NHS
Tees Valley
Clinical Commissioning Group

| Corporate | CCG CO25 Management of General Practice Performance Concerns |
|---|---|

| Version Number | Date Issued | Review Date |
|---|---|---|
| V1 | March 2020 | December 2020 |

| | |
|---|---|
| **Prepared By:** | Clinical Quality Team,<br>North of England Commissioning Support |
| **Consultation Process:** | South Tees CCG Combined Management Group<br>DDES CCG Executive Committee<br>Darlington CCG Executive Committee, Governing Body<br>HaST CCG Executive Committee, Governing Body<br>North Durham CCG Management Executive |
| **Formally Approved:** | March 2020 |
| **Approved By:** | Combined Management Group |
| **Policy Adopted From:** | (CO30 South Tees CCG Combined Management Group approved January 2020)<br>(CO30 DDES CCG Executive Committee approved February 2018)(v2.1)<br>(CO25 Darlington CCG Executive Committee, Governing Body approved September 2017)(v1.2)<br>(CO31 HaST CCG Executive Committee, Governing Body approved September 2017)(v1.1)<br>(CO21 North Durham CCG Management Executive approved February 2018)(v1.3) |

## Equality Impact Assessment

| Date | Issues |
|---|---|
| December 2019 | See Section 9 |

**POLICY VALIDITY STATEMENT**

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3 year period.

# Version Control

| Version | Release Date | Author | Update comments |
|---|---|---|---|
| V1 | April 2020 | Clinical Quality Team,<br>North of England Commissioning Support | New policy template. |

# Approval

| Role | Name | Date |
|---|---|---|
| Approval | Combined Management Group | 10 March 2020 |

## Contents

# 1. Introduction

The Clinical Commissioning Group (CCG) aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

For the purpose of this policy, NHS Tees Valley will be referred to as 'the CCG'.

Healthcare professionals are responsible for complying with the relevant standards set by their regulatory or professional bodies (e.g. the GMC's good medical practice), contract requirements and duties in accordance with the relevant Performers List Regulations. A breach of such standards, contract or regulations might indicate a performance concern, which may be dealt with through this policy and procedure, independent of any action taken by the regulatory or professional body concerned. In such cases, performance concerns will be investigated fairly using a supportive approach with appropriate steps being taken to address the issues and prevent a recurrence.

Failure to meet accepted standards of professional clinical practice in healthcare is not a common occurrence and can be manifested in diverse ways. For example, poor clinical performance can be associated with an error or delay in diagnosis, use of outmoded tests or treatments, failure to act on the results of monitoring or testing, technical errors in performance of a procedure, poor attitude and behaviour, inability to work as a member of a team or poor communication with patients. In some cases, several aspects of these areas of poor performance may be present in one service. In other cases, there may also be underlying ill-health problems contributing to a failure to perform to an acceptable standard

## 1.1 Status

This is a corporate policy and procedure for the management and handling of performance concerns related to general practitioners working within the CCG.

## 1.2 Purpose and scope

NHS England is the responsible body for professional performance issues.

The CCGs have an established General Practitioner Performance Triage Group (GP PTG). The GP PTG has responsibility to triage general practitioner concerns to identify if it's potentially a professional performance issue and therefore requiring referral to NHS England for further consideration.

## 2. Definitions

Definitions used are contained in the body of the document.

## 3 Local Policy and Procedures for Management of General Practitioner Performance Concerns

This policy and procedure applies to management, support and handling of performance concerns in respect of general practitioners working within the CCGs.

Additionally all relevant Human Resource Policies and Procedures will be applied to those directly employed by the CCGs.

### 3.1 The General Practitioner Performance Triage Group Duties and Functions

The Terms of Reference and processes supporting the GP PTG are detailed in Appendix 1.

The duties and functions of the GP PTG are:

- To receive information and data relating to general practitioners from a variety of sources and to process this information and or data in accordance to the data protection act.
- To ensure all relevant corporate policies and procedures are applied with specific regard to Safeguarding Children and Adult's, Information Governance and maintaining confidentiality.
- To use the information and data to make an informed decision relating to the concerns raised, through use of the approved tools and methodologies.
- To use a set of adapted tools based on the National Patient Safety Agency (NPSA) Incident Decision Tree combined with the Risk Matrix to facilitate discussion and document these decisions (see appendices 2, 3, 4 & 6).
- To keep action logs of all decisions made for the minimum retention period in accordance to Information Governance retention schedules.
- To complete documentation relating to the decision making process as detailed (see appendices 2, 3, 4 & 6)..
- To refer any practitioner to NHS England in accordance with the developed framework (see appendix 5).
- To track all referrals made to NHS England.
- To receive information from NHS England regarding referrals made to them about general practitioner professional performance concerns.
- Adhere to NHS England Framework for managing performers concerns.

### 3.2 Conflict of Interest

All conflicts of interest that arise in relation to the GP PTG process will be declared and managed appropriately and in accordance with the requirements of:

- NHS England's Code of Conduct
- Managing conflicts of interests: Revised statutory guidance for clinical commissioning groups (NHS England, published July 2017 and updated August 2018),
- CCG Standards of Business Conduct and Declarations of Interest policy

In the event that a PTG case concerns a member of the GP PTG then the case will be escalated to the responsible Chief Clinical Officer.

### 3.3 Reporting and Communication Details

Action logs identifying issues and decisions will be treated in the strictest confidence and NECS will include anonymous details of referrals made to NHS England as part of the quarterly and monthly quality reports to the CCG quality groups.

An annual report detailing referrals made to NHS England will be presented in the confidential section of the CCG Management Executive by the CCG Medical Director.

The GP PTG will receive information from NHS England relating to all the performance concerns they are considering and ensure triangulation with local CCG Incidents, Complaints and Serious Incidents reported via the STEIS mechanism and local soft intelligence captured on the electronic incident reporting system SIRMS (Safeguard Incident and Risk Management Reporting System).

## 4. Implementation

This policy will be available to all Staff for use in relation to the specific function of the policy.

All directors and managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

## 5. Training Implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

## 6. Documentation

### 6.1 Other related policy documents

- NHS England -Framework for managing performers concerns
- Serious Incidents (SIs) Management Policy
- Incident Reporting and Management Policy
- Complaints Policy and Procedure

### 6.2 Legislation and statutory requirements

The overarching legal duty is to assure, monitor and improve the quality and safety of services in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and the Health and Social Care Act 2012.

There is a wide range of other legal requirements relevant to the management and handling of performance concerns, which are amended from time to time, related to general practitioners. These are listed below in relation to this policy and can also be found on the NHS England website. These legal duties, and any statutory re-enactment, amendment or modification of them during the currency of this policy, will be observed in the application of this policy and procedure.

### 6.3 General Regulations

- NHS England -Framework for managing performers concerns: Managing concerns in line with NHS (Performers Lists, England) Regulations 2013 Published May 2018 (Revised).
- Medical Profession (Responsible Officers) Amendment Regulations 2013.

The procedures and processes relevant to this policy are included in appendices.

### 6.4 Best practice recommendations

- Supporting Doctors to Provide Safer Healthcare: Responding to concerns about a doctor's practice, version 2. March 2013.
- NPSA Incident decision making tree, see appendices 2, 3, 4, 6 and 7.

### 6.5 References

- Supporting Doctors to Provide Safer Healthcare: Responding to concerns about a doctor's practice, version 2. March 2013.
- The National Reporting and Learning Service. *National Patient Safety Agency Guidance for Risk Managers.* [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

## 7. Monitoring, Review and Archiving

### 7.1 Monitoring

The governing body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

### 7.2 Review

7.2.1 The Accountable Officer, will ensure that each policy document is reviewed in accordance with the timescale specified at the time of approval. **No policy or procedure will remain operational for a period exceeding three years without a review taking place.**

7.2.2 Staff who become aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives that affect, or could potentially affect policy documents, should advise the sponsoring director as soon as possible, via line management arrangements. The sponsoring director will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

7.2.3 If the review results in changes to the document, then the initiator should inform the policy manager who will renew the approval and re-issue under the next "version" number. If, however, the review confirms that no changes are required, the title page should be renewed indicating the date of the review and date for the next review and the title page only should be re-issued.

7.2.4 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

**NB:** If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

### 7.3 Archiving

The governing body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2016 and NHS England's Corporate records retention and disposal schedule and guidance (Published 24 May 2018).

# 8 Equality Impact Assessment Statement

Partners in improving local health

North of England Commissioning Support

## Introduction - Equality Impact Assessment

An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

| | |
|---|---|
| **Policy** | A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue. |
| **Service** | A system or organisation that provides for a public need. |
| **Process** | Any of a group of related actions contributing to a larger action. |

## STEP 1 - EVIDENCE GATHERING

| | |
|---|---|
| **Name of person completing EIA:** | **Helen Osborn, Clinical Quality, NECS** |
| **Title of service/policy/process:** | **GP Performance Triage Group Policy** |

**Existing:** X **New/proposed:** ☐ **Changed:** √

**What are the intended outcomes of this policy/service/process? Include outline of objectives and aims**

The policy sets out the procedure for the management and handling of performance concerns related to general practitioners working within the Southern Collaborative of CCGs.
The purpose of this Policy is to provide a framework to triage concerns about general practitioners to identify if there's potentially a professional performance issue and therefore requiring referral to NHS England for further consideration.

**Who will be affected by this policy/service /process? (please tick)**

☐ **Consultants** ☐ **Nurses** **x Doctors (general practitioners)**
**x Staff members** ☐ **Patients** ☐ **Public**
**x Other**

**If other please state:** Temporary/agency staff

**What is your source of feedback/existing evidence? (please tick)**

☐ **National Reports** ☐ **Internal Audits**
☐ **Patient Surveys** ☐ **Staff Surveys** ☐ **Complaints/Incidents**
☐ **Focus Groups** ☐ **Stakeholder groups** **X Previous EIAs**
☐ **Other**

**If other please state:**

| Evidence | What does it tell me? (about the existing service/policy/process? Is there anything suggest there may be challenges when designing something new?) |
|---|---|
| National Reports | |
| Patient Surveys | |
| Staff Surveys | |
| Complaints and Incidents | |
| Results of consultations with different stakeholder groups – staff/local community groups | |
| Focus Groups | |
| Other evidence (please describe) | |

## STEP 2 - IMPACT ASSESSMENT

| |
|---|
| **What impact will the new policy/system/process have on the following: (Please refer to the 'EIA Impact Questions to Ask' document for reference)** |
| **Age** A person belonging to a particular age |
| None identified. |
| **Disability** A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities |
| None identified. |
| **Gender reassignment (including transgender)** Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception. |
| None identified. |
| **Marriage and civil partnership** Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters |
| None identified. |
| **Pregnancy and maternity** Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. |
| None identified. |
| **Race** It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities. |
| None identified. There is currently no requirement to have this staff policy in another language however should this change provisions would be made. |
| **Religion or belief** Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. |
| None identified. The policy does not make any distinction between religious groups. |
| **Sex/Gender** A man or a woman. |
| None identified. This policy is gender neutral. |
| **Sexual orientation** Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes |
| None identified. |
| **Carers** A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person |
| None identified. Corporate policy accessible via intranet |
| **Other identified groups** such as deprived socio-economic groups, substance/alcohol abuse and sex workers |

| |
|---|
| None identified. |

 **STEP 3 - ENGAGEMENT AND INVOLVEMENT**

| **How have you engaged stakeholders in testing the policy or process proposals including the impact on protected characteristics?** |
|---|
| Not applicable. |
| **Please list the stakeholders engaged:** |
| Not applicable |

 **STEP 4 - METHODS OF COMMUNICATION**

| **What methods of communication do you plan to use to inform service users of the policy?** |
|---|
| **–** **- Telephone**<br>**–** **– Leaflets/guidance booklets**<br>☐ **Email** ☐ **Internet** ☐ **Other** |
| **If other please state:**<br>Not applicable. |

**ACCESSIBLE INFORMATION STANDARD**

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

| **Tick to confirm you have you considered an agreed process for:** |
|---|
| ☐ **Sending out correspondence in alternative formats.**<br>☐ **Sending out correspondence in alternative languages.**<br>☐ **Producing / obtaining information in alternative formats.**<br>☐ **Arranging / booking professional communication support.**<br>**er appointments for patients / service users with communication needs.** |
| **If any of the above have not been considered, please state the reason:**<br>Not applicable to patients/service users as it's a staff policy. |

 **STEP 5 - SUMMARY OF POTENTIAL CHALLENGES**

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

| Potential Challenge | What problems/issues may this cause? |
|---|---|
| 1 | |
| 2 | |
| 3 | |

## STEP 6- ACTION PLAN

| Ref no. | Potential Challenge/ Negative Impact | Protected Group Impacted (Age, Race etc) | Action(s) required | Expected Outcome | Owner | Timescale/ Completion date |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

| Ref no. | Who have you consulted with for a solution? (users, other services, etc) | Person/ People to inform | How will you monitor and review whether the action is effective? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## SIGN OFF

| | |
|---|---|
| **Completed by:** | **Clinical Quality Team** |
| **Date:** | **December 2019** |
| **Signed:** | |
| **Presented to: (appropriate committee)** | |
| **Publication date:** | |

**Appendix 1**

# Terms of Reference
# General Practitioner Performance Triage Group

## 1. Constitution

1.1 South Tees CCG along with Darlington, Durham Dales Easington and Sedgefield (DDES), Hartlepool and Stockton on Tees (HaST)and North Durham CCGs have an established General Practitioner Performance Triage Group (GP PTG).

1.2 The role of the GP PTG is to provide a forum to ensure concerns raised about general practitioners can be discussed internally within the CCGs, with the support of North of England Commissioning Support (NECS), to determine whether further investigation by NHS England is required.

## 2. Membership

2.1 Membership of the GP PTG comprises:

- Medical Director DDES CCG
- Medical Director North Durham CCG
- Medical Director Darlington CCG, Hartlepool and Stockton CCG and South Tees CCG
- Clinical Quality representative.

Chair arrangements to be agreed within the GP PTG

## 3. Quorum

A quorum shall be when a minimum of two CCG/Medical Directors, or their deputies, and a Clinical Quality Representative.

## 4. Attendance at Meetings

4.1 Other members of the CCGs, NECS and NHS England (Cumbria and North East) may attend meetings when requested by the Chair.

4.2 Where a Medical Director is unable to attend a GP PTG meeting they are to be represented by a nominated deputy.

## 5. Frequency of Meetings

5.1 Meetings shall be held quarterly and will normally be two hours in duration however the first half hour of the meeting may be utilised, as per current arrangements, as a confidential information sharing meeting between the CCG members and NHS England (NHSE). The members of the group may request additional ad-hoc GP PTG meetings according to operational or business requirements.

5.2 For urgent cases requiring immediate escalation to NHS England, meetings and decisions may be held and made 'virtually', i.e. through telephone calls and emails. The decision and justification for referral will be recorded in writing in all circumstances.

## 6. Authority

6.1 The GP PTG is an advisory group established within the CCGs to ensure fair, equitable and auditable decisions are made regarding the referral of general medical practitioners to NHS England.

## 7. Duties and Functions

The duties and functions of the GP PTG are:

- To receive information and data relating to general practitioners from a variety of sources and to process this information and/or data in accordance to the Data Protection Act.
- To ensure all relevant corporate policies and procedures are applied with specific regard to Safeguarding Children, Information Governance and maintaining confidentiality.
- To use the information and data to make an informed decision relating to the concerns raised, through use of the approved tools and methodologies.
- To use a set of adapted tools based on the NPSA Incident Decision Tree and a standardised Risk Matrix to facilitate discussion and document these decisions (see appendices 2, 3 & 4 Local Policy and Procedure for Management of General Practitioner Performance Concerns ).
- To keep minutes of the meetings and all decisions made for the minimum retention period in accordance to NHS retention schedules.
- To complete documentation relating to the decision making process as detailed in appendix 4 Local Policy and Procedure for Management of General Practitioner Performance Concerns.
- To refer any practitioner to NHS England in accordance with the developed framework (see appendix 5 Local Policy and Procedure for Management of General Practitioner Performance Concerns).
- To ensure that all information considered by the GP PTG is forwarded to NHS England so that one organisation has an overview of all actual and potential performance concerns.
- To track all referrals made to NHS England.
- To receive information from NHS England regarding referrals made to them about general practitioner performance concerns.
- Adhere to NHS England' s Framework for managing performer concerns.

## 8. Reporting and Communication Arrangements

A copy of the action log of meetings identifying issues and decisions will be treated in the strictest confidence.

Where required, anonymous details of referrals made to NHS England will be included as part of the cycle of quality reports to the CCG quality committees.

An annual report detailing referrals made to NHS England will be presented in the confidential section of the CCG Management Executive by the CCG Medical Director/GP Quality Lead.

The GP PTG will receive information from NHS England via the confidential information sharing meetings relating to all the performance concerns they are considering to ensure triangulation with local Incidents, Complaints, Serious Incidents and local soft intelligence captured on the electronic incident reporting system (SIRMS).

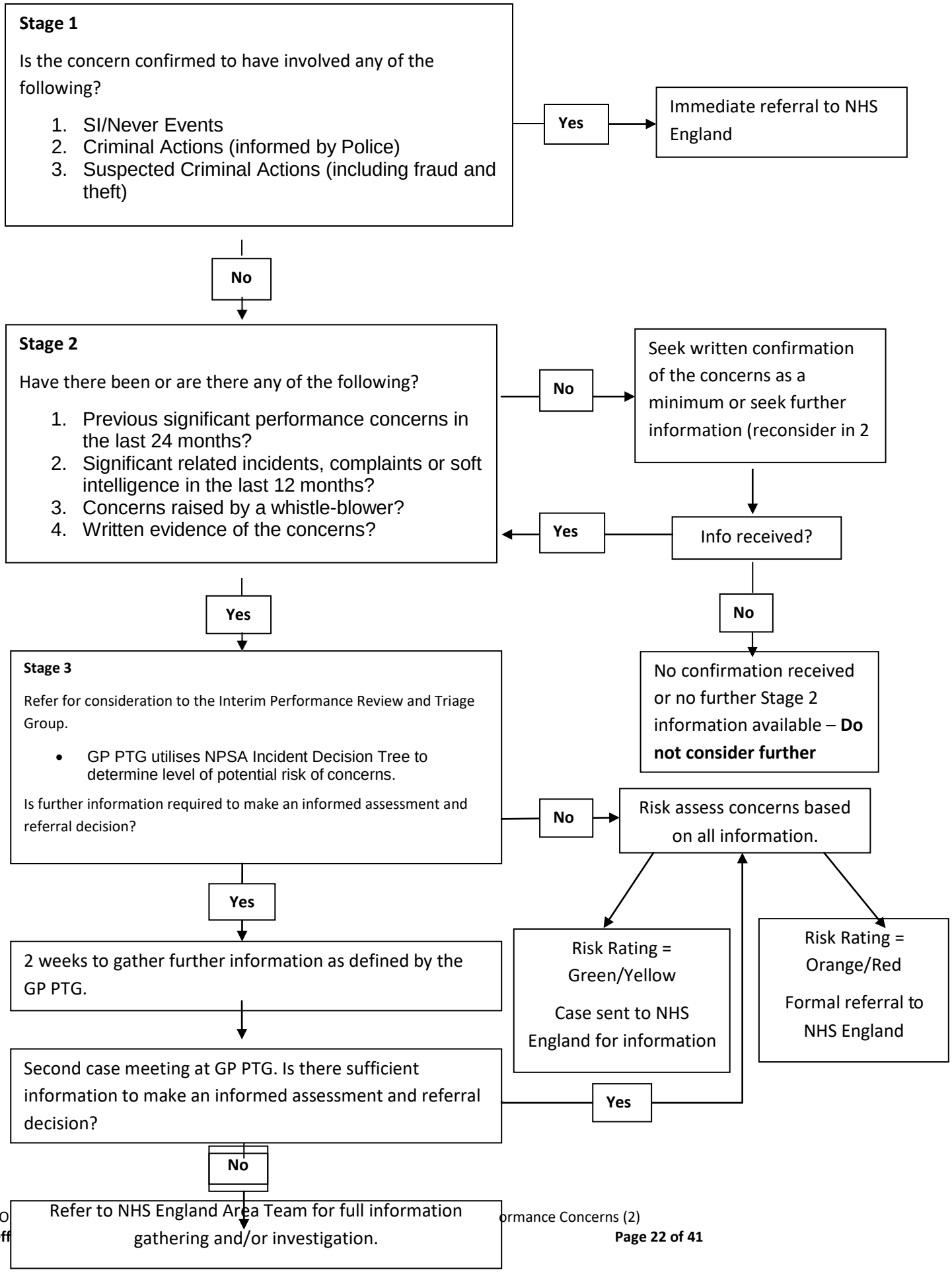
## 9. Review

These Terms of Reference will be reviewed after a period of twelve months.

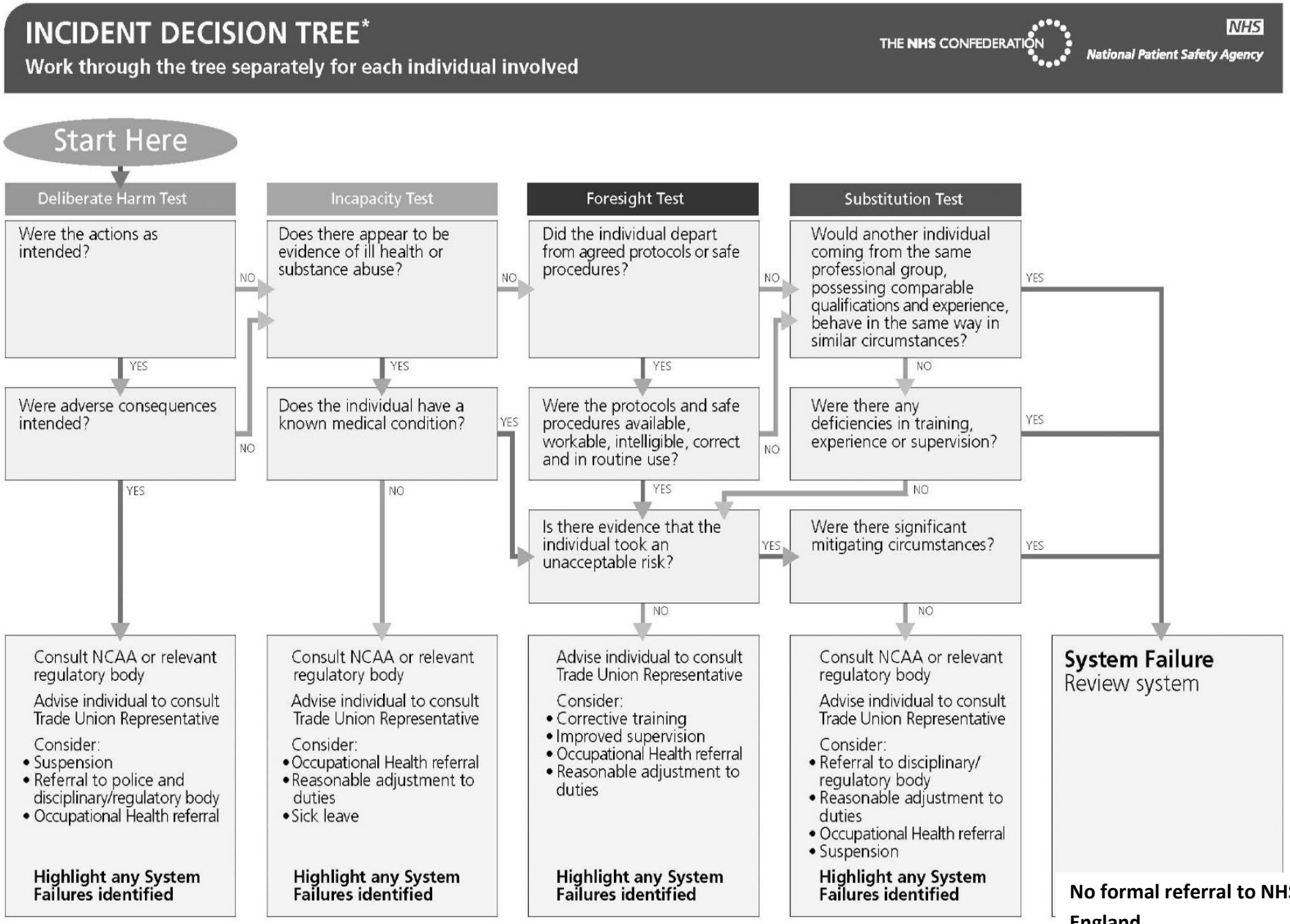
Date of Last Review:

January 2020

## Appendix 2: Performance Concern Referral Triage Flowchart



**Appendix 3**




**Risk Assess and RAG-rate**

**Refer to NHS England**

**Risk Assess and RAG-rate**

**Refer to NHS England**

**Risk Assess to determine RAG-rating and referral status.**

**Risk Assess to determine RAG-rating and referral status.**

**No formal referral to NHS England**

**Information gathered to be forwarded for their records**

## Appendix 4

# General Practitioner Performance Concern Risk Matrix Assessment

This assessment should be made in conjunction with discussion facilitated by the use of the NPSA Incident Decision Tree.

| **Personal Details** | | | |
|---|---|---|---|
| **Performer Name** | | **Profession** | |
| **Location/Base** | | **Registration No.** | |

**Risk Assessment**

| **Likelihood** | **Consequence** | | | | |
|---|---|---|---|---|---|
| | **1 – Negligible** | **2 - Minor** | **3 - Moderate** | **4 - Major** | **5 - Catastrophic** |
| **1 – Rare** | **1** | **2** | **3** | **4** | **5** |
| **2 – Unlikely** | **2** | **4** | **6** | **8** | **10** |
| **3 – Possible** | **3** | **6** | **9** | **12** | **15** |
| **4 – Likely** | **4** | **8** | **12** | **16** | **20** |
| **5 – Almost Certain** | **5** | **10** | **15** | **20** | **25** |

| **Risk Rating** | **Action** | **Tick** |
|---|---|---|
| **Low Risk** | No formal referral to be made to NHS England. Case information forwarded to contact at NHS England for their records (letter template 2) | |
| **Medium Risk** | No formal referral to be made to NHS England. Case information forwarded to contact at NHS England for their records (letter template 2) | |
| **High Risk** | Formal referral to be made to Medical Director at NHS England (letter template 1) | |
| **Extreme Risk** | Formal referral to be made to Medical Director at NHS England Area Team (letter template 1) | |

| | |
|---|---|
| **Date of Assessment** | |
| **Date of Referral** | |
| **Signed** | |
| **Print Name / Position** | |

[*insert CCG log*]

## Appendix 5

Our Ref:

Direct line

[*insert CCG name and address*]

[Date]

**Strictly Confidential**

Medical Director
NHS England

Dear X,

**Re: [Practitioner Name and Address]**
**Formal referral for consideration for NHS England performance investigation procedures.**

Following an internal review of concerns raised about [practitioner name] [*insert CCG name*] Clinical Commissioning Group General Practitioner Performance Triage Group (GP PTG) has concluded that a formal referral to NHS England is required.

The purpose of this referral is to notify NHS England that the GP PTG considers the attached concerns of potentially sufficient seriousness to require further formal consideration by NHS England performance team.

This conclusion follows an assessment of the following information;

[List details]

The concerns have been risk-rated as [high/extreme risk] on our Practitioner Performance Risk Matrix which requires subsequent formal referral to NHS England.

Where the CCG retain responsibility for overseeing the local resolution of the issues referred (for example, through the NHS Complaints Regulations) the North of England Commissioning Support Unit Clinical Quality Team will continue to liaise with NHS England to ensure that they are kept up to date with the outcomes of that resolution.

Under the memorandum of understanding: -

1. The CCG General Practitioner Performance Triage group request the NHS England Area Team to..... [action as a performance issue and investigate according to Assuring High Standards of Professional Performance Policy]

2. The CCG will .....[ e.g Continue to investigate/action the complaint/SUI/CD incident/prescribing analysis etc]

3. Additional actions agreed are .....

[Complete sections 1 – 3]

I would be grateful if you would confirm receipt of this information, and confirm the next steps to be taken in light of this referral, with the Senior Clinical Quality Officer, North of England Commissioning Support Unit at John Snow House, Durham University Science Park, Durham, DH1 3YG.

Yours sincerely

***[insert name]***
***[insert job title]***
***[insert CCG]***

Enc: Practitioner Performance Concern Framework: Individual and Overall Assessment
Additional information as follows: [State information]

*[insert CCG logo]*

Our Ref:
Direct line

[*insert CCG name and address*]

[Date]

**Strictly Confidential**

Medical Director
NHS England

Dear x,

**Re: [Practitioner Name and Address]**
**For information only**

Following an internal review of concerns raised about [practitioner name], [*insert CCG*] Clinical Commissioning Group General Practitioner Performance Triage Group (GP PTG) has concluded that a formal referral to NHS England is **not** required.

In order to maintain a single record of potential concerns and prevent fragmentation of information on performers, please find enclosed the information on the case for future reference should further concerns arise about the practitioner.

This conclusion follows an assessment of the following information;

[List details]

The concerns have been rated as [low/medium risk] on our Practitioner Performance Risk Matrix and as such did not require formal referral to NHS England, based on the information that we have at this time.

If this information is triangulated to other performance concerns you may have received regarding this practitioner I would appreciate it if you could inform us of the action that NHS England intends to take.

I would be grateful if you would confirm receipt of this information, and confirm the next steps to be taken in light of this referral, with the Senior Clinical Quality Officer, North of England Commissioning Support Unit at John Snow House, Durham University Science Park, Durham, DH1 3YG.

Yours sincerely

***[Insert name]***
***[insert job title]***
***[insert CCG]***

Enc: Practitioner Performance Concern Framework: Individual and Overall Assessment
Additional information as follows: [State information]

[*insert CCG logo*]

Our Ref:
Direct line

[*insert CCG name and address]*

[Date]

**Private & Confidential**
**FOR ADDRESSEE ONLY**

Dear

At a recent meeting, the General Practitioner Performance Triage Group (GP PTG) discussed information that has been raised through [***detail source of concern***].

[***Detail of concern***]

In order to comply with its duties and responsibilities for the management, support and handling of performance concerns in respect of general practitioners the five CCGs across the Southern Collaborative have formed the GP PTG. The GP PTG is responsible for considering information about the performance of both individual practitioners and the contracts they work within.

Information received is assessed through an open, fair, equitable and auditable process as to whether the issues raised require onward referral to NHS England, who manage performers lists and GP contracts.

The GP PTG assess the information obtained on the basis of risk to patient safety and according to the processes set out in the CCGs' *'Local Policy and Procedure for the Management of Independent Contractor and Practitioner Professional Performance'*, which I have enclosed for your information.

The GP PTG has assessed this information and has determined that a referral to the NHS England Area team is required for consideration of further action on the grounds of [***detail reason eg patient safety / non-compliance with good medical practice***]. Any questions that you may have regarding this referral and any further actions that may be taken should be directed to ……..

Yours sincerely

**[name]**
**[job title]**
**[CCG]**
Enc.

**Appendix 6**

# Model Matrix

**For the full *Risk matrix for risk managers*, go to [www.npsa.nhs.uk](http://www.npsa.nhs.uk)**

## Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

| | **Consequence score (severity levels) and examples of descriptors** | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Impact on the safety of patients, staff or public (physical/psychological harm)** | Minimal injury requiring no/minimal intervention or treatment.<br><br>No time off work | Minor injury or illness, requiring minor intervention<br><br>Requiring time off work for >3 days<br><br>Increase in length of hospital stay by 1-3 days | Moderate injury requiring professional intervention<br><br>Requiring time off work for 4-14 days<br><br>Increase in length of hospital stay by 4-15 days<br><br>RIDDOR/agency reportable incident<br><br>An event which impacts on a small number of patients | Major injury leading to long-term incapacity/disability<br><br>Requiring time off work for >14 days<br><br>Increase in length of hospital stay by >15 days<br><br>Mismanagement of patient care with long-term effects | Incident leading to death<br><br>Multiple permanent injuries or irreversible health effects<br><br>An event which impacts on a large number of patients |
| **Quality/complaints/audit** | Peripheral element of treatment or service suboptimal<br><br>Informal complaint/inquiry | Overall treatment or service suboptimal<br><br>Formal complaint (stage 1)<br><br>Local resolution<br><br>Single failure to meet internal standards<br><br>Minor implications for patient safety if unresolved | Treatment or service has significantly reduced effectiveness<br><br>Formal complaint (stage 2) complaint<br><br>Local resolution (with potential to go to independent review)<br><br>Repeated failure to meet internal | Non-compliance with national standards with significant risk to patients if unresolved<br><br>Multiple complaints/ independent review<br><br>Low performance rating<br><br>Critical report | Totally unacceptable level or quality of treatment/service<br><br>Gross failure of patient safety if findings not acted on<br><br>Inquest/ombudsman inquiry<br><br>Gross failure to meet national standards |

| | | | | | |
|---|---|---|---|---|---|
| | | Reduced performance rating if unresolved | standards<br>Major patient safety implications if findings are not acted on | | |
| **Human resources/ organisational development/staffing/ competence** | Short-term low staffing level that temporarily reduces service quality (< 1 day) | Low staffing level that reduces the service quality | Late delivery of key objective/ service due to lack of staff<br><br>Unsafe staffing level or competence (>1 day)<br><br>Low staff morale<br><br>Poor staff attendance for mandatory/key training | Uncertain delivery of key objective/service due to lack of staff<br><br>Unsafe staffing level or competence (>5 days)<br><br>Loss of key staff<br><br>Very low staff morale<br><br>No staff attending mandatory/ key training | Non-delivery of key objective/service due to lack of staff<br><br>Ongoing unsafe staffing levels or competence<br><br>Loss of several key staff<br><br>No staff attending mandatory training /key training on an ongoing basis |
| **Statutory duty/ inspections** | No or minimal impact or breech of guidance/ statutory duty | Breech of statutory legislation<br><br>Reduced performance rating if unresolved | Single breech in statutory duty<br><br>Challenging external recommendations/ improvement notice | Enforcement action<br><br>Multiple breeches in statutory duty<br><br>Improvement notices<br><br>Low performance rating<br><br>Critical report | Multiple breeches in statutory duty<br><br>Prosecution<br><br>Complete systems change required<br><br>Zero performance rating<br><br>Severely critical report |
| **Adverse publicity/ reputation** | Rumours<br><br>Potential for public concern | Local media coverage – short-term reduction in public confidence<br><br>Elements of public expectation not being met | Local media coverage – long-term reduction in public confidence | National media coverage with <3 days service well below reasonable public expectation | National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)<br><br>Total loss of public confidence |
| **Business objectives/ projects** | Insignificant cost increase/ schedule slippage | <5 per cent over project budget<br><br>Schedule slippage | 5–10 per cent over project budget<br><br>Schedule slippage | Non-compliance with national 10–25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met | Incident leading >25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met |
| **Finance including claims** | Small loss Risk of claim remote | Loss of 0.1–0.25 per cent of budget<br><br>Claim less than £10,000 | Loss of 0.25–0.5 per cent of budget<br><br>Claim(s) between £10,000 and £100,000 | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget<br><br>Claim(s) between £100,000 and £1 million<br><br>Purchasers failing to pay on time | Non-delivery of key objective/ Loss of >1 per cent of budget<br><br>Failure to meet specification/ slippage<br><br>Loss of contract / payment by results<br><br>Claim(s) >£1 million |
| **Service/business interruption Environmental impact** | Loss/interruption of >1 hour<br><br>Minimal or no impact on the environment | Loss/interruption of >8 hours<br><br>Minor impact on environment | Loss/interruption of >1 day<br><br>Moderate impact on environment | Loss/interruption of >1 week<br><br>Major impact on environment | Permanent loss of service or facility<br><br>Catastrophic impact on environment |

## Appendix 7

# The Incident Decision Tree: Guidelines for Action

*(Adapted from guidance issued by the NPSA).*

### The IDT and Performance Concerns

In the context of assessing a performance or contract concern, the Incident Decision Tree is not intended to be a fool-proof tool to provide a definitive outcome for a referral decision. It is intended to facilitate informed discussion for the performance group around the potential factors involved in performance concerns and provide an approved methodology within an agreed format for doing so.

### Introduction

The National Patient Safety Agency developed the Incident Decision Tree to help National Health Service (NHS) managers in the United Kingdom determine a fair and consistent course of action toward staff involved in patient safety incidents. Research shows that systems failures are the root cause of the majority of safety incidents. Despite this, when an adverse incident occurs, the most common response is to suspend the clinician(s) involved, pending investigation, in the belief that this serves the interests of patient safety.
The Incident Decision Tree supports the aim of creating an open culture, where employees feel able to report patient safety incidents without undue fear of the consequences. The tool comprises an algorithm with accompanying guidelines and poses a series of structured questions to help managers decide whether suspension is essential or whether alternatives might be feasible. The approach does not seek to diminish health care professionals' individual accountability, but encourages key decision makers to consider systems and organizational issues in the management of error.

Initial findings show the Incident Decision Tree to be robust and adaptable for use in a range of health care environments and across all professional groups. It is hoped that applying the tool throughout the NHS will encourage open reporting of actual and prevented patient safety incidents and promote a uniformly fair and consistent approach toward the staff involved.

### How the tool works

The user is guided through a series of structured questions about the individual's actions, motives, and behaviour at the time of the incident. These may need to be answered on the balance of probability—i.e., determining the most likely explanation—taking into account the information available at the time, although the importance of pausing to gather data is emphasized. The questions move through four sequential "tests":

- Deliberate harm
- Incapacity
- Foresight
- Substitution

Possible reasons for the individual's action are reviewed and the most likely explanation identified. A list of recommended options is then provided for the manager's consideration. The further the route travelled through the Incident Decision Tree, the more likely the underlying cause is to be a systems failure. The tool does not seek to take away the manager's judgment by imposing firm answers or solutions. Rather, it emphasizes that the outcome of a particular incident needs to be based on the investigation of individual circumstances. Indeed, the importance of the manager applying judgment rather than slavishly following the tool is emphasized.

The tool can be used for any employee involved in a patient safety incident, whatever his or her professional group. Ideally it should be applied as soon as possible after the incident, while the facts are still fresh in people's minds. If new information comes to light, it can be worked through again and may or may not indicate a different outcome.

**The four tests**

**The deliberate harm test**

In the overwhelming majority of patient safety incidents, the individual had the patient's well-being at heart. However, the deliberate harm test helps to identify at the earliest possible stage those rare cases where harm was intended.

The test asks the manager to consider whether the individual's actions were as intended and whether the outcome was as intended. In the majority of cases, the actions will be as intended, but the outcome will not. The Incident Decision Tree is not a "wrongdoer's charter." When it appears deliberate harm was intended, the importance of immediate suspension, together with referral to the police and/or the relevant disciplinary and regulatory bodies, is flagged.

**The incapacity test**

If intent to harm has been discounted, the incapacity test helps to identify whether ill health or substance abuse caused or contributed to the patient safety incident. The tool can be used whether or not the individual is absent on sick leave. Advice is given on assessing the degree of impact illness might have had on the individual's behaviour. The whole spectrum of substance abuse is considered, including inappropriate self-medication.

The manager is asked to consider whether the employee was aware of their condition at the time, whether they realized the implications of their condition, and whether they took proper safeguards to protect patients.

## The foresight test

If intent to harm and incapacity have been discounted, the foresight test examines whether protocols and safe working practices were adhered to. Our preliminary findings indicate the majority of patient safety incidents involve protocol violation. Users tend to find this section the most challenging to work through, and the need for careful judgment and assessment of the facts is emphasized.

The test asks the manager to consider whether the incident arose because:

- No protocol or safe procedure existed.
- The protocol was poor.
- There were conflicting protocols.
- Good protocols were misapplied, routinely violated, or not in regular use.
- The individual decided to ignore protocols.

In particular, managers are alerted to the fact that what at first sight appears to be a workable protocol may be problematic in practice. Where the individual violated a sound protocol, the manager is advised to look at a range of factors, such as motivation, information available at the time, the speed with which a decision had to be reached, and the degree of awareness the individual had of the risk being created. Generally, the more control the individual had over the situation, the more likely it is that the risk was unacceptable. Conversely, in emergency situations where the individual was under extreme pressure and had little time to think through the consequences, the more understandable their action is likely to be.

Guidance is also provided regarding situations where the individual violated a sound protocol for no apparent reason. Such cases often involve a “perceptual slip,” such as picking up the wrong medication or ticking the wrong box on a form.

It is emphasized that there are some circumstances where no further action is required, such as when the individual acted heroically in extreme circumstances or when nothing could have prevented the mishap. In other situations, the incident highlights the need for the individual to receive corrective training, improved supervision, medical support, or adjustment to his or her role.

## The substitution test

Finally, if protocols were not in place or proved ineffective, the substitution test helps to assess how a peer would have been likely to deal with the situation.
James Reason advises:

*“Substitute the individual concerned, for someone else coming from the same domain of activity and possessing comparable qualifications and experience. Then ask the question ‘In the light of how events unfolded and were perceived by those involved in real time, is it likely that this new individual would have behaved any differently?’”*

This test also highlights any deficiencies in training, experience, or supervision that may have been a factor in the patient safety incident and helps to assess whether the individual was properly equipped to deal with the situation. Managers are advised to avoid deducing behavioural norms from blanket judgments and prejudices, such as “All surgeons have temper tantrums,” or “Radiographers find talking to patients difficult,” and to consider what a “reasonable” peer acting sensibly, maturely, and sensitively would have done.

### Unacceptable risk

The Incident Decision Tree has one purpose - to guide initial management action following a patient safety incident. It does not explore the standards of proof legally required to support claims of “recklessness,” “reckless behaviour,” or “negligence”. The term “unacceptable risk” has been used instead to describe the concept of an individual taking a risk that would normally be considered unreasonable. This has been found to help users focus on the employee’s motivation and circumstances rather than on the potential consequences of their action.

### Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

| **Likelihood score** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **Frequency** How often might it/does it happen | This will probably never happen/recur | Do not expect it to happen/recur but it is possible it may do so | Might happen or recur occasionally | Will probably happen/recur but it is not a persisting issue | Will undoubtedly happen/recur, possibly frequently |

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

### Table 3 Risk scoring = consequence x likelihood (C x L)

| | **Likelihood** | | | | |
|---|---|---|---|---|---|
| **Likelihood score** | **1** | **2** | **3** | **4** | **5** |
| | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **5 Catastrophic** | 5 | 10 | 15 | 20 | 25 |
| **4 Major** | 4 | 8 | 12 | 16 | 20 |
| **3 Moderate** | 3 | 6 | 9 | 12 | 15 |
| **2 Minor** | 2 | 4 | 6 | 8 | 10 |
| **1 Negligible** | 1 | 2 | 3 | 4 | 5 |

*Note: the above table can to be adapted to meet the needs of the individual trust.*

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

| | |
|---|---|
| 1 - 3 | Low risk |
| 4 - 6 | Moderate risk |
| 8 - 12 | High risk |
| 15 - 25 | Extreme risk |

**Instructions for use**

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score).
5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organization's risk management system. Include the risk in the organisation.

## Appendix 8

### NHS England ‘Never Events’

There are 16 "never events" on the revised NHS England list published 17 January 2018.

1. Wrong Site Surgery
2. Wrong Implant / prosthesis
3. Retained foreign object post-procedure
4. Mis-selection of a strong potassium containing solution
5. Wrong administration of medication
6. Overdose of Insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis-selection of high strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of AOB incompatible blood components of organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients
15. Unintentional connection of a patient requiring oxygen to an air flowmeter
16. Undetected oesophageal intubation (NB: temporarily suspended as a Never Event as of 31 January 2018)

## Appendix 9

**Referral Form**

**North (Cumbria and North East)**

## Raising a Performance concern regarding a clinician

**Guidance note:** This form should be used to refer a performance concern regarding a clinician to NHS England – North (Cumbria and North East). The template will ensure general information is provided and will help the referrer to articulate what the specific concerns are. It is accepted that some of the boxes may not be relevant to every referral and may be amended to capture any key aspects of a particular concern.

In addition to completing this form, you may wish to discuss the concerns with the Responsible Officer or one of the Assistant Medical Directors (contact details further below) prior to submission of the form where verbal communication may provide greater clarification.

| | |
|---|---|
| **Date of referral sent to NHS England:** | |
| **Details of individual raising the issue** | |
| Name: | |
| Designation: | |
| Organisation: | |
| Telephone number: | |
| Address: | |
| | |
| | |
| | |
| E-mail address: | |
| **Details of incident and practitioner concerned:** | |
| Date of incident: | |
| Clinician Name: | |
| GMC/GDC/GOC/Other regulatory body number: | |
| Source of concern: | PALS ref: |

| | |
|---|---|
| | DATIX ref:<br>Complaints:<br>Other please specify: |
| **Summary of concern:** (linked to regulatory standards i.e: GMC, GDC, GOC, NICE etc) | |
| **Relevant background to clinician or case:** | |
| **Investigation steps to date/action taken by referrer:**<br>(please include relevant meetings with clinician, i.e dates, place, attendees and outcomes and any internal processes still on-going) | |
| **Clinician response to concern:** | |
| **Potential ongoing risks:** | |
| **Referral opinion including any identified next steps:** | |
| **Supporting information attached:** | |
| **Please see attached Consent Form for consideration / completion** | |
| **For Office Use only:**<br><br>Recommendations to NHS England – North (Cumbria and North East)<br><br>For Information ☐<br><br>For action ☐<br><br>Other (Please State): | |

If you would like to speak to someone:-

- regarding completion of the form please contact a member of the Quality and Performance Team on (0113 824) 7237/7229/7213/7248 and ask to speak to one of the Programme Managers; or
- to discuss a performance concern, in the first instance where possible please contact one of the first response Assistant Medical Directors, as below:

| First response Assistant Medical Directors (and Deputy Responsible Officers) | | |
|---|---|---|
| North of Tyne & South of Tyne and Wear area:<br><br>Dr Tim Butler – Department Lead | 0113 825 1610 or<br><br>07900 715 343 | timbutler@nhs.net<br><br>PA: Lindsay Balderson |
| Durham, Darlington and Tees area:<br><br>tbc | 0113 825 1610 or<br><br>tbc | tbc<br><br>PA: Lindsay Balderson |
| Cumbria area:<br><br>Dr James Gossow | 0113 825 1610 or<br><br>07824 432 834 | james.gossow@nhs.net<br><br>PA: Lindsay Balderson |
| | | |
| Or, Medical Director and Responsible Officer | | |
| Dr Jonathan Slade (Deputy Medical Director & Responsible Officer) | 0113 8251602 or<br><br>07584 385 657 | jonathan.slade@nhs.net<br><br>PA: Sarah Harrison<br><br>sarah.harrison30@nhs.net |
| Professor Chris Gray (Medical Director) | | christopher.gray@nhs.net<br><br>PA: Sarah Harrison<br><br>sarah.harrison30@nhs.net |

## Once completed, please return the referral form to:

Dr Jonathan Slade
Deputy Medical Director and Responsible Officer
NHS England – North (Cumbria and North East)
Waterfront 4
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY

**or alternatively if you have an NHS Mail account, you may prefer to scan and attach the referral form to an email to: england.performancereferral@nhs.net**

**North (Cumbria and North East)**

Raising a Performance concern regarding a practitioner

Consent Form

**Practitioner Name:**

**Regulatory Body Number:**

In order to investigate your concerns regarding the practitioner named above, NHS England – North (Cumbria and North East) (NHS England) may need to disclose details of your concern(s) to the practitioner concerned. Please provide us with your consent to do this by signing and dating where indicated below.

Please complete below

I agree that NHS England may share the information I have provided on [date]_____and as contained in the Referral Form dated_____, and any subsequent information I may provide in connection with the same to the practitioner named on this form.

I understand that any information that NHS England receives during the course of any investigation into the concerns I have raised will likely be shared with legal representatives, clinical advisers and the relevant Regulatory Body. It may also be shared with the Police and other NHS Bodies as applicable to the investigation and as deemed appropriate by NHS England.

Name:

Signature:

Date:

Please return this form with your completed Referral Form.

**Note:** If you feel unable to provide this consent please contact one of the named Assistant Medical Directors to discuss – details on the previous page.

| Guidance notes for Referrers to complete Practitioner referral Form | |
|---|---|
| **Details of Individual** | Self- explanatory – all information requested should be provided in full. |
| **Source of concern** | Self- explanatory. |
| **Summary of Concern** | Clarify the nature of the performance concern e.g. patient / public safety; clinical performance (detailing specifics); behavior / attitude; specifics of any complaint; fraud; ill health; practitioner in difficulty; conduct. These examples are not exhaustive. |
| **Relevant Background** | Include details of any other current or historical concerns with the practitioner – action taken / outcome. Any issues which may be linked to the concerns raised. |
| **Investigation steps** | Provide a brief chronology of the steps taken prior to the referral e.g. internal investigations undertaken – outcome / meetings held / actions / agreements / current position etc. |
| **Clinician Response to Concerns** | Completion of this section will be subject to whether or not the referrer has informed the clinician at the time of the referral. Complete as applicable. |
| **Potential ongoing risks** | Highlight any risks or potential risks if this matter is not addressed. |
| **Referral opinion** | Based on the information available at the point of the referral, the referrer may wish to provide their opinion on how the case may be addressed, and any steps to resolution that may have been considered. |
| **Supporting Information** | The referrer should provide any available evidence to support the concerns raised / allegations made e.g. meeting notes; records; file notes; complaint letters; SUI's etc., |

## Appendix 10

## Duties and Responsibilities

| | |
|---|---|
| **CCG Accountable Officer** | The Accountable Officers have overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements. |
| **Medical Director** | The CCG Medical Director has overall strategic and operational responsibility for the local policy and procedures for assuring high standards of professional performance.<br><br>The Medical Director responsible for ensuring that:<br><br>● The document is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies.<br>● The necessary training or education needs and methods required to implement this policy are identified and resourced or built into the delivery planning process.<br>● Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this policy.<br>● Reports are presented to the CCG Management Executive on an annual basis.<br>● A seamless and coordinated approach is maintained in relation to performance concerns working with NHS England.<br>● Recommendations from National Reviews and Coroners directives which impact on general practitioner performance concerns are implemented.<br>● The CCGs maintain a culture of an organisation with a memory in relation to performance concerns in order to ensure patient safety. |
| **Clinical Quality** | The representative from the Clinical Quality Team, North of England Commissioning Support (NECS), is responsible for ensuring that; |

| | |
|---|---|
| | • The process detailed in appendix 1 is implemented, reviewed and audited on an annual basis.<br>• NECS will include anonymous details of referrals made to NHS England as part of the quality reports to the CCG quality groups.<br>• Annual report detailing referrals made to NHS England will be presented in the confidential section of the CCG Management Executive by the CCG Medical Director.<br>• Support is given to the CCGs ensuring that a seamless and coordinated approach is maintained in relation to performance concerns, working with NHS England, including the implementation of Liberating the NHS, national reviews, ombudsman and coroners reports/directives.<br>• The CCGs maintain a culture of an organisation with a memory in relation to performance concerns in order to ensure patient safety.<br>• Practitioner performance concerns from all data bases, issues logs, soft intelligence, complaints, serious incident reports, incidents and near miss reports and patient experience within the CCG and concerns from external sources are considered by the GP PTG. |
| **GP PTG Administrator** | The GP PTG administration is provided by the NECS Clinical Quality team and is responsible for ensuring that;<br><br>• A schedule of quarterly meetings are arranged.<br>• Additional meetings are arranged where required.<br>• An accurate record of the meetings is made and disseminated within 5 working days of the meetings.<br>• Actions recommended by the GP PTG are recorded accurately.<br>• Communications and referrals to NHS England are processed within 5 working days.<br>• An accurate database of the actions and referrals to NHS England are maintained.<br>• All data in the referrals to NHS England is scrutinised and any unnecessary patient and staff identifiable information is redacted. |
| **All staff** | All staff, including temporary and agency staff, are responsible for:<br><br>• Compliance with relevant process documents. Failure to comply may result in disciplinary action being |

| | |
|---|---|
| | taken.<br>● Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities.<br>● Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly.<br>● Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager.<br>● Attending training / awareness sessions when provided<br>● The CCGs maintain a culture of an organisation with a memory in relation to performance concerns in order to ensure patient safety. |