Administrative aspects of health-centre management

A small conference sponsored by the Department of Health and Social Security was held by the Health Services Research Unit of the University of Kent at Canterbury on 6–7 April, 1972 under the Chairmanship of the Director of the Unit, Professor M. D. Warren. The purpose of the conference was to provide a forum for the exchange of information and ideas on health-centre administration including the role of health centres in relation to other community health and hospital services, the organisation structure within health centres, and the practical and financial considerations involved in initiating health centres.

Delegates included administrators, medical and nursing officers from the Department of Health and Social Security and local authority health departments, general practitioners working in group practices and health centres, a clerk of an executive council, in addition to research workers.

1. Health-centre management

Professor Michael Warren

Professor Michael Warren, opening the conference, stressed that it was concerned with administrative aspects of group practice and multiple group practices inside or outside ' Section 21 ' health centres, covering both administration and management—if these two are different—of the centres. The number of health centres had been growing rapidly and a parliamentary statement in March 1972 reported that at the end of February 1972 there were 284 health centres in operation in England with another 80 centres planned to open in 1972 and 90 planned for 1973. It is estimated that about eight per cent of general practitioners now practise from health centres and this proportion and the trend towards larger group practices is increasing.

In health centres there is another phenomenon, multiple group practices. This raises new management problems as does the employment of an increasing number and variety of staff, doctors, reception and secretarial staff, social workers, health visitors and nurses, dentists, chiropodists and various members of the remedial services. There is often a need for more sophisticated appointment systems, rota schemes and records and registers of patients (age–sex, morbidity and surveillance). In addition, some health centres are being used for outpatients sessions by hospital consultants, casualty work and minor surgery and for training staff in community medicine. All these factors can create problems regarding management, maintenance and accommodation.

In looking at the management needs of health centres it is essential to define the objectives of the centres, which include improved accommodation, co-operation and an improvement in the standard of work with use of greater variety of skills.

Unambiguous methods of reaching decisions are required in the health centre itself, while at the district level the main problem would seem to be the co-ordination of staff hierarchies and the representation of the general practitioner. At the area level, questions of staff and personnel management and the role of the community physician need attention. In addition, financial management techniques and information systems need to be established to evaluate costs of health-centre services and performance. These were just some of the questions the conference might discuss.

Mr John Bevan

Mr John Bevan, Deputy Director of the Unit, described briefly the current work of the Unit in health centres. The studies, some of which were still in progress, were in three main areas:

1. *Transport.* The effect of public and private transport on the demands made of health centres.

2. *Workload.* The implications for the nature and magnitude of the workload resulting from the mix of personnel and the availability of more sophisticated equipment.

3. *Attitudes.* Attitude studies relating to patients' views on the quality of care, convenience and congeniality of health centres.

Among the findings that had so far emerged were the importance of transport arrangements on attendance at centres, an increase in patients' attendances, fewer requests for home visits, and an initial move to conformity by doctors in their working practices, followed by a reversion to their original pattern.

One study was examining attitudes of patients to the use of a practice nurse for a variety of additional duties, and another study now in progress was looking at attitudes to a new arrangement of services. In this system the patient is examined by a doctor and any other necessary personnel in a cubicle while the doctor is mobile, visiting other patients in other cubicles after they have been prepared for treatment or examination by nursing staff.

2. Organisation theory and the health service

Mr Stephen Cang

Mr Stephen Cang of the Health Services Organisation Research Unit of Brunel University prefaced his talk by stressing that his experience of the health service had been mainly gained in the hospital environment. However, in all parts of the health service there were similar problems, the main ones being the complexity of the provision of service to the patient, involving many separate services, and the autonomy of the medical practitioner.

In this complex situation how can the theories of organisation be seen to apply, and, in particular, do the concepts of management operate? A major problem was the lack of definition of a manager. A *managerial* relationship can be said to exist when one person is accountable for the work of a subordinate, a concept that does not apply to all working relationships. Accountability in this situation implies three basic elements of authority, namely:

1. The manager must be able to decide the subordinate's work assignments.
2. The manager must be able to record an assessment of the performance of the subordinate.
3. The manager must be able to veto the appointment to the position, i.e. he must find his subordinate although not necessarily choose him himself. If he finds the subordinate unacceptable then he must have the authority to have him transferred.

In the health service these conditions are to be found in some working relationships but not in others. In particular general practitioners and consultants cannot *be* managed (although they can manage) because of their clinical autonomy. Moreover, the existence of a professional body also affects the rules of an employment situation, as an individual's professional performance must be governed by professional ethics and codes of conduct, and his employer cannot make him act otherwise. Thus professionals can be organised in a hierarchy (apart from consultants and general practitioners) but the managers must come from and be part of that same professional group.

Group discussion

The group discussed with Mr Cang how these concepts applied to doctors employed in community health services. Mr Cang emphasised again that general practitioners and consultants are not accountable to anyone for the quality of their professional judgment, although in local authority health departments there may be fairly well-established hierarchies.

It is necessary to distinguish between managerial and representative relationships. The latter involve group membership, perhaps with a chairman being given some authority by group consensus over members and acting as their representative. Group membership relies on the use of sanctions and other group methods, rather than a superior/subordinate relationship.

Other more precise descriptions of different elements of authority have had to be developed to cover the various working relationships in the health service. These cover monitoring situations and co-ordinating relationships.

The first, the *monitoring* relationship, must be seen as different from the managerial one. The conditions covering it are that the monitor has to have the authority to gain access to examine progress and activities. The monitor may then report upwards and advise on the need for further review of activities.

On the other hand, a *co-ordinator* is usually a role established for a particular project. There is usually an agreed plan and the co-ordinator expedites progress by persuasion, calling meetings of the collaterals involved and may inform those responsible for his appointment of

progress. Representative structures have recently been established in the various professions in the Health Service and the monitoring and co-ordinating methods have also been used and proposed across the board. There appears to have been confusion between an understanding of the limits of these kinds of structure, and those of a true managerial nature.

Discussion then focused on the relationship between general practitioners and health visitors and other community nurses. Concepts of out-posting, attachment and alignment were examined. In an *out-posting* situation the subordinate works in a different territory but still the same relationship exists with the original superior, with perhaps some monitoring of hours and provision of office services by the local manager.

Attachment occurs when a junior specialist is required to serve under a non-specialist, while at the same time remaining subordinate to a specialist superior. A situation of alignment exists when those providing the services allocate personnel to work within the structure of the general-practitioner services. This depends on good liaison and working relationships between the local authority and executive council. The delegates examined these concepts in relation to particular examples of the use of nurses in the community.

Members commented on the changes inherent in the future structure of the health service at area board level. General practitioners will still not be directly accountable for their professional judgment but more mechanisms will exist to represent them in policy-making bodies for the area. Moreover, the community nursing service, following the Maston report, will be established as a professional hierarchy and in this situation a managerial-type structure relating to general practitioners would be inappropriate as nurses would have their own professional hierarchy.

With regard to health centres, Mr Cang pointed out the need for a clearly defined policy-making structure. Teams had their limitations, often obscuring the line of authority between those providing the services and those who are formally accountable for the use of these resources. He pointed to an example in the hospital service where a nurse had been included in a radiology department. There it was found possible for the radiologist to have managerial responsibility for the nurse on the day-to-day work while the chief nursing officer had more of a monitoring role. This might provide a point of consideration in relation to the health centres.

3. The administration of health centres

Mr Philip Lloyd

Mr Philip Lloyd, Chief Administrative Officer, Hampshire County Council Health Department, outlined the experience of his county in administering health centres, describing some of the problems that had arisen and the solutions found. In the development of health centres Hampshire had seen the general practitioner as the ' king-pin ' and this thought had been behind their actions.

Various methods of administering health centres had been tried. Initially a manager had been appointed at one centre at a fairly junior level to be responsible to the health centre committee for office management and maintenance but this approach had failed to get the co-operation of the general practitioners. The centre had then been administered by the head-quarter organisation but there had been problems of distance and lack of on-the-spot knowledge of situations.

Another method tried at a health centre had been to give the centre committee management responsibility with a senior receptionist having day-to-day responsibility. Finally, it had been decided that it was necessary to have a full-time manager at a fairly senior (middle manager level), able through his background and personality to gain the confidence of those working in the centre. This solution, in practice at one centre, was now being welcomed by others.

Mr Lloyd identified some of the problems inherent in the administration and management of health centres. These included the role of the general practitioner as an independent contractor and his training in independence with his lack of training and experience in administration. The relationships in the centre need attention in terms of long and short-term general and financial control, the balance between the general practitioners' service to patients and the local health authority's administrative responsibility, and the many professional services involved. And in the day-to-day running of the centres there could be problems because of the distance

of centres from local offices, and in the misuse of time of professionally trained staff in minor administrative matters.

Mr Lloyd then defined the objective of management of a health centre as follows: "To enable doctors belonging to one or more practices to work together and with other professional colleagues to maintain health and treat illness in a defined community in the most effective way." This means that services have to be provided to enable doctors and others to provide treatment, there has to be co-ordination of professionals without authority over them, and control must be retained by the professionals.

The task of the manager is to co-ordinate these services and, therefore, the manager must have the personality, experience and authority to work to the centre committee and to be accepted by all the staff. He advocated that a salary of at least £2,500 per annum was necessary to recruit someone of sufficient calibre, the major part contributed by the general practitioners at the centre. It would be possible to make the manager responsible for more than one centre, or to move him to new centres as they were opened.

The question of necessary status was raised—could a senior receptionist, or similar, do the job as well. In Devon, Dr Lyons said it was felt that experience with people was more important than management expertise. Senior receptionists or ' queen bees ' had been appointed, with their salaries entirely paid by the County Council. Problems had only arisen in two of the 30 health centres. However, these centres were generally small, the largest accommodating seven general practitioners.

Philip Lloyd emphasised that it was advantageous to employ someone well versed in modern management techniques. In the future there would be great competition at area health board level for resources. Health centres and group practices would be among those competing and it would be essential to present their case in a professional way using the techniques of management espoused by the Department of Health and Social Security. The manager of the centre must be the person best fitted to do this. The members then discussed how far those in group practices and individual general practitioners would be left out in this competitive system.

The centre committees in Hampshire vary in their constitution. Usually each principal is a member of the committee together with representatives of the County Council (medical officer of health, chief nursing officer and administrative representatives) and the executive council. Some have sub-committees representing all the practices, and it was suggested that the committee should include other professions and even a consumer.

Discussion on the structure of health centres followed, including the need for some formal structure within the centres to ensure feedback from all in the centre, and on the role of the manager in relation to the centre committee and his responsibility to the medical officer of health. Questions on the confidentiality of information on general practitioners' claims to the executive council, the benefits of administrative backing for nursing staff and the optimum size of centres were also discussed.

In conclusion, Mr Lloyd said that he was confident that the employment of a manager of sufficient status, suitable experience and with a pleasant personality could enable an improvement in the services provided by health centres. The job of the manager would extend as services developed and information needs grew. The manager would enable the professional staff to concentrate on their professional services and would serve to co-ordinate these services.

4. Planning, design and financial considerations

Mr J. Saunders

Mr J. Saunders, Chief Administrative Officer of West Sussex County Council Health Department, gave a talk, illustrated by slides, on the practical aspects of planning and managing health centres. He traced the history of the establishment of health centres from the early calls for co-ordination of services, to the present provision of 280 centres with plans for more than 700 in 1974. In particular, Mr Saunders said, county councils have been more forward-looking in their provision than county boroughs.

West Sussex was opening its fifth health centre, six more are in progress and another 14 are planned over the next three years. The experience of West Sussex has been that the success

or otherwise of centres is determined by the amount of care and attention given at the planning stage. Sites must be well served by public transport, with car parking facilities, and should allow for future expansion of services.

In the design of accommodation the Ministry of Health *Design Guide* of 1968 has been helpful, but it is also necessary to discuss with those who will work in the building, and the design architect, such details as circulation patterns and the layout of rooms.

Mr Saunders illustrated his points on design and planning with slides showing parts of the health centres in West Sussex. These covered the following points:

1. *Treatment rooms.* The first health centre included two treatment rooms, each serving five general-practitioner suites, with county council nurses provided in these rooms at no charge to the general practitioners. In future, unless the centre is very large, only one treatment room is likely to be provided.

2. *Layout of rooms.* Room layouts must be agreed with those who will work in them. A well-planned consulting room can be provided in 120 sq. ft.

3. *Floor finishes.* West Sussex has provided wall-to-wall carpet in all non-treatment areas of centres with the advantage of cheaper long-term outlay, reduced sound and increased comfort.

4. *Common room.* This is very important for staff co-operation and should be near the office if it is to be used regularly.

5. *Office accommodation.* Office accommodation for nurses and social workers. West Sussex has found well-landscaped large offices successful if private interview rooms are provided.

6. *Planning of office systems.* Time must be spent with general practitioners discussing the systems they plan to use. Mr Saunders claimed that a doctor who uses an appointment system with an average list of 2,500 patients requires only 60 per cent of the waiting area of one without such a system.

If building costs are £7 a sq. ft., about £4,000 can be saved on waiting accommodation in a health centre with ten consulting suites, and, in addition, there are continuing revenue savings on cleaning and maintenance. Mr Saunders showed slides illustrating patient-call systems and various methods of helping patients to find their way around buildings, including signposting and the use of coloured symbols.

7. *Communications.* Other important considerations are the telephone system to allow for easy transfer of calls, and tele-dictating facilities for doctors. Document conveyors can also improve communication between reception, consulting and treatment areas.

8. *Storing records.* Medical record storage must be flexible to cope with present cards and to allow for change. West Sussex use wall cabinets with lockable roller blinds—five shelves will hold 3,500 EC5 records.

In the allocation of costs, general practitioners are less concerned with rent and rates for which they are reimbursed, but estimates of service charges are of great concern to them. West Sussex operate a standard charge in all their centres: at present £260 a year for each consulting suite plus £15 a year for use of a dispensary. Mr Saunders said that all should be treated alike. The employment of clerical and reception staff by the local health authority has also promoted the smooth-running of centres and reduces the housekeeping of general practice. Staff can benefit from national conditions of service and pension schemes.

Accounting and information systems must be devised to enable costing and evaluation of preventive medicine to provide comparable and overall information for an area or region. Individual systems for each centre would be too localised. Mr Saunders said this was one of the reasons against having managers in individual health centres. Good management is a scarce resource and should be concentrated at the county or area headquarters. Each health centre should then receive as much support as it needs within the framework of an efficient central administration. Large centres might require about 20 per cent of the time of a ' middle manager ' from headquarters.

Discussion

The members of the conference questioned Mr Saunders about the involvement of regional

hospital boards at the planning stage and the optimum size for centres. In West Sussex the planning team consisted of local authority and executive council representatives, and the regional board where appropriate. Regional boards receive annual revisions of the county's capital development plans.

As for the question of size, no optimum had been established. Members cited examples of health centres of many different sizes. Dr Gooding of Buckinghamshire County Council pointed out that only in a new town area is there a possibility to determine the catchment area and the size depends on the services to be provided. Under 30,000 population it would be uneconomic to provide a full-time staff such as a speech therapist and a physiotherapist. It was suggested that research was needed to look at the size and services of centres and Mr Saunders said that the Health Services Research Unit of the University of Kent were at present undertaking a major study of one of the centres in West Sussex in co-operation with the executive council; it was hoped that this would produce useful information for forward planning.

Communication and information

Dr C. Hodes

Following Mr Saunders, Dr Hodes described the information system for doctors and attached staff established in his practice. This computer-based system was developed in conjunction with the executive council and county council and based on the patient register.

There were three main sources of information—the patient, the team and the contacts which took place between them. The system covered only basic information of patients and not the case record. The National Health Service number was used as the basic patient indentification number and the executive council helped in providing information on new patients.

The system could provide much useful information for planning and preventive health purposes. Dr Hodes showed members the age-chart produced by the computer which could be used to assess need for geriatric and other services, and showed the changing age profile of the practice. Other uses included immunisation records, timetables for planning rotas, appointment sheets for new and reappointments, treatment records and follow-up visits after bereavement. Some pilot schemes had already been developed elsewhere to cover case records and Dr Hodes stressed that he saw computer-based syatems as being very important in the future in extending prevention, treatment and administration.

Professor M. Warren

Summing up the proceedings, Professor Warren observed that the main points that had been made during the conference were the need to define the objectives of community health services and health centres; to study the relationships between the staff working in the centres and at district and area levels; to identify the management expertise required and used to allocate resources; to ' plan out ' or ease management difficulties at the planning stage; and to develop record systems for professional and administrative purposes.

He thanked the Department of Health and Social Security for sponsoring the conference.

NANCY WOOLLEY
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SELF-POISONING

Of a series of 138 self-poisoning cases, 61 per cent expressed themselves satisfied with the emotional support from their general practitioners. There was a significant negative relationship between patient's satisfaction and admission rate per doctor. This was most noticeable in female depression and in inpatients distressed enough to require transfer to a psychiatric unit. Women and younger patients express most dissatisfaction. It is concluded that a general practitioner's sympathetic interest helps people to resist suicidal impulses and that this is especially true of depressed women.

Doig, R. J. (1973). *Practitioner*, **210**, 268–270.