The Management and Administration of Health Centres - A Study of the Effects of the 1974 Reorganisation of the National Health Service

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SUMMARY

A study was made of the administration of health centres after the 1974 NHS Reorganisation. We were interested in finding out what effect Reorganisation had had upon the running of health centres, and whether there had been any developments in this field.

The main method used for this study was the interviewing of administrators in health centres and health authorities. The centres and authorities chosen were those* we had similarly visited in a period before Reorganisation, but in addition we saw some centres and one health authority for the first time.

We found that the diversity of administrative arrangements in centres which had existed before Reorganisation had largely continued. However, by contrast with local government health departments, the new health districts had a complex system for administration and decision-making, since they had extended hierarchies and functional management. From the health centre point of view this made getting things done a slow and complicated process. At the same time health centre administrators had opportunities to go on courses and were often involved in meetings of district administrative staff. The family doctors in health centres on the other hand, often seemed more separate from the health authority than they had been under local government. The position in this respect of health authority employed nurses working from health centres seemed effectively unchanged following Reorganisation.

Alongside the changes which can be attributed directly to Reorganisation, we noted the formation of two new organisations for particular groups. One is the Association of Health Centre and Practice Administrators, formed in 1975, which is especially concerned with the training, salaries and prospects of its members and similar staff. The second and more recent is the National Association for Patient Participation in General Practice, formed in 1978 by a number of patient groups which have been in existence for up to several years. It is not possible at this stage to assess the effect of these two groups.

We recommend:-
that ways should be found to simplify health centre administration probably by delegation of more authority to that level; that health centre administrators should be given opportunities to become involved in appropriate district meetings of administrators and to proceed to

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* that is the successors of the local health authorities originally visited.

further responsibilities and jobs within the National Health Service; that efforts should be made to involve GPs in the administration of centres where this is not happening; and that patient involvement should be encouraged at least experimentally.

INTRODUCTION

The first phase of the study

This is the report on the second phase of a study of administration of health centres. The development and findings of the first phase are briefly outlined below.

In 1973 we began a study of health centre and group practice centre administration. We set out to find what administrative activities were needed in these centres and who undertook the necessary tasks; what procedures there were for decision-making in and concerning centres; and what the policies of local health departments were towards running health centres. The fieldwork for this study was completed before the Reorganisation of the NHS in 1974 and the findings were reported in 1975.*

The main method of gathering this information was by interviewing administrators in centres and local authority health departments. We identified a considerable number of administrative tasks necessary in the running of health centres and group practice premises, but the range of these tasks varied according to the complexity of the centres. In particular group practice centres, because of their financial autonomy, needed some person or persons to deal with many financial aspects which in a statutory health centre will be undertaken by the health authority. (for a list of the tasks identified, see the Administrative activities proforma, Appendix 1).

Administrative activities could 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 was needed in a centre varied according to a number of factors. These included the variety of services, the numbers of staff in the centre, the number of practices in the centre, whether the centre was a group practice or health centre, and, in the case of health centres, the degree to which administrative tasks were delegated to the centre by the health authority.

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* G.E. Baker and J.M. Bevan (1975) Management and Administration of Health Centres. HSRU Report No. 13.

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

There was likewise a diversity of employment arrangements for administrators. In group practice premises the family doctors were 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 were operating in a number of health centres. For statutory health centres the Department of Health and Social Security has given guidance on the legal contracts needed, which include provision for a health centre committee.* There was 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 was prepared to delegate decision making down to a health centre, then also the centre committee gained importance.

The Second Phase of the Study

The second phase of the study, of which this is the report, has been concerned with the administration of health centres since the 1974 Reorganisation of the NHS. We were particularly interested to see what the effect of being transferred to the new health authorities from the local authorities had upon health centres. We were also looking out for changes which occurred but could not necessarily be attributed to Reorganisation. For instance, since we visited again the same centres chosen in the first phase of the study, we could see developments in the 'natural history' of a centre such as a new administrator, an increase in the number of GPs or an additional service provided.

* DHSS (1977).

The Third Phase -
Survey of Health Centre Administration

The work of phase 1 and 2 highlighted both the variety of possible arrangements for health centre administration and the lack of information about what arrangements were in existence in different health authorities. To fill this gap, it was decided to carry out a postal survey of health districts in England. The fieldwork for this took place in the second half of 1977 and is currently being analysed and will be reported on later. The questions asked in the postal survey were largely determined by our experience interviewing for the study in the first and second phases mentioned above. The postal survey complements the work already done, and gives a general picture in addition to the more narrow but 'in depth' study which preceded it.

Objectives

Two objectives of the first phase of the study were:-

a) to find out what was the current policy (i.e. prior to 1974 NHS Reorganisation) and experience in health centre and group practice centre administration,

b) to identify and describe the administrative tasks and decision making procedures concerned with these centres.

The objectives of the second phase were (using earlier results for comparisons):-

a) to find out what impact the reorganisation of the NHS made upon the administration and decision making concerned with these centres,

b) to find out if any other changes, not necessarily attributable to Reorganisation, had taken place.

METHODS USED IN THE SECOND PHASE

a) Interviews

As in the first phase, the main method used was interviewing. We visited health centres and group practices which we had seen in the first phase, and interviewed administrators and practice managers in these centres as well as the administrators in the health authorities who were concerned with health centre administration. In this way we were able to make comparisons between the before and after Reorganisation experiences in these centres. In several places the same staff were in post (either the same centre administrators or managers, or local authority staff who had

transferred to districts or areas). This applied to four health centres out of the ten and three out of the nine health authorities visited in both phases. Altogether then we visited 10 health centres and 9 health authorities in both phases, and in addition in Phase Two only, 2 further health centres in the same districts and also for the first time visited a single district area and 3 health centres in it.

One problem revisiting health centres was selecting the appropriate health authority to apply to for permission, health centres being transferred from local government to areas and districts. It was decided to apply in the first instance to the authority which coincided geographically with the old local authority. In most cases this was the area, who usually referred us to the district in which the health centre was sited. In the three London authorities the district was applied to as this was coterminus with the old London borough boundaries. In one place there had been major boundary changes, as a new county had been formed from the old county borough (visited in the first phase) and parts of surrounding counties. In another place the health centre turned out now to be in the middle of a complex 'overlap' area, involving three areas.

The same proforma and check lists for obtaining information were used as in the first phase (see Appendix) with suitable amendments allowing for the change in authorities (e.g. referring to health authority instead of local authority).

As we pointed out in our earlier Report, the centres and authorities visited were not representative* but were chosen for the range and variety of their administrative arrangements.

b) Documents and Literature

We studied official material which affects health centre administration, including the 'Grey Book'** and circulars issued, as well as articles appearing in journals. We also looked at advertisements (see examples in Appendix 4) for health centre administrators (or their equivalent) in England, which appeared in the Health and Social Service Journal in the period 1973-1978 inclusive.

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* In the conventional statistical sense

** DHSS (1972)

AFTER REORGANISATION - HEALTH CENTRES IN A NEW SETTING

Introduction

The Reorganisation of health services in 1974 transferred health centres from the control of local government to the control of the new health authorities. The transfer of health centres was not only a matter of the buildings themselves (including their planning, construction and maintenance) but also affected the community health staff (such as nurses, dentists, doctors, speech therapists etc.) who had formerly been employed by local government health departments. These organisational changes, and other developments since 1974, are outlined below.

1. Transfer to a larger health authority

Health centres became part of a unified and much larger health authority. Whereas under local government they were (with clinics) the only buildings for health care delivery owned (or leased) by local health departments, under the new health authorities they form but a small part of the total buildings for health care. Similarly, the staff working in health centres are now only a small group compared to those working in hospitals, within any given health authority. Thus health centres were transferred from the supervision of a local government health department which was a small scale organisation (although part of a larger local government organisation) to a large organisation, the health district or single district area.

2. Transfer into a highly complex administrative system

The new health authorities have a much more complex system of administration than that found in the former local health authority department. This is substantially due to the extent and complexity of the services provided by the new health authorities, but that is not the only reason. The local authority health department, albeit a small department, was essentially a well-defined hierachy, headed by a medical officer of health who had executive power. The department was of course not independent of other departments in local government in particular finance and works departments, but in many fields, within a given budget, it was self-contained for decision making. By contrast, the new health authorities have several administrative tiers (unit, sector, district, area) and several functional departments within these tiers (personnel, finance, supplies, works etc.). Inevitably this meant that there were more staff in the administration who would , as part of their work, be concerned with health centres.

3. The demise of the medical officer of health

In the new health authorities there is no equivalent figure to the former medical officer of health for a local authority. His role has been described in Appendix C of the 'Hunter' Report of 1972:-*

> Within the health services provided by local health authorities, the tendency in recent years has been for individual professions to seek internal self-management, so that although the medical officer of health has remained the head of the health department, his administrative role as a manager of health service personnel generally has changed. He does, however, remain formally in a different position from the senior administrative medical officer of a regional hospital board in that he is directly responsible for the work of a wide range of medical, nursing and other professional staff who are, in organisational terms, subordinate to him.
>
> The role of the medical officer of health over the last century, has, therefore, been an evolving one. His managerial role in relation to the non-medical staff has declined, but not his importance as medical adviser to the extensive range of agencies now responsible for the well-being of the community and the protection of the environment: and as chief officer of the health department and principal medical officer to the education authority he has responsibility for the planning and control of considerable resources in terms of skilled manpower and money, and has become increasingly involved in management functions relating to the assessment of objectives, the evaluation of services, and the determination of priorities."

Where health centres were concerned he was often instrumental in getting a health centre building programme underway (or on the other hand in obstructing such a programme) and where health centres were built often took considerable interest, if not pride, in them.** Health centres represented a substantial amount of plant and capital expenditure for a local authority health department. The M.O.H.*** as a doctor was an officer who could be approached directly as a peer by the local GPs - and indeed he could approach them with any plans. It is fair to say that much variation in the geographical distribution of health centres which is evident today can be attributed to the varying attitudes of M.Os.H. in the country.

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* DHSS (1972) Report of the Working Party on Medical Administration. London: HMSO (The Hunter Report).

** See for example the large number of papers and reports on health centres written by medical officers of health.

*** For abbreviations see Glossary on page 53.

4. Change of personnel administering health centres

Although some local government health authority staff successfully applied for posts in the new health authorities, senior posts were taken up substantially by staff in the former hospital administration. An example of this is the appointment of area administrators for the 90 areas in England.* Persons with a 'hospital' background were appointed to 93% of the posts, although they constituted 72% of the applicants. On the other hand, persons with a 'local authority' background were appointed to 3% of the posts,although they constituted 18% of the applicants.

Often hospital administrators had no experience in the running of community health services which had been the province of local government, and their lack of experience and hospital administration background could be expected to affect their attitudes. With time, of course, this situation could change, as staff gain experience in community health services, and new staff were recruited into the reorganised NHS.

5. Change of boundaries of health services

The new AHA boundaries were coterminus with the new local government boundaries. (The exception is London, where some boroughs were 'grouped' to be coterminus with an AHA, and where some boundaries were not coterminus.) In local government reorganisation, the county borough was absorbed into its surrounding county. Thus community health services belonging formerly to a county borough were absorbed into a larger unit - the AHA corresponding to the boundaries of the county. The majority of AHAs are sub-divided into health districts which have no necessary relation to local government boundaries.

Added to these general changes were some further complications. Firstly, some counties changed boundaries, taking in or losing part of adjacent counties (e.g. the Berkshire/Oxford border). Secondly, some new counties were created e.g. Avon, Cleveland, out of parts of surrounding counties. The new AHAs followed these altered boundaries. Thirdly, the new health districts do not necessarily have boundaries corresponding precisely with the relevant boundaries of the AHA to which they belong, since health districts are based on criteria such as catchment areas or distribution of hospitals. Thus 'overlap' areas were created which can complicate administration.

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* DHSS (1975) NHS Staff Commission Report (1972-5) London: HMSO

Finally it should be added that the site of the administrative HQ often changed, since the area and district offices were not necessarily based in the same towns as the former local government HQ.

6. Potential integration of health centre administrative staff

As health centre administrative staff transferred into the new health authorities different opportunities were theoretically available; firstly for more contact between staff in community and hospital services, secondly, for NHS employed administrative staff (e.g. health centre administrators, clerical officers in health centres etc.) to have wider responsibilities, such as community hospitals, and thirdly for these staff to have some career prospects in the NHS. However one problem for local authority staff transferring was the relatively poor salary scales offered by the NHS.

7. The establishment of family practitioner committees

With 1974 Reorganisation, executive councils, which had been directly accountable to the DHSS, were replaced by family practitioner committees, which are statutory committees of the area health authorities. The staffing and administrative costs of the FPCs are paid for out of AHA funds, separate from the money which comes direct from the DHSS for paying general practitioners etc. who are in contract with the FPCs. The FPC administrator "as well as serving the family practitioner committee, is also directly accountable to the area administrator in respect of his work on health centres and attachment schemes". "... the intention clearly is to bring this part of the service closer to the rest of the NHS ..."* However it could equally well be argued that this arrangement makes for divided loyalties and weakens the FPC.

Before Reorganisation, the executive council was the body in contract with local government to provide general medical services in a health centre. The E.C. also had a separate contract with the general practitioners to provide services in the health centre, so there were two legal contracts needed for the provision of services in each health centre, which spelt out the rights of the parties concerned. Having two contracts was a cumbersome process but meant that the E.C. could act as a 'buffer' between the other parties, and also it gave the E.C. an essential part to play in the legal arrangements.

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* Levitt, R. (1976) The Reorganised National Health Service. London: Croom Helm.

Since Reorganisation, the DHSS has decided that there should be only one legal agreement, namely between the AHA and the GPs, thus excluding the FPCs which succeeded the old ECs. This change is set out in Circular HC (77)8 'Health Centres: Licence for occupation of premises by general medical practitioners'. The role of the FPCs concerning health centres is now one of consultation, co-ordination of the views of local practitioners, and advice giving only.

8. Growth of 'consumer' groups in the health service

In the last few years there has been a growing interest in the representation of the patient or 'consumer' in the National Health Service. Officially this interest has been embodied in the setting up of community health councils under the 1973 NHS Reorganisation Act. At the same time some general practices and health centres have set up their own patient groups. CHCs are concerned with primary medical care as part of the NHS. Patient groups are set up in relation to particular practices or centres and are non-statutory.

CHCs have the explicit duty of representing "the interests of the health service of the public in its district".* The AHA has the duty of consulting the CHC when any substantial changes or developments are planned in the health services, and of allowing CHCs reasonable access to AHA premises, including health centres. Access to health centres though does not include access to the family doctor occupied parts of the health centre, except with the doctors' permission. And of course no CHC could visit surgery premises owned by GPs except with their permission. In some health centres a CHC member has been co-opted onto the health centre committee. CHCs can make recommendations about primary care services, and conduct surveys of patients' views, but have no executive powers.

Early in 1978 the National Association for Patient Participation in General Practice was formed with Sir George Godber as president, bringing together a number of groups which had already been set up in practices and health centres.

These groups vary in their organisation and objectives, but each provides a forum for complaints, questions, information and discussion between doctors and patients. These types of groups are only found in

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* HRC (74)4 Community Health Councils.

a minority of practices but are at present gaining more notice. They may not develop more widely but do indicate a need which has not been fulfilled in the delivery of primary medical care and reflect a trend to take more account of the 'consumer' view in general practice in particular.

9. Guidance from the Department of Health and Social Security on the running of health centres for the period following the 1974 NHS Reorganisation

Guidance from the DHSS for the period before NHS Reorganisation was discussed in our 1975 report (Baker and Bevan, 1975). Most guidance was concerned with planning and design and with the financial arrangements in the contracts between the EC and the GPs, and the EC and the local government authority. Health centres were transferred to the new area health authorities by the 1973 NHS Reorganisation Act. This Act repealed Section 21 of the 1946 NHS Act, which made the provision of health centres a duty of local authorities. The 1973 Act does not refer to health centres as such, but provision for them is in effect made under Section 2(2), in which the Secretary of State has the duty of providing, among other items, accommodation for health services (This is set out in HRC (73) 26 Statutory Provisions: Framework of the NHS after Reorganisation).

HRC (74) 21: Health Centres, which was issued in March 1974, dealt with the transfer of centres. It drew attention to earlier circulars which were to apply until further notice, in particular those relating to charges and private practice. It set out transitional and new arrangements for planning and building health centres. However it did not give specific guidance on administration. There has been no detailed guidance from the DHSS on the running of health centres for the period after Reorganisation. What there is, is to be found usually among general recommendations for health services, and is discussed below.

'Management Arrangements for the Reorganised NHS' (1972)(The Grey Book) mentioned responsibilities for health centres in some of the job role specifications in its Appendix 3. The District Administrator's role includes the management of institutional and support services required by health service properties in the district, health centres being among these. The Sector Administrator has the job of co-ordinating these services for the institutions in his sector. HRC (74) 29 gives some more guidance on the defining of sectors (paragraph 13 (d)). Sectors may be divided in 3 ways. These are:

a) A sector comprising one large hospital or a group of hospitals.

b) A sector comprising hospitals and other institutions (including health centres) in a geographical sub-division of a district.

c) A sector comprising health services other than those in hospitals for at least a large part of a district.

An individual health centre will not constitute a sector, although it may 'require outposted administrative staff accountable to a General or Sector Administrator'.

Another alternative (suggested in Community Hospitals: their role and development in the NHS, DHSS 1974) is for the administrator of a community hospital to have responsibilities for the administration of other local institutions, including health centres.

Although the size and type of health centre which could merit having its own administrator is not referred to in earlier circulars, some guidance on this subject can be inferred from HN (76) 54 Health Building: revised cost allowances for health centres. This circular includes a schedule of accommodation related to staff and population served, and for health centres with primary care teams serving a population of 12,000 or more, allowance is made for an administrator's office.

Some more specific guidance is given in HC (77) 8 Health Centres: licence for occupation of premises by general medical practitioners. As its title suggests, this circular is mainly concerned with a model licence, but it also deals with some aspects of running health centres. This circular states that although the licence is made between the AHA and the general practitioners, "In multi-district areas District Management Teams will be responsible for the administration of health centres and should be brought into the negotiations." The DMT "will have oversight of the maintenance of the fabric of the building, the providing of services and the day-to-day running of the centre".

The circular also makes recommendations about committees in the health centre, and the two paragraphs describing these in the "Notes on Licence etc." are reproduced in full below:-

PRACTITIONERS' STAFF COMMITTEE

24. It is usually considered desirable to provide machinery for the discussion and settlement of matters of common interest to the practitioners, e.g. a proposed increase in charges (Clause 2(ii)(iii) and (iv)). This is done by creating a Practitioners' Staff Committee of which every practitioner (other than an assistant) is automatically a member, or is represented along with the Area Medical Officer and/or other professional area officers as appropriate or their representatives.

In some centres it might be considered helpful to have the advice of the Administrator FPS for the area. This can be achieved by inviting him to become a member of the Committee, or making him an observer, or by inviting him to particular meetings of the Committee - the choice depending on local circumstances and wishes of the Committee. As an essential preliminary the Committee would need to define its own membership and make rules governing the nomination of a chairman and the conduct of its business.

HEALTH CENTRE COMMITTEE

25. It is recommended that there should also be a Health Centre Committee representing the interests of all staff (professional and non-professional) working at the centre. This Committee would usually have power to make rules where necessary covering minor day-to-day matters and should be consulted by the AHA regarding any rules the latter may make concerning the management of the health centre or the control of staff.

The 'Practitioners' Staff Committee' here described is almost the same in membership as the 'Medical Staff Committee' recommended in the earlier Model Agreement of 1972 (circulated with ECL 100/72) (In the earlier version, the MOH and clerk of the Executive Council were referred to.)

The recommendation for having a Health Centre Committee was not in the earlier Model Agreement. Significantly, it is recommended that membership of this committee should include representation of both the professional and non-professional staff in the centre. In the earlier Model, non-professional staff were not mentioned as recommended members of any committee.

Where they are set up, any rules made by these committees on the subjects specified, in consultation with the AHA, must be complied with by the general practitioners. (In the earlier Agreement, this obligation on the GPs only applied to rules made by the Medical Staff Committee.)

SUMMARY OF RESULTS FROM THE INTERVIEWS

In this section we have summarised the changes in health centre administration and decision-making since Reorganisation which we found from our interviews. (We were not concerned in this study with the initial period after Reorganisation when it could be assumed there would be problems.) The information came from interviews in 10 health centres visited both before and after Reorganisation and in addition 5 centres visited after Reorganisation only. The headings in this section are based on those in the proforma and

check lists used (See Appendices 1 and 2). Five case studies of individual health centres visited both before and after Reorganisation are given in Appendix 3. These examples were chosen to illustrate changes encountered and the range of issues discussed below.

(a) Changes in the content of the administrative work (in order of headings in the proforma used)

1. General Administration

As might have been expected, much of the work undertaken in the health centre was unchanged. One improvement due to Reorganisation was that centres were often integrated into the district mail collection service (for post internal to that district) and into a hospital pathology collection service. Another alteration was that in one centre the administrator had taken on the administrative work of the adjacent hospital, and this type of arrangement had been established in other centres in a couple of the districts we visited. This joint responsibility is a change that is facilitated by Reorganisation. Also in some districts, health centre administrators had been given administrative responsibilities for clinic premises. This had occurred before Reorganisation (when both clinics and health centres were owned by local authorities) but seemed now more in evidence. In another district the two centres visited before were now administered by one person. In a single district area not visited before administrative assistants were each responsible for a group of health centres and related community hospital.

2. General Finance

The effect of Reorganisation in this area was to restrict the amount of money which could be spent locally by the health centre administrator. No more than petty cash was authorised for health centres, whereas previously in several authorities health centre administrators could spend a limited sum on small repairs or purchases; and they did not like this restriction. One authority was hoping to give more local spending power in future.

3. Practice Administration and

4. Practice Finance

These activities appeared to be unaffected by Reorganisation.

5. Personnel Work

As before Reorganisation, personnel work relating to professional staff in the health centre was carried out centrally by the health authority. Of more interest is the personnel work relating to office and domestic staff in

the centre employed by the health authority, where delegation of the various tasks to a health centre administrator is possible. As before some delegation took place. Personnel departments did any necessary advertising, and the health centre administrator if in post was involved in the actual selection of staff. In one centre where the GPs had complained about delays in replacing staff because the task was done by the district, the advertising for and selection of office staff was delegated to the centre administrator. Employment of cleaning staff was more likely to be left entirely to the health centre administrator. One problem resulting from Reorganisation which was mentioned in two health districts was replacing or increasing numbers of staff who worked for the GPs but who were employed by the district. Although the FPC reimburses 70% of the salaries of up to two such staff per GP, the actual payment by the FPC went to the AHA, not the district. Districts had encountered difficulties in obtaining this reimbursement from the AHA and were therefore reluctant even to replace such staff when they left.

In a couple of centres the health centre administrator had been appointed without any consultation with the GPs, and they had complained about this.

6. Maintenance and supplies

Most complaints about the effects of Reorganisation were found under this heading, in particular maintenance caused problems. The responsibility for initiating any repairs etc. lay with the same staff, i.e. health centre administrators or senior secretaries/receptionists, as before. They complained that there were delays due to the hierarchy of administrators and functional officers in the district or area who had to authorise jobs. Before Reorganisation there was no such extensive hierarchy to be gone through and health centre administrators had sometimes a limited budget allowed to them which they could use for minor matters.

Another complaint was that there was no flexibility in what could be done - one example cited was the chairs which the health authority replaced when they were worn out, although with recovering they would have been quite satisfactory to staff. Less money was said to be available - although this could be attributed to financial constraints rather than Reorganisation - and resulted in less frequent decorating, poorer cleaning materials etc. Maintenance generally seemed to be a source of considerable frustration, and it was felt that health centres were having to fit into a system originally designed for the needs of hospitals.

(b) Decision-making

1. House Committees

Most centres we visited before Reorganisation had provision for a House Committee. Committees still met, although in a couple of centres they had not met for more than a year. In one centre a lot of internal problems (mainly due to a new practice arriving,and building alterations) had brought about the formation of a house committee where none existed before. Where committees lapsed it could be due to having no urgent problems to discuss.

With Reorganisation the person representing the health authority on the committee obviously had changed; it was most commonly now a sector administrator. In one centre a CHC member had been invited by the committee to attend meetings, at the suggestion of the GPs. However the district administration were annoyed that this was done without referral to them.

2. Liaison

Decisions, as before Reorganisation, were often taken informally without reference to any committee especially in day-to-day matters, through liaison between health centre staff and central staff. This was another area which some centre administrators had complaints about. They had to liaise with several officers in functional departments, usually as well as with their official superior such as the sector administrator. If liaison was restricted to the immediate superior, it was said that decisions often had to be referred through a hierarchy, causing delays. Centre administrators who had worked before Reorganisation in the same post, found liaison unsatisfactory by comparison with their previous experience. This was not because of the personal qualities of staff, but because of the system resulting from Reorganisation.

(c) Changes in the situation of health centre administrators

1. Extension of roles

As mentioned above, in some districts administration of a GP (or similar) hospital and a health centre was undertaken by one person, and some health centre administrators were carrying out administration of local clinics or services in them.

2. Salary grades

Whereas on our previous visits there had been a considerable variation in grades between different local authorities, grades since Reorganisation

for health centre administrators appear to be more homogenous. Health authorities we visited were appointing on general administrative assistant or higher clerical officer grades, and this trend is confirmed by advertisements for such posts placed in the Health and Social Services Journal for 1973-78 inclusive. Higher grades were exceptional (see e.g. Appendix 4).

3. Involvement in district committees

In several districts health centre administrators regularly attended meetings of district personnel, such as unit administrators or senior officers. This brought them into contact with hospital administrators in a way which had not been possible before Reorganisation. One health centre administrator felt that such meetings made hospital administrators more aware of health centres.

4. Involvement in the Association of Health Centre and Practice Administrators (AHCPA)

Three of the health centre administrators were now actively members of the AHCPA, which was formed in 1975, they had been on courses organised by the Association, and were concerned about the training and status of such administrators.

ISSUES

This study (phase 2) has been based on information relating only to a very small number of health centres and authorities but a number of issues emerged which we believe are generally relevant. Phase 3 (see page 3) will throw more light on a number of these issues, but in the meantime we put them (and the recommendations following) forward as a check-list of problems and possibilities which have occurred.

1. Administrative Integration of Health Centres

One of the aims of Reorganising the NHS was the integration of the three separately administered services formerly provided by hospital boards, executive councils and local government. In this report we are concerned solely with the administrative integration of health centres.

Integration of health centres has taken place in that they are administered by the district or area which also administers all the other types of health services, and which employs the community health staff who work in health centres. Health centres have usually been incorporated into the systems of the district or area (e.g. mail collection, pathology collection, CSSD, supplies and maintenance).

The community health staff and the office staff employed by the health authority are parts of hierarchies culminating in the DMT (or ATO in single district areas). Reorganisation has brought to administrative staff more opportunities to go on management courses and to participate in meetings with other staff both community and hospital. Similarly community nursing staff and hospital nursing staff are both now employed by the health authority, with a hierarchy of nursing officers, ending at the DMT level. There were some indications that community and hospital nursing staff met via district committees. In this sense health staff have been 'integrated' into the health service. However community services are often separately organised, for example by having community sectors, separate from other sectors, such as acute, or long-stay, rather than having 'geographical' sectors. It could be argued that this 'separation' does not foster administrative integration.

2. Potential 'isolation' of general practitioners in health centres

There were signs in a number of the health authorities we visited, that GPs for various reasons arising out of Reorganisation were more isolated (or in danger of being so) from the administering authority than they were before Reorganisation. There are several factors which can be identified as predisposing towards this 'isolation.'

The former executive councils have been replaced by family practitioner committees which are statutory committees of the area health authorities. The role of the FPC concerning health centres is now limited to consultation and advice giving, and the legal agreement giving the GPs a licence to practise from a health centre is now made between the GPs and the AHA alone. (Formerly the agreements were between the executive council and the local health authority on the one hand, and between the GPs and the Executive Council on the other.) The new arrangement would seem sensible, and more direct than the old arrangement, but it does emphasise the 'owner' and 'tenant' relationship between the AHA and the GP. As mentioned earlier, in the section on Guidance from the DHSS on the running of health centres, the new model licence provides for a health centre committee (which the earlier version did not). From the GPs point of view this committee is significant in that it is to include representatives of non-professional staff in the centre, and that any rules made by the committee in consultation with the AHA must be complied with by the GPs.

The former MOH has been superseded by the district community physician (or the area medical officer in single district areas). The MOH headed the local authority health department and was a medical man whom the GPs in health centres (or planning to go in) could contact direct if necessary,

particularly since the MOH was responsible for community health services and was therefore closely concerned in any health centre development. By contrast, the DCP is a member of a district team, with an overall interest in all the health services in the district, of which health centres are but a small part. GPs are involved in this district structure via a representative on the DMT. Only if the DCP has a particular personal interest in health centres is he likely to be much involved in them - these are many other demanding and competing interests in a district. Hence GPs in health centres appeared to have a diminished opportunity for getting their immediate problems dealt with.

Staffing for health centre GPs was causing some problems. Partly this was because reimbursement for reception staff employed by the health authority was paid to area authorities and did not always get transferred to the district for actual payment of staff. Districts were reluctant then to replace such staff. Also not all districts consulted with GPs about staff replacements. In one district health centre administrators had been appointed without any reference to the GPs, who objected to this. In another district a sector administrator had wanted to take over entirely the recruitment of reception staff who were working for the GPs, but this had been successfully resisted. On the other hand it must be said that if GPs employed their own staff, they were sometimes reluctant to pay wages comparable to NHS employees in the same jobs.

With the decline of the health centre committee in quite a few centres, there was no regular forum where GPs met and discussed issues with health authority administrative staff. If the GPs employed their own reception staff, particularly in larger centres, there was little or no contact necessary between the GPs and the district administration. In a number of centres this 'separation' was marked. Apart from a representative on the DMT* they had no rights to be on committees in the district (or area) administration. Presumably in theory the FPC puts forward their views when being 'consulted' by an area on planning of health centres, and GPs may be on health care planning teams, but these are not committees concerned with the day-to-day running of primary care services.

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* Quite often a GP with no connections with a health centre (we did encounter in one area an association of GPs working from health centres who met to form a "common front" in negotiations with the authority).

This situation is unsatisfactory, given that GPs are a vital part of primary health care services, that integration of health services was an objective of reorganising the NHS and that integration of the preventive and curative sides of primary health care has for more than 50 years been given as the main reason for building health centres.

3. Administration in the health centre

The content of the administrative work in the health centre was substantially unchanged, but there had been changes in the persons undertaking some of these tasks which had caused complaint - in other words there was less delegation of some tasks, particularly spending money on repairs or small items.

Before Reorganisation some health centre administrators we visited were allowed limited sums of money which they could spend locally on small items needed or small repair jobs. This authority to spend went with the coming of Reorganisation, leaving health centre administrators with only petty cash to control, and having to go through the district to get these small jobs done. This change might have been unimportant if the new system worked well. However health centre administrators complained that there were delays because of all the staff in the district (functional managers and sector administrators etc.) who had to be applied to, and that the system was inflexible, in not allowing for small repair jobs or the particular needs of one health centre.

Before Reorganisation only one or two persons in the "central" administration (i.e. the local authority health department) were contacted about health centre administrative matters. On Reorganisation health centres were brought into a complex system involving functional management and a hierarchy of administrators culminating in a district management team (or area team of officers). Whatever the merits of this complex system it was understandably orientated towards hospitals, which concentrate many staff and resources at relatively few sites. In contrast to hospitals health centres are small institutions which are widely scattered geographically so that they can provide access to primary care for a local population. Nonetheless health centres are heavily used, providing services for a large number of patients, and with professional staff both based there and visiting in order to hold sessions. Such centres may need a rather different administrative structure to function efficiently.

4. The health centre administrator

The employment of a full-time administrator in a health centre is now an established practice, begun when health centres were local government premises and continued under the new health authorities. Reorganisation has not resolved a number of inter-related issues connected with these posts, which we mentioned in our first report,* namely selection, training, grading, career prospects and roles.

Health centre administrators are not, as far as we could tell from our visits, selected with a view to their progressing into other branches of health services administration. As before Reorganisation, personality and organising ability were important factors, enabling appointments to be made from a wide variety of backgrounds. If a health centre administrator wishes to go into health services administration he is then probably not easily assimilated, since his background and qualifications are not suitable. Also he may be too old, since one policy is to recruit those nearing retirement who will be content to stay in that post until they do retire. Health centre administrator posts are often seen then as an end in themselves, and selection is likely to inhibit further progress.

This is not to say that health authorities are deliberately trying to hold people back. Indeed although training for the job is normally minimal, health centre administrators in post employed by the health authority have opportunities to go on management courses and often participate in some committees dealing with community or general health services in the district. (This participation is not available when administrators are employed by the GPs.) Their role has also been extended by giving them administrative responsibilities in clinics and GP hospitals. However some health centre administrators felt that their responsibilities were not fully appreciated, and that their salary grades and prospects reflected this. As health authorities are both replacing and recruiting (for new centres) health centre administrators this will be an increasing problem.

5. Decision-making

We had found from our interviews with administrative staff before Reorganisation that several groups are involved in health centre administration. These included the GPs, the office staff in the health centre, other professional staff working in the centre (e.g. nurses) and of course the

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* Baker and Bevan (1975)

administrators in the local health authority. With Reorganisation these groups remained, except that the health department administrators were in effect replaced by a hierarchy of administrators in the district (or single district area) as well as (usually) functional managers and their staff. Although normally only one or two persons in the district administration will be given responsibilities for health centres (for instance a geographical sector administrator or community services administrator) they may have to refer matters to their superiors or contact functional management staff. Some decisions (e.g. employing more reception staff or buying new equipment) may have to be referred to the district management team. In effect this system has increased the numbers of persons involved in the running of health centres and consequently in decision-making. Thus decision-making is now both more cumbersome and slow - or so it appeared to health centre administrators with experience of local government administration. One answer to this problem could be to delegate more authority (e.g. to employ office staff) and allow some money (e.g. for minor repairs) to the health centre level.

6. Patient involvement

Whether patients should have any direct involvement in the provision of their local primary care services is a new issue, emerging with the appearance in some centres and practices of patient committees. Community health councils are the 'statutory' way now instituted for putting forward the views of patients, but despite the councils, local, ad hoc patient groups have appeared. Administrators in the health authority do not necessarily welcome patient representation on health centre committees. We found one district on our visits that reacted this way, and a similar reaction by district administrative staff has been reported by GPs in a Welsh health centre*.

Obviously in general practice outside health centres, GPs are free to co-operate (or not) in patient committees. The problem above arises in reconciling the administrative structure of the health authority (with its provision for consumer involvement via community health councils), with a more informal, ad hoc, and 'grass roots' involvement by patients.

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* Hart, J.T., and Haines, A.P. (1975) Correspondence - Representation of Community Health Councils in Health Centre Management. Lancet, 1, 571.

RECOMMENDATIONS*

i) Administration of health centres should be made more simple. In particular functional management systems, and inflexibility in meeting the particular needs of health centres, cause delay and frustration. Probably the answer is to delegate more authority, including limited spending power, to the health centre level.

ii) Administrative integration of health services has been of benefit in bringing more contact between centre (administrative) staff and those concerned in hospital services, and in bringing opportunities for health centre administrative staff to take on new responsibilities with possible career opportunities. These contacts and opportunities should be encouraged.

iii) Care should be taken to ensure that general practitioners are brought fully into the running of health centres from which they work. They are an essential part of primary care services but because of their independent contractor status can easily become separated from the administrative systems of the health authority. This particular problem does not of course apply to (health authority employed) nurses who in numerical terms are the other main professional group working from health centres. (This is part of the larger issue of the involvement appropriate for health service professionals in the running of facilities such as health centres. These recommendations are only concerned with problems noted as arising out of Reorganisation of the National Health Service.)

iv) Patient involvement in health centre administration, on an experimental basis, should be encouraged. Staff and patients could benefit from discussion of issues raised and there may be more material benefits for the NHS if money can be raised for the local centre along the lines of hospital leagues of friends.

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* see the remarks on page 16.

POST N.H.S. REORGANISATION VISITS

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	Delegation could be to
Allocation of rooms used by more than one authority (H.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 H.A. statistics			
Preparation of other statistics, e.g.research,			

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 health authority (sector, district, area)			
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 H.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 Family Practitioner Committee			
Negotiating terms for non-N.H.S. appointments			

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			
H.A. office equipment			
G.P. owned medical equipment			
H.A. owned medical equipment			
Ensuring rooms equipped and prepared for varying purposes (where applicable)			
Requisitions from Family Practitioner Committee Medical			
Stationery			
Requisitions from Health Authority : 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 2

CHECK LISTS

DECISION-MAKING IN THE CENTRE

1. Constitutions of Committees (e.g. may be found in Agreement between HA or LA and EC and/or RHB).
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 of delegated between committee meetings,
   What type of minutes are kept.
3. 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 with Health Authority and FPC,
   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 HEALTH AUTHORITY AND HEALTH CENTRE ADMINISTRATION

1. General Policy

   Does the Region
   Area
   District
   have a policy on health centre administration.

What is the policy?

Administrators/practice managers,

Supervisors/senior secretaries,

Administrators for more than one centre,

Variation in policy between small and large centres.

2. Liaison

Who in centre liaises with whom in health authority (sector, district, area, region?)

Structure/hierarchy in health authority for liaison.

3. What is the role of the health authority on the centre committee?

4. Limitations on administrators/supervisors:-

Administrative activities,

Financial,

c Personnel,

Supplies.

5. Problems/conflicts which have occurred.

ADMINISTRATIVE ACTIVITIES - ADDITIONAL INFORMATION

1. Employer of reception/secretarial staff - health authority or general practitioners.

2. Employer of manager, HA or GPs.

3. Salary of manager paid by.

4. Salary grade of manager.

5. Where manager is based.

6. Former occupation of manager, how long in post.

7. Procedures for liaising with higher levels of authority:-

DCP

Administrative officers in health authority (sector, district, area),

Nursing officers,

Hospital where applicable.

APPENDIX 3

CASE STUDIES

Centre A

General

This centre, housed above a modern shopping complex in an urban industrial area, was described as a 'case study' in our 1975 report.* The number of doctors, in seven practices,had increased from 21 to 23. There is the possibility of an orthopaedic out-patient session being held, and chiropody is being added to the services in the centre. As before, there were seven GP practices and these retain their separate suites of reception, waiting and consulting rooms.

Administration

Before Reorganisation, Centre A had been run by the local health authority of a large county borough, whose MOH was particularly keen on building centres and where the centres built had been especially well-equipped and furnished. Following local government Reorganisation, this county borough was enlarged by incorporating sections of adjacent counties, and the AHA corresponded to this enlarged new 'county'.

The AHA was concerned only with the planning of health centres and working on this was at least one person who had been in the former county borough LHA. The running of centres was left to the three districts. The district in which Centre A was placed divided its sectors geographically and a sector administrator included Centre A in the 'units' for which he was responsible. He, and the general administrator to whom he was accountable, were both experienced in hospital administration. They felt that Centre A had a better standard of furnishings than the local hospitals and that this would not be maintained in future. Both the sector and general administrator regarded some of the activities, such as toddlers clubs and Darby and Joan clubs, as unsuitable for a health service building and these would not be renewed when they lapsed. In this district, decisions were referred from the health centre administrator upwards in a strict hierarchy, ultimately if necessary reaching the DMT.

Several changes had followed Reorganisation regarding the administration of the health centre. The original health centre administrator had left at the time of Reorganisation. He was replaced by his lady assistant.

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* Note that all centres (A to E) discussed individually in this section were also visited in the first phase of the study (Baker and Bevan, 1975).

The original administrator had been on SO1 grade, but his replacement was on GAA, promoted from HCO (SO1 was unusually high for a post of this type). It is perhaps significant that her appointment had been made by the District, who employed her, without reference to the GPs and they had objected to not being consulted. (By contrast, the first administrator had been appointed by a committee which had included representatives from each GP practice.)

The administrator before Reorganisation had had a limited sum of money to spend on requisitions, but this had been discontinued. However, in some ways, the role of the administrator had been extended, for she attended meetings of unit administrators, had been on a management course and had been given some responsibilities in relation to local clinics.

Decision-making

Before Reorganisation, this centre was unusual among those we visited in that its house committee was planned to be a 'managing' committee rather than just a discussing and recommending type of committee. The committee still meets regularly, but is now said to be an 'advisory' committee. Obviously, the old type of committee would not easily be reconciled with the structure of the health district administration. The membership of the committee was substantially the same (with administrators from the district instead of the former health department). However, the doctors had suggested, and the committee had agreed to, a CHC member coming as an observer. There was annoyance that this decision had not been referred to administrators in the health district.

Comments

This centre is of interest because before Reorganisation it was given rather favourable treatment by the health department, in its furnishing and equipment and degree of autonomy. Its administrator was also the most highly paid we encountered. It was probably inevitable that this preferential treatment would not continue after Reorganisation, as the centre had to be incorporated into the health district organisation.

The services it provided were substantially unchanged, and the family doctors had retained their individual practices, employing all their own staff as before. However, it did seem that Reorganisation had increased the separation between the doctors and the administrators of the health service, although the health centre administrator as such was more involved in the health district.

The same effect, namely separation of the GPs from the health district administrators, was found in another centre in the same district, which we had not visited before Reorganisation. The 18 GPs there operated quite separately from health authority staff and services in the centre, and the district-employed health centre administrator had also been appointed without reference to the doctors.

Centre B

General

Built adjacent to the GP hospital in a country town, the centre housed 9 doctors in one practice, (eight on our visit prior to Reorganisation) and was in heavy use as the local population was increasing. The centre is in one of the 'overlap' areas which have resulted from Reorganisation, and is administered by a district of the neighbouring area health authority.

Administration

This centre had originally been administered by a county health department which (unusually) believed in leaving the running of its health centres to the GPs. As before, the centre was administered by a practice manager employed by the GPs and the GPs still employed all their own secretarial and reception staff. The manager seen on the previous visit had left, and had been replaced by another ex-armed-forces officer. His role seemed to be in continuity with that of his predecessor. The same deputy (a woman) was in post. Much of the administrative work, such as the supervision of practice staff and practice finances, was under the control of the manager and remained unaffected by Reorganisation. However, maintenance and supplies were a major source of complaint.

Previously, the county had allocated a small amount of money which could be spent by the manager locally to get repairs done. This had been discontinued, and instead all requirements had to be referred to a sector administrator. The central-heating system, which had been attended to promptly by a local man, now has to be dealt with by district personnel, who are not so quick in coming. Some GP chairs which needed repairing, a job which would have been done locally in the past, were instead replaced by the district. The lawn-mower for the grounds which used to be repaired locally, now has to go to the area H.Q. for this . The district was reluctant to replace the handyman for the centre, who had died, on the grounds of cost. A replacement was eventually agreed to after the manager had prepared a detailed job description.

Decision-making

Although one or two general meetings of health centre staff (said to be about 40-50 people) had been held, there was still no health centre committee as such. The doctors held practice meetings each week by themselves, and also a short weekly meeting was held to discuss administrative matters, the GPs and the manager being the participants. The manager did not go to any district staff meetings, he liaised when necessary with the sector administrator.

Comments

This centre seemed to be running much as before Reorganisation, as the doctors were left to decide on the internal administration themselves, and when the manager they employed left, they recruited someone to continue in this role. The main change was a deterioration in the means of getting maintenance and repairs done. The manager was not involved in the district, in the way that district-employed health centre administrators in other places which we visited were. There was still no house committee, and the centre still resembled a group practice-owned centre in its administration.

Centre C

General

Sited in a county town next to a GP hospital, this centre housed 8 GPs and services provided were little changed since before Reorganisation. The same health centre administrator, employed by the district, was in post.

Administration

The main change since Reorganisation was that the administrator had taken on the administrative duties required by the adjacent GP hospital. This change had occurred when the 'matron' retired, and her duties were divided between the health centre administrator and a chief nursing officer. A higher clerical officer is the administrative deputy in the hospital. These duties include more staff supervision and responsibility for several types of cash payments which the hospital receives.

Another change has been that the administrator no longer has a sum to spend within a budget allowed for the health centre, as under the county health department, although there was some talk of this being renewed. The administrator felt that the new health authorities did not understand the role of a health centre administrator, and said that such administrators appointed since Reorganisation had been put on a lower grade than that used by the county.

Decision-making

The health centre committee was still officially in existence although it had not met for a year, as no matters had arisen warranting a meeting. The health centre administrator attended regular meetings of health centre administrators in the same area health authority. These meetings had been started before Reorganisation and common problems and issues arising from their work were discussed.

Liaison was much more complex than formerly, involving a sector administrator and several functional district officers. The administrator thought this was a difficult system, as decisions had to be referred to central officers, so that locally staff had responsibilities without authority.

Comments

Although the services provided in this centre, and the health centre administrator, had remained the same, Reorganisation had made some differences. The liaison system was complex and officers were geographically remote. The maintenance budget allowed to the administrator had been withdrawn. However, the administration of the GP hospital had become the responsibility of the health centre administrator, which would not have been possible before Reorganisation, although this role again gave rise to problems over liaison. There were no complaints about maintenance, which was still being done by the county two years after Reorganisation but this was about to be transferred to the health authority. The house committee met much less, but this often seems to happen when centres have been open for some years.

Centre D

General

This centre houses 9 doctors, the usual community health services, child guidance, and also a social services department. This department has continued to be based in the health centre, although it remains a county council department. The same health centre administrator, employed by the district, was in post, so that in terms of services and staff provided from this centre there were no significant changes.

Administration

For the first year after Reorganisation, management was done by the area health authority, as the district did not have the necessary staff in post, or sufficient offices. The county, on an agency basis dealt with maintenance and supplies for 18 months after Reorganisation.

The health centre administrator had been given the authority, since our last visit, to advertise for and appoint clerical and reception staff, informing the relevant personnel officer when the appointment is made. This authority was delegated because the doctors complained that there were delays in replacing staff. However, since then more problems over staff have arisen. The district was not prepared to recruit some more staff (allowable under the reimbursement scheme to the doctors) because the FPC pays the reimbursement to the area, not the district.

The administrator was still on a local authority salary grade, and said he would have to apply for his own job on a Whitley Council agreed grade.

Decision-making

As before Reorganisation there were two internal committees for the health centre. One committee was for the health services in the centre, and met frequently. There was no FPC representative whereas there had been an EC representative before, a district representative had replaced the former local health department representative, and the GP on the DMT attended in addition. Otherwise, the basic membership (GP representatives and the health centre administrator with others co-opted as necessary)was the same. Another committee still met, which was for the building as a whole and included social services department representatives. Certain costs are still shared between the health and social services departments.

The health centre administrator also now attended regular meetings of senior officers in the health district, most subjects discussed had been related to hospitals.

Comments

With Reorganisation the health centre administrator had gained authority to appoint office staff which the local government health department had not allowed. However, there were financial problems preventing the recruitment of further staff who were in theory allowed to the centre, (using the rate of 2 per GP). The administrator was also an attender at regular district officers' meetings, whereas similar meetings had not occurred under local government administration. Maintenance and supplies at the time of interview were still being done by the county, and there was no change in this field.

Centre E

General

This busy urban centre housing 11 GPs and linked by corridor to a GP hospital, provided a comprehensive range of community health services, and had recently been enlarged to cope with extra demand. Doctors employed their own staff including a deputy to the health centre administrator. The district employed the health centre administrator, who had been in post since the centre opened, before Reorganisation. The GP hospital was administered separately.

Administration

As the office staff (excepting the health centre administrator) were GP employed there had been no effects on their selection and supervision, and the internal organisation of the centre was little altered. The health centre administrator was still being paid a local authority salary grade and felt that health authorities were appointing health centre administrators on lower grades not commensurate with the job. Problems had arisen over maintenance since Reorganisation, as it was said that going through functional officers caused delay and was frustrating.

Decision-making

Internal committees continued to function as usual after Reorganisation. There was a house committee comprising the GPs, the health centre administrator and the deputy, a district nurse, a nursing officer, a health visitor and her superior, the sector administrator (formerly there had been a local health department representative), the DCP (formerly a local medical officer had attended) and occasionally an FPC representative. The committee met as regularly as before, and another meeting continued to be held regularly for office staff with a GP representative to sort out problems of reception etc.

The health centre administrator, however, since Reorganisation was now involved in two district committees, both held monthly. One comprised the sector administrator and the health centre administrators in the district, the other was a line management meeting including health centre administrators, unit administrators (from hospitals) and the district administrator.

Liaison was said to be difficult now because there were so many lines of communication, both to various functional officers and through the administrative hierarchy,whereas before there was usually one person to contact.

Comments

In this centre getting maintenance done, and the general problem of liaison in a complex administration, had caused complaint. This was in spite of goodwill towards health centres in this district, and the involvement of health centre administrators in regular meetings with district personnel.

Some other variations found of special interest

We noted three further types of administrative arrangement of interest. Firstly, in one district, one administrator, at GAA level, was appointed to be the health centre administrator of two centres, which were some miles apart. Her time was divided strictly in half between the two, and there was a deputy* in each centre. This arrangement might be an answer for those who object to appointing a full time GAA administrator for one health centre on the grounds that the work does not justify the grade. It is also an arrangement that increases the workload of a health centre administrator, which often diminishes once a centre has "settled down", leaving the administrator feeling there is not enough to do.

Secondly, we visited a small rural health centre (3 GPs) where one of the GPs had effectively taken on the "internal administrator role". He said they could not afford to employ, although they would like to have, a practice manager type of person. The GP liaised with functional departments or the appropriate administrator in the health authority as well as supervising administrative matters within the health centre.

Thirdly, one single district area we visited had established committees for professional users of its community hospitals and the related community health services, including the health centres associated with the community hopsitals. The health centres as such tended to be small and in rural areas, and the senior secretary or receptionist employed in them would liaise with a community administrator for a geographical area. This administrator was on the users committee, together with hospital and community health staff, and local GPs.

This was the only arrangement we came across which seemed to be attempting to integrate and co-ordinate local community health services. In particular it was an arrangement which included the GPs, and as we discussed in 'Issues' above, GPs may easily be excluded** from the structure of district or area administration which has come about with Reorganisation.

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* Primarily a secretary/receptionist

** i.e. below the DMT level

APPENDIX 4

EXAMPLES OF ADVERTISEMENTS FOR ADMINISTRATIVE POSTS IN HEALTH CENTRES

The following are some advertisements which appeared in the Health and Social Service Journal during the period 1973 to 1978.

1973

County Borough of TEESSIDE

HEALTH DEPARTMENT

MANAGER REDCAR HEALTH CENTRE — £2,388 to £2,661

The Manager, to be appointed before the Health Centre opens, will carry out the preparatory organisation culminating in the creation of a co-ordinated administration structure and leading to the formation of a largely autonomous Health Service unit. The post calls for reserves of energy and tact, and the salary reflects the challenge and problems associated with this opportunity to be involved in an exciting project. Applicants able to demonstrate appropriate levels of achievement will be encouraged, and it is expected that the successful candidate will possess degree level qualifications.

This advertisement is placed after consultation with the Staff Commission and applications are restricted to Local Government Officers serving in England (excluding London) and Wales.

Job description and application forms may be obtained from the Medical Officer of Health, 108a Borough Road, Middlesbrough, Teesside, and should be returned by 16th July, 1973.

Health Centre Appointments

LONDON BOROUGH OF WALTHAM FOREST
Health Department

ADMINISTRATIVE ASSISTANT
at St. James Street Health Centre

Applications are invited for this senior post at a very busy health centre opened in September, 1970. The successful candidate will be required to organise and control the clerical and reception services, appointment and record systems and day-to-day running of the Centre, where seven General Practitioners are based.

Salary AP2, £1,635 to £1,908, inclusive of London Weighting.

Application forms and detailed job description from Personnel Officer, Town Hall, Forest Road, London, E17 4JF. Closing date 27th July, 1973. Quote Ref. F029.

Local Authority Administration

HAMPSHIRE

HEALTH CENTRE MANAGER

Alton

The Person—We are looking for a person with an all-round background in administration—either a non-medical officer from the administrative branch of the Services, or someone appropriately qualified with similar experience in a Hospital, Executive Council, or Local Health Authority.

The Job—The Manager will have the opportunity of exercising a wide range of skills in a newly built Health Centre providing 7 General Practitioners' suites, Local Health Authority and Regional Hospital Board Services.

The Salary—Within a range £2,100 to £2,661 per annum (under review).

Application forms returnable by 17th September, 1973, are obtainable from the Clerk of the County Council, The Castle, Winchester, quoting Reference SE2133/PEV.

DONCASTER

HEALTH CENTRE ADMINISTRATOR

£1,926 to £2,235

Experienced administrator required immediately at a new Health Centre to take full responsibility for all non-medical work. Duties will include management of clerical and ancillary staff, ordering of supplies and equipment, organisation of clinic activities, office administration and aspects of building maintenance.

An administrative qualification and work experience in a medical environment would be advantageous but proven administrative ability is more important.

Removal expenses and housing available if appropriate.

Application forms from the Management Services Section, Town Clerk's Department, 8 Kingsgate, Doncaster, telephone Doncaster 6543, to be returned by 16th November, 1973.

2. HEALTH CENTRE MANAGER, GRADE AP4

Salary: £2,205 to £2,493, including London allowance. A purpose-built health centre providing accommodation for general medical and dental practitioners is to open shortly on the new Grahame Park Estate, Colindale, NW9. Applicants will need to be of proved experience either in hospital or local health authority administration or similar work in general medical practice. The person appointed must be able to establish good relationships between medical practitioners, dentists, nursing, clerical and reception staff who will be working in the centre.

MANAGER

Hanwell Health Centre

£2,340 to £2,640 per annum inclusive

Required now for the Centre which is due to open in January 1974. The Centre will accommodate 4 general practitioners, family health and school health services, including dental services.

Duties of the post will include organising and supervising 10 clerks and receptionists, liaising with general practitioners and being responsible for the general administration and security of the Centre. The Manager will also act as secretary to the Centre Management Committee.

Job description and application forms from Medical Officer of Health, Town Hall, Ealing W5 2BY (Tel. 567 3456, ext. 206). Closing date 24th September, 1973 (Ref. 764HS).

Ealing
London Borough

Buckinghamshire County Council

HEALTH CENTRE ADMINISTRATOR

A.P.4 — £2,235 to £2,535

Experienced administrator required immediately at a new Health Centre at Stony Stratford, Milton Keynes, serving a population of 20,000 with General Practice, Hospital Out-patient and Local Authority services, to take full responsibility for all non-medical work. Duties will include management of clerical and ancillary staff, ordering of supplies and equipment, organisation of clinic activities, office administration and aspects of building maintenance.

An administrative qualification and work experience in a medical environment would be advantageous but proven administrative ability is more important.

Removal expenses and lodging allowance where applicable. Housing may be available.

Application forms from Area Medical Officer, Area Health Office, 224 Queensway, Bletchley, Milton Keynes MK2 2SU.

1974

After Reorganisation (NHS)

Camden & Islington Area Health Authority

KENTISH TOWN HEALTH CENTRE

ADMINISTRATOR

(£2,676 to £3,291, plus £126 London Weighting)

To be responsible for the smooth running of the Centre which comprises two medical group practices a general dental practitioner and extensive range of school health and personal health services.

Duties will include responsibility for proper maintenance of the premises, replenishment of stores, allocation of duties and training of some of the Area Health Authority staff employed at the Centre.

Should be administratively capable of maintaining a high level of support to professional members of the various disciplines and providing a prompt and efficient service to the public.

Further details and application forms from the Staff Section, Community Health Services (Camden), Camden and Islington Area Health Authority (Teaching), Bidborough House, 38-50 Bidborough Street, London, WC1H 9DB. Reference No. 26/HSJ. Closing date 16th September, 1974.

KENSINGTON AND CHELSEA AND WESTMINSTER
AREA HEALTH AUTHORITY
COMMUNITY HEALTH SERVICES

ADMINISTRATIVE OFFICER

Laymede Health Centre
Telford Road, London, W.10

Applications are invited for this post which has been established to provide administrative support to the staff at this newly built centre which provides child health services, chiropody unit, dental centre and where Health Visiting and Home Nursing services are based to serve the local community.

Salary scale £1,866, rising to £2,502, plus London Weighting (General Administrative Grade).

Conditions of service as prescribed by the Administrative and Clerical Staffs Whitley Council

No housing accommodation.

Application forms and further particulars from Staff Section, 25a Kensington Square, London, W.8 (Telephone 01-937 5464).

SEFTON AREA HEALTH AUTHORITY
SOUTHERN DISTRICT
Netherton Health Centre

HEALTH CENTRE MANAGER

(General Administrative Grade, £1,995 to £2,676, plus Threshold payments)

An Administrator is required for the Netherton Health Centre which is to be opened in February 1975.

The Centre, which will serve a population of some 30,000, will provide General Medical Practitioner Services through two full-time practices and one large group practice. It will provide Community Health Services including child health, dental, chiropody, speech therapy and other specialist medical services and also a base for other members of the primary care team—health visitors, school nurses, district nurses and social workers. A staff of 52 will be based in the centre (excluding family practitioners) but including 11 clerical and reception staff, etc.

The successful candidate will have to be of proven administrative ability and should preferably have experience in at least one branch of the health service.

Application forms and job descriptions available from the: District Administrator, Sefton Area Health Authority, Southern District, District Headquarters, Walton Hospital, Rice Lane, Liverpool, L9 1AE, to be returned not later than 28th December, 1974.

1975

SUNDERLAND AREA HEALTH AUTHORITY
Community Health Services

HEALTH CENTRE ADMINISTRATOR

Applications are invited from officers employed in the merged Health Services for the above post which is on the General Administrative Assistant Grade £3,691 to £3,534

The successful candidate will be based at Monkwearmouth Health Centre and be responsible for the Sunderland North Sector, one of four sectors within the Community Health Services in Sunderland

Specific duties include responsibility for the smooth running of clinic activities, management of clerical and secretarial staff and monitoring the services within the Sector.

Job description and application form may be obtained from Area Personnel Officer, Administrative Annexe, General Hospital, Chester Road, Sunderland, Tyne and Wear. Closing date 22nd August, 1975. Y136

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY
Aylesbury District

HEALTH CENTRE ADMINISTRATOR

General Administrative Grade : Salary £1,895 per annum, rising to £2,676 per annum, plus threshold payments

Administrator required at the recently commissioned Stony Stratford Health Centre. The Centre, one of several such units to be built throughout the new city of Milton Keynes, provides general practice, hospital out-patient and community services for a population of 20,000 and the administrator is responsible for all non-clinical work. Specific duties include management of clerical and ancillary staff, ordering of supplies and equipment, organisation of clinical activities, office administration and aspects of building maintenance.

Proven administrative ability essential. Possession of an appropriate professional qualification and administrative experience in the Health Service an advantage.

Single or married accommodation may be available. Application form and job description available from the Community Services Administrator, 234 Queensway, Bletchley, Milton Keynes. Tel: Milton Keynes 74701, Ext. 10.

Closing date 2nd April, 1975. D158

Administration Section

SENIOR ADMINISTRATIVE OFFICER

Administration

Salary scale: £3,534 to £4,344 (SAA grade)

To be responsible to the Administrator for the control of the Administration Section of the Service.

ADMINISTRATIVE OFFICER

Health Centre planning and Management

HEALTH CENTRE ADMINISTRATORS

(2 posts)

Salary scale: £2,691 to £3,534 (GAA grade)

Applications are invited from persons suitably experienced in hospital or community health work for the above posts. Possession of an appropriate qualification will be of advantage.

The first post will be based at Lyon House, Wandsworth High Street, SW18: the Health Centre Administrators will be based at new Health Centres in Battersea, Wandsworth, to be opened later this year.

A London Weighting allowance of £312 per annum is payable in respect of all posts. Closing date: 21st August.

Application forms and further details obtainable from the Administrator, Wandsworth Community Health Services, Staff Section, Lyon House, 102/104 Wandsworth High Street, SW18 4LA. Tel. 870 4211, ext. 34 and 36.

Community Health Services

Wandsworth and East Merton
Teaching District

Islington District

Health Centre Administrator

Salary : £3,003 to £3,846 per annum inclusive.

The successful applicant will be required to carry out general management of the centre and the supervision and control of the clerical and manual staff. This is a busy Health Centre (situated next to the Essex Road Underground station) and is purpose-built to facilitate the full range of Community Health Clinic Services; General Medical Practices and an ILEA Child Guidance Unit. Previous experience and/or an appreciation of Health Centre functions would be an advantage. This post will provide ample scope for initiative and drive.

For further details and application form, please contact :

The Sector Administrator (CHS/Staff),
Camden and Islington Area Health Authority (T),
Community Health Services,
Islington District,
159-167 Upper Street,
N1 1RE.
(Telephone 226 4488, ext. 280.)

Closing date 22nd October, 1975.

H63

Camden and Islington A.H.A. (Teaching)

1976

WORCESTER HEALTH DISTRICT

HEALTH CENTRE ADMINISTRATOR

General Administrative Assistant

Salary £2,691 to £3,534

Worcester Health District will be requiring an Administrator for the new Health Centres opening at Evesham and Pershore during 1976. Plans are also being prepared for a Centre in Droitwich to be built in 1977.

The Administrator will be required to commission each Health Centre and provide general administrative services for each. The post holder will be based at Pershore.

Job descriptions and application forms obtainable from:

District Personnel Office,
Worcester Health District,
Croft Road,
Worcester.
Tel: Worc. 27122, Ext. 239.

Closing date 19th January, 1976.
SG

South Camden Health District

Kentish Town Health Centre

Bartholomew Road, NW5
(close to Euston and Kings Cross Station)

ADMINISTRATOR

(Senior Administrative Grade)

For this modern and well-known Health Centre. Applicants should possess general administrative skills and enough knowledge of the Health Service to enable them to co-ordinate the activities of about 100 staff (of many disciplines), including two large Group Practices. Stimulating post for one interested in promoting and supporting a primary health care service.

Salary on scale £3,534 to £4,344 per annum, plus £312 London Weighting and £312 supplement.

Job description and application form, returnable by 27th July, 1976, available from Personnel Department,

University College Hospital, Gower Street, WC1E 6AU. Tel. 01-387 9300, ext. 381.

U77

Camden and Islington A.H.A. (Teaching)

1977

WINCHESTER AND CENTRAL HAMPSHIRE HEALTH DISTRICT

UNIT ADMINISTRATOR/ HEALTH CENTRE MANAGER (GAA Grade)

required for the Andover War Memorial Hospital and two Health Centres in Andover.

Challenging post provides opportunity for hospital and health centre management and planning experience, on a site being actively planned for development as a Community Hospital.

Person appointed will have scope for demonstrating qualities of drive and initiative over a wide range of duties. Post suitable for young administrator with flair and a mature approach to solving management problems.

Informal enquiries to Mr I. Weale, Sector Administrator 1, Royal Hampshire County Hospital, Romsey Road, Winchester, Hants. Telephone Winchester 63535.

Job description and application form obtainable from the District Personnel Department, Royal Hampshire County Hospital, Romsey Road, Winchester, Hants. Telephone Winchester 63535, ext 350.

Closing date: January 18, 1978.

O44

CLINIC MANAGER

The successful candidate will be responsible for the North Sector of the three Sectors in the Community Health Service in Wolverhampton.

Specific duties include responsibility for the smooth running of five Clinics and one Health Centre, also management of secretarial and clerical staff, and in monitoring of services within the Sector.

Salary scale £2,691-£3,534 plus £312 pa supplement plus 5%. Job description and application form available from the Administrator, Community Health Services, Bankfield House, Wolverhampton. Telephone 24625, ext 42.

Q12

North Hammersmith Health District (Teaching)

Community Health Services

As a result of our community health services being expanded a new health centre is being opened in Avenue Road, Acton. We therefore require a

Centre Supervisor

to ensure the smooth and efficient running of the services provided including the providing of clerical support when required. Ability to work with all grades of staff essential and previous health centre experience an advantage. The successful candidate will be required to cover a clinic session on one or two evenings a week.

Salary on scale £2,989-£3,524 pa inclusive. First appointments to the Health Service normally commence on minimum of scale.

Hours 8.30am-4.45pm Monday to Friday with time off in lieu for evening work.

Application forms and job description obtainable from Personnel Department, Hammersmith Hospital, DuCane Road, London W12 0HS. Tel: 743 2030, ext 323.

Closing date November 7, 1977.

K82

DARWEN HEALTH CENTRE

Applications are invited from persons with National Health Service or similar experience for the new post of

SENIOR RECEPTIONIST

(General Administrative Assistant Grade)
Salary £2,691-£3,534 plus £312 pa plus 5% pay award

The Darwen Health Centre is a new purpose-built unit shortly to be brought into use and will provide accommodation for eight general practitioners and other professional staff, providing health services for the community served by the centre.

The person appointed therefore, in addition to having responsibilities to the General Practitioners for General Practitioner Services including the organisation of their receptionist, will be responsible to the Sector Administrator for the upkeep of the Centre and for matters connected with the provision of other Community Health Services. The ability to communicate with many disciplines — for example: medical nursing, para-medical, ancillary etc — is essential together with proven organising and co-ordinating ability.

Application form and job description available from the District Personnel Officer, Health District Central Offices, Queen Park Hospital, Blackburn, Lancs. Tel: 661311.

Closing date: August 8, 1977.

BLACKBURN HEALTH DISTRICT
Lancashire Area Health Authority

1978

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH DISTRICT

Fareham Health Centre

GENERAL ADMINISTRATIVE ASSISTANT (£3153-£4038 inclusive of supplements)

To manage this very busy Health Centre including the supervision of some 85 staff.

We need someone of proven ability, with tact and drive, able to liaise with staff at all levels.

If you think you meet this requirement, please send stamped addressed envelope for job description and application form to: Administrator, Community Health Services, 16 High Street, Gosport. Closing date: 26th April, 1978.

(J5)

City & East London Area Health Authority (Teaching)
Tower Hamlets Health District

Health Centre Administrator

Salary: £2989-£3525 inclusive p.a.

We are looking for an Administrator for our Health Centre in the Limehouse area E14. As the Administrator you would be responsible for the day to day management of the centre, the co-ordination of its services and support staff, and would become an active member of the Districts Community administrative staff.
Helping medical and nursing staff in the development of primary care, assisting the public in making full use of the centre, acting as host and guide to visitors, all form elements of the post which will go together to make this a successful centre.
Previous Health Service experience may be an advantage but applicants with other management experience will be welcomed. This post offers an excellent opportunity to begin a satisfying and rewarding career in the Health Service and may well appeal to those of graduate or equivalent educational level.

For further details application forms and job description contact either Mike O'Meara or Staff Section on 01-377 9217, Personal Health Services 22-28 Underwood Road, London E1 5AE. Closing date 2nd June.

(O34)

SOUTH WEST DISTRICT

ADMINISTRATIVE ASSISTANT

Hinckley Hospital and Health Centre

As a result of the opening of a new health centre in Hinckley, this post, which is on the general administrative grade, is now available. It offers good experience to administrators who wish to gain detailed knowledge of community work and there will also be some involvement in Hinckley Hospital.

If you would like to discuss the post, please contact John Mansfield, Sector Administrator, Carlton Hayes Hospital, Narborough, Leicester. Tel: 863481.

Job descriptions and application forms are available from Richard Jones, District Personnel Officer, South West District, The Leicester Royal Infirmary, Infirmary Square, Leicester.

D12

Leicestershire Health Service

LEICESTERSHIRE AREA HEALTH AUTHORITY (TEACHING)

HIGHER CLERICAL OFFICER

HEALTH CENTRE MANAGER

Applications are invited from enthusiastic persons for this post in the new Meadows Health Centre, due to open in autumn 1978. The successful candidate will work closely with the Unit Administrator assisting in the task of commissioning the new premises and this may involve working part of the time at Cedars Hospital, Mansfield Road, Nottingham, prior to the opening of the Health Centre. Following the opening you will be responsible for the day-to-day management of the Centre, the co-ordination of its service and support staff, and would become an active member of the Community Administrative Staff. Helping medical and nursing staff in the development of primary care, assisting the public in making full use of the Centre, acting as host and guide to visitors, all form elements of the post which will go together to make this a successful Centre.

Previous Health Service experience may be an advantage, but applicants with other management experience will be welcomed.

An excellent opportunity to begin a satisfying and rewarding career in the Health Service.

Salary: £2623-£3153 p.a. (inclusive of non-enhanceable supplements). Pay award pending. New entrants to NHS commence at the minimum of the salary scale.

Current Driving Licence desirable, but not essential.

Further details and application form from: Mr. J. Luck, Community Administrator, Cedars Hospital, Mansfield Road, Nottingham. Tel: Nottm 623355.

(T113)

Closing date: 30th June.

SOUTH NOTTINGHAM HEALTH DISTRICT (T)
Nottinghamshire Area Health Authority

Manchester Area Health Authority (T) Central District

Community Health Services

HEALTH CENTRE ADMINISTRATIVE OFFICER

G.A.A. Grade. £3133 pa-£4025 pa inclusive (pay award pending.) Car an advantage — mileage allowance payable.

The successful applicant will be initially based at the Moss Side Health Centre and will ultimately control a second Centre in the District.
The post involves the management and development of the Community Health services clerical staff provided in the health centres, liasion with the General Practitioners and community Medical Nursing, para medical and support services to ensure the smooth running of the Centre.
Previous supervisory/managerial experience desirable.
For further details and application form contact, The District Personnel Dept., St. Marys Hospital, Manchester M13 0YH Telephone 061 224 9633 ext 594.

Closing date 7th July 1978.

(T50)

BERKSHIRE AREA HEALTH AUTHORITY (EAST DISTRICT) (BRACKNELL/ASCOT SECTOR)
Skimped Hill Health Centre

HEALTH CENTRE ADMINISTRATOR

Applications are invited for this new post. The health centre is situated in the Bracknell Town Centre and will provide facilities for general practitioners, nurses and health visitors, together with other community health services. The successful applicant should be tactful, understanding, resourceful, and preferably have had previous Health Service experience. Other administrative duties within the sector will be included in the post which may be discussed informally with Colin J. Harris, Sector Administrator. Tel: Bracknell 22722.

Application forms together with a copy of the job description from District Personnel Officer, East Berkshire Health District, 81 Frances Road, Windsor. Tel: Windsor 62365, ext 13.

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- DHSS and Welsh Office (1974) Community Hospitals: Their role and development in the NHS. Enclosed with HSC (IS) 75.

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GLOSSARY

AHA	Area Health Authority
CHC	Community Health Council
DCP	District Community Physician
DMT	District Management Team
EC	Executive Council
FPC	Family Practitioner Council
FPS	Family Practitioner Services
GAA	General Administrative Assistant
GP	General Medical Practitioner
HA	Health Authority
HC	Health Centre
HCO	Higher Clerical Officer
LA	Local Authority
LHA	Local Health Authority
MOH	Medical Officer of Health
RHB	Regional Hospital Board
SOI	Senior Officer I