NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Meeting Title	**Primary Care Commissioning Committee – meeting in public**	**Date**	**Tuesday 3 April 2018**
Meeting No.	**36.**	**Time**	**9:30am – 10:40am**
Chair	**Mr Alan Smith Independent Lay Member (and Deputy Chair of the Committee)**	**Venue / Location**	**Guthlaxton Committee Room, Leicestershire County Council, County Hall, Glenfield, Leicester, LE3 8TB.**

ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PC/18/27	Welcome and Introductions		Alan Smith	**Verbal**	9:30am
PC/18/28	To receive questions from the Public in relation to items on the agenda	To receive	Alan Smith	**Verbal**	9:30am
PC/18/29	Apologies for Absences: • Clive Wood • Dr Girish Purohit • Tim Sacks • Donna Enoux	To receive	Alan Smith	**Verbal**	9:35am
PC/18/30	Notification of Any Other Business	To receive	Alan Smith	**Verbal**	9:35am
PC/18/31	Declarations of Interest on Agenda items	To receive	Alan Smith	**Verbal**	9:40am
PC/18/32	To Approve minutes of the previous meeting of the ELR CCG Primary Care Commissioning Committee held on 6 March 2018	To approve	Alan Smith	**A**	9:40am
PC/18/33	To Receive Actions and Matters Arising following the meeting held on 6 March 2018	To receive	Alan Smith	**B**	9:45am
OPERATIONAL ISSUES					
PC/18/34	ELR CCG GP Practices Access During Core Hours	To receive	Hayley Moore	**C**	9:50am

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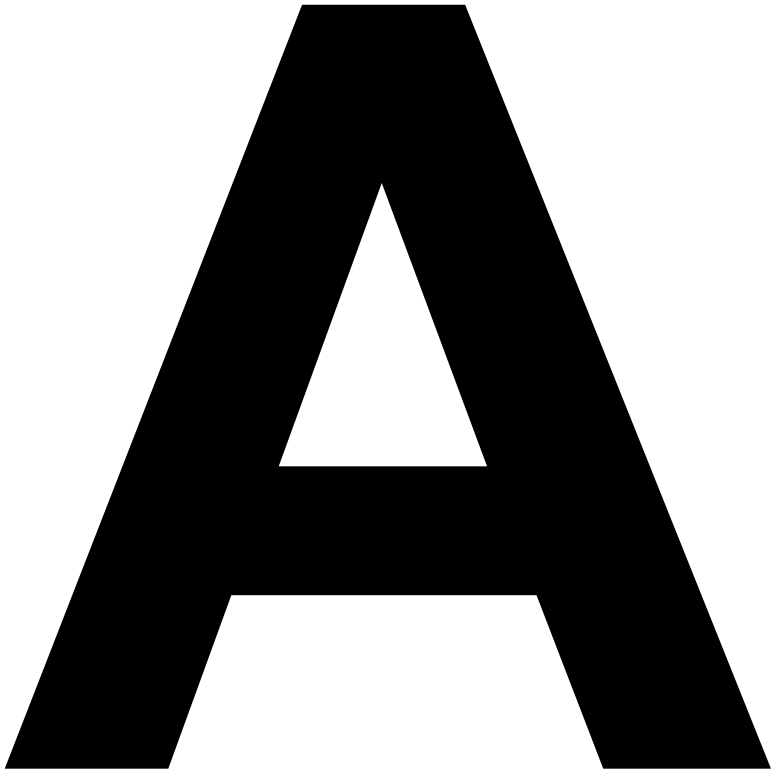
ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PC/18/35	GP5FV - Sustainability and Transformational Partnership (STP): GP Work stream	To receive	Jamie Barrett	**D**	10:00am
PC/18/36	Uppingham Surgery: Ketton Branch Public Consultation Update	To receive	Jamie Barrett	**E**	10:10am
PRIMARY CARE FINANCE REPORT					
PC/18/38	Primary Care Co-Commissioning Finance Report 2017-18: Month 11 (February 2018)	To receive	Donna Enoux	**F**	10:20am
SUB-COMMITTEE REPORTING					
PC/18/37	Primary Medical Care Risk Sharing Group: Updated Terms of Reference	To approve	Fiona Fretter	**G**	10:25am
ANY OTHER BUSINESS					
PC/18/39		To receive	Alan Smith	**Verbal**	10:30am
DATE OF NEXT MEETING					
PC/18/40	**Tuesday 1 May 2018 at 9:30am, Guthlaxton Committee Room**, ELR CCG, Leicestershire County Council, County Hall, Glenfield, Leicester, LE3 8TB.		Alan Smith	**Verbal**	10:35am



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Minutes of the Primary Care Commissioning Committee held on Tuesday 6 March at 9:30am in Gartree Committee Room, ELR CCG, County Hall, Glenfield, Leicester, LE3 8TB

Present:

Mr Clive Wood	Deputy Chair and Independent Lay Member (Chair of the Committee)
Mr Alan Smith	Independent Lay Member (and Deputy Chair of the Committee)
Dr Nick Glover	GP Locality Lead, Blaby and Lutterworth
Dr Girish Purohit	GP Locality Lead, Melton, Rutland and Harborough
Mr Tim Sacks	Chief Operating Officer
Dr Anne Scott	Deputy Chief Nurse (and Interim Chief Nurse and Quality Officer)
Ms Donna Enoux	Chief Finance Officer
Mr Colin Thompson	Public Health Consultant

In attendance:

Mr Jamie Barrett	Head of Primary Care
Mrs Daljit Bains	Head of Corporate Governance and Legal Affairs
Mrs Seema Gaj	Primary Care Contracts Manager
Dr Nainesh Chotai	Chair of the Leicester, Leicestershire and Rutland Local Medical Committee
Mrs Jennifer Fenelon	Healthwatch Rutland
Mrs Claire Middlebrook	Corporate Affairs Support Officer (Minutes)

ITEM		LEAD RESPONSIBLE
PC/18/15	**Welcome and Introductions** Mr Clive Wood welcomed all members to the Primary Care Commissioning Committee (PCCC) meeting.	
PC/18/16	**To receive questions from the Public in relation to items on the agenda** There were no members of the public present at the meeting and no questions had been received.	
PC/18/17	**Apologies for absence:** • Dr Tabitha Randell, Secondary Care Clinician • Mrs Sue Staples, Healthwatch Leicestershire • Dr Vivek Varakantam, GP Locality Lead for Oadby and Wigston	
PC/18/18	**Notification of Any Other Business** Mr Wood had not received notification of any other business.	
PC/18/19	**Declarations of Interest** GPs present declared an interest in items relating to commissioning of primary care where a potential conflict may arise. No specific	

ITEM		LEAD RESPONSIBLE
	declarations were raised. It was **RESOLVED** to: • **RECEIVE** the conflicts of interest declared and note the actions taken.	
PC/18/20	**To Approve the Minutes of Previous Meeting of the ELR CCG Primary Care Commissioning Committee held on 6 February 2018 (Paper A)** The minutes of the meeting held in February 2018 were accepted as an accurate record of the meeting. It was **RESOLVED** to: • **APPROVE** the minutes of the previous meeting.	
PC/18/21	**To Receive Matters Arising following the meeting held on 6 February 2018 (Paper B)** The matters arising following the meeting held in February 2018 were received, and the following update received: • **PC/18/11 Narborough Health Centre** – Mrs Bains confirmed a meeting was held on 5 March 2018 with Mr Sacks and Mrs Gaj to review the application required by NHS England in order to change the Constitution; paperwork to be submitted to NHS England. **Action ongoing.** It was **RESOLVED** to: • **RECEIVE** the matters arising and note the progress to date. *Dr Nainesh Chotai joined the meeting.*	
PC/18/22	**GP Five Year Forward View (GP5YFV) – Sustainability and Transformational Partnership (STP): GP work stream (Paper C)** Mr Sacks presented the paper and noted the following items: • The paper is being brought back to the committee, following presentation last month and after seeking advice from NHS England regarding the GP workforce numbers. • Mr Sacks will be looking to staff to help drive forward the agenda; the CCG will be under significant scrutiny from NHS England for the eight workstreams.	

ITEM		LEAD RESPONSIBLE
	• To date, support with IM&T has been received from Leicestershire Health Informatics Service (LHIS) and Arden and Great East Midlands Commissioning Support Unit (AGEM CSU). The service is due to be recommissioned and therefore notice has been served on AGEM CSU. The plan is to bring the service in-house as a hosted function for GP IT services; and a report will be presented to the Commissioning Collaborative Board (CCB) in March 2018 for sign-off of the proposal. • A development session took place in February 2018, which was a positive event and focussed on how the GP5YFV can be embedded in the day to day work, as part of the LLR wide system. • Following the letter received from NHS England in relation to when the CCG was going to achieve the national target number of GPs and the view of the Committee last month; a letter was sent in reply to NHS England from Dr Azhar Farooqi (Chair of Leicester City CCG), Dr Peter Miller (Chief Executive of Leicestershire Partnership Trust (LPT)) and Mr Sacks noting the challenge of meeting the national target and the risks this may entail. **Mr Sacks to provide an update for confidential CCB next week.** Dr Anne Scott suggested that this issue be highlighted at the Local Workforce Action Board (LWAB), to ensure that the members are sited on the problem; **Mr Sacks agreed to inform the LWAB with the suggestion and will ensure that this is raised appropriately.** Mr Alan Smith thanked Mr Sacks for the letter and praised the appropriateness of the response and asked if a response had been received from NHS England. Mr Sacks confirmed that no response had been received. Mr Sacks noted that he reviewed the letter carefully, recognising the national target, however, NHS England have told the CCG what we have to achieve the target of recruitment. Ms Enoux noted that there is a similar situation with the acute sector, in that national activity was based on a growth assumption and will be impossible to deliver, despite the caveat from NHS England stating the target to be achieved. It was **RESOLVED** to: • **RECEIVE** the report and **NOTE** the update.	**Tim Sacks** **Tim Sacks**

ITEM		LEAD RESPONSIBLE
PC/18/23	**Paper Switch Off (PSO) Programme: Update (Paper D)** Mr Jamie Barrett presented this report, which provided an update on the PSO programme and additional information on the intentions, deadlines and suggested timelines involved. The CCG has contacted Practices, who are low users of electronic systems, to ensure that they understand the need for utilisation and the reasons for systems not being used. More information was also shared on providers that are available in the area. There has been some confusion over switch-off dates, as University Hospitals of Coventry and Warwickshire have a different switch off date to Leicester, Leicestershire and Rutland (LLR). Actions that the University Hospitals of Leicester (UHL) need to take are listed as part of the paper; an update on the 'go live' date will be presented next month. Dr Nick Glover acknowledged the support of Mr Barrett and the Primary Care team, as it has been a challenge to meet the high e-referral target. The large number of providers was also recognised; as this has provided challenges, including waiting times, which have had to be resolved in order to move the project forward. Dr Glover expressed concern over the availability of real appointments and asked for clarity on what monitoring is in place to ensure ghost clinics are not on the system. When a patient is given an appointment they expect it to take place and not to be told that the clinic is not happening. Mr Wood acknowledged Dr Glover's comment, as we do not want to give patients false hope and ghost clinics can affect RTT figures. Mr Barrett noted that a lot of the actions listed for UHL, are more primary care flow actions, which are currently being reviewed to ascertain whether these can be resolved internally. Flow needs to be directed through the PRISM system; however this has not been clearly articulated; **Mr Barrett will ensure the actions are articulated to UHL in clearer manner.** Mrs Jennifer Fenelon noted that at the previous meeting, the importance of telling patients what is happening was noted and asked for timelines to be included. Mr Barrett recognised the importance of linking between Healthwatch, PPGs and other groups; however, reported that patients should not notice any changes. Mr Barrett will engage with the groups as requested. Mr Smith spoke about ghost clinics and reported that these should have stopped two years ago. Clarification was also sought on the alternative if the electronic system fails. **Mr Barrett agreed to look**	**Jamie Barrett** **Jamie**

ITEM		LEAD RESPONSIBLE
	into this issue and report back at the next meeting. Mr Barrett noted that with the move to a single referral method, there is less risk and the main changes are to the administration of the patient around the system. Dr Nainesh Chotai reported that there is no real way to follow up a patients' referral, unless the patient presents at the GP practice and queries the lack of a referral appointment. Mr Wood thanked Mr Barrett for the update and asked that a further update be presented at the next meeting. It was **RESOLVED** to: • **RECEIVE** the report and **NOTE** the progress to date.	**Barrett**
PC/18/24	**Primary Care Co-Commissioning Finance Report 2017/18: Month 10 (January 2018) (Paper E)** Ms Enoux presented this report, which was taken as read and highlighted the following items: • At month 10, the primary care budget was showing an underspend of £865k and an outturn underspend of £1.8m by year end is anticipated. Prescribing had a £1.6m NSCO cost pressure and a £2.8m QIPP plan; despite this the prescribing budget line is on track to show an over-delivery against plan. This has been nationally recognised and noted that the £1.6m was out of our control. • Co-commissioning is showing an overspend of £36k and a forecast outturn of £109k. This is mainly due locum payments and indemnity payments, some of which have been off-set. • The GP support framework budget is currently under by £200k and the Urgent Care Centre recharges have produced a £250k underspend in 2016/17. • Attention was brought to paragraph seven of the report, which shows an underspend of £871k. This is due to the allocation of £500k from NHS England to assist with the NSCO cost pressures and the allocation not being totally spent this year and being moved into next year. Dr Glover noted the good news regarding the prescribing budget; however, suggested caution going forward as making savings next year will be harder to achieve as we look to increase the prevalence. The burden of long term diseases will ensure that there is additional	

ITEM		LEAD RESPONSIBLE
	pressure; this has been acknowledged in conversations with NHS England. Ms Enoux noted the national focus on three main areas: 1) over the counter medications, 2) low clinical value drugs and 3) Biosimilars. The CCG needs to be able to justify spending on over the counter medications and low clinical value drugs. Dr Glover asked about support for practices in relation to Biosimilars; especially when patients specifically ask for a branded drug. If patients are ill and are not prescribed the drugs they want, this may turn into a different referral or a prescription for a higher cost drug. Ms Enoux asked for clarity over this issue and it was agreed that Mr Sacks, Dr Glover and Ms Enoux will discuss this outside of the meeting. Mr Sacks thanked his team and the ELR Practices for their hard work in managing the prescribing spend, whilst still ensuring high quality prescribing; at the same time as dealing with the NCSO cost pressure. Mr Sacks suggested some caution in the CCG and reported that the Medicines Quality Team will undertake a full review of the three areas. An example was given of anti-depression medication; sometimes there is only one medication which works for a patient, even if it is high cost. Guidance from NHS England is clear, however, a letter will need to be written to practices informing them of the national decision, so that they have some back-up when speaking to patients. GPs need to see clinical evidence and information on the cost implications in order to be able to make these changes. Dr Glover stated that it is important that this is communicated as a national decision and asked that the wider clinical pathways are considered; as he is concerned that a GP could be accused of a breach of contract if they do not prescribe the drug requested by the patient. We have to ensure that prescribing is appropriate for the patient's needs. Dr Scott asked if there was any evidence from NHS England on the impact of prescribing costs. Mr Sacks noted that the evidence has shown that the change to Cat M pricing has created a situation where drug companies have put pressure back onto NHS England due to the change in their margins. Ms Enoux noted that this has been recognised by NHS England and has stated that the CCG can make a paper adjustment for Cat M. It was noted that the CCG is paying for the decision made by NHS England on Cat M. It was **RESOLVED** to:	

ITEM		LEAD RESPONSIBLE
	• **RECEIVE** the report and **NOTE** the progress to date.	
PC/18/25	**Any other Business** There was no other business to discuss.	
PC/18/26	**Date of next meeting:** The date of the next Primary Care Commissioning Committee meeting will be held on **Tuesday 3 April 2018 at 9:30am, Guthlaxton Committee Room, County Hall, Glenfield, Leicester, LE3 8TB.** Apologies were received from Mr Wood, Mr Sacks and Dr Purohit; Mrs Bains to check for quoracy in order to determine whether the meeting can take place.	

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NHS EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONI NG GROUP
PRIMARY CARE COMMISSIONING COMMITTE MEETING

ACTION NOTES

Key

Completed	On-Track	No progress made

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at 27 March 2018	Status
PC/18/11	February 2018	**Narborough Health Centre (NHC): Update leading to NHC Closure**	Tim Sacks / Seema Gaj / Daljit Bains	To review the application required by NHS England to change the constitutional membership.	~~February 2018~~ June 2018	Meeting held on 5 March 2018; paperwork to be submitted to NHS England. **Action ongoing.**	**AMBER**
PC/18/22	6 March 2018	**GP5FV – Sustainability and Transformational Partnership (STP): GP work stream**	Tim Sacks	To present an update to the Commissioning Collaborative Board in March 2018.	March 2018	Report on LHIS / AGEM CSU IM&T Contract Re-Commissioning 2018-2021 presented to the CCB in March 2018. **Action complete.**	**GREEN**
				To highlight the problem of recruiting the additional GPs to the Local Workforce Action Board (LWAB).	March 2018	Issue raised at the LWAB meeting held on 22 March 2018. **Action complete.**	**GREEN**
PC/18/23	6 March 2018	**Paper Switch Off (PSO) Programme: Update**	Jamie Barrett	UHL actions to be more clearly articulated.	April 2018	Under review; to be incorporated in next update to the Committee in May 2018. **Action ongoing.**	**AMBER**
			Jamie Barrett	Alternative options in case of failure of the electronic system to be explored.	April 2018	Under review; to be incorporated in next update to the Committee in May 2018. **Action ongoing.**	**AMBER**

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Front Sheet

REPORT TITLE:	**ELR CCG GP Practices Access During Core Hours**
MEETING DATE:	**3 April 2018**
REPORT BY:	**Hayley Moore, Primary Care Contracts Manager**
SPONSORED BY:	**Jamie Barrett, Head of Primary Care**
PRESENTER:	**Hayley Moore, Primary Care Contracts Manager**

EXECUTIVE SUMMARY:

In October 2017, NHS England issued guidelines for Commissioners and GP practices pertaining to provision of access during core hours. Therefore the purpose of this paper is to provide the Primary Care Commissioning Committee with an outline of the new guidance in relation to how commissioners should manage GP practices that close for a period of time during core hours, including assessment of reasonable needs and subcontracting arrangements during these periods.

This paper provides a summary of the audit undertaken for ELR which identified eight practices had declared they close during the lunchtime period and outlines the arrangements in place. The Primary Care Commissioning Committee is asked to consider these findings and agree to the recommendations to establish assurance of provision during core hours. This will be reported back to NHS England for record.

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG Primary Care Commissioning Committee is requested to:

- **NOTE** the guidance outlined by NHS England and current access provision for ELR Practices during core hours.

- **NOTE** the commencement of a full audit of all (including; lunchtimes, EOH arrangements, PLT's & half day) closures during core hours for all ELR CCG Practices will be undertaken. This is to ensure an up to date record of all practice closures, provisions are in place to ensure a consistent message is provided to patients and that all practices have clear and accurate processes in place.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2017 – 2018:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience	x	Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

EQUALITY ANALYSIS
An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is not deemed appropriate for this report.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:	
The content of the report identifies action(s) to be taken / are being taken to mitigate the following corporate risk(s) as identified in the Board Assurance Framework:	BAF3 – Primary Care

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

ELR CCG GP Practices Access during Core Hours

3 April 2018

Background and Context

1. NHS England wrote to local teams in January 2018 to formally set expectations of "reasonable needs" for core hours within GP Practices. This followed on from national negotiations with the General Practitioners Committee (GPC) that also involved a change to the Extended Hours Directed Enhanced Services, preventing practices that close for half a day from providing the service.

2. The General Medical Services (GMS) Regulations require general practice contractors to provide essential and additional services at such times within core hours, "as are appropriate to meet the reasonable needs of patients," and require the contractor to have in place arrangements for its patients to access those services throughout core hours in case of emergency. Core hours for GMS practices are 8:00 – 18:30, Monday – Friday, excluding weekends and bank holidays. The wording of the GMS contract permits practices to subcontract their services during core hours with the approval of the commissioner.

3. Relevant GMS Contract Information.

   8.1 Essential Services
   8.1.1. Subject to clause 8.1.8, the Contractor must provide the services described in Part 8 (namely *essential services*) at such times, within *core hours*, as are appropriate to meet the reasonable needs of its patients, and to have in place arrangements for its patients to access such services throughout the *core hours* in case of emergency

4. 7.13. Duty of co-operation in relation to additional, enhanced and out of hours services

   (b) comply in core hours with any reasonable request for information from such a person or from the Board relating to the provision of that service or those services; and
   (c) in the case of out of hours services:
   (i) take reasonable steps to ensure that any patient who contacts the practice premises during the out of hours period is provided with information about how to obtain services during that period;

5. There has never been a national standard or definition of what constitutes 'appropriate to meet the reasonable needs of patients' and as a result there have been multiple historical interpretations and arrangements in place for practices that close during core hours, some of which have been in place for many years and dating back to days when commercial/retail outlets closed routinely.

6. In a letter dated 30 January 2018 regarding GP Access; expectations in respect of extended and core hour, the Head of Primacy Care, NHS England (Central Midlands) made CCGs aware of the guidance and the actions that are expected to be undertaken (appendix 1).

7. The focus of this guidance is on "half day" practices but also those practices that don't appear to open for the entirety of core hours. It is expected that commissioners prioritise practices in the following order:

NHSE Guidelines	**CCG Consideration**
Those practices that are intending to remain closed for half a day weekly and who continue to claim DES funding (see para 24 on process to be adopted for approval). Commissioners will be expected to reclaim any DES related funding post 1st October 2017	Further investigation is needed
Those that plan to surrender the extended hours DES funding and continue to close for half a day weekly as this would result in both reduced access and a poorer service for those patients	Narborough Health Centre (C82119) closes on Thursday afternoon and therefore surrendered Extended Hours DES from 1st October 2017.
Those practices with ½ day closing arrangements whose GPPS data is a negative outlier in terms of accessibility against the CCG average	Further investigation is needed Including: • Self-returns provided by practice. • Primary Care Web Tool (trigger levels) • Patient Experience Survey
Those practices that declare a period of closure where a significantly higher number of patients attend A&E compared to a CCG average suggesting the patients' needs are not truly being met.	Further work to be undertaken to determine this.

8. There are a number of reasons why a practice may opt to close their surgery for a short period of time including practical operational considerations e.g. for team training or reviewing the quality of services. The contract however does not support a closure during core hours without alternative arrangements being in place to provide services as described in the following guidelines.

9. The services listed below (I to VIII) have been distilled following engagement with patient groups and patient representatives so whilst not explicit in the contract these represent in broad terms the types of services that we expect will form the basis of discussions with practices;
    I. Ability to attend a pre-bookable appointment (face to face)

II. Ability to book / cancel appointments
III. Ability to collect/order a prescription
IV. Access urgent appointments / advice as clinically necessary
V. Home visit (where clinically necessary)
VI. Ring for telephone advice
VII. Ability to be referred to other services where clinically urgent. (including for example suspected cancer)
VIII. Ability to access urgent diagnostics and take action in relation to urgent results

10. ELR CCG undertook an audit to determine access and provision during core hours based on data from the Primary Care Webtool (eDeclaration) and found that a number of practices were closed during lunch time. This promoted CCG to contact those ELR practices that closed during lunch time to determine what provision was in place for patients this included checking what telephone message was available for patients and if there were any signposting arrangements.

Current Situation

11. All eight practices that had declared their practice was closed during lunchtime were called during their specified closure times so that the message given to patients could be documented.

12. 7 of the 8 Practices were found to not be meeting the I-VIII requirements in paragraph 9.

Practice Name & Code	**Closed for lunch From - To**	**Message on telephone system at 12.03.18**
Long Clawson MP C82016	1pm – 2pm Daily	The practice is currently closed and will re-open at 2pm. For emergencies please call 01664 821924
The Billesdon Surgery C82055	1pm – 2pm Daily	The surgery is currently closed. We open 8.30am-1pm and 2pm-6pm. For OOH medical services call 08450450411 or visit the website (the 0845 number was tried 4 times and the call failed)
The Limes MC	1pm – 2pm Thursday	Call diverted straight to The Home Visiting Service for OOH signposting they then tell non-urgent pts to call back at 2pm.
The Croft MC C82067	12:30pm – 1:30pm Daily	Practice is closed 12.30-1.30 for urgent cases please hold or call back after 1.30pm. Doors are closed but patients can access the surgery reception by pressing the bell on the front door.

Practice Name & Code	Closed for lunch From - To	Message on telephone system at 12.03.18
Northfield MC C82068	1pm – 2pm Daily	The surgery is closed for emergencies press 1
South Wigston HC C82079	12:30pm – 1:30pm Daily	Practice is closed for business delivery. Practice has been contacted and has spoken with their telephone systems provider to change the message to include practice closure times. Practice also advised that patients can access the practice by using the buzzer on the front door. will take approx. 3 weeks for phone message to change
Market Overton & Somerby Surgeries C82649	1pm – 2pm Daily	Surgery is closed for lunch until 2pm please call 111 for emergencies
Severn Surgery C82112	12pm – 2pm Daily	The surgery is closed we open from 8.30-1 & 2-6.30 call 999 for emergencies or for OOH call 0845 0450411 (number failed 4 times when tried to call) Do not leave a message as it will not be heard (although no facility to leave a message is available)

13. The results demonstrate a non-standardised approach across ELR.

Protected Learning Time (PLT's)

14. In addition to the guidance around core hours and reasonable needs, this latest guidance also provides details for sub-contracting arrangements. As mentioned above, the GMS contract permits practices to subcontract their services during core hours with the approval of the commissioner. It is unlikely that subcontracting agreement can be approved without meeting the requirements set within this guidance particularly the services listed from I to VIII.

    This does potentially place commissioners in a difficult position with regards to historical agreements for coverage during PLT. In many areas practices switch to the local out of hours provider during PLT which is likely to be a longstanding agreement inherited from Primary Care Trusts. This new guidance is clearer on what the requirements are for sub-contracting and as a result CCGs are going to need to review what is in place during this time to ensure it does offer the full service, and if not, what arrangement need to be made over a reasonable period to address this. Further investigation may find that Primecare is used by practices during lunchtime closures without the knowledge of the commissioner.

15. The CCG have been advised by Primecare (PLT OOH Provider) that the following arrangements are provided based on the large ELR CCG geographical area. These include:

    - 2 X Triage Doctors
    - 1 X Call Handler
    - 1 X Dispatcher/Call handler
    - 2 X Visiting Doctors
    - 2 X Health care assistants
    - 2 X Vehicle running costs

Recommendation

16. The East Leicestershire and Rutland CCG Primary Care Commissioning Committee is requested to:

    - **NOTE** the guidance outlined by NHS England and current access provision for ELR Practices during core hours.

    - **NOTE** the commencement of a full audit of all (including; lunchtimes, EOH arrangements, PLT's & half day) closures during core hours for all ELR CCG Practices will be undertaken. This is to ensure an up to date record of all practice closures, provisions are in place to ensure a consistent message is provided to patients and that all practices have clear and accurate processes in place.

To All Central Midlands CCG AOs and PC leads
Central Midlands Locality Directors

Midlands & East (Central Midlands)
Fosse House
6 Smith Way
Grove Park
Enderby
Leicestershire

Tel: 0113 8248224

di.pegg@nhs.net

30th January 2018

Dear Colleague

Re: GP Access; expectations in respect of extended and core hours

As you are aware there has been much discussion about the expectations of GP practices during extended and core hours. As part of last year's negotiations with GPC, it was agreed to introduce new requirements in the extended access DES and this was implemented last October to ensure that the policy intent behind the negotiations was being met through any local arrangements.

In parallel to this, work was also undertaken with patient groups to test the principles of what services should be defined as appropriate to meet the 'reasonable needs of patients'. As a result National standards and commissioner guidance has been produced to assist commissioners in

- ensuring that patients know what they can 'reasonably' expect of their GP practice during core hours;
- working with GP practices in respect of the services they offer to patients during core hours as well as the conditions that should govern the commissioning of extended hours.

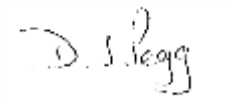
The guidance is attached to this letter (Appendix A) and includes the required actions for commissioners plus the reporting requirements to monitor progress.

I don't intend to repeat the guidance in this letter but I should like to take this opportunity to reiterate that this NHS England guidance has been produced to help commissioners in coming to a *judgement* about whether a practice's access arrangements meet the reasonable needs of its patients. There is no single test or set of rules that can be applied to all practices so commissioners should take into consideration each of the points in the attached guidance and review each practice individually, prioritising those practices that close regularly for longer periods and where subsidiary data (e.g. patient complaints, A&E demand etc.) may suggest that alternative arrangements are failing to adequately meet patient needs.

Given the commissioner actions set out in Appendix A, this guidance and its implementation should be considered at your next Primary Care Commissioning Committee to ensure that committee members are fully sighted on the requirements and have the necessary governance arrangements in place for any decisions that arise from its implementation.

If it would be helpful to discuss the attached guidance further please do not hesitate to contact the named lead for your CCG within the local NHS England Primary Care Team.

Yours sincerely



Di Pegg
Head of Primary Care
Central Midlands

Appendix A:

GP access; expectations in respect of extended and core hours- National standards and guidance for commissioners

Context and Background:

1. The General Medical Services (GMS) and Personal Medical Services (PMS) Regulations require general practice contractors to provide essential and additional services at such times within core hours, "as are appropriate to meet the reasonable needs of patients," and require the contractor to have in place arrangements for its patients to access those services throughout core hours in case of emergency. Core hours for GMS practices are 8:00 – 18:30, Monday – Friday, excluding weekends and bank holidays. PMS terms are applied in the same manner following national negotiation and the definition 'core hours' is in the contract and in the underpinning regulations. Schedule 2 of the PMS contract allows local commissioners the flexibility to agree alternative opening hours 'normal hours' and this should be specified in the contract where they have been agreed

2. Opening hours for APMS practices are set out in their contract largely mirror GMS opening hours or longer.

3. The Public Accounts Committee (PAC) report into GP access held in March 2017 set out a number of recommendations. One was to ensure that no practice that was closed weekly for half a day should be in receipt of additional funds to provide 'extended hours' i.e. outside 'core hours' and secondly that patients should know what they can 'reasonably' expect of their GP practice during core hours

4. This Guidance has been drafted to help commissioners to work with their providers of general practice in respect of the services that they offer to patients during 'core hours' as well as the conditions that should govern the commissioning of extended hours

5. Specifically it considers the issues surrounding the subcontracting of services during core hours

Core Hours:

6. The wording of the GMS contract permits practices to subcontract their services during core hours with the approval of the commissioner. As there is no limitation within the contract to the number of hours that can be subcontracted, commissioner approval is central in determining what is acceptable or unacceptable.

7. There are a number of reasons why a practice may opt to close their surgery for a short period of time including practical operational considerations e.g. for team training or reviewing the quality of services. The contract however does not support a closure during core hours without alternative arrangements being in place to provide services as described in paragraph 1.

8. Practice closures according to the practice E-Declaration (as at December 16/17) indicated that 53% of practices reported that their reception closed for 30 minutes, on at

least one day a week and 25% of practices closed for 30min every day during the week. This could be a short closure for lunch, opening at 08:30 instead of 08:00, or perhaps closing at 18:00 instead of 18:30. At the other end of the spectrum one in seven GP practices close for a half day every week.

9. There has never been a national standard or definition of what constitutes 'appropriate to meet the reasonable needs of patients' and as a result there have been multiple historical interpretations and arrangements in place for practices that close during core hours, some of which have been in place for many years and dating back to days when commercial/retail outlets closed routinely

10. The regulations says the following in terms of subcontracting;

GMS (Schedule 3, Part 5, Sub contracting)

44. (1) Subject to sub-paragraph (2), the contractor must not sub-contract any of its rights or duties under the contract in relation to clinical matters to any person unless-

(a) In all cases, including those duties relating to out of hours services to which paragraph 45 applies, it has taken reasonable steps to satisfy itself that-

(i) It is reasonable in all the circumstances to do so, and
(ii) The person to whom any of those rights or duties is sub-contracted is qualified and competent to provide the service; and

(b) Except in cases to which paragraph 45 applies, the contractor has given notice in writing to the board of its intention to sub contract as soon as reasonably practicable before the date on which the proposed sub-contract is intended to come into effect

(2) Sub-paragraph (1)(b) does not apply to a contract for services with a health care professional for the provision by that professional personally of clinical services

(3) A notice given under sub-paragraph (1)(b) must include-

(a) the name and address of the proposed sub-contractor;
(b) the duration of the proposed sub-contract
(c) the services to be covered by the proposed sub-contract; and
(d) the address of any premises to be used for the provision of services under the proposed sub-contract

Furthermore

(5) The contractor must not proceed with a sub-contract or, if the sub-contract has already taken effect, the contractor must take steps to terminate it, where—

(a) (a) the Board gives notice in writing of its objection to the sub-contract on the grounds that the sub-contract would—

(i) put the safety of the contractor's patients at serious risk, or

(ii) put the Board at risk of material financial loss, and notice is given by the Board before the end of the period of 28 days beginning with the date on which the Board received a notice from the contractor under sub-paragraph (1)(b); or

(b) the sub-contractor would be unable to meet the contractor's obligations under the contract.

Paragraph 45 relates to sub-contracting of out of hours services.

PMS (Schedule 2, Part 5, Sub-Contracting)

43. (1) The contractor must not sub-contract any of its rights or duties under the agreement in relation to clinical matters to any person unless it has taken reasonable steps to satisfy itself that-

(a) it is reasonable in all the circumstances to do so;
(b) the person to whom any of those rights or duties is sub-contracted is qualified and competent to provide the service; and
(c) the person holds adequate insurance in accordance with regulation 83

(2) Where the contractor sub-contracts any of its rights or duties under the agreement in relation to clinical matters, it must-

(a) inform the board of the sub-contract as soon as reasonable practicable; and
(b) provide the board with such information in relation to the sub-contract as the board may reasonably request

Services that should be available during core hours (including in subcontracted arrangements):

11. Some practices have established a sub-contracted arrangement using local providers (a mix of OOHs providers or from practices that group together such as within a federation). Some of these arrangements will have developed to improve system resilience and would be recognised as a development towards 'at scale' working, underpinning primary care transformation and delivery of the GP forward view. What is not acceptable however is where arrangements are little more than a signposting service directing patients to urgent care providers

12. Subcontracting arrangements will need to be assessed to ensure that the arrangements in place are considered adequate contractually and there are a number of suggestions below to guide commissioners in making that assessment

13. CCG initiated training events are designed to support an overall system wide benefit and should be supported, recognising that these are rarely more frequent than monthly/6 weekly. Consideration should be given however to how these are delivered so as to limit the impact on access to GP services e.g. agreeing practice representation over a practice closure

14. Where subcontracting arrangements exist, the requirements may differ between GMS and PMS contracts. The regulations state that GMS contractors have to give notice (in writing) {to the commissioner} regarding sub-contracting arrangements and the board

has the right to object to any such arrangements whereas under PMS arrangements, the contractor need only inform the board {commissioner} of the sub-contracting arrangement. That said in the standard PMS contract there is a term that requires PMS contract holders to seek approval before sub- contracting which aligns it with the GMS contract.

15. The services listed below have been distilled following engagement with patient groups and patient representatives so whilst not explicit in the contract these represent in broad terms the types of services that we expect will form the basis of discussions with practices;

- Ability to attend a pre-bookable appointment (face to face)
- Ability to book / cancel appointments
- Ability to collect/order a prescription
- Access urgent appointments / advice as clinically necessary
- Home visit (where clinically necessary)
- Ring for telephone advice
- Ability to be referred to other services where clinically urgent. (including for example suspected cancer)
- Ability to access urgent diagnostics and take action in relation to urgent results

16. Subcontracted arrangements approved by the commissioner should consider the views of local patients.

- We expect practices to consult patients (through the PPG[1]) about both the need for the closure so that they understand the context and the proposed subcontracted arrangements and commissioner approval should take account of their views.
- Patients should know in advance of the closure and not arrive at the practice to find it closed.
- During core hours a patient needs to be able to speak to a receptionist or clinician over the phone not given an answering machine message i.e. either at the sub contracted practice or the patients responsible practice.
- Patients should not have to redial another number as this could cause a delay which might jeopardise patient safety
- If telephone calls are diverted to a sub-contractor the responder should treat these patients as they would their own registered patients.
- The sub-contractor must be able to have access to the patient's clinical record (not just the summary care record) again in the interests of patient safety.
- Where practices close for training purposes, these dates should alternate so it is not the same day each time.
- Any alternative service should be local or easily accessible by public transport so that there is no need for excessive travel on the part of the patient (and/or their carer). This especially important for elderly or fragile patients

17. Commissioners will need to be assured that there is no duplication of payments for example provision of 7 day access. All subcontracted arrangements must be resourced by the practice(s) wishing to sub-contract essential services during core hours.

[1] Commissioners should make sure that the PPG has reasonable representation of the patient population, or, if not, should engage with patients of the practice through a different medium to gain an understanding of the support or concerns of the patient population

18. Evaluation of local arrangements where subcontracting of core services is a key feature should include:

- Patient feedback (Family & friends test / GP Patient Survey / patient complaints)
- Triangulation with other activity data e.g A&E / admission activity etc).

Extended Hours:

19. The commissioning of extended hours is governed by a directed enhanced service (DES), details of which can be found here.

20. These are **additional** hours (average 3 hours per practice) usually provided during the week or on a Saturday morning, as distinct from any other CCG funded access initiative.

21. The intention behind the DES is to pay additional funds to practices for providing additional hours of service i.e. additional to core hours. Therefore the policy intention is to only pay practices the DES funding on that basis.

22. Following negotiations with the GPC an amendment has been made to the extended hours DES directions such that as of the 1st October 2017, a practice can only qualify for the DES if;

- The contractor's practice is not closed for half a day on a weekly basis unless by written prior agreement of the board and
- Requirement that patients must be able to access essential services during core hours from the contractors practice or from any person who is sub-contracted during core hours

23. In responding to the DES changes, some practices (supported by CCGs) have established a sub contractual arrangement using local providers similarly to the sub contracted arrangements that have been established to meet the core hour's requirement. Whilst these arrangements support the principles of 'at scale' working, they do not reflect the policy intention which underpinned the negotiations regarding the Extended Hours DES.

24. Whilst the revised directions give a degree of flexibility i.e. 'with prior agreement of the board,'; use of this flexibility is considered highly exceptional requiring commissioner (NHS England or delegated CCG COO) plus NHS England regional director support and finally sign off by the National Director.

25. Any subcontracted arrangements should also ensure that the overall appointment capacity delivered by the sub-contracted arrangements increases patients' ability to seek advice or appointments to see a clinician across those practices involved (in the host provider and also sub-contractor), with in addition, where commissioned, extended access capacity being maintained as well.

Required Commissioner Action:

26. Commissioners should first consider the 16/17 GP contract electronic declaration (e-dec), the bi-annual access collection and any local intelligence in identifying those practices that are closed routinely during core hours. [NB e-dec data from 17/18 should be available by end December 2017]

27. Commissioners will be expected to prioritise conversations with those practices that are closed for the longest periods with a particular focus on;

- Those practices that are intending to remain closed for half a day weekly and who continue to claim DES funding (see para 24 on process to be adopted for approval). Commissioners will be expected to reclaim any DES related funding post 1st October 2017
- Those that plan to surrender the extended hours DES funding and continue to close for half a day weekly as this would result in both reduced access and a poorer service for those patients.
- Those practices with ½ day closing arrangements whose GPPS data is a negative outlier in terms of accessibility against the CCG average
- Those practices that declare a period of closure where a significantly higher number of patients attend A&E compared to a CCG average suggesting the patients' needs are not truly being met.

28. Practices should be given the opportunity to substantiate with evidence that they are meeting their reasonable needs during a routine closure and this should include how they have engaged patients and worked with their PPG to properly consider the impact of any sub contracted arrangement, in particular on the elderly, less mobile or patients with protected characteristics.

29. Commissioners are asked to form a judgment on the 'test' of meeting reasonable need using as a guide;

- The services describe in sections 15 and 16
- The evidence provided by the practice including patient views and opinions
- The impact on the rest of the health system e.g. the contribution of a practice closure may be having on secondary or community care provision

30. Commissioners should also consider what benefits will be realised by choosing a subcontracted model over being open during the full core hours period

31. Where a CCG has full delegated powers, all practices operating a subcontracting arrangement to allow closure during core hours, should be approved by the Primary Care Commissioning Committee.

32. The change to some historical arrangements will take time to effect and commissioners should consider the support that practices may require in addressing the new requirements including agreeing an appropriate pace of any change e.g. appropriate alternative arrangements negotiated or an amendment to terms and conditions of employed staff. It is expected however that the necessary arrangements will be put in place by April 2018

Contractual Measures/Next Steps:

33. After assessment of the arrangements in place during core hours has been completed and where there is a dispute between the commissioner and the practice either on the services available or the subcontracted arrangements in place/proposed then commissioners may need to consider contractual action

34. Practices who decide to withdraw from the extended hours DES and therefore the provision of extended hours, should be reminded of their responsibilities to inform patients and ensure sufficient notice/minimum disruption

35. For practices that are found to be in breach of contract, remedial notices will be required to agree a reasonable and proportionate pace of change and ongoing dialogue between the commissioner/practice on progress

36. Failure to respond would result in a Breach notice

Reporting:

37. Commissioners will be required to report progress on this requirement via the Primary Care Activity Report between November 2017 and April 2018 including what if any contractual action has been taken

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Front Sheet

REPORT TITLE:	**Sustainability and Transformational Plan (STP): GP Programme Update**
MEETING DATE:	**3 April 2018**
REPORT BY:	**Tim Sacks, Chief Operating Officer; Sharon Rose, Locality Lead Manager & STP GP Programme Lead; Sue Price, Operations Team Support Officer**
SPONSORED BY:	**Tim Sacks, Chief Operating Officer**
PRESENTER:	**Jamie Barrett, Head of Primary Care**

EXECUTIVE SUMMARY:

This Paper provides an update on the Work Programme for the STP General Practice Programme Board.

The documents included are:

- The tracker for the GP Programme board (appendix A)
- Agenda for GP Workforce Showcase Event 17 April 2018 (appendix B)

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG Primary Care Commissioning Committee is requested to:

- **RECEIVE** the report.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2017 – 2018:			
Transform services and enhance quality of life for people with long-term conditions	*	Improve integration of local services between health and social care; and between acute and primary/community care.	*
Improve the quality of care – clinical effectiveness, safety and patient experience	*	Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare	*	Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

General Practice Five Year Forward View

Introduction

1. The Aim of the programme is to deliver the GP Five Year Forward View strategy that was published in April 2016. The 5 priority areas for 18-19 for GP resilience are;
    - Workforce
    - Models of Care
    - IMT and estates
    - Funding and contracts and,
    - Workload/demand

Workforce Progress:

2. Work streams for 18-19 have been agreed and an event is planned for the 17 April 2018 (see Appendix B for the agenda). The event will be an opportunity for work stream leads to present to the group their delivery plans and receive confirmation or challenge around the intentions. The Local Workforce Action group are invited to attend this meeting as key partners in the delivery.

IM&T progress

3. Project Manager for on- line consultations in place. Practices have been invited to pilot software systems and a number of expressions of interest has been received. The outcome of the pilot will inform future delivery of this project.

4. Work to finalise and amended SLA with Leicestershire Health Informatics to agree a split of work/responsibility of the work previously undertaken by AGEM.

GP Programme Board

5. The GPPB has not met since the last PCCC meeting.

6. Date confirmed of May 3 for the next GPFV assurance meeting called by NHSE GPFV team.

7. GP Funding schemes to be brought to the April meeting by each CCG to share process from the three CCGs.

RECOMMENDATIONS

8. The East Leicestershire and Rutland CCG Primary Care Commissioning Committee is requested to:

    - **RECEIVE** the report.

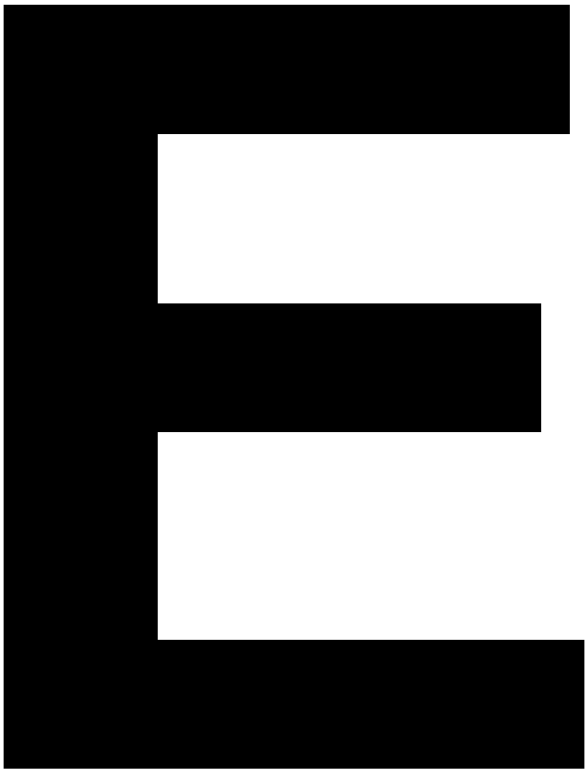
LLR STP General Practice Delivery Plan 17-18 Priorities

No.	Work stream	Priority Area	Overview of project	Managerial Lead	Clinical Lead	Project Lead	Delivery Group	Funding £	Funding Source (GP5FV / CCG)	PID Submitted	EIA	QIA	Most recent HL Report	Date of Next Critcal Milestone	Current RAG status	Decisions required/items for escalation
1	**Communication & Engagement**	Communications Plan	Visionary event to define the vision and inform the plan. • Formulation and agreement of a single vision for all LLR parties and stakeholders for STP and public. • Communication plan in place and implemented.	Tim Sacks	Dr Azhar Farooqi	Richard Morris / Melanie Shilton	GP Programme Board		CCG				M10 Comms	Mar-18	amber	
2	**Workforce**	Workforce Mapping	• Produce a comprehensive baseline of current workforce numbers and skills in General Practice to show current and projected workforce gaps and to map future supply of trainees, informing reporting tool development. • Map the future workforce needs in line with the proposed new models of care in General Practice	Tim Sacks		Bridget Roberts	GP Workforce Group	£50K	HEEM	Workforce Delivery PID				Jan-18	Green	
3		Clinical Pharmacists	• Increase clinical pharmacists in general practice through national and local funding • Coordinate bids for funding to employ pharmacists within General Practice across LLR as part of Wave 3 of the national funding programme, Clinical Pharmacists within General practice to increase the numbers of clinical pharmacists working in primary care	John Nicholls	TBC	James Watkins	GP Workforce Group	60% yr 1 40% yr2 20% yr 3	NHSE	Clinical Pharmacists PID			pharmacists	Apr-18	amber	
4		International recruitment	The General Practice Forward View (GPFV) included a commitment to deliver a major international recruitment drive to attract up to 500 appropriately trained and qualified GPs from overseas by 2020. NHS England's general practice workforce team has been engaging with regional and local colleagues, Health Education England, RCGP and the BMA to agree an approach for delivering the commitment. It is recognised that across LLR there is a shortage of GPs which is compounded substantial difficulties with recruitment both of qualified GPs and GP trainees, with local training places unfilled. This project aims to deliver a sustainable general practice across LLR by successfully recruiting international GPs to work within LLR. August 2017 NHS England has announced it is embarking on a £100m international recruitment drive to boost the number of GPs, and contracts have been offered to agencies to help NHS England achieve its goal of recruiting 5,000 extra doctors by 2020.	Tim Sacks	Dr Nil Sanagee	Sharon Rose	GP Workforce Group	£36,000 per new recruit (£2500 to CCG for training)	NHSE	Int Recruitment PID			M11 IGPR	Mar-18	red	
5		Care Navigators	• Active Signposting and Correspondence Management Training to upskill admin staff and release GP time • Organise and coordinate CLAP courses, incorporating active signposting and social prescribing.	Ian Potter	TBC	Daniel Nerini	GP Workforce Group	£665K 2017-2020	NHSE	Receptionists Training PID			M10 Active Signposting	Mar-18	Amber	
6	**Access**	7 day Access	• An integrated service that provides at least 45 minutes of GP services per 1000 population in evenings and weekends across LLR • An integrated home visiting service available 24/7 for urgent and complex patients across LLR	Julia Cory Paula Vaughan David Muir	Dr Prasad Dr G Purohit Dr G Hanlon		Strand 1 UEC	£3.69M 18/19 £6.62M 19/20 onwards	NHSE	to CCG PCCC				Mar-18	Amber	
7	**Workload**	Transferring Care Safely (TCS)	• Implement a clinical integration group across LLR • Development of new common reporting pathways for both operational and quality concerns • Development of a guide book	Amy Linnett	Dr Nick Pullman		GP Programme Board						M11 Transferring Care Safely.pdf	Mar-18	Green	
8		10 High Impact Actions (HIA)	• Collaborative learning in action programme for practices, targeting HIAs 1)active signposting & 8) Social prescribing. • Work with NHS England to reach agreement, structure and content of offer to practices. • Key learning outcomes agreed across LLR.	Ian Potter			GP Programme Board							Aug-17	Green	
9	**Models & Contracts**	Toolkit for new models of care delivery	• Modelling delivery of complex / non-complex pathways • Develop new ways of joint working / contracting to deliver sustainable models • Development of a toolkit for practices.	Julia Cory	TBC	James Watkins	GP Programme Board			Models and Contracts PID			M11. Toolkit	Mar-18	Green	
10	**IM&T**	Online consultations	• Online General Practice Consultation Software Systems, development of online consultation systems with a view to improving access and making the best use of clinical time • Pilot online General Practice Consultation Systems in 3 areas during 2017/18 as part of a range of initiatives to improve access and make best use of clinical time to identify the appropriate IT solution for LLR in line with national guidance once available.	Tim Sacks	Dr Tony Bentley		STP GP IM&T Group	£820K 2017-2020	NHSE	Online Consultations Project Plan Jul-17 E consultation PID			M11. Online Consultations.pdf	Feb-18	amber	Following a number of delays, guidance was released by NHSE 30th October 2017. Awaiting outcome of LLR bid.
11		System Migration and Interoperability	• Support practices to migrate as part of the local transition towards a footprint wide clinical system estate towards a single interoperable platform in line with GPSoC • Develop plans for expression of interest.	Tim Sacks	Dr Tony Bentley	Jennie Caukwell	STP GP IM&T Group	£550K 17/18	ETTF	GP Programme Migrations PID.docx			Migrations.pdf	Mar-18	Amber	
12	**Finance**	Transformation and models of funding	• ELR CCG Funding to support groups of General Practices to come together in line with the proposed new care models • WL CCG outcome based federation level QIPP scheme. closely aligned to our strategic priorities which include the sustainability of general practice primary care at scale • LC CCG - through the four city Health Needs Neighbourhoods(HNNs) which encompass all of LC CCG practices. Consider transformational opportunities of practices working together to free-up capacity and enable resources to be redirected to the areas of greatest need.	Tim Sacks / Ian Potter / Richard Morris	TBC		GP Programme Board	£3.28M 17/18 and 2018/19	CCG Baseline	3 CCGs PCCCs				Sep-17	Amber	CCGs to complete transformation plans

University Hospitals of Leicester
Leicestershire Partnership Trust
East Midlands Ambulance Service
East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group

STP General Practice Workforce Group
17th April 2018 9.00-12.00
Gartree Committee Room County Hall
17-18 Showcase and 18-19 priority setting

Time	Item	Lead
9.00-9.10 10 minutes	Welcome and Introduction An overview of the GP Workforce group and progress to date	TS
9.10-9.30 20 minutes	Retention	BH
9.30-9.40 10 minutes	International Recruitment	NS
9.40-10.00 20 minutes	Locums	AC/TS
10.00-10.20 20 minutes	Practice Managers Academy	WH
10.20-10.30 10 minutes	Care Navigators	IP
10.30- 10.45 15 Minutes	General Practice Nursing	WH
10.45-10.55 10 minutes	Training Hubs incl. Physician Associates	IJ
10.55-11.05 10 minutes	Training and Development Department	LE
11.05-11.20 15 minutes	Clinical Pharmacists	LK/LG
11.20 -11.40 20 minutes	Workforce Explorer	Vicky Hill
11.40-11.50 10 minutes	18-19 Priority overview and closing comments	TS
	Date of Next Meeting Tuesday 15th May 9.30-11.30 room 173 County Hall	



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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Front Sheet

REPORT TITLE:	**Update on Ketton Branch Surgery Public Consultation**
MEETING DATE:	**3 April 2018**
REPORT BY:	**Jamie Barrett, Head of Primary Care** **Pragati Baddhan, Senior Communications and Engagement Manager**
SPONSORED BY:	**Tim Sacks, Chief Operating Officer**
PRESENTER:	**Jamie Barrett, Head of Primary Care**

PURPOSE OF THE REPORT:
The purpose of the report and the attached letter is to update the Primary Care Commissioning Committee on the public consultation in relation to the branch surgery at Ketton, Rutland.

RECOMMENDATIONS:
The ELR CCG Primary Care Commissioning Committee is requested to: • **RECEIVE** the report.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2017 – 2018:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience	Y	Listening to our patients and public – acting on what patients and the public tell us.	Y
Reduce inequalities in access to healthcare	Y	Living within our means using public money effectively	Y
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

EQUALITY ANALYSIS
An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has been completed.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:
The report highlights the following risks: • BAF3 – Primary Care

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Update on Ketton Branch Surgery Public Consultation

3 April 2018

BACKGROUND

1. As you will be aware, Uppingham Surgery began a public consultation on 1 February 2018 on its proposal to close Ketton Branch Surgery. This is because the practice has been experiencing difficulty in managing and sustaining the site. Details of the business case including an options appraisal were presented to East Leicestershire and Rutland Clinical Commissioning Group's (ELR CCG) Primary Care Commissioning Committee (PCCC) in November 2017.

2. The PCCC considered the options presented by Uppingham Surgery and based on the information given within the business case, agreed that the practice would be given permission to consult with the public on a proposed closure.

3. ELR CCG through its delegated responsibility for primary care commissioning, follows a formal process in decision making pertaining to any contract variation. These decisions are considered through the PCCC and a formal process is adhered to, including ensuring decisions are based on a fair and appropriate consultation process in line with NHS England.

CURRENT SITUATION

4. A number of concerns have been received by the CCG via the CCG Enquiries function and also formally from local stakeholders. It appears that the concerns relate to calls for more information to be made available as well as changes to the survey questionnaire.

5. After seeking advice from the Consultation Institute, a national body made of professionals with expertise in the field of consultation, the CCG has advised Uppingham Surgery of a revised approach, which should be implemented for the consultation. This consists of:

    - Additional questions to the survey questionnaire
    - More detailed information for patients
    - A longer timescale to respond
    - An additional drop-in session at Ketton

6. The consultation will be extended by one month so that the end date is 1 June 2018. The additional timescale will provide people with an opportunity to read through the detailed information and respond.

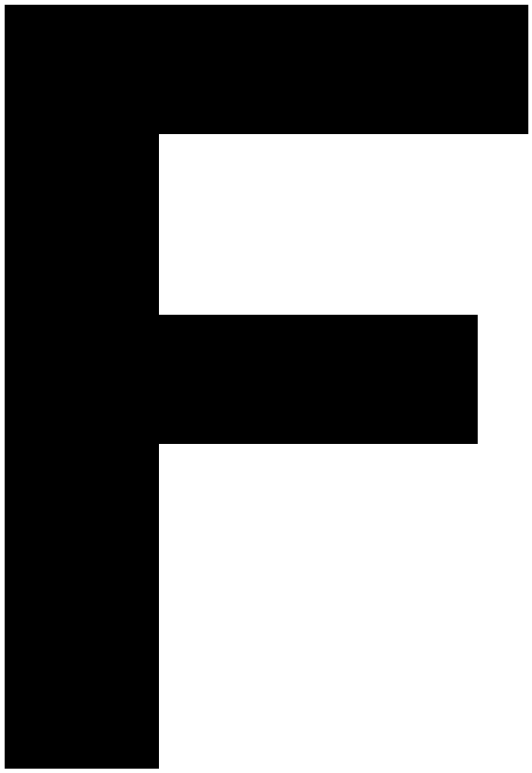
7. This approach has been backed by the Consultation Institute and also has the support of Healthwatch Rutland and NHS England, both of whom have had an input to the additional information and revised survey questions.

8. The revised methodology demonstrates:

    - The commitment to patients
    - Listening to the views and feedback to date
    - Further information will be provided and made available through various communication channels
    - Extension of the consultation by 1 month.
    - CCG advice from the Constitution Institute
    - CCG representation at April Rutland HOSC

9. The ELR CCG Primary Care Commissioning Committee is requested to:

    - **RECEIVE** the report.



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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Front Sheet

REPORT TITLE:	**Primary Care Finance Report 2017/18 (Month 11, February 2018)**
MEETING DATE:	**3 April 2018**
REPORT BY:	**Richard George, Senior Primary Care and Non-Acute Commissioning Accountant**
SPONSORED BY:	**Donna Enoux, Chief Finance Officer**
PRESENTER:	**Donna Enoux, Chief Finance Officer**

PURPOSE OF THE REPORT:

The purpose of this report is to provide a 2017/18 year to date and forecast outturn position for Primary Care services.

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG PCCC is requested to:

- **RECEIVE** the reported variance position against the Primary Care budgets based on reporting information available.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2017 – 2018: (tick all that apply)

Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	✓
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

EQUALITY ANALYSIS

An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is judged that it is not required at this point.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:

- Report covers finances for (but not the operational delivery of) Primary Care Budgets that support the delivery of Primary Care Strategy (BAF 6);
- Report supports the appropriate management of Primary Care Budgets and the achievement of financial targets (BAF 10).

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Primary Care Finance Report 2017/18 (Month 11, February 2018)

3 April 2018

1. Month 11 Year to Date and Forecast Position

The 2017/18 annual budget for Primary Care services totals £98.2m. At month 11 (February 2018) a year to date underspend of £567k and an outturn underspend of £1,044k is being forecast. Appendices 1 and 2 provide further analysis of all service areas.

2. Primary Care Prescribing

Based on Month 9 PPA data, the forecast outturn position (including high cost drugs and central prescribing) is an underspend of £298k.

It is forecast that the QIPP programme for prescribing will over deliver at £2.9m against a target of £1.5m. In addition to this there is a £700k benefit following the expiration of the pregabalin patent.

The forecast includes a £1.5m cost pressure in relation to NCSO drugs. The number of drugs being added to the list has started to reduce in recent months. This risk, and the impact it may have on the outturn position will continue to be monitored closely.

3. Community Based Services

Based on activity data for quarters 1 to 3, a year to date underspend of £98k and forecast outturn underspend of £92k is being forecast. This underspend mainly relates to anti coagulation monitoring as more patients transfer to DOACS.

4. GP Co Commissioning

The year to date position for co commissioning is an overspend of £138k and a forecast outturn overspend of £163k.

There are a number of pressures in this area, the main ones including:

- Global sum payments reflecting the continuing increase in practice list sizes.
- Locum costs following changes to rules around practice reimbursement for sickness cover and maternity / paternity leave.
- Indemnity insurance payments to practices. This comes out of the GP Five Year Forward view that practices would be reimbursed for this cost at a rate of £0.516

per patient. In 2016/17 this was funded by NHSE England, however for 2017/18 it has become the CCGs responsibility.

To partially offset overspending areas, a £407k benefit is included in the forecast in relation to business rates reimbursements where local authority billing to gp practices has been challenged.

In addition to this, there is an underspend against PMS / FDR reinvestment of £106k. This budget will be reinstated in the 2018/19 financial plan.

5. GP Support Framework

A small underspend is being reported against the GP Support Framework. The forecast outturn mirrors the level of achievement reached in 2016/17.

There is an underspend of £200k being reported against the Primary Care Transformational Support Funding budget where the only expenditure to be incurred this year is in relation to the GP Federation. An equivalent amount of funding will be built into the 2018/19 financial plan to ensure the CCG meets the GP Forward View requirement to invest £3/patient on transformational support.

6. **GP IT**

As at month 11 this area is forecast to underspend by £115k. The main reasons for this include:

- Underspend in the on-line consultation programme – this budget will be recreated in the 2018/19 financial plan to enable this project to continue as planned.

- The funding allocated from NHS England for HSCN N3 data links was not sufficient enough to cover the costs and has resulted in a £35k cost pressure for the CCG.

7. **Primary Care Licenses & Other**

This budget area is forecast to underspend by £185k. There are a number of variances that make up this value, the main ones being:

- -£86k – GP Workforce training. The CCG has received funding for supporting GP workforce development. This underspend relates to the elements of work that will be undertaken during 2018/19 and built into the financial plan accordingly

- -£30k – International GP Recruitment. Funding received from HEEM has not been committed until 2018/19.

- -£22k – Funding received from the Home Office to support the cost of health care for families who have moved to the area under the Syrian Refugee Resettlement Programme

- -£25k – Winter pressures funding. The CCG has received an allocation of £100k to support winter pressures, of which £75k has been used to increase capacity within GP Practices. The costs associated with the remaining £25k are incurred elsewhere within the CCG.

8. **Urgent Care Centres**

Urgent Care Centre activity is in line with expectations and no additional payments beyond the core contract value are being forecast. However, there are ongoing discussions with the Provider who has requested additional funding in relation to inflation and premises costs backdated to 2016/17 which presents a financial risk to the CCG.

As at month 11 an outturn underspend of £284k is being forecast. This is the net benefit to the CCG in relation to the cross charging of urgent care centre activity.

9. Recommendation:

The ELR CCG Primary Care Commissioning Committee is requested to:

- **RECEIVE** the reported variance position against the Primary Care budgets based on reporting information available.

Appendix 1

-	YTD Position			Forecast Outturn Position		
M11 Primary Care Commissioning Report	**YTD Budget**	**YTD Actuals**	**YTD Variance**	**Annual Budget**	**Annual Forecast**	**Annual Variance Over/ (Under)**
Area	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**
CCG Prescribing						
OptimiseRX	84	84	-	91	91	-
Central Prescribing	1,149	1,086	-63	1,256	1,187	-68
High Cost Drugs	866	820	-46	947	896	-51
GP Prescribing	42,474	42,762	287	46,435	46,308	-128
Prescribing Incentive Scheme	633	586	-47	691	640	-51
Total Practice Prescribing	**45,206**	**45,337**	**131**	**49,420**	**49,122**	**-298**
Enhanced Services						
Community Based Services	2,394	2,295	-98	2,611	2,519	-92
Total Enhanced Services	**2,394**	**2,295**	**-98**	**2,611**	**2,519**	**-92**
Co Commissioning	**37,140**	**37,278**	**138**	**40,516**	**40,680**	**163**
GP Support Framework						
Care Homes	444	429	-15	484	468	-16
End of Life	300	300	0	327	327	0
Long Term Conditions	600	568	-32	655	620	-35
Demand Mangement	300	300	0	327	327	0
Dementia	150	168	18	164	181	18
Primary Care Transformation Fund	300	116	-183	327	127	-200
Total GP Support Framework	**2,093**	**1,881**	**-212**	**2,284**	**2,050**	**-233**
Other						
GP IT	893	788	-104	974	859	-115
Primary Care - Licenses & Other	505	333	-172	551	367	-185
7 Day Working BCF	0	1	1	0	1	1
Urgent Care Centres	1,644	1,394	-250	1,794	1,509	-284
Total Other	**3,042**	**2,516**	**-526**	**3,319**	**2,735**	**-583**
Total Primary Care	**89,874**	**89,307**	**-567**	**98,150**	**97,106**	**-1,044**

Appendix 2

Month 11 Primary Care Co-Commissioning	Year-to-Date Position			Forecast Outturn Position		
	Budget	Actual	Variance (Under)/ Over	Budget	Forecast	Variance (Under)/ Over
	£000's	£000's	£000's	£000's	£000's	£000's
GMS Global Sum	23,453	23,587	134	25,585	25,744	159
MPIG Correction Factor	1,507	1,507	0	1,644	1,644	-0
PMS Reinvestment	5	0	-5	5	0	-5
FDR Payment	76	0	-76	83	0	-83
Ear Irrigation	75	75	-0	82	82	-0
Wound Clinics	300	300	0	327	327	0
SLA Pharmacists	600	584	-16	655	637	-17
Subtotal PMS & FDR Reinvestment	1,056	959	-97	1,152	1,046	-106
Total General Practice - GMS	**26,016**	**26,053**	**38**	**28,381**	**28,434**	**53**
Occupational Health	43	42	-1	47	46	-1
Locum Adoption/Paternity/Maternity	128	98	-30	140	109	-31
Locum Sickness	18	139	121	20	152	132
Locum Suspended Doctors	0	0	0	0	0	0
Seniority	430	365	-65	469	398	-71
Sterile Products	0	0	0	0	0	0
GP Training	87	87	0	95	95	0
PCO Doctors Ret Scheme	18	14	-5	20	21	1
Kingsway Management Plan	97	111	14	106	111	5
CQC Registration	138	142	3	151	155	4
Total Other GP Services	**961**	**998**	**38**	**1,048**	**1,086**	**38**
QOF Achievement	1,089	932	-157	1,188	1,016	-172
QOF Aspiration	2,541	2,848	307	2,772	3,107	335
Total QOF	**3,630**	**3,780**	**150**	**3,960**	**4,123**	**163**
DES Extended Hours Access	538	564	26	587	613	26
DES Learning Disability	71	77	6	78	84	6
DES Violent Patients	43	43	0	47	47	0
DES Minor Surgery	468	430	-37	510	469	-41
DES TPP QRisk	0	0	0	0	0	0
Avoiding Unplanned Admissions	0	0	0	0	0	0
LES Translation Fees	46	53	7	50	58	8
Imdemnity Insurance	0	156	156	0	170	170
Leicester Asylum Service	30	17	-13	33	18	-14
Total Enhanced Services	**1,195**	**1,339**	**145**	**1,303**	**1,459**	**156**
Dispensing Quality Scheme	87	88	1	95	96	1
Prof Fees Dispensing	1,375	1,375	0	1,500	1,500	0
Prof Fees Prescribing	202	202	0	220	220	-0
Prescribing Charge Income	-275	-275	0	-300	-300	0
Total Dispensing/Prescribing Drs	**1,389**	**1,390**	**1**	**1,515**	**1,516**	**1**
Premises Actual Rent	1,558	1,430	-128	1,700	1,560	-140
Premises Clinical Waste	138	148	11	150	162	12
Premises Cost Rent	28	0	-28	30	0	-30
Premises Health Centre Rates	20	13	-7	22	14	-8
Premises Health Centre Rent	87	120	33	95	132	37
Premises Notional Rent	1,375	1,449	74	1,500	1,581	81
Premises Rates	651	823	172	710	897	187
NHSE / GL Hearn Rates Rebates	0	-382	-382	0	-407	-407
Premises Water Rates	57	46	-11	62	50	-12
Other premises	37	70	33	40	70	30
Total Premises Cost Reimbursement	**3,950**	**3,717**	**-233**	**4,309**	**4,060**	**-249**
GRAND TOTAL - Co-Commissioning	**37,140**	**37,278**	**138**	**40,516**	**40,680**	**163**

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Front Sheet

REPORT TITLE:	**East Leicestershire and Rutland CCG: Primary Medical Care Risk Sharing Group – Terms of Reference**
MEETING DATE:	**3 April 2018**
REPORT BY:	**Fiona Fretter, Quality Lead**
SPONSORED BY:	**Anne Scott, Interim Chief Nurse and Quality Officer**
PRESENTER:	**Fiona Fretter, Quality Lead**

EXECUTIVE SUMMARY:

This report presents the revised Terms of Reference for the ELR CCG Primary Medical Care Risk Sharing Group, as agreed at the March 2018 meeting. At the meeting it was agreed to update the rules around quoracy to include a CQC representative.

The Terms of Reference are next due for review in March 2019.

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG Primary Care Commissioning Committee is requested to:

- **APPROVE** the terms of reference.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2017 – 2018:			
Transform services and enhance quality of life for people with long-term conditions	X	Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience	X	Listening to our patients and public – acting on what patients and the public tell us.	X
Reduce inequalities in access to healthcare		Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

EQUALITY ANALYSIS

An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is judged that it is not proportionate on the basis that each data source will have already undergone an equality analysis. This completes the due regard required.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:	
The content of the report identifies action(s) to be taken / are being taken to mitigate the following corporate risk(s) as identified in the Board Assurance Framework:	BAF 3 QUALITY – PRIMARY CARE: The quality of care provided by primary care providers does not match commissioner's expectation with respect to quality and safety.

East Leicestershire and Rutland Clinical Commissioning Group and NHS England – Midlands and East (Central Midlands)

Primary Medical Care Risk Sharing Group
Terms of Reference

Purpose of the group

In order to enact the concordat between the East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) and NHS England – Midlands and East (Central Midlands) this group has been established to:

- Share intelligence between partners in relation to any identified moderate risk which could impact on the quality and/or safety of care being provided within Primary Medical Services. Risks can be in relation to an individual practitioner or a practice

- Ensure effective communication and dialog between partner organisations to ensure consistency of approach and to eliminate duplication of effort

- Agree responsibilities and actions to be taken to mitigate any identified risk

- Ensure continued focus until any issues of concern are resolved

Governance arrangements

- Each organisation will be responsible for reporting through their respective governance structures the key quality and safety issues, actions and progress.

- The group will communicate any relevant information to the Care Quality Commission (CQC) as specified in the statutory notifications under the Health and Social Care Act 2008 (Appendix 1)

- The risk ratings and actions will be shared with the ELR CCG Primary Care Commissioning Committee on a monthly basis.

- Risk ratings are assessed against the “Guidance on reporting concerns to the Quality Surveillance Group” (Central Midlands, May 2016), all risks identified as “Enhanced” or “Risk Summit” levels, are reported to the Leicestershire Quality Surveillance Group.

Membership

The membership of the Primary Medical Care Risk Sharing Group will include:

- Chief Nurse and Quality Officer (East Leicestershire and Rutland CCG) or nominated deputy as appropriate

- Chief Operating Officer (East Leicestershire and Rutland CCG) or nominated deputy as appropriate
- Assistant Medical Director (NHS England – Midlands and East (Central Midlands)) or nominated deputy as appropriate
- Primary Care Contract Support Manager (Central Midlands Sub Regional Team/ELR CCG) or nominated deputy as appropriate
- Care Quality Commission - Central Region Inspection Manager or nominated deputy as appropriate
- Other co-opted members as appropriate

Frequency of Meetings

The Primary Medical Care Risk Sharing Group will meet on a monthly basis. Some meetings may be arranged as teleconference calls. Extra-ordinary meetings will be called if required.

Quoracy

The group will be deemed quorate if the following members are present;

- a member East Leicestershire and Rutland CCG,
- a member of the Medical directorate (NHS England – Midlands and East (Central Midlands)),
- a member of the Primary Care Commissioning directorate (NHS England)
- A representative from the CQC

If the CQC representative or nominated deputy cannot be is present the group will have received an updated report in relation to the practices under review or any recent visits from which there are unpublished concerns.

Reporting and Escalation

Where risks identified are considered to impact on patient safety these will be escalated to the ELR CCG Primary Care Commissioning Committee for consideration.

Where risks identified relate to specific practitioner performance these will be escalated to the Medical Directorate of NHS England – Midlands and East (Central Midlands).

Review

These Terms of Reference will be reviewed annually

Date of Next Review: March 2019

Appendix 1

Table of statutory notifications under the Health and Social Care Act 2008

This list is a summary. Please see the essential standards document and the guidance on the NHS, adult social care or independent healthcare pages for full details of what must be notified.

Regulation	Essential standards outcome	Notification
12	15	Changes to the provider's statement of purpose
14	27	Absence (and return from absence) of registered persons
15	28	Changes affecting a registered person
16	18	Death of a person who uses the service
17	19	Deaths and unauthorised absences of people who are detained or liable to be detained under the Mental Health Act 1983
18	20	Serious injuries to people who use the service
18	20	Application to deprive a person of their liberty (under the Mental Capacity Act), including its outcome
18	20	Abuse and allegations of abuse involving people who use the service
18	20	Events that prevent or threaten to prevent the provider from carrying on regulated activities safely and properly
18	20	Incidents reported to or investigated by the police*
18†	n/a	Placement of children or young people on an adult psychiatric ward
20†	n/a	Death of a woman after a termination of pregnancy*
21†	n/a	Death of a service provider (including a personal representative's plans for a service following the death of a provider)
22†	n/a	Appointment of liquidators

* Does not apply to NHS trusts

† These notifications are not part of an essential standards outcome. Please see the relevant regulation in the Care Quality Commission (Registration) Regulations 2009

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part3)

Regulation 4: Requirements where the service provider is an individual or partnership

Regulation 5: Fit and proper persons: directors

Regulation 6: Requirement where the service provider is a body other than a partnership

Regulation 7: Requirement relating to registered managers

Regulation 8: General

Regulation 9: Person-centred care

Regulation 10: Dignity and respect

Regulation 11: Need for consent

Regulation 12: Safe care and treatment

Regulation 13: Safeguarding service users from abuse and improper treatment

Regulation 14: Meeting nutritional and hydration needs

Regulation 15: Premises and equipment

Regulation 16: Receiving and acting on complaints

Regulation 17: Good governance

Regulation 18: Staffing

Regulation 19: Fit and proper persons employed

Regulation 20: Duty of candour

Regulation 20A: Requirement as to display of performance assessments