MANAGEMENT AND ADMINISTRATION OF HEALTH CENTRES

by

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E R R A T A

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Page 7 reference [1] should read -

Further articles on health centre administration are listed in Baker and Bevan (1973) and Baker, Bevan and Harvey (1974).

References Page 77

Baker, G. etc should read -

Baker, G., Bevan, J. and Harvey, L. (1974) A Bibliography on health centres in the United Kingdom : Supplement for 1973 and addendum to the original Bibliography. Health Services Research Unit, University of Kent.

Cammock, R. (1972) should read -

Cammock, R. (1973) Health Centres Reception, Waiting and Patient Call. London : H.M.S.O.

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SUMMARY

A study was made of the variety of administrative arrangements, the content of administrative work and the decision making processes in health centres and group practices, prior to the reorganisation of the National Health Service in April 1974.

The main method of gathering this information was by interviewing administrators in centres and local authority health departments. Reports of visits to health centres undertaken by officers of the Department of Health and Social Security were also analysed for the possible relation between 'successful functioning' of centres and their administrative and other characteristics.

There is a considerable body of administrative work necessary in the running of health centres and group practice premises, but the range of this work varies according to the complexity of the centres. In particular group practice centres, because of their financial autonomy, need some person or persons to deal with many financial aspects which in a statutory health centre will be undertaken by the health authority.

Administrative activities can be broadly classified into three levels, routine (non supervisory) administration, supervision of office staff and systems, and higher administration.

The amount of each of the three levels of administration referred to above which is needed in a centre will vary according to a number of factors. These include the variety of services, the numbers of staff in the centre, the number of practices in the centre, whether the centre is a group practice or health centre, and, in the case of health centres, the degree to which administrative tasks are delegated to the centre by the health authority.

Administrators of health centres and group practice premises (who may be variously referred to e.g. as practice managers or senior secretaries) come from a variety of backgrounds. These include nurses, secretaries, clerical workers and former armed forces personnel, who may or may not have had previous experience in the health service field. There would seem to be no overriding advantage in having previous health service experience, especially if the post requires a substantial element of 'higher administration', for which experience in 'management' would seem at least as appropriate.

There is likewise a diversity of employment arrangements for administrators. In group practice premises the family doctors are the

employers. In health centres, the family doctors may employ a person accepted by the health authority as carrying out administration for the centre, or the health authority may employ such a person sharing the cost of the salary with the doctors (in varying proportions theoretically based on the distribution of work between the authority and the doctors) or the health authority alone may employ and pay for the administrator.

Committees with an agenda and minutes have a potentially important part to play in the running of centres. For statutory health centres the Department of Health and Social Security has given guidance on the contracts needed, which include provision for a health centre committee. As larger health centres and group practice premises for more than one practice develop, a committee system ensures that at least representatives of all parties concerned are able to discuss issues, which in small, non-complex centres could be discussed informally. There is a trend towards more consultation and participation in decisions, particularly with the emphasis now upon the 'team' in primary medical care, the team often being widely defined to include, for instance, office staff. Where the health authority is prepared to delegate decision taking down to a health centre, then also the centre committee gains importance.

The fieldwork for this report took place prior to the reorganisation of the National Health Service in April 1974, and forthcoming fieldwork will attempt to assess some of the effects of reorganisation on the administration of centres.

A number of questions come to mind. What is the relationship between health centres and group practice organisations on the one hand and the district and area officers on the other? How does the family practitioner committee relate to these groups? How in practice will policy on health centre administration be decided, by whom and at what level? (It will be of interest to examine the extent to which officers formerly responsible for health centre development continued in the same field following reorganisation). And will there be a tendency towards greater uniformity in health centre administration?

1. INTRODUCTION

(a) Background

The question of how best to administer health centres becomes more pressing as their number increases and larger and more complex centres are built. Until recently, centres have been built by local health authorities, each with its own solution on how its centres should be run, and there has been little official guidance on the subject (for what there has been, see Section 3(c)). Parallel with the growth of health centres there has been the more general trend for family doctors to work in larger groups, which also need to work out their administrative arrangements, whether or not they are in a health centre.

Throughout this report we have used the term 'administration' and avoided the term 'management' to refer to the kinds of activities we are describing (except where we quote other authors, in which case we use their words). We have done this because we do not see any clear distinction between the two terms in relation to the running of centres. The Shorter Oxford English Dictionary defines administration (among other things) as 'management' and vice versa. In the studies undertaken by the Health Service Organisation Unit at Brunel University[1] a manager is defined very specifically as a person who is accountable for the work of a subordinate, prescribing his work, vetoing his appointment and initiating his transfer. Clearly these powers are not held by many 'managers' in health centres, in group practices, or only in relation to a few people. Our impression is that the use of these words depends on their context, thus 'managers' are employed in the private industrial sector, and 'administrators' in public institutions, such as the Civil Service, and the National Health Service. In primary health care this distinction tends to be maintained, in that there are health centre administrators (employed by the health authority) and practice managers (employed by the general practitioners). However this is at times confounded, since we have encountered the terms health centre managers and practice administrators, but these appear to be less commonly used. For the sake of simplicity therefore, we have opted for using the term 'administration'.

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[1] R. Rowbottom et al (1973), Hospital Organisation

The work on which this report is based began effectively in April 1973. It is mostly concerned with information obtained from a number of visits to individual health centres and privately owned group practice premises and to local health authority departments in England. The object of these visits was to learn something of the administrative practices and experiences at and above the level of individual premises. We have also drawn upon reports of visits (made available to us by the Department of Health and Social Security) to section 21 health centres made by regional medical officers[1] and nursing officers of the Department of Health and Social Security. These reports were not primarily concerned with the administration of the centres but do give some indication of the types of administrative arrangements encountered and enabled us to relate these to other features of the centres visited.

April 1973 was an opportune point at which to embark on such an enquiry. By this time a considerable body of experience on planning and running health centres had been accumulated especially in some local health authorities. However, the approaching reorganisation of the National Health Service meant that many local government officers experienced in the development of the health centres were likely to move on to other responsibilities, not necessarily within the National Health Service (or to retire). It would have been difficult to tap their corporate knowledge after April 1st 1974.

The aim of the study, as implied above, has been to look at administration in both health centres and group practices, and to find out what actually happens in these institutions. It must be stressed that the descriptive part of this study relates entirely to experience of administration under the 'old' pattern of the National Health Service. At the level of the individual health centre or group practice premises at least reorganisation seemed unlikely in the short term to bring about any radical changes in administration.

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[1] These are health centres built under Section 21 of the 1946 National Health Service Act, and the regional medical officers are those of the Department of Health and Social Security, and not those of the new regional health authorities.

(b) Previous work

Interest in the administrative aspects of running health centres and group practice has developed along with the growth in number of these institutions. Some indication of this awareness has been the number of advertisements for administrators and of articles appearing in journals upon this subject. In the report of a conference concerned with nurses and the community health team, held in 1971, a practice manager described her role (Scobbie 1972). (This talk was more fully reproduced in a later issue of the same journal (Harcus 1972).) The evolution of a practice manager from the medical secretary of a practice was described in the British Medical Journal (1971). Gibson (1970), former chairman of the British Medical Association Council, wrote on the 'Organisation and Management of Health Centres'(1970) and was "impressed by these centres with a 'manager' in overall charge". He also felt that probably the best way of running the centres was by a committee of representatives of all who worked there and who would elect an executive committee. Another view has been advocated by Saunders (1972), then a principal administrative officer in a county health department, who felt that centres were best run by officers in the county or area headquarters, as standards of management would be diluted by having an administrator in each centre.

There have been some articles publishing results of surveys into administration in general practice. Drury and Kuenssberg (1970) made a survey of administrative work in 1969, of 140 practices known to be interested in organisation, and found much variation in the staffing arrangements and methods of working. "There was no uniformity in job description, staff classification, or delegation of administration". In the British Medical Association Planning Unit Survey of General Practices 1969 (Irvine and Jeffreys 1971) it was found that "97% of practitioners had some non-medical help, compared with 66% in 1963", nearly 60% having 4 or more such staff. (Presumably many of these are part time.) Responsibility for the day to day running of the practice was more likely to be undertaken by doctors when practising outside health centres or not receiving a group practice allowance. Thus 51% of these doctors were responsible for day to day running, compared to only 23% of doctors in health centres, and 29% in group practice. Also "Twenty per cent of the doctors in health centres said a local authority officer, nurse, or health visitor was responsible for the routine activities of the centre."

Conferences and courses on the administration of general practice and health centres have been held by interested organisations, such as the Association of Medical Secretaries and the Royal College of General Practitioners. The Health Services Research Unit sponsored a conference (funded by the Department of Health and Social Security) on 'The administrative aspects of health centre management', at Kent University in 1972 (Woolley 1973). This gave an opportunity for doctors, research workers, nursing officers, local health authority personnel and others interested to exchange views and information. It was clear that there were widely differing opinions on the 'best' type of administration, and that there was a need for much more information and discussion. The conference was especially helpful to the authors, in giving us both lines of enquiry to pursue, and an occasion to meet people who were willing to cooperate in our studies.

Reedy and Nelson (1974) have recently reviewed some papers written about the practice manager, and discuss attempts to set up training courses for them. A report on the training needs of practice administrators (assessed on the results of a small survey) and an evaluation of a pilot course which was subsequently held, has been published in 'The Medical Secretary' (1973).

At this point we should make it quite clear that we are not concerned in this study with clinical management. Brooks (1973) in an article on the 'Management of the team in general practice' distinguished between the practice team and other workers. The team was the "professional, primary care team, composed of people directly concerned with patient-care" (and this team could include social workers as well as health service staff). This primary care team was supported by "secretarial and administrative staff". Brooks was concerned with discussing team-work among <u>professional</u> people. We are concerned with the administration of the supporting staff for these professionals,and of the buildings.

(c) Objectives

(In setting out the objectives of this study, 'centre' has been used to refer to both health centres and group practice premises.)

1. To review current ideas and experience by

i. studying the reports of visits to health centres prepared by regional medical officers and nursing officers of the Department of Health and Social Security, with particular reference to administrative arrangements in relation to size and other characteristics of the health centre visited,

ii. discussing policies on administration with officers of some local health authorities, hospital administrators and administrators employed in individual health centres, and similar but privately owned premises.

2. To develop systematic methods of identifying and describing,

i. the content of the general administrative work relating to the running of the centre,

ii. the decision making committees and officers concerned with the planning and operation of health centres, their responsibilities, powers and activities, and the formal and informal relationships between the various decision makers.

To use the methods and documents developed to study a small number of centres and group practices in privately owned premises.

3. To make preliminary observations in the light of the information collected on such matters as the role of centre administrators, the nature of decision making bodies and the relationships of both with the reorganised National Health Service.

2. METHODS OF STUDY

(a) Department of Health and Social Security Reports on health centres

In 1969 the Department of Health and Social Security organised a series of visits to health centres (those built under Section 21 of the 1946 National Health Services Act) mostly opened in the previous year 1968, chiefly to help in the preparation of the Health Centre Design Guide. Each visit was carried out by a regional medical officer and a nursing officer from the Department of Health and Social Security (Seelig and Rooke, 1971) and we had access to these reports. In the period 1970-1972, three further series of visits were organised to centres opened in 1969-1971, a year after each had opened in order to give them time to settle down. These reports were also made available to us.

The reports for centres opened in 1969-1971 were made using the same proforma (see appendix). Apart from basic details of staff, population served, and design features, there was information about the administration, and also a general summing up of the impression the centre gave. We have extracted information from the reports for 1969-1971 centres, not using the reports for the 1968 centres[1] because the information collected on administration was not comparable with that of the later reports. We have related type of administration in centre to the size of the centre (as measured by the number of doctors practising full time there), type of authority(County, County Borough or London Borough) , and 'success' of functioning as a health centre, (good, bad or indifferent), as assessed by us from the officers' summing up. These results are discussed in Section 3(a).

The reports we have only include some of the centres opened from 1969-1971. The percentage of centres visited is shown in Table 1. In 1969 and 1970, all London Borough centres, almost all County Borough centres and not less than 78% of County centres opened, were visited, but in 1971 visits to centres in Counties fell below 50% of those opened. (See page 10 for further discussion.)

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[1] Apart from one centre opened in 1968 but included in the round of visits to 1969 centres.

(b) Documents and literature

Some articles appearing about administration in journals have already been referred to in Section 1(b)[1]. Apart from the general ideas put forward, these were helpful in much of the detail they gave, for instance, in listing the duties of a practice manager or health centre administrator, or in describing the background and training of people appointed to these positions. Advertisements for administrator posts have also appeared in journals and newspapers, and have been collected and scrutinised.

Local authority health departments have provided us with some printed material, including advertisements used, job descriptions, staffing structures, and agreements between the Executive Council and local health authority in setting up health centres. Material has also come from centres themselves, such as staffing arrangements and copies of minutes kept for health centre and practice meetings.

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[1] Further articles on health centre administration are listed in Baker and Bevan (1973) and Baker, Bevan and Harvey (1975).

(c) Interviews

The main method used in gathering information for this study was by interview. Visits have been made to health centres, group practice premises and local authority health departments, to interview administrators, practice managers, and local authority personnel. A proforma and check lists were designed for use in these interviews.

i. Proforma 'Administrative Activities'

A proforma was designed to list administrative activities which might arise in any given health centre or group practice, and to record who carried out these activities (or tasks, the words are used interchangeably). More than one person would probably carry out these tasks, so the proforma is not a record of the extent of one person's activities, but rather a record of who undertook the activities in any one place. We wanted in particular to know, who was responsible for certain tasks, not just who did them, and the proforma allowed for this to be recorded.

At first sight the proforma seems rather long. This was inevitable since the list of activities was intended to cover a wide range of possibilities, and many do not apply in any one place. The list was compiled partly from certain articles which had set out job descriptions for administrators or practice managers (Maylin 1972, Tate 1971, Lloyd 1972). We also had the help of the practice managers at Herne Bay and Whitstable, from whom we had job descriptions and who discussed their duties and roles with us. An early version of the proforma was piloted with the administrative officer at Dover Health Centre.

With this information and advice, a proforma was compiled, and used in interviews. It was revised once during the course of the study in the light of experience gained during interviews (see appendix for final version used). It is divided into sections as follows:-

1. General Administration - the activities in this section might apply to any health centre and most could apply in a group practice.
2. General Finance - this section could equally well apply to a health centre or group practice.
3. Practice Administration)
4. Practice Finance) - as the headings imply, these sections comprise tasks which arise exclusively from general practice, although the carrying out of the tasks could be done by persons not employed by general practitioners.

5. Personnel - this section aims to include tasks relating to the employment of staff, whether by local authority or by general practitioners.

6. Maintenance and Supplies - similar to 1 and 2 above, this section includes tasks which could be needed in both health centres and group practices.

It must be stressed that the proforma does not aim to include every minute task, or breakdown of one task into several parts, but is intended to list the main activities which arise.

The proforma was normally completed in the course of an interview with a health centre administrator or practice manager, which does mean that only one person's view of matters was recorded. At the centre we made a point of interviewing the administrator or practice manager but sometimes spoke also with other persons, for example doctors or reception staff. These persons, together with the information obtained from the health department, served usually to confirm the impressions received from the administrator or manager, and sometimes to throw new light upon the issues involved.

ii. Administrative activities - additional information

This was a check list used (see appendix for copy), to obtain information partly from local health department personnel (where applicable), and partly from the administrator or practice manager. This division was necessary as one did not wish to ask an administrator directly about his salary grade, or perhaps his former occupation (although this might be mentioned in the course of conversation).

iii. Decision-making in the centre

Like the above check list, this one (see appendix for copy) was used in interviews both with local health authority personnel, where applicable, and with administrators.

iv. The local authority and health centre administration

As its name implies, this list (see appendix) was used in interviews at health departments, which were usually with an administrative officer. Sometimes the Medical Officer of Health was present for at least part of the interview.

(d) The selection of the centres and authorities visited

Altogether we visited 10 health centres, of which eight had administrators whom we interviewed. The other two were run by a health department officer in liaison with reception staff in the centre, and in each case we interviewed that officer.

The 10 health centres were in nine different local authority areas (five counties, one county borough and three London boroughs). We discussed views and policy on running of centres with officers from each of these authorities, in all four Medical Officers of Health, one deputy Medical Officer of Health and 13 administrative officers. From them we learned too about centres in their areas other than those we actually visited.

We also have been in touch with five group practices, discussing their administration with four practice managers, two doctors and two senior receptionists.

We wanted to find out about the range of experiences and views on running centres, and so aimed at variety instead of a 'representative' sample. In the case of health centres, the majority we visited had an administrator, whereas this is probably not true of England as a whole - in the Department of Health and Social Security reports referred to in Section 2(a) only 27% had an administrator. Among the group practices all but one had a practice manager, which again is probably not typical.

We had personal contacts (doctors or local authority officers) in several areas which enabled us to interview and visit these, but otherwise, we selected areas with the help of information (in the case of health centres) from the Department of Health and Social Security reports and the Directory of British Health Centres (1973). We particularly wanted to visit large centres, and some centres in densely urban areas, to see how these had dealt with their special problems.

3. RESULTS OF THE STUDY

(a) Analysis of reports of the Department of Health and Social Security on health centres obtained by regional medical officers and nursing officers (see page 6)

The regional medical officers and nursing officers visited a total of 138 health centres in the period 1970 to 1972. They do not, as Table 1 shows, comprise all centres opened during these years or even a representative sample of these, since the officers were instructed to make a point of visiting all centres which were the first to be built by their respective local authorities and all large centres (other centres visited were then at the discretion of the regional medical officers). Thus we probably have a sample of centres which is purposely biased towards those which might be expected to have teething troubles. Since the visits generally took place at least one year after the centre had opened we might expect some of the more obvious difficulties to have been resolved by then and again it may be that authorities took extra care in staffing etc of their first or very large centres.

Fourteen of the centres visited were in London Boroughs, 42 were in County Boroughs and 82 were in the area of County authorities.

Classification of centres according to type of administrator

The following classification was used to describe the person, if any, in charge of a health centre.

1. Senior secretary/receptionist - i.e. performed routine clerical and/or secretarial duties.
2. Nurse (including health visitor) - i.e. performed nursing or health visitor duties.
3. Full time administrator - full time on administration.
4. Part time administrator - having no other role than administrative in the centre.
5. Local authority clerk (by which was meant someone who was not based at the centre but who attended to its administrative matters).
6. Practice manager - a person employed by the general practitioners.
7. 'no administrator' (this related to centres where it was explicitly stated that there was no one acting as centre administrator).

8. Other (covers such possibilities as caretaker, divisional medical officer, each practices' senior receptionist, senior partner of a practice).
9. Not known.

In fact in most of the following section we have reduced the number of types of administrator down to the following.

1. Senior secretary/receptionist (1)
2. Nurse (including health visitor) (2)
3. Administrator - full time or part time centre administrator, local authority clerk, or practice manager (3,4,5,6)
4. Ill defined arrangements (includes no administrator, 'other' and 'not known' as defined above all of which suggest that the functions of the centre administrator have low status or profile or are perhaps taken for granted) (7,8,9)

Assessment of general functioning of the centre

General comment was often made on the functioning of the centre by the visiting officers with particular reference to the degree of cooperation between the various staff in the centre, and we have classified these comments as one of, functions well, functions indifferently, and functions badly. Of course, many factors other than the type of administrator can effect the way a centre functions. However if centres with one type of administrator appear generally to function less satisfactorily than those with another type then it is possible that this is directly related to the type of administrator and the issue worth further exploration.

Results

Table 2 shows that lay administrators (other than secretary/receptionists) were employed in the case of 27% of the centres visited. A nurse or health visitor was recorded as being in charge in a similar proportion (22%). Secretary/receptionists looked after 15% of the centres and in the case of the remainder the arrangements were 'ill defined' (in the sense we have described above). Nurses were rather more likely to be responsible for administration in town (county borough or London borough) centres than in county centres and the reverse was the case for secretary/receptionists. The proportion of lay administrators was somewhat greater in counties than in boroughs but there was no difference between boroughs and counties in the proportions for centres with ill defined administrative arrangements.

We might expect some differences between town and country health centres administrative arrangements. County boroughs and London boroughs are geographically fairly compact and it is possible to centralise some at least of the administration at the local health department. Some county centres might have been many miles from the health department headquarters and have to be much more self sufficient administratively speaking. We would expect health centres on average to be larger in towns than in counties, table 3 shows that this was the case, if we exclude the relatively few centres with no family doctors listed as practising full time from them, though there was not a great deal of difference.

Overall three fifths of centres visited were described as functioning well, and the remainder were equally divided between those described as functioning indifferently and badly respectively (Table 4).

Those centres where the administration was the responsibility of the secretary/receptionist were much more likely to be classified as functioning well. Centres administered by a nurse or a lay administrator appeared equally likely to be described as functioning well. However, those with ill defined administrative arrangements were the least likely to be so described and indeed nearly 30 per cent were described as functioning badly.

So far then it appears that the traditional administrator in general practice, namely the senior secretary/receptionist comes out well above her rivals and the centres where the administrative arrangements are obscure function least well. However, we have not so far explored the relation between type of administrator and size of centre.

Predictably centres with lay administrators tend to be rather larger (judged in terms of the number of general practitioners using the centre as main surgery) than those administered in other ways. Centres administered by senior secretary/receptionists were at least as large on average as those administered by a nurse but somewhat smaller than those administered by ill defined means (Table 5).

The number of partnerships of doctors[1] in a health centre is some measure of the complexity of an administrator's job. If the number of partnerships is large he has a lot of independent persons or units with which to negotiate.

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[1] Treating single handed doctors as partnerships of size one

Once again the lay administrator was much more likely to be administering centres in which several practices were involved than either nurses or secretary/receptionists. However, the centres whose administrative arrangements were ill defined in this respect resembled rather more closely those listed as having a lay administrator (Table 6).

The centres most likely to be described as functioning well were those with eight or more doctors using them as their main surgeries. Small centres with three or fewer principals were somewhat more often described as functioning well (and indeed badly) than medium size centres of four to seven doctors. However centres where all the principals were in one partnership seemed more likely to fare well than those with two or more partnerships. So it would appear that while a larger number of principals practising at a centre is no impediment to the centre running well, its running is likely to be facilitated by the doctors being in one partnership (Tables 8 and 9).

When we come to examine the assessment of health centres running by centre size and complexity (i.e. number of principals and number of partnerships) and type of administrator in charge, we run into difficulties because of the very small numbers involved. However it would appear that the secretary/receptionists' 'success' in running centres is most noticeable for centres with four or fewer doctors. All three centres with a secretary/receptionist in charge which were assessed as other than running well, were larger centres (five or more doctors). The nurse too appeared to fare much better in smaller centres. By contrast large centres with a lay administrator in charge and, more surprisingly, those with ill defined administrative arrangements appeared to be as likely to be assessed as function well as those with four or fewer doctors (Table 7).

The impression emerges that there is nothing to choose between the administrator and secretary/receptionist in the case of larger centres, perhaps in fact secretary/receptionists in larger centres really are for all practical purposes administrators by another name. Health centres with ill defined administrative arrangements and larger health centres administered by a nurse tend not to be assessed as functioning well.

The relationship between number of partnerships and the assessment of a health centre's functioning noted above is supported when we look at results by type of administrator. Regardless of the type of administrator involved it always appears that centres with two or more partnerships were less likely to be assesses as functioning well than those with one partnership only. The numbers are very small but the consistency is worth

noting (Tables 7 and 9).

The centres in county boroughs or London boroughs were more likely to be assessed as functioning well (and functioning badly) than those in counties - this was true (though remember numbers are very small) for centres administered by nurses, lay administrators and centres with ill defined administrative arrangements. (There were only five borough centres with secretary/receptionists in charge.) This result is the more interesting since London borough and county borough centres tended to be larger than county centres and generally to involve more partnerships than county centres. (Note this result is reinforced when the six centres with no full time principals - five in boroughs and one in a county - are excluded from consideration.)(Table 2)

Summing up

It must be emphasised that the results discussed in this section do not come from a representative sample - we simply do not know how these centres compare in terms of functioning with others not visited. The purpose of the analysis is to enable us to form some preliminary hypotheses about the functioning of centres in relation to size and type of administrator (if any) employed. Moreover the assessment of functioning is affected by the attitudes of the assessors, the regional medical officer (not infrequently a former general practitioner) and the nursing officer.

Health centres bring together services formerly provided in local authority clinics on the one hand and privately owned general practitioner premises on the other. The nurse or health visitor has had an important role in the administration of the local authority clinic. The secretary/ receptionist played a similar role in general practice. It may well be that the fact that the administration of a centre is entrusted to a nurse or to a person described as a secretary/receptionist implies a desire to continue with the local authority or general practice tradition respectively. If so given the key position of general practitioners in health centres it is not surprising that centres where secretary/receptionists (presumably with a general practice background) are 'in charge' function more smoothly than those with an administrator such as a nurse whose background is rather different. The problem is perhaps made more acute because the nurse administrator is a member of a professional group which has a somewhat complicated relationship with family doctors. The lay administrator whilst

again in one sense a natural development of the local authority approach to running organisations does not have this professional complication and can to some extent be regarded as a new kind of 'animal' created to deal with the special situation presented by a health centre.

The impression received from our analysis is that centres run by lay administrators seem more likely to be described as functioning well when they are of moderate to large size (five or more doctors). The title administrator or manager may attach to itself a job description inappropriate to the needs of a small organisation. Significantly all centres with four or fewer doctors in which a secretary/receptionist was in charge were described as functioning well. Again the centres consistently least likely to be described as functioning well were those with ill defined administrative arrangements. There is some suggestion that this latter condition may be related to there being several practices in the health centre (see Table 6) which might make it difficult to agree on who shall undertake the administration of the centre (and other matters). Certainly centres with two or more practices seem to be less likely to function well regardless of the kind of person in charge.

It appears to be this measure of the complexity of the centre rather than its crude size as measured in terms of the number of principals using the centre as a main surgery, that is the more important for the smooth running of the centre.

A result which it is not easy to interpret is that centres in London boroughs and county boroughs were more likely to be described as functioning well than those in counties. Especially since borough centres though admittedly somewhat larger in terms of number of principals were disproportionately likely to involve three or more partnerships. A possible explanation is that the office of the local health authority will generally be closer at hand to resolve difficulties for borough centres.

Another factor which may contribute to the successful 'functioning' of centres could be that in certain circumstances, such as centres built in new towns or new estates, the doctors may not be so 'set' in their ways before moving in the centre.

(b) Reports of our visits

i. Introduction

It may be self evident that there is some administrative[1] work to be done in connection with health centres and group practices, but it is worthwhile to look briefly at the kind of tasks, why they exist, and how they might have been distributed prior to the reorganisation of the health service in April 1974. In this section we adopt the convention of using the present tense when referring in general terms to the administrative arrangements and possible distribution of tasks between the bodies then involved in the running of health centres (using the past tense for descriptions of what we have observed in our fieldwork). This is to emphasise that we are discussing continuing issues of health centre and group practice administration presenting these in the context of what is still probably the most familiar organisational framework.

Some administrative tasks arise even in the single handed practices with no secretaries or receptionists. For example, the filing and movement of patients' records, claims made to the Executive Council and the making of appointments where this applies. Again someone has to attend to the maintenance, heating and lighting of the premises. If, as is sometimes the case, receptionists and others are employed to help with these tasks, another task is created - claiming for reimbursement for salaries from the Executive Council, payment of salaries with all the complications of PAYE and National Insurance.

Someone has to perform these tasks wherever the doctors have their surgeries and regardless of whether it is privately or publicly owned premises. In privately owned premises ultimately it is the doctors who must make all the arrangements for the running of the practices and the maintenance of the premises. From the family doctors' point of view, some tasks automatically disappear in a health centre, as the building is owned by the local authority and that body is responsible for the organisation and maintenance. The doctor will also probably have the option of having his reception staff employed by the local authority, which then takes over the task of seeing to their payment etc.

Usually in a health centre other services than those of the family doctor are provided, and provision has to be made for the administrative support of these services. In health centres the responsibility for the administration of the centre and the services is shared formally between the independent persons and bodies providing the services - i.e. the general practitioners, the local health authority,and sometimes the regional

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[1] Throughout this section we shall mean by 'administrative work', work which does not require clinical training such as that given to doctors and nurses.

hospital board, e.g. the local authority is formally responsible for maintaining the building and the administration of local authority health services and the general practitioner is formally responsible for the proper organisation of his practice. Formal responsibilities are, however, only a guide to be invoked in extremis. In practice, the responsible bodies, in particular the general practitioners and the local health authority, agree as to how the various administrative tasks should take place and by whom they should be performed (the same is in a sense true on a much smaller scale in privately owned premises where local authority personnel were attached and based at the premises).

Much of this report is devoted to the study of how some doctors and local authorities cooperated in this way and the arrangements that were made and in fact we observed a good deal of variety. Probably most local authorities expected to employ their own personnel to see to their tasks, even if they did not also carry out tasks specifically for the doctors, but one authority known to us had chosen to leave the running of its health centres entirely in the hands of doctors using them. The doctors employed either a practice manager or a senior secretary, who not only carried out practice tasks but saw to the maintenance and care of the building and equipment, and undertook most of the clerical tasks for local authority staff, such as typing and making clinic appointments. This example is mentioned to illustrate the point that the tasks which have to be carried out where there is a health centre, arising from general practice and local authority services, can be distributed in more than one way. At one end of the spectrum, the local authority may undertake most if not all tasks. At the other end of the spectrum, the practice or practices in the health centre may do all this work. More usually, the tasks would be distributed between the two, in various patterns.

Certain tasks are more or less routine, for instance the transfer of medical records, but others have a more discretionary element, for instance the appointment of new reception staff. The greater the discretionary element in the carrying out of a task, the more significant, for all those affected, is the choice of person or persons who will perform the task. The more complicated the situation (as occurs in a centre with a wide range of services and several practices) the clearer the need to resolve certain questions. How should the administration be arranged? Should there be a local authority administrator, a practice manager, a senior secretary or a nurse responsible for any or all of these tasks? How much freedom should

they be given, (by the local authority and the doctors), and how should they relate to other staff, and to the patients? The answers to these questions will depend not only upon the circumstances (it would not seem sensible to appoint a full time administrator to a small, three doctor health centre with few other services) but also upon the attitudes, values and experiences which the various parties who have a say in the matter bring to bear upon it. There are other parties, personnel who will be working in the group practice or centre, who will be affected by the arrangements but who do not usually have a say in deciding on them, such as reception and paramedical staff. (They may try to have some influence - in one centre the reception staff had asked that their next administrative officer should be a man, but the decision itself rested with the county health department.)

The results of our enquiries are presented as follows, in sections (ii) to (v) below. We first briefly outline their contents.

ii. The setting within which centres operated, prior to April 1974

1. The 'dramatis personae' of a typical centre
2. Variety of organisation and hierarchies
3. Professional values and etiquette
4. The medical setting

iii. The content of the administrative work

We examine in detail the content of administrative work associated with the running of a typical health centre of medium size and then consider how this differs from that of a privately owned group practice premises of comparable size. Particular attention will be given to those aspects of the administrative work which are affected by the special character of clinical and related activities undertaken at a centre (and which are the very raison d'etre of the centre), the professional customs associated with medicine and nursing and the structure of the National Health Service (as it was prior to the 1974 reorganisation). These will be taken in the same order as that used in the proforma :-

1. General Administration
2. General Finance
3. Practice Administration
4. Practice Finance
5. Personnel
6. Maintenance and Supplies

iv. Decision making in centres

In this section we look in particular at committees in centres and the kinds of decisions they made.

v. Case studies of centres

We shall present five case studies to illustrate different styles of administration :-

A. A health centre run by a practice manager
B. A health centre with a local authority administrator who had considerable autonomy
C. A health centre with a local authority administrator who had much less autonomy than B
D. A very large urban health centre with seven practices, with a local authority administrator
E. A group practice centre owned by the general practitioners

vi. Some other variations found of special interest

Under this heading some features of centres and local authority policy not included in the 'case studies' above, but which are of interest, are discussed.

ii. The setting within which centres operated prior to April 1974

1. The 'dramatis personae' of a typical centre

This list includes those who work there for at least part of their working week, and who therefore may be involved in the administrative process either by undertaking some of the administrative work or by being administered. Also included are those outside with administrative roles.

At the local health authority level:

The medical officer of health and his senior medical, nursing and administrative officers (possibly also some local authority officers outside the health department, e.g. those in the personnel, financial and building and maintenance departments).
(mainly relevant to a health centre)

In the centre:

Those providing family practitioner services, almost invariably this means only general practitioners.

Local authority medical, and nursing and clinical services:

Doctors, dentists, district nurses, midwives, health visitors, etc., etc. (Usually of these only community nursing staff would work from a group practice centre.)

Other nurses and paramedical staff:

e.g. Those employed directly by the general practitioners.

The administrative, reception, clerical and domestic staff:

The centre administrator (or manager), his deputy, the caretaker, the senior receptionist (who may sometimes be the administrator's deputy), receptionists, the senior secretary (there may be more than one, say one per practice), secretaries and clerks, telephonists, cleaners.

Hospital and specialist staff:

Consultant and other hospital doctors and their supporting staff (including occasionally, radiographers and members of the remedial professions, pathology laboratory technicians and secretaries). These operate largely independently of the main stream of work in the health centre and so we will mostly exclude them from consideration in the following section.
(These would not usually work from a group practice centre.)

2. Variety of organisation and hierarchies

A further complication of centres for primary medical care, is the differing ways in which the various groups working there are organised. Family doctors work in practices, and there may be more than one practice in a centre, so conflict may arise and have to be settled between them. Moreover doctors are independent contractors, (in contract with the National Health Service via the Executive Council), beholden to nobody else in the centre except insofar as the contract between the local authority and the Executive Council lays down any obligations such as sharing rooms.

Nurses (unless practice nurses) are employed by the local authority, and organised in a hierarchy (in contrast to family doctors). Where there are attachment schemes, this further complicates matters, as the nurse is then clinically responsible to the doctor, as well as being in her own professional and administrative hierarchy.

Other local authority professional staff (dentists, chiropodists, speech therapists, etc) do not have the complication of attachment to general practice in the centre. Hospital consultants may work in the centre, and other agencies (Family Planning Association, probation service, Red Cross) may use accommodation.

The office staff who 'service' the professionals in the centre, are normally organised in a de facto hierarchy, with an administrator, practice manager, senior receptionist, or senior secretary in charge of secretarial, clerical and reception staff. However this can be complicated by the fact that office staff may be employed either by general practitioners or the local authority. Thus a situation can occur where receptionists are employed by the general practitioners working for a practice, but are supervised by an administrator, employed by the local authority, who is partly paid for by the general practitioners. Or conversely, the receptionists may be employed by the local authority, although working for the doctors and in part paid for by them.

Clearly, with all these various groups (which are each organised differently) and no overall structure of authority and hierarchy, much depends upon cooperation and negotiation between parties concerned. The formal processes for decision-making, which are set up in the case of a health centre in the contract between the local authority and the Executive Council, may go some way towards resolving conflicts. Obviously, however, the kinds of values referred to below in '(3) Professional values and etiquette' may influence the manner and outcome of decisions.

3. Professional values and etiquette

Many of those working in centres are 'professionals', such as doctors, dentists, nurses and para-medical persons. Each of these groups brings into the centre certain expectations about how they should be regarded, what they should do and what sort of relationships they should have with other workers. (This is not to say that 'non-professionals' such as receptionists do not have expectations also, but in the health care field the 'professionals' are dominant.) The attitudes of the professionals affect the type of administration that is feasible. It is not simply that professionals have autonomy within their own professional field, but they often enjoy such a high status that this inhibits the freedom with which the lay staff can tell them what to do in many other matters. For example a senior secretary may be given the responsibility of supervising the appointment system, and seeing that it runs smoothly. She can supervise the receptionists and tell them what system of booking to follow, but the doctor may disrupt all the arrangements, by for instance, fitting in extra patients on demand, which the receptionists had not planned for. The senior secretary has no authority over the doctor, and is of lower status, and so has to ask,and not tell, him to alter his system.

In a whole range of matters, therefore, the administrative staff have to rely on cooperation and negotiation with the professionals for the running of the centre, using persuasion where possible. In these circumstances, the committee structure becomes more important.

4. The medical setting

Owing to the nature of the work carried out in centres, particular problems arise which do not occur necessarily in other non-medical institutions. Confidentiality, of records and conversations, is important and affects choice of personnel. Patients attending centres may often be anxious and unwell, which demands tact and diplomacy from staff dealing with them. These kinds of problems have to be taken into account whatever system of administration is adopted.

iii. The content of the administrative work

1. General administration

Allocation of rooms could be important whenever there was either pressure on space, or much sharing of rooms. Waste disposal, surprisingly, assumed importance because of the problem of disposable syringes. Doctors

did not always put these properly into their waste boxes, so that needle ends projected and were a hazard to cleaning staff. An administrator then would need to 'nag' the doctors into changing their ways. An additional problem in connection with these emerged in one of the London boroughs, where outside bins were 'raided' for the syringes.

In health centres nearly all the tasks listed in the 'General administration' section were usually allocated to the person (whether administrator or senior secretary) who was given responsibility for day-to-day running. In other words there was more general agreement as to who should do these tasks than in many other areas.

In group practice premises there appeared to be more variation with the family doctors, for example, playing a greater part in some cases.

2. General finance

Significant here are preparation of estimates and authorisation of expenditure. In health centres, the health department normally did accounts, estimates, and kept tight control over expenditure. However, one county (see Case Study B) had allowed its administrators to prepare annual estimates, and gave them power to sanction spending up to £50, whereas the rest only sanctioned from £5 to £10 without going back to the health department. An allowance to spend gives some measure of local autonomy permitted.[1]

In group practice premises the doctors sanction spending of money so the question of getting approval for expenditure and the keeping of accounts was a much more local affair.

3. Practice administration and 4. Practice finance

These tasks are mostly straightforward and routine once practices are established. In health centres the interest lay in seeing how far non-practice employed personnel, such as administrators or senior secretaries, undertook or supervised these tasks. There was considerable variation in the distribution of these between personnel, unlike 1 and 2 above. Where general practitioners employ their own office staff, there is a sizeable body of work in connection with salaries, which the local authority do if they employ staff for the general practitioners.

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[1] We are here referring to purchasing and not requisitioning.

5. Personnel

In a group practice centre, the employing body for office staff and practice nurses is the practice itself, so that the responsibility is in the hands of the doctors, who may delegate some or all aspects of the work to a manager or senior secretary. Local authority staff, such as attached community nurses, may work with the practice but the usual employment processes (e.g. National Insurance, P.A.Y.E.) are done by the health department.

In a health centre, the practices may decide to retain the employment of their office staff, although some of the processes (advertising, short-listing, supervising etc.) may be delegated to a person outside the practice (e.g. the health centre administrator). Or the practices may decide to let the local health authority employ office staff on their behalf. When this happens, although the local authority is the employer, the staff will have to work for the doctors, and so they need to be brought in at some stage, such as the interview. It should be clear from this, that when it comes to employing office staff in health centres, there are possibilities for considerable variation in thepersons undertaking the personnel type tasks involved. Of course, as mentioned earlier, local authority nurses and other professionals, are employed directly by the authority, and general practitioners.are not usually involved in the processes. This also normally applies to staff such as cleaners and caretakers who work in the health centre.

In looking at personnel tasks in health centres, there are two areas of interest. One of these is the flexibility possible in allocating these tasks, which can be distributed between health departments, office staff employed by the local authority in the centre, or staff employed by the general practitioners or even the general practitioner himself. There is no one person or group who usually does all of these tasks. Secondly, it is of interest to find out how far these tasks are delegated from the central health department officers to the staff in the centre. For instance, advertising and selecting of cleaning and office staff were in some authorities delegated to the health centre administrator.

The situation is further complicated in health centres as the doctors in their rental are paying partly for cleaning and office staff employed by the local authority, and these staff in some sense must be responsible both to the local authority and to the general practitioners,especially since issues of confidentiality may be important.

In the field of personnel (apart from the professionals employed by the local authority) there was no uniformity in the allocation of tasks.

6. Maintenance and supplies

Supplies are usually a routine matter, which various people undertook as the tradition had grown in a particular practice or centre.

Maintenance of the building and its equipment, on the other hand was usually the responsibility of one person (the same person as undertook 1. General administration), although the person selected could vary. In a group practice, this might be the practice manager, a senior partner, or a senior secretary. In health centres it would be, as in 1. above, an administrator or senior secretary.

iv. Decision making in centres

All kinds of decisions are taken before any centre opens, about the numbers and types of staff working there, the services and clinics to be provided, and the organisation of the centre. Decisions about a wide range of matters will also be needed from time to time once the centre is open. Alterations may be required, from a few additional shelves to an extension to the building. The need for more staff may be felt, especially if also there is any question of providing more, or different, clinic services. The type of records to be kept, any research to be done, or the purchase of more equipment, may come up for consideration.

These matters all involve spending money, either to purchase an item or to provide more staff time. In health centres, any expenditure (apart from petty cash or what the health authority has allowed to the centre to spend) has to be sanctioned by the local health authority (and the general practitioners if staff are to be employed under reimbursement schemes), thus involving the health department and its officers, who are outside the health centres. In group practice premises, the sanction to spend money is solely given by the family doctors, except in for instance the case of extra community nursing staff being wanted for a new clinic session.

Other matters will also come up, which do not necessarily involve expenditure, about how the centre should be run, how the relationships should be worked out between doctors, paramedical staff, and office staff. There may be conflict about who has priority in having work typed, or who has priority in using rooms at a time convenient to them. Generally, the activities and initiatives of one individual or group in the centre may have consequences for others working there which need discussion

in the context of the whole centre.

Clearly, as suggested above the health authority has an interest in what goes on in a health centre, and also in group practice premises insofar as staff employed by the authority (e.g. community nurses) are working there. Family doctors in health centres were contracted to the Executive Council, who in turn were in contract with the health authority, to provide general medical services in health centres. In group practices the doctors are responsible for the running of their centre. Staff employed either by the health authority or by the doctors work from both health centres and group practice premises and also have an interest in the running of centres. Thus there are both those with an interest in centres as a whole (the health authorities, the doctors with their own premises) and staff with sectional interests working in centres.

Decisions in centres can be arrived at in various ways. Formal procedures include house committees and practice meetings, informal procedures include discussion between individuals within the centre, and liaison (in the case of health centre) between the officers of the health department and staff in the health centre.

Committees

House committees

These are committees in health centres representing primarily the two main 'interests' in the centre, the local authority and the family doctors. Representatives of other staff concerned, whether based in the health centre or not, may be members, including nursing officers, nurses, dental officers, administrators, receptionists and (formerly) Executive Council officers. In the case of health centres there was usually a contract between the Executive Council and the health authority (and between the general practitioners and the Executive Council) which set out to some extent the rights and responsibilities of the parties involved. These contracts normally provided for a committee on which the various parties are represented, following the guidelines laid down by the Department of Health and Social Security (for details of this guidance, see Section 3(c) below).

Some sort of house committee may be needed where more than one practice occupies group practice premises.

Practice meetings

Practice meetings are meetings of the doctors in one practice. They may also include the practice manager or senior secretary. Some practices with only a few doctors may not have formal practice meetings, but just informal chats to sort out decisions. In group practice premises with only one practice working there, the practice meeting can in effect be the 'house committee' for these premises.

Other procedures

Apart from formal procedures for decision making, embodied in the health centre or practice committees, many decisions may be made without reference to these kinds of committees. This particularly applies to day-to-day matters and, there may often be liaison between the health department and the centres, at more than one level on each side. In other words about two or even three people in the departments might liaise with various groups (doctors, reception, administrator, nursing) in the health centre. We are here talking about communications concerned with administrative matters, and not professional matters, as may occur between nursing staff at various levels, and other professionals and their supervisors (dentists, chiropodists, speech therapists and so on). The situation is further complicated where there is a divisional structure in the local authority.

Decisions may be made about the health centre, without going through, or being agreed to by the house committee. This is for two reasons, firstly because the house committee does not as a rule have the authority to make final decisions, especially if any expenditure is involved, and secondly because it does not meet frequently enough to deal with any matters which require an immediate decision. This applies when discussing health centres, as when a group, or number of practices, jointly share premises, they can decide quickly on a common policy with little reference to outside bodies. The local authority would only have been referred to if, say, more community nursing staff were requested.

v. Case studies of centres

Introduction

In this section we describe the administration of five centres - four health centres and one group practice centre - in order to show the differences between them in styles of administration, although basically they all provide the same kinds of health care. We do not go into great

detail about each task but intend rather to give a general impression. Each centre described is a real centre, selected to illustrate a 'style' of administration, and not a hypothetical situation thought up by us.

All the health centres are comparatively recently opened, as none had been in operation more than four years when we visited them. By contrast the group practice premises opened in 1959.

CENTRE A

General

This health centre, in a country town and adjacent to the general practitioner hospital was built by the County Council to house a partnership of eight general practitioners, a local authority dental unit, child guidance and other local authority services.

Local authority policy on administration

This county had a policy which was quite different to what we found elsewhere. All health centres in this county (and there were ten open at this time) were run by the general practitioners. The doctors employed and paid either practice managers or senior receptionists to attend to administration, and the health department had no say in the person selected. Moreover all practice staff were employed by the doctors. A few office staff employed by the local authority worked in the centres, mainly with dental clinics, but generally speaking practice employed staff provided clerical services, including manning the telephone switchboard and doing some typing for the nurses. The county actually paid for half of the running costs of the centre, although their room usage was only 40%. This was in exchange for staff employed by the general practitioners doing local authority office work, and the arrangement was written into the contract.

Although a health centre committee was provided for in the contract between the Executive Council and the local authority, as a result of the county's general policy the committee for Centre A (which would have included local authority personnel as well as the doctors) did not in fact meet. County personnel had not intended to convene the committee, and only expected to attend in exceptional circumstances if it were convened.

The manager

The doctors in Centre A employed a practice manager, a retired army officer who had subsequently worked in the Ministry of Defence, and whose salary was entirely paid for by the general practitioners. There was also

a 'supervisor', a woman who had been a telephone supervisor in the Civil Service, and who was in effect the manager's deputy. She could deal with all the work except the doctors' finances, which the manager himself saw to. Although employed by the doctors and dealing with or supervising the practice administration, the manager had responsibilities also on behalf of the local authority.

On the practice side, he supervised directly (or indirectly through his deputy) routine matters, made appointments of office staff, and of cleaning staff (who were half paid for by the county), was present at practice meetings (as distinct from the centre committee) doing agenda and minutes and at the interviews for a new partner in the practice. He dealt with all practice finances as mentioned above, and worked out all duty rotas for doctors.

For the local authority he principally saw to the maintenance of the building, getting any small jobs done locally using county money up to £10. However in this centre the dental unit had its own separate cleaner, and looked after its own maintenance.

He had control of the allocation of rooms between users, and had to record for the local authority the relative annual usage of rooms between the general practitioners and the local authority.

Decision making

The health centre committee did not meet at all and regular meetings were not required.[1] There was a weekly practice meeting for all the doctors and the manager. Most liaison with the health department was through the manager or the doctors.

Comments

The county policy of letting the doctors in effect run health centres, seemed in this centre to have certain effects. There was no institutionalised means (such as would be provided by a health centre committee) for centre users other than the doctors to have their views represented. Presumably these users would have to either influence the practice informally, or refer matters to their superiors in their respective hierarchies in the health department, such as nursing officers.

The dental unit operated quite separately from the centre, and it is perhaps significant that this 'separatist' tendency was being reinforced by an extension being built at the time of our visit. The doctors were to

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[1] by any contract

have their own common room and library on the first floor, apart from the rest of the centre. Another common room is to be provided for office staff, and the manager anticipated that the nurses would have coffee in their own offices. He felt that this was what all concerned really wanted.

CENTRE B

General

Like Centre A, this health centre was also in a country town, next to the general practitioner hospital, and provided accommodation for eight general practitioners (in three practices), child guidance, dental and other usual local authority clinics.

Local authority policy on administration

Centre B was in a county which had built a number of health centres over a period of ten years. An attempt at having a manager in an early centre had not been successful, but after some years and with more centres being built, the pattern of having managers in centres was established. A few centres had no manager, and were usually run, in collaboration with health department staff, by a senior receptionist employed by the general practitioners. More than half of the centres had managers, appointed at AP 4/5 level, employed by the local authority but with 75% of their salaries paid by the general practitioners. Although the health department took a keen interest in the running of centres, even the medical officer of health and senior officers requiring minutes of all health centre meetings, there was at the same time a conscious attempt to delegate to the managers more powers than other authorities we visited. Managers could employ local contractors to do jobs costing up to £50 (within the estimates), they selected reception staff, employed by the local authority, locally and the arrangement had recently been started of managers preparing annual estimates for their centres, which would then be discussed with health department officers.

The county had developed a standard job description for its managers, and a staffing structure for office staff, normally employed by the local authority, which was adapted to the different centres. A telephonist and typists worked for the centre as a whole, and 'teams' of receptionists each headed by a senior secretary, worked for the practices. Each 'team' catered for about four doctors, but was flexible if necessary.

Managers were allowed by the health department to undertake as much work for the practices as the doctors wanted, so this varied between centres.

Health centre committees, for which the managers prepared agendas and did minutes, were encouraged to meet and take decisions about the centre, although as centres settled down after opening, meetings became less frequent.

The manager

The manager of Centre B was a retired army officer formerly in the R.E.M.E., and in conformity with the general pattern in this county, was employed by the local authority, with the general practitioners paying 75% of his salary. The office staff were all employed by the local authority too (which the county always encouraged the doctors to agree to) so in effect the manager was their superior in the office hierarchy. He was responsible for the running of the appointment and filing systems of the practices, although in effect the two senior secretaries directly supervised this. These two also did most of the routine financial work for the practices, but the manager did a certain amount of this for one practice, and there was discussion in progress about whether he might do their accounts.

In general he was responsible for all the activities listed under 'General administration' in the proforma, delegating where applicable to the senior secretaries or the caretakers. He was the secretary to the health centre committee, preparing agendas and minutes. He could, as mentioned above under 'Local authority policy' spend up to £50 on maintenance, without referring to the health department. Advertising, interviewing and selection of reception staff were done by the manager, together at the selection stage with the senior secretaries and a general practitioner. Details of candidates were sent to the health department, but the appointment, although the persons were employed by the local authority, was made locally at the health centre. This system saved considerable time in replacing staff, who were often needed quickly. Cleaners likewise were appointed by the manager, acting with the caretaker.

Decision making

There was a health centre committee, which met at about three monthly intervals, The usual attenders were the general practitioners, a nursing officer, the manager, and a health department officer. The manager aimed

to sort out problems without resort to the committee, and felt it was better if conflict did not come out into the open too much.

No practice meetings were held,the doctors discussed matters informally among themselves.

Comments

This is a centre of interest because it represents an attempt by a health department to give more autonomy to the health centre than was often the case in other authorities. This delegation only applied in centres which had managers. Other centres, where the senior receptionist or secretary of the practice saw to day-to-day running, had far less autonomy, and were visited regularly by a health department officer. In a large county however, a degree of 'devolution' to the centres with managers, saved health department staff time in travelling, and also time spent on administration (which was needed for maintenance or appointing staff) as well as enabling the health centres to get things done more speedily.

CENTRE C

General

This centre in a busy port, housed the social services area offices and the child guidance clinic, as well as the usual general medical and local authority health services. The Family Planning Association and Marriage Guidance Council also rented rooms for sessions. Altogether about 150 staff were either based at the centre or held occasional sessions there, and shortage of space was becoming a problem.

There were nine family doctors based at the centre, housed on both floors of the two storey building. The county health department employed an administrator for the health centre, whose main concern was with the health services side, although he also had duties for the building as a whole.

Local authority policy on administration

The centre we visited was the second the county had built, and there were only two others in operation at that time, so that there had not been a long tradition established about administration of centres. However two of the centres had administrators, and it was planned that future centres would have them too. The health department preferred to have the reception staff employed by the local authority. Administrators were paid

for 'half and half' by local authority and general practitioners, and if the general practitioners wanted him to do any practice work it was understood that they would have to pay more. The health department seemed to regard the administrators as keeping well out of the practice side of things. Administrators were on AP 2/3, and the county realised that the positions were not career posts, so that someone older would, if appointed, be likely to stay for several years.

Health centre committees were instituted on the guide lines laid down by the Department of Health and Social Security,[1] and representatives of the Medical Officer of Health attended.

The administrator

The administrator had been in the R.A.F. for 25 years, including work as a medical clerk, and had then gone into local government administration. There was also a clerical officer (female) who was his assistant. The reception staff although employed by the local authority, worked in practice teams supervised by the senior receptionists.

The administrator had duties mainly in relation to the health services in the centre, and some for the centre as a whole. On the health services side he was responsible for tasks listed under '1. General administration' except that the practice teams were left to themselves, and the clerical officer also could be delegated to in routine matters. Finance consisted only in taking care of the petty cash account, the limit on expenditure per item being £3. Practice administration and finance were supervised by the senior receptionists for each practice. As the office staff were all employed by the local authority, the administrator was involved. He could advertise for office and clerical staff, and appoint cleaners, telephonists and his own clerical assistant. However reception staff working for the practices were chosen in effect by the general practitioners, with a local authority officer, the administrator and appropriate senior receptionist being present. Claims for relief work and overtime had to be approved by the county. The administrator saw to the maintenance of equipment in the health services section, and of the building as a whole.

He also was secretary to the two committees concerned with running the centre, which are discussed below.

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[1] "Check lists of points to be covered in Agreements between Executive Councils and general practitioners practising in health centres", enclosed with ECL 100/72 and LHAL 41/72

Decision making

This centre had both the social service department and the child guidance clinic based in the same building, as well as a wide range of health services. Two committees had been established to cater for this situation. One, known as the management committee, comprised (besides the administrator), the general practitioners, an executive council representative, and local authority administrative representatives. This committee, as its composition suggests, was primarily concerned with relationships between the local authority, executive council and the doctors, and the general medical services provided.

Another committee, known as the house committee comprised (again as well as the administrator), representatives from the social service department, dentists, child guidance and nurses. The general practitioners were entitled to come also, but had opted out. Whenever the committees met the local authority representative made a point of taking the opportunity to discuss matters with the administrator.

Comments

The health department in this county took an interest in the administration of the centre, and also kept (compared to the centres discussed above) a firm control on what the administrator could do, although the centre was about 42 miles from the department, and there would therefore be some argument for delegation (e.g. over maintenance and appointment of receptionists). The family practices seemed to be fairly self contained, not involving the administrator and his assistant in much work. The administrator himself was making efforts to integrate the various elements working in the centre. He had arranged lunch time meetings between the doctors and members of the social services department, and he was trying to start a sports/social club and social committee.

CENTRE D

General

This centre, in an urban area, a large county borough, was unusual in its size and setting. It housed 21 doctors in seven practices and was at third floor level at the top of a new shopping complex, which clearly presents problems not encountered in the centres described so far. Patients had to enter the centre either by lifts from the ground floor, or by a staircase from the car park on the floor below the centre. A reception

area, with a receptionist employed by the local authority, was provided at the ground floor level, to direct patients and enable them to make appointments by telephoning the receptionists upstairs without having to go up into the centre itself. The seven practices were arranged in seven separate suites, each with its own waiting area and reception, to avoid confusion and preserve practice identity with such a large number of doctors.

Local authority policy on administration

The medical officer of health in the borough was enthusiastic about developing health centres, there were already six centres in operation by the time Centre D opened, and there was a policy of having administrators. Health centres were encouraged to be autonomous in day-to-day running, by having both administrators and active committees.

If doctors wished to continue employing their office staff, the health department had no objections, although administrators were employed and paid for entirely by the local authority. Administrators in this local authority were paid at AP 5 or SO 1 level.

This authority was in our experience unusual in its approach to health centre management committees. Not only were these encouraged by the health department, there was also a detailed constitution, setting out membership, procedures for selection of members and procedures for reaching decisions. At ordinary meetings of the committee, agreement had to be by consensus, so that a majority faction could not dominate decisions. (Majority decisions were allowed at annual general meetings at the chairman's discretion.)

The administrator

As mentioned above, the administrator of Centre D was employed and paid for by the local authority. He had been the administrator of another health centre before this. He undertook the kinds of tasks included in 'General administration and 'General finance', with the help of a senior clerk. 'Practice administration and finance' were undertaken within the practices, as the general practitioners still employ their own staff, and have not involved the administrator. This also affected personnel work, as general practitioner office staff, similarly, were dealt with entirely within the practices. The administrator selected cleaning staff and dealt with relief arrangements and overtime for local authority nursing staff and the two office staff employed by the local authority, who helped him and provide a central directing service for patients. He saw to maintenance of the building and local authority equipment, and supplies from the local

authority, but the practice looked after their own equipment and supplies.

He also was a member of the management committee, to which he was responsible.

Decision making

As discussed earlier (under local authority policy on administration) there was a health centre management committee, with a constitution. In the case of Centre D, the membership is of interest, in that a representative of each practice (not every general practitioner) was included. This means that the general practitioners as a group, could not 'swamp' the committee entirely, although by this arrangement they make up half of it. The three nursing representatives have to be chosen from those working in the centre, and there was also a representative of the receptionists. These stipulations ensure a predominance of those actually working in the centre, rather than having senior officers who may be based elsewhere, and demonstrate a more 'grass-roots' approach to health centre committees.

Comments

We included this centre for two main reasons. Firstly it shows one way of running a centre catering for a large population, housing several practices and unusually sited. The problems which could arise here, especially for the patient, have been tackled by maintaining practice identity in the design of the building as well as the organisation, and by providing extra 'central' reception staff, not in the practices.

Secondly this centre represents another variation (compare Centre B) in delegation to the centre from the local authority. The committee structure is intended to foster the participation of all workers in the centre in making decisions affecting it, and the administrator is seen as responsible first to that committee, rather than to the local authority.

CENTRE E

General

This centre, opened in 1959, was a group practice centre (i.e. not a Section 21 centre), housing two partnerships, each with four general practitioners, and also providing some accommodation for local authority services, including chiropody, ante-natal clinics and health visitors. It was sited in a country town, and there was a general practitioner hospital on the outskirts of the town, with which the doctors were associated.

Administration

In effect the administrative activities were divided between three people - the senior partner of one practice, the senior receptionist, and her deputy. (The reception staff were employed by the practices jointly.) This division was the result of personality and ad hoc arrangements rather than of planning and job descriptions, and in this was unlike that encountered in many health centres. For instance the senior partner concerned was keenly interested in administration, and the other doctors let him manage the centre. There were no job descriptions to adhere to (unlike administrators in health centres, and some practice managers) so administration was flexible.

The senior partner took final responsibility for 'General administration' activities, but in effect nearly all were carried out by the senior receptionist and her deputy. Similarly, the senior receptionists dealt with the finances of the practice, including the locum salaries of one practice, and the controlling of staff hours.

Personnel work was divided. The senior partner was responsible for selecting reception and secretarial staff (interviewing with the senior receptionist). The senior receptionist was responsible for selecting caretaking and cleaning staff. The supervision, training and salaries of all these staff, both office and cleaning staff, were dealt with by the senior receptionist.

Supplies were ordered by the senior receptionist, except that the senior partner ordered equipment. However the senior receptionist took the initiative over getting maintenance and repair jobs done.

Decision making

The centre committee comprised the eight doctors (in the two partnerships) and the senior receptionist, who took the minutes. The same senior partner prepared the agenda.

Comments

This group practice centre shows several of the features which are common to traditional general practice. The staffing structure and roles were not formally set out, by being written down. The senior receptionist here, although not designated as such, performed the kinds of activities which were carried out by practice managers in other groups, and was the key administrative person. Who occupied the roles, and what they made of them, was apparently a matter of individual personality, so that with a

change of personnel could come about considerable changes in who carried out various tasks. The ultimate authority was located within the centre (unlike health centres) for it consists of the doctors, meeting corporately. This is a straight forward situation, compared to the complexities of health centre committees, but does mean that the staff in the centre, and other users (in this case some local authority staff) had no rightful place in the decision making body.

v. Some other variations found of special interest

Inevitably in setting out the case studies above, we have excluded features found in other centres and local authority areas known to us. It would not be practicable to go through all these one by one, so at this point we select some features which we consider of special interest.

Local authority policies on administration

As already stated, we have concentrated on health centres with administrators. However some centres were run by local authority officers based in the health department, in liaison with clinic clerks or senior secretaries in the health centre. The officers visited the centre regularly, more often than they would a centre with an administrator, and retained powers (such as appointing local authority receptionists and authorising any expenditure beyond petty cash) which might be delegated where there was an administrator. This system would most obviously make sense in densely populated urban areas, such as are found in the London boroughs, because the travelling distances are relatively short. It was used also in counties in small centres, but at least one county known to us had this policy for all its centres, regardless of size and complexity. The argument for this was that administrative skills were best concentrated in the health department, and officers will visit centres and apply their expertise, as opposed to having less skilled administration at health centre level. This way, it was argued, standards of administration overall will be higher, and varied experience brought together.

In other authorities we visited, there was no rigid policy on this matter, smaller centres (especially if they only had one practice) tended to have no administrative person higher than a senior secretary, whereas larger (in terms of number of doctors) or more complex (in terms of variety of services) centres would have administrators.

Another policy which has been adopted in some local authorities (which we know of although we have not visited centres with the system) was to

designate a nurse or health visitor as part time administrator.[1] By this means the problem of finding enough work to keep a full time administrator going was overcome (this of course also applies in the case of a secretary or receptionist who undertakes the administration). This system also satisfies those who maintain that the administrator needs some nursing knowledge. However this type of arrangement was being phased out at the time of this study, and nurses being deployed in accordance with the Mayston Report[2] recommendations.

Local authorities were aware of the problem of career structure for administrators. Clearly if the policy is to only have secretary or receptionist level personnel in the centre, in liaison with local authority officers, this problem is not acute. But if an administrator of good calibre is employed, he or she could before long become bored and not able to find enough to do, once the centre had settled down and was running smoothly. One authority felt that by employing an older person they would find someone prepared to stay at least a few years before moving. And there was a more general view that because the administrator was employed by the local authority (although his salary was partly paid for by the doctors) he could be transferred into the health department. This had in fact happened in one of the counties visited.

Administrators

All the administrators in the health centre 'case studies' happened to be male, but we also met female administrators who in effect, carried out the same job, except that, taken overall, the women were on lower salary scales than the men administrators.

Some of the authorities we visited gave us job descriptions for the administrators in their health centres. These descriptions are fairly specific about the duties required, but are not clear on the 'working relationships', to use a term given in the specimen job descriptions of the 'Grey Book'.[3]

The duties of administrators were principally seen as those of responsibility for maintenance, supervision of office and cleaning staff and help in their selection, supervision of records and statistics,

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[1] See section 3(a)

[2] D.H.S.S. 1969

[3] Management arrangements for the Reorganised National Health Service (1972) H.M.S.O.

ordering supplies and undertaking the agendas and minutes of health centre committees. The precise limits on expenditure, were not spelt out in the job descriptions, although other matters may be dealt with in some detail.

However the job descriptions tend to be much less clear on the 'working relationships'. Thus it may not be clear to whom the administrator is accountable, whom he manages or has operational control over, monitors or coordinates, and if he has full membership of any committees.

Decision making

The only committee other than health centre management committee and practice meetings that we found, was an office staff meeting, held about two or three times a year in one health centre. This was attended by all the office staff, who were employed by the general practitioners, the administrator (employed by the local authority) and general practitioner representatives. Full minutes were kept, and any problem arising from reception and office routines were discussed. One group practice working in private premises held a similar meeting.

Many of the matters discussed in health centre committees were 'domestic' in character,for instance cleaning standards, decoration and alterations to the building, disposing of syringes and usage of rooms. Equipment, too, came up, the provision of radio telephones for doctors' cars, new medical equipment, and the possibility of a public telephone for the use of patients, requested by a local consumer group (and rejected). Some committees went further than this, and discussed innovations, such as screening clinics, and transport to the centre for the elderly and handicapped. One administrator commented that his house committee was simply a 'progress chaser' for maintenance and alterations. He felt that the function of the committee should be to decide policy on the centre, and act as a means of communication between the local authority and the general practitioners. Another administrator, on the other hand, thought that the longer intervals between meetings at his centre (held 3 monthly) showed that problems were being resolved without the committee. He felt that this was a good sign, and that meetings could bring into the open conflicts which were best resolved informally.

Group practices

In Case Study E, we described a group practice centre for two practices, where the management was in the hands of an interested general practitioner, and two senior office staff. Other groups we visited had more formal

arrangements than this. They had a person, male or female, designated as a practice manager, with quite detailed job descriptions (rather like health centre administrators). Thus the manager's role in these was more clearly defined than in our Case Study E.

In all cases, the manager played a part in the financial aspects of the practice, especially the payment of staff, which would not usually be a part of a health centre administrators work.

(c) Management guidance from the Department of Health and Social Security

In the 1946 National Health Service Act, Section 21, it was set out that the duty of the local authority was to 'provide, equip and maintain' health centres. A number of circulars relating to health centres have been issued. (For a list of these up until 1972 inclusive, see Baker and Bevan 1973, and for 1973, see Baker, Bevan and Harvey 1975).

There has been little official guidance in these circulars about the running of health centres. Most of them have been concerned with the financial arrangements in the contracts between general practitioners and the Executive Council, and the Executive Council and the local authority, and with planning and design.

The Health Centre Design Guide (1970), currently being revised, makes some mention of administration. It emphasises the need for consultation in the planning stage between family doctors and local health authority officers (para 2.6, 2.7). The only reference to decision making procedures is in para 2.24, where it states:

> "Although it is outside the scope of this Guide, attention is drawn to the need for the family doctors and the Medical Officer of Health to establish consultative machinery, e.g. a Medical Staff Committee, to consider day to day matters and discuss policy and so ensure the smooth running of the centre."

The possibility of having an administrator is also mentioned, in para 4.20:

> "In very large health centres an additional office ..... may be required for an administrator or superintendent."

It is not made clear what is meant by 'very large health centres', but in the introductory notes to the Sketch Plans in the Design Guide (para 7.1) 'large' centres are those with more than seven consulting suites.

Some more detail of the Department's views on medical staff committees is to be found in the 'Check list of Points to be covered in Agreements between Executive Councils and General Practitioners practising in health centres', which was enclosed with E.C.L. 100/72 and L.H.A.L. 41/72. Clause 9 is as follows:

> "(a) There shall be a Medical Staff Committee including every Practitioner practising as a principal from the Health Centre and the Medical Officer of Health for the County/Borough of or his representative.

(b) The Committee may make recommendations to the County/Borough Council to the Executive Council or to the Practitioners with regard to the management of the Health Centre and in particular on the subjects of :-

The alteration of the sum payable under Clause 3

The decoration of the Health Centre (Clause 4(v))

The staff to be provided for the management of the Health Centre (Clause 4 xi xiv xv)

The rules to be made by the County/Borough Council for the management of the Health Centre or the Control of the staff (Clause 6(v)). "

Taking first the membership of the committee, the clause mentions only every principal practising from the health centre, and the Medical Officer of Health or his representative. In the Explanatory note F.16 to the Agreement, it is added 'in some centres it might be considered helpful to have the advice of the Clerk of the Executive Council'. The notes suggest inviting him to be a member, an observer, or to attend particular meetings. Also in note F.16 the following appears - 'Consideration might be given to using this Committee as a means of liaison with other professionals using the Health Centre.' It is not clear what 'liaison' means here, unless it is the types of arrangement suggested for the Executive Council clerk (i.e. membership, observership or occasional attendance). A potentially much wider membership of the committee is implied here, although it is, again, not clear where the lines are to be drawn. Do 'the other professionals using the Health Centre' include itinerant workers (chiropodists, speech therapists, etc) or only those based at the centre, such as community nursing staff?

Looking at the powers of the committee, as referred to in Clause 9, these are to make 'recommendations to the County/Borough Council to the Executive Council or to the Practitioner'. The clause goes on to outline the areas (management, staff, decoration, sums payable by general practitioners) which the committee is to consider in particular. However in Clause 6 (v) it is stated that the practitioners shall -

"comply with any rules made by the County/Borough Council after consultation with the Medical Staff Committee for the management of the Health Centre or the control of the staff."

which suggests, in this sphere, that the health department has more authority than the doctors.

A further point which touches the practitioners interests, is dealt with in the notes to the Agreement (H.19), and concerns the 'Succession to

Practice' of a doctor in a health centre, where the vacancy does not arise in a partnership or group -

"Succession to practice

The Medical Practices Committee have said that they consider it desirable, when candidates are being interviewed for possible appointment to a vacancy at a Health Centre, that every doctor practising in the Health Centre should have the opportunity of being represented during the interviews in an advisory capacity. They say that it is always a matter to which an Executive Council should give weight, that the doctor to be appointed should be acceptable to the others. They stress however, that the function of the representatives of the remaining doctors would be strictly advisory and that any recommendation made to them (the Medical Practices Committee) by an Executive Council must be that of the Executive Council and of no one else."

This is a matter between the doctors and the Executive Council, and does not bring in the local authority.

4. DISCUSSION

In this section we present a number of provisional conclusions. The exploratory nature of the study means that our findings at this stage are inevitably supported by limited data. We put these forward as hypotheses to be further explored in the next phase of this project.

(a) Levels of administration

In each health centre or group practice three levels of work can be identified. (It may be possible to distinguish more levels, but not less.) These levels can be identified as follows :-

i. Basic, routine administration

Under this heading are included such tasks as transferring National Health Service records, making appointments for patients, sorting mail and filling in claim forms to the Executive Council. These tasks are straightforward, although they have to be done meticulously and continuously.

ii. Supervision of office staff and systems

Supervision of the staff carrying out the tasks included in (i) above, and of the systems involved, such as the records and files kept, is necessary. By this means the routine administration should be maintained to the required standard and queries or conflicts arising dealt with.

iii. Higher administration

This area of administration is more difficult to define, it includes tasks which, in a more traditional setting (such as a practice with no practice manager, or a health centre in which the practice secretary liaises with the health department officer) would be carried out by a 'senior' person such as a doctor or health department officer. These tasks involve more discretionary decisions (for instance the allocation of room space between personnel), and to be successfully carried out need a degree of respect and confidence from the 'professionals'. Together with responsibility (for instance the security of the building, or of drugs) the person allocated these tasks needs to take on communication and co-ordination between the various parties, especially the'professionals', involved. Under this heading also is included the general task of innovation.

(b) Factors which increase the amount of higher administration

There are a number of ways in which the amount of 'higher administration' needed in a centre may be increased, and these complicating factors are listed below.

i. Number of personnel in centre

The more personnel working in the health centre or group practice, the greater the possibility of misunderstanding through poor communication, and the more potential problems in organising office staff, other common services and facilities.

ii. Variety of services

Particularly in health centres, there may be in addition to the usual general practitioner and community nursing services, other services such as child guidance, speech therapy, outpatient sessions and sessions by non National Health Service bodies like the Family Planning Association provided. This complicates liaison and co-ordination of support services.

iii. Multiple usage of accommodation

Again, a situation most likely in health centres, is that where rooms have to be shared between professional staff. This is liable to happen especially when occasional sessions (outpatient, chiropody, speech therapy etc) are held in the centre, with the consequent problems of time tabling and preparing rooms appropriately.

iv. Number of general practitioner practices

More than one practice may operate from a health centre or group practice premises, which means that any serious differences between them have to be resolved, for instance if they share the office staff and space, they need to agree on the record system used.

v. Number of patients

Apart from the amount of routine administration (records, claim forms and so on) which large numbers of patients create, the management of their reception and direction presents greater problems as their numbers increase - especially in crises.

vi. Suitability of accommodation

If the accommodation is inadequate, if rooms are in short supply, or the building not well designed for its purpose, administration is made more difficult.

vii. Amount of decision making and innovation

Certain circumstances, such as the commissioning of a new centre, an extension to a present centre, or substantial innovations (the introduction

of a new clinic) increase the higher administration needed, as many decisions have to be taken with consequent consultation and communication.

(c) The differences between health centres and group practice premises

There are several clear differences between health centres and group practice premises, which affect the administration needed in each.

i. Autonomy of group practice

As the group practice is autonomous, all decisions are taken within it, ultimately by the doctors of the practice (or practices). This avoids the complications of having office staff in the centre employed by an outside body, the local authority, as often happens in health centres, and means that all equipment, supplies and maintenance are decided upon internally, again without reference to an outside authority. Apart from this being a more straightforward arrangement, it also is likely that the doctors will be the sole decision makers, and that any inclusion of other staff in their decisions is by courtesy only. This is unlike a health centre, where other factions have at least a formal right on the health centre committee to take part in decisions.

Another aspect of this autonomy is that all financial work has to be carried out within the practice (or practices) involved. This gives independence in purchasing policy and staff rates of pay, but does entail a considerable amount of work,especially that which in a health centre (particularly where office staff are employed by the local authority) would be undertaken outside the centre. Apart from the sheer amount of work involved, anyone undertaking administration in group practice premises needs to be able to deal with the financial aspects of the practice, which is not necessarily a requirement of his health centre counterpart.

ii. Less variety of services

Group practices primarily provide family doctor serviees, community nursing staff often having use of the premises as well. They may provide room for other staff, such as social workers, but usually do not compare with the health centre which may have a wide variety of services, including dental clinics, child guidance, chiropody and speech therapy as well as the usual infant welfare and ante natal clinics. Where group practice premises are linked to health authority premises, in the form of 'conjoint clinics' then again the situation is sometimes more comparable to that found in many health centres.

iii. Number of practices in group practice premises

Where a single group operates from group practice premises, the organisation is that much more straightforward. However where more than one practice is housed in such premises, the organisation becomes more like that in a health centre, as 'central' or 'general' administration has to be separated out from purely practice administration. Even so it is only the doctors who are really involved.

(d) Levels of administrator necessary

Depending on their size and complexity, centres need different types of administrative arrangement. In this section we have adopted a classification into three types of centre: small, medium and large.

Small centres

In small centres (up to four doctors inclusive) someone will need to carry out supervision of office routines, and liaise (if in a health centre) when necessary with staff at 'headquarters' over maintenance, supplies etc. As this job is not in itself full time, a suitable person for it is a senior secretary or receptionist. This is a better solution than having a part time 'administrator', who will only be in the centre half the time, whereas a 'combination' person will be around the centre full time and is therefore on hand to deal with administration problems if they arise. Because of the long opening hours of centres, someone will also need to deputise for this administrative person.

Medium size centres

For centres with about five to eight general practitioners a 'supervisor' (probably a secretary or clerk by training) is needed, to undertake supervision as in small centres, but also more of the 'higher administration' level work. Such a person might well undertake some clerical or secretarial work as well (e.g. committee minutes, handouts to staff and patients) but this would not be a large element of his job. In this size centre, the complexity of the centre, rather than the actual number of general practitioners, will determine the type of supervisor needed. A health centre with this number of doctors could well have additional services, above the family practitioner and usual clinics available, or there could be more than one practice operating there.

Large or complex centres

For large (nine or more doctors) centres, or centres with a wide variety of services based in them, a full time administrator is needed, with the background, salary and status to enable him to successfully handle the 'higher administration' which the post necessarily involves.

A deputy to the administrator (e.g. a senior secretary) will be necessary, not only to carry out supervisory and clerical tasks, and to cover for times when the administrator is not in the centre, particularly since centres are open for long hours, but to act as a personal assistant.

(e) Location of administrators

Health centres

As implied above, someone must be in the centre to carry out the 'irreducible minimum' of administration, the supervision of routine tasks, and the liaison with 'headquarters' staff. The 'higher administration' level can (since decisions here are not usually urgent) be retained by administrative officers at 'headquarters'. This is the system advocated by Saunders (1972) for all centres.

Alternatively, much 'higher administration' can be delegated from headquarters to the health centre, to an administrator there. In this way, there is the advantage of having someone 'on the spot', particularly if there is some distance to travel between the health centre and headquarters.

Administrators in health centres must be able to refer back to headquarters for advice (e.g. over finance, supplies, personnel problems) so that there needs to be someone able to handle these questions at headquarters, who has sufficient seniority to deal authoritatively with general practitioners and the administrator.

Group practice premises

Here the situation is straightforward, as all levels of administrative staff are employees of doctors in the centre, although advice and information may be sought from sources outside the centre, from publications, courses and conferences or persons involved in practice administration.

(f) Selection of administrators

From the literature available (mainly articles about how individual centres are run) as well as from our visits, we gained some idea of the variety of backgrounds from which 'administrators' are drawn. These include

senior receptionists and secretaries, nurses and health visitors, clerks and retired personnel from the armed forces.

There has been some debate in the literature as to who should become an administrator. The pros and cons of the alternatives available are discussed by Reedy and Nelson (1974), who are preoccupied, like most writers on the subject, with the question as to whether a nursing training or work in a 'medical' environment are needed. They take up the suggestion made by Tate (1971) and Deacon (1973) that a senior nurse could liaise with a 'lay' administrator. The Association of Medical Secretaries, which has produced a report on the training needs of practice administrators sees the trained medical secretary as having the right background for the job. In the Editorial of 'The Medical Secretary' (1973 No. 3) it is stated "Intake from outside might well result in wastage because general practice administration might not prove congenial", and "Economically speaking, medical secretaries are half way there". (This is a reference to the expense of providing a course for one's secretary, which the Editorial says would be greater for those recruited from outside general practice.) However Cammock (1973) points out that whoever is given the post of supervising non clinical staff brings into that role the objectives and attitudes of their former roles. In particular she was concerned with the difference in outlook between the nursing sister (with a local authority clinic tradition of management) and the secretary (in the general practice tradition). In the case of the secretary, trained to control patient demand, the centre staff were under much less stress (see Section 3(a)).

Given that administrators from non medical environments appear to hold their posts successfully, the debate as to whether such people should be appointed is perhaps superfluous. It is more helpful to look at the background of the administrator in relation to the type of centre he or she will be in.

In Section (d) above, it was suggested that a senior secretary is an appropriate choice for administrator in small or medium centres if not too complex. This allows for a 'part time' administrator, who is nevertheless working full time in the centre. Obviously if this kind of appointment is made, the person needs to have the requisite skills (secretarial or reception) to do the 'non administrative' part of her job.

Where a full time administrator is needed, there comes the debate as to whether the person selected could come from the health services field. From our visits and literature review, this would not seem to be necessary.

It is perhaps even less necessary for those administering very large or complex centres, for the tasks involved are more at a 'higher administration' level. If the administrator has a deputy (secretarial or clerical) there might be some argument for them to come from a health services background, if they are closely involved in routine administration.

The need for a different type of administrator for more complex centres has been recognised. The British Medical Association report on Primary Medical Care (1970) notes :-

> "We have seen that in some health centres and group practices these duties are admirably carried out by a senior nurse or competent secretary. However as larger units comprising possibly two, three or four clinical teams emerge, as we think they may, there will be a place for a lay administrator."

And also :-

> "In some centres the complexity of the day to day non medical organisation will necessitate the appointment of an office manager who may or may not have a medical or nursing background."

Here it is clear that a background in the health service field is not thought essential for this kind of post.

The Report on the Organisation of Group Practice (1971), generally known as the Harvard Davis Report, recommended that :-

> "the functions of practice manager should be a part time function of the senior receptionist with a group practice, but in multiple group practices and in health centres accommodating more than one group practice, we think there should be a separate post of practice manager, ... We think that it would be advantageous if such a person had trained and served as a receptionist in group practice and if the post is seen as the senior appointment in the secretarial service."

Seelig and Rooke (1971) in their report on visits to health centres opened in 1968, state :-

> "The appointment of an Administrative Officer in the larger centres was found to be helpful. This work does not seem appropriate to professional staff and although in some cases a health visitor undertook it she found it an arduous addition to her already full programme."

A distinction needs to be made also between health centres and group practice. Because the latter is financially self contained, the administrator there will need to be able to deal much more with finance than the average health centre administrator. Many group practice premises too, especially if only one practice operates there, would be able to be administered by a senior secretary. (This would also apply to small health centres.)

However, where there is more than one practice, the situation can be more complicated, and an outside appointment might be more acceptable. (Again, this situation is more like that found in many health centres.) The administrator in group practice premises is employed by the doctors, but in a health centre (unless the practice manager is allowed to undertake administration of the health centre as a whole, see Centre A Section 3(b)) the administrator is employed by the health authority, although the doctors are usually allowed a say in the matter. Different qualities may be emphasised by general practitioners than by the health authority, especially if the latter has established conventions for grading.

So far the question as to whether the administrator is male or female has not been discussed. When it is a secretary or nurse who has this role, not surprisingly they are female. However the ex-armed forces personnel we met on our visits were all men (although presumably there are women who have held similar posts). These full time posts, administering large centres, were not in existence until the last few years, so that there was no real opening in the field for men, since the 'senior secretary' type of person, inevitably female, looked after the administrative tasks in her practice.

In the Editorial of the Medical Secretary (1972) No. 20, a strong view is taken on this change.

> "The trend towards the appointment of men as practice administrators is to be welcomed as long as it is an indication of growing equality between the sexes, but in the case of health centres it looks much more like the old civil service and local authority prejudices against women in charge."

(g) Training of administrators

Reedy and Nelson (1974 state "No specific training for practice managers exists on a regular basis" and mention attempts which have been made to set up such a course. The Association of Medical Secretaries in 1973 produced a report on a pilot course in Practice Administration. The Report, published in No. 25 of the Medical Secretary 1973, falls into two parts. The first part gives the results of a survey of practice administrators, aimed at finding out what skills they needed and the scope of their work. From this study a two week course was devised and put on, and the second part of the Report evaluates that course. A revised course is recommended on the basis of this evaluation. There have also been one, two or three day courses or conferences held, on administration in centres.

The Association for Medical Secretaries suggests (see Section (f) above) that the training given to medical secretaries is a good basis for further courses for 'administrators in large group practices'. However this basis is clearly more appropriate for administrator posts where the holder is closely involved with routine and supervisory administration. Where these levels of administration are not needed to any extent, such a background becomes less important, hence the successful recruitments of administrators from outside the health service field. The British Medical Association report on Primary Medical Care (1970) sees training as needed especially for lay administrators in large centres, not so much for secretaries or nurses administering small, relatively uncomplicated centres.

> "Sophisticated management requires appropriate training which might be similar to that of hospital administrators, and, if it is to attract suitable people, it must hold out the possibility of a career."

At present, training seems to be 'on-the-job', apart from any previous experience which the administrator had in the health services. The administrators we met, if employed by the local health authority, usually had spent a little time (one or two weeks) with the authority, learning about procedures and getting to know personnel with whom they would have to liaise. Some time also was spent in getting to know Executive Council procedures. What sort of training is needed, has to be thought about in relation to the kinds of posts administrators will fill. It is clear that certain administrative tasks, those we have called the routine and supervisory levels, are common to all centres. However where there is more 'higher administration' the administrator does not need to be nearly so familiar with these, as his role is rather different (see Section (f) above). This is not to suggest that there should be any lack of opportunity for say, secretaries, to proceed to becoming administrators of large centres.

(h) Career structures

The need for a career structure for administrators has been recognised. The British Medical Association Report on Primary Medical Care (1970), sees this as a need especially related to lay administrators in large primary medical care units, not so much for secretaries or nurses administering small centres. It can be argued that for say,a secretary, or receptionist, working one's way up to administering a centre is a 'career structure' in itself. However having reached that point, or having been established an administrator of a complex centre for some time, there is the question of where to go next.

As health centres in any number have only been built in the last few years, many administrators were appointed to a new centre, with all the work which that entailed. In the time immediately during and after a centre is opened, there is much work to be done, (organising the office systems, taking decisions on room usage, ordering equipment, holding meetings) which is not needed once the centre has 'settled down' and routines have been established. The same applies to group practice premises. So the job loses some of its challenge in time, apart from there being a limit to the number of complex health centres to which administrators can 'aspire'.

Local authorities we visited were aware of this potential problem, and approached it in two ways. One was to deliberately appoint administrators well on in their working life, or retired from the services and thus receiving a pension, so that they would probably stay in the job for some years. The other was to transfer the administrator into the health department, which of course was enabled by having administrators employed by the local authority. This latter solution would not be so easily available to administrators employed by doctors. (With the reorganisation of the National Health Service, a wide range of administrative posts have become available in the service. Some of these new posts could provide opportunities for health centre administrators.)

i. Decision making and committee systems

With the advent of group practices, particularly multiple group practices, and health centres, the process of decision making becomes more complicated. More parties are involved and, in the case of health centres where more than one practice is sharing premises, the independent parties have to come to agreement over many matters. At the same time there has been a trend towards deliberately involving persons in decisions, who do not have specific rights. Words such as 'democracy','consultations', 'participation' are used, together with an emphasis on'the team' in primary medical care. Thus we find that a representative of the reception staff is given a place on the health centre committee in some centres, although the original legal agreement regarding the use of the centre was one between the local authority and the Executive Council, the latter in their turn having had a contract with the general practitioners. The receptionist is simply an employee of the health authority or the general practitioners, and has no 'right' as such to participate in decision making.

Because of the numbers of people and interests now recognised as having a part to play in decision making, there has been a need to make

this more formal, by having appropriate committees. This is not to ignore the fact that many decisions, especially on a day-to-day basis, will be made informally by those who have the authority to do so.

The British Medical Association Planning Unit Report on Primary Medical Care was aware of these changes:-

> "The formation of primary medical care teams bringing together doctors, medically related workers and supporting secretarial staff will raise new problems in management. .... It will be particularly important to establish unambiguous methods of reaching decisions concerning the operation of the unit as a whole, and to ensure that those who work in the unit should have a clear indication of their responsibilities and their rights to participate in the decision making which is likely to affect these responsibilities.
>
> There is a need for some kind of formal committee procedure where minutes are carefully kept .... "

The Harvard Davis report on the organisation of group practices also emphasizes the necessity for meetings in group practice, and adds :-

> "In a multiple group practice or a large health centre there will also be a need for a centre committee on which all staff are represented."

Summing up these observations, three trends are evident. Firstly it is agreed that there is a need for a committee system to discuss and decide matters in centres, particularly large health centres and multiple group practices, because of the number of interests and individuals involved. Secondly it is felt desirable to make the system fairly formal, by for instance having a constitution and minutes of meetings kept. Thirdly it is felt that some right of representation in the committee system is owed to staff employed in the centre who do not have a 'tenant/landlord' position in relation to the centre (as do doctors or health authority representatives).

Again a distinction has to be made between health centres and group practices. The health centre is owned by an authority from which the Executive Council leased some accommodation for the family doctors in contract with the council, whereas group practice premises (which may be leased or owned by the doctors) are managed ultimately by the doctors alone. In the case of the health centre, there is a contract setting out the rights of the parties concerned, and, if it follows the guidelines laid down by the Department of Health and Social Security, of any health centre committee established (see Section 3(c)). In the case of the group practice premises, where more than one practice works there, some agreement may be needed between the practices, setting out their rights.

Mostly the role of health centre committees seems to be to 'recommend', rather than to 'decide' matters, and some interests, for instance doctors or health authority officers, might prefer them to stay that way if representatives are drawn from a much wider base than the contracting parties. However one authority at least (see Centre D Section 3(b)) had set up health centre committees which could take policy decisions, although decisions had to be by consensus. In its centres, all types of staff working there were represented, and administrators were held to be directly responsible to the committees.

Despite the provision that is made for health centre committees, there is a tendency for meetings to become much less frequent once the newly opened health centre is 'settled down'. This can be attributed to the decrease in the number of decisions needing to be taken, but also suggests that decisions are being taken without reference to the committee. Such committees are a relatively new feature in general practice and community health services, and staff may not be accustomed to referring matters to a committee.

Clearly there is room for variety in types of committees in health centres, as there is in types of administrator to be selected. In a small centre for instance, probably all the general practitioners can sit on the health centre committee, but in large centres, we find representatives of practices are members. In this latter context, a general meeting at some interval may be more necessary than in the small centre. Again where a committee has real autonomy the method of taking decisions becomes important. For example in Centre D the requirement that decisions be taken by consensus prevents a faction with a permanent majority from dictating policy.

The practice meeting is in effect the committee for running a group practice premises, if only one practice works there. If the premises house more than one practice, there is a need for a committee for the whole centre as well. In the group practice premises, the doctors have the ultimate authority, unlike the health centre where the health authority owns the building and has rights to use of the building and its facilities and employs many of the staff working there. In group practice premises therefore the doctors constitute the effective members of any committee in the premises. If others attend they do so in a secretarial capacity or as a courtesy, in the case of doctors' employees or attached staff. Sometimes we have found also in group practice centres a staff committee consisting of practice employees and representatives of the family doctors which have as their main objective communication rather than decision

making. Practice employees and attached staff are potentially in a weaker position at least formally than their health centre counterparts, although individual group practice centres may operate very 'democratically' because of their small size or the personalities of the people working there.

A suitably constituted centre committee can serve several important purposes. It is a tangible expression of a desire to integrate the services of the centre. This is at least as important psychologically as for practical reasons. In particular it enables reactions to ideas to be aired before decisions are taken. Moreover as time passes and individual doctors and other staff come and go it serves to maintain continuity and in its records can provide an orderly account of issues considered and decisions taken. To achieve these purposes committees need to be representative of interests in the centre, to have well defined functions and procedures, and to be adequately minuted.

APPENDIX I

HEALTH SERVICES RESEARCH UNIT, UNIVERSITY OF KENT AT CANTERBURY

MANAGEMENT OF HEALTH CENTRES AND GROUP PRACTICES STUDY

ADMINISTRATIVE ACTIVITIES PROFORMA

CENTRE	OWNED BY	INFORMATION FROM	DATE

1. GENERAL ADMINISTRATION

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegatic could be to
Allocation of rooms used by more than one authority (L.A.,G.P., etc.)			
Allocation of rooms used by one authority, where more than one person uses			
Distribution of incoming mail			
Sending of outgoing mail			
Organisation of internal post			
Organising filing and record systems e.g.treatment room, cleaners, fuel consumption, etc.			
Day-to-day maintenance of filing and record systems listed above			
Preparation of required L.A. statistics			
Preparation of other statistics, e.g.research, R.H.B.			

1. GENERAL ADMINISTRATION (CONTD.)

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Staff notices			
Public notices			
Press releases			
Circulars and handouts in centre - to staff			
Circulars and handouts in centre - to patients			
Complaints of staff			
Complaints of patients			
Conducting students and visitors around			
Communications with other centres			
Relations with: Hospitals			
Post-graduate medical centres			
Social services			
Pathology transport arrangements			

1. GENERAL ADMINISTRATION (CONTD.)

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Secretary to Centre Committee			
Agenda for Centre Committee			
Minutes of Centre Committee			
Liaison with local health authority			
Liaison with other branches of local government authority (U.D.C., Borough, other Departments, etc.)			
Supervision of fire equipment and drills			
Ensuring safety in building			
Security: of drugs and medical equipment			
of records			
general			
Waste disposal			
Ensuring regulations kept on conditions of employment			
on working conditions			

2. GENERAL FINANCE

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Accounts			
Petty cash: Keeping			
Receiving			
Issuing			
Preparation of estimates: Equipment			
Maintenance			
Reception, secretarial, cleaning staff and telephonists			
Other staff			
Authorisation of expenditure within approved limits: Petty cash			
Furnishing			
Staff hours			

3. PRACTICE ADMINISTRATION

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Supervision of: G.P. appointment system			
Home visit requests			
Repeat prescription arrangements			
Organisation of N.H.S. records system			
Maintenance of N.H.S. record system			
Transfer of N.H.S. records			
Organisation of registers: Age/sex			
High risk			
Other (specify)			
Maintenance of registers: Age/sex			
High risk			
Other (specify)			
Preparation of duty rotas for G.P.s			
Arrangements for: Ambulance and hospital car service			
Outpatients			
Discharges			
Secretary to Practice Committee			
Agenda for Practice Committee			
Minutes of Practice Committee			
Notifying infectious diseases to L.A.			

4. PRACTICE FINANCE

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Practice Accounts: Maintenance for submission to accountants			
Payment of accounts			
Receipt of money			
Petty			
Submission of accounts to insurance companies etc			
Private patients			
Submission of claims to Executive Council			
Negotiating terms for non-N.H.S. appointments			

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5. PERSONNEL

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Advertising for: Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			
Shortlisting for interview: Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			
Dismissal of: Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			
Specifying duties of: Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			

5. PERSONNEL (cont'd)

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Training of: Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			
Preparation of duty rotas: Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			
Supervision of : Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			
Making relief arrangements: Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			

5. PERSONNEL (cont'd)

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Salaries/wages: Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			
P.A.Y.E. Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			
N.I. Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			
Overtime claims : Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			

5. PERSONNEL (cont'd)

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Holiday and Sickness Returns: Nursing			
Paramedical			
Reception/secretarial			
Caretaking/cleaning			
Other (specify)			

6. MAINTENANCE AND SUPPLIES

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Maintenance of: Building			
Heating system			
G.P. office equipment			
L.A. office equipment			
G.P. owned medical equipment			
L.A. owned medical equipment			
Ensuring rooms equipped and prepared for varying purposes (where applicable)			
Requisitions from Executive Council : Medical			
Stationery			
Requisitions from Local Authority : Medical			
Stationery			
Requisitions from Regional Hospital Board : Medical			
Stationery			
Requisitions from Public Health Laboratory : Medical			
Stationery			

6. MAINTENANCE AND SUPPLIES (cont'd)

ACTIVITY	NORMALLY UNDERTAKEN BY (AND NOTES)	Formal responsibility for	Delegation could be to
Purchasing supplies : Medical			
Stationery			
Catering			
Equipment			
Issues of supplies : Medical			
Stationery			
Catering			
Equipment			

APPENDIX II

ADMINISTRATIVE ACTIVITIES - ADDITIONAL INFORMATION

Information collected about centres

1. Employer of reception/secretarial staff, local authority or general practitioner
2. Organisation of reception/secretarial staff
   - Do they work in practice teams
   - Are they flexible in working with another practice team
   - Do they specialise in tasks (e.g. filing, making appointments)
3. Employer of manager, local authority or general practitioner.
4. Salary of manager paid by?
5. Salary grade of manager?
6. Where manager is based.
7. Former occupation of manager.
8. Procedures for liaising with higher levels of authority
   - Medical officer of health
   - Administrative officers in Health Department
   - Nursing officers
   - Hospital where applicable
9. How does manager/administrator (if applicable) see role?

DECISION MAKING IN THE CENTRE

1. Constitutions of committees (e.g. may be found in agreement between local authority and Executive Council and/or Regional Hospital Board).

2. Committees in existence e.g. is there a health centre/house committee, practice committee(s).

   For each committee :-

   - What are the arrangements for convening?
   - Who sits on the committees?
   - How often have they met?
   - What has been discussed?
   - Have constitutions been amended?
   - Are there sub-committees and are their reports accepted?
   - To whom are powers delegated between committee meetings?
   - What type of minutes are kept?

3. Appointment committees :-

   - Secretarial/reception
   - Paramedical/nursing
   - Cleaning

   Who sits on appointment committees?

4. Who recommends for regradings, gives warnings and dismisses secretarial/reception staff. On whose authority.

5. Issues which have arisen:-

   e.g. Setting up screening clinics
   - Setting up family planning clinics
   - Doing research
   - Type of records kept
   - Change of records e.g. to family folder system
   - New partners
   - New single-handed doctors
   - New nurses
   - Attachments
   - Policy toward local authority and Executive Council
   - Accommodation
   - Changes in organisation of reception staff

   For each issue:-

   - How was it resolved?
   - What information was obtained to make decisions?
   - Were changes monitored or evaluated?

THE LOCAL AUTHORITY AND HEALTH CENTRE ADMINISTRATION

1. General policy - do health centres have ....
   - Managers/practice managers
   - Supervisors/senior secretaries
   - Managers for more than one centre
   - Variations in policy between large and small centres
2. What are the liaison arrangements - who in centre liaises with whom in local authority.
3. Role of local authority on house committee.
4. Limitations on manager
   - Administrative activities
   - Financial
   - Personnel
   - Supplies
5. Staffing policy in centres.
6. Problems/conflicts which have occurred.
7. Hierarchy in local authority.

APPENDIX III

PROFORMA USED FOR THE VISITS TO HEALTH CENTRES ORGANISED BY THE D.H.S.S.

(see page 6)

Report of Visit by Dr. ..... and Miss/Mrs.....

Facts relating to the visit.

File No. E/H9/ .....

Name of L.H.A. .....

Name of Health Centre .....

Date of opening .....

Date of visit .....

No. of GPs Working at Health Centres: (By practices) e.g. s/h - 1
2-partners - 2
5-partners - 1
Total - 10 doctors

Main Surgery .....

Branch Surgery .....

No. of G.P. Patients Served by the Health Centre:

Main Surgery .....

Branch Surgery .....

No. of Practice Nurses employed by G.P.s .....

No. of LHA Nursing Staff working at Health Centre:

Health Visitors ..... Clinic Nurses .....

Homes Nurses SRN ..... SEN .....

Midwives .....

Nursing Auxiliaries .....

Size of population served by Health Centre for child health purposes.

1. Site and General Design Considerations

Site (2.10)*

Character of the building (3.1)

Noise factor (3.4)

2. Description of Accommodation and Suitability for Function

Car and pram parking (4.7 - 4.11)

Entrances (4.12 - 4.13)

Reception/Records Storage/Office and Food Sales area (4.14 - 4.23)

Waiting area (4.24 - 4.29)

Consulting suites (4.30 - 4.37)

Treatment Room (4.38 - 4.43)

Health Education area and storage (2.41 - 4.45 - 4.49)

Play Room (4.53)

Local authority medical services (4.54 - 4.55)

Health visitors and Fieldwork Instructors (2.49, 4.56, 4.57)

Home Nurses and Domiciliary Midwives (4.58 - 4.60)

Other Services (2.42 - 2.47, 4.61)

Common Room (4.62 - 4.63)

Sanitary Accommodation (4.64 - 4.65)

Facilities for storage, cleaning etc. (4.66)

Heating, ventilation, lighting, signposting etc. (5.2 5.10 - 5.13 5.24 - 5.27)

3. Function and Co-operation

Administration within the centre (2.24)

Contact with Medical Officers of Health and local authority Headquarters (2.24)

Employment of Staff (reception, Office Treatment Room) (2.24)

Attachment and liaison schemes (2.32)

Access to records (2.21)

Diagnostic Facilities (2.40)

Emergency Service for Casual attenders (2.30)

Student and trainee facilities (2.31)

4. Other Points of Interest

5. Summary and Assessment

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* Numbers in brackets correspond to those in the Health Centre Design Guide 1970.

APPENDIX IV

Salary scales in local government applicable to health centre administrators

£ p.a. as at July 1st 1973

Administrative and Professional Grade

AP 1	1,353 - 1,644
AP 2	1,644 - 1,926
AP 3	1,926 - 2,235
AP 4	2,235 - 2,535
AP 5	2,535 - 2,820

Senior Officer Grade

SO 1	2,820 - 3,390
SO 2	2,165 - 3,504

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TABLES

The following tables 1 - 9 are based on data obtained from the reports of regional medical officers and nursing officers of health centres, (see page 6).

Percentages along appropriate rows or columns do not always sum to exactly 100% due to rounding effects.

Full time general practitioners are those using the health centre as a main surgery.

Number of partnerships is the number of firms of family doctors, some of whose members practise from the health centre (using it as a main surgery).

Type of administrator - for definition see page 10.

TABLE 1

Department of Health and Social Security reports on centres open by type of authority

Year opened	County Councils			County Boroughs			London Borough Councils			Total		
	No. open	No. reports	% reports	No. open	No. reports	% reports	No. open	No. reports	% reports	No. open	No. reports	% reports
1968[1]	26	-	-	6	1	17	4	-	-	36	1	3
1969	36	28	78	10	10	100	3	3	100	49	41	84
1970	38	31	82	17	16	94	5	5	100	60	52	87
1971	57	23	40	20	15	75	6	6	100	83	44	53
Total	157	82	52	53	42	79	18	14	78	228	138	61

[1] One health centre opened in 1968 was included by the Department of Health and Social Security in the round of visits for centres opened in 1969 (see page 5).

TABLE 2

Assessment of function by type of administrator and type of authority

Centre functions	Boroughs (London and County) Type of administrator					Counties Type of administrator					All Type of administrator				
	Sec/ Rec	Nurse	Admin	Ill/ Def	All	Sec/ Rec	Nurse	Admin	Ill/ Def	All	Sec/ Rec	Nurse	Admin	Ill/ Def	All
Well	4	11	9	11	35	14	6	13	12	45	18	17	22	23	80
Indifferently	0	4	2	2	8	1	3	6	11	21	1	7	8	13	29
Badly	1	3	2	7	13	1	3	5	7	16	2	6	7	14	29
All	5	18	13	20	56	16	12	24	30	82	21	30	37	50	138

TABLE 3

Number of principals practising full time from centre by type of authority

Number of principals	Boroughs (London and County)	Counties	All
None	5(9%)	1(1%)	6(4%)
1, 2 or 3	14(25%)	22(27%)	36(26%)
4, 5, 6 or 7	22(39%)	43(52%)	65(47%)
8 or more	15(27%)	16(20%)	31(23%)
All	56(100%)	82(100%)	138(100%)

The percentage figures in brackets add down columns

TABLE 4

Assessment of funtioning by type of administrator

Centre functions	Type of administrator				
	Sec/rec	Nurse	Administrator	Ill defined	All
Well	18(86%)	17(57%)	22(59%)	23(46%)	80(58%)
Indifferently	1(5%)	7(23%)	8(22%)	13(26%)	29(21%)
Badly	2(10%)	6(20%)	7(19%)	14(28%)	29(21%)
All	21(100%)	30(100%)	37(100%)	50(100%)	138(100%)

The percentages figures in brackets add down columns

TABLE 5

Type of administrator by number of principals practising full time from centre

Type of administrator	Number of principals				
	None	1, 2 or 3	4, 5, 6 or 7	8, or more	All
Sec/receptionist	-	9(43%)	9(43%)	3(14%)	21(100%)
Nurse	1(3%)	9(30%)	17(57%)	3(10%)	30(100%)
Administrator	1(3%)	5(14%)	16(43%)	15(41%)	37(100%)
Ill defined	4(8%)	13(26%)	23(46%)	10(20%)	50(100%)
All	6(4%)	36(26%)	65(47%)	31(23%)	138(100%)

The percentage figures in brackets add across rows

TABLE 6

Type of administrator by number of partnerships in centre

Type of administrator	Number of partnerships				
	0	1	2	3 or more	All
Sec/receptionist	-	13(62%)	6(29%)	2(10%)	21(100%)
Nurse	1(3%)	17(57%)	7(23%)	5(17%)	30(100%)
Administrator	1(3%)	11(30%)	9(24%)	16(43%)	37(100%)
Ill defined	4(8%)	17(34%)	11(22%)	18(36%)	50(100%)
All	6(4%)	58(42%)	33(24%)	41(30%)	138(100%)

The percentage figures in brackets add across rows

TABLE 7

Proportion of centres assessed as functioning well by type of administrator

by

(a) number of principals based at centre

(b) number of general practitioner partnerships

Type of administrator	(a) Number of principals		(b) Number of partnerships	
	4 or less	5 or more	1 or none	2 or more
Sec/receptionist	13/13	5/8	12/13	6/8
Nurse	13/19	4/11	11/18	6/12
Administrator	6/10	16/27	8/12	14/25
Ill defined	10/24	13/26	10/21	13/29

The denominator of each fraction is the total number of centres in that category and the numerator is the number of such centres that are described as functioning well.

TABLE 8

Assessment of function by number of principals practising full time from centre

Centre functions	Number of principals				
	None	1, 2 or 3	4, 5, 6 or 7	8 or more	All
Well	5	22(61%)	32(49%)	21(68%)	80(58%)
Indifferently	1	4(11%)	19(29%)	5(16%)	29(21%)
Badly	0	10(28%)	14(22%)	5(16%)	29(21%)
All	6	36(100%)	65(100%)	31(100%)	138(100%)

The percentage figures in brackets add down columns

TABLE 9

Assessment of function by number of partnerships

Centre functions	Number of partnerships				
	None	1	2	3 or more	All
Well	5	36(62%)	17(52%)	22(54%)	80(58%)
Indifferently	1	10(17%)	8(24%)	10(24%)	29(21%)
Badly	0	12(21%)	8(24%)	9(22%)	29(21%)
All	6	58(100%)	33(100%)	41(100%)	138(100%)

The percentage figures in brackets add down columns