

# NHS London

**An Introduction to a Pan  
London Approach to  
Improve Quality, Access  
and Patient Experience in  
General Practice**

**Appendix 2: Guidance for  
Good Performance  
Management of General  
Practice**

**April 2011**

# **Guidance for Good Performance Management of General Practice**

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# Guidance for Good Performance Management of General Practice

## 1. Introduction

### *1.1 Background*

Commissioners are expected to understand the strengths and weaknesses of commissioned services, driving improved quality and outcomes through effective performance management and provision of support where necessary.

This guidance provides an outline for assessing general practice through the normal contractual framework (e.g. Personal Medical Services (PMS), General Medical Services (GMS) or Alternative Provider Medical Services (APMS)) and in due course pan-London Outcome Standards. It sets out an approach to working with GP contractors and provides a guide to managing these where there is a potential or actual breach of contract.

This document has been written at a time of major NHS reorganisation. The guidance is intended to ensure consistency of approach and to help any primary care contract manager and commissioner regardless of their organisation. It is also intended to provide clarity to GP practices about the performance management routes available to their commissioners and guide them through the process. It will be a working document which will be revisited as the new structures embed and the performance management function transfers to the NHS Commissioning Board.

It is important that this document is read in conjunction with any relevant contract and, if appropriate, the relevant regulatory framework. It is essential to always check clause numbers and clauses in the specific contract if taking formal action (such as issuing breach or remedial notices).

### *1.2 The performance approach*

NHS London is working with GP Leaders, Primary Care Commissioners and Londonwide Local Medical Committees (LMC), in consultation with Surrey & Sussex and Barking & Havering LMCs, to develop a framework to drive improvements in quality in general practice. This will consolidate the best from existing PCT performance frameworks as well as adding new standards developed by clinicians that set clear expectations about what patients should expect to receive from general practice. *An Introduction to a Pan London Approach to Improve Quality, Access and Patient Experience in General Practice* and a summary of the London Outcome Standards have been published alongside this guidance. The standards will be reported from April 2011 onwards. This will help to provide an in-depth assessment of local practice performance and enables both the commissioner and GP contractors to reach an objective and rounded view of performance and compliance with their contractual obligations.

Active contract management will enable providers and commissioners to better identify situations where action may need to be taken. For example, if it looks as though a contractor could be in danger of committing a breach of contract, the

commissioner may be able to forewarn the practice and deal with the matter on a relatively informal basis. In other cases where a breach has already occurred, the commissioner may be left with no alternative but to put the matter on a more formal footing (e.g. by issuing a breach or remedial notice). It will also, where necessary, support improvements in quality and performance by identifying different kinds of support and helping to address specific issues where appropriate.

### *1.3 Principles*

The ultimate aim of this process is to drive up quality and develop good quality services for patients.

There is a distinction between concerns relating to the provision of contracted services and issues around an individual's practice as a performer. In the former situation, the matter will be dealt with under the contractual framework (which this guidance is concerned with). In the latter situation, the matter will usually be dealt with under the Performers' Lists regulations. However, the two do often overlap and commissioners need to be clear about which route they intend to take or indeed if both are to be progressed simultaneously.

Contract management needs resources and this should be identified up front. For example this includes identifying who, within the commissioning organisation, will have overall responsibility for the matter, its urgency and the resources which will be required, both internal and external. This can present a challenge given the management cost savings programme and drive toward affordable services. The cost of commissioning high quality general practice medical provision and robust management of the contract will need to be considered in local decisions on future allocation of resources and to ensure that this continues to be dealt with effectively.

This document is a guide to support maintaining the high quality of services and to drive up improvements where there is an identified need. It presents an overview of the steps and actions a commissioner might take to address the poor provision of services. Any concerns must be handled on a case by case basis and legal advice should be sought where appropriate.

### *1.4 Responsibilities*

This document clearly sets out the primary responsibility of commissioners for ensuring and assuring that high quality general practice is provided to the local population. However it is important to acknowledge that, by accepting and working within the agreed contract, the contractor is therefore accepting their responsibility for the quality of care delivered and, furthermore, should acknowledge the legitimate role of the commissioner and be prepared to engage constructively in any fair and reasonable process of review and remedy.

In reality most contractors are also clinicians who will also have their wider professional responsibilities to patient safety and quality and this should also be recognised by commissioners, in order to develop the culture of respect and understanding which will ensure that the approaches taken to assurance can be seen by all parties as mutually beneficial and effective.

## **2. Performance Monitoring – Recognising and Identifying Underperformance**

### *2.1 Principles for setting clear expectations*

Where possible, there should be a shared vision between the commissioners, LMCs and individual practices of what good, acceptable and unacceptable practice looks like. Ultimately however, responsibility for ensuring the proper and adequate provision of services rests with the commissioner.

It is helpful to have a clear and robust policy for dealing with contractual issues, and where possible agreed by all the key stakeholders. If there are concerns around the provision of services, then any resulting actions taken by the commissioner should be fair, proportionate and reasonable. Where possible, this should be underpinned by open and transparent dialogue between primary care commissioners and GP contractors.

### *2.2 Good performance management*

Good performance management requires sufficient capacity and capability in the responsible organisation. Managers should know their own organisation's escalation procedures prior to dealing with any matter or having to enact them. There should be regular review of data and good record keeping. Face to face meetings with GP contractors should normally happen on a regular basis with agreed minutes or notes kept as a joint record.

### *2.3 Failure to comply with contractual requirements*

Primarily, contract management is around ensuring that services provided to patients are, as a minimum, in line with the agreed contractual requirements. Poor or unacceptable service provision will occur where a contractor is in breach of their contract. One of the functions of the commissioner therefore is to monitor the contract to ensure that the relevant contractual provisions are being complied with.

Effective monitoring of contracts also means that commissioners should be able to identify potential problems at an early stage and help GP contractors to try and deal with these problems before they escalate into a full-blown breach.

However, once a breach occurs, the commissioner may be left with no alternative, but to take formal action (for example, issuing a remedial or breach notice).

### *2.4 Sources of information*

There are a number of sources of information that may be relevant in the context of managing and monitoring contractors and the provision of services that they are responsible for. They are set out below:

Table 1: Information sources:

Referral and out of hours data	Complaints and other PALS
Quality Outcomes Framework (QOF)	information
Financial systems	Employment law and workforce
Infection control	Clinical audit
Prescribing data	HR policies
Referrals	Whistle blowing
Public health targets	Patient experience
Infection control	A&E data
Clinical governance systems and IT control	Expected health outcomes
Visits to the practice e.g. the annual contracting visit	Controlled drugs
Serious Untoward Incident (SUI)	Equity of Healthcare
	Safeguarding Children

Good information governance (*Information Security Management: NHS Codes of Practice*<sup>1</sup> and *Records Management: NHS Codes of Practice*<sup>2</sup>) is essential. Commissioners should normally have a practice file where all relevant sources of information are kept. For example, the file may include all relevant correspondence and notes of any meeting held with the contractor.

<sup>1</sup> Department of Health; Information Security Management: NHS Code of Practice; <http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/codes/securitycode.pdf>

<sup>2</sup> Department of Health; Records Management; NHS Code of Practice [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4131747](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747)

### **3. Early Warning and Support**

In many cases, the best opportunity to address concerns successfully is if potential problems are identified at an early stage.

#### *3.1 The process for recognition*

Good record keeping is essential for early recognition of any emerging problems. All the available information should be kept up to date to build a complete picture of the GP contractors and the quality of services that they are responsible for. Where appropriate, this should be done with expert support and with clinical input. In many cases, it may be helpful to have input from the commissioner's medical director or other GP advisers. It is important there is the right expertise when analysing the information, as incorrect conclusions and faulty judgements can bring the whole process into disrepute.

Where one is considering the provision of services and comparing, for example, different GP contractors, one may need to take into account the local context in which the services are being provided. Accordingly, benchmarking against the norm for that practice and area as well as against professional standards may be appropriate.

If there is any indication from these data sources that a GP contractor is failing to provide adequate services, then depending on how serious this is, it may trigger discussion in the first instance with the contractor.

In any event, there should normally be ongoing communication, including regular informal contact, as well as face to face meetings, between the contractor and the commissioner to discuss relevant data and information or issues faced by the contractor. This should help identify issues at the earliest opportunity and facilitate a joint approach to resolution. These relationships will help to establish a transparent relationship where GP contractors will feel comfortable to be open and honest about the services that they are responsible for providing. This is where there is the highest chance of a successful outcome for all concerned.

#### *3.2 Early warning*

Regular review of information is only part of the picture. This will help support early identification of a performance issue but a good relationship between the commissioners and the contractors will also help. When commissioners really engage with practices, and fully understand the context in which they work, this builds a constructive relationship where support required is identified and issues are resolved at the earliest opportunity.

Where there is early warning of a problem then the first step would normally be to discuss this with the practice. By doing this it may be possible to identify the extent of the problem and whether it can be easily resolved.

There are lots of reasons why systems and process can break down, some of which can be resolved very quickly, for example, if there is a change in management or

staffing at a practice. In this situation the commissioner may want to identify sources of support that the GP contractor could access.

### *3.3 Support*

There are a wide variety of sources of support available to practices. Some of these are set out in additional section 2 at the end of this document. Additional section 3 sets out a case study for how Tower Hamlets PCT has approached providing support and guidance to general practice.



## 4. Managing Contractual Underperformance

### 4.1 Contractual underperformance

It is not really possible to define the full range of contractual underperformance which may give rise to a concern that a GP contractor is in breach of their contract. However, concerns can range from one-off specific incidents, for example, a complaint or a serious untoward incident (SUI) through to where there are a range of ongoing minor issues around the quality of services being provided. Often, engagement with the practice at an early stage in these types of situations can be crucial to resolving the concerns.

However, if a breach has occurred then the commissioner may be left with no alternative but to issue a breach or remedial notice.

It is also worth bearing in mind that where a GP practice fails to remedy a breach or continues to breach the contract, then again, that may give grounds to terminate the contract. Further, if the safety of the contractor's patients is at serious risk if a contract is not terminated or the commissioner considers that it is at risk of material financial loss, then it may need to look to terminate the contract and, possibly, on an expedited basis.

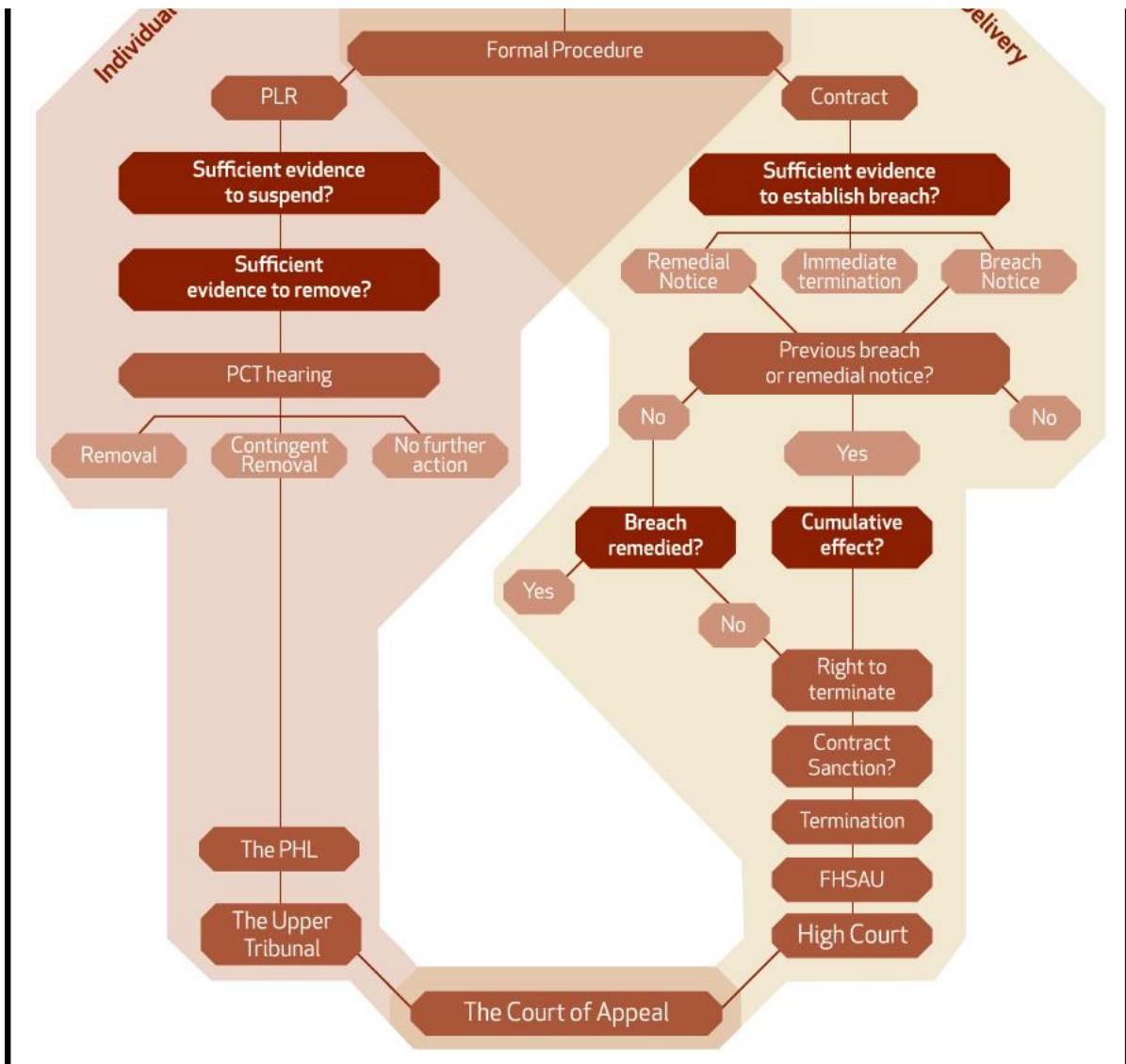
### 4.2 Individual performer or the contractual route

There is often an overlap between a failing GP practice and the performance of individual clinicians and therefore there should be clarity in managing performance and contractual issues. In some cases commissioners will need to instigate both contractual review and individual performer proceedings simultaneously. The steps commissioners may take under the Performers' Lists Regulations to regulate the performance of GPs are separate (i.e. subject to different regulatory frameworks) from the arrangements they have for ensuring that GMS and PMS contractors comply with their contracts to provide services.

The National Clinical Assessment Service (NCAS), in collaboration with the Royal College of General Practitioners (RCGP) and the NHS Clinical Governance Support Team (CGST) published *Local GP Performance Procedures (November 2007 – Second edition)*. This document provides information on local procedures for handling concerns about the performance of GPs working in England. It offers advice and a suggested approach on the principles, structures and processes for local arrangements, and builds on extensive work already undertaken in this field. The document is written primarily for commissioners in England who are directly involved in handling concerns about individual GP performance.

The key messages from this document that are specific to the individual performer route are included in additional section 4.

Diagram 1: Contract management flow chart:



### 4.3 Governance

Set out below are some general principles that the commissioner should bear in mind, in respect of dealing with contract management.

1. Identify who has overall responsibility for contract management within the commissioning organisation.
2. In terms of day to day management of the practice, this should be dealt with by the responsible member of the contract team, i.e. the person / team appointed to deal with the practice. They will then normally be responsible for liaising with the practice; collecting and collating information; arranging for meetings (such as annual contract reviews) and generally forming a point of contact between the GP practice and the commissioning body.

3. Where a situation is identified which could give rise to concerns then it would usually be good practice for the person / team with day to day responsibility for the relationship to report the concern to their line manager. If the concern is minor and there is no actual breach, then all that might be required is a visit / telephone call to the practice, followed up in writing confirming what was discussed.
4. If the concern is more serious, then the matter may have to be escalated to the person with overall responsibility for contract management within the commissioning body. That person can then take a decision as to whether the matter can be dealt with on an informal basis or whether formal action needs to be taken, such as the issuing of a remedial or breach notice or in certain situations a contract sanction. If the matter is very serious, then that person may need to consider whether or not the commissioning body should be considering termination.
5. If a remedial or breach notice needs to be issued, then the commissioner should agree a process which identifies who will be responsible for signing the notices off.
6. It would normally be good practice for the commissioning board to be informed of situations where breach or remedial notices have been issued. The board can then review these on a regular basis. This will also help to identify wider trends or concerns.
7. Where the commissioner needs to consider issuing a termination notice, then there are various steps that need to be followed, including liaising with the LMC. In this type of situation, it would normally be good practice for the commissioner to refer the decision to terminate a contract to the board. Where a termination notice is issued, then there are a number of implications that the commissioner will need to take into account. These include the risk that any decision to terminate will be challenged by reference to the Family Health Services Appeal Unit (FHSAU). Where the contract is terminated, then issues around what happens to the contractor's staff, the premises, and whether there are any ongoing consultation and procurement issues, will also need to be considered.
8. In conclusion, the commissioner needs to be clear about how contracts will be managed on a day to day basis and where more formal action needs to be taken, how that will be dealt with.

#### *4.4 The initial diagnostic*

Clearly in a perfect world issues about quality of care and performance in general practice would arise from analysis of multiple data sets looking at different aspects of the services provided that could be considered in a measured and balanced way, and leading to a robust diagnostic of the issues and potential remedies. In reality this cannot always be the case and it is often necessary to make a more rapid

assessment of the issue(s) presented, in order to protect patient safety and make key decisions about next steps.

In these circumstances it is usually important to have agreed in advance who will consider the issues and to ensure that they have the position and authority to act. In reality this is likely to be a Director with primary care responsibility working with a suitable clinical director/advisor.

It may be useful to consider the following questions as part of these discussions.

1. Is this practice already known to have performance issues?
2. Is it already subject to receiving practice support or remedial action?
3. How reliable is the source of the information on the issue? Can it be triangulated from other sources?
4. Have other matters been brought to the attention of the commissioners in the last month? Last 3 months? Last 6 months?
5. Are these issues predominantly about the operation of the practice or the practice of the practitioners or both?
6. Is the issue consistent with existing issues or does it come as a surprise?
7. Does the issue put actual or potential patients at risk?
8. How likely is the issue to reoccur?
9. Have there been any changes or issues in key staff in the practice recently?  
E.g. sickness absence, maternity leave, retirements, staff turnover
10. What is happening with the practice list? Growing? Shrinking? Staff turnover?  
Has this changed recently?
11. What is known about practice income e.g. as a result of list cleansing reductions or reduction in QoF achievement?
12. Have there been changes in usage of other services e.g. OOHs services, A&E etc?
13. What else is known about overall performance?

After consideration of the above and other relevant questions, it is normally helpful to visit the practice and get them to identify issues and challenges from their perspective. Critical to the assessment of degree of concerns at this point will be the extent to which practice/practitioners appears to be aware of the issues themselves, has insight into the significance and has, or is prepared, to take steps to address the issue.

This initial assessment is important to determine necessary speed of response and to assist with deciding whether the matters are best managed contractually or via individual performer route or both.

#### *4.5 The formal and informal contract management process*

To a large extent, whether a matter is dealt with informally or formally will depend on the nature of the concerns and the assessed risk to the quality of services that the contractor is responsible for.

For example, if a concern has been identified which though minor, has the ability to escalate, then all that is likely to be required is a visit / telephone call to the practice

by a member of the contracting team, to explain the concern and suggest ways in which this should be addressed. This should then be followed up in writing and kept under review.

If the concern is more serious (but it is not clear whether there has been a breach of contract) then it may be necessary to have a more formal meeting with the practice. In this situation, a letter should be sent to the contractor setting out the basis of any identified concerns, a request for a meeting and details of which officers from the commissioner will be attending. The practice should also be invited to have someone from the LMC present.

If following any meeting the concerns identified are considered to be low risk and the commissioner is satisfied that there is no breach of contract, then no formal action will be required. However, the commissioner may wish to follow the meeting up with a letter confirming the outcome.

If the concern is more serious, for example, the practice is providing services in such a way that could give rise to a breach of contract in due course, then the commissioner may wish to agree a more formal action plan to try and help the practice to prevent a breach from occurring.

In this situation the following actions could be considered:

- An action plan to be agreed by both parties with SMART deliverables and timescales for completion.
- A process for monitoring and reviewing the steps taken, at agreed time intervals.
- Identifying ways in which the practice should be seeking support, whether from the commissioner or other organisations.
- A process for ensuring that all steps taken are clearly documented and that all relevant evidence is kept on the contractors file.

If during the currency of the action plan, further concerns come to light or the commissioner considers that the practice is not taking the necessary steps in a sufficiently timely manner, and it becomes clear that a breach has occurred or is occurring, then it may need to take action under the formal contract management process as outlined below.

The commissioner may also consider that if appropriate, a more formal investigation should be carried out before considering the ambit of any action plan, or before considering whether more formal action needs to be taken.

#### *4.6 The formal contract management process*

In undertaking formal contract management it is important to ensure that the commissioner has a copy of all relevant contracts; that they are up to date and that any variation to the contract is set out in writing and, where necessary, signed by and on behalf of the commissioner and the contractor.

Each type of contract is underpinned by a regulatory framework whether it be a GMS, PMS or APMS contract. For example, for GMS contracts these are underpinned by the NHS (General Medical Services Contract) Regulations 2004. There is also a standard GMS contract, published by the Department of Health, which is invariably used by commissioners and contractors as a basis for the core contract. Equivalent regulatory frameworks exist for PMS and APMS contracts. However, these contracts are less standardised than GMS contracts, since they tend to be agreed on a more local basis.

It is also helpful to have a good understanding of the contractual provisions set out in the main body of any contract and any relevant schedules. It is important to recognise that there are substantive differences between GMS / PMS and APMS contracts.

Set out below are some of the provisions that are commonly breached in respect of PMS and GMS contracts. This is not a definitive list, but gives an idea of the range of breaches that can occur.

<b>Breach</b>	<b>NHS (General Medical Services Contract) Regulations 2004</b>	<b>Standard GMS Contract</b>	<b>NHS (Personal Medical Services Agreements) Regulations 2004</b>
Failure to provide essential contracted services	Various. For example Regulation 15	Clause 46	Various. For example Schedule 5 paragraph 1
Premises are not suitable for the delivery of services	Schedule 6 paragraph 1	Clause 27	Schedule 5 paragraph 2
Inappropriate storage of vaccines	Schedule 6 paragraph 8	Clause 40	Schedule 5 paragraph 6
Excessive prescribing	Schedule 6 paragraph 46	Clause 304	Schedule 5 paragraph 44
Practice leaflet	Schedule 6 paragraph 76	Clause 438	Schedule 5 paragraph 72
Failure to have an effective system of clinical governance	Schedule 6 paragraph 121	Clause 488	Schedule 5 paragraph 112
Inadequate patient records	Schedule 6 paragraph 73	Clause 427	Schedule 5 paragraph 70
Failure of the contractor to carry out his obligations under the Agreement with reasonable care and skill	Schedule 6 paragraph 67	Clause 25	Schedule 5 paragraph 67
Failure by the Contractor to adequately check the qualifications and other matters relating to a healthcare professional seeking to perform services under the Contract. For example, this includes (but is not limited to); <ul style="list-style-type: none"> <li>Failing to check, in the case of any healthcare professional (including medical practitioners) that the contractor is seeking to employ or</li> </ul>	Schedule 6: Paragraph 54 and 58	Clause 342 and 348	Schedule 5 paragraph 54 and 58

engage to provide clinical services, that he is registered with his relevant professional body and his registration is not suspended and/or allowing such a person who is not so registered or suspended to perform clinical services.			
<ul style="list-style-type: none"> <li>Failing to ensure, in the case of any medical practitioner that the contractor is seeking to employ or engage to perform medical services, that he has provided the name and address of the PCT on whose medical performers list he appears and / or allowing a person who is not so included in a list to perform medical services.</li> </ul>	Schedule 6: Paragraph 53 and 57	Clause 340 and 345	Schedule 5 paragraph 53 and 57
<ul style="list-style-type: none"> <li>Failing to ensure that, in the case of any healthcare professional that the contractor is seeking to employ or engage to perform medical services, that he has provided two clinical references relating to two recent posts which lasted 3 months without a significant break, or where this is not possible, a full explanation and alternative referees and the contractor has checked and is satisfied with the references (this applies to both medical practitioners and other healthcare professionals).</li> </ul>	Schedule 6: Paragraph 59	Clause 351	Schedule 5 paragraph 59
<ul style="list-style-type: none"> <li>That the contractor has failed to take reasonable care to satisfy itself that any person the contractor is seeking to employ or engage is both suitably qualified and competent to discharge the duties for which he is to be employed or engaged.</li> </ul>	Schedule 6: Paragraph 60(1)	Clause 354	Schedule 5 paragraph 60(1)
<ul style="list-style-type: none"> <li>That the contractor, when considering the competence and suitability of any person that it is seeking to employ or engage as above, has failed to have regard to: <ul style="list-style-type: none"> <li>that person's academic and vocational qualifications;</li> <li>his education and training; and</li> <li>his previous employment or work experience.</li> </ul> </li> </ul> <p>NB: Depending on the urgency of the situation or the exact circumstances there may be exceptions to the above requirements. It is therefore always important to check the precise facts and cross reference to the relevant clause and / or paragraph of the regulation / contract. Please also note that there are also specific requirements relating to GP registrars and those undertaking a post registration programme.</p>	Schedule 6: Paragraph 60(3)	Clause 355	Schedule 5: Paragraph 60(3)

Where a breach has occurred, then normally the steps open to the commissioner to manage this will be to issue a breach or remedial notice, or in certain circumstances applying a contract sanction. The stages are set out in more detail below.

## Stage 1: Review of evidence

As with the early warning and informal processes good information governance is key. Before issuing any breach notices commissioners must ensure that there is clear evidence of a breach of a specific clause or clauses of the contract.

## Stage 2: Remedial notices and breach notices

Generally the provisions relating to the remedial and breach notices under the GMS contract are mirrored in the PMS contract. APMS contracts will also have similar provisions. It is however always sensible to check the provisions that are being referred to and to ensure that they are incorporated into the relevant remedial or breach notices.

### *Remedial notice*

Where the contractor has breached the contract, other than in certain specified situations and the breach is capable of remedy, the commissioner shall, before taking any action it is otherwise entitled to take under the contract, serve a notice on the contractor requiring it to remedy the breach (this is a remedial notice).

A remedial notice shall specify:

- Details of the breach
- The steps a contractor must take to the satisfaction of the commissioner in order to remedy the breach
- The period during which the steps must be taken (this is known as the notice period).

The notice period shall, unless the commissioner is satisfied that a shorter period is necessary to protect the safety of the contractor's patients or protect itself from material financial loss, be no less than 28 days from the date that notice is given.

If the commissioner is satisfied that the contractor has not taken the required steps to remedy the breach by the end of the notice period, the commissioner may terminate the contract with effect from such date as the commissioner may specify in a further notice to the contractor. This is a discretionary power so the commissioner's decision needs to be proportionate, reasonable and fair.

The specified situations where a remedial notice (and also a breach notice – see below) would not be appropriate are where certain breaches give the commissioner other grounds for terminating the contract. These include:

- Termination by the commissioner for breach of a condition in regulation 4 of the GMS regulations
- Termination for the provision of untrue information
- Termination, including, where the contractor is subject to a national disqualification, the contractor has been refused admission or has been removed from the performers list or is subject to certain convictions, where



the contractor has been adjudged bankrupt or is in a partnership and it has been dissolved (this is a specific GMS ground)

- Termination by the commissioner for a serious breach
- Termination for unlawful subcontracting.

### *Breach notice*

Where the contractor breaches the contract and the breach is not capable of remedy, the commissioner may serve notice on the contractor requiring it not to repeat the breach (this is referred to as a breach notice).

The specified situations referred to above in respect of remedial notices also apply to breach notices.

<b>Example of what a breach / remedial notice should contain.</b>
<p><b>1) Details of the breach</b></p> <p>Examples might include that the contractors record keeping is inadequate and / or any clinical governance system is inadequate and / or the contractor's premises are substandard and not fit for purpose.</p>
<p><b>2) Identifying the specific clauses in the contract</b></p> <p>It is important to identify the actual contract held between the commissioner and the contractor and to ensure that the relevant clause numbers are correct. It is also important to bear in mind that the clause numbers will be different depending on whether it is a PMS / GMS or APMS contract.</p> <p>It is important to cross reference these breaches with the evidence that the commissioner has obtained which may include reviews of medical records, reports obtained by GP advisers, annual contract reviews, complaints etc.</p>
<p><b>3) In the case of a breach notice</b></p> <p>There should be a requirement that the contractor does not repeat the breach</p>
<p><b>4) In the case of a remedial notice</b></p> <p>It should set out the steps that the contractor must take to the satisfaction of the commissioner in order to remedy the breach.</p> <p>The steps should be clearly set out, transparent and with clear timescales.</p> <p>The minimum time period is usually 28 days from the date of service (unless there is a clear risk to patient safety or the financial resources of the commissioner) but in many cases, the commissioner may decide to grant a longer period.</p> <p>So for example, where the patient records are of a poor quality, the commissioner may require the contractor to ensure that all note keeping complies with guidance set out in good medical practice published by the General Medical Council. Further, it may require the contractor to carry out a review to ensure that all its patient records are up to date and include accurate clinical summaries and to</p>

ensure that the practice provides written confirmation that this has been done by a certain date followed by a further review by the commissioner to ensure that it has been done to an adequate standard. Clear timescales also need to be set out. It is also good practice to set out the consequences of not remedying the identified breach, for example, that failure to do so may give grounds to the commissioner for terminating the contract.

Stage 3: Review of action taken by contractor following the notice period (this applies to a remedial notice)

It is often helpful to use a compliance matrix. This helps to ensure a robust system for identifying the steps taken. An example is given below. To use simply identify the actions the contractor has to address with relevant timescales and use the comment box to identify if the action was completed to the standard required by the regulations.

Table 2 Compliance matrix:

<b>Term of the remedial notice</b>	<b>Was the remedial action completed within the required timeframe? YES/NO</b>	<b>Was the remedial action completed satisfactorily (regardless of timeframe)? YES/NO</b>	<b>Comment</b>
NB: The Remedial Notice required the practice to carry out remedial steps by the agreed timescales unless otherwise stated.			

If the contractor has complied with all of the actions of the remedial notice the commissioner shall normally confirm in writing that no further action will be taken other than to continue to monitor the practice in line with other practices as part of the performance management arrangements.

If the contractor fails to remedy the breach within the notice period this may give rise to a right to terminate the contract (see below).

Stage 4: Termination by the commissioner

There are a number of grounds on which a commissioner may look to terminate a GMS, PMS or APMS contract. Insofar as remedial and breach notices are concerned, there are certain specific situations which may give rise to a right to terminate.

Firstly, as outlined above, a right to terminate may arise if a contractor fails to comply with a remedial notice. Where the commissioner is satisfied the contractor has not taken the required steps to remedy the breach by the end of the notice period, the commissioner may terminate the agreement with effect from such date as the commissioner may specify in any further notice to the contractor. (This normally needs to be at least 28 clear days from the date of service).

Secondly and more generally, if, following a breach notice or a remedial notice, the contractor:

- Repeats the breach that was subject of the breach notice or remedial notice
- Otherwise breaches the contract resulting in either a remedial notice or a further breach notice.

The commissioner may serve notice on the contractor terminating the contract with effect from such date as may be specified in that notice.

As already stated it is important to note that the above grounds for terminating are discretionary grounds. Accordingly, the commissioner needs to be in a position to justify that its decision is reasonable, proportionate and fair.

This is reinforced by the fact that in the second situation, as set out in the second bullet point above, the commissioner cannot exercise its right to terminate the contract unless it is satisfied that the cumulative effect of the breaches is such that it would be prejudicial to the efficiency of the services to be provided under the contract to allow the contract to continue. Accordingly, the commissioner has to identify why, in these circumstances, it is satisfied that it would be prejudicial to the efficiency of the services to be provided under the contract to allow it to continue.

Possible grounds may include the fact that the failure to remedy any identified breach is placing patients at increased risk of receiving inadequate care and / or the commissioner is having to use a disproportionate amount of its resources to deal with the breaches and concerns identified.

Finally, if the contractor is in breach of any obligation under the contract in respect of which a breach or remedial notice has been issued, then the commissioner may withhold or deduct monies which would otherwise be payable under the contract in respect of the obligation in question which is the subject of the default.

#### *Alternatives to termination (contract sanctions)*

In a number of situations, where the commissioner has grounds to terminate a contract it may instead impose a contract sanction if the commissioner is reasonably satisfied the sanction to be imposed is appropriate and proportionate to the circumstances giving rise to the commissioner's entitlement to terminate the contract.

A contract sanction means:

- Termination of specified reciprocal obligations under the contract
- Suspension of specified reciprocal obligations under the contract for a period up to six months
- Withholding or deducting monies otherwise payable under the contract.

If the commissioner decides to impose a contract sanction it must notify the contractor of the contractual sanction that it proposes to impose, the date upon

which that sanction will be imposed and provide an explanation of the effect of the imposition of that sanction.

The notice period shall unless the commissioner is satisfied that a shorter period is necessary to protect itself from material financial loss and to protect the safety of patients be 28 days from the date that the sanction notice was given.

If the contractor refers the dispute relating to the sanction to the NHS dispute resolution procedure within 28 days beginning on the date which the commissioner served notice on the contractor or a longer period as may be agreed in writing with the commissioner, and notifies the commissioner in writing that it has done so the commissioner shall not impose the sanction unless:

- There has been a determination of the dispute and the outcome of the dispute has made clear it permits the commissioner to impose the sanction
- The contractor ceases to pursue the NHS dispute resolution procedure.

If the commissioner is satisfied that it is necessary to impose the sanction before the NHS Dispute resolution procedure is concluded in order to protect the safety of the contractor's patients or to protect itself from material financial loss, the commissioner shall be entitled to impose the agreement sanction forthwith, pending the outcome of that procedure.

#### Stage 5: NHS dispute resolution procedure and termination

There are a number of grounds on which a commissioner may look to terminate a contract. These include:

- Termination by the contractor
- Termination by the commissioner on notice (without cause) in the case of PMS and APMS contracts
- Termination by the commissioner for breach of conditions in regulation 4 of the GMS regulations
- Termination by the commissioner for provision of untrue information
- Other grounds for termination by the commissioner, including if the contractor is subject to a national disqualification; removed from a performers list adjudged bankrupt and various other grounds
- Termination by the commissioner for a serious breach (this may also allow the commissioner to expedite the notice period)
- Termination by the commissioner for unlawful subcontracting
- Termination by the commissioner for failure to comply with remedial notices and breach notices.

This is not a definitive list and it is important to refer to the actual contract in respect of considering any of these grounds further. Again, where the grounds are discretionary the commissioner should act in a fair, proportionate and reasonable way.

In the context of contract management, the most important grounds are likely to be around termination arising out of failure to comply with remedial notices and breach notices and / or where there is a serious breach.

Where the commissioner is entitled to serve written notice on the contractor terminating the contract, then in the normal cause, the commissioner must specify a date on which a contract terminates that is not less than 28 days after the date on which the commissioner has served the notice on the contractor.

This period can be shorter, if the commissioner is satisfied that it is necessary to do so in order to protect the safety of contractor's patients or protect itself from material financial loss. Again, in the normal course, if the contractor invokes the NHS dispute resolution procedure before the end of the 28 day period of notice and it notifies the commissioner in writing that it has done so, the contract shall not terminate at the end of the notice period but instead shall only terminate where there has been a determination of the dispute and that determination permits the commissioner to terminate the contract or the contractor ceases to pursue the NHS dispute resolution procedure, whichever is sooner.

If the commissioner is satisfied that it is necessary to terminate the contract before the NHS dispute resolution procedure is concluded in order to protect the safety of contractors patients or protect itself from material financial loss, the commissioner is entitled to confirm by written notice to be served on the contractor that the contract will terminate at the end of the initial notice period.

#### *Consultation with and support from the Local Medical Committee (LMC)*

Whenever the commissioner is considering terminating the contract, or looking to impose a contract sanction or to take certain other measures under the contract, then it shall, whenever it is reasonably practical to do so, consult the Local Medical Committee (GMS Regulations 2004).

The LMC has an extended role in supporting practices facing remedial, breach and termination notices or those undergoing performance investigations. The LMC can advise practices on how to complete actions required by remedial notices, how to address issues in order to avoid further contract breaches and how to appeal against termination notices if appropriate. The LMC can signpost practices to experts who can help, e.g. the practices' Medical Defence Organisation or consultants who can advise on practical issues such as practice policies, etc. For those practices undergoing performance investigations, the LMC can support practices in preparatory meetings with the investigating officers and the commissioners, assist with drafting terms of reference, guide practices through the investigation process and sit in on interviews with clinicians and staff to ensure that due process is followed.

Commissioners are encouraged to advise practices in these circumstances to make contact with their LMC as early as possible to ensure they have access to expert help and advice.

### *Service of notice*

It is important to check the correct process for serving any notice under the relevant contract.

Normally, any notice must be in writing and served on the other party, in the following ways:

- Personally
- By post, or in the case of any termination notice, by registered or recorded delivery post
- By telex, electronic mail or facsimile transmission (the latter confirmed by telex or post)
- Unless the context otherwise requires by electronic mail (although this cannot be used for confirming a variation to the contract)
- By any other means which the commissioner specifies by notice to the contractor.

Any notice or other information shall be sent to the address specified in the contract or such other address that the commissioner or the contractor has notified to the other.

Any notice or other information shall be deemed to have been served or given:

- If it was served personally, at the time of service
- If it was served by post, 2 working days after it was posted
- If it was served by telex, electronic mail or facsimile transmission, if sent during normal hours then the time of transmission, and if sent out of hours then on the following working day.

If a notice is not validly served, then it will usually be treated as being invalid unless the person receiving it elects in writing, to treat it as valid.

The commissioner shall specify a date on which the agreement terminates that is not less than 28 days after the date on which the commissioner has served that notice on the contractor (unless there are grounds for expediting the period).

The contractor will then usually have the right to invoke the NHS dispute resolution procedure within 28 days of the notice being served on him (or longer if both parties agree).

Please note that one should always check the relevant contract to ensure that the necessary steps have been complied with and that the relevant clauses have been identified.

## Glossary of Terms in this Document

<b>Term</b>	<b>Definition</b>
British Medical Association (BMA)	The British Medical Association is an independent trade union and professional association for doctors and medical students, with over 140,000 members worldwide.
Breach of Contract	A formal process should be instigated if it constitutes a breach of contract, regardless of whether the issue of concern is deemed to be low risk. If a breach of contract has occurred that is remediable, a remedial notice may be served.
Contracts	PMS (Personal Medical Services), GMS (General Medical Services), APMS (Alternative Provider Medical Services) collectively, provide contracts, that are a flexible framework with which commissioners can plan, commission and develop services to offer greater patient choice, improved capacity and access, and greater responsiveness to the specific needs of the community. It is currently for commissioners to decide how to use the contracting routes, and for which scenarios.
Contract Management	Monitoring of the delivery of the specifications of the contract by the contract holder, carried out by the commissioner.
Contractual Route	Contractual proceedings where contractual performance issues arise.
Contractual Underperformance	Failure to deliver services to the standard required by the contract.
Contract Sanction	Termination of specified reciprocal obligations under the contract; Suspension of specified reciprocal obligations under the contract for a period up to six months; or Withholding or deducting monies otherwise payable under the contract.
Escalation Procedures	The process of referring a matter to an organisational entity with a greater degree of expertise or authority through an established process.
Formal Proceedings	Following established/official procedures.
General Practice	GP contract holders and all others that make up the practice e.g. general practitioners, nurses, practice managers, reception team etc.
General Practitioners/GPs	An individual clinician that delivers medical services within a general practice.
GP Contractors/ Contract Holders	The practitioners with responsibility for delivering services as agreed in the contract, who are also the signatories to the contract.
Individual Performer	An individual general practitioner that provides clinical care to patients within a general practice setting.
Informal Proceedings	Taking steps to resolve minor concerns without necessarily

	following formal procedures.
Information Governance	The way by which the NHS/general practice handles all organisational information. In particular the personal and sensitive information of patients and employees. It allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.
London Deanery	Training and development organisation responsible for postgraduate medical and dental training in London.
Londonwide Local Medical Committees (LMC)	The statutory representative body for London's 6000+ GPs and their practice teams across the capital.
London Outcome Standards	A pan London agreed set of outcome standards for general practice to be published from April 2011.
Medical Defence Organisations	A professional organisation which undertakes to protect, support and safeguard the character and interests of registered medical and dental practitioners in the United Kingdom, and elsewhere.
National Clinical Assessment Service (NCAS)	NCAS is part of the NHS and was established to provide comprehensive support to the health service in managing doctors and dentists whose performance gives cause for concern.
National Health service Litigation Authority (NHSLA)	The NHSLA is responsible for ensuring a prompt and fair resolution of disputes between primary care practitioners and their local Primary Care Trusts (PCTs).
Performers List	Management accountability (by the PCT or a delegated organisation) for ensuring the quality of the workforce by managing their primary care medical Performers List. This covers admission of doctors to the list, removal or contingent removal of doctors from the list, and doctors' disqualification for inclusion in a list.
Primary Care Commissioners	Primary Care Commissioners work for commissioning organisations and commission primary medical services from general practice that meet the needs of their local populations.
Quality and Outcomes Framework (QOF)	The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice.
Remedial Notice	Where the contractor has breached the contract, other than in certain specified situations and the breach is capable of remedy, the commissioner shall, before taking any action it is otherwise entitled to take under the contract, serve a notice on the contractor requiring it to remedy the breach.
Serious Untoward incident (SUI)	The principle definition is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a



	commissioned service. SUIs are not exclusively clinical issues.
Stakeholders	Stakeholders are a person, group, organisation, or system who affects or can be affected by an organisation's actions.
The Family Health Services Appeal Unit (FHSAU)	The FHSAU is the arm of the NHSLA that is responsible for ensuring a prompt and fair resolution of disputes between primary care practitioners and their local commissioners.
Termination of Contract	The commissioner may serve notice on the contractor terminating the contract with effect from such a date as may be specified in that notice.
Whistle Blowing	A whistleblower is a person who raises a concern about wrongdoing occurring in an organisation or body of people.

## **Sources of Guidance and Support for GPs**

Medical Director

PEC Chair (Professional Executive Committee)

Londonwide LMCs - GP Support

BMA (if BMA member)

BMA (Guidance for professional returning after working overseas)

MDO (Medical Defence Organisation)

Deanery (Continuing Professional development Programmes for GPs inc. the Fresh Start Programme)

NCAS (National Clinical Assessment Service)

RCGP (Royal College of General Practitioners)

The Kings Fund

Support from other local practices

Local GP trainers or training practices

Mentorship / supervision from fellow GP colleagues

Peer review and training, attending educational sessions

Recruiting a practice manager to provide part time support

Using experts on a consultancy basis, e.g. specialist nurses, practice managers, HR consultants

External agencies (e.g. Skills for Health)

## **Case Study – Improving Quality in General Practice in Tower Hamlets**

A clear and coherent strategy agreed in partnership with key players, Tower Hamlets developed a comprehensive strategy called Improving Health & Wellbeing in Tower Hamlets developed jointly with the Local Authority, the Local Area Partnership residents and crucially the local Healthcare Professionals. First developed in 2005, it was refreshed in 2009 and continues to form the basis for development of local health services.

### *Clinical leadership and clinical engagement*

The PCT committed to a full time Medical Director and a full time Deputy Medical Director coupled with well remunerated salaried leadership posts in key roles including leadership of GP appraisal, clinical leadership of the local GP Out of Hours service and clinical leads in clinical areas underpinning the strategy. These included:

- Diabetes
- Coronary heart disease
- Cancer
- Children's services
- Maternity services
- Respiratory disease
- Mental health
- Substance misuse
- Medicines and prescribing

All of these roles had job descriptions setting out their duties and requiring professional accountability to the Medical Director.

### *Developing high quality GP appraisal*

Recruited and trained a cohort of excellent GP Appraisers against very clear criteria in their job description through a competitive selection process. The appraisers are all locally practising GPs on the PCT's Performers List of GPs and all subject to approval by the local LMC. Appraisal has a written framework and clear standards which appraisers are required to maintain, including regular updating of their training in appraisal, attendance at steering group events and an annual externally facilitated quality assured study day hosted by the PCTs with a mix of external speakers, small group work and simulated appraisals videoed using actors specialising in this field. Experience suggests a cohort of one appraiser for 10 appraisees on the performers list is required. The work is skilled work and is therefore remunerated at a generous rate to attract and retain high quality candidates. Appraisees are themselves appraised in their appraisal role and their form 4's and personal development plans are scrutinised by the lead appraiser and quality assured by the team.

### *Support for continued professional development*

NHS Tower Hamlets established a significant budget available to the Medical Director to support continuing professional development for GPs and their staff. Educational programme was co-ordinated by a steering group chaired by the Medical Director including the GP Tutor from the Deanery, the Local Vocational Training Course organiser, local GP Trainers representative of small practices, the Local Medical Committee, Practice Nurses, Practice Managers and the PCTs Education Department. Activities supported include:

- Protected Learning Time monthly ½ days for all practice staff including clinical and non-clinical events on topics related to newly commissioned services and local enhanced services
- NICE Guidance
- Quality and Outcome Framework domains
- Learning needs identified from appraisal and personal development plans, and emerging research findings
- Lunchtime one hour seminars
- A monthly GP Forum for all local GPs with an independent GP chair supported by an honorarium paid by the PCT
- Sessional GP Forum with an independent chair again supported by an honorarium from the PCTs meeting monthly (NB. Over 60% of the GP workforce are now not partners but sessional doctors)
- A monthly forum for Practice Nurses
- A monthly forum for Practice Managers
- Consultation skills training in groups led by RCGP College examiners and local GP trainers with a firm of actors trained in providing simulated surgeries
- Individual one to one coaching by GP trainers on consultation skills clinical record keeping skills
- Funded support for externally facilitated preparation for the Royal College of GPs membership by assessment of performance (iMAP)
- Encouragement with some practice subsidy for practices to engage with Royal College of GP's Quality Practice Award
- Commissioning of external consultancies to work with practice teams to overcome dysfunctional teams to address team development and to support high achieving practices to develop even further. External firms used include Edgcumbe Medical, Miad, Healthskills, the NHS Institute but there are many others on the market
- Encouragement of academic General Practice
- The PCT has supported links with the Local University, Queen Mary University of London and its medical school. This included support for the development of a North East London Health Innovation and education cluster. In addition the PCT has part funded 2 Walport academic GP posts and made a non-recurrent financial contribution to the establishment of an academic GP post leading the development of Masters in Primary Care.

### *Clinical engagement*

The PCTs Senior Management Team encouraged the organisation as a whole to foster “up close and personal” working relationships with healthcare professionals, in particular local GPs, the basis of mutual respect and trust. This has included formal routes such as the Professional Executive Committee, the Practice Based Commissioning Executive and the fore mentioned clinical leads (of whom there are over 40) but also informal methods including evening dinner meetings hosted by the Chief Executive in the Local Education Centre for opinion leaders and formers. The PCT has run a 3 times a year clinical engagement event for clinicians drawn from Primary Care but also the Local Acute Hospital provider and the Local Mental Health Trust. The PCT has encouraged the Local Acute Hospital provider to appoint a part-time Director of Primary Care to help cement the relationship with the local practices. This example has recently been followed by the Local Mental Health Trust.

### *One to one peer support*

GP Educationalists drawn from a panel many of whom are GP appraisers working beyond their appraisal role undertaking to provide coaching clinical supervision on a one to one basis but funded to report back to the PCT.

### *Mentoring*

Similar to the above but requiring the mentor to have been trained in mentoring and undertaken in complete confidence with no information being shared back to the PCT.

### *Clinical supervision*

Either one to one or in groups such as the kind of course supplied by the Tavistock Centre for Clinical Supervision under the leadership of Dr John Launer.

## NCAS Individual Performer Route – Key Messages

Principles of working with performance problems:

- Commissioners committees or sub-committees such as decision making groups (DMGs) must be properly constituted and have properly delegated powers.

The Commissioning Organisation's responsibilities:

- A commissioning organisation is able to manage its statutory duty of quality through a number of mechanisms, including the management of the Performers List. These allow Commissioners to manage the quality of care provided by a full range of primary medical professionals, including GP principals, salaried GPs, locums, registrars and sessional doctors.
- All practitioners who are performing primary care services should be on a Performers List. Where a GP is on a Performers List and is employed by a commissioning organisation, the Performers List Regulations<sup>1</sup> apply for patient care provided in a general practice setting. A commissioning organisation may need further advice to clarify the position with regard to an individual practitioner and where the use of Maintaining High Professional Standards (MHPS) is appropriate.
- Where serious concerns are raised about a GP on the commissioner's Performers List, the commissioners will need to consider whether, in addition to conducting an investigation of the case, it needs also to suspend the GP. Suspension by the commissioners may also be required pending consideration of whether to remove, or contingently remove, the GP from its list or while it waits for a decision of a regulatory body or court. Any suspension must comply

Structures for managing performance concerns:

- NCAS advises a two-tier model, comprising a Decision Making Group (DMG) within the commissioning organisation and Performance Advisory Group (PAG) or Performance Support Unit (PSU) which may cover one or more Commissioners.
- Commissioners, via their DMGs, have overall responsibility for managing performance concerns, taking decisions on individual cases and liaising with other agencies.

Actions following local investigation:

- Having reached a preliminary understanding of a performance problem, the DMG or commissioning organisation individuals who are managing the case need to consider the range of possible actions. These range from closing a case as unfounded, monitoring the case further or providing local support, to suspending or removing a GP from the Performers List, and referral to another agency, for example, the General Medical Council (GMC) or the police.
- Commissioners need to understand the role of other bodies involved in handling performance concerns, in particular the criteria for referral, for example to NCAS or the GMC.
- Commissioning organisation is considering suspending a GP from a Performers List (or exclusion under MHPS for other medical staff), they should contact NCAS or the GMC

#### Assessment:

- Where local investigation identifies that assessment of a GP's performance is required, Commissioners may wish to refer to NCAS for performance assessment. NCAS provides a comprehensive assessment of a doctor's health, behaviour and clinical performance.
- NCAS assessment involves trained assessors and tools that have been tried and tested. Thorough assessment is essential because the information it provides may be used to make decisions that impact on patient safety and a doctor's ability to practise.

#### Resolving problems: support and training

- Where required, a clear development/improvement plan should be agreed with the GP, whether this follows local investigation or NCAS assessment. NCAS has recently circulated a document to guide action planning for practitioners following local or national performance procedures, the Back on Track framework document. Copies can be downloaded from the NCAS website ([www.ncas.npsa.nhs.uk](http://www.ncas.npsa.nhs.uk)).
- It is important for everyone involved to understand what the next steps might be if efforts to improve performance are unsuccessful, for example removal from the Performers List or referral to the GMC.

#### Resourcing local procedures:

- The commissioning organisation needs to commit a realistic budget to cover the cost of staff and the meetings required, and to provide some support to practices and GPs where problems are identified.
- Funding, support and training for an individual GP will need to be agreed on a case-by-case basis, and may well require the GP to make a substantial contribution to any programme put in place.