CHC NEWS

A newsletter for community health council members and staff

LABOUR'S HEALTH PLANS

Ministerial team

The Prime Minister has announced the following appointments:

Secretary of State for Health
Frank Dobson

Minister for public health
Tessa Jowell

Health ministers
Alan Milburn
Baroness Jay of Paddington

Parliamentary under-secretary
Paul Boateng

Parliamentary under-secretary in the Welsh Office with responsibility for the NHS
Win Griffiths

Baroness Jay will have responsibility for CHCs. An opposition health spokeswoman from 1992 to 1997, she has been a member of the House of Lords select committee on medical ethics and vice-chairwoman of the all-party parliamentary group on AIDS. Outside Parliament, she has chaired the National Association for the League of Hospital Friends, and worked with various NHS and health-related organisations.

DoH press release

Immediate plans

Some steps can be taken without new legislation. Frank Dobson has asked Alan Langlands, the NHS chief executive, to draw up plans for:

- the distribution of resources across primary and secondary care to ensure that they reflect local needs;
- tackling two-tierism between the patients of GP fundholders and non-fundholders;
- cutting down bureaucracy associated with invoicing in order to release money to treat more patients and cut waiting times for cancer patients.

Ministers will also be able to use powers under the recent Primary Care Act (see page 3) to set up pilot schemes for locality commissioning.

Frank Dobson has told *The Mirror* that he will strengthen CHCs and make health authorities and hospitals hold their meetings in public. Speaking of trust boards, he said that in future, those running hospitals will have to be users of the NHS and live in the hospital's locality.

Mirror 5 May

Warning of the problems ahead

Before the election, the Institute of Fiscal Studies (IFS) warned of the difficulties the NHS will face over the next few years. Current spending plans allow for lower increases than at any time in the history of the NHS. Projected increases are 1.8% for 1997/98 and zero for the next two years. In the past, when planned increases have been low, the government has increased spending by drawing on contingency reserves. At present reserves are half the level they were in the 1980s. For various reasons, the IFS concludes that spending is set to rise: the question is whether this will be met by the private or the public sector.

Guardian 10 April, DoH press releases; Guardian and Daily Telegraph 15 May

The Queen's Speech

The Labour government will not go ahead with an early Bill on the abolition of the internal market. There is to be a White Paper on the replacement of GP fundholding by local commissioning groups. However, a Bill on speeding up Private Finance Initiative deals will be rushed through Parliament (see page 2).

Guardian/Daily Telegraph 15 May

In this issue:

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ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES
Earlsmead House, 30 Drayton Park, London N5 1PB. Phone: 0171 609 8405 Fax: 0171 700 1152

Labour to push ahead with PFI

The Labour government is pushing ahead with PFI and seeking to reduce delays in reaching deals. In the Queen's Speech it announced a Bill to streamline arrangements for trusts to enter into contracts under PFI and for the Department of Health to give speedy approval to deals. In order to speed up the passage of the Bill, it will go first to the House of Lords. It remains to be seen whether the Bill will have implications for the ability of CHCs to be consulted on plans.

Exposing the contradictions

Consultation in the NHS has always been far from perfect and the 1991 NHS reforms created new obstacles to strategic planning to meet local health needs. However, an editorial in the *BMJ* argues that the PFI initiative has exacerbated both problems.

Health authorities have to consult CHCs about substantial developments, including those in which PFI deals are proposed. However, a health authority does not have to disclose the contents of PFI bids, which are treated as commercially sensitive. During the negotiating process, a health authority needs to take account of its own perceptions of health needs, the responses to consultations and the requirements of the private consortia involved. The scheme may change so much that the proposal should theoretically go back for further consultation, but this may not be feasible if the private sector option is to work. As the editorial comments it is "little wonder that accountability to the public comes a poor second".

Another problem is that schemes are generated by individual trusts, which may not take account of wider health needs and provision in a locality. It is doubtful whether health authorities are able to maintain an overview of all the rapidly changing PFI proposals in their areas.

Something has to give

An article in the same issue of the *BMJ* interprets some available statistics on NHS activity and bed numbers and projected figures for a number of PFI projects.

One of the main conclusions is that bed numbers will decrease. In the 14 PFI schemes in England which are at an advanced stage of planning, bed numbers are projected to decrease by an average of 26% over the next five to seven years. Whereas it is generally in the interests of the health services to avoid a lack of capacity in hospitals, from a commercial perspective it is better to have too few beds than too many.

Over the last few years, inpatient activity has been increasing (finished consultant episodes in England increased by 5.4% between 1991/92 and 1995/96).

What is PFI?

The private finance initiative (PFI) was launched to transform "public sector organisations from being owners of assets and direct providers of services into purchasers of services from the private sector" (HM Treasury 1997). Under PFI in the NHS, new hospitals are built using private capital and leased to the NHS at market rates for 20-60 years. NHS land and buildings are often sold to the private companies as a part of the deal.

Since 1994, all major hospital building schemes have been required first to seek private funding. However, no such projects have yet started. The delays pose serious problems, especially since public funding for new hospitals has been cut by 22% between 1994 and 1999.

If bed numbers decrease as projected in the PFI schemes considered in the article, and activity continues to rise, then throughput (inpatient episodes per bed per year) will have to increase dramatically – to about double the current national average. The authors suggest that the system is already at saturation point and that the projected bed reductions will reduce the level of NHS activity.

Towards the privatisation of clinical services?

Before the election, both the Labour Party and the Conservatives ruled out the provision of clinical services by the private consortia involved in PFI. The director of the Institute of Health Services Management, Karen Caines, has warned that politicians may have to accept that private firms should employ doctors and nurses in NHS hospitals if PFI is to get off the ground. Similarly Chris Ham, head of the Institute of Health Services Management, has said that investors involved in PFI will want to have a big say in how hospitals are run. "That will mean a seat on the board ... and a say in the appointment of consultants."

The health service consultants Newchurch and Company have warned that most PFI deals are unlikely to deliver the savings which have been promised. Acute hospitals built under the scheme could cost as much as 50% more than had been thought. The company, which has advised on 25 schemes, now says that financial performance would improve if PFI schemes were allowed to include clinical services.

Nursing Times 16 April, Guardian/Independent 22 April, BMJ 26 April, Daily Telegraph 15 May

NHS (Primary Care) Act

The NHS (Primary Care) Act became law on 21 March. The Act enables pilot schemes to be set up to provide personal medical services. As part of an agreement to get the Act passed before the general election, the Conservative government dropped a provision that GPs in pilot schemes could be employed by "alternative" (including commercial) providers. Official guidance states that the Act allows only members of the "NHS family" to provide services under a pilot scheme.

The NHS Executive has set out guidance on the procedures to be followed. Applications to set up pilot schemes must be made to health authorities, which then prepare proposals to put to the Secretary of State. Preparation of detailed applications for pilots, including local consultation, is to take place between June and September 1997. During this process, health authorities must comply with requirements to consult. For example, they "might be expected to consult with CHCs ...".

The Secretary of State will select pilots for approval. The criteria to be used are not yet fixed. However, the guidance lists some possible criteria, including the following:

- The proposal should identify "accountability arrangements (financial, clinical and to public ...)".
- The health authority's recommendation should cover the "level of support for the proposal, including response to outcome of consultative process".

Professor Angela Coulter of the King's Fund has warned that the pilots could lead to a further fragmentation of primary services. She is concerned that innovation may occur only in "leafy suburbs" and that equal care for patients has not been guaranteed. The criteria in the NHS Executive guidance do not explicitly mention equality of care, although they do mention that the effect of a proposal on the distribution of GPs will be taken into account.

Doctor 12 March; Guardian 18 April; A guide to personal medical services pilots under the NHS (Primary Care) Act 1997, NHS Executive, for copies phone 0541 555455.

GPs pessimistic over Health of the Nation targets

A survey of GPs (257 (66%) responded) found that a majority thought that the Health of the Nation targets for the year 2000 are unattainable. They are most likely to believe this for targets which they believe are strongly linked to socioeconomic factors (e.g. reducing suicide rates). There was more optimism over clearly medical targets, such as the incidence of cervical cancer.

Overall 137 (50%) of the GPs said that they had a strategy for meeting some of the targets. A high proportion of these 137 GPs had such a strategy in some areas (e.g. 72% for reducing death rates from coronary heart disease), but hardly any had a strategy for meeting the targets in relation to accidents or HIV and AIDS. Only 13% had a strategy for "improving appreciably health and social functioning of mentally ill people".

BMJ 26 April

Waiting targets not being met

Official statistics show that the NHS is failing to meet Patient's Charter targets for waiting times for an outpatient appointment.

Targets: 90% of patients should see a consultant within 13 weeks of a written referral by a GP to a consultant. 100% should be seen within 26 weeks.

Achievements: In the last quarter of 1996, only 83% of patients saw a consultant within 13 weeks of referral. The figures were particularly poor for trauma and orthopaedics, with only 70% being seen within 13 weeks. On 31 December, 275,000 patients on the waiting list had been waiting for more than 13 weeks and 68,500 had been waiting for more than 26 weeks.

Health Service Journal 17 April

Efficiency index criticised

The NHS Efficiency Index, the Patient's Charter and the contracting system have been criticised in a recent NHS Confederation report, *Acting on the Evidence*, for working against the provision of the most effective treatment. The authors, Chris Ham and Keiran Walshe, say that the mechanisms put in place by the Department of Health put great value on efficiency and economy, but not on effectiveness.

The Efficiency Index measures efficiency in terms of patient throughput. This, say the authors, "rewards needless activity and punishes watchful waiting". The Patient's Charter waiting lists targets also encourage ineffective procedures on patients who have been waiting for a long time, at the expense of more effective treatment on other patients. The contracting system is criticised for valuing all admissions equally, regardless of the appropriateness of care.

Although some trusts and health authorities have tried to tackle the problem, some had made little progress beyond raising awareness and generating debate. The report calls for new measures which recognise and reward effective clinical practice.

Times 15 April

A MISCELLANY

Reference manual for public involvement

Jacqui Barker, Maxine Bullen & Jenny de Ville
Bromley Health, West Kent Health Authority and Lambeth, Southwark and Lewisham Health Authority
Availability details from Jacqui Baker, Bromley Health on phone: 0181 315 8315; fax: 0181 462 6767

This manual on public involvement in health care commissioning is divided into two parts. Part 1, on planning, gives background information and covers issues which need to be considered in preparing to involve the public. It includes subsections on who to involve, how to involve people, how to use results, accountability and evaluation. Part 2 presents an "à la carte" range of approaches, giving pros and cons and a checklist of hints. The approaches covered are meetings, interviews, giving information, using local media, other research techniques, panels and handling complaints.

Informed consent

The *BMJ* is asking its readers to give their views on whether the journal should reject all studies in which the informed consent of research subjects was not sought. The *BMJ*'s editors and reviewers are divided on the issue and argue that the answer is not as straightforward as it might seem. The World Medical Association's Declaration of Helsinki allows doctors sometimes to do without informed consent. In addition, research ethics committees sometimes approve studies in which researchers do not obtain informed consent. One example of this happening is a study presented in this issue of the *BMJ* which looked at whether stroke family care workers improve outcomes. In this study the researchers argued that if patients had had a detailed knowledge of the trial, then the outcomes of the trail could have been biased.

Much of the 12 April issue of the *BMJ* is given over to a debate on the question. It includes two studies in which fully informed consent was not sought. Each paper includes an explanation of why this was so. The issue of the *BMJ* includes commentaries and letters from people reaching different conclusions. Some would seek to reject for publication all research in which informed consent was not sought. Others suggest specific areas in which such research might be accepted – for example research on stored tissue from anonymous donors. Others argue for a looser policy which accepts that informed consent is not always necessary.

Only one of the contributions in the *BMJ* issue is from a patient. CHCs might be interested in getting hold of a copy and contributing to the debate.

BMJ 12 April

National Diabetes Week, 8–14 June

Campaign for a Cure

This year the British Diabetic Association is sponsoring 160 research projects including three into genetic research on the causes of diabetes and on gene therapy. The association is launching **Campaign for a Cure** during its national Diabetes Week 1997 in order to raise funds for the research. We have been asked if CHCs could help by displaying posters.

For further information contact: Anne Byard, BDA, 10 Queen Anne Street, London W1M 0BD; phone: 0171 323 1531; fax: 0171 637 3644. Posters can be ordered on freephone 0800 585 088.

Ineffective prescribing

A study on prescribing found that antibiotics prescribed for sore throat were ineffective. The article calls on GPs to develop protocols to limit such prescriptions.

The study was into 719 patients who went to a GP surgery complaining of a sore throat. Patients were assigned to one of three strategies:

- immediate antibiotics
- no antibiotics
- a chance of antibiotics later if the symptoms had not cleared up.

There was no difference in the average length of illness or in the satisfaction of patients with their consultation. This suggests that the antibiotics were not effective. However, the group who were immediately given antibiotics believed that their recovery *was* due to the antibiotics. They said that they intended to return to the surgery the next time they had a sore throat – and attendance of these patients was found to increase relative to the other groups.

Possible disadvantages of ineffective prescription of antibiotics

- building up drug resistance
- preventing patients from developing immunity
- cost of drugs
- creating extra work for GPs

While some patients may put GPs under pressure to prescribe antibiotics, this is not the only reason for unnecessary prescriptions. In 1995 the Prescription Pricing Authority issued a report on antibiotics which said that 41% of patients expect a prescription, but that 67% of patients leave the doctor's surgery with one.

Medeconomics April 1997

Developing local 'continuing care' policies and guidelines

National Primary Care Research and Development Centre, £5.95
Contact: Maria Cairney, NPCRDC, 5th Floor, Williamson Building, University of Manchester, Manchester M13 9PL; phone: 0161 275 7633

This study was carried out in three health authority areas during the winter of 1995/96, when consultation on local draft guidelines for continuing care was taking place. It found that:

- The health authorities had tried to inform primary care professionals about draft policies and to discuss their implications. However, the response from GPs had been poor. There were few examples of 'round table' discussions involving all relevant sectors.
- GPs had welcomed the existence of clear local policies though they would have preferred to have a single national policy.
- Services to nursing and residential homes and early hospital discharge both caused workload problems for primary care professionals. They did not feel that local continuing care policies would tackle these problems.
- GPs and primary care managers acknowledged that they had little information about their patients' likely needs or preferences for continuing care services.
- None of the health authority areas had included consultation on plans for financial investment in continuing NHS services. It might well be easier to involve GPs in shaping local policy if there was a prospect of additional service investment.

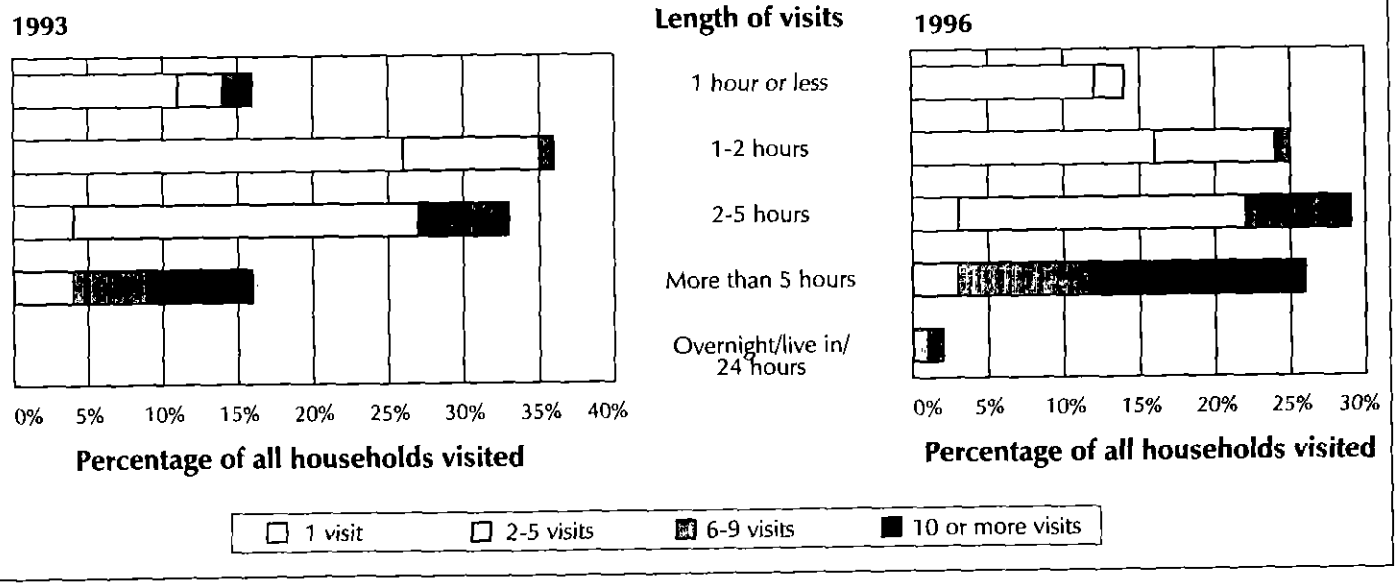
Community care statistics

The Department of Health has produced an interesting 31 page statistical bulletin on community care. It gives information on home help and home care services, meals services and day centres.

The figures show that, while the number of contact hours provided by home help and home care services has been increasing, the number of households receiving services has been falling. In other words, fewer households are receiving more intensive help. Detailed statistics, such as those illustrated in the graphs below, show this trend over the last few years. In the graphs, intensity of provision increases as you move from white to black (more visits to a household in a week) and as you move down the graph (longer visits). Similar trends are seen with meals services, but not day centres.

Community care statistics 1996
Department of Health
£2 from DoH, PO Box 410, Wetherby, North Yorkshire, LS23 7LN, phone: 01937 840250; fax: 01937 845381.

Intensity of home help and home care services, 1993 and 1996
England, during one survey week in each case
Source: Department of Health Statistical Bulletin, 8 April 1997



Newcastle Emergency Doctor Service: a survey of patients' views, Newcastle CHC
Calling out the doctor, Bristol & District CHC

The Newcastle Emergency Doctor Service started in May 1996. It offers services after surgery hours (up to 11 p.m.) to patients phoning their GPs out of hours. The scheme covers 11 GP practices. **Newcastle CHC** surveyed patients who had contacted the service during its first 6 weeks of operation.

The service is staffed by two GPs, one of whom is available for home visits, a nurse, a receptionist, a driver for patients and a driver for the GP doing home visits. When people phone the centre a doctor or nurse decides what action should be taken: telephone advice, a home visit by the doctor or a visit to the centre by the patient. The decision is made on social as well as clinical grounds, e.g. if a single parent is looking after children who are in bed. (At first the receptionist was making some of these decisions, but this has now been changed.)

In its survey the CHC found high levels of satisfaction. In some respects, the service was an improvement over previous arrangements: waits to see a doctor and for a home visit were shorter. Most respondents did not know about the centre beforehand, but most were happy to attend. Of the five who were not, two said that they would be happy to go there in the future.

One of the (few) problems which arose was transport. In one case the respondent had to borrow money to get a taxi and was worried that her child would be sick in the taxi, for which she would be fined. It had not been explained clearly where the centre was, and the taxi driver did not know. The CHC recommends that patients should always be asked how they will get to the centre, and that they should not have to get a taxi.

Transport was also highlighted as a problem in a survey by **Bristol & District CHC**. In this survey group discussions were held with people who used a range of out of hours services (because they were registered with various different GPs). In one of the areas surveyed, 44% of households have no car. The CHC says that in such cases, a home visit should be made or transport should be provided.

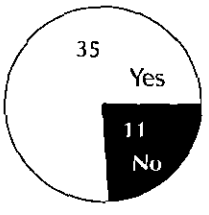
The survey found that local people had very different experiences of the service offered. For example some people were offered telephone advice, while others were not although they would have found it useful. A clear set of standards would help to show what the service can, and cannot, provide.

Doctors often complain that patients call them unnecessarily out of hours. This survey shows that it is not only doctors who are unhappy with this situation. Complaints about the difficulty of getting a daytime appointment were made in all the discussions, and a number of people felt that this was having a knock-on effect on the demand for out of hours services.

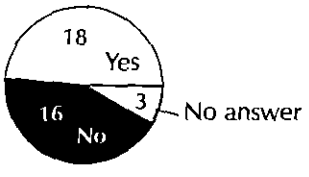
Patients' experiences of the hospital discharge process
Coventry CHC

In a detailed survey of the discharge process, researchers interviewed 46 patients who had been discharged from surgical and medical wards. The main problem revealed was in obtaining services, aids and home adaptations after discharge. As the graphs below show there were often delays in provision and some patients did not know who to contact if things went wrong. In addition, 28% of patients developed new needs after discharge: of these 46% did not know who to contact.

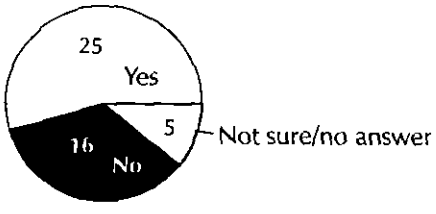
Arrangements for aids/adaptations on discharge
Source: Coventry CHC survey



Needed aids/adaptations?



Aids available when you arrived home?



Told who to contact if arrangements broke down?

Proposals to extend trust powers

Last month we told you of developments in the former government's plans to extend NHS trust powers. Since then ACHCEW has obtained the opinion of leading barristers Peter Duffy QC and Perdita Cargill-Thompson. This confirms that the new functions granted to some trusts and the proposed wording of amendments to trust establishment orders is so wide as to remove previous limits on the private activities of trusts. The effect is to give the trusts the potential to operate outside the NHS. Officers and ministers from the Department of Health had repeatedly stated that this was not their intention, but had refused to consider a different form of wording that would have eliminated the problem. In view of this and in view of the fact that several CHCs were wrongly advised by the DoH during the consultation exercise, the barristers confirm ACHCEW's view that the consultation exercise was flawed and that, as a result, the individual CHCs concerned could challenge the DoH in the courts. Further, they advise that the consultation exercise was inadequate for a number of other reasons, including the short period of time the CHCs were given to consider the proposals and respond.

ACHCEW has sent a copy of the advice to Frank Dobson, the new Secretary of State for Health, and advised him of the problems CHCs have experienced. We have also asked him to review the wording of those amendment orders which have already been made. Watch this space for developments.

If you would like a copy of the barristers' opinion, please contact Marion Chester, ACHCEW's legal officer.

Consultation rights

ACHCEW's legal officer is receiving an ever-increasing number of enquiries from CHCs concerning their rights to be consulted. It seems that recently, many health authorities have merely been paying lip-service to their legal obligation to consult with local CHCs, and some authorities have been failing to do even this.

Regulation 18 of the Community Health Council Regulations 1996 SI 640 provides that *'..it shall be the duty of each relevant Health Authority to consult a Council on any proposals which the Health Authority may have under consideration for any substantial development of the health service in the Council's district and on any proposals to make any substantial variation in the provision of such service.'*

There have always been disputes between health authorities and CHCs over what constitutes a substantial development/variation in service. The health authority/trust boundary has also caused some problems. However, a significant number of health authorities are now refusing to seek the views of CHCs about proposals which in the past would have been the subject of formal consultation. When challenged, authorities have put forward a number of justifications, such as:

- **There is no need to consult formally because the CHC was given a copy of the health authority's purchasing intentions.** Unless the plans contain full details, with an exact timetable for implementation, the CHC cannot be said to have been provided with sufficient information.
- **The CHC receives minutes of, and its representatives attend, health authority meetings. It should, therefore, be fully aware of the proposals under consideration.** The legislation provides for this flow of information **and** places on the health authority the duty to consult. In any event, the courts have made it clear that a consulting authority must not only provide sufficient information for consultees to be able to give a proposal intelligent consideration, but must also genuinely consider the responses it receives. A consultation exercise which comprised a flow of information in one direction only would not be held to be authentic. It is advisable for CHCs to offer advice to health authorities outside formal consultation exercises, but this is not a substitute for consultation.
- **There is no time to consult because the authority has to limit its expenditure to keep within its budget**. Regulation 18(3) provides an exemption to the duty to consult, but this is only in cases where there genuinely is no time to consult. In these cases the authority is required immediately to notify the CHC of the decision taken and the reason why no consultation has taken place. This would be appropriate, for example, if a ward had to be closed immediately on discovery of a health and safety hazard. Regulation 18(3) cannot be used as an excuse to cover an authority's failure to anticipate or plan properly. If an authority cites financial reasons for not consulting, the CHC should scrutinise the reasons, asking when the authority became aware of its budget and why it did not consult then.

If a health authority refuses to honour fully its obligation to consult, the CHC has the right to refer the matter to the Secretary of State for Health (or Wales) - sending a copy of the referral to the NHS Executive Regional Office. It is arguable that the CHC has a legitimate expectation that the authority will not implement the proposals until the Secretary of State has reached a view and advised the CHC of the outcome of the referral, giving reasons for the decision. If the CHC is unhappy with this determination, the only avenue left to it is an application for judicial review of the health authority's (and in some cases the Secretary of State's) decision.

Role of complaints conveners

ACHCEW has received clarification from the NHS Executive on an aspect of the convening process in the NHS complaints procedure. A CHC had contacted ACHCEW about the handling of a particular complaint. After there had been an attempt at Local Resolution, the complainant had asked for an Independent Review. Before agreeing to this request, the convener set up a meeting between the convener, the independent chairperson, the trust clinical adviser, the complainant and a CHC representative. During this meeting there was some investigation of the complaint itself. The CHC believed that this might put off the complainant from pursuing an independent review.

The NHS Executive has confirmed that at this stage, there should be no attempt "to resolve or investigate the complaint". A convener can set up a meeting, but only to decide whether there are "outstanding issues (from Local Resolution) which should be dealt with by further action at local resolution or by setting up a panel".

GMC performance procedures

ACHCEW has responded to the GMC's consultation document on its new performance procedures, which reflect the considerable changes which have taken place in the GMC over the last few years. The new procedures, which now involve more lay input, have four stages: screening of complaints, assessment, remedial training and reassessment.

ACHCEW broadly agrees with the overall direction proposed by the GMC and welcomes the constructive involvement of patients' representatives. However, it has some reservations about some specific details. Among other things, ACHCEW would like to see:

- greater involvement of lay screeners and assessors in various specific decisions
- explicit guidelines for the recruitment of lay screeners
- publication of the results of screening
- the continuation of an investigation even if the doctor concerned retires or removes him/herself from the register
- as much public consideration of complaints as possible bearing in mind the need to maintain patient confidentiality.

ACHCEW AGM/CONFERENCE

"In the name of the patient"

Bournemouth, 8–10 July 1997

From the information team

The last month has been a busy period since, whilst the NHS never quite received the attention it deserved in the general election campaign, ACHCEW received numerous enquiries from the media looking for the patients' perspective. Thank you to all CHCs which agreed to help with media enquiries.

With Frank Dobson barely in place as the new Health Secretary, ACHCEW has already been putting CHCs' concerns to him. According to *The Mirror* (5 May), Mr Dobson has pledged that the role of CHCs will be strengthened. We will continue to lobby the new government with the same vigour as we did the last.

We have liaised with the General Medical Council about its new performance procedures and our response to the consultation document has been finalised. The GMC seems to be becoming more receptive to the concerns of patient representatives. This is a development that ACHCEW welcomes and hopes will continue.

Last month also saw the publication of the Health News Briefing *A stronger voice for patients in the new millennium* – our response to the **Insight** report – and the Health Perspective *Dignity and Privacy in Hospital: the Issue of Mixed Sex Wards in Hospital*. We have also been busy putting together the Annual Report which will be published shortly. The questionnaires returned to us on out of hours care and the new complaints procedure provided us with extremely useful information. Many thanks to all CHCs which returned the questionnaires.

Research will continue in all areas that are of concern to CHCs. This month will see the publication of the Health Perspective on "Did Not Attends". We will of course be continuing to support members with their telephone and written enquiries.

Training update

From Liz Rickarby, ACHCEW training organiser

I will be leaving ACHCEW to take six months maternity leave, starting in June. My locum will be Allison Anthony.

Can I also take this opportunity to remind you about the questionnaire on Training for CHC staff and members. You will remember that I am intending to develop a database of training resources for CHCs. For those of you who have not had a chance to complete and return the questionnaires, please could you do this as soon as possible.