NATIONAL PLAN – PATIENT EMPOWERMENT

INITIAL CONCERNS : 1st AUGUST 2000

This note sets out some initial concerns about the section of the National Plan dealing with Patient Empowerment. It is based on the experience of CHCs in the past 26 years as the public's voice in the NHS.

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• **Joined Up Empowerment**

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One of the strengths of CHCs is that they carry out a number of different functions, which feed into each other. The complaints work, scrutiny work, visiting and public involvement functions all relate. Issues raised in one feed into action and results in another. This synergy is cost effective, efficient and benefits patients. Under the National Plan, CHCs work appears to be divided between at least 5 different agencies – PALS, Trust Patient Forums, LA Scrutiny Committees, the Commission for Health Improvement, and Local Advisory Forums. It is not clear from the plan how these will be linked and managed.

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• **Independence**

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We are concerned that, regardless of the goodwill of the individuals involved in any new structures, they will not be perceived as independent. Patient advocates are to be based in trusts. It is not clear what steps will be taken to ensure they will be, and will appear to be, independent. To many people who have had a bad experience, the complaints process becomes a "them and us" situation.

The independence, and more importantly perceived independence of CHCs is what has made their "patient's friend " role so valuable. Similarly, it is not clear what steps will be taken to ensure that the management of the advocates service will enable them to be genuinely independent.

We are also concerned about the independence of trust patients forums. If they are to be set up by the trusts, then it is hard to see how they can be truly independent. It is not clear what staffing support they will have, or whether it will come from trust staff or independently employed staff. One of the reasons why PCG lay members have formed such strong links with CHCs in many areas is because they appreciate the value in having access to independent information and advice.

Similarly, it is also unclear in the plan what the arrangements will be for the servicing of local advisory forums to be established by health authorities. It is also not clear what mechanisms will be used to ensure that such forums will be both independent and representative of their local communities.

It is also unclear what mechanisms there will be to ensure commonality of standards across the country for these new mechanisms. ACHCEW's submission argued for minimum standards and core activities across the country for CHCs to avoid "postcode representation". The same arguments apply to any new models for patient and citizen empowerment.

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- **National Issues**
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Two key functions of the Association of Community Health Councils for England and Wales (ACHCEW) are the exchange of best practice and the identification of national

trends. For example, the recent report "Fair Comment" which identified the extent to which health professionals use the threat of defamation actions to undermine the NHS complaints procedure, came about because the ACHCEW legal officer had noticed that this issue had been raised by a growing number of local CHCs. Nationwide Casualtywatch, which has placed the issue of A&E waits on the national agenda, is only possible because there is a nation wide network of CHCs with a national association. Our report "Hungry in Hospital", by involving CHCs across the country in monitoring hospital feeding practices, , raised issues which lead to significant changes in guidance and practice. In the service. ACHCEW's national database of local projects allows CHCs to learn from each other when starting new work. Similar benefits accrue from the work of Regional Associations of CHCs. The plan does not set out how the more fragmented structures proposed are going to work together nationally, in identifying national trends and learning from best practice.

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• **Primary Care**

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The proposals in the plan are very hospital focussed. ACHCEW's submission to the National Plan highlighted the need to improve scrutiny, inspection and the handling of complaints in primary care, and this matter is not addressed fully in the National Plan. We would hope that this is an area that could be developed in the coming months, drawing on the good work that CHCs have done with local practices and primary care groups.

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• **Lack of detail**

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These concerns arise in part out of the lack of detail in the plan. This lack of detail also means that almost no

information has been given about the rationale for the abolition of CHCs. CHCs have sought, despite the lack of statutory change, to develop a role that suits the new NHS. At local level across the country, CHCs have extended their remit, through building on well-established local relationships, to encompass Primary Care Groups, Health Improvement Programmes, the work of Health Action Zones and other new initiatives. As our contribution to the National Plan, CHCs developed and signed up to radical proposals for reform, which were submitted to ministers and the modernisation action team. Member CHCs have also supported ACHCEW in carrying out modernisation work in recent months, including: a project to develop external accreditation for our member training, a private public partnership agreement with an IT company seeking to make user friendly information about health services readily available and the setting up of the independent Commission on Representing the Public Interest in the Health Service.

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• **Abolition of CHCs**

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The above makes it clear that our concerns about the abolition of CHCs are not based on narrow self interest, but on a desire to see patients and the public well served in the New NHS. CHCs have recognised the need for change, as detailed above. However, we feel that the proposals set out in chapter 10 of the plan do not require the abolition of CHCs. Modernised and rejuvenated CHCs could have a positive role in delivering the plans aims.

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• **Statutory powers**

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The statutory rights of CHCs have been powerful tools in gaining a fair deal for patients and local communities. It is not yet clear what statutory rights the new structures will

have, for example to information, in addition to that which will have to be produced more generally for patients and the wider public.

- **Cost effectiveness of proposals**

If the proposals are to be effective, they are likely to produce significantly less value for money than CHCs. A recent report by Community Service Volunteers estimated that CHC members contribute £7.9m worth of free labour to the NHS, if each hour is costed at the average wage. Furthermore, CHCs with an average budget of less that £130,000 per annum in England, and an average of 3 whole time equivalent staff provide a cost-effective service. If the new proposals do not include dedicated staffing for groups of lay members, they will not work as a powerful voice for patients. The fragmentation and lack of synergy in the proposals as they currently stand is likely to provide less value for money. As well as the employment of patient advocates, there will need to be staffing for patient forums, and local advisory forums, as well as additional health specialist staff to advise Local Authority Scrutiny Committees in many areas. Additional expenditure on patient empowerment would be very welcome, but could be provided more effectively under one roof by modernised CHCs.

- **Method of dissemination**

Staff and members have been very concerned about the way this decision was announced. Most of them found out about it from the internet, via ACHCEW, or from colleagues. No attempt was made to brief CHC staff simultaneously with the announcement. There has also been no prior discussion about abolition, and assurances have been given throughout the year by both ministers

and civil servants that CHCs had a strong future in the New NHS. It is vital that any further decisions are taken in a more open and consultative way, with appropriate information at an appropriate time for all interested parties, if we are to ensure that the spirit and work of CHCs over 26 years is not lost in any new arrangements.

CHCs have done tremendous work in the past 26 years. They have often been the sole voice for patient empowerment. Our concern now must be to ensure that this work is built upon in any new proposals that are developed for the NHS. The Department of Health is talking about a timetable that sees CHCs continuing to exist in their current form until March 2002. What happens in the coming months will be crucial if patients are to be properly served.