A Primary Care Performance Management Framework for NHS South West Essex
Primary Care is at the heart of our vision for health services in South West Essex. Evidence has shown that high quality health systems and healthy populations require strong and effective primary medical services. Our vision is to transform primary care locally to ensure that the entire population of South West Essex has access to consistently high quality primary medical services. The effective commissioning of primary care is central to our aspiration of becoming a world class commissioner of world class services.

Many practices are already performing to high standards and we are keen to promote and celebrate these successes. However, we also need to recognise that there is wide variation in performance across South West Essex and as the leader of the NHS locally, we need to be clear that poor performance is unacceptable.

Development of this performance framework is an important step towards achieving our vision. It establishes a clear policy framework within which we will operate; allowing the application of a consistent approach to performance monitoring and management.

In the coming months I will be working to identify the practical help needed to enable contractors to fulfil their potential as high quality service providers. Working with providers, I will be looking to draw on national and local best practice to further develop the framework. I envisage that we will take steps to learn from our experience of applying the framework allowing us to become more sophisticated in the use of metrics and benchmarking.

I look to working with you to implement the performance framework and begin working to deliver our vision for primary care.

Marc Davis
Director of Primary Care
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Chapter 1 – Overview of NHS performance regime

Introduction and context

The final report of the NHS Next Stage Review “High Quality Care for all”(1) published in June 2008 sets out the strategic direction for driving improvements in the quality of care across the health service. “Our Vision for Primary and Community Care”(2) published in July 2008 draws together the main conclusions of the Next Stage review for community based NHS Services and sets out a strategy based on four key areas: Shaping services around people's needs and lives, promoting healthy lives and tackling health inequalities, continuously improving quality and ensuring that change is led locally.

“Developing the NHS Performance Regime”(3) was published in June 2008 and sets out the NHS Executive's approach to performance management of the NHS.

The World Class Commissioning (WCC) organisational competencies(4) highlight effective performance management as one of the key levers in driving quality improvement of NHS services.

This document builds on the key principles of the NHS Performance Regime and the national strategic direction for community based NHS services and sets out NHS South West Essex's approach to performance management of primary medical service providers (GP Practices) in line with the PCT’s vision. This is the first of a series of primary care performance management framework documents. Future performance management framework documents which focus on primary dental services, pharmacy services and eye care (optometry) services will also be published by NHS South West Essex shortly.

NHS organisations have not always been consistent, open and transparent in their approach to addressing under performance by contractors and supporting recovery. We do however need to be clear with patients and the public about what they can expect from local NHS primary care services and how NHS South West Essex will hold organisations and the people who run them to account. We need to be clear as to what is considered underperformance and triggers intervention, what is a reasonable timescale within which an organisation will be expected to demonstrate recovery and what will happen if recovery is not achieved.

Our objective in developing this document is to ensure greater consistency and transparency in:
- Identifying and celebrating high performing primary care providers.
- Identifying underperformance.
- Supporting recovery.
- Managing failure.

The aim is to ensure that a primary care performance system enshrines the essential levels of quality and safety that all providers will be expected to demonstrate in order to be eligible to provide NHS services. We need consistent measures of performance in service delivery across all primary care providers which ensure that services are personalised to meet the needs of patients and take into account the need to promote equality of opportunity under disability, gender and race legislation. This will allow NHS South West Essex to take a coherent approach to tackling underperformance.

Roles and responsibilities

This document provides a detailed framework for managing the performance of all primary medical contracts. NHS South West Essex is accountable through its Board for improving performance and addressing underperformance in relation to all NHS health care commissioned on behalf of our local population. Equally we need to hold individual providers to account at organisational level in accordance with their NHS contracts with NHS South West Essex.

The key elements of our performance management of primary medical contractors will be based on the following:
- The use of consistent information to define a spectrum of performance and to support patient choice (including the development and publication of balanced scorecards for primary care contracts) (see Chapter 3).
- The commissioning and contracting processes used by PCTs to hold providers to account, to identify and celebrate high performance and to tackle early signs of underperformance (see Chapter 3).
- Independent regulation by the Care Quality Commission (CQC) to safeguard essential levels of quality and safety (see Chapter 4).

PCTs are held accountable for delivery of high quality NHS care across their areas by the East of England SHA. This document sets out how NHS South West Essex intends to deliver these responsibilities through performance management of contracts held with primary medical providers in line with Competency 10 of the World Class Competencies for commissioning organisations. Competency 10 requires PCTs to “effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and value for money.” Further details on our approach to delivering Competency 10 is set out in Chapter 3.

(1) NHS Next Stage Review “High Quality Care for All”, Department of Health, 2008
(2) NHS Next Stage Review “Our Vision for Primary and Community Care”, Department of Health, 2008
(3) Developing the NHS Performance Regime, Department of Health, 2008
(4) World Class Commissioning: Competencies, Department of Health, 2007
Support for “challenged” organisations

In line with the NHS Performance regime guidance NHS South West Essex recognises the concept of “challenged” organisations. This relates to organisations that have been underperforming persistently over time and are likely to require significant support to achieve recovery. The PCT’s role as commissioners in providing support for challenged organisations is set out in Chapter 3.

There may also be instances where an organisation is failing to address persistent underperformance due to poor management and does not engage with PCT offers of support. In these exceptional circumstances NHS South West Essex may decide to publicly designate primary care contractors as challenged. This would usually occur if there is a failure to address underperformance within a defined period (eg 9 months to a year).

The PCT does not envisage taking such action lightly and does not propose that any primary care contractor is designated as challenged until the end of 2009/10 at the earliest.

Key principles

NHS South West Essex proposes that this performance management framework is based on the following key principles:

- **Transparent** – clear and predetermined performance measures and interventions.
- **Consistent** – a broadly uniform approach across NHS South West Essex for all similar primary care contracts.
- **Promotion and celebration of high performing primary care providers**
- **Proactive** – thresholds for intervention should aim to assist in identifying underperformance at an early stage so that it can be addressed and action taken, especially where there is a significant risk to patient safety.
- **Proportionate** – The PCT will broadly aim to ensure that actions are proportionate to risk except where cumulative failures are perceived by the PCT to add up to being serious.
- **Focus on recovery** – initial interventions will seek to focus on recovery and aim to include actions to address the root causes of issues where it is reasonably possible for the PCT and GP to work out the root causes.

Scope of this document: Developing NHS South West Essex primary care performance framework

This document sets out the roles and responsibilities described above in relation to upholding standards and driving improvements in primary medical service delivery.

It focuses on:

- The role of primary care providers in maintaining standards and driving quality improvements in service delivery.
- The role of PCTs as commissioners in holding providers to account for service delivery through their contracts.
- The role of PCTs as system managers in supporting recovery.
- The role of independent regulation in safeguarding minimum standards (for example Care Quality Commission (CQC), General Medical Council (GMC) and Nursing and Midwifery Council (NMC)).

Crown copyright © 2008, Department of Health ‘Developing The NHS Regime’

The diagram below sets out the different roles and responsibilities across the NHS for managing performance.

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Crown copyright © 2008, Department of Health ‘Developing The NHS Regime’

The diagram below sets out the different roles and responsibilities across the NHS for managing performance.
Chapter 2 - Measuring performance, driving improvements in quality and safeguarding minimum standards

The performance spectrum

Driving improvement in the NHS depends on measuring how services perform and using this information to inform the judgement of clinicians, commissioners, and regulators. The PCT intends to use broadly comparable performance measures and systems for performance management for all primary medical services contractors, building on existing national good practice. There will be variations depending on the type of contract held and possibly variations due to the type of practice and challenges which we are trying to overcome for the particular practice. This information will support comparative analysis and benchmarking of performance as well as informing patient choice.

By adopting this approach, NHS South West Essex will be able to provide:

- An evidence based approach by giving a quantifiable measure of performance.
- Consistency in allowing organisations to be categorised according to their performance.
- Transparency by giving organisations and services a clear perspective of their own performance, the circumstances under which the PCT and national regulators will intervene to address underperformance and of their performance benchmarked against their peers.
- Public accountability by helping patients and the public understand how local primary care contractors are performing and what level of performance they should expect.

We will use metrics and other performance sources to identify a spectrum of performance ranging from underperforming or failing performers at one extreme to excellent “platinum” or world class performers at the other extreme:

Breaching registration requirements or authorisation

Non-compliance with selected improvement standards or failure to meet improvement targets

Compliance with criteria, adoption of improvement standards and performance management against national and local targets

Exceeding national targets, benchmarking and continued improvement

Figure 2: The performance spectrum

World-class
Underperforming
Average to good
Failing

(Exceeding national targets, benchmarking and continued improvement)

(Compliance with criteria, adoption of improvement standards and performance management against national and local targets)

(Non-compliance with selected improvement standards or failure to meet improvement targets)

(Breach of registration requirements and/or authorisation)

(The spectrum of performance must be measured in terms of metrics, targets and standards)

The PCT will use the metrics as an objective measure to determine an organisation’s performance and then use its discretion to identify the most appropriate way forward for the organisation bearing in mind other issues of which the PCT is aware.

Our approach in NHS South West Essex

NHS South West Essex recognises that implementation of an effective primary care performance management framework requires significant investment in capacity and capability within the PCT. The PCT is investing in additional capacity within the Primary Care Directorate; it is anticipated that the expanded team will be in place by September 2009. A modular training and development programme will be commissioned to support all primary care commissioning team members.

Recruiting additional primary care contracting and performance managers will facilitate the development of an effective two-way dialogue with all primary care providers through named contract leads and regular performance review meetings.

In addition the Primary Care Directorate is recruiting a new service improvement team led by a senior Primary Care Programme Development manager. The aim of this team will be to improve the capacity of all primary care providers through leading and supporting changes in service delivery and developing a prospectus of practical support for primary care providers.

Informing quality improvement

The PCT is keen that service improvement is seen as a key motivator for clinicians through the publication of comparative information on performance to facilitate self assessment and comparison with peers at both local and national level. Nationally, work is ongoing to develop financial rewards for quality, so that ultimately provider payments will be linked to patient experience of services from providers.

In addition it is recognised that national schemes such as Revalidation of General Practitioners and the Royal College of General Practitioners Accreditation tool kit will play a significant part in encouraging this drive for quality improvement in primary care.

NHS South West Essex will agree annual quality improvement standards with all primary care contractors to drive service improvements with a focus on identifying and rewarding continuous quality improvement. It is recognised however that this alone may not be sufficient and that we need to empower local people through provision of information, offer more choice and through contestability to drive improvements in service quality.
Informing patient choice

NHS South West Essex is committed to provide local people with information through a range of communication channels, including regular updates through the public board meetings, publication of the Patient Prospectus, NHS Choices website and an improved PCT website.

NHS South West Essex recognises that information about performance of NHS primary care services is critical for public accountability and that this is a key pledge within the NHS Constitution published in January 2009. This needs to include information about standards of access and quality, performance, patient and staff satisfaction levels and how and to whom to complain.

Information together with choice, such as choice of GP practice, can empower patients and drive improvement and responsiveness in NHS services. Providers who do not respond to patients should be aware that ultimately patients may choose to go elsewhere and some providers may therefore become financially unviable.

Informing independent regulation

Information and standards are central to the regulation of primary care NHS services. The Care Quality Commission (CQC) which was formed on 1 April 2009 will require all NHS primary care providers to register with the CQC. Registration with the CQC is likely to include national levels of quality and safety. It is currently envisaged that regulation of primary care providers will not be formally implemented until 2011.

Criteria for monitoring compliance will be developed and if a provider is found to be in breach of these requirements, the CQC will have the power to take enforcement action and in extreme cases will be able to close services in order to ensure patient safety.

Chapter 3 - The role of NHS South West Essex as a commissioner, accountable to the local community

Overview

NHS South West Essex is accountable to the Secretary of State for Health for commissioning all NHS services on behalf of its population. We are statutorily responsible for the quality and accessibility of services which we commission and for securing value for public money. Our vision is “for the entire population of NHS South West Essex to become one of the healthiest and best cared for in the country.”

The contract which NHS South West Essex holds with a primary care provider is the key line of accountability for service performance.

NHS South West Essex recognises that in order to be recognised as a World Class Commissioning (WCC) organisation, we need to demonstrate our competency against the 11 WCC organisational competencies. Competency 10 relates to effective performance management. While this alone does not demonstrate our overall effectiveness as a world class commissioning organisation, this document sets out an effective primary care performance management framework which will ensure that variation in primary care performance is minimised and overall quality of primary care provision improves across South West Essex. Our approach is also consistent with Competency 5 (use of health service benchmarks) and Competency 8 (promotion of continuous quality improvement and outcomes).

A summary of the World Class Competencies is set out as an appendix to this document. (appendix 1)

Our aim is to recognise and reward high performing practices, swiftly identify and support primary care providers who do not currently meet performance standards and ultimately take action where performance does not improve to decommission providers who are unable to deliver against contractual performance standards.
A Comprehensive approach to managing performance


Accountability for the performance management of primary care contracts is delegated by the Trust Board via the Chief Executive to the Director of Primary Care.

To support the decision making process, the Director of Primary Care will chair a Primary Care Performance Management Group (PMG) whose purpose shall be to ensure that NHS South West Essex has an equitable, consistent and transparent process to implement the primary care performance management framework for all primary care provider contracts. This focuses on a formal annual accountability review meeting with all primary care providers with quarterly meetings with providers to review progress during the year.

The Terms of Reference for the Performance Management Group is set out in appendix 2. A framework for decision making to assist the Performance Management Group is set out in appendix 3.

Measuring service performance

NHS South West Essex is developing a consistent approach to measuring service performance and providing a transparent basis for intervention under primary care contracts. This approach will reflect the principles for “intelligent” commissioning as outlined in “The Intelligent Board” published in February 2006.

This will take into account existing good practice guidance and proposed national primary care metrics by the Department of Health. This will allow the PCT to monitor performance trends for primary care providers both against their peers and also against regional and national benchmarks.

Our performance management framework for primary care is a whole systems approach which will include the four key elements outlined on the next page. Analysis of this information will provide a snapshot of current performance and inform the priorities for further investigation as part of the contract review process. The assessment of provider capacity and capability will also inform the type of support to be provided by the PCT primary care programme development team.
1. Assessment of current primary care capacity and capability
   This assessment will inform the strategies required by the PCT to support all practices to continuously improve their performance.

2. Practice profile
   This is a summary of information relating to the individual provider, for example contract details, contract type, number and type of clinical and non clinical staff employed, compliance information, additional and enhanced service provision and practice population profile.

3. Balanced scorecard
   This provides an assessment of primary care performance across a number of domains. This will be developed over time to ensure that the scorecard reflects national and local priorities. The balanced scorecard developed by NHS South West Essex for Primary Medical Services is included as appendix 4.

   The scorecard will triangulate performance data from a variety of sources, including national Patient Access surveys and performance against Choose and Book, local data including prescribing figures, secondary care referrals, premises quality and patient feedback from a variety of sources including independent local surveys, information from LINKs, mystery shopper exercises and information already collected across the PCT.

4. Value for money assessment based on a range of financial metrics
   This will include assessment of provider spend per head of population, acute services utilisation per 1000 weighted population, spend against PBC budgets, etc.

Summary of Primary Care Performance Management Framework

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<th>Outline approach to performance assessment</th>
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<td>Assessment of individual providers to inform strategies required to support quality improvement</td>
<td>N/A</td>
</tr>
<tr>
<td>Practice profile</td>
<td>This will provide contextual summary for individual providers</td>
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| Balanced scorecard              | This will assess individual provider assessment against a number of key service performance domains: • Clinical outcomes • Access and responsiveness • Choose and book utilisation • Prevention and screening • Prescribing • Acute services utilisation | 20%  
                                         25%  
                                         5%   
                                         20%  
                                         15%  
                                         15%  |
| Value for money                 | Financial metrics including spend per head of population | N/A                                                  |

Managing service performance by domains (balanced scorecard approach)

Balanced scorecards will be compiled for every primary medical service provider. Scores across the key service performance domains will be weighted as set out above.

The analysis of information from the performance management framework will be reported to the Primary Care Performance Management Group. The information will inform both the seniority of the management team undertaking the performance review visit and the priority for visit within the annual programme. NHS South West Essex will initially target visits on practices where there appears to be a number of different performance issues.

The PCT will undertake an assessment of individual provider capacity and capability as part of the performance review visit as it is important that there is a shared understanding of the provider’s current position.

Chapter 2 outlined the PCT’s plans to develop its own capacity and capability within the Primary Care Directorate to implement the primary care performance management framework. The PCT will implement a quarterly review process with all GP providers from Quarter 4 of 2009/10. Quarterly performance meetings will be held with all primary care providers from 2010/11.

Identifying and celebrating high performing providers

NHS South West Essex wishes to recognise and publicise the significant achievements of high performing and innovative providers who consistently meet the challenges arising from national and local priorities. NHS South West Essex will also recognise those who are able to demonstrate above average or “platinum” achievement across the balanced scorecard service performance domains. High performing providers are also important influencing role models both across South West Essex and the East of England and can provide peer support to local primary medical service providers.

NHS South West Essex will develop performance incentives for high performing practices during 2009/10. This could include earned autonomy status, for example less frequent QOF visits and an increased role as clinical commissioning leads for Practice Based Commissioning. “Platinum” practices would also be eligible for accreditation to provide new community based services through a willing provider process. NHS South West Essex will also support these practices to become accredited training practices for the next generation of primary care clinicians.
Identifying underperformance

Through regular monitoring and active contract management, both NHS South West Essex and providers will be able to jointly identify early signs of underperformance and target where remedial action is needed.

Outcomes of each performance review meeting will be reported to the Primary Care Performance Management Group (PMG).

The PMG will have the right to set improvement/practice development plans in discussion with the provider and to receive updates on progress on an exception basis. The PMG will provide annual progress reports to the Board.

Where a potential contractual breach is identified or where a provider underperforms systematically or persistently then NHS South West Essex may intervene through the contract; in such circumstances a full statement of the case will be made to the PCT’s Primary Care Performance Management Group who will be responsible for approving further action.

A flowchart setting out the primary care performance management framework is set out in appendix 6.

Intervening to support recovery

NHS South West Essex will intervene to address underperformance. Interventions will initially be aimed at supporting recovery. However where a provider underperforms seriously or persistently then the PCT will intervene to safeguard patient safety and/or initiating action to procure services from elsewhere.

The contractual interventions for underperformance will depend on the type of contract held with a provider (General Medical Services (GMS), Personal Medical Services (PMS), Alternative Provider Medical Services (APMS) or Specialist Provider of Medical Services (SPMS) but are likely to include:

• Dispute resolution procedures and meetings and escalation;
• The serving of formal notices identifying breaches and requiring certain steps to be taken within certain timescales;
• Withholding or deducting money for obligations for which the provider is in default;
• Possibly direct financial sanctions linked to the breach in question; and
• Suspension and termination of parts of the contract - for example certain local enhanced services if they are not being provided to the required standard.

Hopefully through working together to resolve breaches before they become too serious, the ultimate sanction of termination can be avoided.

In the first instance, underperformance is likely to occur at service level, for example where a provider underperforms against specific targets i.e. screening targets or access satisfaction scores. However persistent or systematic underperformance against a range of metrics is likely to be an indication of problems at an organisational level. Interventions will need to be proportionate to the scale of the underperformance identified.

An effective remedial plan is likely to include responsibilities for both the PCT as commissioner as well as for the provider. For example, the PCT’s Primary Care Programme Development team will focus on service improvement, offering a range of support including external organisational support to work with providers to address specific areas of underperformance or provide dedicated support from within the PCT’s Primary Care Programme Development team. However in more challenging or persistent cases, the nature of the intervention may be different and could include additional income to address short term capacity issues in the short to medium term, while consultation on alternative options is carried out.

Escalation and intervention defined stages

As mentioned elsewhere, NHS South West Essex will usually seek to intervene initially with the aim of recovery and expects that in the majority of cases it will work with providers to resolve performance issues successfully. Therefore the option of termination would not usually be used.

The Performance Management Group (PMG) will assess the type of performance issue to be addressed and recognises that these may arise from a number of sources, for example these may be clinical issues, organisational problems, breach of minimum standards, breach of contractual issues or failure to meet developmental standards.

The solution to these issues will therefore vary; for example concerns about clinical issues could relate to individual contractor health or performance concerns. In such cases the PMG will refer the case to the PCT Poor Performance Group for advice on next steps including assessment through the National Clinical Assessment Service (NCAS), Performance Advisory Group (PAG) and other options for supporting the individual clinician. The PCT Policy for managing poor clinical performance amongst primary care clinicians is attached as appendix 8.

The table on the next page sets out the defined stages of escalation and intervention including both informal and formal resolution stages.
The interventions for underperformance will depend on the type of contract held with a provider (GMS, PMS, SPMS or APMS). The chart below sets out the stages of escalation and intervention stages which are likely to be followed by the PCT. Sometimes a stage or stages will be omitted due to the type of contract or particular issue - for example for a serious issue or cumulative series of more minor issues the intervention might go straight to the more formal contractual sanctions, under some contracts financial deductions will take place at an early stage. Sometimes the nature of the breach may mean that termination of the contract is the most appropriate contractual remedy for the PCT to use. Files and records are likely to be kept for all stages.

### Stage 1: Concerns including potential or actual contractual breaches identified through variety of routes including performance review meeting, patient feedback etc

**Intervention 1:** Informal resolution between Senior Contracting and Performance Manager and Provider

**Escalation to another stage is likely to occur if:**

- Informal resolution route is not successful after given period of time or if the PCT has concerns about risks to patient or other service delivery concerns.

### Stage 2: Informal resolution of potential or actual contractual breaches under Stage 1 unsuccessful or type of breach seen to be of a more serious or repeating nature by the PCT.

**Senior intervention by the PCT through the relevant Head of Commissioning or Associate Director and a senior member of the Provider’s team.**

**Escalation to another stage is likely to occur if:**

- Senior intervention is unsuccessful after given period of time or if the PCT has concerns about risks to patient or other service delivery concerns.

### Stage 3: Underperforming practice is identified - either through Stages 1 and 2 above or otherwise

**Practice required to improve within defined period eg 28 days to 6 months and report on progress to PMG each month. Depending on seriousness of issues, formal contractual notices may be issued at this stage.**

**Escalation to another stage is likely to occur if:**

- Lack of performance against recovery plan within the given period of time or the PCT has concerns about risks to patient or other service delivery concerns.

### Stage 4: Seriously underperforming practice

**PMG reviews progress against set plan/requirements after a given period of time–if not satisfied will consider other remedies including formal contractual notices and other contractual remedies. Decommissioning/suspension/termination of certain services will be considered.**

**Escalation to another stage is likely to occur if:**

- There is insufficient evidence of progress against recovery plan within the given period of time or if the PCT has concerns about risks to patient or other service delivery concerns.

### Stage 5: Challenged practice

**The PCT will identify the primary care provider as being “challenged”. Any further actions or decisions will be taken by senior personnel within the PCT rather than the PMG.**

**Escalation to another stage is likely to occur if:**

- The PCT has concerns about risks to patient or other service delivery concerns which have not been addressed to the PCT’s satisfaction (for example despite formal contractual notices having been served if such are required by the contract).

### Stage 6 Termination

**The PCT will take action to formally terminate the contract.**

**Escalation to another stage is likely to occur if:**

- The PCT has concerns about risks to patient or other service delivery concerns which have not been addressed to the PCT’s satisfaction (for example despite formal contractual notices having been served if such are required by the contract).

Appendix 5 sets out in more detail a proposed schedule contract variation to existing GMS, PMS, APMS or SPMA contracts which will be developed further in discussion with primary medical service providers.

A flowchart illustrating the various escalation and intervention stages is included as appendix 7.

### Managing provider failure

The PCT will always consider taking any formal contractual action carefully in relation to any primary medical service provider.

As mentioned elsewhere the PCT hopes that the majority of performance failures identified will be able to be quickly and successfully resolved without needing recourse to the more formal contractual sanctions and therefore that the ultimate sanction of termination can be avoided. The whole process of contract management will be in line with current legislation.

As part of the processes outlined in this document the PCT will be considering a range of options to ensure that patients are able to access high quality primary care services. Actions that the PCT might take would include eventual closure of an existing practice if, for example, other options had failed, managing staff redundancies or transfers and taking on temporary management of a practice.
Chapter 4 -
Independent Regulation

Practice Accreditation – assuring minimum standards

The RCGP has recently completed a pilot scheme, Primary Medical Care Provider Accreditation (PMCPA) involved 36 GP practices across 4 different PCT areas; an independent evaluation of this scheme is due to be published by the DH in June 2009. The pilot was designed to support and monitor the development of quality primary care through a voluntary scheme, patient focused, developmental, professionally led and encouraged continuous quality improvement. It involved self-assessment by the pilot practices against 30 core criteria representative of a safe and acceptable provider and a series of six domains that incorporated 82 developmental criteria that enabled providers to work towards improving the quality of care provided in specific areas.

The six developmental domains were: Health Inequalities and Health Promotion, Provider Management, Premises, Records, Equipment and Medicines Management, Provider Teams, Learning Organisation and Patient Experience/Involvement.

Following self-assessment, practices received a multidisciplinary accreditation visit which resulted in a Final Assessor Report and Quality Improvement Plan.

Following publication of the independent evaluation of this pilot scheme, NHS South West Essex would be keen to encourage local primary care providers to take part in any future expansion of this initiative.

The role of the Care Quality Commission and Professional Regulatory Bodies

There are broadly two forms of regulation:

- Regulation of organisations providing health and social care (for example Care Quality Commission).
- Regulation of individual professionals working in these organisations or providing care as independent self-employed practitioners through organisations such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC).

These forms of regulation are complementary and together provide assurance that care will be safe and of an acceptable quality. The Care Quality Commission (CQC) will also be able to review services commissioned and provided across the whole care pathway.

Regulation of organisations ensures that healthcare providers meet their respective regimes; the CQC will have enforcement powers to protect patient safety i.e. to suspend or close a service. The CQC will have responsibility for registering all health and social care providers including primary care providers; while this will be phased from 2009, primary care providers should note that they will need to demonstrate that they can meet the essential levels of safety and quality required for registration and will need to continue to meet them to maintain their registration.

The regulation of healthcare professionals ensures that individuals fulfil their role through setting standards, ensuring the quality of initial and postgraduate professional education, overseeing the quality of systems of professional appraisal and investigating specific concerns brought to their attention.

The regulators are responsible for setting thresholds which will trigger regulatory intervention; these are applied in accordance with principles of consistency and transparency. Information will be taken from a variety of sources including measures of existing targets and standards. Regulators have their own compliance and enforcement regimes to safeguard requirements and where requirements are not met they can take action and apply sanctions to organisations or individuals.

It is important to note that the Primary Care Performance Management Group will advise the appropriate regulatory bodies of any persistent or serious concerns which arise as a result of the performance management of primary care providers.

Appraisal and revalidation

Current thinking on the process for revalidation of General Practitioners is outlined in the Royal College of General Practitioners (RCGP) “Guide to the Revalidation of General Practitioners” published in April 2009.

The GMC proposes to introduce a system of licensing during 2009 – all existing doctors on the GMC Register will be entitled to a licence to practice and this licence will be required in future for all doctors working within the NHS whether on permanent or locum basis. GPs will continue to be listed on both the General Medical Register and the General Practice Register.

GPs will need to be re-licensed and re-certified periodically through the process of revalidation which will require all GPs to provide evidence that they keep up to date and remain fit to practise. The RCGP paper sets out its current proposals for the evidence required for revalidation of GPs. This sets out 13 key evidence areas which GPs will be required to satisfy for revalidation:

(5) Guide to the Revalidation of General Practitioners, Royal College of General Practitioners, 2009
1. Statement of professional roles and other basic GP details
2. Statement of exceptional circumstances
3. Evidence of active and effective participation in annual appraisals
4. A Personal Development Plan (PDP) from each annual appraisal
5. A review of the PDP from each annual appraisal
6. Learning credits in each year of the revalidation period and in the revalidation period overall
7. Multi source feedback from colleagues
8. Feedback from patients
9. Description of any cause for concern and/or formal complaints
10. Significant event audits
11. Clinical audits
12. Statement on probity and health
13. Additional evidence for areas of extended practice (ie for appraisers, GPs with Specialist Interests etc.)

Ultimately the GMC will be required to approve the standards and methods before they are introduced.

Pilots are being undertaken in 2009 in preparation for the commencement of revalidation from April 2010; GPs are therefore advised to commence putting together their portfolios of evidence from April 2009. This initially should include all evidence required for annual appraisal for the year 2009/10 and should be compiled using an electronic portfolio for each GP.

Appendices

Appendix 1 – World Class Commissioning Organisational Competencies

The WCC Competencies
1. "NHS South West Essex" – leading on the health agenda for the local population
2. Work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities
3. Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health
4. Lead continuous and meaningful engagement of all clinicians to inform strategy and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the NHS
7. Effectively stimulate the market to meet demand and secure required clinical and health and well-being outcomes
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. Secure procurement skills that ensure robust and viable contracts
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and value for money
11. World Class Commissioners make sound financial investments to ensure sustainable development and value
Appendix 2 – Terms of Reference for Primary Care Performance Management Group (PMG)

Name of Group: Primary Care Performance Management Group
Chair: Director of Primary Care
Reporting to: Corporate Management Team (CMT)

Role of Group:
The Performance Management Group will ensure that NHS South West Essex has an equitable, consistent and transparent process to implement the primary care performance management framework in line with World Class Commissioning Competency 10 (Management of local health system). This includes performance management of GP practices, dental practices, pharmacy contractors and optometrist (eye care) in line with the terms and conditions of their contracts and national regulations.

The performance management group is to carry out the following functions:
• To formalise contract performance management activity across all primary care contracts
• To develop expertise across the PCT Directorates in relation to primary care performance management
• To ensure a consistent, transparent and equitable decision making approach to implementation of the primary care performance management framework.
• To provide assurance to the PCT’s Board that all contractual requirements for primary care contracts are being met
• To assess primary care performance by individual contractors against a balanced scorecard and review trends in performance over time
• To review balanced scorecard information to determine priority and composition of visiting team for performance review meetings with primary care contractors
• To review practice visit reports and agree practice improvement plans with clear deadlines for delivery where appropriate
• To identify and celebrate high performing practices
• To follow up improvement plans and ensure that practices deliver agreed improvements against agreed timescales
• To make recommendations to the Poor Performance Group where performance review meetings highlight concerns regarding individual clinical performance
• To consider any contractual action required where compliance with Improvement Plans is not achieved, including issuing of contract remedial notices or contract breach notices to primary care contractors
• To make recommendations on the issue of appropriate contract sanctions to the Part 2 PCT Board
• To make recommendations where appropriate on the termination of contracts to the Part 2 PCT Board.
• To receive reports to benchmark primary care contractor performance in line with national and local performance standards
• To receive updates on clinical quality, safety, infection control or other issues across the PCT and ensure that these issues are addressed as part of the practice performance review meetings.
• To report regularly to the PCT’s Board on primary care contractor performance including annual performance review performance for all contractors.

For information:
• the Poor Performance Group is a body which considers action needed in relation to alleged poor performance of individual primary care contractors – action can include referral to GMC or occupational health services for the individual contractor, or investigations using external clinical; and
• the Part 2 PCT Board is a separate meeting to the PCT’s main public board meeting where confidential issues are discussed and agreed by the PCT’s board.

Membership of performance management group who are all employees of the PCT:
Director of Primary Care (Chair)
Associate Director for Primary Care Commissioning
Head of Primary Medical Services Commissioning
Head of Dental, Pharmacy and Eye Care Commissioning
Associate Medical Director
Head of Integrated Governance
Associate Director for Quality
Appendix 3 - Primary Care Performance Management Group (PMG) – A Framework for Decision Making

1. Key principles for decision-making
The standard of proof adopted for all decisions should be that of common law i.e. “On the balance of probabilities”

Each case should be considered on its own merits however the PMG should be guided, in order of priority, by

- Statute (The Primary Medical Services and any other relevant Regulations)
- Determinations by the NHS Litigation Authority
- Determinations by any other recognised Senior NHS Body
- Established Precedents of NHS South West Essex
- Similar cases considered by other Primary Care Trusts.

The PMG may seek appropriate Legal Advice from the Trust solicitors

When considering the imposition of sanctions the PMG shall allow the contractor, if he so wishes, an opportunity to make an appropriate statement either in person, via a representative or through written communication

2. Administration matters
A Contract Performance File should be established for each Primary Medical Services Contractor. Any information presented to the PMG together with a record of any associated actions should be retained in the Contractors Contract Performance File.

3. Procedures prior to the consideration of contract Breaches.
The Contractor should be formally notified in writing that the PCT is investigating a possible breach to contract.

The PCT will present the evidence of the Breach to the contractor for comment or response.

The Contractor shall be formally notified in writing of the date that the PMG is considering the Breach.

Other representatives will be invited as appropriate to facilitate the effective working of the group.

Frequency of Meetings: Monthly
Accountable to: PCT’s Corporate Management Team (CMT)
Reporting to: PCT’s Corporate Management Team (CMT)
Support for Meetings: Administrative support will be provided by the Business Manager of the Primary Care Directorate of South West Essex PCT
Quorum: 4 members including Chair
Date of Terms of Reference: April 2009
4. Appeals against decisions made by the PMG

A contractor may appeal to the Chief Executive Officer if they consider that due process has not been followed. The Chief Executive Officer shall, under such circumstances, appoint an "Independent Review Officer" to examine the processes undertaken by the PMG preceding the decision pertaining to the Appeal.

There is no other internal appeal process relating to the decision of the PMG. A Contractor can however exercise his rights to appeal to the NHS Litigation Authority or take other legal action allowable under contract.

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**Appendix 4 - Primary Medical Service Balanced Scorecard**

**Practice Profile**

**Compliance Information**

- Performance against quality targets
- Patient satisfaction scores
- Compliance with data protection laws

**Out of Hours**

- Available and contactable during evening and weekend emergencies
- Patients' feedback on after-hours services

**Capacity**

- Number of patients seen per clinician
- Waiting times for appointments
- Staff utilization rates

**Additional Services**

- Cervical screening
- Maternity medical services
- Minor surgery
- Vaccinations and immunizations
- Contraceptive advice

**Profile of Practice Name**

- Total list size: 11,614
- Age bands and population distribution:
  - 0-14 Years: 2,000
  - 15-64 Years: 6,000
  - 65+ Years: 3,614

**Deprivation Score (IMD2007)**

- Practice Name average Deprivation Score: 20
- Highest and lowest PCT areas:
  - Highest: EOE PCT
  - Lowest: PCT Average

---

**Access and Choice**

The data presented here are the results from the patient satisfaction questionnaire. Two years worth of results are presented and a comparison made to distinguish whether a practice has improved or deteriorated in this time. An overall score is also presented which is an average of all other scores.

The comparison is made by applying 95% confidence intervals to the scores at both time points and using these to assess whether we can conclude a change with 95% confidence. If confidence intervals overlap then we cannot be confident of a change. If they do not then we can be 95% confident of a change in the relevant direction.

The methodology is not applied to the last of the indicators (% of patients who recall a choice conversation) as this is a new measure which some practices did not record last year. The methodology will be applied to this variable in the future.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trend (last 6 quarters)</th>
<th>Trend</th>
<th>Rank</th>
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<td>Acute Service Utilisation</td>
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<td>First OP Attendances per 1000 weighted population</td>
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<td>Follow up OP Attendances per 1000 weighted population</td>
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<td>First to follow up ratio</td>
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<td>Outpatient Did Not Attend rates</td>
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<td>1st OP Att. percentage Consultant-to-Consultant referred</td>
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<td>Elective admissions per 1,000 weighted population</td>
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<td>Conversion rate from Outpatient to Inpatient for elective specialties</td>
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<td>% readmissions within 10 days following an elective admission</td>
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<td>Emergency Admissions per 1000 weighted population</td>
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<td>% readmissions within 10 days following an emergency admission</td>
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<td>Bed days occupied by patients with long term conditions per 1000 weighted population</td>
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<td>Total Non elective admissions per 1,000 weighted population</td>
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<td>A&amp;E Attendances per 1000 weighted population</td>
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<tr>
<td>Ratio of Emergency Admissions to A&amp;E Attendances</td>
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<td>19 ACS Conditions</td>
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| Quality Outcomes Framework                                              |                          |       |      |      |      |      |
| Clinical                                                               |                          |       |      |      |      |      |
| Patient Experience                                                      |                          |       |      |      |      |      |
| Additional Services                                                     |                          |       |      |      |      |      |
| Organisational                                                          |                          |       |      |      |      |      |
| Total QOF Score                                                         |                          |       |      |      |      |      |
| Disease Prevalence                                                      |                          |       |      |      |      |      |
| CHD                                                                     |                          |       |      |      |      |      |
| Heart Failure                                                           |                          |       |      |      |      |      |
| Stroke and TIA                                                          |                          |       |      |      |      |      |
| Hypertension                                                            |                          |       |      |      |      |      |
| Diabetes                                                                |                          |       |      |      |      |      |
| COPD                                                                    |                          |       |      |      |      |      |
| Epilepsy                                                                |                          |       |      |      |      |      |
| Hypothyroidism                                                          |                          |       |      |      |      |      |
| Cancer                                                                  |                          |       |      |      |      |      |
| Palliative Care                                                         |                          |       |      |      |      |      |
| Mental Health                                                           |                          |       |      |      |      |      |
| Asthma                                                                  |                          |       |      |      |      |      |
| Dementia                                                                |                          |       |      |      |      |      |
| Depression                                                              |                          |       |      |      |      |      |
| Chronic kidney                                                         |                          |       |      |      |      |      |
| Atrial fibrillation                                                     |                          |       |      |      |      |      |
| Obesity                                                                 |                          |       |      |      |      |      |
| Learning Disabilities                                                   |                          |       |      |      |      |      |
| Smoking                                                                 |                          |       |      |      |      |      |

| Access and Choice                                                       |                          |       |      |      |      |      |
| GP patient survey - response rate                                       |                          |       |      |      |      |      |
| Telephone access                                                        |                          |       |      |      |      |      |
| Appointment within 48 hours                                             |                          |       |      |      |      |      |
| % able to book with specific GP                                         |                          |       |      |      |      |      |
| % satisfied with opening hours                                          |                          |       |      |      |      |      |
| % able to do advanced booking                                           |                          |       |      |      |      |      |
| Overall Patient satisfaction                                            |                          |       |      |      |      |      |
| % of patients who can recall a choice conversation                      |                          |       |      |      |      |      |
| Choose and Book                                                         |                          |       |      |      |      |      |
| Utilisation of Choose and Book                                          |                          |       |      |      |      |      |
| Screening and Prevention                                                |                          |       |      |      |      |      |
| Flu - Over 65s (current ongoing campaign)                               |                          |       |      |      |      |      |
| Flu - Under 65's at risk (current ongoing campaign)                     |                          |       |      |      |      |      |
| Pneumococcal - Over 65s (%)                                             |                          |       |      |      |      |      |
| Childhood immunisation - 2 years MMR                                    |                          |       |      |      |      |      |
| Childhood immunisation - 5 years MMR                                    |                          |       |      |      |      |      |
| Childhood immunisation Men C - 2 years                                  |                          |       |      |      |      |      |
| Childhood immunisation Men C - 5 years                                  |                          |       |      |      |      |      |
| Cervical screening coverage                                             |                          |       |      |      |      |      |
| Prescribing                                                             |                          |       |      |      |      |      |
| % of selected products prescribed in line with PCT generic/formulation recommendations |                          |       |      |      |      |      |
| % of proton pump inhibitors prescribed as lansoprazole or omeprazole   |                          |       |      |      |      |      |
| % of oral antibiotics prescribed in line with PCT recommendations       |                          |       |      |      |      |      |
| Cephalosporin items per 1,000 StarPU's                                  |                          |       |      |      |      |      |
| Quinolones items per 1,000 StarPU's                                    |                          |       |      |      |      |      |
| Prescribing Budget Percentage Distance                                  |                          |       |      |      |      |      |
| Cost Per age, sex and temporary resident originated prescribing units (ASTRO-Pu's) |                          |       |      |      |      |      |
Appendix 5 – GMS Contractual Clauses

This is a draft document which is subject to amendment following further discussion with primary medical service providers.

Definitions

The following words have the following meanings:

“Business Days” means any day except Saturday, Sunday, Good Friday, Christmas Day and any Bank Holiday;

“Contractor Contract Manager” means [insert name and contact details];

“Contractor Senior Contract Manager” means [insert name and contact details];

“Failure Issue” means an actual or potential contractual breach identified by the PCT;

“PCT Senior Contracting and Performance Manager” means [insert name and email] or as notified by the PCT from time to time;

“PCT Associate Director” means [insert name and email] or as notified by the PCT from time to time;

“PCT Head of Commissioning” means [insert name and email] or as notified by the PCT from time to time; and

“PMG” means the performance management group at the PCT having the functions notified to the Contractor from time to time;

“Poor Performance Group” means the body constituted within the PCT which considers action needed in relation to alleged poor performance of individual primary care contractors;

“Rectification Plan” has the meaning set out in stage 3 of paragraph 2 below;

“Stage 1 Notice” has the meaning set out in Stage 1 of paragraph 2 below; and

“Stage 2 Notice” has the meaning set out in Stage 2 of paragraph 2 below

1. In relation to Failure Issues which are capable of remedy the PCT may, in its absolute discretion, submit the Failure Issue to the stage in the following table that it believes is most appropriate to resolve the particular Failure Issue. Therefore not all stages must be completed for a particular Failure Issue although usually the resolution of Failure Issues will start at stage 1 and proceed through the stages in consecutive order until resolution of the Failure Issue is achieved. If the PCT reasonably believes at any time that quicker resolution is required of the particular Failure Issue then the PCT may escalate the Failure Issue to another stage.

2. Failure Issue procedure table

<table>
<thead>
<tr>
<th>Stage number</th>
<th>Intervention that is likely to occur</th>
<th>Escalation to next stage will occur if</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1:</strong> Concerns including potential or actual contractual breaches identified through variety of routes including performance review meeting, Patient feedback etc</td>
<td>Intervention 1: The PCT shall call a meeting between the PCT Senior Contracting and Performance Manager and the Contract Manager giving at least 5 Business Days’ notice. Such notice shall specify: (a) the date, time and place of the meeting; (b) the Failure Issue(s) to be resolved; (c) the time period for informal resolution of the Failure Issue before the Failure Issue is escalated to Stage 2, the “Stage 1 Notice”.</td>
<td>Informal resolution route is not successful after the period of time set out in the Stage 1 Notice.</td>
</tr>
</tbody>
</table>

The parties agree to procure that the PCT Senior Contracting and Performance Manager and the Contractor Contract Manager shall attend the meeting called by the Stage 1 Notice and any subsequent meeting required by either party under this Stage 1.

| **Stage 2:** Informal resolution of potential or actual contractual breaches under Stage 1 unsuccessful or type of breach seen to be of a more serious or repeating nature by the PCT. | The PCT shall call a meeting between the PCT Head of Commissioning or PCT Associate Director and the Contractor Senior Contract Manager by giving at least 5 Business Days’ notice. Such notice shall also specify: (a) the date, time and place of the meeting; (b) the Failure Issue(s) to be resolved; (c) brief details of any Stage 1 meetings relating to the Failure Issue; and (d) the time period for resolution before the Failure Issue is escalated to Stage 3, the “Stage 2 Notice”. | Senior intervention is unsuccessful in resolving the Failure Issue within the period of time set out in the Stage 2 Notice. |

Either party may call subsequent meetings on giving at least 5 Business Days’ notice. The parties agree to procure that the PCT Head of Commissioning or PCT Associate Director and the Contractor Senior Contract Manager shall attend the meeting called by the Stage 2 Notice and any subsequent meetings requested by either party under this Stage 2.
<table>
<thead>
<tr>
<th>Stage number</th>
<th>Intervention that is likely to occur</th>
<th>Escalation to next stage will occur if:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 3: Underperforming practice is identified - either through Stages 1 and 2 above or otherwise</td>
<td>The Failure issue will be escalated for consideration by the PMG who will provide the Contractor with: (a) a plan of action for resolution of the Failure Issue (&quot;Rectification Plan&quot;) (b) periods of time to achieve particular stages in the Rectification Plan; and (c) details of monthly reporting and information required. The PMG will also consider issuing and issue if the PMG considers reasonable formal contractual notices pursuant to the Contract relating to the Failure Issue. The PMG may require the Contractor and such other individuals as the PMG may reasonably require to send the Contractor's Senior Contract Manager to such meetings as the PMG may reasonably require on giving at least 5 Business Days' notice. The Rectification Plan has not successfully resolved the Failure Issue by the time(s) specified in the Rectification Plan and/or the Rectification Plan is not being materially adhered to by the Contractor.</td>
<td></td>
</tr>
<tr>
<td>Stage 4: Seriously underperforming practice</td>
<td>Unless the Failure Issue relates to an individual's performance (in which case it shall be dealt with pursuant to paragraph 4 below), the Failure Issue will be considered by the PMG who will provide the Contractor with: (a) a plan of action for resolution of the Failure Issue (&quot;Rectification Plan&quot;) (b) periods of time to achieve particular stages in the Rectification Plan; and (c) details of monthly reporting and information required. The PMG will also consider issuing and issue, if the PMG considers reasonable, formal contractual notices pursuant to the Contract relating to the Failure Issue. The PMG may require the Contractor to send the Contractor's Senior Contract Manager to such meetings as the PMG may reasonably require on giving at least 5 Business Days' notice. The Rectification Plan has not successfully resolved the Failure Issue by the time(s) specified in the Rectification Plan and/or the Rectification Plan is not being materially adhered to by the Contractor.</td>
<td></td>
</tr>
<tr>
<td>Stage 5: Contractor is identified as being a &quot;challenged&quot; practice by the PCT.</td>
<td>The PCT will publically identify the Contractor as being &quot;challenged&quot;. Any further actions or decisions will be taken by senior personnel within the PCT rather than the PMG. Termination of the whole or part of the Contract will be given serious consideration by the PCT and steps to terminate (including issue of formal notices) are likely to occur in accordance with the Contract. The PCT will also consider whether partial termination or suspension of the Contract in relation to specific Services which are affected by the Failure Issue is appropriate and take steps to terminate or suspend such Services. The PCT may require the Contractor and such other individuals as the PMG may reasonably require to such meetings as the PMG may reasonably require on giving at least 5 Business Days' notice. Further plans may be implemented by the Contractor under the PCT's direction with timescales set by the PCT. Further meetings may be held with the Contractor. The Contractor agrees to attend such meetings and abide by directions given.</td>
<td>As determined by the PCT.</td>
</tr>
<tr>
<td>Stage 6: Termination</td>
<td>The PCT will take action to formally terminate the Contract in accordance with the Contract.</td>
<td></td>
</tr>
</tbody>
</table>

3. Nothing in this Schedule [●] is intended to change either party's rights to refer a dispute pursuant to the NHS dispute resolution procedure and is intended to set out a more formal framework for discussions occurring pursuant to Clause 518.

4. After Stages 1 – 3 a Failure Issue relating to an individual will be escalated to the Poor Performance Group who will consider the Failure Issue and determine the way forward. Such actions could include, as a first step, further investigation and then referral to regulatory bodies, the GMC or suspension or removal from the medical performers list.

5. Prior to Stage 1 the PCT may seek to resolve performance issues through plans to improve the Services implemented and overseen by the PMG. The PCT may elevate such performance issues to being Failure Issues at any time.

[Please note that this procedure will be amended if you have a PMS or APMS agreement]
Appendix 6 – Primary Care Performance Management Frame Work Flowchart

- Prepare balanced scorecard & calculate weighted priority score for each provider
- PCT to undertake Segmentation Assessment for each provider
- Information considered by PMG. Priority of visit determined for each provider
- Visit to Provider
- No issues identified – high performing provider
  - Report sent to Provider
  - PMG considers report & determines whether platinum status should be awarded
- PCT determines whether issue should be formally recognised as a Failure Issue or whether more informal resolution should be attempted first and Report sent to Provider
- No more informal resolution first
  - PMG review report – improvement plan drafted by PMG, discussed with Provider and implemented by Provider
  - Improvement Plan progress reviewed by PCT Senior Contracting and Performance Manager
  - Improvement Plan progress reported to PMG after timescale set out in improvement plan
- Yes Failure Issue
  - Refer to Appendix 8 for next steps. PCT chooses appropriate stage in escalation process
- No Failure Issue
  - Information considered by PMG. Priority of visit determined for each provider
  - Visit to Provider
  - Yes
    - Refer to Appendix 8 for next steps. PCT chooses appropriate stage in escalation process
  - No
    - PMG considers escalation and chooses appropriate stage in escalation process
    - Concerns raised on individual clinical performance
    - Improvement Plan progress reported to PMG after timescale set out in improvement plan
    - Progress has not been achieved
      - Provider advised that required steps in improvement plan have been met
    - Improvement Plan progress reviewed by PCT Senior Contracting and Performance Manager
    - PMG considers escalation and chooses appropriate stage in escalation process

*See appendix 7 for next steps.

Appendix 7 – Escalation and Intervention Process Flowchart

- Any Performance Issue identified by the PCT
  - Stage 1: Informal Resolution by contract managers
    - Issue Resolved
    - Escalation to Stage 2 Senior informal intervention
  - Fails
    - Escalation to Stage 3: PMG Referral
      - Improvement Plan
        - Issue resolved
        - Contracual Remedial Notice
          - Fails
            - Immediate Contractual Action
              - Breach
                - Investigation
                  - No further action required
                  - Action Required
              - Referral to Poor Performance Group if individual Clinical Performance concerns are identified
                - Investigation / Suspension/Removal from Performer List
                  - Referral to PCT Part 2 Board (contractual)
                - Referral to Regulatory Body
                  - Termination of Contract
                    - Investigation / Suspension/Removal from Performer List
                      - Referral to PCT Part 2 Board (clinical)
      - Referral to Poor Performance Group if individual Clinical Performance concerns are identified
        - Investigation
          - No further action required
          - Action Required
        - Referral to PCT Part 2 Board (contractual)
          - Termination of Contract
            - Investigation / Suspension/Removal from Performer List
              - Referral to Regulatory Body

Note: Please see appendix 5 which contains more detail on all of these stages.
Appendix 8 – PCT Poor Performance Policy

POOR PERFORMANCE POLICY-
PRIMARY CARE PROFESSIONALS

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<td>Integrated Governance Committee</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>Original: 9 October 2007</td>
</tr>
<tr>
<td>Updated version:</td>
<td>(September 2008)</td>
</tr>
<tr>
<td>Name of Director Sponsor</td>
<td>Barbara Stuttle</td>
</tr>
<tr>
<td>Name of originator/author:</td>
<td>Brid Johnson</td>
</tr>
<tr>
<td>Name of responsible committee/individual:</td>
<td>Integrated Governance Committee</td>
</tr>
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<td>Brid Johnson</td>
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<td>Date issued:</td>
<td>September 2008</td>
</tr>
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<td>Review date:</td>
<td>September 2009</td>
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<td>PCT wide</td>
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<th>Page</th>
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<td>3</td>
<td>Local Procedure</td>
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<td>Further Investigation</td>
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<td>5</td>
<td>What to do for Patients</td>
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<td>6</td>
<td>Handling the Media</td>
</tr>
<tr>
<td>7</td>
<td>Algorithm for the Local Management of alleged Performance Problems</td>
</tr>
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<td>8</td>
<td>List of all Stakeholders consulted as part of this Policy development</td>
</tr>
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<td>9</td>
<td>Equality Impact Assessment</td>
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<td>10</td>
<td>Version Control Sheet</td>
</tr>
<tr>
<td>11</td>
<td>Abbreviations</td>
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## Appendices

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<td>2</td>
<td>Information required for referring a practitioner to PAG for assessment</td>
</tr>
<tr>
<td>3</td>
<td>Removal etc. of Practitioners from the Professional List</td>
</tr>
<tr>
<td>4</td>
<td>Hearing of Representations</td>
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### 1. Introduction

This policy provides a common pathway of referral, assessment and recommendations. This process must be transparent and understood by everyone in the local health community. We aim to continue to improve the protection of patients from poor practice and support practitioners in difficulty. This will necessitate promoting the latter concept, so that this policy is not seen as purely punitive.

This policy does not apply to non-clinical staff employed by independent practitioners, where poor practice should be managed through mechanisms within the employing practice.

All clinical staff should under the terms of their ‘Professional Codes of Conduct’, report any significant concerns about performance.

The management of performer’s lists is currently under review by the Department of Health. This policy will be amended as necessary when the Department issues its recommendations.

### 2. Lines of responsibility

The National Health Service Act 2006 supersedes all other NHS legislation. The Act is a major consolidation statute for health legislation. It has consolidated a dozen enactments, relating to the NHS, mostly with effect from March 2007.

The organisation has a responsibility to protect the public by terminating its relationship with professionals where there are grounds for concerns about conduct or capability. This ruling applies to substantive posts, contractors, fixed term posts and locum/bank arrangements.

The organisation also carries a responsibility for ensuring that a practitioner posing a risk to patients does not move to another organisation but is referred to their professional body e.g. GMC/NMC, for investigation and potential removal from the register.

The objectives of the organisation and the professional regulatory bodies are to protect the patients from harm but their terms of reference are not the same and the organisation may exercise its right to take action in relation to a practitioner even though the professional regulatory body has not yet made a decision.

Concerns about a health professional’s conduct or capability can come to light in a wide variety of ways, e.g.

- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff and via audits
3. Local Procedure

Each case will be reviewed by the Lead for Clinical Standards and Director of Primary Care using the criteria listed below (Manchester Performance Panel Criteria) to make a considered decision whether there is significant cause for concern about performance with a view to establishing whether patient safety is seriously at risk. Not every professional identified will have a serious problem. Advice will be sought from Professor Mike Pringle, Collingwood Health Education Centre, or via, the local representative committee (LMC, LDC, LOC, LPC) CEO, or for dentistry via the local practice advisor, as needed.

- Review of performance against contracts, job plans, annual appraisal or revalidation
- Monitoring of data on performance and quality of care
- Intelligence gathered through the Local Intelligence Network relating to the use and storage of controlled drugs
- Clinical governance, clinical audit and other quality improvement activities
- Complaints about care by patients or relatives of patients
- Information from the Regulatory bodies or Police
- Litigation following allegations of negligence, would be reviewed at PCT level, where available

Additionally via:

Self-referral - Self-referrals might originate as a result of appraisals. Appraisals are viewed positively as a means for planning for future personal and professional development and, if conducted appropriately, will benefit the individual, as well as satisfying a requirement of clinical governance and being part of the revalidation process. However, it is likely that, if all professionals are involved in appraisals, then some will be identified through this process as potentially under performing.

The appraiser, if concerned, may encourage the appraisee to access the local performance process through self-referral, as this is a route through which they might access necessary resources and support for improvement (e.g. a mentor or clinical support).

Training - Concerns about the capability of health professionals in training should be considered initially as a training issue and the postgraduate dean/course leader (as appropriate) should be involved from the onset.

Concerns noted at PCT level - Triangulation of data is key to identifying concerns about performance through pattern recognition. Patterns will vary and in general they may be considered for:

- Gravity: which might be determined in terms of patient harm
- Frequency: both absolute and in comparison to other colleagues

Whistle-blowing

The PCT has a policy on whistle-blowing, which should be read in conjunction with this policy. The PCT will promote the existence of the whistle-blowing policy, with its safeguards and support mechanisms, to ensure that concerns about clinical performance can be brought forward at the earliest opportunities.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>Service Provision</td>
<td>Is there alleged poor performance in one or more of the following:</td>
</tr>
<tr>
<td></td>
<td>- Inappropriate treatment or medication?</td>
</tr>
<tr>
<td></td>
<td>- Poor clinical performance?</td>
</tr>
<tr>
<td></td>
<td>- Poor behaviour or attitude?</td>
</tr>
<tr>
<td></td>
<td>- Poor administration or management?</td>
</tr>
<tr>
<td></td>
<td>Or if there is consistent absence from work, particularly when the absence is with little or no notice and is not medically certified?</td>
</tr>
<tr>
<td>Severity</td>
<td>It is acknowledged that if the expressed concerns are substantiated, at the very least, they represent sufficiently sub-standard performance to the point that they cannot be ignored and demand some form of action</td>
</tr>
<tr>
<td>Repetitious</td>
<td>Has the alleged poor performance been ongoing over a period of time, or occurred on at least two separate occasions?</td>
</tr>
<tr>
<td>Substantiated</td>
<td>On the evidence available (preferably written) do the expressed concerns appear to be accurate and factual statements?</td>
</tr>
<tr>
<td>Inexcusable/indefensible action</td>
<td>Do the actions about which concerns are expressed fall well short of what a colleague would be expected to do in similar circumstances?</td>
</tr>
</tbody>
</table>

If all or some of the above criteria are met, the basis for defining poor performance has been established. If poor performance has been established, the nominated Lead will consider the following to assist the decision for further action:

- Are there mitigating circumstances which are now resolved?
- Is the professional aware and addressing the concerns?
- Were there temporary circumstances inside or outside the practice that might reasonably have been expected to affect performance?
- The professional has acknowledged areas of poor performance and is addressing them. However, at this stage, their improvement will require monitoring.
Local resolution

If a decision is made that poor performance has been identified, but is initially to be addressed locally (patient safety not currently being compromised) then the following will be put in place:

- A meeting will be arranged to identify issues, ramifications and evidence to be collected. Attendance at this meeting will usually be the Director of Primary Care and the Lead for Clinical Standards with other PCT members as necessary. The investigating officer may request the attendance of the practitioner under investigation.
- A discussion will subsequently be held with the health professional involved to agree an action plan with timescales for regular monitoring.
- Training needs will be identified and addressed with the Deanery/Local GP Tutor/Optometrist Adviser/Dental Adviser/Pharmaceutical Adviser as appropriate; the NHS Business Services Authority has dental reference officers who can also investigate concerns and support remedial action with general dental practitioners.

Other support will be organised as required, e.g. Occupational Health, mentorship. The PAG has experience in supporting poorly performing practitioners to enable a controlled return to work to benefit practice and has available to it experienced practitioners who will provide support and mentorship where that is thought to be necessary. It also has strong links with the Deanery.

If a decision is made that poor performance has been identified and further action is required then the nominated lead will refer to the Essex PAG. This decision will normally be communicated to the contractor prior to the formal referral being made. The PCT will set clear objectives and terms of reference for any review by the PAG.

The case with independent contractor own employed staff is even more complex, as they have contractual arrangements directly with practices or out-of-hours providers. Such individuals are subject to internal performance management. Individual practitioners still have to satisfy the rigours of their professional regulatory body and the expectations of the PCT and will be investigated if thought to be exposing patients to unnecessary risk.

PCT employed practitioners need to be dealt with in accordance with PCT employment procedures. Practitioners must also be on a Performers List, and therefore the PCT also has the option to consider action in accordance with the relevant regulations e.g. The National Health Service (Performers Lists) Regulations 2004.

4. Further Investigation

4.1 There are three levels at which to manage performance issues, through the Essex PAG, NCAS, the GMC or other Professional/National bodies.

a) Performance Advisory Group (PAG)

The local process, co-ordinated at PAG level, (Appendix 1) is both an investigative and supportive process (Maintaining High Professional Standards in the Modern NHS). Concerns regarding Pharmacists, General Practitioners, Dentists, Optometrists, Allied Health Professionals (AHP) and Nurses are dealt with through the PAG.

Suspension of a practitioner may only be used (section 154 of the National Health Service Act 2006) if the PCT is satisfied that it is necessary to do so for the protection of members of the public or is otherwise in the public interest. Even then it may only suspend a practitioner from the list whilst it decides whether or not to exercise its powers of removal or whilst it waits for a decision affecting the practitioner of a court or a regulatory body.

Consideration will also be given to whether an alert letter should be issued via the Medical Director of East of England Strategic Health Authority to make other NHS organisations aware of local suspension/removal as appropriate.

On receipt of the report from the PAG, the PCT will consider what action, if any, it needs to take; it might consult the NCAS. The PCT will set clear objectives and terms of reference for any review by the PAG.

Other support will be organised as required, e.g. Occupational Health, mentorship. The PAG has experience in supporting poorly performing practitioners to enable a controlled return to work to benefit practice and has available to it experienced practitioners who will provide support and mentorship where that is thought to be necessary. It also has strong links with the Deanery.

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PCT employed practitioners need to be dealt with in accordance with PCT employment procedures. Practitioners must also be on a Performers List, and therefore the PCT also has the option to consider action in accordance with the relevant regulations e.g. The National Health Service (Performers Lists) Regulations 2004.
If a PCT panel hearing is requested via the Director of Quality/Chief Executive, membership will be as per Appendix 4, page 21. The Director of Primary Care or other PCT/PAG officer will present the case. Other members may also be asked to attend, as needed e.g. other Professional Representatives, Performance Advisory Group (PAG) member. Advice may also be sought from an External Medical Adviser.

If the PCT decides to remove or contingently remove the practitioner from a Medical or Dental List, the practitioner is entitled to appeal against the decision. The appeal needs to be made in writing setting out the grounds of appeal to the Family Health Services Appeal Authority, 30 Victoria Avenue, Harrogate, HG1 5PR, within 28 days of the PCT’s decision. Legal representation is permitted at this level.

A “lessons learnt” review will be undertaken after each case and a Part II Board paper prepared to share lessons learnt with an action plan.

b) National Clinical Assessment Service (NCAS)
Any significant concerns about a Medical or Dental Practitioner should be notified to the NCAS, even if the matter is referred to the PAG (as per guidance on Pg.3).

Some Practitioners will not co-operate either through lack of insight or fear of the process itself. In such cases, serious consideration needs to be given to the suspension of the practitioner (see Appendix 3). It is also recommended that the NCAS be involved if there is concern about performance and the professional cannot be persuaded to participate in the local process by either seeking:

- Immediate telephone advice, available 24-hours
- Advice, then detailed supported local case management
- Advice, then supported local clinical performance assessment
- Advice, then detailed NCAS clinical performance assessment
- Support with implementation of recommendations arising from the PAG assessment

Summary of key steps when contacting NCAS:
- Clarify what has happened and the nature of the problem or concern
- Discuss with NCAS what the way forward should be
- Consider whether restriction of practice or exclusion is required
- If a formal approach under the conduct or capability procedures is required, appoint an investigator

Lastly, the NCAS might reasonably take a request from a Doctor/Dentist with alleged performance problems if the professional felt that they were not being reasonably treated or assessed.

c) When to involve the GMC or other regulatory bodies
The main criterion used to decide whether immediate referral to the regulatory body is indicated is “Is there a serious risk to patient safety?” If an urgent decision is required before a Panel meeting is convened, the decision will be made by the Chief Executive/representative and the Non-Executive Director, in accordance with the PCT’s standing orders.

The regulatory bodies are the General Medical Council (GMC), the General Dental Council (GDC), the General Optical Council, the Royal Pharmaceutical Society (RPS), the Nursing and Midwifery Council (NMC) and the Health Professions Council (HPC) – contact numbers on page 11.

d) When to involve the Healthcare Commission
Some performance problems arise not because of the professional themselves but because of the organisation in which they work. In this respect, if there are concerns that this is the case, then it is recommended that the Healthcare Commission are informed (if not already aware). This concern might be expressed by the PCT level assessment and PCT panel (after assessment and realising this was a system problem), or by the professional themselves who feel they are unable to provide proper care because of problems with their employing organisation.

e) Involving the police
Some cases will involve alleged criminal activity. These cases will need to be reported to the police for investigation, as well as being referred to the PAG and notified to the NCAS and the appropriate Professional Misconduct Lead informed. The PCT Panel will need to decide when and how they handle this situation, particularly in respect to handling the media and caring for patients. If urgent, the Panel decision will be made by the Chief Executive/ Representative and the Non-Executive Director.

f) NHS Counter Fraud and Security Management Service
Some cases will involve alleged fraud. These cases will need to be reported to the counter fraud team for investigation. Advice will be sought by the PCT Panel who will need to decide when and how they handle this situation. If urgent, the Panel decision will be made by the Chief Executive/representative and the Non-Executive Director.

5. What to do for Patients
If a doctor/dentist is suspended, provision must be made for patients registered in the practice. The PCT will act quickly to arrange care. This might be through:

- Sharing within the practice (especially if a large practice)
- Local non-principals (especially if there is a local virtual practice) or locums
- Sharing amongst local practices
- Arranging appropriate cover for the practitioner in the practice
6. Handling the Media

The PCT must maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released in regard to any investigation or hearing into disciplinary matters.

Doctors and Dentists names are included in the performer’s lists, which are public documents. In the event that a practitioner is suspended, removed or contingently removed from a list, a short press release could be issued to that affect, as necessary.

The importance of confidentiality is paramount. However, there are incidents where despite the wishes of those involved, (i.e. early in a case before any problems have been established), the media might be alerted. Whilst the public has a right to know if it is being exposed to harm, this must be balanced with the reduced potential of helping to improve performance if a case is exposed too early.

The Strategic Health authorities have a Communication Specialist with considerable experience in dealing with the media. It is therefore recommended that their advice be sought through the Director of Corporate Development and Governance team.

The strategy recommended includes the following components:

- A designated representative responsible for liaising with the media
- A statement to be prepared to give an overview of what has taken place
- Careful consideration to what information is given to the media
- Media strategy disseminated to others involved, in the event that they are approached

7. Algorithm for the local management of alleged performance problems

Health Professional comes to your attention

Gather all available evidence

Is there a problem requiring action (Use Manchester Performance Panel Criteria)

Provide recommendations

Poor performance identified but being/will be addressed

Can engage but need an investigative and supportive process

Decide if Performance Advisory Group referral, support from external medical adviser is needed

Inform Practitioner and assessment undertaken

Provide recommendations e.g. Occupational Health referral, knowledge and/or skills assessment, practice visit

Meet with health professional and develop action plan

Regular meetings. Support as required

- PCT consider recommendations (support from NCAS as required)
- Professional considers recommendations with Defense organisations/Professional advisers
- PCT make a decision on recommendations (representation can be made by professional)
- Recommendations implemented
- Plan for improvement, e.g. Mentor, education, Occupational Health, extra management, etc.
- Further PAG review, as required
- Lessons learnt review and Part II Board paper

Action taken as agreed i.e. disciplinary or dismissal

Nursing & Midwifery Council (0207 333 9333)
General Optical Council (0207 580 3898)
Royal Pharmaceutical Society of Great Britain (0207 572 2308)
National Clinical Assessment Service (08702670850) for Doctors and Dentists
GMC (0845 357 3456)
Health Professions Council (0207 840 9814)

Regular review of progress
8. List of all stakeholders consulted as part of this policy development

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Department</th>
</tr>
</thead>
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<tr>
<td>Senior Management Team</td>
<td>Executive Directors</td>
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</tr>
<tr>
<td>Locality Directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Stanley</td>
<td>LPC</td>
<td></td>
</tr>
<tr>
<td>Joan Skeggs</td>
<td>PAG</td>
<td></td>
</tr>
<tr>
<td>Andrew Bradshaw</td>
<td>LMC</td>
<td></td>
</tr>
<tr>
<td>Tony Clough</td>
<td>LDC</td>
<td></td>
</tr>
<tr>
<td>Lynn Price</td>
<td>LOC</td>
<td></td>
</tr>
<tr>
<td>Sara Lingard</td>
<td>Primary Care</td>
<td></td>
</tr>
<tr>
<td>Caroline Humphreys</td>
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<tr>
<td>Eileen Bryant</td>
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<tr>
<td>David Hill</td>
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<tr>
<td>Olatunde Macaulay</td>
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<td>Robin Bell</td>
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<tr>
<td>Integrated Governance Ctte</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stephen Janisch</td>
<td>Solicitors</td>
<td>RadcliffeLeBrasseur</td>
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9. Equality impact Assessment for ‘Poor Performance Policy – Primary Care Professionals

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<th>Comments</th>
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<td>• Ethnic origins (including gypsies and travellers)</td>
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<td>• Nationality</td>
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<td>• Gender</td>
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<tr>
<td>• Culture</td>
<td>No</td>
<td></td>
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<tr>
<td>• Religion or belief</td>
<td>No</td>
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</tr>
<tr>
<td>• Sexual orientation including lesbian, gay and bisexual people</td>
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<td></td>
</tr>
<tr>
<td>• Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2. Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4. Is the impact of the policy/guidance likely to be negative?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>5. If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>6. What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
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<tr>
<td>7. Can we reduce the impact by taking different action?</td>
<td>N/A</td>
<td></td>
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If you have identified a potential discriminatory impact of this procedural document, please refer it to the Head of Integrated Governance, together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact the Head of Integrated Governance.
10. Version Control Sheet

Policy Title: Poor Performance Policy – Primary Care Professionals

<table>
<thead>
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<th>Version</th>
<th>Date issue/review</th>
<th>Author Name and title</th>
<th>Comment</th>
</tr>
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<td>001</td>
<td>Ratified at integrated Governance on 9 October 2007</td>
<td>Brid Johnson, Associate Director Commissioning and Quality, Adults and Older People</td>
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11. Abbreviations

- CEO  Chief Executive Officer
- GDC  General Dental Council
- GMC  General Medical Council
- GOC  General Optical Council
- HPC  Health Professions Council
- LMC  Local Medical Committee
- LDC  Local Dental Committee
- LOC  Local Ophthalmic Committee
- LPC  Local Pharmacy Committee
- NCAS  National Clinical Assessment Service
- NMC  Nursing Midwifery Council
- PAG  Performance Advisory Group
- PCT  Primary Care Trust
- RPS  Royal Pharmaceutical Society
Appendix 1

Essex Performance Advisory Group [PAG] – Terms of Reference

Membership
PCT Non Executive (Chairman)
Corporate Services Manager (Secretary)
Clinical Co-ordinator
An Essex PCO Director with responsibility for Primary Care
GP, Nursing, Dental, Pharmacy and Optometry Advisors
An observer from EoE Strategic Health Authority shall attend, but is not a member of the Group

Purpose
To oversee the management of poorly performing clinicians in primary care and to ensure appropriate action is taken to protect patients with due regard to the fair treatment and support of the clinician.

Terms of Reference
1. Committee to meet every month. Fifty per cent of the membership shall form a quorum.
2. Carry out investigations of poorly performing practitioners when commissioned to do so by a PCT.
3. Make recommendations to PCTs following investigations.
4. Review Assessment Panel case reports of serious clinical under-performance with a view to endorsing or agreeing recommendations made by the investigating officers.
5. Commission support or development work for clinicians as recommended in Assessment Reports, including agreeing funding with the PCT and / or the subject of the development work.
6. Monitor Assessment panel activity and ensure appropriate standards of investigation/assessment are maintained.
7. Review incidents of poor performance including Independent Review reports, where a PCT has agreed to share Independent Review reports with the PAG.
8. The Group is accountable to the PCT Boards for its activities in relation to the management of poorly performing clinicians in primary care, although in exceptional cases the SHA Observer on the PAG may wish to discuss a matter with the particular PCT if it is felt that there is a performance issue relating to the particular PCT.
9. Follow up and track progress of all cases referred to either a statutory agency or the Assessment Panel.
10. Maintain liaison with PCOs and Local Representative Groups as appropriate.
11. At the conclusion of a case the PCO will formally confirm to the PAG that the case is completed.
Appendix 2

Information required for referring a practitioner to the PAG for assessment – PCTs may refer any practitioner to the PAG for assessment and/or investigation

SECTION 1 – CONTACT DETAILS

Please give contact details here for the practitioner being referred:

<table>
<thead>
<tr>
<th>Surname</th>
<th>First Names</th>
<th>Work Address</th>
<th>Direct phone number</th>
<th>Fax number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The PAG also needs direct confidential access to the referring body's responsible officer:

<table>
<thead>
<tr>
<th>Name of referring body</th>
<th>PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referring body's principal contact with the PAG – the responsible officer</td>
<td>Surname</td>
</tr>
<tr>
<td>Position in referring body</td>
<td></td>
</tr>
<tr>
<td>Direct phone number</td>
<td></td>
</tr>
<tr>
<td>Confidential fax number</td>
<td></td>
</tr>
<tr>
<td>Confidential email</td>
<td></td>
</tr>
<tr>
<td>Address for confidential correspondence</td>
<td></td>
</tr>
<tr>
<td>Secretary/PA's name</td>
<td></td>
</tr>
<tr>
<td>Secretary/PA's phone</td>
<td></td>
</tr>
</tbody>
</table>

If the practitioner being referred also works for another organisation, please give details here and say whether there has been any discussion between the organisations about the practitioner's performance:

SECTION 2 – INFORMATION REQUIRED FOR A PRACTITIONER’S REFERRAL

A. About the Practitioner

<table>
<thead>
<tr>
<th>Current working status: normal working, sick leave, suspended, extended holiday leave etc., with dates as relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Registration Number</td>
</tr>
<tr>
<td>Joint Committee on Postgraduate Training for General Practice (JCPTGP) number, if applicable</td>
</tr>
</tbody>
</table>

B. Background to Concerns

Does the PCT hold any fitness to practise record on this practitioner in the public domain? If yes, please provide details:

Any concerns about health problems, including details of any referrals to occupational health medicine with referral dates and conclusions

Do any other bodies, e.g. GMC, GDC, etc, have any relevant information:
C. Reasons for Request for Assessment and/or Investigation

| Please provide as much detail as possible, supplying relevant dates where possible and including supporting documentation. This may include records of phone calls and interviews, minutes of meetings, any statements received from professional colleagues (e.g. GPs, practice nurse, health visitor, pharmacist, prescribing adviser, hospital clinician), patients or others. The history of the concerns about this practitioner’s performance may be relevant here, as may any complaints about the practitioner |
| Please list here all documents sent to the PAG with this referral. Please arrange for copies of application for inclusion in the relevant list to be included, as well as all documents relating to matters of concern |

| Please list numerically |
| 1. |

| Has there been any police involvement with this case? (please summarise) |

| |
| |

| |
| |
### D. Action taken so far

<table>
<thead>
<tr>
<th>What information has been given to the practitioner about this referral? (The practitioner should normally be informed of your intention to refer before this form is sent to the PAG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detail here local work already undertaken with the practitioner, if any, to address the difficulties identified and their possible causes and the results achieved. Please provide as much detail as possible, e.g. what approaches were tried, over what periods, who was involved and what were the outcomes?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What information was given to the practitioner about the concerns raised about their performance?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What has been the involvement of the Local Representative Committee, if any?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Response of the practitioner to the above (please append any comments)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Willingness of the practitioner to co-operate with local procedures undertaken so far</th>
</tr>
</thead>
</table>

### E. PAG Referral

| Has the practitioner agreed a ‘friend’ or mentor? | YES / NO |
| --- |

| Does the practitioner have a representative, e.g. Solicitor, LRC Officer, etc? If yes, give name and contact details, if known | YES / NO |
| --- |

| Does the practitioner regularly consult in a language other than English? If yes, which? | YES / NO |
| --- |

| Are there a significant proportion of patients registered with the Practice whose | YES / NO |
F. Request for Assessment and/or Investigation from …………………………………………………………………………..  PCT

On behalf of the referring body, I ask the PAG to undertake an assessment/investigation of (insert practitioner’s name)

The PCT will work with the practitioner to devise a reasonable action plan to implement the recommendations made in the PAG report, where appropriate.

I have copied / shall copy this referral to the practitioner being referred and have appended/will append comments from the practitioner regarding the information in this referral form.

NOTE: in some cases it will not be appropriate for the practitioner to be informed of concerns or referral to the PAG, for example, where the concerns relate to possible criminal issues.

On receipt of the referral, the PAG will inform the PCT how the matter will be dealt with, e.g. by assessment, investigation or both.

I am authorised by ………………………………………………………… PCT to make this referral

Signed: Date:

Position in organisation: Telephone number:

Please return this form to:

Business Development Manager

Essex Performance Advisory Group
Suite 3, The Tekhnicon Centre
Springwood Drive
Braintree
Essex
CM7 2YN

In an envelope marked CONFIDENTIAL

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Removal etc of Practitioners from the Professional List

SUMMARY OF PROCESS

BACKGROUND

The National Health Service (Performers Lists) Regulations 2004 as amended and the National Health Service (General Ophthalmic Services Amendment and Consequential Amendment) Regulations 2005, empower PCTs to remove practitioners, suspend practitioners and to apply conditions to a practitioner’s terms of service. The guidance issued by the Department of Health concerning these matters is extensive.

The PCT has the right to exercise these powers and a practitioner has the right to appeal to the Family Health Services Appeal Authority. The Family Health Services Appeal Authority will also act as a national body so far as national disqualifications are concerned following local disqualification, where that is appropriate.

The guidance issued to support the regulations envisages these matters being overseen by an Executive Member of the PCT Board. It is also good practice to have a deputy and the guidance suggests that this person should normally be of Board, or near Board level. The responsible Board Member or authorised deputy would make all decisions to suspend, remove or contingently remove a practitioner. The guidance envisages that the responsible Board Member should be the Chief Executive, Director of Primary Care (or a Board Member with those responsibilities according to PCT standing orders), or Human Resource Director. PAG will carry out the investigation as there has to be a separation between the investigation (which would normally be carried out under the auspices of the Clinical Performance Committee by the Corporate Services Manager of the Strategic Health Authority working with PCT staff) and the Director making a decision to suspend, remove, etc., a practitioner.

If the designated Board Member decides to remove or contingently remove a practitioner, the latter may seek an oral hearing and a panel must be convened to consider his or her representations. The PCT’s scheme of Delegation provides for such a panel.

The guidance further suggests that the panel should be chaired by the responsible Board Member, or authorised deputy, and should also include one PCT Non-Executive Director plus a suitably qualified person normally nominated by the relevant Local Representative Committee or the Local Representative Committee of a neighbouring Health Authority.

There is no right of appeal against suspension, but the practitioner may make representations against the consideration of suspension. A practitioner may make representations and appeal against removal and contingent removal.
HEARING OF REPRESENTATIONS

The Panel hearing representations will consist of:

- Chief Executive, SW Essex PCT
- Executive Nurse, SW Essex PCT
- Clinical Lead, SW Essex PCT and other nominated lead clinician for advice e.g.
- Dental Adviser
- Non-Executive Director, SW Essex PCT (Chair)

Notes of the hearing will be taken by the Lead for Clinical Standards or another Manager.

Representatives from PAG will be in attendance, as requested.

The Purpose and Status of the Hearing

The purpose of the Hearing is to afford the Practitioner the opportunity to make representations to the Panel against the proposals agreed following the receipt of recommendations made in the PAG review report.

The Procedure to be adopted by the Panel

This procedure will apply to most cases but occasionally complexity will require adjustments to the estimated times.

The Chairman of the Panel will be the sole arbiter of procedure on the day of the Hearing.

The Panel will have before it a copy of the report of the Essex Performance Advisory Group (the PAG), a copy of the written representations made by the Practitioner and relevant letters between the Practitioner and the PCT.

The Panel will invite PAG to present the PCT’s case against the Practitioner, estimated duration 1-2 hours. Presentations that may take longer need to be accommodated and all representatives given due warning.

There will follow either a break of ten minutes, or lunch, depending on the time.

The Panel will then invite the Practitioner to make representations, estimated duration 1-2 hours. On more complex cases a longer time frame will need to be factored into the meeting.

After the presentation of representations, the Panel may ask questions of the Practitioner and PAG.

No other witnesses are expected to be called.

The Panel will retire to consider the evidence. They will deliver their decision, with reasons, in writing as soon as possible and may give their decision verbally on the day of the Hearing.

A summary report will be provided in Part II of the next Board meeting.

Other than as set out above, no other person shall be permitted to be present during the Hearing.

Note: the parties will each be provided with a room for the day of the Hearing.