii**
Date of Meeting:	**26 November 2019**		
Paper Title:	**WAKEFIELD PRACTICE PREMIUM CONTRACT 2019/2020 MID YEAR PERFORMANCE REPORT**		

Public/Private Section:	
Public	
Private	✓
N/A	

Purpose (this paper is for):							
Decision		Discussion		Assurance	✓	Information	✓

Report Author and Job Title:	**Natalie Knowles, Primary Care Support Manager**
Responsible Clinical Lead:	**Dr Greg Connor, Executive Clinical Lead**
Responsible Governing Board Executive Lead:	**Mel Brown, Commissioning Director for Integrated Care**

Recommendation (s):

It is recommended that Probity Committee

- Note the progress in regards to performance against the Wakefield Practice Premium contract up to Quarter 2.

Executive Summary:

In May 2019, the Probity Committee agreed to the terms of the Wakefield Practice Premium Contract for 2019/2020 following an extensive review of the previous contract. Given the financial context and feedback from commissioners and providers a new contract was agreed with the aims of;

- focus on improving patient care
- exceed core contract requirements and national achievement levels
- build on what works
- minimise bureaucracy for practices and the CCG
- make workload proportional to available funding

The purpose of this report is to set out the progress made since this contract was agreed and the performance of practices to date, to provide assurance in regards to KPI delivery and contract monitoring.

Link to overarching principles from the strategic plan:	Reduction in hospital admissions where appropriate leading to reinvesting in prevention	
	New Accountable Care Systems to deliver new	

	<table><tr><td>models of care</td><td></td></tr><tr><td>Collective prevention resource across the health and social care sector and wider social determinant partners</td><td></td></tr><tr><td>Expanded Health and Wellbeing board membership to represent wider determinants</td><td></td></tr><tr><td>A strong ambitious co-owned strategy for ensuring safe and healthy futures for children</td><td></td></tr><tr><td>A shift towards allocation of resources based upon primary and secondary prevention and social determinants of ill health</td><td></td></tr><tr><td>Transforming to become a sustainable financial economy</td><td></td></tr><tr><td>Organising ourselves to deliver for our patients</td><td>✓</td></tr></table>
Outcome of Integrated Impact Assessment completed (IIA)	Not applicable.
Outline public engagement – clinical, stakeholder and public/patient:	Not applicable.
Management of Conflicts of Interest:	Not applicable.
Assurance departments/ organisations who will be affected have been consulted:	Not applicable.
Previously presented at committee / governing body:	Not applicable.
Reference document(s) / enclosures:	Not applicable.
Risk Assessment:	Not applicable.
Finance/ resource implications:	Not applicable

NHS WAKEFIELD CCG

PROBITY COMMITTEE

WAKEFIELD PRACTICE PREMIUM CONTRACT 2019/2020 MID YEAR PERFORMANCE REPORT

Introduction & Context

In May 2019, the Probity Committee agreed to the terms of the Wakefield Practice Premium Contract for 2019/2020 following an extensive review of the previous contract. Given the financial context and feedback from commissioners and providers a new contract was agreed with the aims of;

- focus on improving patient care
- exceed core contract requirements and national achievement levels
- build on what works
- minimise bureaucracy for practices and the CCG
- make workload proportional to available funding

The total investment under this contract is £1.62m for a 12 month period, reduced from £3.2m in 2016-18.

Purpose

The purpose of this report is to set out the progress made since this contract was agreed and the performance of practices to date, to provide assurance in regards to KPI delivery and contract monitoring.

Contractual Performance

Access Domain

All practices are working towards the requirements under this domain. The practices were asked to complete an audit to demonstrate same day clinical triage within 4 hours. 34 practices have provided evidence to demonstrate this by undertaking an audit in Q1. There were some practices that did not provide a 4 hour triage, however assurance was gained that if a patient required an appointment they would be seen on the same day.

Twenty six practices achieved 30/30. Some practices that achieved 25/30 or less are smaller practices within the district. We have cross referenced the responses from the patient survey and are assured patient care has not been affected. Practices that have achieved below 25/30, and whose results are below the CCG average in the GP patient survey, have been identified to meet with the CCG to discuss action plans on improving access to same day clinical triage. (Please see table 1 in appendix)

The Access 4 requirement states the practice should provide a range of nursing procedures to their practice population. These procedures are B12 injections, suture removal, wound care, ear irrigation, phlebotomy, spirometry, ECG. Assurance has

been gained practices are working to provide these services and to achieve within 15% of their baseline by year end.

Learning Disabilities Domain

In regards to learning disabilities, practices approach this in different ways; the majority of practices have a plan in place to ensure the LD health checks are completed by year end. We are monitoring the LD health check performance with 47% of practices on target to complete 75% of LD health checks by year end. The CCG has had assurance from remaining practices they have the appropriate plans in place to achieve the required target by the end of the financial year. Support has also been offered to practices from the Strategic Health Facilitation Lead and information provided to support the delivery of high quality health checks. New guidance has been published to support the quality of health checks and we will work with the practices in order to implement the new guidance.

SMI Mental Health Checks

The requirement under this domain focuses on ensuring patients on the GP SMI QOF register receive a full and comprehensive physical health check ensuring all 6 elements set out in the contract are completed. There are 2372 patients across the district on the SMI register. At Q2, 710 (30%) checks had been completed of those 710, 42% (297) had received all 6 elements. The CCG is working with the practices to ensure when checks are completed all six are included. The areas which need specific attention are blood lipid testing, HBa1c and BMI.

Cancer Domain

All practices are contacting patients who have failed to respond to invitations from the national screening programme. At Q2, 67% (24) of practices had invited 80% or more of their patients who had failed to respond to the national screening programme. This will be a rolling programme based on the responses received by practices from the screening programme.

Diabetes Domain

The requirements in the diabetes domain focus on prevention. As part of the contract, practices are required to refer their patients with Non Diabetic hyperglycaemia to the NHS England National Diabetes Prevention Programme. 75% of practices are referring more than 50% of patients within this cohort to the National Diabetes Prevention Programme. Also within the diabetes domain practices are required to provide the 8 care processes to patients on their diabetic register. There are 24,064 patients on the diabetes register at Quarter 2. The practices are required to improve on their 2018/2019 baseline, at mid-year 58% of practices are on target to exceed their March 2019 baseline.

Heart Domain

58% of practices in Wakefield are treating above 90% of their male patients who are at increased risk of strokes with anticoagulant therapies, with the aim of reducing the risk; we expect this to increase to 95% by year end. Evidence shows patients that are on the appropriate treatment have a lower risk of stroke. It is important to note

that female patients are already treated through the quality and outcomes framework.

33% of practices are providing Q-Risk assessments on 80% and above of their newly diagnosed hypertensive patients, of those with a risk score of >10% over the next 10 years, 36% of practices are treating 80% or higher of patients with a statin. Our aim is for all practices to increase their uptake to above 80% by year end of newly diagnosed hypertensive patients receiving a Q-Risk and then being treated with a statin. Each practice will be sent the remaining work to do list for this domain so we can gain assurance the target will be achieved by year end.

71% of newly diagnosed hypertensive patients have had an assessment of risk in regards to cardiovascular disease, of those patients with a risk score of >10% over the next 10 years, 49% of patients have been treated with a statin. Our aim is to increase this uptake to 80% consequently reducing cardiovascular disease. The number of patients newly diagnosed increased from quarter 1 to quarter 3 by 20%.

Respiratory Domain

The CCG is working closely with Public Health colleagues in regards to consistency of spirometry diagnosis. For this indicator, those practices with spirometry results which required further assessment have been contacted and given additional support in conjunction with a Respiratory consultant from The Mid-Yorkshire Hospitals NHS Trust.

Practices are required to ensure that patients on the COPD registers have a spirometry recording consistent with diagnosis. There are a few exceptions to this but should be documented with an appropriate rationale. From Q1 to Q2 there has been a small reduction of patients on the COPD register, some practices list have been increasing due to coding given by secondary care. There are discussions ongoing to support the diagnosis coding between Primary and Secondary Care. Practices have been contacted to ensure they are following the requirements in this domain and have been offered support to further reduce the number of patients with an inconsistent diagnosis of COPD.

In regards to the Respiratory 2 requirement, the contract focuses on patients at-risk of asthma under this requirement and requires them to be contacted for a review, 33% of practices have invited more than 60% of their at risk asthma patients for a review, with 30% of practices having completed 50% or more reviews on their at risk population. We are expecting all practices will have invited 100% of their at risk patients with 75% completing a review by year end.

KPI Management

Under the terms of the contract there are three KPIs which make up 10% of the contract value. These are;

KPI	Requirement	Value	Submission
KPI001 - LD1	The practice provides a learning disabilities health check to 75% of patients on the learning disabilities register.	5%	April 2020
KPI002 –	The practice ensures that those	5%	April 2019

Enhanced Mental Health Checks	patients on their GP SMI QOF (MH002) register receive a full and comprehensive health check.		

For payment for the delivery of KPIs, practices will be required to demonstrate that each KPI has been achieved by the submission dates listed above. Each KPI has a weighted value which will correspond to the payment received where practices successfully achieve the KPIs as shown above.

KPI001 – The number of Learning Disabilities health checks completed in Q1 to Q2 is included as appendix A. There has been an increase of 25% from the 2018/2019 target from 50% to 75%. The CCG and the Strategic Health Facilitation Lead is working closely with practices to ensure they are on track to meet the 75% target by year end. In addition, some practices have small register numbers and historically complete all checks in Q4; this is taken into context when reviewing provider performance.

KPI002 – The number of Enhanced Mental Health Checks complete in Q1-Q2 is included as appendix B. Practices are required to complete all 6 elements in order to achieve the KPI. The CCG are working with practices to ensure they are completing the required elements so patients are receiving a full and comprehensive health check.

Contract Management

In addition to the reporting and KPIs the standards under the Wakefield Practice Premium Contract are discussed during our Network Assurance visits. This includes those areas of the contract where practices are performing well and areas for further development. Where necessary, the primary care team will agree with providers an action plan to ensure improved performance.

Recommendations

It is recommended that Probity Committee;

- Note the progress in regards to performance against the Wakefield Practice Premium contract up to Quarter 2.

Natalie Knowles
24/10/2019

Practices	Access 3 Submission	/30
TRINITY MEDICAL CENTRE	YES	30/30
ALVERTHORPE SURGERY	YES	24/30
ASH GROVE SURGERY	YES	29/30
CASTLEFORD MEDICAL PRACTICE	YES	30/30
CHAPELTHORPE MEDICAL CENTRE	YES	30/30
CHURCH STREET SURGERY	YES	30/30
COLLEGE LANE SURGERY	YES	30/30
CROFTON HEALTH CENTRE	YES	30/30
DR SINGH AND PARTNERS	YES	30/30
DRS DIGGLE AND PHILLIPS	YES	27/30
EASTMOOR HEALTH CENTRE	No	
HEALTH CARE FIRST PARTNERSHIP	YES	30/30
FRIARWOOD SURGERY	YES	30/30
HENRY MOORE CLINIC	YES	30/30
HOMESTEAD CLINIC	YES	27/30
KINGS MEDICAL PRACTICE	YES	30/30
LUPSET HEALTH CENTRE	YES	30/30
MAYBUSH MEDICAL CENTRE	YES	30/30
MIDDLESTOWN MEDICAL CENTRE	YES	30/30
NEW SOUTHGATE SURGERY	YES	30/30
NEWLAND LANE SURGERY	YES	30/30
NORTHGATE SURGERY	YES	30/30
ORCHARD CROFT MEDICAL CENTRE	YES	30/30
OUTWOOD PARK MEDICAL CENTRE	YES	30/30
PATIENCE LANE	YES	27/30
PROSPECT SURGERY	No	
QUEEN STREET SURGERY	YES	30/30
RIVERSIDE MEDICAL CENTRE	YES	30/30
St. THOMAS ROAD	YES	23/30
STANLEY HEALTH CENTRE	YES	22/30
STATION LANE MEDICAL CENTRE	YES	30/30
STUART ROAD SURGERY	YES	30/30
THE GRANGE SURGERY	YES	29/30
TIEVE TARA MEDICAL CENTRE	YES	30/30
WARRENGATE	YES	30/30
WHITE ROSE SURGERY	YES	30/30

The above table shows which practices submitted the Quarter 1 Access Audit. Practices were asked to audit 30 same day triage calls, the final column shows how many patients met the 4 hours same day appointment target.

Appendix A – KPI001 Learning Disabilities Health Check Performance

This table shows the LD patients on practices register, how many checks were delivered in Quarter 1&2 and how many checks are left to do in order to meet the practices end of year 75% target. The practices in green are on target, the practices in yellow are over 30% and the practices in red are under 30% of checks completed. We have contacted all practices under 30% to seek assurance plans are in place to meet the year-end target.

Practice	Register	Q1	Q2	Q3	Q4	Latest Percent	To Meet Year End Target
White Rose Surgery	267	99	53	0	0	57.14%	48
Alverthorpe Surgery	13	2	0	0	0	15.38%	8
Station Lane Medical Centre	62	11	12	0	0	37.70%	24
Newland Lane Medical Centre	18	0	5	0	0	27.78%	9
Middlestown Medical Centre	17	4	1	0	0	27.78%	8
Orchard Croft Medical Centre	27	9	0	0	0	31.03%	11
College Lane Surgery	47	6	22	0	0	60.87%	7
Warrengate Medical Centre	52	7	14	0	0	39.62%	18
Riverside Medical Centre	89	0	23	0	0	25.00%	44
Dr Singh And Partners	76	2	36	0	0	53.52%	19
Northgate Surgery	51	0	13	0	0	25.49%	25
Lupset Health Centre	90	14	13	0	0	29.03%	41
St. Thomas Road Surgery	71	4	2	0	0	8.11%	47
Friarwood Surgery	40	9	5	0	0	35.90%	16
Maybush Medical Centre	53	4	19	0	0	43.40%	17
Outwood Park Medical Centre	44	7	12	0	0	42.22%	14
Stuart Road Surgery	84	4	20	0	0	41.38%	39
Trinity Health Centre	114	4	10	0	0	12.07%	72
Henry Moore Medical Centre	59	0	8	0	0	13.33%	36
Stanley Health Centre	62	2	2	0	0	6.35%	43
Chapelthorpe Medical Centre	68	6	9	0	0	21.13%	36
Ash Grove Surgery	71	41	4	0	0	65.22%	8
Homestead Medical Centre	104	15	29	0	0	43.56%	34
Castleford Medical Practice	48	3	1	0	0	8.00%	32
The Grange Medical Centre	65	1	10	0	0	16.42%	38
New Southgate Surgery	58	8	8	0	0	26.67%	28
Crofton Health Centre	42	1	1	0	0	4.65%	30
Healthcare First Partnership	69	3	2	0	0	6.67%	47
Church Street Health Centre	71	11	10	0	0	32.31%	32
Drs Diggle And Phillips	35	8	4	0	0	35.29%	14
Kings Medical Practice	51	11	6	0	0	34.69%	21
Prospect Surgery	43	10	7	0	0	38.64%	15
Tieve Tara Medical Centre	41	5	5	0	0	25.00%	21
Queen Street Surgery	2	0	0	0	0	0.00%	2
Patience Lane Surgery	7	3	0	0	0	33.33%	2
Eastmoor Health Centre	18	0	0	0	0	0.00%	14

SMI Enhanced Mental Health Check reviews

MH Plus 1	Register	BP	Blood Lipid	Glucose	Alcohol	Smoking	BMI	All Six	Had Review	% completed
Alverthorpe Surgery	23	5	2	2	5	5	4	2	**6**	**33%**
Ash Grove Surgery	52	13	10	12	17	16	7	6	**19**	**32%**
Castleford Medical Practice	40	13	8	8	15	13	8	5	**16**	**31%**
Chapelthorpe Medical Centre	84	18	13	11	14	15	15	8	**34**	**24%**
Church Street Health Centre	96	34	34	31	33	34	30	28	**35**	**80%**
College Lane Surgery	41	13	8	8	13	12	11	8	**14**	**57%**
Crofton Health Centre	34	11	10	10	11	11	11	10	**11**	**91%**
Dr Singh And Partners	67	16	18	14	17	16	15	12	**18**	**67%**
Drs Diggle And Phillips	23	5	4	4	4	7	6	2	**10**	**20%**
Friarwood Surgery	62	22	11	17	22	18	17	9	**22**	**41%**
Healthcare First Partnership	138	11	7	8	10	11	10	7	**12**	**58%**
Henry Moore Medical Centre	45	18	6	7	18	13	7	4	**19**	**21%**
Homestead Medical Centre	44	10	7	7	12	11	9	5	**12**	**42%**
Kings Medical Practice	79	4	3	3	6	5	3	3	**6**	**50%**
Lupset Health Centre	136	55	58	41	65	67	67	36	**69**	**52%**
Maybush Medical Centre	58	26	24	21	24	26	26	20	**26**	**77%**
Middlestown Medical Centre	36	14	6	6	12	16	12	6	**16**	**38%**
New Southgate Surgery	88	41	25	23	38	36	33	14	**43**	**33%**
Newland Lane Medical Centre	33	9	6	7	6	7	8	4	**14**	**29%**
Northgate Surgery	79	23	17	18	19	25	18	9	**30**	**30%**
Orchard Croft Medical Centre	72	31	28	29	29	31	28	23	**40**	**58%**
Outwood Park Medical Centre	81	18	18	18	18	19	18	18	**19**	**95%**
Park View Surgery	15	1	1	1	2	2	1	1	**2**	**50%**
Patience Lane Surgery	9	3	2	2	3	3	2	2	**3**	**67%**
Prospect Surgery	38	5	5	5	1	5	0	0	**8**	**0%**
Queen Street Surgery	7	0	0	0	0	0	0	0	0	0%
Riverside Medical Centre	91	6	4	6	5	8	3	2	**13**	**15%**
St. Thomas Road Surgery	54	7	3	3	4	9	5	3	**16**	**19%**
Stanley Health Centre	48	8	6	4	7	7	7	4	**12**	**33%**
Station Lane Medical Centre	51	24	14	18	19	19	14	7	**30**	**23%**
Stuart Road Surgery	57	7	2	4	8	6	6	2	**8**	**25%**
The Grange Medical Centre	66	7	5	4	7	7	6	4	**9**	**44%**
Tieve Tara Medical Centre	36	6	6	6	6	6	6	6	**6**	**100%**
Trinity Health Centre	210	21	15	16	20	21	16	10	**28**	**36%**
Warrengate Medical Centre	72	14	8	10	16	16	15	6	**17**	**35%**
White Rose Surgery	181	39	17	27	35	32	32	9	**59**	**15%**
Eastmoor Health Centre	26	6	5	6	5	5	4	**2**	**8**	**25%**
Grand Total	**2372**	**564**	**416**	**417**	**546**	**560**	**480**	**297**	**710**	**42%**

The above table shows how many patients are on the SMI mental health register, how many checks have been completed with all 6 elements. The green highlighted in the final column is the practices who have achieved above 90% of checks completed with all 6 elements.

NHS Wakefield Clinical Commissioning Group

Title of meeting:	**Probity Committee**	**Agenda Item:**	**6i**
Date of Meeting:	**26 November 2019**	**Public/Private Section:**	
		Public	✓
		Private	
Paper Title:	**Probity Committee Terms of Reference**	N/A	

Purpose (this paper is for):							
Decision		Discussion	✓	Assurance		Information	

Report Author and Job Title:	**Amrit Reyat, Governance & Board Secretary**
Responsible Clinical Lead:	**Not applicable**
Responsible Governing Board Executive Lead:	**Ruth Unwin, Associate Director Corporate Affairs**

Recommendation:
Members of the committee are invited to:

i. Note the proposed change of name and terms of reference.

Executive Summary:

The Governing Body of 12 November 2019 approved a revised draft Constitution to bring NHS Wakefield CCG in line with the new model constitution set by NHS England.

The revised Constitution will require formal approval by the GP membership in line with the current Constitution and Standing Orders.

The revised Constitution includes a change of focus for the Probity Committee, including a change of title to Primary Care Commissioning Committee and amended Terms of Reference to support the work to be undertaken. The Terms of Reference show track-changes for ease of reference.

Link to overarching principles from the strategic plan:

Reduction in hospital admissions where appropriate leading to reinvesting in prevention	
New Accountable Care Systems to deliver new models of care	
Collective prevention resource across the health and social care sector and wider social determinant partners	
Expanded Health and Wellbeing board membership to represent wider determinants	
A strong ambitious co-owned strategy for ensuring safe and healthy futures for children	
A shift towards allocation of resources based upon	

	<table><tr><td>primary and secondary prevention and social determinants of ill health</td><td></td></tr><tr><td>Transforming to become a sustainable financial economy</td><td></td></tr><tr><td>Organising ourselves to deliver for our patients</td><td>✓</td></tr></table>
Outcome of Integrated Impact Assessment completed (IIA)	None required.
Outline public engagement – clinical, stakeholder and public/patient:	Not applicable.
Management of Conflicts of Interest:	None identified.
Assurance departments/ organisations who will be affected have been consulted:	All Committees will be consulted about their terms of reference following the approval of the new Constitution.
Previously presented at committee / governing body:	Not applicable
Reference document(s) / enclosures:	Terms of Reference for Probity Committee including proposed amendments
Risk Assessment:	A primary function of the Governing Body is to ensure that the CCG has made appropriate arrangements for ensuring that it complies with principles of good governance. This assurance that all committees are operating in accordance with terms of reference.
Finance/ resource implications:	None identified.

TERMS OF REFERENCE FOR THE NHS WAKEFIELD CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE	
Accountability arrangements and authority	The Governing Body for NHS Wakefield Clinical Commissioning Group (CCG) hereby resolves to establish a committee of the Governing Body to be known as the Primary Care Commissioning Committee in line with NHS Wakefield CCG's constitution. The Primary Care Commissioning Committee will operate within the legal framework for NHS Wakefield CCG. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions to NHS Wakefield CCG. The Governing Body has determined that the Primary Care Commissioning Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers. Consequently decisions of the Committee related to these delegated functions and delegated powers cannot be over-ruled by the Governing Body. The membership, remit, responsibilities and reporting arrangements of the Primary Care Commissioning Committee are set out in these terms of reference and shall have effect as if incorporated into the CCG Constitution and Standing Orders. The Primary Care Commissioning Committee has no executive powers, other than those specifically delegated in these terms of reference or otherwise agreed by the Governing Body. The Primary Care Commissioning Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee within its remit as described in these terms of reference. The Committee has full authority to commission any reports or surveys it deems necessary to help fulfil its obligations, including legal or other independent professional advice.
Relationship and reporting	The Primary Care Commissioning Committee is a committee of the Governing Body for NHS Wakefield CCG. Minutes of meetings will be presented to the Governing Body. Reports on specific issues will also be prepared when necessary for consideration by the Governing Body and in some instances Audit Committee where appropriate. Other committees of the Governing Body for NHS Wakefield CCG will refer items to the Primary Care Commissioning Committee if it is identified that the issue presents a conflict of interest for all or the majority of GP members of the Governing Body. The Primary Care Commissioning Committee may establish groups to support it in its role (on an ongoing or short term basis). The scope and membership of those groups will be determined by the Primary Care Commissioning Committee.
Role and function	The role of the Committee is to facilitate decision making about items which present conflicts of interest for all or the majority of GP members of the Governing Body, which cannot be managed in accordance with the CCG's arrangements for management of conflicts of interest as set out in the Standing Orders..

	Specifically, the role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act and to other areas which present a conflict of interest. Specific duties of the Primary Care Commissioning Committee are categorised in the "Responsibilities" section below. In performing its role the Committee will exercise the functions in accordance with the agreement the CCG has entered into with NHS England. The work of the Committee will be flexible to new and emerging priorities and risks. The Committee will ensure that appropriate clinical engagement (including from primary care) is sought before reaching decisions. In carrying out its role and function the Committee can monitor and assure itself (including by assigning delegates or through a subgroup or committee) that any decision it has made; or any responsibility it has been delegated by the Governing Body has been carried out within best practice or to the appropriate quality or standard expected.
Responsibilities	**Conflicts of Interest for GPs** • make decisions on behalf of the Governing Body about items which present conflicts of interest for all or the majority of GP members of the Governing Body, which cannot be managed in accordance with the CCG's arrangements for management of conflicts of interest as set out in the Standing Orders. . • Make decisions in relation to commissioning, monitoring and decommissioning of services to support the development and resilience of general practice in line with the general practice strategy **Commissioning of primary medical services** • seek to increase quality, efficiency, productivity and value for money and to remove administrative barriers in primary medical services in Wakefield district; • co-ordinate a common approach to the commissioning of primary care services generally; • direct the management of the budget for commissioning of primary medical services in Wakefield district; • to plan, including needs assessment, primary medical services in Wakefield district; • undertake reviews of primary medical care services in Wakefield district; • make decisions on the review, planning and procurement of primary medical services in Wakefield district, under delegated authority from NHS England; • make decisions in relation to GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, movement by practices between GMS / PMS contracts , taking contractual action such as issuing breach/remedial notices, and removing a contract);

	• make decisions in relation to enhanced services ("Local Enhanced Services" and "Directed Enhanced Services"); • make decisions in relation to commissioning urgent care (including home visits as required) for out of area registered patients; • make decisions in relation to local incentive schemes, including the design of such schemes; • make decisions on whether to establish new GP practices (including branch surgeries) in an area; • make decisions in relation to closure of GP practices (including branch surgeries) in an area; • make decisions in relation to boundary changes and list closures in an area; • approving practice mergers • make decisions to decommission primary medical services or Local Enhanced Services; • make decisions in relation to the management of poorly performing GP practices (excluding any decisions in relation to the performers list); • make decisions in relation to Premises Costs Directions (in accordance with guidance issued by NHS England or the Secretary of State); • approve commissioning policy recommendations on the use of medicines, based on guidance from clinical cabinet, proven clinical outcomes, affordability and value for money • agree optimal tender routes and procurement method when commissioning primary care medical services; • consider co-commissioning risks and threats to the CCG referring items to the Integrated Governance Committee as required; • consider the outcome of programmes of post payment verification. **Monitoring and assurance** Seek assurance on behalf of the Governing Body in relation to the implementation of any actions, plans or policies that have been approved by the committee. ~~**Multispecialty Community Provider (MCP)**~~ **Primary Care Networks (PCN)** • Make decisions in relation to financial allocation regarding ~~the~~ Primary Care Networks ~~procurement of~~ **Other Duties** The Committee will agree an annual work plan to ensure that it covers all the duties above and undertake an annual self-assessment. The Committee may agree other areas of responsibility as appropriate with the Governing Body.
Membership	**Membership** The Committee appointments will be approved by the Governing Body on an annual basis. The membership of the Committee is given below : • Chair of the Committee (Lay Member (Deputy Chair of Governing Body)); • Lay Member – Audit

Comment [a1]: Mel asked this to be PCNs

Comment [r2]: Is this still relevant – ICP responsibility?

	• Lay Member – Patient and Public Involvement (Deputy Chair); • Director of Commissioning Integrated Health and Care • Chief Financial Officer; Deputy Chief Officer • Registered Nurse; • Secondary Care Specialist; • Executive Clinical Advisor (GP). All members of the Committee have one vote. In the event of a tied vote the Chair will hold a second and casting vote. The Chief Officer of the CCG will not be a member of the committee but will have an open invitation to attend. Nominated appropriate equivalent deputies can attend in extenuating circumstances. Nominated deputies will only be in attendance and cannot vote. Any director or senior managers may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. Other officers may be requested to attend in an advisory capacity.
In Attendance	• Healthwatch Wakefield representative; • Wakefield Health and Wellbeing Board representative; • Chief Officer – Open invitation • NHS England representative; • Head of Primary Care • Associate Directors, as appropriate; • Head of Communications • Director of Public Health; • Director of Corporate AffairsGovernance & Board Secretary • Heads of Service, as appropriate; Those in attendance do not qualify to vote. For those attending, named deputies should attend in exceptional cases only and this should be communicated to the Chair and secretary of the meeting in advance. **Members of the public and representatives of the press** Meetings of the Committee will be held in public, and members of the public and representatives of the press will be permitted to attend and observe the meeting. In accordance with the CCG's Standing Orders the public and representatives of the press shall be required to withdraw upon a resolution of members of the Committee as follows: *'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960.*
Chair	The Chair of the Committee will be the Lay Member - Deputy Chair of the Governing Body.

Comment [AP3]: Query whether DOPH needs to be in attendance should rather be a member

	The Deputy Chair of the Committee will be the Lay Member – Patient & Public Involvement.
Quoracy	The Committee shall be quorate when a minimum of four members are present. This must include a Lay Member, one Executive Director and one Clinical Member.
Frequency of meetings	There shall be appropriate flexibility as the frequency of meetings of the Committee as agreed between the Chair of the Committee and the Chair of the CCG Governing Body., but these shall normally be held Quarterly. The frequency of meeting should be such as to ensure the Committee achieves its annual work-plan.
Frequency of attendance	Members are expected to attend all meetings; however a nominated appropriate equivalent deputy can attend in extenuating circumstances. Deputies will only be in attendance.
Conduct	Members of the Committee and those in attendance at meetings will abide by the 'Principles of Public Life' and the NHS Code of Conduct, and the Standards for members of NHS boards and governing bodies, Citizen's Charter and Code of Practice on Access to Government Information. All members will have due regard to, and operate within, the prime financial policies, standing orders, the constitution and other policies and procedures of NHS Wakefield CCG.
Declaration of interests	All potential conflicts of interest will be declared and dealt with in line with the CCG's policies / procedures for handling conflicts of interest. Declarations of interest will be an agenda item at each meeting. Everyone at a meeting will be required to declare any interest they have in any agenda items as soon as it becomes apparent. The Chair will determine whether the individual will be excluded from relevant parts of meetings, or be able to join in the discussion, but not participate in the decision making itself or vote. All declarations of interest will be recorded in the minutes.
Administration	Secretariat support for the Committee will be provided by the administration function within the CCG. They will ensure that minutes of the meeting are taken and provide appropriate support to the Chair and Committee members. Duties will include: • agreement of agenda with Chair and attendees and collation of papers; • ensuring that minutes are taken and keeping a record of matters arising and issues to be carried forward; • timely distribution of papers, no later than five working days before a meeting for agenda and papers and no later than five working days after a meeting for distribution of minutes; • record of matters arising, issues to be carried forward.
Urgent matters arising between meetings	• The Chair of the Committee and Chief Finance Officer, in consultation, may also act together on urgent matters arising between meetings of the Committee; or • In the absence of the Chair, the Chief Finance Officer and a Lay

	Member, in consultation, may act together; or • The Committee has delegated a specific function within prescribed limitations to an individual, sub group or sub-committee. These matters will be ratified at the next meeting of the Committee.
Monitoring of compliance	The Governing Body will monitor the effectiveness of the Committee through receipt of the minutes and the Committee's Annual Report to the Governing Body.
Date agreed	Approved by Governing Body on
Review date and **Monitoring**	Annually, or as and when legislation or best practice guidance is updated.