Community health councils

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In the NHS reorganization of 1974 the functions of management and public representation were split and community health councils (CHC) were established to represent the interests of patients and the community to the managers of the Health Service (DHSS, 1974). Their formal rights and duties related, initially, to the hospital services but in 1985 these were extended to family practitioner services, except the right to enter the premises of private contractors, when the family practitioner committees became independent health authorities (DHSS, 1985).

However, from the outset community health councils interpreted their role broadly as covering all aspects of the NHS and increasingly found themselves well occupied at the interfaces of hospital and primary care, health and social services, the public and the private sectors. If general practice is the gateway to health services, it is hardly surprising that a significant proportion of contacts with patients and the public concerned primary health care services.

A chequered response

The advent of community health councils and the perceived experience of their interventions by managers and professionals has met with a chequered response but, in spite of the lack of resources which has placed constraints on their ability to offer a comprehensive range of activities in the districts, and the confusions about their tasks and powers and limited public awareness of their achievements, they have grown in stature and have been recognized from within the NHS, grudgingly or enthusiastically, as "part of the scene".

The Health Advisory Service reported in 1977 that community health councils had been "one of the very few success stories of the reorganization of the NHS". The Royal Commission on the NHS in 1978 said that they had made "an important contribution towards ensuring that local public opinion is represented to health service management". Even the NHS Management Inquiry (Griffiths Report) in 1983 was "impressed with the grass-roots work of some community health councils".

Government, particularly since 1981, and the political parties have remained more ambivalent. Doubts have been expressed as to whether it is necessary to

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divide representation from management, particularly if health authority members could combine management oversight with authentic representation. A Government review of the situation has been postponed indefinitely or, at least, until after the next General Election.

From within the community health councils there is a more confident sense that the investment of mainly voluntary time and effort has yielded considerable achievements:

- They have had a considerable impact on putting managers in touch with local communities
- They have given lay people the opportunity to challenge and question the providers and professionals
- They have highlighted the needs of women, mentally ill, handicapped, elderly and people from ethnic minorities, and have helped to shift the traditional balance of power in the NHS from acute specialties to community care and priority services
- They have raised public awareness and undertaken original and innovative work to develop good practices
- From a user perspective they have been a training ground for council members who move on to serve on district health authorities and family practitioner committees.

In 1981 a study on the relationships between managers and community health councils concluded: "It is clear that community health councils are having a significant and beneficial impact on the administrators with whom they most deal — the district management teams. . . community health councils have clearly succeeded in turning the minds of administrators towards the community and to hitherto neglected groups of patients" (Bates, 1982).

Their most valuable roles were considered to be bringing in new ideas, keeping management on its toes and commenting on priorities in service provision. However, in this study only 12 per cent of FPC managers thought they had made a definite impact on decision making, while 84 per cent said not.

Family practitioner committees have been the part of the health service most resistent to collaboration with community health councils so that, until they became health authorities with a relationship to community health councils analogous to that with district health authorities, only 40 per cent of community health councils had been granted observer status by local arrangement.

In 1986 it was too early to assess what progress had been made under the new formal arrangements although, at a more informal level, there were signs of increased CHC activity in relation to primary care services and positive efforts being made on all sides to create links between community health councils, faculties of the Royal College and local medical committees.

Against a background of conjecture about Government intentions towards the primary care services, considerable shifts in the focus of health care from hospital to a variety of more community-based services and widespread public interest in the concept of consumerism and participation, it seems likely that community health councils and general practice will draw closer together in alliance on issues to do with planning and resources and in creative tension, or conceivably conflict, in areas such as complaints and possible changes in professional attitudes towards patients' needs and expectations.

Activities and priorities

General practitioners will need to be aware that, in spite of the diversity of CHC perceptions of their role, which are firmly wedded to autonomy within their districts, their main activities fall into the following broad areas: planning, consultation on service changes, monitoring existing services, identifying unmet need, information and advice to the public, complaints and acting as "patient's friend", health education and health promotion, and public health approaches to the environmental causes of ill health.

In 1980 a survey identified five CHC priorities: the promotion of better, more equitable health services (83 per cent), the improvement of services for the mentally and physically handicapped (54 per cent), opposing cuts and closures (50 per cent), maternity services (33 per cent) and services for the elderly (33 per

cent) (Farrell and Adams, 1981). In terms of attitudes to health policy, a 1984 study showed that the views of community health councils, although much less unanimous than those of the professionals and political parties, were 90 per cent in agreement on 10 key issues (Landsberger, 1984):

- The dignity of the patient
- The need to ensure that plans are adhered to
- The development of a team approach to health care with more co-operation between doctors and other professionals
- The prevalence of over-prescribing
- The need for Government control over the pharmaceutical industry
- The need for more joint planning and joint finance
- The need for more screening and more health promotion by the occupational health services
- Maintaining the ideals of the NHS founders
- The need for more expenditure on health
- The need for more health promotion by professionals.

Much of this smacks of the World Health Organization's targets for primary care, the more innovative opinions and practices of doctors and the initiatives of the Royal College as exemplified by the report on *Promoting Prevention* (RCGP, 1983), the establishment of the Patients' Liaison Group and implied support for patient participation groups, and the proposals contained in *Quality in General Practice* (RCGP, 1985).

Doctor/patient relationships

Among community health councils there is a determination to tackle the "cultural rift" between providers and users of public services and this is, in part, a response to the *sotto voce* complaint made to community health councils about doctors rightly or wrongly, given the pressures on them, that they do not talk, do not tell and do not ask enough. The 1984 study revealed that 49 per cent of CHC chairpersons agreed strongly and 29 per cent on the whole that "Doctors not treating patients with sufficient respect and dignity — not giving them a chance to express themselves — need more attention" (Landsberger 1984).

The collective and practical response of community health councils to the vital issue of doctor/patient relationships was, in 1986, to engage in a major consultation with the health community on the need for, operation of, and elements in, a Patients' Charter. Inevitably, a list of principles did little more than touch upon daily practice and the constraints which obstruct the achievement of the ideal, but it was hoped that a mutual understanding of expectations would be helpful in burying the shibboleths of the past and working towards a constructive vision for the future.

While it is the community health council's job to reflect back to the health service the satisfactions and the dissatisfactions of the patients and to search out good and bad practice, it is also to promote consideration of a shopping list of possibilities, to work together with professionals on agreed goals and to make sure that pioneering initiatives are not relegated to novelty status.

A question of access

Community health councils have access to hospitals. They do not have access to surgeries. Whether or not they should or could, it is hardly necessary to await the adjudication of Government. A Scarborough general practitioner, believing that community health councils should have access, invited his local community health councils into his three-doctor practice. He said: "We have nothing to be embarassed about and feel it right and proper to invite them in. . . the community health council's role will be improved if they understand the way general practice is run" (*Doctor*, 1986a).

Family practitioner committees in Nottinghamshire and Barnsley have been referring patients with complaints about their doctors to the community health councils (*Doctor*, 1986b). An FPC administrator said that "while FPC members . would help complainants, sometimes the community health councils can provide more assistance. . . Often, if the complaint gets to hearing level, the community health council will be able to help and that makes our job easier".

The handling of complaints is always a vexed question and the community health council role, be it limited to offering advice and sometimes acting as patient's friend, has seldom been popular with the professionals likely to be complained about. However, it is worth bearing in mind that CHC secretaries, for the most part, find themselves explaining, reassuring and diverting potential complainants from a sometimes unnecessary escalation into the formal complaints machinery. Where a formal complaint may be necessary and while offering assistance and advice, their parallel function will be to provide counselling and sympathy. While many CHC secretaries do not feel they have the power or the time to make complaints a major priority, there are those who believe that where complainants are unable to carry their own case forward for whatever reason, they should be allowed to act on their behalf. As one CHC secretary put it: "I have yet to deal with a complainant who has not been astonished, perplexed and somewhat frightened by both the formality and bureaucratic nature of the rules and regulations involved in the Complaints Procedure."

They find it surprising, as does the public, that private contractors cannot be compelled to be present at service committee hearings. Any such hearings cause stress to both parties even though experience has shown that the predominating motive among complainants is not to castigate the professional but to establish what happened, why it happened and, if it did, to prevent such problem in the future. No-one wants an adversarial procedure with paid or unpaid advocacy on either side. However, it takes little imagination to see the value of a "patient's friend" who can apply his or her knowledge of health services and medical matters to assist a complainant to express himself and gain the assurance he needs that he has had a fair hearing. The discretion left to the chairmen of service committees and those involved in the clinical complaints procedure to deem a CHC secretary a professional advocate is neither tenable nor comprehensible to the public. Even leading the hearings aside, the delays experienced by complainants and the unsatisfactory outcomes of many such hearings have convinced many community health councils that the tacit support for the role of patient's friend by the DHSS is insufficient and a proper subject for regulation. The situation is dominated by personalities rather than procedures that could secure the confidence of the public.

Need for information

General practitioners and community health councils share a common concern that the public should become well informed about health and health services and how to use them. In its report *Promoting Prevention*, the Royal College of General Practitioners (1983) recommended that community health councils, the Health Education Council, the Pharmaceutical Society of Great Britain and the College itself should engage in exploring ways to educate the public to make the best use of health service resources so that general practitioners could be freed from some of the burdens imposed by trivial and self-limiting illness and allow them more time to expand their services to include anticipatory care; and it is unfortunate that this recommendation was never implemented.

All the same, community health councils and general practitioners have started to work in collaboration and in parallel on providing information to patients. In 1985 Exeter Community Health Council worked with its local

medical committee to produce a model leaflet for general practitioners to give information to their patients about the services they provide and how best to use them. Also, among others, Exeter CHC has made suggestions on the improvement of the Medical List to assist patients in exercising choice, identifying more clearly the characteristics of group practices, delineating practice areas, giving women an opportunity to choose women doctors, describing appointment systems and dispensing doctors, and giving more information about the maternity and contraceptive services available.

Given that most people are willing to take general practices as they find them, there is a growing interest in making informed choices, or shopping around. This can be harnessed to persuading rather than compelling practices to adapt to the needs and expectations of their neighbourhood communities. But information can go both ways. In 1984 the Leeds community health councils sought the help of local general practitioners in identifying examples of new and innovative developments in primary care. The information so teased out included a "well person clinic", an anti-obesity clinic and preventive counselling. There is still much to be learned from the "Good Practices in Mental Health" project, which could be and, in some cases, has been extended to other aspects of health service provision.

If community health councils, acting on behalf of patients and the community, need information from and about general practice, they themselves are a valuable source of information for general practitioners and very willing to collaborate with them.

In the hospital sector much information deployed by community health councils comes from contact with patients and the public, systematic visiting and contacts with people working within the NHS. Draft planning documents and variable opportunities for monitoring services are another source. However, the Griffiths exhortation to measure client satisfaction and the useful results of systematic investigation by some community health councils have increased the volume of the survey work undertaken by the councils, often in collaboration with NHS management and professionals. In 1985, for example, the published CHC survey reports included the views of Harrow general practitioners on local provision for termination of pregnancy, primary care services in Hull, surgery hours in Leeds, practice premises in Liverpool and a primary care study in Plymouth. Other reports have included matters germain or peripheral to general practice including abortion referral, primary medical care for the single homeless, doctor availability, the language and health care needs of ethnic minorities, and the views and needs of other discreet groups of consumers such as women, brain-damaged people and the elderly.

Assuming, as I can believe we can, that community health councils and general practitioners need to know more to respond more efficiently and effectively, and given that general practitioners are pre-occupied with providing a service, they might well find it productive to engage the interest and co-operation of community health councils to find out more, not only about patients' views but about the strategic health issues in their districts and neighbourhoods.

Conclusion

In summary, community health councils are the watchdogs for the public so that their relationship with professionals or the providers of NHS and other services may not always be convenient or comfortable. On the other hand, again with public and patient interests paramount, they are potential and actual allies in tackling problems and opportunities that are of direct concern to general practice. They are well informed and will seek out more information if sources permit. They can spread that information among the public and among service providers. They can reflect mutual concerns back to managers and Government. If they attack bad practice they can also promote the good and help to discover what communities, and groups within those communities, really want and need.

They, like general practitioners, are having to cope with change and prospects for change and to work out new relationships with family practitioners services and all those who work within the field of primary care.

While they represent patients and signal the collective views of the community to all levels within the NHS, and while they can complain and act as irritants, their track record is of enhancing rather than detracting from the best of medical practice in the belief that public participation in the provision of health services and collaboration between the different professions and agencies working for promotion of health, the cure of illness and the care of the sick, disabled and disadvantaged, represents the only means available to retain the principles of the NHS, uphold standards and develop the nation's capability to adapt and provide for changing health needs. □

References

Bates B (1982) Can the public's voice influence bureaucracy? The case of Community Health Councils. *Public Administration.* **60.**

Department of Health and Social Security (1974) Community Health Councils. NHS Reorganization Circular HRC (74) 4.

Department of Health and Social Security (1985) *The Community Health Council Regulations 1985.* Statutory Instrument. London. DHSS.

Doctor (1986a) 16 January.

Doctor (1986b) 27 March.

Farrell C and Adams J (1981) *CHCS at Work: 1980.* Department of Applied Social Studies, Polytechnic of North London. April.

Griffiths Report (1983) *NHS Management Inquiry.* Report to the Secretary of State for Social Services. London, Department of Health and Social Security.

Health Advisory Service (1977) *Annual Report for 1986.* London, HMSO.

Landsberger H A (1984) *Preliminary Report to Participating Organizations of the 1984 Survey of Expert Opinions on Health Policy Issues.* Institute for Research in the Social Sciences, University of North Carolina.

Royal Commission on the National Health Service (1979) *Report.* Cmnd 7615. London, HMSO.

Royal College of General Practitioners (1983) *Promoting Prevention. Occasional Paper 22.* London, RCGP.

Royal College of General Practitioners (1985) *Quality in General Practice. Policy Statement 2.* London, RCGP.