



Special points of interest:

New Clinical DESs

Preparing for Pandemic Influenza

World Class Commissioning

Inside this issue:

New Clinical DESs 2/3

GP Referral Incentive Schemes 4/5

World Class Commissioning 6/7

Summary Care Records 8/9

BMA Salaried GPs Handbook 10

Reform of Health & Social Care Complaints 12

P is for ...

Performance Management

All practices have a contract with the NHS through their PCT. The flavours vary between GMS, nationally negotiated but occasionally Department of Health imposed, PMS which is locally agreed but tends to mirror GMS, and APMS, which is the flavour of the month and is usually time-limited. In 2009-10 the PCTs will be expected to performance manage all primary care contracts.

This is a new concept for many people especially PCTs. PMS contracts, for example, should have been managed annually from the start, but this has rarely if ever occurred. PCTs will in future be expected to address this through formal practice performance visits and frameworks, often irritatingly called "scorecards". This is actually a welcome change as it will allow a more constructive dialogue between practices and the PCT, and it will enable practices to demonstrate their development needs. Performance management is not something to worry about as long as PCTs handle it in a positive way. Most of the information within frameworks is already available to PCTs. The trick will be to

properly "manage" suspected poor performance and not get bogged down in oceans of data which mean little to anyone.

Patient Participation

This is a tricky subject as

We need to recapture this agenda. Practice satisfaction rates across Essex are vastly better than any recent opinion poll on this dying, or at best ageing, government.

The number of patient participation groups has grown rapidly in recent years and every practice should explore their potential. There is nothing more effective at grabbing the PCTs' attention than a combination of practice and patients. Even the aliens at the SHA are wary of upsetting patients.



Experience the DARZICCINO

All froth, and with a bitter aftertaste that'll last for years!

patient questionnaires are now used to determine part of practice income, and the government has poisoned this agenda with its biased and untested questions.

I also believe that we need to try to influence the crazed quarterly questionnaires. (See LMC information booklet enclosed with this newsletter) Practices and patients must make an effort to communicate their real needs, both between one another and to the PCTs. This is an agenda that could benefit everyone, if only the politicians were not so frightened of real feedback. The increasingly centralist NHS will struggle with genuine feedback from local communities. Look at the way the Commons Select Committee attacked the imposition of "Darzi" Centres on every PCT.

P is for ...



“Watch out for maintenance and service charges, and make sure all PCT promises about future re-imburement or other support are in writing”

Polyclinics

Darzi centres, or “GP-Led clinics”, are planned for all PCTs. Some PCTs, such as South East Essex, are planning a series of centres of varying sizes to provide more “primary care” services. One danger is that such plans will be so well organised and streamlined that they will be unrecognisable as primary care. The dreams of PCT commissioners could be the nightmare of patients, struggling for continuity in a labyrinth of tower block centres that only managers could worship. (Can you see my

primary care building from space?)

The cost of this empire building could be prohibitive. One small practice, which shall be nameless, is about to increase its rent re-imburement (taxpayers’ money) from £12,000 to £55,000 through moving into a new primary care centre at the insistence of the PCT, and the floor space is smaller than the old practice premises. Is this the future, or will it be killed off by the new financial climate. (Thanks Gordon). I believe that

the rush to LIFT will gather momentum as developers see the benefits of dealing with PCTs, I make no comment, and ensuring a steady return via the taxpayer.

A further warning to practices. Watch out for maintenance and service charges, and make sure all PCT promises about future re-imburement or other support are in writing, preferably in blood.

New Clinical Directed Enhanced Services 2008/9 & 2009/10

The Statement of Financial Entitlements (SFE) and the Directions for the five new Clinical DESs have at last been published. PCTs now have the authority to commission and pay for these services.

The DES directions and the SFE amendments can be accessed on the following link

[http://www.dh.gov.uk/en/Publicationsandstatistics/PublicationsLegislation/DH_094166](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_094166) or on the LMCs’ website at www.essexlmc.org.uk

The Five Clinical DESs are:-

Ethnicity and First Language Recording Scheme

(ends 31st March 2010)

To encourage practices to record the ethnicity and first language of all their registered patients. This is intended to assist the practice and the PCT in assessing the needs of registered patients and to help address inequalities in accessing care and in health outcomes.

Payment:

5.6 pence per registered patient.

Heart Failure Treatment Scheme *(ends 31st March 2009)*

To encourage practices to

improve the treatment of registered patients who are diagnosed as having left ventricular systolic dysfunction by prescribing appropriate beta-blockers.

Payment:

£35.00 per diagnosed registered patient.

Osteoporosis Diagnosis and Prevention Scheme *(ends 31st March 2010)*

To encourage practices to confirm diagnosis of Osteoporosis in those of their female registered patients aged 65 and over with a history of fragility fractures and to prescribe appropriate pharmacological



New Clinical Directed Enhanced Services 2008/9 & 2009/10 Cont'd

secondary prevention in such patients.

Payment:

Per average practice that meets all the criteria is £588.21.

Alcohol Risk Reduction Scheme (ends 31st March 2010)

To encourage practices to review newly registered patients aged 16 or over. To offer and deliver a brief intervention aimed at patients identified as possibly drinking alcohol at hazardous or harmful levels.

Payment:

£2.33 for each new registered patient that has been screened.

Learning Disabilities Health Check Scheme (ends 31st March 2010)

To encourage practices to identify registered patients aged 18 and over and who are known to

the local Social Services department primarily because of their learning disabilities and to offer and provide such patients with an annual health check.

Payment: £100.00 for every health check.

IMPORTANT NOTE

It is important to stress that the Learning Disabilities DES only authorises payment for medicals carried out on patients who are known to the Local Authority.

A substantial number of patients who are not currently known to the Local Authority are likely to qualify under the terms of the DES. Some PCTs elsewhere in the country are suggesting that practices should identify these patients and send their details to the Local Authority. The rationale behind this is that confidentiality issues are

covered by the Local Authority's governance arrangements.

The LMCs' advice is that practices should identify patients who qualify for the DES but are not known to the Local Authority. The consent of the individual or their carer should be obtained before their details are shared with the Local Authority.

Whilst PCTs may take the view that this approach is unnecessary it is important to be aware that being known to the Local Authority is a prerequisite if practices are to be paid for the service. An annual medical and review should take place but the practice will not qualify for payment.



"The LMCs' advice is that practices should identify patients who qualify for the DES but are not known to the Local Authority."

QMAS - End of Year Communications - Part 1

Records 23 (Ex Smoker)

There is an issue with records 23. This issue relates to non-smokers aged 25 and under and ex-smokers being required to have their status recorded within 15 months in the current business rules. The indicator requires smoking status to be recorded within the last 27 months. The business rules for 2009/10 will be amended to

ensure that smoking status under this indicator is only required to be recorded within the last 27 months. The QMAS team are in discussions with GP System suppliers to provide a local query that will include non smokers aged 25 and under and ex-smokers in the achievement figures provided that their smoking status was recorded within the last 27

months. PCTs will be able to use the query to adjust the year end payments for 2008/09, where required, as part of the year end review. Alternatively PCTs can follow the QOF guidance for Records 23 for checking records manually.



GP Referral Incentive Schemes



“All referral analysis and demand management schemes must only explore or promote suitable alternative pathways of care which are acceptable to the patient.”

GP Referral Incentive Schemes

There have been concerns nationally at the development of Incentive Schemes by PCTs that aim to reduce referrals or the costs of referrals from general practice to secondary care. The GPC has recently produced some helpful guidance for practices which can be accessed on the LMCs' website at www.essexlmc.org.uk

Referral Analysis Funding

Practice Based Commissioning (PBC) encourages practices to make the most appropriate use of NHS resources, particularly secondary care services. PCTs have been encouraging practices to reflect on their patterns of referrals and identify whether any of these referrals could have been managed differently.

Practices should be aware that:

Discussions of this nature both within the practice and between GPs must be conducted in a supportive and educational environment. Undue pressure must not be placed on colleagues to alter how they care for patients.

It is not acceptable for

practices/groups of practices to receive funding or payments for demand management and referral analysis schemes that provide specific financial rewards for reducing referral numbers or costs to certain levels or by certain amounts. These types of target based schemes could result in a perverse incentive to reduce referrals in a manner that does not benefit patient care. All referral analysis and demand management schemes must only explore or promote suitable alternative pathways of care which are acceptable to the patient. They must not contain an incentivised, target based element.

Referral Incentive Payments

Some PCTs have offered financial incentives or rewards to practices to maintain or reduce referral rates at levels reached in previous years, or to maintain or reduce referral costs within their indicative practice commissioning budget. It is not acceptable for GPs to receive incentives to refer in such a manner. GPs must only refer patients to the service that they in their professional opinion believe is most appropriate for that patient's condition, whether that be

secondary care or other 'care closer to home' and/or 'in house' services. This is in line with paragraphs 74 & 75 of the GMC guidelines 'Good Medical Practice' 2006, on conflicts of interest.

“74. You must act in your patients' best interest when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients. You must not offer such inducements to colleagues.”

“75. If you have financial or commercial interest in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients.”

It is not acceptable for practices to continue reducing their referrals to secondary care when this means that decisions are being taken that are not clinically appropriate and will have a detrimental effect on the health care of patients. Referral decisions must always be driven by patients' best interests and choices.



GP Referral Incentive Schemes—Cont'd

Freed Up Resources and Incentive Schemes

The ability for practices to achieve freed up resources with PBC is an inherent incentive to make cost effective use of commissioning budgets. Incentive payments "are to be treated as practice income." It is therefore important that all referral incentive schemes contain safeguards to ensure they are not misconstrued as paying GPs for not referring patients to hospital as an end in itself with no regard to clinical appropriateness.

GPs taking part in a

referral incentive scheme must ensure that they are not pressurised into compromising their professional and clinical duties to patients to refer to the most appropriate provider of care.

Referral Management Centres

A number of referral schemes involve referring patients to referral management centres. When these are developed with the support and involvement of local GPs, PBC groups and hospital clinicians they may offer a useful approach to manage demand and provide an alternative option to direct referral to

secondary care.

Unfortunately some PCTs have inappropriately employed the blanket use of referral management centres to triage all GP referrals. GPs are reminded that there can be no compulsion on them to refer to these centres. GPs should only refer to these centres if it is clinically appropriate and to the clinical benefit of the patient.



"Referral decisions must always be driven by patients' best interests and choices."

BMA Salaried GP Seminars

The BMA is running a number of half day seminars aimed specifically at salaried GPs.

These events aim to:

- ◇ Advise on employment rights for nGMS, PMS, APMS and PCO-employed GPs including sickness, maternity and redundancy issues, as well as general guidance on contractual rights following maternity leave and at the end of FCS and Retainer Scheme funding.
- ◇ Outline in detail the benefits of the model/minimum salaried GP contract negotiated by the BMA, and how to ensure that at least these minimum are obtained.
- ◇ Provide helpful tips for successful negotiations on salary, terms and conditions, and contract changes for use with current and new employers, with practice sessions.
- ◇ Provide an interactive setting, with the opportunity for delegates to ask questions on the day.

Dates of seminars:

York

Tuesday 24th March 2009

Oxford

Wednesday 27 May 2009

London

Tuesday 22 September 2009 - BMA House,

More details on these events can be found at:

www.bma.org.uk/conferences



World Class Commissioning



“The guidance lists some of the challenges and opportunities faced by PCTs when commissioning GP services”

This 56 page document was published on 27th January and all practices are strongly advised that at least one GP in the practice and the Practice Manager reads it.

It has been provided as a guidance tool to PCTs and offers advice on how they can assess their current performance, identify their vision for the future and commission services that meet the needs of their local communities. Alongside this, further practical advice is being developed for senior managers responsible for commissioning primary medical care, including:

- ◇ How to benchmark primary care services and assess how far they reflect local health needs.
- ◇ How to measure quality improvement in primary care, including developing ‘quality scorecards’ or ‘balanced scorecards’.
- ◇ How to commission accessible and responsive GP services.
- ◇ How to undertake a pharmaceutical needs assessment.
- ◇ How to support improvements in primary care premises.
- ◇ How to improve

primary care for socially excluded groups.

The guidance lists some of the challenges and opportunities faced by PCTs when commissioning GP services and suggests mechanisms for mapping the baseline of where they are now before they can begin making improvements to primary care services. This includes assessing local needs and mapping existing services (i.e. capacity, quality, access, patient choice, value for money, premises, demand and enhanced services). Once PCTs have concluded their mapping exercise an analysis of current provision will highlight what needs to change and inform their vision of what GP services will look like in the future.

Chapter 6 suggests a range of commissioning tools that PCTs can use to “Make it Happen”, which include:

- ◇ Transparent use of information on quality and performance;
- ◇ A comprehensive approach to managing performance;
- ◇ Supporting improvements in quality and performance;
- ◇ Information for

patients and the public;

- ◇ Assuring minimum standards;
- ◇ Promoting patient choice;
- ◇ Developing the market;
- ◇ Commissioning additional capacity;
- ◇ Improving premises and estates;
- ◇ Practice based commissioning.

Within this is a model for developing a performance cycle setting out what will happen and when and key components are likely to include:

- ◇ Jan – Feb: Negotiate objectives and development plan.
- ◇ March: sign off agreements and contract variations with every practice.
- ◇ May: formal review with every practice assessing last twelve months performance.
- ◇ July: publish quarter 1 key performance metrics for each practice.
- ◇ Oct: mid-year review with every practice and publish quarter 2 key performance metrics.
- ◇ Nov-Dec: review of performance



World Class Commissioning—Cont'd

framework and metrics.

- ◇ Jan: publish quarter 3 key performance metrics.
- ◇ April: publish quarter 4 key performance metrics.

This is a mere flavour of what this document is about and hence the strong suggestion at the beginning of this item that practices familiarize themselves with it and discuss within practice. You can find 'World Class Commissioning: Primary Care & Community

Services – Improving GP Services' on our website at www.essexlmc.org.uk. The LMC will be exploring options for supporting practices throughout any implementation of this process.



Preparing for Pandemic Influenza – Guidance for GP Practices

Oh no not that again I hear you sigh and I can quite appreciate why.

It seems the PCTs are asking so much from practices when there is already so much to do, particularly when nobody can say when the pandemic is going to happen anyway – only that it is! It therefore is easy to understand why this may not be a priority, particularly when in reality planning can only go so far and there is no telling what may happen on the day – the best laid plans, etc comes to mind.

The reality from those in the know is that the pandemic is going to happen. In practical terms therefore, recognising the impossibility of being able to plan for every eventuality, it makes sense to have some sort of idea of what we will need to do in the event and many of you will already have

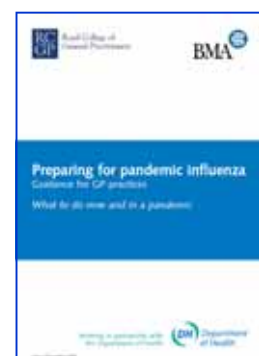
done this or be well underway. There may be bits of the plan that become untenable on the day but there is no doubt that some information contained within the plan will be invaluable in managing the service. This shouldn't be seen as a tick box exercise either – plan done, move on to the next thing! In order to be relevant plans need to be reviewed on a regular basis to ensure information contained within is current.

The DH, RCGP and BMA have recently issued joint guidance "Preparing for Pandemic Influenza – Guidance for GP Practices, what to do now and in a pandemic". The guidance reinforces advice to practices on what they need to do now and in the future in the event of responding to a pandemic, setting out actions that GPs, LMCs and PCOs can take now. I am not going to regurgitate the advice

here (it is 57 pages) but the guidance can be found on the LMC website at www.essexlmc.org.uk and it makes fairly easy reading.

PCTs will be working to support practices in their planning – North East Essex PCT recently held 2 shutdown afternoons for their practices. The SHA has purchased a planning toolkit called "IQ Planner" for every practice and it is envisioned by the LMC that PCTs will be supporting practices with adequate resources to complete the toolkit - they have been allocated resources to support the extra work involved in flu pandemic planning. The LMC will be looking at its own plan for the pandemic and is available to support both practices and PCTs in reaching sensible planning arrangements.

"The reality from those in the know is that the pandemic is going to happen."



Summary Care Record Service



Once uploaded clinicians seeking to access the record will require consent from the patient on each occasion the record is to be accessed.

Now that the four Early Adopter sites have been evaluated, Health Authorities have been looking for the next phase and have asked for PCTs to volunteer to be "fast followers". All PCTs are being required to have implementation plans in place so that practices have the system running by 2010.

What is the summary care record? The software will take basic details from a patient's record and attach it to the spine so that it is available to other clinicians, primarily in A&E departments and out of hours centres. The initial record will contain details of:

- ◇ Medication
- ◇ Allergies
- ◇ Adverse Reactions

The consent model being adopted has been changed from the original five pilot sites and is a mixture of presumed consent and direct consent as the following procedure describes:

1. The PCT will widely advertise the introduction of the SCR service.
2. Patient groups will be consulted.



3. All patients aged over 15 ³/₄ will be sent letters telling them of the service, its advantages and giving a period of twelve weeks for individuals to state their preference. If they do nothing consent will be presumed.
4. Patients who do not want a SCR have to actively opt out.
5. Patients who have not opted out will have their records uploaded at the end of the twelve week period.
6. Once uploaded clinicians seeking to access the record will require consent from the patient on each occasion the record is to be accessed.

Unauthorised access of patient records will be treated as a serious disciplinary offence. All access will be monitored with a formal audit trail. N3 is said to be highly secure with little evidence of "hacking".

Researchers at UCL undertook the evaluation of the pilot sites and some of the findings are set out below.

- ◇ 614,052 patients in four Early Adopter sites were sent a letter

informing them of the programme and their choices for opting out. Of these, 4,961 (0.81%) have actively opted out of having an SCR and 154 (0.03%) have asked for data on their SCR not to be shared.

- ◇ The SCR is currently an immature technology which staff have described as "clunky" and which currently interfaces poorly with other ICT systems. Many staff have given up using it "until it works better".
- ◇ There is a wide variability amongst NHS staff on whether they feel the SCR has significant benefits, though most are broadly enthusiastic.
- ◇ The SCR is widely seen as "too complex", to the extent that many see it as unworkable in its current format.
- ◇ The SCR is seen by some GPs as incompatible with a fundamental part of their professional role and identity – protector of patient confidentiality.
- ◇ The 'observability' of the benefits of the SCR is more apparent to some users (mainly A&E and OOH staff) than others (mainly

Summary Care Record Service—Cont'd

GPs and their staff who create the record), though there is some overlap between these groups.

- ◇ GPs who are participating (or considering participation) in the SCR programme worry about workload, especially in the phase 2 upload in which selected aspects of patients' medical history will be added to the record by explicit consent. Much uncertainty surrounds how phase 2 (which has only just begun in two practices) will play out in practice.
- ◇ Some GPs are also concerned about the ethics and legality of creating a SCR on a patient who has not given full informed consent. These concerns have led at least two GP practices to withdraw from the Early Adopter Programme.
- ◇ The practicalities of

SCR use, such as time taken to access it and how it will align with existing work roles and routines. Early usage in unscheduled care settings suggests that job roles and patterns of interaction between healthcare staff sometimes have to be rethought. This is not necessarily a bad thing but it may temporarily delay efficient use of the SCR. (Note Adastral have recently announced an integrated solution that will make SCR quicker and easier for clinicians to use).

- ◇ The hoped for benefits of the SCR (notably improvements in the quality and safety of care and the opportunity for patients to be more actively involved in their care) remain unproven, but this is not surprising since there has not yet been sufficient opportunity to demonstrate them.

- ◇ Whilst the technical security measures of the SCR appear to meet high standards, and whilst nobody is yet known to have 'hacked' into the N3 network, there remain unresolved questions raised by experts about whether a series of linked smaller systems would be safer than a large single system, and whether the plans for operational security will be fully enforceable in the busy environment of the NHS.

- ◇ The SCR was specifically intended to help address the "inequalities agenda". Data suggest that despite commendable efforts on the part of CFH and participating PCTs to address the needs of these groups, there is much work still to be done.

Courtesy of Kent LMC



"Patients who do not want a SCR have to actively opt out"

QMAS - End of Year Communications - Part 2

National Prevalence Day (NPD)

GPs are reminded that NPD has moved from 14 Feb to 31 March in line with the year end submission. This means

that GPs no longer need to make a separate submission for NPD. Manual and Automatic Practice submissions should continue to be made at year end



BMA Salaried GPs' Handbook



"Each interested general practice will be invited, as part of a bidding process, to provide a business case that outlines the needs of the practice in order to expand its capacity and capability to support learners from different backgrounds."



The BMA has recently produced a Salaried GPs' Handbook.

The Handbook explains the legal entitlements of all salaried GPs as employees. It helps to ensure that salaried GPs are aware of their statutory and contractual rights. In addition, it helps to prevent GP employers falling foul of the law. The Handbook also contains sections on the national and local representation of salaried GPs, how to become a salaried GP and the work involved

Salaried GPs who are BMA members will be sent their own individual hard copy of the Handbook. Other BMA members who would like a hard copy of the Handbook, can request this via the BMA website, by telephoning 0300 123 1233 or by e-mailing support@bma.org.uk For ease of use, the Handbook is also available on the BMA website for BMA members

The BMA is able to provide expert employment advice

for salaried GPs and their GP employers. The Handbook is intended to supplement not replace the individual advice that is available and which, at times, it is essential that GPs continue to obtain from the BMA.

East of England SHA: Initiative to develop Multi Professional Learning Organisations within General Practice

This initiative is funded for two years to support engaged GP Primary Health Care Teams to develop as Multi Professional Learning Organisation (MPLO), using current expertise and a commitment to expand practice access to all learners.

All health care trainees are required to undertake periods of time within a service setting in order to support the application of knowledge to a clinical situation as well as further developing their skill base. There is therefore a need to develop truly multi professional learning organisations who can deliver a range of practice learning experiences to a broad range of trainees and meet the demand for a 'fit for purpose' primary care workforce in the

near future. The health workforce of the future will need to be flexible, capable of growth and working in a non blame culture, where honesty is respected and staff are learning from, and supporting, each other. Learners need to be exposed to these 'Learning Organisations' so they can engender similar organisations in the future.

The East of England Towards the Best Together (TTBT) pledges all require healthcare practitioners to be trained to a high standard, and this training needs to include the opportunity for the future workforce to understand the vital role that primary care contributes in delivering care.

Each interested general practice will be invited, as part of a bidding process, to provide a business case that outlines the needs of the practice in order to expand its capacity and capability to support learners from different backgrounds. Funding will be provided to support this developmental need.

If you and your practice are interested in learning more about this project which commences in Spring 2009 please contact either Jackie Jones, Professional Advisor Primary Care Nursing

Jackie.jones@eoe.nhs.uk or Simon Downs, Deputy Director General Practice

simon.downs@eoe.nhs.uk

Essex LMCs Ltd Buying Group

The Essex LMCs Ltd Buying Group was introduced to practices in November 2008. To date practices should have received information in respect of the following:

- ◊ Flu Deals 2009/10
- ◊ Whittaker Office Solutions
- ◊ TAG Medical Equipment Testing & Calibration.

MidMeds Medical Essentials brochure was shared with Practice Managers who attended the conference on 10th February and the office will be distributing the brochure to all other practices in the near future. Also on its way are details of a new scheme "LMC Drive", a special car purchase scheme available to buying group members and their

staff.

If you haven't received any of the above please contact the office and we will arrange for further copies to be sent to you. We also welcome any feedback on your experiences if you have taken the opportunity to use any of the suppliers recommended to date.



Essex LMCs Practice Manager Conference 2009

The LMCs held its second annual Practice Managers conference on 10th February at the Ivy Hill Hotel in Margaretting. Despite roads closed due to flooding and consequent terrible traffic problems that morning (including the A12 at Margaretting), Practice Managers braved the awful conditions and turned out in their numbers.

Presentations were received on the new Essex Buying Group, Partnership Agreements/Partnership Splits, Employment Law, Customer Service and Any Willing Provider.

Feedback from the event is extremely positive and certainly on the day, given the terrible journeys that some had endured, the atmosphere was very

relaxed. An overwhelming majority of delegates rated the conference as a whole as 'Excellent' on their evaluation form.

This event is definitely becoming a fixture in the LMC calendar and we look forward to seeing even more of you at the 2010 conference.



The use of 084 telephone numbers in the NHS

The Department of Health is currently consulting on the use of 084 telephone numbers in the NHS.

The Government is considering banning the use of 084 numbers in the NHS because of concerns that patients who use 084 numbers are paying more than the equivalent cost of a local rate call to access

NHS services. However, the Government also recognises the extra functions offered by 084 numbers can improve access to services.

The consultation is seeking the views of GPs, practice managers and other staff working in the NHS as well as callers to the NHS. The closing date for responses is **31st March 2009**. The

consultation document can be found on the LMC website or alternatively contact the LMC office for further details.





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Promoting the interests, aspirations and welfare of general practitioners

Reform of Health & Social Care Complaints – Proposed changes to the legislative framework

A single complaints system for health and local authority adult care services will be introduced on 1st April 2009.

The aims of the new system are to:

- ◇ Resolve complaints more effectively by responding more personally and positively to individuals who are unhappy;
- ◇ Ensure that opportunities for services to learn and improve are not lost.

The revised complaints framework will apply to all statutory providers of NHS care, including primary care providers and final regulations will come into force on 1st April 2009.

Main changes are:

- ◇ People will have the choice of making their complaint to either the organisation providing the service (i.e. the practice) or the PCT. If a complaint lodged with the practice is not resolved locally it cannot then be referred to the PCT although it can still be referred to the Health Service Ombudsman.
- ◇ If the PCT receives a complaint it will discuss with the complainant how best to handle the case and decisions will ultimately reflect the complainant's wishes.
- ◇ If a PCT receives a complaint it will check with the complainant whether they have also lodged a complaint with the provider.
- ◇ Primary care contractors will be expected to copy

to the PCT all complaints received locally, whether in writing, by email or (when written up) over the telephone. This should be done within 3 working days of receipt, unless the complaint is resolved "on the spot".

- ◇ All NHS organisations must have a person readily identifiable to service users who is responsible for managing complaints.
- ◇ A complaint must be made within 12 months from the date on which a matter occurred or the matter came to the notice of the complainant. Organisations will have discretion to investigate beyond this time if it is still possible to investigate the case effectively. If it is decided not to investigate the complainant can approach the Ombudsman.
- ◇ The revised arrangements will enable front line staff to resolve verbal complaints quickly and if the complainant is not satisfied they may make a more formal complaint.
- ◇ More formal complaints will be acknowledged within 3 working days and complainants will be offered the opportunity to discuss by telephone or face to face how the complaint will be handled.
- ◇ The reforms will allow local organisations to determine the handling of complaints on an individual basis – the

legislation will not lay out a detailed, prescriptive process that must be followed

- ◇ Complaints will be acknowledged within 3 working days and complainants advised on how the complaint is to be handled and expected timescales on handling the complaint.
- ◇ All complaints will have "organisational sign-off" when actions have been concluded. Sign off will rest with a senior member of the organisation.
- ◇ Each organisation will have an identified designated senior person responsible for the operation of the complaints arrangements and for ensuring that lessons learned are implemented. In primary care, the government envisage that the senior person would be a partner. There will however be flexibility to reflect the needs of small organisations.
- ◇ All organisations will have to prepare an annual report on complaints, which will be copied to the PCT and an anonymised version made available to the population served by the organisation.

Complaints received prior to 1st April '09 will be dealt with in accordance with current provisions and any complaint received on or after that date will be handled under the provisions of the new regulations.

