KF

REPORTS

CHCs and FPCs:

TOWARDS A CLOSER COOPERATION

A report of a conference held
at the King's Fund Centre on
19th February 1985
by
Annabelle May

35 King's Fund Centre KFC 85/154

King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre has a particular role in promoting advances in policy and practice in relation to problems of health care. It offers a forum for informed debate, provides an information service and organises a range of activities designed to support service development.

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Foreword

For those of our members who have experienced some of the tensions and misunderstandings which have arisen in the past when the formal relationship between FPCs and CHCs was less clear and more dependent on goodwill than good management, the title of the Conference, 'Towards a Closer Cooperation', must have seemed a trifle optimistic.

In the event the quality of both speakers and discussion in an atmosphere of great goodwill, which cannot just be put down to the ambiance of the King's Fund Centre, gave more than a touch of realism to the intentions of the organisers.

We should have guessed. The Conference was over-subscribed and such dissatisfaction as was voiced came from those who did not get a place and some who would have preferred not to make the long trek to London.

The Conference was made possible by Pat Gordon and our hosts at the King's Fund Centre and it was only resources which prevented us from running similar events in other regions. Those who attended, knowing the constraints but impressed by the results, urged FPCs and CHCs, with or without the help of benefactors like the King's Fund, to consider organising similar events locally and/or regionally and a few have already done so. We, together, endorse this proposal, which notwithstanding the regular, formal contacts which will now take place, is particularly important during the early months of the new Family Practitioner Committees. We very much hope that this report will provide the starting point for the organisation of such meetings as well as being a record of the Conference.

We would both like to take this opportunity of thanking Pat Gordon, the King's Fund, the speakers and all who participated.

John Knighton, Society of FPCs

Tony Smythe, ACHCEW

CHCs and FPCs: TOWARDS A CLOSER COOPERATION

Introduction by the Chairman, Morning Session: Dr A H MacLaren, President of the Society of FPCs, Chairman of Nottingham FPC

Dr MacLaren reminded delegates that the idea for this national meeting between FPCs and CHCs had arisen at one of the DHSS seminars in Harrogate for chairmen and administrators of FPCs. It was proposed by Michael Pringle (then President of the Society of FPCs) and by Sue Thorne (then Secretary of West Lambeth CHC). The present meeting had been organised jointly by the Society of FPCs, the Association of CHCs of England and Wales and the King's Fund and had attracted a great deal of interest. Unfortunately not all those who wished to attend could be accommodated and Dr MacLaren hoped that colleagues up and down the country might arrange similar meetings in other regions. A time was coming when both FPCs and CHCs would be working in close cooperation, and they would need considerable understanding of each other's functions, both present and future.

Training for CHC members, said Dr MacLaren, was not his responsibility, but he believed that training for FPC members was of vital importance. The NHS Training Authority incorporated a training unit for FPC members and officers, and he was concerned that this body should continue to inform new members of the shape of the organisation and of their responsibilities within it.

Dr MacLaren then introduced Joe Pilling, Under Secretary, Family Practitioner Services, DHSS.

TO UTOPIA ON THE BACK OF AN ELEPHANT?

Joe Pilling, Under Secretary, Family Practitioner Services, DHSS

Referring to the title of his talk, Joe Pilling began by pointing out that if Utopia were in fact to be achieved, the result would be the dissolution of CHCs. 'Their raison d'etre is our failure to achieve that state'. But perhaps his real title should be 'the plans of central government to enhance the performance of FPCs from 1 April 1985'.

He planned to divide the discussion into three parts.

I Do FPCs matter, from a CHC point of view?

Some might say that the profile of FPCs' has been low to the point of invisibility so why should CHCs, with their limited resources and therefore restricted priorities, bother about them? - particularly when some might say that the local representative committees of the practitioner services are reasonably effective professional watchdogs?

One very important reason is the fact that FPCs spend over £3 billion a year: one quarter of all NHS expenditure. Another is that there are 190 million patient consultations with GPs every year, and for 90 per cent of all NHS consumers this is their only contact with the health service. Because of the numbers involved, there must be many more grass-roots grumbles about the time it takes to get a GP appointment than about the length of hospital waiting lists.

The idea of community care is currently politically popular. Community care is founded on the family practitioner services so if FPCs don't matter now, they should, and over the next 20 years FPCs will be more important than ever before.

II How are FPCs to develop?

Joe Pilling went on to describe five areas in which the DHSS is anxious to see FPCs develop:

(a) policy making. While recognising that FPCs have limitations in giving effect to policy the Department wants to encourage FPCs to see themselves as policy making bodies.

(b) planning. Some FPCs have acted as planning bodies for years; others not at all. The task is one of persuasion and influence rather than direction and executive control. The first step must be the development of an information base, so that both needs and gaps in services can be identified. FPCs should be seeking ways to improve provision. How many FPCs, Mr Pilling asked, had given any thought during the past year to the problems of providing medical services for the homeless and rootless in their communities?

(c) monitoring. FPCs must give their attention to economy and efficiency: value for money as well as effectiveness. Money should be allocated to those GPs who were entitled to it, or the other GPs - not the taxpayer - would suffer. While he could foresee possible difficulties on the horizon between the BMA and the DHSS, neither side, he felt, should be needlessly abrasive. Mutual cooperation was essential.

(d) information to patients. Patients need an informed choice of local services; and informed use was a Government priority. There was room here for both FPCs and CHCs to develop.

(e) complaints. Joe Pilling reiterated Kenneth Clarke's remark, at the recent conference for FPC chairmen, that there was room for improvement in handling complaints. It was not always the case that complainants perceived justice to have been done.

III Mr Pilling went on to give a historical account of the relationship between FPCs and CHCs which he called 'A Case-study of a Journey on the back of an Elephant'

Progress in the FPC/CHC relationship had been slow but steady - perhaps, viewed in Whitehall terms, not all that slow. The Government circular HC(FP)(77)2 in September 1977, declared that the Secretary of State intended to leave it to individual FPCs whether or not they invited CHC observers to attend their meetings, but wished it to be known that he considered that satisfactory arrangements for attendance of CHC observers 'could and should be made'. This was followed by HC(81)15 in December 1981, which repeated that while FPCs were not required to admit CHC observers, 'many now do so voluntarily'. Others were urged to adopt this practice. The elephant was now moving through the jungle, albeit slowly.

In August 1983, HC(FP)(83)2 informed FPCs that they were now required, as from August 15 1983, to admit the press and interested members of the public to FPC meetings and sub-committee meetings which included all FPC members. This document also stated that CHC observers should be admitted, and furnished with all non-confidential papers and 'in this way the development of mutual understanding between CHCs and FPCs should be enhanced'.

Eventually, the new Regulations following Schedule 3 to the Health and Social Security Act 1984 (March 1984) imposed a duty on FPCs to consult CHCs and to provide them with such information as they might require. The elephant, claimed Joe Pilling, had now definitely made some progress.

Concluding his analogy, he did not think that the future ride on the elephant's back would be a comfortable one. The sun would probably be hot; and the elephant's canopy might get torn.

There were likely to be unforeseen hazards hidden in the jungle. Perhaps CHCs would undertake the role of the mahout, or elephant-keeper, and see that the elephant - and its passengers - kept on the right track.

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In the discussion that followed the Chairman of Frenchay CHC asked whether there would be any means of monitoring whether the requirements in the circulars were actually being carried out? He described how although admitted as an observer to FPC meetings, he was made to feel 'odd man out'. Mr Pilling said that a key feature of the new position of FPCs was that they would be directly accountable to the DHSS, who were therefore in a position to ask penetrating questions about their performance.

In response to a question about giving more information to patients about GPs, Dr MacLaren intervened to say that most FPCs were currently taking up this issue. He understood from his own local medical and dental committees that both doctors and dentists were now more willing to allow their details and descriptions to be made publicly available.

TOWARDS A MORE DEMOCRATIC FAMILY PRACTITIONER SERVICE

Ged Moran, Community Affairs Health Adviser, London Borough of Greenwich

Ged Moran began by remarking that democracy and family practitioner services were two concepts not often associated. Nevertheless, he intended to explore the connection by looking first at the relevance of democracy to the NHS generally, and to the family practitioner services in particular; then at the proposed FPC structure in the light of democracy and accountability. Thirdly, he would assess these changes in the wider context of Government policy on health; and lastly, discuss some ideas for making the best of the new structure.

Democracy in the NHS

Starting with the issue of democracy in the NHS, Ged Moran posed the question 'which individuals, groups or institutions might legitimately expect to influence NHS policy?' Once these had been identified, what decision-making structures might best accommodate these legitimate (and frequently conflicting) demands for influence?

The market model reduces health care to a simple transaction between user and supplier: the individual consumer buys health care from an individual practitioner. In this model, influence is exercised by market forces, while the legitimate interests are those of the consumer and the provider. The Government has no need to concern itself with wider issues such as the distribution of health professionals because, in theory, self-correcting market mechanisms will reflect consumer preferences. But of course practice does not always match theory and even in the USA the state is playing an increasing role in health care.

However, in the UK we have chosen to adopt a different model; collective provision via public funding. Immediately, a third interest is introduced. The Government becomes the paymaster; and the Government sets the policy goals.

But where welfare services, including health, are concerned, there are huge local variations in needs and resources, in populations and preferences. Therefore, argued Ged Moran, we need to introduce a strong local voice on health as already exists in the other welfare services. Existing mechanisms are not sufficient to protect the consumer's interests.

In the debate over deputising services, for example, the Government capitulated to the family practitioners. In the case of limited list prescribing, the Government is being tough - but only because the Treasury needs the money. From the consumer's point of view, neither case is reassuring. All too often it seems that users' interests are ignored.

New FPC structure

Turning to his second point, the proposed new structure of FPCs, Ged Moran asked whether the new FPCs would be different. Looking at the DHSS circulars HC(FP)(84)4, Nominations to FPCs (paras 2, 4, 10, 19, 20) and HN(FP)(84)37, Accountability Arrangements (paras 2, 5, 6, 7), Ged Moran found it extraordinary that such requirements were only now being made mandatory. He discerned a sharp contrast between the vaguerequirements relating to collaboration and the very specific and increased powers given to the Secretary of State. If anything, he claimed, the new structure would further undermine the already weak local voice. The secrecy of the selection process for members had not helped matters.

But was this pessimism premature? The portents were not encouraging. Every single recent initiative in the NHS has had a centralising effect. Manpower targets, privatisation, regional reviews, Griffiths: all these were imposed from the top down. Privatisation has meant Ministers overturning local contracts; Griffiths has resulted in wholesale interference in advertising and shortlisting, even the vetoing of appointments. Clearest of all was John Patten's letter on privatisation of 9 October 1984, which stated that health authorities were now expected to implement Government circulars, whether or not they were legally binding. Local discretion in decision-making, promised in 1982, had not become a reality for health authorities nor was it likely to for FPCs.

FPCs and health policies

The NHS is obsessed with confidentiality. It is the occupational disease of administrators. But there is massive public interest in health. FPCs must become more outward-looking. They should be informing the public, and generating informed debate. FPCs are part of the health lobby and should be actively confronting the interests that are damaging health.

FPCs could do more to promote health at local level. Local authorities need their input, and their constructive criticism. If problems were being caused by central government policies, FPCs should not be afraid to say so. Historically, for example, the medical profession has always argued for better housing. As well as the hundreds of medical letters sent to Housing Departments about individuals, what is needed is for the FPC to sit down with the local authority and talk about housing policy. GPs are community-based, and in the front line of medical intelligence. The information which they could provide would be more valuable than any amount of platitudes about collaboration.

How far was the proposed planning role of FPCs compatible with independent contractor status? Ged Moran confessed to scepticism. Certainly FPCs could be more active and less reactive. The planning function also implied asking more searching questions about current health needs. Much of the relevant information was already in existence, in census and NHS data, but it needed to be brought together and analysed. FPCs are advised by the Collaboration Working Party to use the skills and local knowledge of CHCs but in future consultation will need to go beyond CHCs, who are already over-stretched. They will have no extra resources

with which to monitor the expanded FPC role. Existing consultative mechanisms are highly selective, and frequently inaccessible to those with the greatest health needs. Perhaps FPCs could actually come out and meet the public and engage in local dialogue; possibly at public meetings.

Ideas for improving responsiveness

Ged Moran concluded with some specific suggestions for both lay and professional FPC members. The existing selection system militated against truly representative lay members. How many of these lived in the most deprived areas? More determined efforts must be made to remedy this situation. Local organisations must put forward names of people to the DHSS as potential members of their FPC. FPCs should be much more 'available' to service users. One way of doing this would be for each FPC member to be responsible for a 'patch' of the district to get to know its practitioners, social services, housing officers, voluntary organisations and to be able to talk to them about the service.

Professionals are the individual's point of contact with the services. How can the dialogue between them be improved? Patient participation groups deserve wider currency. The issue of patients' access to records will have to be faced. Professionals should give patients more information. A guide to drugs (perhaps MIMS) could be available in every surgery or pharmacy. Service committee procedures for handling complaints were in need of scrutiny.

Finally, he asked, why should we bother to provide ourselves with more work and more controversy in this way? The pious answer (nonetheless true) is that a strong local voice on health can only benefit patients. The more pragmatic answer is that if FPCs do not demonstrate that they can do the job, there are two possible outcomes: market medicine; or locally elected health authorities.

FPCs fought hard for their independent status. Now, they are riding a tiger. Instead of greater independence they have greater central interference. Resisting this centralisation of power must become a major priority for both FPCs and CHCs after April 1.

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In the discussion that followed John Knighton (Administrator, Dorset FPC) agreed that the principle of community care was a good one, but pointed out that it could not be achieved without adequate resources. When FPCs became clearly responsible for all primary health care services, he was apprehensive that they would be an uncomfortably visible target.

W G Blake (Chairman, Sheffield FPC) stated that he saw the FPCs' primary duty as the providing of administration for a service run by professionals. Because this administration had to be efficient, he believed that FPCs should concentrate on their own job rather than interfering with others. Ged Moran's response was that lack of collaboration could cause an even greater workload for both FPCs and GPs, as they would then have to cope with the outcomes of inefficient policies in other fields.Current developments obviously held clear implications for the selection of members, otherwise FPCs could end up having responsibility without power.

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In the second part of the morning the conference divided up into six groups. The groups' task was to talk through some of the difficulties experienced in relations between FPCs and CHCs, and to offer positive suggestions for improvement. There was no formal report back session, but delegates were asked to share any good ideas in the open discussion session in the afternoon.

The afternoon session was chaired by Dame Elizabeth Ackroyd, Chair of the Patients Association and Vice-Chair, Waltham Forest CHC. She introduced the first speaker, Dr Green

'TO TRY TO BE WISE ALL ON ONE'S OWN IS SHEER FOLLY'

Dr L M Green, General Practitioner and Member of the Management Committee of the Society of FPCs

Dr Green recalled the early days of FPCs, which dated back to Lloyd George's Insurance Act of 1911. In the past, friendly societies and trade unions had played an important role in ensuring the delivery of health care in the community. Doctors would appear before local committees to negotiate their terms of service.

Today, the general medical practitioner's contract states that s/he 'shall render to his patients all necessary and appropriate medical services of the type usually provided by general medical practitioners'. But, he pointed out, needs and services are constantly changing due to advances in medical science, individual initiatives, or to what the community defines as need.

There was also the constant necessity to balance the professional and the consumer view. Initiatives have frequently been taken by patients or their representatives. Here, the FPC needed to look to the CHC for help and guidance. One example was the field of care for the homeless. Dr Green cited the important experimental work carried out by Dr David El Kabir at the Great Chapel Street hostel in Soho, London.

CHCs could also contribute to the debate over information. How much information should be disclosed, about either patients or contractors, in order to benefit the community as a whole? When research is needed for planning purposes, how can the facts relating to small areas of population be revealed without infringing either personal or clinical confidentiality? The designation 'deprived borough', for instance, was sometimes not sensitive enough to distinguish variations found between wards, streets, even individual houses. A draft code of conduct was needed on the use of information. The decision on disclosure should be made by the community.

The use of Accident and Emergency Departments, the dispersal of practices, minor surgery - these were some of the many issues where the CHC should be consulted, and help to determine priorities. While CHCs do not manage services, they are important advisers. In future their role will be even more important than in the past.

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In the discussion that followed Judy Allsop (Ealing, Hammersmith and Hounslow FPC) asked why graphically presented information should threaten confidentiality. Dr Green replied that if small areas of illness or need were to be identified (eg in an FPC Report) he thought that confidentiality could be threatened. Michael English (West Lambeth CHC) reminded delegates about the famous health map of Soho which, by plotting the incidence of disease, had revealed a contaminated pump to be the source of infection. He compared British attitudes to freedom of information unfavourably with those in Sweden.

M R Pringle (Chairman, Croydon FPC) asked Dr Green for his feelings about the suggestion that a copy of MIMS should be in every doctor's waiting room. Would this affect the doctor's prescribing habits? While Dr Green felt that patients would not understand the technicalities of MIMS, he was all in favour of their having more information about their prescriptions. He was concerned about the growing practice of parallel importing, which resulted in drugs being dispensed with instructions in foreign languages.

Judy Thomas (Secretary, Bradford CHC) asked whether FPCs would take account of a recent Women's National Commission Report on NHS provision which suggested that evening and Saturday morning surgeries would be a valuable facility for working women with family responsibilities. Dr Green responded that in the 19th century, when doctors were trying to build up their practices and attract more patients, they frequently worked on Saturdays and Sundays and in the evenings.

If the Government were to provide more resources, he declared, there might be more doctors and dentists available to provide such services.

'THE WATCH-DOG'S HONEST BARK'

Sue Jenkins, Secretary, Leeds Western CHC

> 'Tis sweet to hear the watch-dog's honest bark
> Bay deep-mouthed welcome, as we draw near home;
> 'Tis sweet to know there is an eye will mark
> Our coming, and look brighter when we come. (Byron)

Sue Jenkins hoped that most FPC members now recognise the necessity for and validity of a separate consumer role in the NHS. Similarly, CHCs need to understand the rules within which FPCs have to function, and their consequent limitations. In her district, people constantly talk about the FPC's lack of real power. But is this powerlessness inbuilt, she wondered, or is it simply the result of timidity in practice?

To the patient, some FPC rules appear to be unfair and unjust. A practice can, for example, strike off a patient without the need for any explanation. It is this very lack of explanation that is disturbing. Clearly there is nothing that the FPC can do about this at present - unless they would consider making representations about changing the rule. This leads to a - possibly naive - question about the role which professionals, appointed by local representative committees, play on the FPC. Do they see themselves as trade unionists for their professions, or as representatives of the local community?

On the question of what FPCs could and could not do, Sue Jenkins expressed her conviction that the Secretary of State would now like FPCs to feel that they could do more. Whether or not they had the financial resources was another matter, but when she considered what her CHC managed to accomplish with one administrative member of staff, one secretary, and a budget of £35,000 she thought that it was possible to do more - especially with computerisation. She went on to suggest what that 'more' might be.

More information should be available to patients about every doctor on the FPC list. The Royal College of General Practitioners' (RCGP) Patients' Committee recommends including the name and sex of doctor; year of birth; names and sex of partners; surgery times; how night and weekend cover is provided; family planning and other services offered. Patients should be informed about how to change doctors; what to do if there are problems in contacting them; standards that must be met by deputising services; how to complain; practitioners with premises accessible to the disabled.

FPC lists need to be kept up to date, in spite of the difficulties involved. It is surprising how many people seek doctors through that list, and it is important that they should know how and where to find an accurate copy of it. The leaders of the profession have made clear their belief that services should be patient-oriented. Sue Jenkins hoped that FPCs accepted this too. Happily, professional attitudes were changing towards the thought of information as 'advertising'.

She went on to describe a project in Leeds called Ideas in Practice, on which both Leeds CHCs were working with the advice and cooperation of the Local Medical Committee and the RCGP. The project aims to publicise good examples of primary care and to make the public aware of the services available from GPs and from the primary care team. It was realised at an early stage that GPs would not cooperate if names and addresses were to be quoted, so unlike the 'Good Practices in Mental Health' work sponsored by the International Hospital Federation the booklet to be published in Leeds will contain descriptions of practices which have to remain anonymous. Other FPCs and CHCs might consider collaborating on similar initiatives.

Perhaps the strength of CHCs and their members lies in the fact that CHCs are not particularly prestigious bodies. Active members often have a background of local service, either in the community or in politics; and they are genuinely concerned about improving services. Possibly the same is true of FPC members, but it is not always apparent to the CHC. While the CHC is interested in the provision of services, it seems that the FPC's concern is with the payment and regulation of the providers. This situation can give rise to frustration, particularly when CHC members are excluded from meetings or from parts of meetings. Most CHC members are happy to be excluded from service committee hearings. However when, as in many districts, the CHC observer is present at the DHA meeting for reports on appointments and disciplinary proceedings, CHCs do wonder why FPCs are more exclusive.

Looking into the future, Sue Jenkins asked whether FPCs and CHCs could begin to share an interest in the quality of primary care provided. If this came about, perhaps the snares and pitfalls of the NHS planning process - the draft strategic plans, the operational plans, the operational planning guidelines - could be avoided, and more attention given to the patient. While CHCs would not want to be excluded from the planning process, they would not want to be overwhelmed with documents either. They would be more interested in providing consumer feedback and considering possible responses with FPC members. In Leeds, they had an extremely useful - and informal - quarterly meeting between the Chairmen, Vice-Chairmen, and the officers of the FPC and CHCs.

One area of planning which did interest CHCs - and about which they knew very little - was the decision process as to where and when a GP might practise: the rules on closing surgeries, restricting practice areas or reducing surgery hours. One CHC member had spent some time comparing an out-of-date FPC list with the current one, and had found that over a period of 18 months there had been a 20 per cent reduction in surgeries open after 6 pm, and a 40 per cent reduction in Saturday morning surgeries. Meanwhile, 24 per cent of patients questioned said that they lost pay if they took time off work to visit the doctor's surgery. While doctors may not much like such CHC inquisitiveness, if working hours are reduced in this way surely somebody has an obligation to ask patients what they think?

It is possible that CHCs do not know about many occasions when FPCs have protected patients' interests. The very secrecy and confidentiality of FPC work means that outsiders cannot know whether such successes exist. But perhaps feeding watchdogs with meaty information would be a better tactic than keeping them half-starved and angry with too little.

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In the discussion that followed C W Parr (Administrator, Cheshire FPC) explained that current regulations precluded CHCs from being present during service cases, or from being sent the minutes; it was a question of legality.

Janet Upward (Secretary, S Birmingham CHC) regretted the timidity of FPCs, together with their tendency to shelter behind the status quo. In seeing themselves as simply providing a service, and by not campaigning for change, they were in fact defending their present position. She hoped that they would be more constructive in the future and would feel able to use their knowledge from specific cases to argue for a change of rules if that was what was needed. Graham Betts (Joint Secretary, Greenwich CHC) declared that CHCs would need more information on service cases in order to monitor services and to be able to advise patients better. Sue Jenkins drew attention to the fact that a professional could have a local Medical Committee representative at a hearing, but the patient had no such privilege.

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Dame Elizabeth Ackroyd then opened the meeting to questions and discussion on issues that had been raised throughout the day and started with a question to Joe Pilling about the Secretary of State's written answer of 11th February 1985, regarding the new regulations on formal links between FPCs and CHCs. Did these regulations provide for consultation? The question was referred to Marcia Fry (DHSS), who replied that the new regulations would simply consolidate earlier initiatives. Dame Elizabeth expressed her disappointment, as she believed that both FPCs and CHCs had been looking forward to a new dimension in their relationship. Perhaps some of the proposals suggested at this conference could be incorporated in new guidelines?

Dame Elizabeth commented further that the machinery for communication, let alone consultation, between FPCs and CHCs varied in different parts of the country. Was it possible to lay down any guidelines in this area? Naomi Honigsbaum (Chair, Paddington and N Kensington CHC) replied that CHCs in NW Thames Region had attempted to formulate basic guidelines on the information needed from districts, but had come up with great variations. She wondered what weight was attached to community views (as expressed by the CHC) compared with other interests. Turning to the subject of complaints, Mrs Honigsbaum commented that complaints received were only ever the tip of the iceberg and she hoped that FPCs would feel able to draw lessons from complaints and use them in order to improve the quality of service.

In response to another question about improving the quality of service, Dr MacLaren stated that the most satisfactory situations existed where there was a good personal relationship between the FPC officers and the contractors. In his area, the General Purposes Committee and the Hours of Service Committee provided constant surveillance of such matters as surgery hours.

Mrs A D Sealey (Member, Hampshire FPC) asked what was actually meant by 'good service'. Could we define it? We needed to look hard at what individual people defined as good for them. We were saturated with

information, but needed to use what we had more effectively. Ged Moran commented that current channels for information-gathering only tapped a selected audience. Perhaps once a year the FPC could gather together all its information about housing and services, and arrange a discussion with the local authority? Dr Green remarked that patients were often content to accept a low level of care. Their response to the quality of provision was frequently influenced by the personality of the provider. John Stickland (Chairman, Greenwich and Bexley FPC) returned to the subject of publicising information relating to GPs. It would need, he thought, two or three people working on a permanent basis to keep such a list up to date. What information should go out of the FPC? Where should it go? How should the FPC get the information to the patient? Perhaps the Association of FPCs could discuss this subject with the Association of CHCs and produce some guidelines.

Michael English (W Lambeth CHC) asked what steps were taken, if any, to keep FPCs informed about good practices engaged in by other FPCs. Mr Knighton (Society of FPCs) explained that an interchange of information already took place through the Society of FPCs and the Society of Administrators of the Family Practitioner Services.

Dame Elizabeth Ackroyd then introduced the subject of coterminosity and non-coterminosity between FPCs and DHAs, and the difficulties caused by non-coterminosity in joint planning of primary and secondary care. Tony Ruffell (Administrator, Greenwich and Bexley FPC) made a plea to CHCs, when there were several in an FPC area, to collaborate in both asking for and coordinating information. Joe Pilling asked whether anyone would defend the existing number of FPCs. In response, C W Parr (Administrator, Cheshire FPC) declared that FPC opinion appeared to be split on the issue of the importance of a one-to-one relationship between DHAs and FPCs. He himself would argue that a sizable FPC with ample resources was necessary to cope with the new role.

In the final round of comments from the speakers, Sue Jenkins stated that in the past CHCs had not received enough information from FPCs. Too few FPCs published reports. Ged Moran made the point that if we are going to have more information it will cost more money. His message to the Government would be that if they want FPCs and CHCs to develop their roles, they must provide them with adequate resources to do so. Joe Pilling here expressed his surprise that he had been allowed to escape so far without commenting on the issue of allocation of resources. He would have liked to discuss Ged Moran's point about local democratic involvement in general practitioner services at greater length. However, he would comment that demands for greater DHSS intervention in problem-solving did not sit well with greater local control or less central involvement.

Tony Smythe (Secretary, Association of CHCs for England and Wales) observed that it was surprising how much of the discussion at CHC annual conferences referred to FPCs. Some CHC/FPC relations were extremely bad, and this would undoubtedly affect the opportunities for cooperation after April 1. CHCs had two important roles to play: a representational role; and an advocacy role, to correct the imbalance of power between

patient and profession. He hoped that this meeting would encourage people to pick out examples of good practice and to consider organising similar meetings in other regions where FPC and CHC people could meet together to explore ideas.

Chair and speakers were then thanked from the floor for their contributions. Dame Elizabeth Ackroyd thanked all participants, and concluded the conference by expressing the hope that both FPCs and CHCs would in future work hard at their new relationship.

APPENDIX I

KING EDWARD'S HOSPITAL FUND FOR LONDON
King's Fund Centre

CHCs and FPCs: TOWARDS A CLOSER COOPERATION

A conference to be held on Tuesday 19 February 1985 at the King's Fund Centre

PROGRAMME

Morning session Chair: **Dr A H MacLaren**, President of the Society of FPCs
Chair of Nottingham FPC

10.00 am	Coffee and registration
10.30	Introduction from the Chair
10.35	"To utopia on the back of an elephant?" **Joe Pilling**, Under Secretary, Family Practitioner Services, DHSS
	Questions
11.10	"Towards a more democratic FPC" **Ged Moran**, Community Affairs Health Adviser, Greenwich
	Questions
11.45	Small group discussions
12.45 for 1.00 pm	LUNCH

Afternoon session Chair: **Dame Elizabeth Ackroyd**, Chair of the Patients Association
Vice-Chair, Waltham Forest CHC

2.00	"To try to be wise all on one's own is sheer folly" **Dr L M Green**, General Practitioner Member of Management Committee of Society of FPCs
	Questions
2.30	"The watchdog's honest bark" **Sue Jenkins**, Secretary of Leeds Western CHC
3.00	Questions and open discussion
4.00	Tea and close.

APPENDIX II

King Edward's Hospital Fund for London

King's Fund Centre
126 Albert Street London NW1 7NF

CHCs and FPCs: towards a closer cooperation

A conference held on Tuesday 19 February 1985

PARTICIPANTS

*Dame Elizabeth ACKROYD	Chair	The Patients Association
	Vice-Chair	Waltham Forest CHC
Mr D J ALLAWAY	Administrator	Leeds FPC
Mr B T ALLEN	Administrator	Hillingdon FPC
Ms J ALLSOP	Member	Ealing, Hammersmith & Hounslow FPC
Mr F J ALTON	Administrator	Sandwell FPC
Mrs P G ASQUITH	Secretary	Eastbourne CHC
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