

Corporate	CO32 - Local Policy and Procedure for the Management of Healthcare Professional Performance
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V3	September 2018	September 2020

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Consultation Process:	Medical Director CCG Performance Triage Group (PTG)
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Policy Adopted From:	V2 Local Policy and Procedure for the Management of General Practitioner Professional Performance Corporate Policy
Approval Given By:	Quality, Safety and Risk Committee

Document History

Version	Date	Significant Changes
V1	December 2013	Initial draft of policy document
V2	February 2014	Second draft of policy document
V3	August 2018	Reviewed and updated. Minimal amendments.

Equality Impact Assessment

Date	Issues
August 2018	Please see section 9 of this document.

POLICY VALIDITY STATEMENT

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid. Policy users should ensure that they are consulting the currently valid version of the documentation.

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1. Introduction

For the purposes of this policy NHS Newcastle Gateshead Clinical Commissioning Group will be referred to as “the CCG”.

The 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 carer’s, 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.

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 or the NMC code of conduct), contract requirements and duties in accordance with the relevant Performers List Regulations. A potential breach of such standards, contract or regulations might indicate a performance concern, which may be assessed through this policy and procedure, independent of any action taken by the regulatory, professional or contractual body concerned.

In such cases, performance concerns may 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.

2. Status

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

3. Purpose and scope

NHS England is the responsible body for the investigation and management of professional performance issues in general practitioners and other primary care services. They do, however, rely on local intelligence that may be gathered and assessed by the CCGs.

The CCG has a formally constituted healthcare professional Performance Triage Group (PTG). The PTG has a responsibility to assess and triage potential concerns relating to healthcare professionals within its member practices and other primary care providers in order to identify if there is potentially a professional performance issue which may require referral to the NHS England Area Team or other responsible body for further consideration.

4. Definitions

The following terms are used in this document:

Healthcare Professional

Medical, clinical and other staff, such as allied health professionals, who have regular clinical contact with patients. This includes staff such as doctors, dentists, pharmacists, optometrists, nurses and other clinical support staff.

Performance Concern

When a concern about the performance of a healthcare professional, measured against an agreed professional or regulatory standard, is raised by a patient, carer, other healthcare professional or whistleblower.

Clinical Commissioning Group (CCG): CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Commissioning Support Unit (CSU): CSU's are designed to offer an efficient, locally-sensitive and customer-focused support service to CCGs.

Any other special terms or abbreviations used in this document are defined as they occur.

5. Procedure for management of Professional Performance Concerns

This policy and procedure applies to management, support and handling of potential performance concerns in respect of general practitioners and other healthcare professionals working within the CCGs, their member practices and other commissioned primary care providers.

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

5.1 Performance Triage Group (PTG) Duties and Functions

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

The duties and functions of the PTG are:

- To receive information and data relating to healthcare professionals from a variety of sources and to process this information and/or data in accordance with the General Data Protection Act (2018);
- 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 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);
- To keep action logs of all decisions made for the minimum retention period in accordance with information governance retention schedules;
- To take any actions deemed necessary following consideration of the information received, including but not limited to:

- Refer any relevant primary care healthcare professional practitioner to the NHS England Area Team;
- Refer to relevant professional body in accordance with the developed framework;
- Refer any concern to the employer of the healthcare professional;
- In the case of nurses, to refer to the relevant healthcare professional body (eg. NMC, GMC etc)
- Refer relevant concerns to the Police, where criminal actions are suspected.
- To track all referrals made to the NHS England Area Team;
- To receive information from the NHS England Area Team regarding referrals made to them about healthcare practitioner performance concerns.
- Adhere to the NHS England Area Team Policy and Procedures for Assuring High Standards of Contractors and Performers.

5.2 Reporting and Communication Details

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

A 6-monthly report detailing any referrals made will be presented in the confidential section of the CCG Management Executive by the CCG GP Quality Lead.

The PTG will receive information from the NHS England Area Team 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.

6. 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.
CCG Medical Director	<p>The CCG Medical Director has overall strategic and operational responsibility for the local policy and procedures for assuring high standards of professional performance.</p> <p>The Medical Director is responsible for ensuring that:</p> <ul style="list-style-type: none"> ● This document is drafted, approved and disseminated in accordance with the CCGs processes. ● The necessary training or education needs and methods required to implement this policy are identified and resourced or built into the delivery planning process. Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this policy. ● Reports are presented to the Management Executives of the CCGs on a six monthly basis. <p style="text-align: right;"><i>Continued</i></p>

	<ul style="list-style-type: none"> • Liaison with general practitioners who may be the subject of performance concerns in order to discuss concerns in the first instance; • A seamless and coordinated approach is maintained in relation to general practice performance concerns, working with the NHS England Area Team. • Recommendations from National Reviews and Coroners directives which impact on general practitioner performance concerns are implemented. • The CCGs maintain a culture of an organisation with a memory in relation to performance concerns in order to ensure patient safety.
Executive Director of Nursing, Patient Safety and Quality	<p>The Executive Director of Nursing, Patient Safety and Quality is responsible for:</p> <ul style="list-style-type: none"> • Ensuring that the PTG receives professional advice and support for any concerns regarding nursing issues. • Liaising with member practices regarding professional concerns and issues raised about Practice Nurses; • Reports are presented to the Management Executives of the CCG on a six monthly basis; • The CCG maintains a culture of an organisation with a memory in relation to performance concerns in order to ensure patient safety.
Clinical Quality Manager	<p>The Clinical Quality Manager North of England Commissioning Support Unit (NECS) is responsible for ensuring that:</p> <ul style="list-style-type: none"> • The process detailed in appendix 2 is implemented, reviewed and audited on an annual basis. • NECS will include anonymous details of referrals made as part of the routine quality reporting to CCG quality groups. • The 6-monthly report detailing referrals made is provided to the CCG Medical Director to be presented in the confidential section of the CCG Management Executive; • The CCGs maintain a culture of an organisation with a memory in relation to performance concerns in order to ensure patient safety. • 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 PTG.

<p>PTG Administrator</p>	<p>The PTG administrator (NECS) is responsible for ensuring that:</p> <ul style="list-style-type: none"> • Meetings are arranged monthly, or when required; • An accurate record of the meetings is made and disseminated within 7 working days of the meetings; • Actions recommended by the PTG are recorded accurately; • Communications and referrals are processed within 3 working days; • An accurate database of the actions and referrals are maintained. • All data in the referrals is scrutinised and any unnecessary patient and staff identifiable information is redacted.
<p>All staff</p>	<p>All staff, including temporary and agency staff, are responsible for:</p> <ul style="list-style-type: none"> • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • 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. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training/awareness sessions when provided • The CCG maintains a culture of an organisation with a memory in relation to performance concerns in order to ensure patient safety.

7. Implementation

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

8. Training Implications

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

9. Related Documents

9.1 Other related policy documents

- NHS England Area Team Primary Care services Agency Policy and Procedures for Assuring High Standards of Professional Performance of Contractors and Performers
- CCG CO18 Serious Incidents (SIs) Management Policy
- CCG CO08 Incident Reporting and Management Policy
- CCG CO02 Complaints Policy and Procedure

9.2 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 Department of Health 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.

General Regulations

- Cabinet Office (2008) *The NHS Act 2008*. London. HMSO
- Cabinet Office (2004) *The NHS (Performers Lists) Regulations 2004 (as amended)*. London. HMSO
- Cabinet Office (2004) *The NHS (General Medical Services Contracts) Regulations 2004*. London. HMSO
- Cabinet Office (1992) *The NHS (Services Committees and Tribunal) Regulations 1992 (as amended)*. London. HMSO
- Cabinet Office (1998) *The Human Rights Act 1998*. London. HMSO
- Cabinet Office (2004) *The NHS (Personal Medical Services Agreements) Regulations 2004*. . London. HMSO
- Cabinet Office (2003) *Health and Social Care (Community Health Standards) Act 2003*. London. HMSO
- Cabinet Office (2012) *Health and Social Care Act 2012*. London. HMSO
- Cabinet Office *The NHS Act 2006 Department of Health*. London. HMSO

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

9.3 Best practice recommendations

- Supporting Doctors, Protecting Patients, London 1999
- NPSA Incident Decision Making Tree, see appendix 7 & 8

9.4 References

Department of Health. *Supporting Doctors, Protecting Patients*. London 1999
The National Reporting and Learning Service. *National Patient Safety Agency Guidance for Risk Managers*. www.npsa.nhs.uk

10. Monitoring, Review and Archiving

10.1 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.

10.2 Review

The governing body will ensure that this 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.

Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The council of members will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

For ease of reference for reviewers or approval bodies, changes should be noted in the 'version control' table on the second 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.

10.3 Archiving

The Governing Body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2016.

11. Equality analysis

A full equality impact assessment has been completed. Please refer to Appendix 9.

**NHS Newcastle Gateshead
Clinical Commissioning Group
Performance Triage Group
Terms of Reference**

1. Introduction

The performance triage group of the Clinical Commissioning Group is established as a sub-committee of the Quality, Safety and Risk Committee, in accordance with the constitution, standing orders and scheme of reservation and delegation.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the performance triage group and shall have effect as if incorporated into the CCG constitution and standing orders.

2. Principal Function

The performance triage group (PTG) shall provide a forum to ensure concerns raised about primary care clinicians, such as general practitioners, can be discussed internally within the CCGs, with the support of North of England Commissioning Support (NECS), in order to determine whether further investigation may be required by the NHS England, or other appropriate professional body.

The PTG will also provide a forum to share intelligence or any concerns identified in relation to primary care practices, from a variety of sources including but not restricted to NHS England and the CQC. The PTG will consider this information to determine if any action is required by the CCG, such as providing support to individual practices or seeking advice from NHS England.

The PTG is formally constituted within the CCG and has delegated responsibility to ensure fair, equitable and auditable decisions regarding the referral of practitioners to NHS England or professional bodies are made. The PTG does not have delegated responsibility to investigate concerns raised by NHS England or CQC regarding primary care practices.

3. Membership

The membership of the performance triage group will consist of,

- i). The CCG Medical Director
- ii). The CCG Director of Nursing
- iii). The CCG Head of Quality
- iv). A CCG representative from the Delivery Team
- v). The CCG Director of Operations & Delivery
- vi). The CCG Portfolio Manager – Primary Care
- vii). Clinical Quality Manager or Senior Clinical Quality Manager, NECS
- viii). Clinical Quality Administrator, NECS (notes)

4. Chair

Chair arrangements to be agreed within the PTG.

The Chair has the responsibility to ensure that the group obtains appropriate advice in the exercise of its functions.

5. Secretarial support

The Clinical Quality Administrator (NECS) shall ensure that a minute of the meeting is taken and provide appropriate support to the Chair and Group members.

6. Quorum and decision making

A quorum shall be when a minimum of one director from the CCG and the NECS Clinical Quality Manager or Senior Clinical Quality Manager is present.

In the event of the Chair of the Group being unable to attend all or part of the meeting, he/she will nominate a replacement from within the membership to deputise for that meeting.

Generally it is expected that decisions will be reached by consensus. Should this not be possible then a vote of members will be required. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) will have a second, and casting vote.

7. Frequency of meetings

Meetings of the PTG shall be held monthly and will normally be one hour in duration. The meetings will be stood down if there are no potential performance concerns to consider. The chair may request additional meetings according to operational or business requirements. If there are no practitioners to discuss, the meeting will be cancelled no later than one day prior to the meeting.

For urgent cases requiring immediate escalation to NHS England or professional bodies, 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.

Members will be expected to attend each meeting.

In exceptional circumstances and where agreed in advance by the chair, members of the group or others invited to attend may participate in meetings by telephone, by the use of video conferencing facilities and/or webcam where such facilities are available. Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

8. Agendas and papers

The agenda for meetings of the group will be set by the chair. The agenda and papers for meetings of the group will be distributed 5 working days in advance of the meeting. Items for the agenda should be notified to the chair 10 days in advance of each meeting.

9. Remit and responsibilities of the group

- i). To receive information and data relating to healthcare professionals from a variety of sources and to process this information and/or data in accordance to the Data Protection Act.
- ii). To ensure all relevant corporate policies and procedures are applied with specific regard to Safeguarding Children, Information Governance and maintaining confidentiality.
- iii). To use the information and data to make an informed decision relating to the concerns raised, through use of the approved tools and methodologies.
- iv). 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).
- v). To keep minutes of the meetings and all decisions made for the minimum retention period in accordance to NHS retention schedules.
- vi). To complete documentation relating to the decision making process as detailed in appendix 4.
- vii). To refer any practitioner to the NHS England or relevant professional body in accordance with the developed framework (see appendix 5).
- viii). To ensure that all relevant information considered by the PTG is forwarded to NHS England so that one organisation has an overview of all actual and potential performance concerns.
- ix). To track all referrals made to NHS England or relevant professional body.
- x). To receive information from NHS England regarding referrals made to them about healthcare professional performance concerns.
- xi). Adhere to NHS England Policy and Procedures for Assuring High Standards of Contractors and Performers.
- xii). To receive and consider information and data relating to primary care practice from a variety of sources and to process this information and/or data in accordance to the Data Protection Act.

10. Reporting arrangements

The group reports to the Quality, Safety and Risk Committee.

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

NECS will include anonymous details of referrals made as part of the quarterly and monthly quality reports to the CCG quality groups.

A 6-monthly report detailing referrals made will be presented in the confidential section of the CCG Management Executive by the CCG GP Quality Lead.

The PTG will receive information from NHS England relating to all the performance concerns they are considering ensuring triangulation with local incidents, complaints and concerns, serious incidents reported via the STEIS mechanism and local soft intelligence captured on the electronic incident reporting system (SIRMS).

11. Policy and best practice

The group will apply best practice in its decision making, and in particular it will:

- i). ensure that decisions are based on clear and transparent criteria
- ii). comply with CCG policy and procedures for the declaration of interests

The group will have full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

12. Conduct of the Group

All members of the group and participants in its meetings will comply with the Standards of Business Conduct for NHS Staff, the NHS Code of Conduct, and the CCG's Policy on Standards of Business Conduct and Declarations of Interest which incorporate the Nolan Principles.

13. Date of Review

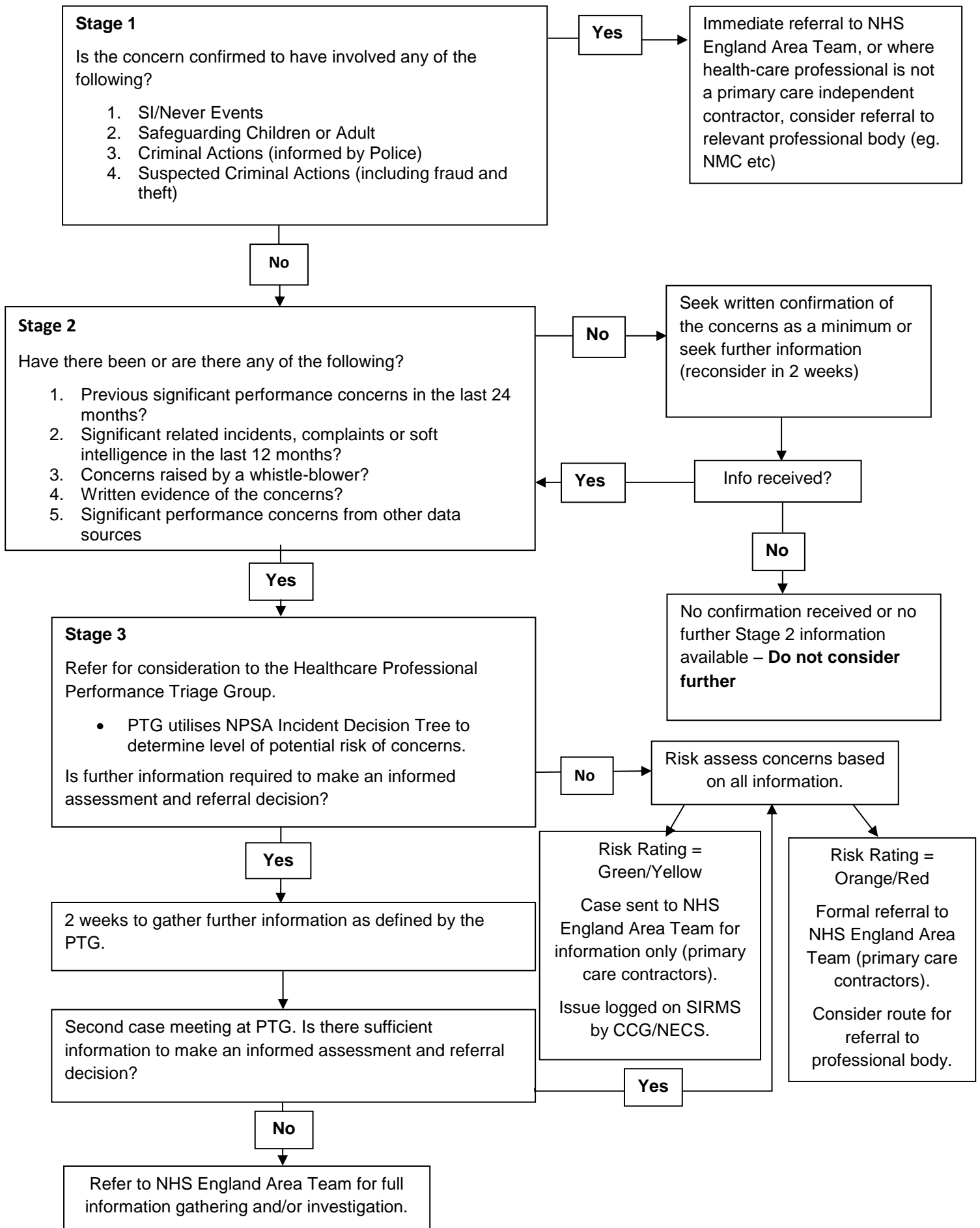
The group will review its performance, membership and these Terms of Reference at least once per financial year. It will make recommendations for any resulting changes to these Terms of Reference to the Quality, Safety and Risk Committee for approval.

No changes to these Terms of Reference will be effective unless and until they are agreed by the Quality, Safety and Risk Committee.

Approval Date: 21/06/2018

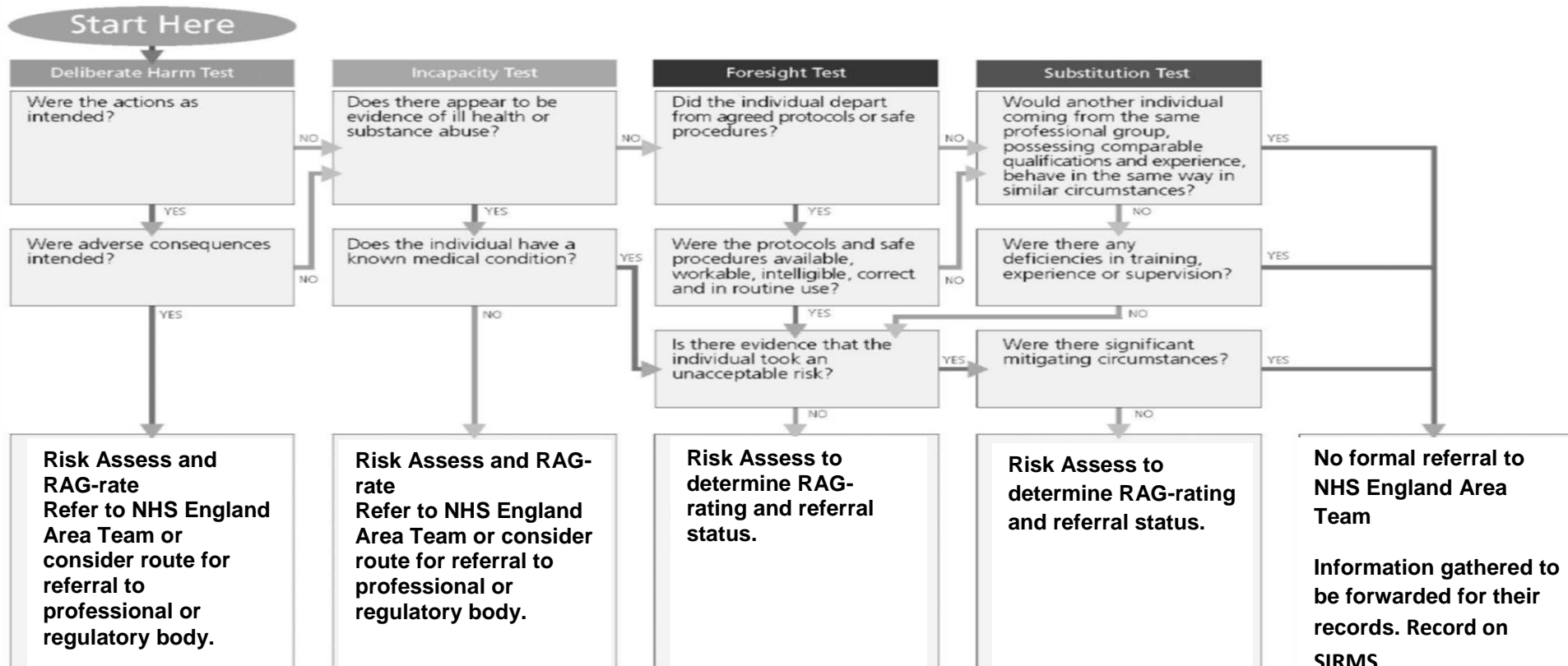
Review Date: 06/2019

Performance Concern Referral Triage Flowchart



INCIDENT DECISION TREE*

Work through the tree separately for each individual involved



*

11

Appendix 4

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 Area Team or relevant professional body. Case information forwarded to contact at NHS England Area Team (where relevant) for their records (letter template 2)	
Medium Risk	No formal referral to be made to NHS England Area Team or relevant professional body. Case information forwarded to contact at NHS England Area Team (where relevant) for their records (letter template 2)	
High Risk	Formal referral to be made to Medical Director at NHS England Area Team using agreed NHSE form and letter template 1	
Extreme Risk	Formal referral to be made to Medical Director at NHS England Area Team using agreed NHSE form and letter template 1	

Date of Assessment	
Date of Referral	
Signed	
Print Name / Position	



North (Cumbria and North East)

Referral Form

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: Complaints: 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:
(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:

Recommendations to NHS England – North (Cumbria and North East)

For Information

For action

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: Dr Tim Butler – Department Lead	0113 825 1610 or 07900 715 343	timbutler@nhs.net PA: Lindsay Balderson
Durham, Darlington and Tees area: Dr Anji Curry	0113 825 1610 or 07730 375 492	anji.curry@nhs.net PA: Lindsay Balderson
Cumbria area: Dr James Gossow	0113 825 1610 or 07824 432 834	james.gossow@nhs.net PA: Lindsay Balderson
Or, Medical Director and Responsible Officer		
Dr Jonathan Slade (Deputy Medical Director & Responsible Officer)	0113 8251602 or 07584 385 657	jonathan.slade@nhs.net PA: Sarah Harrison sarah.harrison30@nhs.net
Professor Chris Gray (Medical Director)		christopher.gray@nhs.net PA: Sarah Harrison 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

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.

<u>Guidance notes for Referrers to complete Practitioner referral Form</u>	
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.,

Risk matrix

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

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

The Incident Decision Tree: Guidelines for Action

(Adapted from guidance issued by the NPSA. The original guidance can be found at www.npsa.nhs.uk)

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 has 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 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.

NHS Improvement - Never Events list 2018

There are 16 never events. Any general practitioner that is directly involved in an incident that features on this list should be referred immediately to the NHS England Area Team.

Surgical

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post procedure

Medication

4. Mis-selection of a strong potassium solution
5. Administration of medication by the wrong route
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

Mental health

9. Failure to install functional collapsible shower or curtain rails

General

10. Falls from poorly restricted windows
11. Chest or neck entrapment in bed rails
12. Transfusion or transplantation of ABO-incompatible blood components or 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



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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:	Kirstie Atkinson
Title of service/policy/process:	Local Policy and Procedure for the Management of Healthcare Professional Performance
Existing: <input type="checkbox"/> New/proposed: <input type="checkbox"/> Changed: <input checked="" type="checkbox"/>	
What are the intended outcomes of this policy/service/process? Include outline of objectives and aims	
<p>NHS England is the responsible body for the investigation and management of professional performance issues in general practitioners and other primary care services. They do, however, rely on local intelligence that may be gathered and assessed by the CCGs.</p> <p>The Performance Triage Group (PTG) has a responsibility to assess and triage potential concerns relating to healthcare professionals within its member practices and other primary care providers in order to identify if there is potentially a professional performance issue which may require referral to the NHS England Area Team or other responsible body for further consideration.</p>	
Who will be affected by this policy/service /process? (please tick)	

Staff members
If other please state:
What is your source of feedback/existing evidence? (please tick)
<input type="checkbox"/> National Reports <input checked="" type="checkbox"/> Internal Audits <input type="checkbox"/> Patient Surveys <input type="checkbox"/> Staff Surveys <input checked="" type="checkbox"/> Complaints/Incidents <input type="checkbox"/> Focus Groups <input type="checkbox"/> Stakeholder groups <input type="checkbox"/> Previous EIAs <input type="checkbox"/> 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	N/A
Patient Surveys	N/A
Staff Surveys	N/A
Complaints and Incidents	N/A
Results of consultations with different stakeholder groups – staff/local community groups	N/A
Focus Groups	N/A
Other evidence (please describe)	N/A



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

No impact 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

No impact 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.

No impact 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

No impact 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.

No impact identified

Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.

No impact identified

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.

No impact identified

Sex/Gender A man or a woman.

No impact identified

Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes

No impact identified

Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person

No impact identified

Other identified groups such as deprived socio-economic groups, substance/alcohol abuse and sex workers

No impact 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?

- Verbal – stakeholder groups/meetings** **Verbal - Telephone**
- Written – Letter** **Written – Leaflets/guidance booklets**
- Email** **Internet** **Other**

If other please state:

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.**
- Sending out correspondence in alternative languages.**
- Producing / obtaining information in alternative formats.**
- Arranging / booking professional communication support.**
- Booking / arranging longer appointments for patients / service users with communication needs.**

If any of the above have not been considered, please state the reason:



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?
None identified	N/A



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



SIGN OFF

Completed by:	Kirstie Atkinson
Date:	28 August 2018
Signed:	
Presented to: (appropriate committee)	Quality, Safety and Risk Committee
Publication date:	September 2018

1. Please send the completed Equality Analysis with your document to:
necsu.equality@nhs.net
2. Make arrangements to have the EA added to all relevant documentation for approval at the appropriate Committee
3. Publish Equality Analysis

**For further advice or guidance on this form, please contact the NECS Equality Team:
necsu.equality@nhs.net**