HEALTH CENTRES

PAPERS GIVEN AT A CONFERENCE AT
THE HOSPITAL CENTRE
24, NUTFORD PLACE
LONDON, W.1
ON
THURSDAY 24TH NOVEMBER 1966

THE HOSPITAL CENTRE

Health Centres

Introduction

A conference was held at The Hospital Centre, 24, Nutford Place, London, W.1 on 29th November, 1966, on the subject of Health Centres.

The Chairman was Dr. H.N. Levitt, Chairman of the Council of the College of General Practitioners, and the principal speakers were:

Dr. M.D. Warren,
Senior Lecturer in Preventive and Social Medicine,
London School of Hygiene and Tropical Medicine

Dr. R. Smith,
Head of General Practice Research Unit,
Guy's Hospital Medical School

Dr. A.S. Mackenzie,
Assistant Senior Administrative Medical Officer,
South East Metropolitan R.H.B.

Dr. R.C. Wofinden,
Medical Officer of Health,
County Borough of Bristol

Dr. R.W. Elliott,
Medical Officer of Health,
West Riding of Yorkshire

Dr. J.H.M. James,
General Practitioner,
Hythe Health Centre

The papers of the first five speakers are reproduced in the following pages. Dr. James' talk was given in accompaniment to a display of many slides, and cannot therefore be reproduced in the same way.

At the end there are attached a number of floor plans illustrating different health centres.

Health Centres

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DEVELOPMENT OF HEALTH CENTRES

Paper by Dr. M.D. Warren
Senior Lecturer in Preventive and Social Medicine,
London School of Hygiene and Tropical Medicine

The concept of a health centre as a base for all the staff providing local health services and domiciliary medical care has been accepted in principle by the medical profession since 1920, when the report of a Committee on the future provision of medical and allied services, chaired by Lord Dawson, was published. That report stated that "The provision of these Primary (Health) Centres would be required in both rural districts and towns, for they are an essential part of an efficient general practitioner service. Their design and scope would vary considerably in town and country and in different localities, but the underlying principle would be the same". It was envisaged that in some of these primary health centres there would be wards, diagnostic facilities, operating theatre, and out-patient clinics. These primary centres would be backed by district hospitals.

In 1942 the B.M.A. Medical Planning Commission again recommended the development of health centres, each of which was to provide accommodation for 6 to 12 general practitioners, all the appropriate preventive health services, radiological and pathological facilities and an operating theatre for minor surgery. A point of interest is that both the Dawson report and the B.M.A. Commission recommended a unified record system; another aspiration we are still striving after.

The National Health Service Act, 1946, made it a duty of every local health authority to provide, equip, maintain and staff (with the exception of general medical and dental practitioners) health centres. However, as is well known and only too apparent, health centres are still few and far between in this country. By the end of 1965 there were only 23 health centres; although there are an additional number of buildings serving the functions of a health centre, but not legally defined as such.

One of the first of the health centres to be built and opened after the 1939-45 war, was that at Woodberry Down, now known as the John Scott Health Centre. This centre embodied many of the ideas about health centres that were current during the war. Although much can now be faulted, it was, nonetheless an important experiment in the provision of medical services. While the John Scott Centre was being built the Government had second thoughts about the development of health centres and decided on a more experimental approach and a policy of encouraging group practice. During this time the centres at Harlow were being planned and built with the financial support of the Nuffield Provincial Hospitals Trust. As will be seen in the exhibition, these centres (e.g. Nuffield Centre) are more modest in size and capital cost than the John Scott Centre. Their successful development showed what could be achieved.

Another approach that occurred at about the same time was the building of joint-premises; that is a group practice centre owned by the general practitioners linked to clinic premises owned by the local health authority. The Oxhey Centre illustrates this approach in the exhibition. The sharing of premises whether they be health centres or clinics is the policy of the health department of the West Riding of Yorkshire and the plan and details of the Southowram Health Centre exemplify a small clinic suitable for joint use in rural areas. An innovation at Nechell's Green, Birmingham was the incorporation of the health centre premises within a large block of flats. Of the centres shown in this exhibition the St. George Health Centre, Bristol and the Hythe Health Centre are the most recently completed. The Hythe Health Centre and Stranraer Health Centre are both linked to small hospitals and for that reason are of special interest.

Progress so far has been slow; but it seems that now nearly 50 years after the Dawson report, health centres will be buildings rather than theoretical conceptions. During the next ten years local authorities are planning to have completed 284 centres, and no doubt, a number of other buildings serving similar functions will be built during this time. Local authorities who have ambitious plans in this respect include Devon, Monmouthshire, Surrey and Staffordshire county councils, Nottingham, Portsmouth, Blackburn, Salford and Bristol county boroughs, and among the London boroughs Haringey, Ealing, Waltham Forest and Hammersmith (Health and Welfare, 1966. Ministry of Health, H.M.S.O. Cmnd. 3022). Another indication of change of opinion among family doctors is the statement by the General Medical Services Committee (Scotland) that "The future of general practice in Scotland is dependent on the closest functional integration of all parts of the Health Service and that, wherever appropriate, and according to geographical situations, this can best be achieved by the provision of health centres" (Report in B.M.J. Supplement, 1966, 1, 106). It is only fair to add, that whilst many doctors accept the concept of combined, purpose-built, practice premises, there still lingers doubts about the ownership of the building (see, for example, the Memorandum of the Sub-committee of the Middlesex Local Medical Committee, 1966). The situation, both in regard to premises and employment of staff, has been radically changed by the terms of the new system of payment for expenses incurred by general practitioners, which recognises that it is essential that general practice should be properly housed and equipped, and supported by appropriate technical and professional help.

We are therefore at a time when there is likely to be increasing discussion, both at ministry level and at the local level, about the development of health centres. In this situation it is wise to look back on the experience gained so far and to look forward to future needs and probable changes in the practice of medicine both in and outside the hospitals. It is, also, necessary to evaluate the effects of change.

In order to know whether any health centre (whether in the past, the present or the future) has improved medical care, it is necessary to define the improvements that the centre is expected to achieve and to find the answers (perhaps by experiment) to a number of questions which can be summarised as follows:-

(1) Why do we want health centres? What objectives are we trying to achieve? One among many objectives is the building up of a domiciliary health team with closer integration of all staff in order to obtain a more appropriate distribution of work between the doctors, nurses, secretarial and technical staff and to off-load work from the hospitals. Such an objective can be studied and should be studied.

(2) What staff and equipment should there be in a health centre? What is the relationship between the number of general practitioners using a centre, the administrative infrastructure and the cost per patient attendance? What equipment should be available in the centre? What factors affect its utilisation? What is the role of the nurse and of the hospital consultant in a health centre? Should social workers be based at health centres?

(3) Where should the centres be sited? Near, or even as part of a hospital? Near shopping centres? Do patients more often than not combine a visit to the doctor with shopping? Should the centres be in the residential areas or near industrial areas? Or should there be one major centre serving a number of satellite centres? Views will vary, customs will vary, but again by a study of the utilisation of centres already in existence, factual answers can be obtained.

New buildings and new services must, in future, be more carefully evaluated.

DEVELOPMENT OF HEALTH CENTRES

Paper by Dr. A.S. Mackenzie
Assistant Senior Administrative Medical Officer,
South East Metropolitan R.H.B.

The two previous speakers have shown the development of thought concerning health centres and their staffing from the early days up to the present time and particularly the pattern that may be established on the Marshes at Erith in the new community which is being developed; and you might feel that there is little left for me other than to dot I s and cross the T's. My aims are primarily two-fold, the one to show the practicability of the type of proposals suggested in terms of man-power available and the other to examine the diagnostic and specialist consultative services as opposed to the preventive and treatment services which should be undertaken in a health centre. It seems clear that as a Nation we are not likely to be in a position to make available many more people or a great deal more money than is presently provided for the running of our health service, preventive and curative. If, therefore, we are to look to an improvement in the service which we give to the community as a whole, in relation to their overall health we must also look to a more economical usage of our existing resources. It has been suggested in the Porritt report that to encompass the three present facets of the Health Service by an area Board would give rise to a more efficient usage of manpower and resources. This would undoubtedly be true with two provisos, the one that such an area for the purpose of overall planning would be too small and that some super planning authority might be required, the other and perhaps more significant, the fact that it would require a complete upheaval of the existing and established statutory authorities for its implementation. It is clear that such a move would be contemplated only after considerable thought and with an appreciable degree of dislocation of existing organisations. Certainly as an interim measure and possibly leading to a permanent solution it would be possible within the existing administrative structure to consider a more comprehensive zoning of patient care as between the community and the hospital with a greater emphasis on preventive medicine and of caring for patients at home rather than in an establishment; and with a greater regard for outpatient hospital and diagnostic procedures. The continuing improvement in housing in the Country must be a factor which will make it easier to treat the borderline cases of sickness at home rather than at hospital and what now seems needed is more comprehensive support of the General Practitioner by nurse, midwife, social worker and home help to make this treatment in the home a reality. It is interesting to consider that as far back as the early 1920's the first report of a Consultative Council on Medical and Allied Services under the Chairmanship of Lord Dawson of Penn proposed this pattern of overall care for patients in the community

You can see from Appendix A that the suggestions are practically those of a community health centre supplying preventive and curative treatments and staffed by General Practitioners although visited by Consultants and Specialists. The latter recommendation is one which I will discuss later and which may not prove in practice to be realistic. The secondary centre for care to all intents and purposes can now be regarded as a hospital

It would not be realistic for me to propose that there should be concentration of General Practitioners adequately supported by ancillary staff unless I were in a position to show that such supporting staff could in terms of manpower, economically be made available.

Appendix B gives an indication of the numbers of various grades of nurses and social workers employed throughout the area of the South-East Region by the individual Local Authorities

I do not claim that this gives an accurate figure of the number of personnel who might be available to staff any health centre but I do want you to look upon it as an indication of a degree of magnitude and as such to see how future patterns of care might move towards health centres with General Practitioners adequately supported by ancillary staff being responsible not only for the curative but also the preventive side of health management and undertaking responsibility in the field presently effected by the local authority Such care based upon a community can be established with staff ratios to population similar to those given here.

In brief you can see that it should be realistic to make available a health visitor to every 4 doctors, a home help to every doctor, a home nurse to every 3 doctors and even a mental health social worker to every 14 doctors The grouping therefore need not be so vast to be able to support a realistic therapeutic team in terms of manpower presently available. It is also of interest that these Regional figures approximate very closely to the staff available nationally and that any inferences drawn may be regarded as applicable to much of the Country Of course there are many basic arguments which may prove these figures relatively inaccurate, but I would reiterate that they are only used as a guide to magnitude and are not significant in themselves. The figure for home nurses at 1 per 3 doctors would perhaps not be sufficient to make available a comprehensive nursing service for all borderline cases of patients who might or might not be nursed in hospital The necessary numbers required of such staff must be a matter for debate and further study, but I would suggest that we might at least double this figure by a realistic appraisal of our existing hospital-care and use of staff.

Appendix C shows you the position of staff and beds for general and geriatric hospitals in the South-East Region A number of surveys have been done throughout the Country, although not particularly in this Region to assess the number of patients in hospital either not requiring hospital care or who are there for purely social reasons or who could be nursed in a self-care unit. Certain of these figures have been startling but there has been a range varying between 10% and 25% of bed occupancy of acute beds by such patients. Certainly not all patients in a self-care category can be looked after at home some are in hospital for investigation and for other and more complex reasons, but many are in hospital primarily for social reasons. With a better community organisation and the Medical Social Worker knowledgable of her patients background within the community rather than the converse, and based upon a hospital often unsuccessfully trying to liaise with General Practitioners and local authorities then it does seem realistic to hope that many of these self-care patients could be adequately cared for at home. Similarly, hospital clinicians would be more prepared to consider an early discharge if they knew proper care and supervision would be available to the patients in the home All this leads me to suggest that at least in this Region it might not be unrealistic that a properly based home care organisation could cause the reduction of acute bed requirements by some 10% or even more. This would certainly not free 10% of the existing nurses

in post for other duties, but it might free half that number and if these people were prepared to work in the community it would then double the number of nurses available i.e. a further 600 giving us 2 nurses per 6,000 of the population. In the event these people may not become available with outside factors such as reductions in working week influencing a changing picture, but the fact remains that the more external factors there are at work leading to a reduction in staff availability, the greater the need for rationalisation. If now you relate this number of nurses to the fact that nationally we consider that 6,000 people would attract about 18 acute and about half that number of geriatric beds in the district hospital and consider that 10% of these people might be nursed at home the magnitude of the problem can be seen in that we are allocating one existing and one additional nurse to care for between 2 and 3 additional relatively seriously ill people. This nursing function will be in addition to their other community duties.

I hope that I have been able to show that there is some degree of reality in the type of proposals which are being put forward and hope that you will feel them worthy of more comprehensive study and more intensive investigation to help determine what the realistic staff needs for such an organisation might be. It is probable that the only way in which this can be achieved is not by setting up involved studies, but actually by carrying out such a pilot scheme.

I would now like to turn away from the question of General Practitioner and health team care to the problem of consultative and diagnostic services within the community and to the problems arising from their dissemination in terms of existing manpower. Again my figures are not of themselves significant, but do indicate an order of magnitude. If we dissipate our manpower and use it less efficiently there will be an attendant reduction in the standard of services which can be offered. I should like particularly to examine the question of consultant services in the community, of X-Ray diagnosis at health centres, and of laboratory pathological investigations at health centres.

Appendix D shows the average population throughout the Country which at present supports a number of consultative clinics per week. You will see that to make such a clinic realistic a population considerably in excess of 17,000 allowing for variability of attendances would be required and it is not usually economical to hold shorter clinics when one bears in mind the travelling time often taken to reach such clinics. We have, at the present time a shortage of doctors and we must use these as efficiently as possible and therefore I must suggest to you that on populations much below 50,000 it is probably not economical to provide consultative services outside the hospital. Clearly circumstances will alter cases and a country community may have a better argument for provision that a town. It is, however, quite useless to hold consultative clinics in health centres not adequately staffed and supported by the proper ancillary services and in running these also we have an acute shortage of manpower which must be borne in mind and must be used as economically as possible. I am not saying that we must provide such a service, I am saying that we must not provide it unless economic.

I should like now to turn to the provision of radiological services in a health centre.

The problem of viability of such a unit particularly with reference to scope of equipment and type of examination undertaken is complex, but it would seem necessary for a scope of examination to be available as comprehensive as would normally be required by a visiting consultant at an outpatient clinic.

To refer patients to hospital for investigation after initial consultation in the community is wasteful of effort, and proper facilities for screening and work with contrast media should be available. Similarly a service should always be available during normal working and consulting hours to the general practitioner, but the capital cost of the equipment and the availability of staff must be cogent factors in determining the point at which such a service provided in the community and away from the hospital becomes a reality. It has sometimes been suggested that a small X-Ray set controlled by General Practitioners would be adequate. In my view to set up an X-Ray room controlled, and run, by persons not properly trained in the techniques of the practice of radiography and radiology would appear fraught with difficulties. Properly qualified radiographic staff are in short supply, and in such a unit there would be little likelihood of cover for holidays and sickness. Equally such staff are unlikely to be utilised fully in departments not based on an economic community catchment, although proper cover would still remain a pre-requisite for the foundation of such a department. Small departments not generating sufficient work would also fail to attract the control of a qualified radiologist. In turn this would lead to problems of control as mandatorily laid down in the appropriate sections of the "Code of Practice for the Protection of Persons Against Ionising Radiations arising from medical and dental uses". Particularly relevant in this context would be the implementation of section 2 - 1 and the availability of suitable persons to act as "Radiological Protection Adviser" and "Safety Officer". The ultimate responsibility (sec. 2.1.1) for setting up the appropriate safety committee would rest with the "controlling authority" of any Health Centre. There are similar problems relating to the employment of untrained staff and the S.I.940 of 1964 N.H.S. Professions Supplementary to Medicine states categorically that "no officer shall be employed in the capacity of ... radiographer unless state registered". It would seem clear to over-come the numerous difficulties of providing radiology in such community health centres that the service must be controlled by a visiting radiologist and be adequately staffed by trained radiographers with appropriate and holiday cover. Such a service must also be able to undertake all standard routine investigations.

Appendix E shows the work presently undertaken in selected X-Ray departments in terms of general practitioner referrals and outpatient referrals together with Regional and National figures It is interesting to note that in areas with a highly organised liaison between general practitioner and hospital that the majority of this work emanates from the former, but that in any event, the overall sum of these two loads, both Regionally and Nationally, varies between 50% and 60%. Assuming that specialist consultative clinics can be held in health centres, then the Health Centre load of radiology might approximate a figure of 50% of the total community load.

Appendix F shows National and Regional average figures regarding staffing of X-Ray departments and attendances. If 50% of this work only is to be undertaken in the community a population much below 50,000 could not economically support such facilities as it is reasonable to expect from 12,000 - 15,000 units of radiology from a major X-Ray set. Again from these figures it can be seen that such a population would support two full-time radiographers together with three sessions weekly of radiology. Such an organisation would constitute a satisfactory viable unit.

I would now like to touch upon the services of laboratory pathology. The present tendancy is towards centralisation of services with an attendant increase in automation. It would seem a retrograde and expensive step to contemplate establishing facilities for comprehensive pathological investigations for a domiciliary population away from the established laboratories housed within the District General

Hospital. The collection of specimens, and simple laboratory procedures for screening and certain other examinations might reasonably be undertaken in "side room" type of accommodation. Other specimens should be transported at suitable intervals to the District Hospital and results returned by a similar transport system. A daily or twice daily service might be considered. The type of work undertaken locally might approximate to that described by Donaldson and Howell in their multiple screening clinic at Rotherham, simple blood and urine examinations and to these might be added simple E.S.R. and microscopic techniques.

With the existing grave shortages both of pathologists and laboratory technicians I would suggest that it is unreasonable for us even to consider pathology undertaken locally by people trained in these disciplines. It is however, surprising the amount of help a pair of hands with a little training, and adequately supervised by an interested general practitioner, can give in the running of routine community pathology services.

I have tried to paint a picture of as comprehensive a service as I can envisage within the existing confines of manpower availability and sordid finance. It may be that you will not agree that the pattern I propose is a correct one, but at least I hope that you will feel that the proposals in terms of available resources are realistic and might be a positive step towards the establishment of a more integrated form of community care.

Appendix A

Primary Health Centre - an institution equipped for services of curative and preventive medicine to be conducted by the general practitioners of the district with an efficient nursing service and with the aid of visiting consultants and specialists.

Secondary Health Centre ... more specialised. Patients would pass from the hands of their own doctors under the care of medical staff of that centre.... A consultant service carried out by specialists or general practitioners acting in a consulting capacity.

The Dawson Report (1920)

Appendix B

L.A. Ancillary staff in S.E. Met. Region

	Number	Pop.	Coverage of ONE ancillary (approx.) G.P.'s.
Health Visitors	459	7,500	4
Home Helps	2,176	1,600	1
Home Nurses	626	5,500	3
Midwives	382	9,000	5
Social Workers -			
Mental Health	127	27,200	14
Other	190	18,200	10

Appendix C

Deployment of Nurses in S.E. Met. Region

	Beds	Nurses
Hospitals (acute & geriatric)		
Present position	19,000	12,000
Possible reduction	1,900 (10%)	600 (5%)
L.A.s (home nurses)		
Present position	-	626

Appendix D

Population required to support CNE outpatient session per week

17,100	General Medicine
17,900	Mental illness
20,300	General surgery
21,000	Traum. and orthop. surgery
21,400	Chest diseases
27,000	Ophthalmology
29,200	Dentistry (consultant)
29,800	Obstetric
37,200	E.N.T.
44,700	Child psychiatry
46,000	Gynaecology
52,700	V.D.
53,900	Dermatology
64,500	Physical medicine.
66,000	Paediatrics

Appendix E

Radiology services

	X-Ray "units" per year per 1,000 population.	G.P.s	O.P.D. present	Other*
England & Wales (R.H.B.s)	457	12	38	50
S.E. Met. region	502	18	36	46
One hospital group	480 (approx.)	35	18	47

*Inpatients, casualty etc.

Appendix F

Minimum requirements of a viable X-Ray Dept.

Equipment : one major set — 12,000 - 15,000 "units" p.a.

Staff : radiographers — 22 - 25 sessions p.w.

consultant radiologists — 2 - 3 " "

Assume:

Volume of X-Rays possible outside hospital (per 1,000 population) — 250 "units" p.a.

∴ Minimum population to support X-Ray department — 50,000

"THE WOOLWICH/ERITH PROJECT".

Paper by Dr. Robert Smith,
Head of General Practice Research Unit,
Guy's Hospital Medical School.

I have been asked to talk about the Woolwich/Erith scheme but first may I be forgiven for drawing your attention to a matter I believe to be of importance relating to Health Centres in general. We have just heard about the origins of the Health Centre concept and how, in more recent years, this type of building has become an increasingly prominent feature in our plans for solving problems of domiciliary medical practice. We have also heard about the changing attitudes within the Health Service, about greater understanding and willingness to co-operate, and with this there is developing an increasing demand for purpose-built medical buildings shared by different professional groups. These are seen by many as welcome signs, promising a new stability and offering much needed opportunities for the growth and development of medicine in Britain. But not all are so sanguine. These new encouraging developments do not yet appear to have had much counterbalancing effect on the pessism that today clouds so many sectors of the Health Service. It is vital to instill a confidence particularly into the minds of every young graduate now leaving our medical schools that the Health Service, in its future form, can offer the doctor a full and rewarding career. This surely must add a special note of urgency to our discussions today. Not only is the future of the Health Centre of immediate relevance to the practical and organisational problems such buildings are meant to solve, but on them now depends something of more far reaching significance in this testing time of staff shortages and financial strain. Health Centres represent, in tangible form, to the rising generation of doctors the shape of things to come. It will be only one of the many options from which will be able to choose the newly qualified doctor his future professional working environment. It is up to us to make this environment as professionally attractive as possible.

Let us pray that those with responsibilities in these matters approach this problem with imagination, with an awareness of the full implications of the situation, with a true appreciation of the opportunities that lie ahead and with the long term interests of the Health Service at heart.

Our future health buildings must be able to capture the imagination of the people who are going to work in them and be seen to be capable of making a real contribution towards helping to solve the problems of health care in the community. They are being built for a rising generation of doctors who will be called on to serve an expanding and changing population, in an era of new town and new city development and at a time of rapid advance in technology and medical knowledge. It would seem that we have yet to learn how best to attune the Health Service to its future, to make it more responsive to these processes of social change with which it is so intimately concerned. This is seen most clearly in what has happened in our new towns. Since the war nearly thirty towns have been built in Britain, more have been projected, and several new cities are on the stocks. We have learnt a great deal in this country about building new towns. There is more to it than just building housing estates. An attempt

is made to create a community where people are happy to live and where there is an air of hopefulness for the second and third generations; where local cultures can take root and develop. In their book "The Development of a New Town" the largest of all the town developers, the L.C.C. now G.L.C., described the planning technique of such an exercise in detail. In an otherwise most excellent document, one part is conspicuously deficient. Health was not considered plannable. This is failure by default. No single co-ordinated group is responsible for the total health plan of any area. Transport, schools, leisure, entertainment, are all planned with meticulous care for the new towns, but the health services are practically ignored. This extraordinary blind spot has, with the exception of Harlow, resulted in many golden opportunities for the development of the Health Service in virgin areas being lost for ever. In 1963 with these thoughts in mind and with the help of Nuffield, Wellcome and Guy's, my colleagues and I turned our attention to the Woolwich/Erith scheme, the newest of the new towns. We saw it as a possible base from which we might be able to explore the future of our Health Service. For many good reasons we saw how necessary it was to mount this exercise from within a medical school. We were very fortunate in having the great help of Professor Butterfield in this enterprise. For too long the medical school has concerned itself primarily with the production of doctors, and not with the setting in which most of them are subsequently destined to work. A bridge was desperately needed between medicine in the University and medicine in the home. Linking the embryo doctor with an embryo town seemed a good way to start.

The London local government decided to fill the vacuum created by the closure of the Woolwich Arsenal with an entirely new community. The low-lying marshy terrain ringed by densely packed industrial areas was a tremendous challenge to the town planner.

The plan for the area was published by the G.L.C. in the Spring of this year and we followed immediately afterwards with the publication of our medical plan. This had been preceded by months of intensive activity in co-ordinating the many statutory interests involved and establishing a good working relationship with the G.L.C. Architects' Department. The link between the two groups established, at the earliest possible moment, was probably the most decisive factor in ensuring the acceptance by the authorities that a health plan was a feasible proposition in the overall plan for the new town. And the same can be said for any area providing there is sufficient goodwill on all sides. But medical planning is a long and costly operation. The first permanent building in the town will begin to function five years after the first discussions took place.

Because the area is divided into two by a borough boundary, two London Boroughs are involved, two Executive Councils, one Regional Hospital Board, and a medical school of London University. Professional bodies such as the local medical committees, dental bodies, and other interests, such as the College of General Practitioners, and the British Postgraduate Medical Federation, are all represented on a Liaison Committee specially created for the purpose. Links with the Pharmaceutical profession, the Opticians and local welfare and social organisations have been established.

It was clear from the outset that the Guy's Unit could only act in a co-ordinating and research capacity. It has no authority or statutory powers. However, when we made our object clear each statutory body involved, formally agreed to work towards developing a new scheme for the area, aiming at providing a planned integrated service working from a network of linked health buildings. Each authority had their part to play and all were prepared to merge their interests voluntarily in the common good. Out Unit acts as the

secretariat to this consortium of interests. It gives me special pleasure to mention the encouragement we have had from all the groups involved, including the Ministry. Our frequent meetings have involved many busy people in a great deal of additional work and travel which has been undertaken cheerfully and with great enthusiasm. My colleague Mr. Michael Curwen acts as general secretary to the project which greatly benefits from his incisiveness of mind, derived no doubt, from his previous distinguished career in medical statistics. He has brought a clarity to a very complex exercise which has been vital for its progress.

The main Liaison Committee has set up a small General Purposes Committee which meets frequently. The dentists have established their own sub-committee and others such as the pharmacists and opticians are also being co-ordinated on a committee bases. In addition to co-ordination and administration the General Practice Research Unit has undertaken studies of general practice and local authority health services. In the exhibit on display we have attempted to give some idea of the type of work we undertake. Much of our research has been orientated towards attempting to design a health team of doctors, dentists, nurses and others who will combine general practice with the personal medical services of the local authority as well as other non-hospital based medical services into a single unified form of family curative and preventive health practice.

The town will have a main centre with a high-density framework enclosing less populous districts. It will have a marina, lakes and canals and much, because of the low-lying land, will be built up on decks.

The town will take fifteen years to build. Work has started and practice will begin there in a year's time. Growth will at first be slow. About 10,000 people will appear in the first five years. The second five years will be one of rapid growth reaching the 50,000 mark. The last phase will be the final trimming off period when a total of 60,000 will be reached.

The work of medical planning for a new town occurs at two levels. First there is the need to have a final plan for the whole town which fits into the overall plan. This means working closely with the planning architects as distinct from the housing architects, learning about the physical structure of the town, population densities, roads and transport systems; the zoning of social amenities and trying to identify the place of medicine's physical relationship to all of this.

You will recall the shape of the town itself.

The town's main centre will contain a single complex of health buildings ranged around a central unit where administration, records, diagnostic facilities, teaching and research will be located. Four groups centres each with a health team for one area of the town will make up the complex. Doctors will work in the group centre, in groups of six to eight and each group will have one or more local centres in their particular area where they will carry out the more preventive aspects of their work including ante-natal and well-baby clinics. The local centres can be used also for special groups such as very aged and the very young who might find it a hardship to travel to the main town centre, although this will be not more than one mile from any part of the town. Patients will be seen by appointment in the main town centre. They will see the doctor with whom they have registered.

but will be prepared to see one of their group in emergency situations or in health screening clinics which we hope will be a feature of the work undertaken. About thirty doctors and the same number of nurses and other ancillary staff will be needed. Dentists will also work in this building on a similar basis and will require their own specialist help. We are hoping that there will be a single unified record system for the whole area.

At a more detailed architectural level, work on the health building for the first area must also proceed at the proper pace. First, temporary quarters are necessary, either in converted new houses, or better still in demountable buildings placed near the first new homes. The first permanent building must await the development of the town's first sub-centre; in our case this will be completed by 1969.

An architect's brief is prepared describing in great detail the functioning of this unit. This will contain the nucleus of the personnel who will grow into the final health team for the area. The first permanent building will aim to provide the full range of services for the area it serves, but as the scheme develops the function of this unit will change and provision must be made for this in the design. The brief describes the personnel, the work they do, and how they do it. The programme for each member of the staff is planned, based on the expected work load for the unit. The brief is then converted into architectural design and detailed plans; costings are worked out and finally general approval has to be given by all concerned. The building is then ready to be included in the general contract for the area. It was decided that the first building should be developed under Section 21 of the Act. It will be built by the G.L.C. who will retain the freehold. The Borough of Bexley will lease the building and then sub-let it to the Executive Council and others. The daily functioning of the building will be the responsibility of a house committee and the overall policy for the area will be decided by the representatives of the statutory bodies involved. These committees will act when necessary in an advisory capacity to the Borough. We are still discussing the final administrative arrangements which become much more complicated when the town spreads over into the adjoining borough.

We believe that this exercise is an exploration of the future of the Health Service in practical terms. We are doing so with the help and guidance of the statutory bodies concerned. This exercise we hope will demonstrate the weaknesses and the strengths of our present arrangements and what will be worth preserving and what needs adaptation.

Finally, I wish to say that we hope the health buildings at Woolwich will rpovide a setting for medical and dental education and research, for nursing and other social and welfare staff training. This contact with students, learning what a health team-spirit means, could be a vital ingredient for the whole exercise.

In the time available I have only been able to sketch in some of the main points of the project. In doing so I hope I have been able to present a coherent picture and why those of us involved believe that it is reasonable to make this effort at this particular time. Above all we feel it provides an opportunity for the various separate branches of the Health Service to co-operate in a new way in building together for the future.

HEALTH CENTRES IN PRACTICE

Summary of Paper by Dr. R.C. Wofinden,
Medical Officer of Health, County Borough of Bristol,
Professor of Public Health, University of Bristol

1. Getting them Going

- Initiative rests with general practitioners, not with Local Health Authorities.
How can the interests of general practitioners be stimulated?

Incentives: Low Rents
Preservation of freedom — self-management of the centre; doctor/patient relationship preservation
Removal of Domestic pressures
Removal of Social pressures
Removal of Financial pressures
The value of success

- "Behind the scenes" activities:

An interested Medical Officer of Health and team including architect -

Informal approaches to Ministry of Health
Ministry of Education
Other Local Authority Departments

Preliminary work with general practitioners :
Working Party to consider:

Joint User — Where : When : Communications
How many G.P.s. — How Chosen : Rents to be charged.
Who else in centre
How planned — "Temporary" or permanent.
How operated

- Official action:

Application to Executive Council : Consideration by Local Medical Committee : Application to Local Health Authority.

"Selling points" to Local Authority:

Saving on Local Health Authority work - Ante-natal, post-natal, child welfare, and minor ailment clinic work.
Joint user of premises - Conservation of capital.
A service to "the people" - not a subsidisation of G.P.

Submission of proposals - Regional Hospital Boards
Board of Governors, etc.
(Local Dental Committee,
Pharmaceutical Committee,

Estimated costs: Capital
Revenue

II. Making them Work:

(1) Official Machinery "Parent" Bodies: Local Health Authority
Executive Council
Local Medical Committee

Joint Advisory Committee
House Committees

Composition : Functions
Agreements (legal) : Security of tenure : Replacement.

(2) Structure

"Functional" planning of building.
Overall charge - professional or lay ?
Staffing - professional or lay.
Responsibilities of individual staff members.
Appointment systems.

(3) Functions

Part III Services and what happens to them
Part IV Services: What price private practice ?
:Dental services
:Pharmacies
Part II Services: Diagnostic Aids - alternatives
Consultant visits

(4) Lessons Learned

(a) Ante- and Post- natal work
(b) Infant welfare work
(c) Minor ailment work
(d) Almoning and other (e.g. psychiatric social workers) work
(e) Nutrition clinics
(f) Geriatric clinics
(g) Development of yardsticks

The statistics of general practice
Family folders
Morbidity measurement

(5) "Gains and Losses"
(Disregarding the question of who is "paying the piper")

To the Patient	To the G.P.	To the L.A. Staff
One "consulting" point.	Good premises	Local Authority doctor: loss of ante-natal, post-natal, infant welfare and minor ailment clinic work
Good environment.	Better work	
No loss of doctor/ patient relationship	Colleague stimulus	
Quick service	Local Authority stimulus	Possible gain: geriatrics, screening, developmental paediatrics.
Better service	Integrated approach	
One doctor (no local health authority)	Preservation of home and wife freedom	Nursing staff: integration widened work scope.

III. Possibilities for Future Development:

(1) Redesignation of Existing Health Clinics.

(2) How many new health centres:

Capital costs
Revenue Costs

(3) Staff secondment to achieve "full" integration.

(4) A base for all field workers (including social workers).

(5) Widened role of the general practitioner in preventive medicine.

(6) Research into general practice.

(7) Opportunities for a "newer" look at group health education.

(8) Opportunities for (medical undergraduate and
for (continuing postgraduate education.

(9) Opportunities for Presymptomatic Diagnostic Screening work
("Automated" medicine and the future)

(10) Opportunities to develop a new role for the Local Authority assistant doctor, e.g. in developmental paediatrics, in geriatrics.

? Reversion to status quo ante for School Medical Service.
(Stems from group practice : possibility of a salaried service).

(11) Where does the future of the General Practitioner lie - Hospital, Health Centre or Both ?

(12) The future of the Health Visitor, Home Nurse and Midwife.

IV. Alternatives to Health Centre:

(1) Group practice loan schemes.
Financial loans for premises (Finance Corporation).

(2) Status quo + buying a little help.

(3) Help under the Housing Acts -

(a) Private houses and surgeries for doctors,
(b) Redevelopment areas and flats.

(4) Help under the Local Government Act, 1933 -

Rented premises, but no statutory duty for Local Health Authority to help with staffing.

Main disadvantages:

Small units.
Not very practicable for re-organisation and re-deployment of Local Health Authority Social and Nursing Staff.

Claimed advantages:

Maintenance of doctors' freedom.
But his freedom is at best illusory and his loan must be repaid!

What happens when he retires ?
when he dies ?
How will he get his money back (or his widow get it back ?)
How will the "vacancy" be filled ?

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HEALTH CENTRES IN PRACTICE

Paper by Dr. R.W. Elliott,
County Medical Officer,
West Riding County Council

I understand that my part in this Conference is to be severely practical. I shall not, therefore, attempt to argue the pros and cons of buildings meant to be used jointly by general practitioners and local health authorities with participation in some cases by hospital services. I shall assume that the general principle has been accepted and that the people attending this Conference are interested in the practical application of these ideas.

My own experience has been that given the initial goodwill of the Executive Council, the Local Medical Committee, and the Local Health Authority, the best way to proceed is to assume right from the beginning that the needs of general practitioners, particularly in a County area, will differ. This is particularly brought about by differing sizes of neighbourhoods and other geographical matters. It is therefore essential to have a flexible approach to the whole problem and to be prepared to produce centres for differing locality needs.

I shall describe below a few of the ways in which this can be done, and it will be my endeavour during the Conference to illustrate these descriptive notes by slides showing what has actually been achieved or what has been approved and is about to be constructed in the very near future.

The Cleckheaton Health Centre.

First Thoughts.

First thoughts on a health centre in Cleckheaton were stimulated in November, 1958, when eight general practitioners working in three partnerships with a total of approximately 20,000 patients expressed an interest in working in a health centre. Cleckheaton is the main township for shopping and administrative purposes of the borough of Spenborough, which is a relatively sparsely populated borough made up substantially of five small townships merging with each other. The population of the borough is 37,370 and that of Cleckheaton and district is approximately 10,000. General practice in the area has had two centres, Cleckheaton, and Liversedge which is some two miles away. Apart from the eight practitioners no other doctors had surgery accommodation in Cleckheaton itself.

The practitioners laid down inter alia that the centre should be designed to facilitate liaison between themselves and all the local authorities' health services, both county and district. At the same time it was obvious to us in the county service that the existing combined clinic and divisional office then in use was totally inadequate and would need to be replaced.

All this gave a wonderful opportunity to develop, in an established community, one centre for the complete health and sanitary services of the area. The experimental nature of Cleckheaton rests on this fact, since in other areas such schemes have been developed either on new estates or in new towns, but here it was being contemplated in a well established township.

Design and Layout

General Practice Wing:

The general practice wing is approached by a lobby opening into a central hall in which are sited the patients' lavatories, and thence to three self-contained practice suites and to the subsidiary rooms. The two group practice suites are identical, each containing a waiting room, receptionist's office, three consulting rooms each with an adjoining examination room, storage and dispensing room, lavatory and cloakroom; the third suite serves a partnership, has two consulting rooms only but otherwise has similar accommodation of a slightly reduced size. Each suite has its own external door with direct access to and from the service road and car park. The subsidiary rooms, which are shared with the public health department's staff, consist of a laboratory and minor surgery room with patient's lavatory and a waiting lobby leading to a secondary entrance, with an outside ambulance bay; this is primarily intended for attention to minor accidents occurring in local industry or otherwise in the locality. There is also a caretaker's central store.

Clinic Wing:

The clinic wing provides facilities for the County Council's health and school health and dental services. The central hall is surrounded by a food sales bar and store room, a tea bar, a duty nurse's room, and with access to general, medical and special store rooms. It leads eastwards to the general clinic in which rooms are provided for school health, specialist consultations and chiropody, mothercraft and ultra-violet light, weighing and antenatal, dressing room with lavatory and testing room and infant welfare consulting room. To the south of the central hall lies the dental clinic with its own waiting room, two surgeries, recovery room and separate exit waiting room, workshop and darkroom. Throughout the wing there are adequate lavatories both for patients and staff. To one end of the clinic wing lies the boiler house with fuel store, bin storage, boilerman's store, gas incinerator and lavatory A store, with external access only to a secondary service road, is provided in this wing for the public health inspectors.

Administrative Wing:

The administrative unit comprises offices for the divisional medical officer, with that of his chief clerk on one side and a conference room on the other; this latter being for the benefit of the whole centre. There are three general offices, offices for the senior assistant county medical officer, the assistant county medical officer, the divisional nursing officer, the mental welfare officer and the health visitors, with a small cloakroom, lavatories and a cleaners' store. A dining kitchen provides adequate facilities for staff meals. A small room is reserved for the housing of the GPC telephone installation equipment.

In the public health inspectors' wing there are offices for the chief public health inspector, the public health inspectors, clerks and foremen, a tea room and storage accommodation, all grouped around an entrance hall at the end of which is the main staircase leading to the administrative offices on the first floor. There is also a small interviewing room for thepublic health inspectors.

After Thoughts.

The culmination of the efforts which the negotiations and design naturally entailed has been rewarding. In operation the centre has proved to be popular with the general practitioners, the public and the health department staff alike, and the added convenience of all the health services being available in one spot was immediately obvious. To complete the picture the health visiting staff and the district nursing staff are now all attached to general practitioners, which is in accordance with out general county policy.

One of the chief causes of misunderstandings in human relationships is the lack of, or inadequate, communications. Perhaps this has been the cause of past discontents. The health centre principle and the other methods of co-operation with practitioners offers new hope by shortening the lines of communication. We see this as an absolute requirement when we and the general practitioners have so much in common. We must get together because of our common interest - the care medically and socially of the human being in his natural setting in the community.

Methods must therefore be found to speed up this process. One of the convictions which has stemmed from the experience and development at Cleckheaton is that we must have more fluidity in our negotiations with general practitioners In order to avoid cumbersome procedures involved in setting up health centres therefore we have developed in other parts of the county the idea of "shared accommodation" as opposed to the "exclusive accommodation" afforded at Cleckheaton for family doctors. Although this idea has been used occasionally in other parts of the country it has now become the general policy of the West Riding for future developments and is proving very attractive to general practitioners and local health authority staff alike.

With this idea the two branches of the service can come even closer together, and should still further improve communications. The basic idea is that the accommodation when not being used by the general practitioners should be available for any other appropriate health department activity.

The concept of shared accommodation has led to the development of different types of building and has led to a new design of clinic which can be used by both general practitioners and ourselves more readily than the older more conventional designs. It led also to the development of the mini-clinic, which would not have been economically possible in areas of smaller population without the added usage afforded by general practitioners.

The importance of the experience of setting up this health centre is therefore that it led quite naturally to the present county policy. This itself is but a means to the end, that general practitioners and local authority staff shall in voluntary co-operation provide an improved service for the communities dependent on them.

The Mini-Clinic.

The Concept of the Mini-Clinic.

Places with small populations have always been problems to the health services. Very frequently they have been remote from the main centres where the hospitals, general practitioners and local authorities have been based and their inhabitants have benefited only with inconvenience to themselves or to the doctors and other professional workers. The mini-clinic was planned to deal with this situation, but from the first it was intended that each such building should be designed to meet the needs of the family doctor requiring a branch surgery and those of the local authority clinic services. It would, therefore be a focus for the community health services of the area.

Such a clinic could be built in any of several situations:

(a) Typical small West Riding villages;
(b) Fringe suburban areas outside the boundaries of large towns;
(c) Small new housing estates; and
(d) Areas of low population within townships.

The essence of siting is that the population should fall between the limits of 1,000 - 5,000 persons; the area should also be reasonably compact.

It has become noticeable that almost all villages within ten miles of large centres of population are undergoing transformation into sizeable units and, whenever land is released by the Planning Authority for building, the number of inhabitants rises rapidly. A common sequence is for areas served by a mobile local authority clinic to outgrow the capacity of the vehicle (usually regarded as 15 - 20 patients average attendance) and the mini-clinic is the natural next stage of provision.

The idea of providing a small clinic for areas of small population is not new and did not originate in the Riding. However, the use of a small clinic as a base for the joint work of the family doctor and local health authority staff is being pioneered by only one or two authorities at the present time.

Since the smallest clinic hitherto built by the County has been for populations of 7,000 upwards and the majority of clinics serve populations within a radius of about two miles (in urban areas), it is expected that most Divisions will discover some demand - so far unfilled - for which the mini-clinic is the answer.

Some Data on the Mini-Clinic.

Size
25 ft. x 25 ft. plus pram shelter.

Approximate Cost
Land - £400 Building (clinic alone) - £3,650
Furniture and Fittings - £500.

Specification
Prefabricated structure.
Heating by off-peak electric storage heaters.
Soundproofing of doctor's room by positioned cupboards.

Population served:
1,000 - 5,000

Purpose - Shares usage for:
Infant Welfare Clinics and sales of Welfare Foods
General practitioner branch surgeries,
Chiropody sessions,
Health education,
Mothers' Club,
Antenatal and relaxation clinics.
Headquarters for health visitor, home nurse and midwife.

The Mini-Clinic - Design and Use.

Design: Requirements for the West Riding mini-clinic are that it should be inexpensive and small so that others like it may be built quickly from available money in the largest possible numbers. For rapid building it is of prefabricated construction, and for low running costs it is heated by electric off-peak storage units. The whole building is only 25 ft. square. The waiting room can accommodate 24 seated patients comfortably. There is one consulting room which is 12 ft. square; the examination couch within the room is behind a ceiling mounted curtain, and is illuminated by daylight from a glass panel in the roof above.

Soundproofing in a building of light construction is always a problem, and in this clinic, cupboards have been intentionally built into the wall between waiting and consulting rooms, and these together with a close fitting heavy door, have achieved good insulation from noise.

The tea bar, as well as providing hot drinks for mothers attending clinics, also serves as a counter at which baby foods, dried milks and the like are sold on clinic days, and provides self-service facilities for general practitioners and their attached nursing staff each day.

Extension: The clinic at Southowram has a nurse's flat built on. A glance at the design will show that the mini-clinic can be extended if required, either sideways over what is shown in the plan as the nurse's flat, or backwards, to provide a larger waiting room, and more consulting rooms. For this reason, the possibility of extension is anticipated by siting all basic mini-clinics on standard sites allowing room for addition of further prefabricated sections should the need arise in the future.

Time-table for use: In its basic form the building is useful for the general practitioner who seeks branch surgery but its limitations must be appreciated. There is sufficient room for only one doctor to consult at any one time. Thus it follows that careful programming is necessary when several general practitioners are using it. Their surgery times should not overlap with each other, with the local authority clinics or other functions.

Receptionist: There is not sufficient space for a receptionist to be present in the building all day to take messages but she can attend during surgery hours. She could either sit at a table in the waiting room proper, or in the partitioned treatment area at the end of the waiting room, from which in future buildings a hatch might communicate with the doctor's room. It seems unlikely that large numbers of records will be left at a branch surgery of this sort and no special facilities are provided.

Dispensing: Facilities for dispensing have not been needed at Southowram, but will be included if needed in other clinics. In the doctor's room there is already a large sink unit with hot and cold running water, a working surface for bottling mixtures and counting pills, with cupboard space underneath. Additional four inch and nine inch shelving may be added to the walls above and adjacent to the sink if it is appropriate to do so. If medicines are "to be called for", an additional shelf could be provided in the lobby.

Telephone: The arrangements for telephones are those applicable to all West Riding clinics, i.e. the general practitioners provides this at his own expense as far as the office records room. After that wiring for intercommunication, via the switch board, will be at the County Council's expense.

Rentals: This is the standard rental for all our clinics, amounting to £15 per annum for each hour of surgery use per week.

The New E. Type Centre

Why a New Design?

From 1955 to 1965 an extensive County building programme produced 51 purpose-built clinics intended only for Public Health Department use. They varied in size and permanence of structure (a large number being prefabricated) according to the populations to be served. They were built principally to run large infant welfare and antenatal sessions, with other lesser activities like minor ailments, speech therapy, ultra violet light, welfare food sales and school medical review examinations.

In urban areas, attendances of up to 100 mothers with babies could be expected in a three hour session, and antenatal clinics could have up to 25 expectant mothers examined in a similar period. These requirements resulted in an attractive series of standardised buildings named alphabetically A, B, C and D, of which A was the largest and D the smallest. (C was a variant of prefabricated D, built of brick with a different arrangement of staff accommodation

and food store.) Each had basic accommodation comprising a large waiting room, weighing and health education room, clinic room (largely used for treatment of minor ailments), changing cubicles, urine testing duty room, kitchen, food store, staff room, and (by present day standards) a small number of consulting rooms.

The prefabricated D type clinic was very similar to its brick built C type cousin. They are now superseded by the E type centre which will serve populations of the same size with greater efficiency.

From the purely public health point of view, there has been a steady rise in provision for sessions by appointment in speech therapy, audiology, chiropody, ophthalmology, child guidance, handicap assessment, and antenatal teaching, and there is a possibility in the future of adult screening for cervical cytology, glaucoma, diabetes and other conditions. There has been a change in the use of floor space due to a falling demand for minor ailments, ultra violet light sessions and antenatal examination clinics (due to rising numbers of hospital bookings and the increasing tendency of general practitioners to do antenatal work at surgeries with midwife in attendance.)

Above all, it has become noticeable that our earlier clinics are deficient in consulting rooms, for the conduct of several appointment sessions simultaneously.

From these several considerations resulted the E type centre, as a new economical building to house expanding public health activities, together with developments expected to result from closer ties with general practice.

The Dual Purpose Centre.

The E type centre is the first standardised West Riding design able to accommodate general practitioner main surgeries.

It measures 64 feet by 32 feet, is intended for public health functions for populations of between 6,000 and 10,000, and also main surgery accommodation for one or more practices whose surgery times are such that no more than three general practitioners are using consulting rooms simultaneously.

A receptionists' office, with hatch to the waiting room is provided to contain all medical records. This includes those of the general practitioners, the health visitor, home nurse and midwife.

General practitioners will decide whether they wish to keep their records locked up in cabinets or freely available to nursing staff but, in any event, the intention is that this room should be the central focus of the clinic for exchange of information between general practitioners, public health medical officers, receptionists and attached nursing staff in the normal to-and-fro of the working day.

Each consulting room will be available on a "shared accommodation" basis so that, when a surgery or clinic is over, it can be used for a succeeding different purpose. No consulting room doors may be locked.

To make for tidiness and to preserve flexibility of use of all four consulting rooms, lockable cupboards and desk drawers in each room will be available for personal items of equipment which need to remain in the rooms between sessions.

Examination rooms are provided on the scale of three per four consulting rooms. Careful attention has been paid to sound-proofing by special construction of certain walls (see plan) through which confidences might be overheard by waiting patients. One consulting room is additionally double-glazed to permit speech therapy and audiometry free from outside noise.

The waiting room has both a bench and chairs sufficient to seat up to 60 persons. It has a sliding partition at one end, which may be pulled right across when special sessions requiring privacy, such as antenatal clinics, relaxation antenatal classes or health education sessions, are in operation. Black-out is available for showing of instructional films. When the partition is fully closed, direct access to two consulting rooms is still possible for patients seen by appointment as, for example, at chiropody sessions. During surgeries, the partition will normally be folded back. Concealed access to consulting rooms from the reception room has been provided for general practitioners and also an "escape route" to the rear of the clinic without need to cross the waiting room.

Dispensing facilities are not shown on the plan as this is not felt to be a feature of importance in the majority of group practices serving a population of near the maximum size for which the clinic is designed. Some general practitioners in rural areas of small populations, may need these facilities for at least a proportion of the patients when using the E type clinic. However, as rural practices tend, in general, to have large visiting lists and small surgeries, there will be under-used consulting and examination rooms, of which one may be fitted with shelves for drugs in current use, with the main bulk stock kept in the store shown on the plan. Such modification is of fittings only and themain structure will remain the same as shown on the plan.

Telephone installation will follow normal County pattern, with a main switch-board in the receptionists' office and an extension to each consulting room.

Heating is by electric storage heaters on off-peak tariff. All furniture is provided by the County Council.

A kitchen is included for refreshment of clinic attenders and all staff, and food sales will take place over the same counter from which tea is served.

The E type centre can be extended by a communicating annexe which will normally lead off outwards from the entrance lobby via a passage some 15 feet long and thence across the front of the store (i.e. from the lobby downward and to the right of the plan). In a proportion of these clinics, dental suites will be so attached. If dental suites are not provided, room will be left on this part of the site for extension into additional consulting rooms for any purpose which may arise.

The personnel expected to work from this clinic, when in full use for its combined purposes, will amount to:-

General practitioners - two or three (simultaneously consulting)
Health visitors - one or two.
District nurses - one or two.
District midwives - one or two.
Voluntary (clinic) workers - two or three.
Public health doctors - one.
General practitioners' receptionists - one or two.
Car parking will be provided for staff.

The rental to general practitioners will be the usual for all West Riding clinics of £15 per annum for every hour of surgery time per week that each consulting room is used. The hours of surgery time are taken as those approved by the Executive Council.

Public health functions intended to be served will include clinics for infant welfare, antenatal, relaxation, health education, toddlers, food sales, mothers' clubs and school children.

Sessions by appointment will be specialist clinics (e.g. ophthalmology, chiropody, handicap assessment, audiology, speech therapy).

The lay-out anticipates the possibility of large scale preventive screening for adults (e.g. cervical cytology and the elderly) at some future date, and in this event, the examination rooms provided will permit a rapid flow of patients to the personnel carrying out tests and medical inspections.

The final item, cost, is not known since the first building has yet to be completed. It is expected to be in the region of £11,000 - £12,000 for a prefabricated structure and correspondingly more if of traditional construction, with the extent of site works an additional factor.

Existing Clinics

As has already been mentioned a large proportion of clinics designed and built for local health authority purposes only were constructed before joint user with general practitioners was envisaged. It has been extraordinary, however, how general practitioners have been quite happy and satisfied with running their surgeries from existing clinics on a joint user basis, and under the same terms and conditions as other centres.

Improvement of Existing Clinics and their Joint Use with Family Doctors

Two of the clinics which will be illustrated are at Rastrick (near Brighouse) and Kirkburton (near Huddersfield). In each locality, general practitioners in partnership, attending patients in the area, made application to the County Medical Officer for use of the clinic buildings as surgeries at the usual standard rental laid down by the County Council (£15.0s. 0d. per annum for each hour per week of surgery use as detailed in the official Executive Council list). The standard provisions covered by this rental applied to both projects.

The buildings were already in use as maternity and infant welfare clinics, but suffered the commonly-met inconveniences of old buildings in being difficult to keep warm in winter and with amenities falling in some respects below the standards attained in purpose-built clinics elsewhere in the County.

It was decided that the proper solution was to modernise by internal adaptations in each building to the mutual benefit of both the public health work and the proposed use for surgeries.

The designs were agreed with the general practitioners concerned before building began.

Adaptations to existing clinics are one aspect of the building programme anticipated in the policy document "Future Developments in the Health Service and Co-operation with General Practitioners", which was approved by the West Riding County Council in July, 1964.

In neither case are the above centres classified as health centres under Section 21 of the National Health Service Act, but remain as clinics under Section 22 of the same Act.

To date, in addition to Rastrick and Kirkburton, other clinics at Dodworth, Elland, Calverley, Carcroft, Rossington, Normanton, Morley and Todmorden have had or will be shortly having, **minor** or major adaptations to increase convenience and efficiency in shared use by general practitioners and public health staff.

Rastrick Clinic

Rastrick Clinic is a former day nursery administered during the war years by the Brighouse Corporation. It was sold by the Ministry of Works to the County Council in 1953, to be converted in 1959 for infant welfare, maternity care, and school clinics.

In November, 1964, two practices in the Rastrick area decided to amalgamate into one group of three doctors, and simultaneously asked to rent Rastrick clinic as main surgery premises.

At that time, only one large consulting room was available and the minimum requirement of the practice was two. As the plans show, it proved possible to split this large room into two by a central partition and to enclose a further area as a receptionist s and records office. The consulting rooms each measure 14 ft. x 9 ft. and the receptionist's office 12 ft. x 9 ft.

Since much heat had formerly been lost by direct passage through the unlined roof, a suspended ceiling was constructed and electric convector and tubular heaters installed.

The undressing cubicles arenot used during surgeries as each general practitioner is in the habit of leaving his consulting room while patients prepare for examination. They have not found this either inconvenient or particularly delaying. The cubicles may be useful in future for cervical cytology sessions and other screening measures. At present they are used exclusively for antenatal clinics. Sound-proofing. Much of the success of this conversion has been due to the integrity of the sound-proof dividing partition between the two newly-formed consulting rooms. This was not achieved without some experimentation. Our general practitioner colleagues showed considerable forbearance when an amendment to the original specifications became necessary during their occupation of the premises.

For the benefit of other engaged in conversions, the final very-effective solution of the County Architect proves to be as follows:

The partition is wood-framed to the ceiling level. It consists of two thicknesses (each $2\frac{1}{4}$ in.) of hardboard-faced "Stramit" separated by an air gap of $1\frac{1}{2}$ in. The ceiling consists of 3 in. joists faced on the underside with "Celotex" $\frac{1}{2}$ in. insulating board and with a "Fibreglass" sound-deadening quilt ($\frac{1}{2}$ in. thick) placed above.

General Practitioner Records. These are filed round the walls of the room in a similar manner to books on shelves in a library. A series of roll-top shutters may be pulled down over the shelves and locked when surgery is over. About 100 records per foot run of shelving are stored in this manner and the receptionist has found the system compact and convenient. She has a hatch through which to speak to patients in the waiting room.

Furniture. Most of the consulting room furniture was brought by the general practitioners from their former premises and, under the shared accommodation principle, it is used by local authority staff holding antenatal, infant welfare and other clinics in the same rooms when surgeries are over.

Ancillary Staff. Apart from the receptionist employed by the general practitioners, a health visitor is attached to the practice list and, at the time of writing, it is expected that a newly-appointed home nurse will shortly be also attached.

It has not proved practicable to attach a midwife solely to the one group because of the low domiciliary confinement rate and the necessity to provide frequent reliefs among the few midwives employed in the area.

Local Authority Services. The approximate population using the clinic services is 9,000. The services include chiropody, infant welfare, antenatal and school clinics.

Time taken over the adaptations. The general practitioners approached the County Medical Officer in November, 1964. They moved, at their own request, into part-completed and undecorated adaptations in July, 1965, and endured some inconvenience for a further two months. They have since been able to work happily and apparently with great satisfaction to their patients through a busy and unpleasant winter.

Some outside jobs are as yet unfinished, including provision of car parking facilities and lighting and improvements to the approach road to the clinic. They are in hand and will be completed shortly. A speaker system between the consulting rooms and the waiting room has also yet to be installed.

Cost. The total cost of the internal adaptations described above was £1,040. Car park, road improvements and external lighting will be extra.

The results at this low cost have pleased everyone concerned.

Kirkburton Clinic

History. The building was erected around the turn of the century and, until 1954, served as a drill hall for the Territorial and Auxiliary Forces Association.

At the further end of the single-storey hall was an attached two-storey caretaker's residence, and - in the basement below ground, under the whole structure - was (and still is) a shooting gallery.

The building was first used for clinic services in 1954 and, in 1957, it was purchased by the West Riding County Council.

Adaptations were carried out in 1959 to convert the caretaker's house into a school dental unit, and to the hall itself for infant welfare, maternity clinics, speech therapy and group-teaching classes for mentally subnormal children.

From time-to-time, the large rooms available have also been used for such purposes as Civil Defence exercises, Blood Transfusion Service collecting sessions, Mass X-Ray, W.V.S., and church services.

Perhaps the main attribute of this old drill hall has been its large floor area on which alterations, using partitioning, suspended ceilings, and modern floor and wall finishings have been easily undertaken.

General Practitioner Participation. In mid-November, 1964, a partnership of two general practitioners asked to use the clinic as main surgery accommodation from which to run their practice which had, for many years, served the population of Kirkburton. Their request was circulated (as normal routine) to other general practitioners having an interest in the area.

No adverse observations were received and plans proceeded for adaptations and improvements to the entire clinic. The building was to provide a convenient lay-out for the practising general practitioners and the usual public health clinics. Under the shared accommodation principle this means that no rooms may be locked and either party may use any consulting rooms available on the rare occasion when activities overlap.

Normally, the general practitioners prefer to work from the new suite across the north side of the hall, and the public health clinics are tending to move over there also for sessions involving individual consultations.

Group activities, however, continue to spread themselves in the relatively spacious consulting rooms of former days.

The general practitioners concerned run antenatal clinics for their own patients with the midwife in attendance.

The attached home nurse and midwife call at the clinic to receive instructions and learn details of the cases for whom they are responsible.

On the public health side, the following activities take place:

Infant welfare sessions, antenatal relaxation classes, immunisation, ophthalmic service, speech therapy, chiropody, school dental services, and individual health visitor consultations. The premises also serve as headquarters for the nursing staff.

Extent of the adaptations and improvements. In view of the internal bare brick walls, the open trusses of the roof, bare board floors and other forbidding military aspects of the building, the following general improvements were effected:

Suspended ceilings.
Plastering of internal brick walls.
New floor finishes.
Improvements to the central heating system and domestic hot water system.
Provision of suitable electric installations.
Complete decorations throughout.

Additions and alterations to the use of floor space involved provision of:

Internal pram parking (14 ft. x 15 ft.)
Waiting room (45 ft. x 17 ft.)
Records and reception room (15 ft. x 12ft.)
Two consulting rooms, each 12 ft. x 9 ft., with examination rooms (9 ft. x 6 ft.) adjacent.
One treatment room (9 ft. x 7 ft.)
Re-siting of the kitchen.
Male and female toilets with access from waiting room.

Furniture and records. Modern furniture, in keeping with the nature of the new adaptations, has been provided by the County Council. The incoming general practitioners elected to bring with them record cabinets, swivel desk chairs, couches, and a numberof smaller items. Total cost of replacement and some additional furniture was £700, the use of these items by general practitioners being included in the standard rental.

Time taken over adaptations. The first approach by general practitioners to the County Medical Officer was in mid-November, 1964. Obtaining Committee approval, making budgetary provision, designing, acceptance of tender and construction time resulted in the finished building furnished and ready for occupation by the general practitioners on 1st April, 1966 - a total period of $16\frac{1}{2}$ months.

Cost and comment. Had the County Council been providing completely new accommodation for clinic (and general practitioner) purposes for this population numbering about 9,000 persons, the choice today would have fallen on the 'E' type clinic with attached dental suite costing, at today's prices, about £19,000 including site, for which price 3,477 square feet of floor space would beusable.

At Kirkburton, the capital cost of the old drill hall, having a usable floor area of about 5,200 square feet and now brought up to modern standards in every way, is made up as follows:

Purchase in 1957	£3,750
Dental and other adaptations 1959-60	3,009
Adaptations 1965-66 for shared accommodation with general practitioners	5,675
Total	£12,434

For this sum, we have a building which, over and above its present very useful function, has sufficient consulting and other rooms for both future increases in public health activities and the entry of additional general practitioners should the population grow and either service expand.

A recent decision of the Kirkburton Urban District Council to provide public car parking next to the clinic will complete the amenities of the centre.

Special Buildings.

Following on the flexible approach to the varying needs of practices in a varied geographical region it will be obvious that the above projects, which have some degree of standardisation, although flexible will not be suitable for every contingency and special buildings will be needed. A number of these are about to be erected and one will be illustrated by plan.

The main thing to note, however, is that these special buildings will follow the basic shared accommodation pattern common to all the other centres, except Cleckheaton, and the same basic principle held as illustrated in the E typre centre. An example of this type of building, which will be illustrated by slides, is the Ilkley centre which will accommodate all the general practitioners in that town, and is to be built next to the local hospital.

Special buildings of this kind are often thought of when town centre planning is being considered, and one then comes across the problem of whether the central site is the right place for such a concentration of medical effort with all its complications and expensive sites, traffice difficulties and car parking.

Sale of Land by Local Health Authorities to General Practitioners.

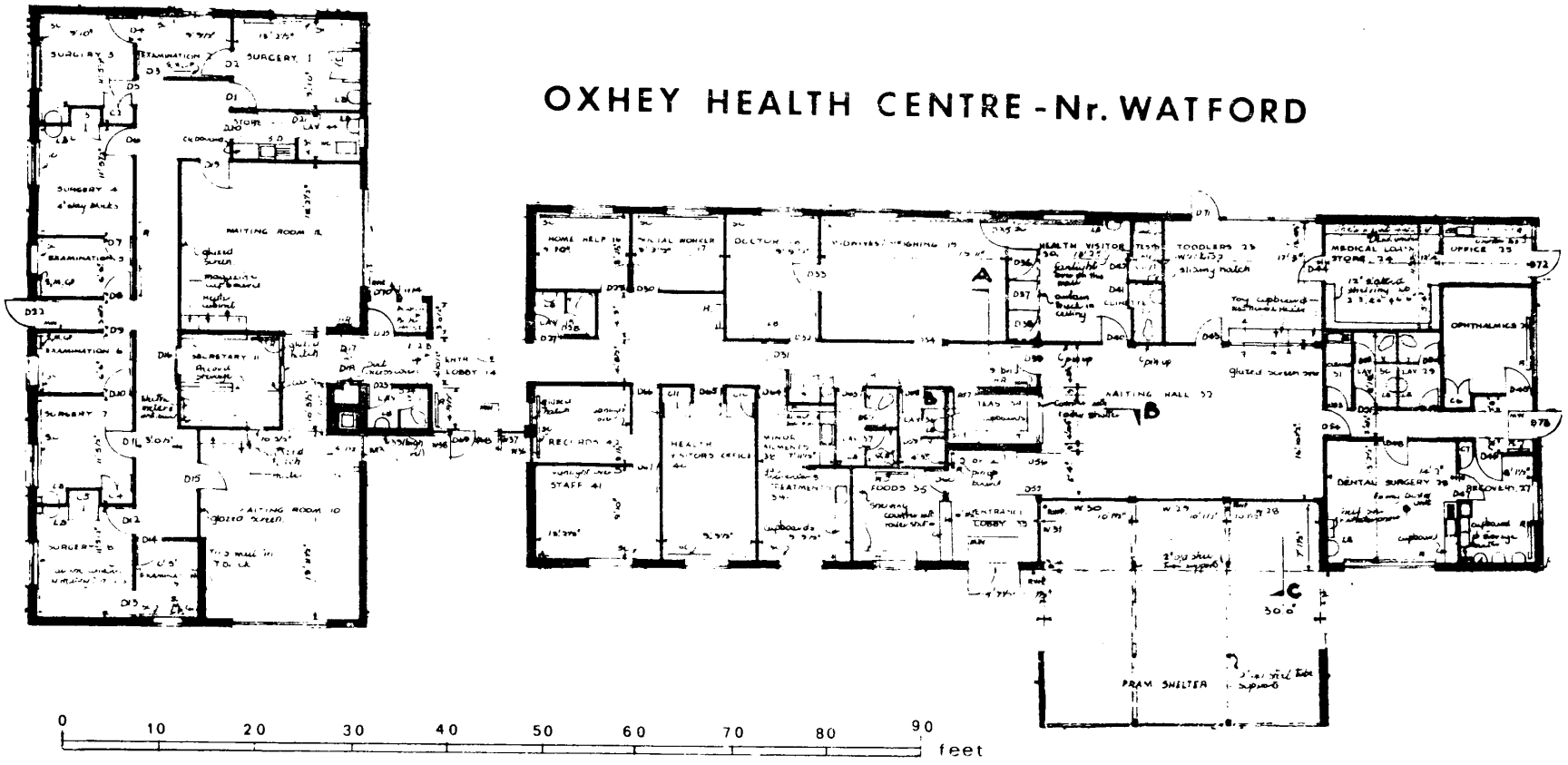
Since local authorities on the whole have rather better opportunities of acquiring sites than private practitioners it should be borne in mind when constructing clinics or centres where general practitioners are not interested in the joint user concept that excess land on the site of such a clinic could be made available to general practitioners for the construction of group practice premises. I think this is second best but it is helpful, and under these conditions joint use of some of the basic services, such as heating, telephones etc. might be advantageous.

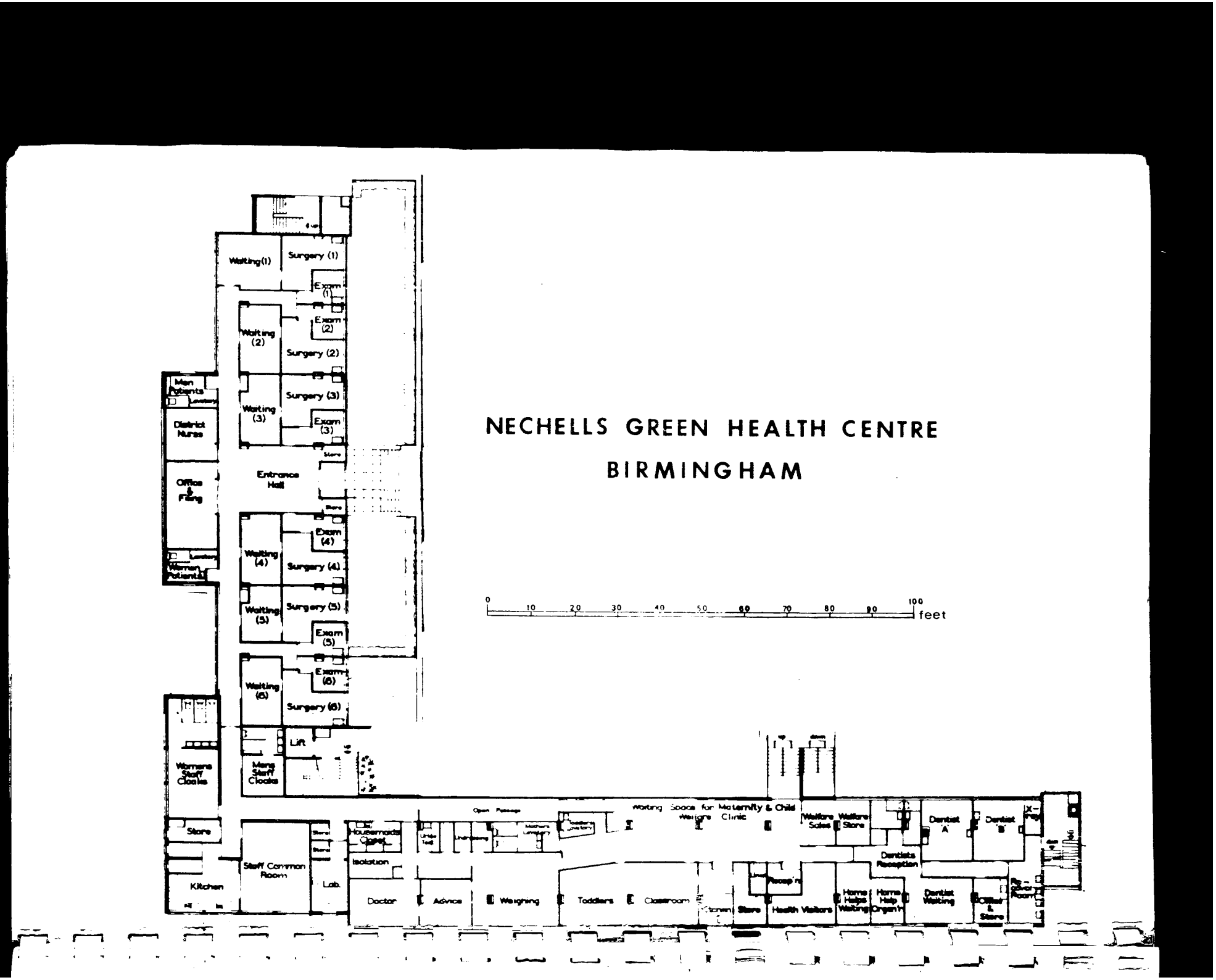
Group Practice Premises

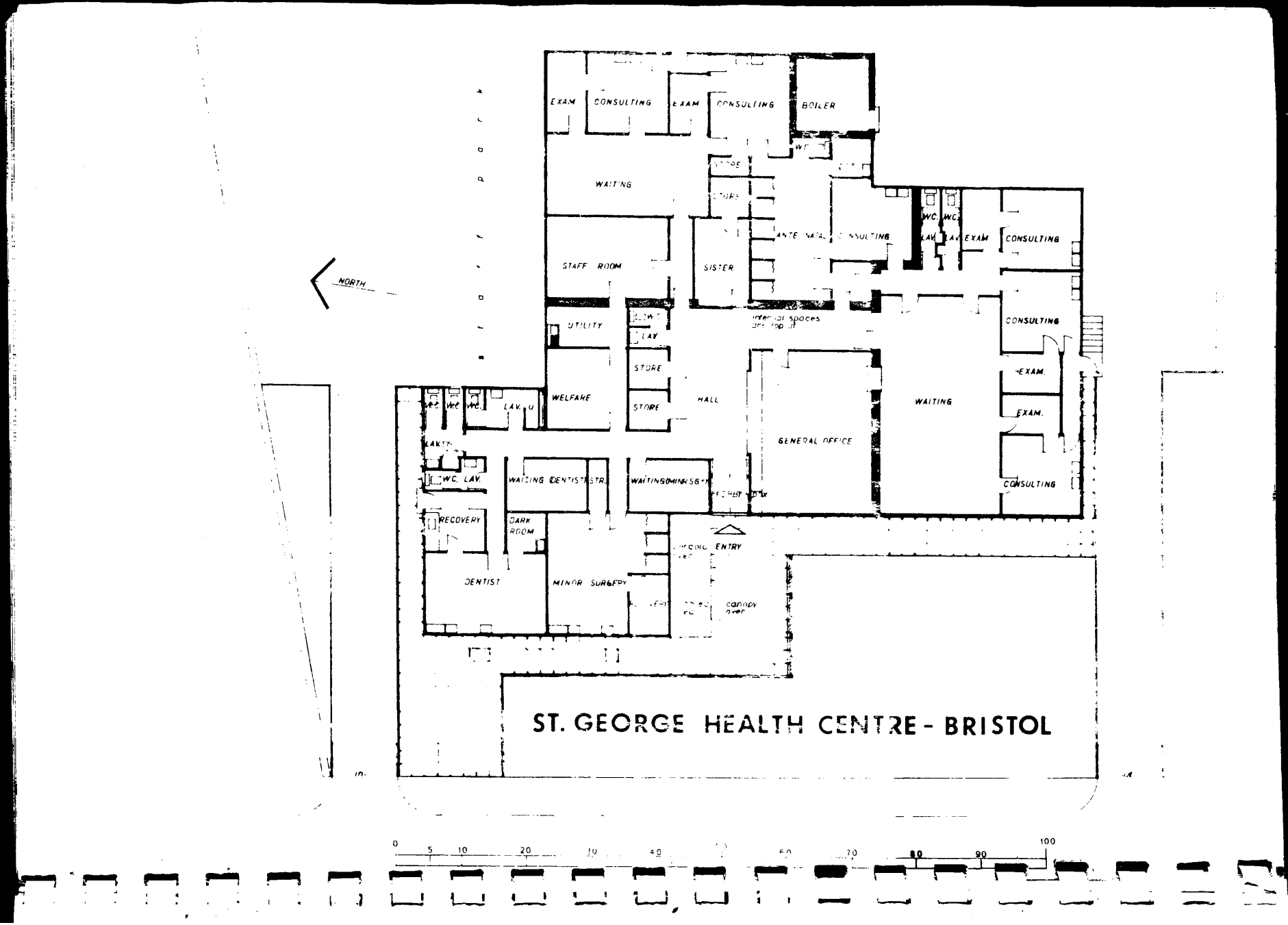
It must not be overlooked that the concept of joint user premises can under certain circumstances, e.g. the small village, work in the opposite direction and the renting of group practice premises by the local health authority for its own purpose is not out of the question and indeed is run successfully in some parts of the area.

I have tried to range quickly over the field of joint user premises as between general practitioners and preventive medicine. I have attempted it in a practical way and hope that the points made will be useful. I am sure they are not exhaustive and as the illustrations to this paper will indicate progress can be made on these lines and by the end of 1966 it is anticipated that somewhere between 80 and 90 general practitioners will be involved in this kind of joint effort. All of them will also receive assistance from attached health visitors and where possible home nurses and midwives.

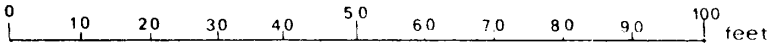
OXHEY HEALTH CENTRE - Nr. WATFORD




NECHELLS GREEN HEALTH CENTRE
BIRMINGHAM
0 10 20 30 40 50 60 70 80 90 100 feet
Waiting (1)
Surgery (1)
Exam (1)
Waiting (2)
Exam (2)
Surgery (2)
Waiting (3)
Surgery (3)
Exam (3)
Men Patients
District Nurse
Office & Filing
Entrance Hall
Waiting (4)
Exam (4)
Surgery (4)
Women Patients
Waiting (5)
Surgery (5)
Exam (5)
Waiting (6)
Exam (6)
Surgery (6)
Lift
Womens Staff Cloaks
Mens Staff Cloaks
Store
Staff Common Room
Kitchen
Lab.
Housemaids Closet
Isolation
Doctor
Advice
Weighing
Toddlers
Classroom
Waiting Space for Maternity & Child Welfare Clinic
Welfare Sales
Welfare Store
Dentist A
Dentist B
X-Ray
Dentists Reception
Recep'n
Store
Health Visitors
Home Helps Waiting
Home Help Organ'r
Dentist Waiting
Dentist & Store
Dr's Waiting Room

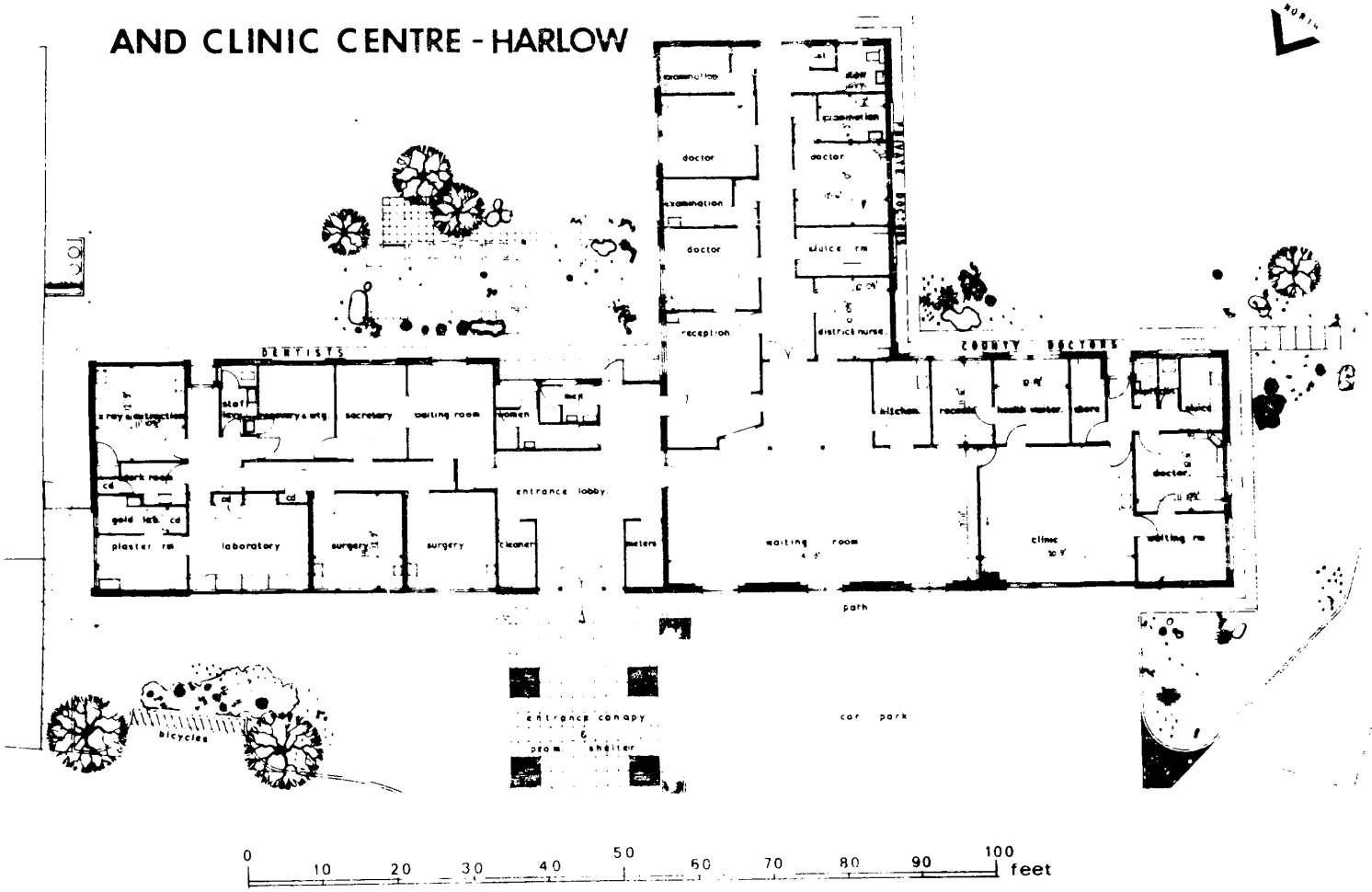

EXAM
CONSULTING
EXAM
CONSULTING
BOILER
WAITING
STAFF ROOM
SISTER
NORTH
UTILITY
LAV.
STORE
STORE
WELFARE
HALL
WC. WC. LAV.
WC. LAV.
RECOVERY
DARK ROOM
DENTIST
MINOR SURGERY
GENERAL OFFICE
WAITING
CONSULTING
EXAM.
EXAM.
CONSULTING
ENTRY
0 5 10 20 30 40 50 70 80 90 100
ST. GEORGE HEALTH CENTRE - BRISTOL

HYTHE HEALTH CENTRE – HAMPSHIRE

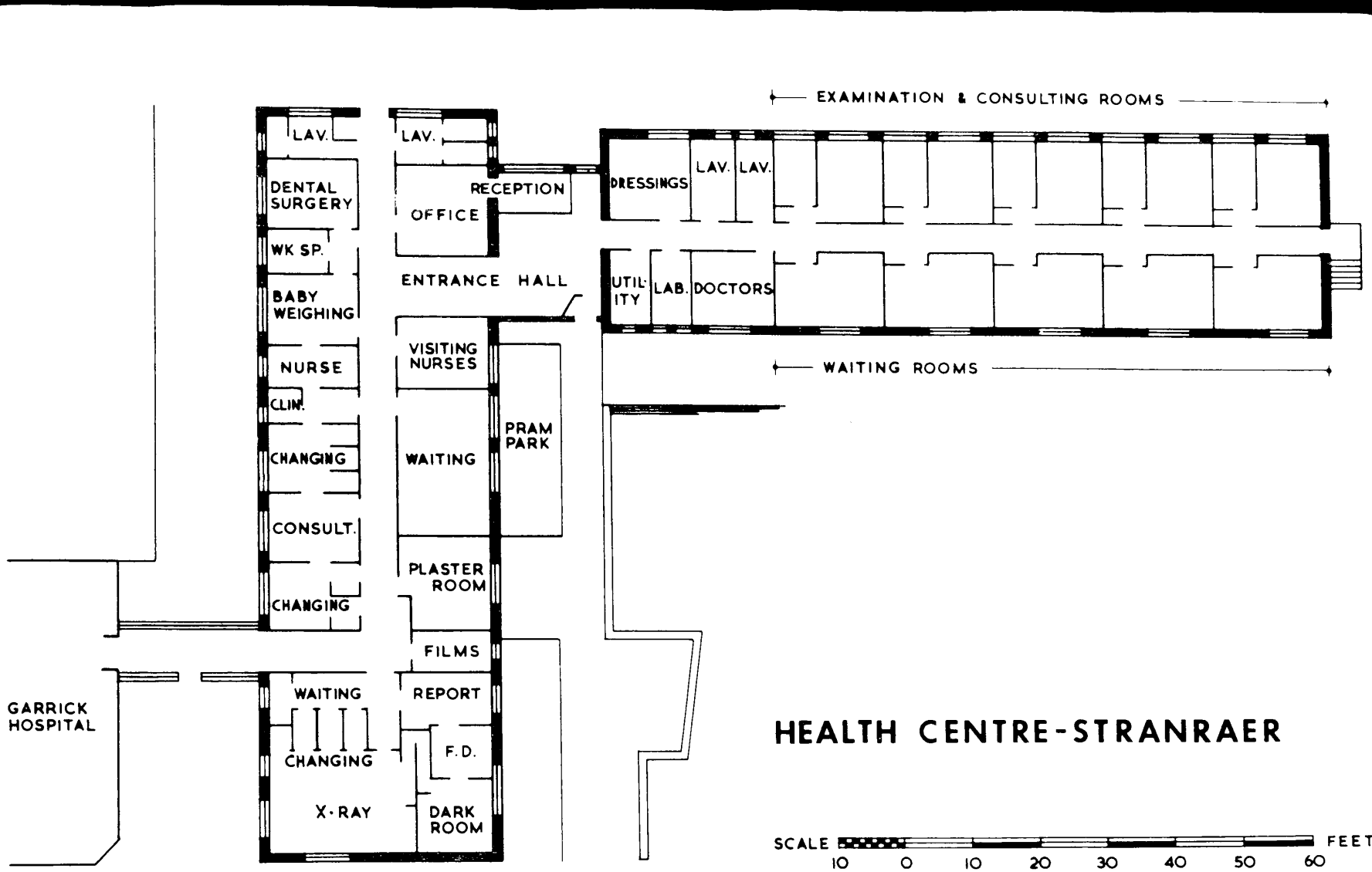


NUFFIELD HOUSE GROUP PRACTICE

AND CLINIC CENTRE - HARLOW

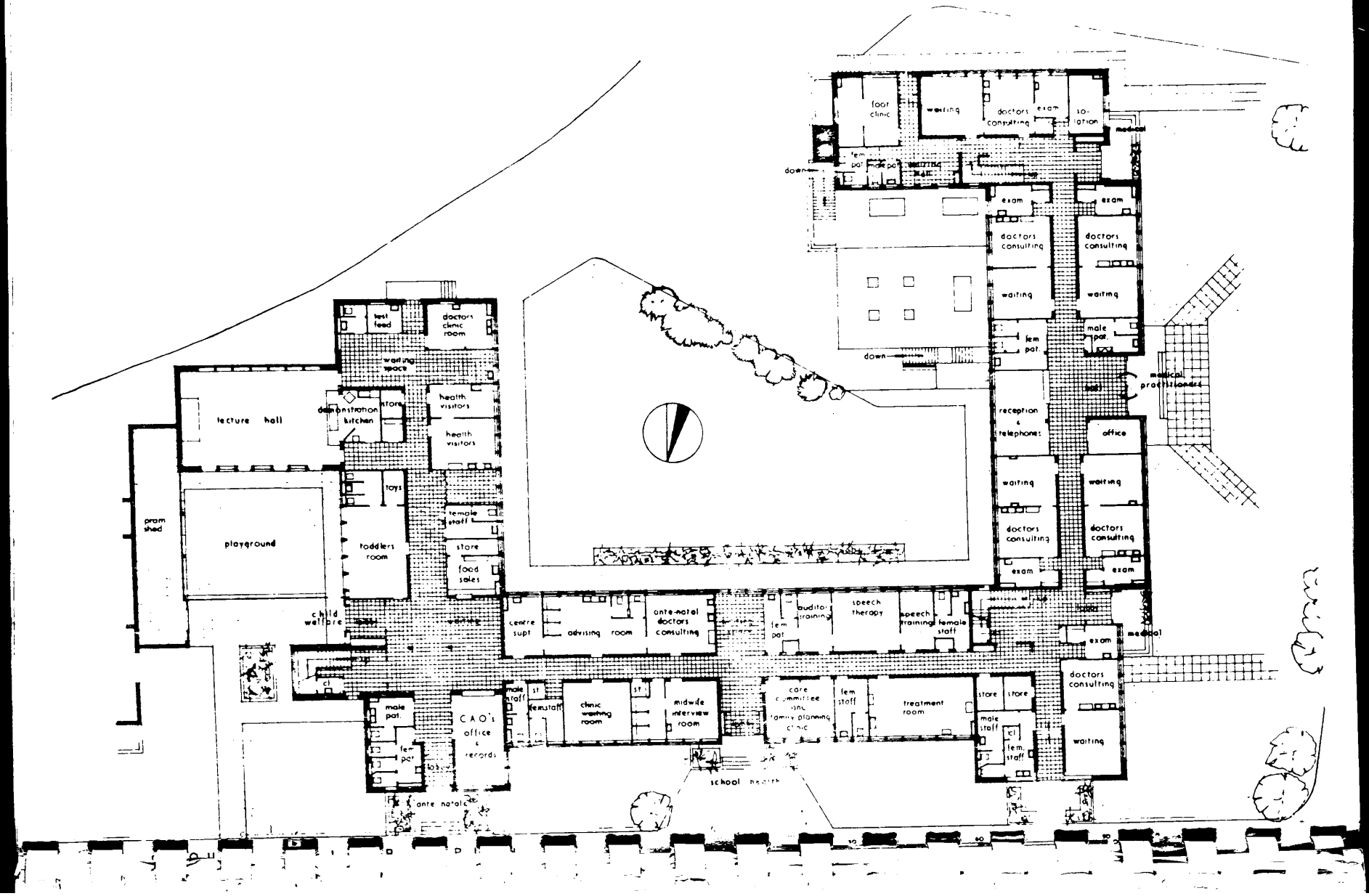


691·21.


EXAMINATION & CONSULTING ROOMS
LAV.
LAV.
DENTAL SURGERY
RECEPTION
OFFICE
DRESSINGS
LAV.
LAV.
WK SP.
ENTRANCE HALL
BABY WEIGHING
UTIL ITY
LAB.
DOCTORS
VISITING NURSES
NURSE
CLIN.
WAITING ROOMS
PRAM PARK
CHANGING
WAITING
CONSULT.
PLASTER ROOM
CHANGING
FILMS
GARRICK HOSPITAL
WAITING
REPORT
CHANGING
F.D.
X-RAY
DARK ROOM
HEALTH CENTRE-STRANRAER
SCALE
FEET
10 0 10 20 30 40 50 60

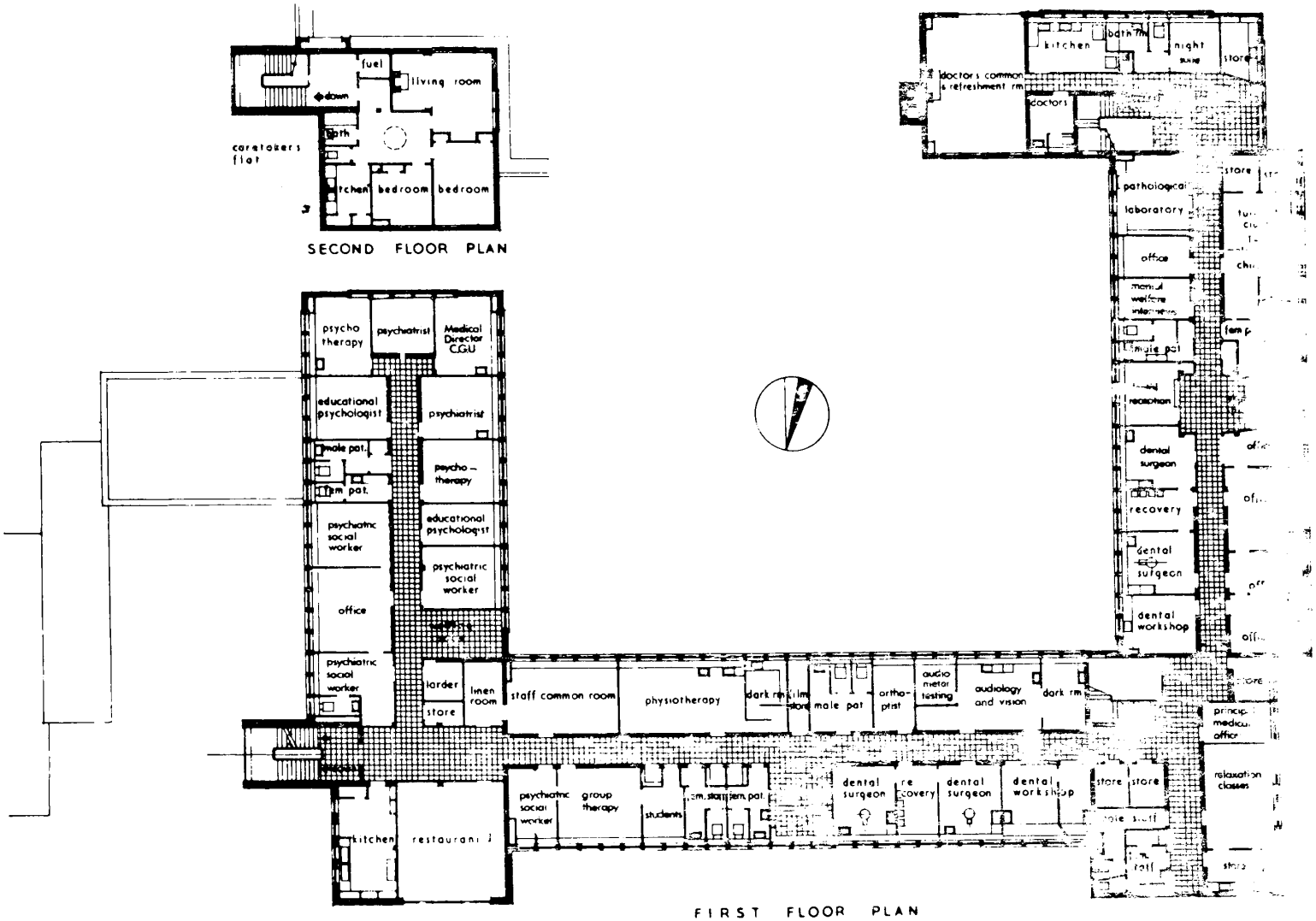
JOHN SCOTT HEALTH CENTRE, WOODBERRY DOWN

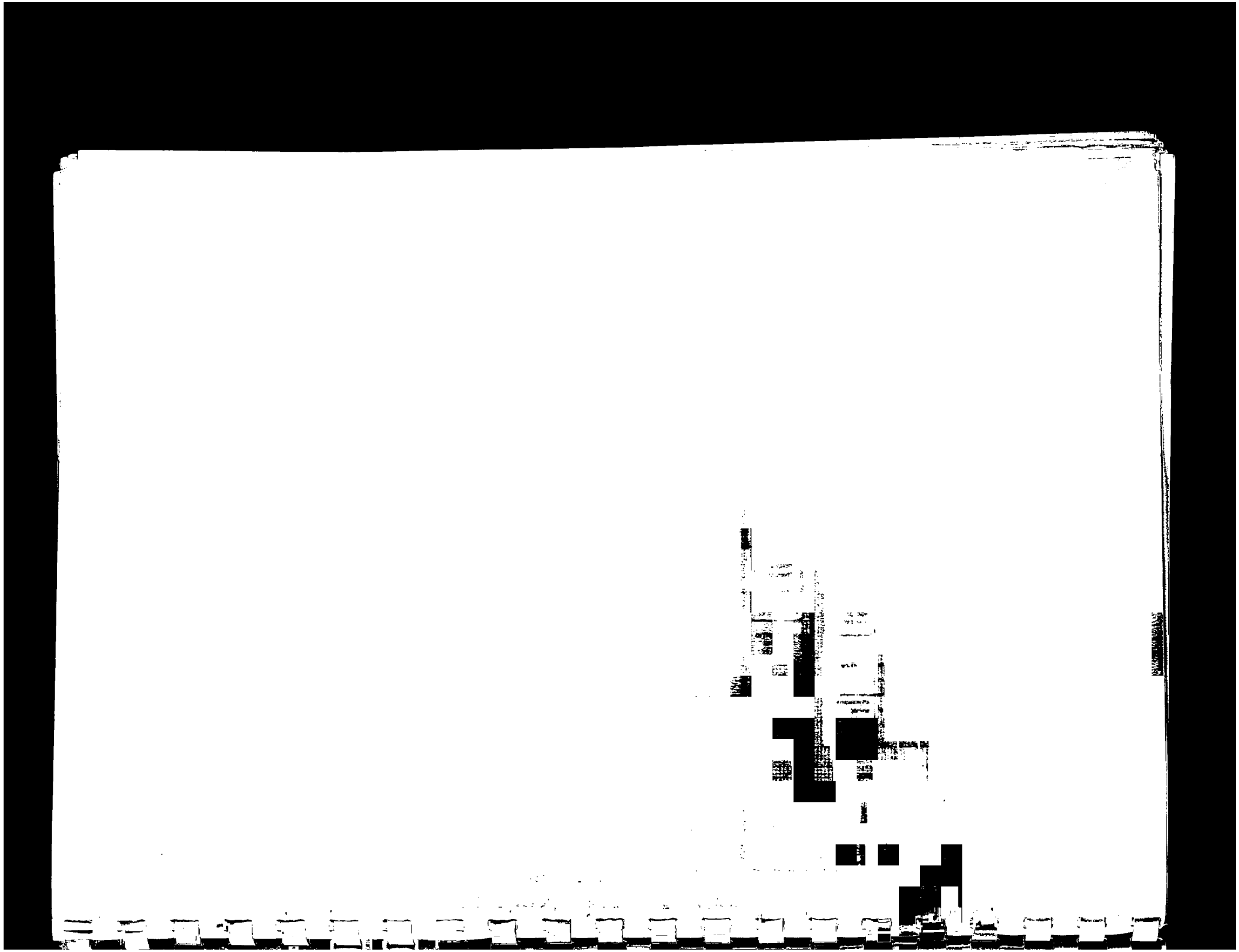
STOKE NEWINGTON N.4.



JOHN SCOTT HEALTH CENTRE, WOODBERRY DOWN

STOKE NEWINGTON N.4.





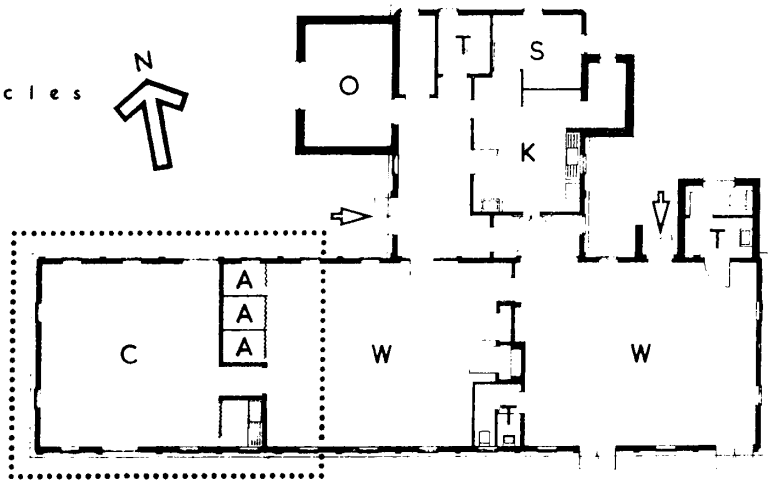
THE CLINIC AT RASTRICK BEFORE ADAPTATION

dotted frame shows rooms concerned
– for detail see over page

KEY

A antenatal undressing cubicles
C consulting
K kitchen
O office
S food store
T toilet
W waiting room

SCALE 0 10 feet

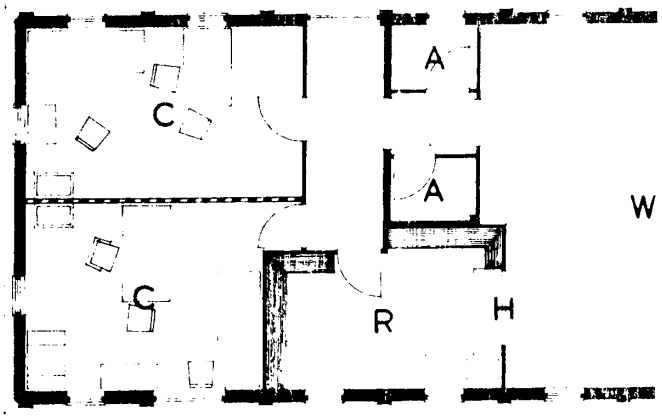


RASTRICK CLINIC – DETAIL OF ADAPTATION

KEY

A antenatal undressing cubicles
C consulting
H receptionist's hatch
R reception & records
W waiting room
shelves for G. P. records
soundproof partition

SCALE 0 10 feet



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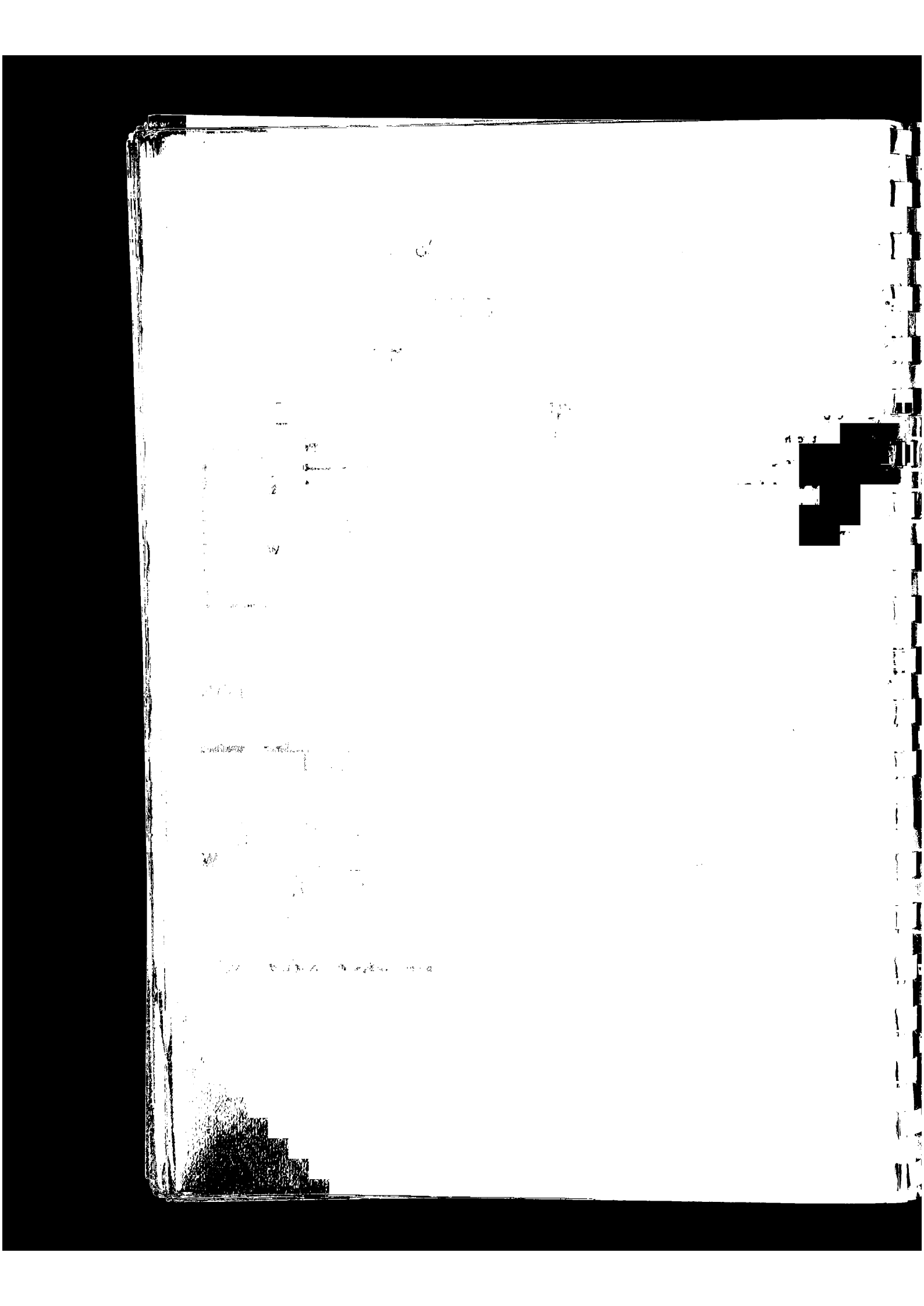
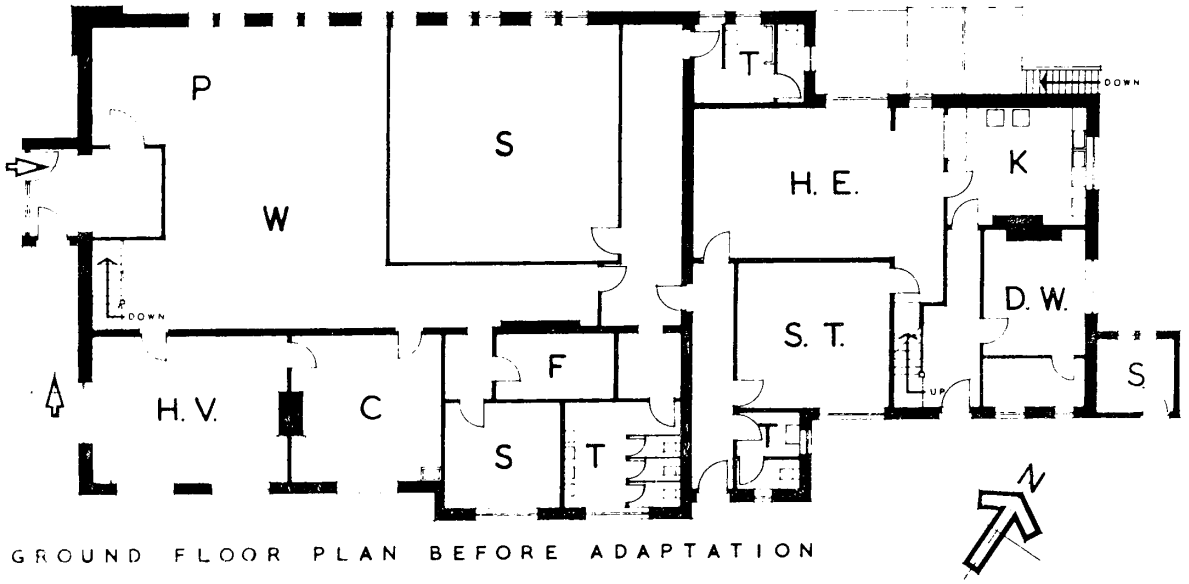
Wakefield



KIRKBURTON CLINIC — ADAPTATION

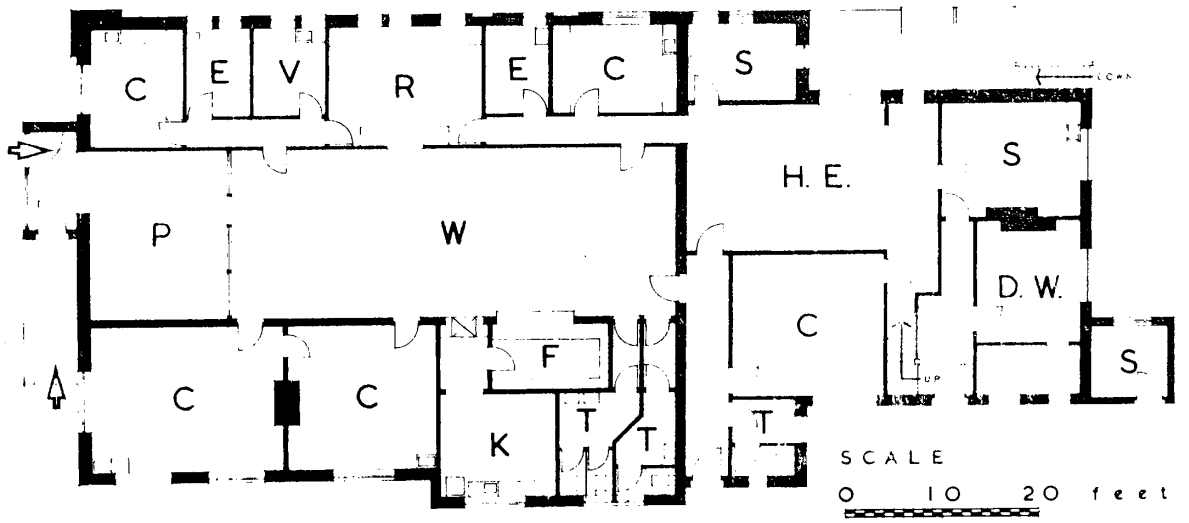
FOR SHARED ACCOMMODATION WITH GENERAL PRACTITIONERS



GROUND FLOOR PLAN BEFORE ADAPTATION

KEY

C	consulting	R	reception and records
DW	dental waiting	S	store
E	examination room	S.T.	speech therapy
F	food sales	T	toilet
HE	health education	P	prams
HV	health visitor	V	treatment room
K	kitchen	W	waiting room



GROUND FLOOR PLAN AFTER ADAPTATION

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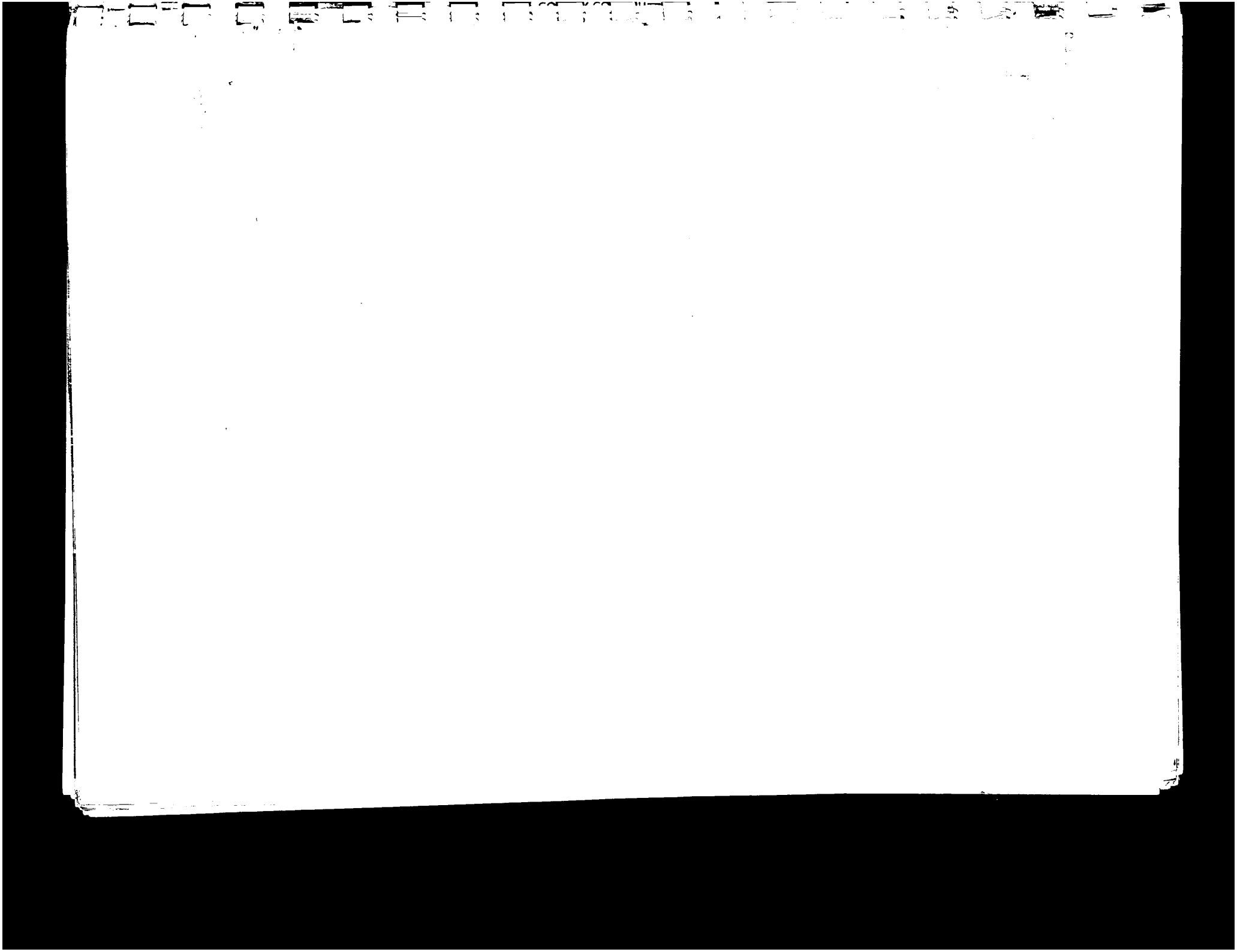
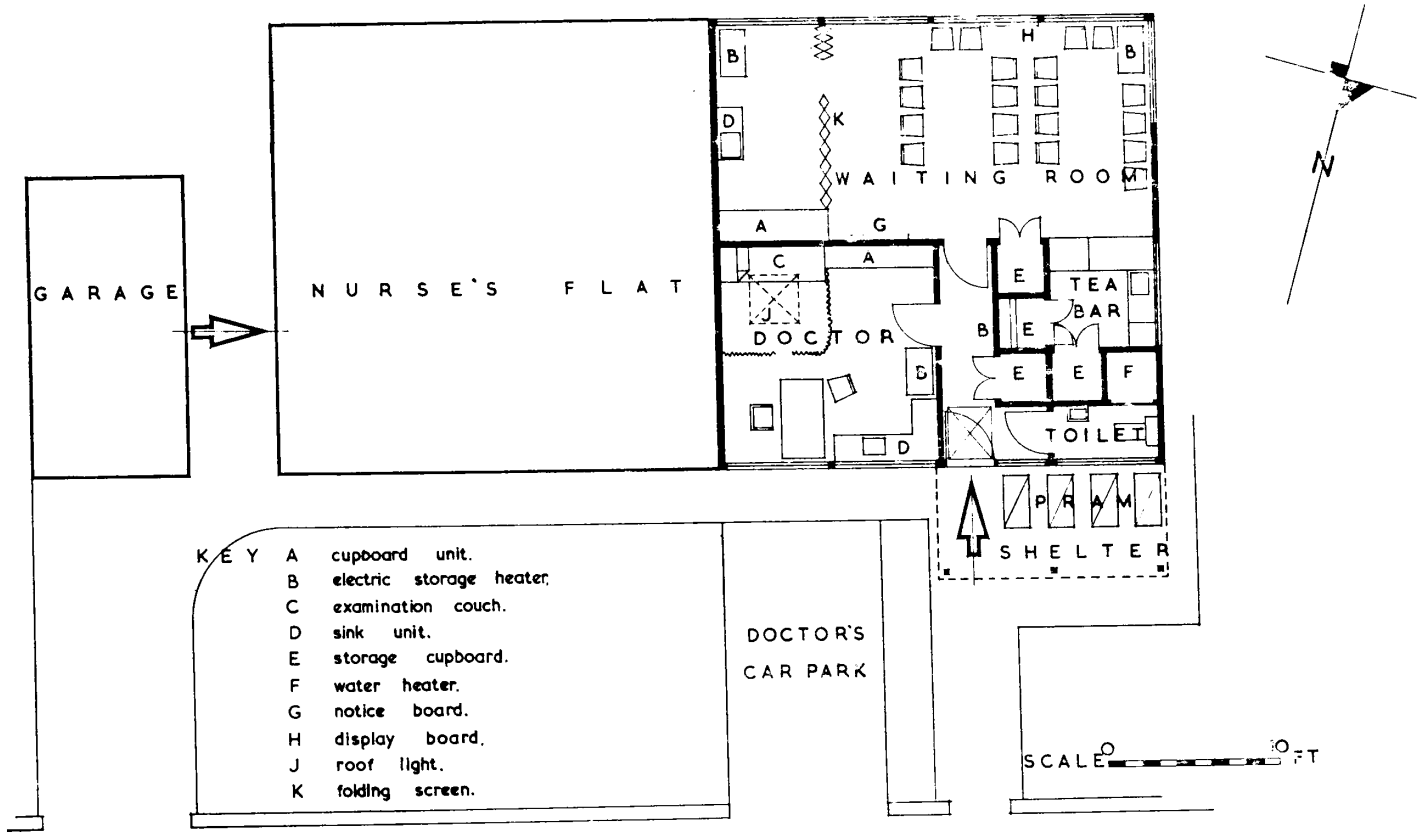


NEW MINI-CLINIC AT SOUTHOWRAM



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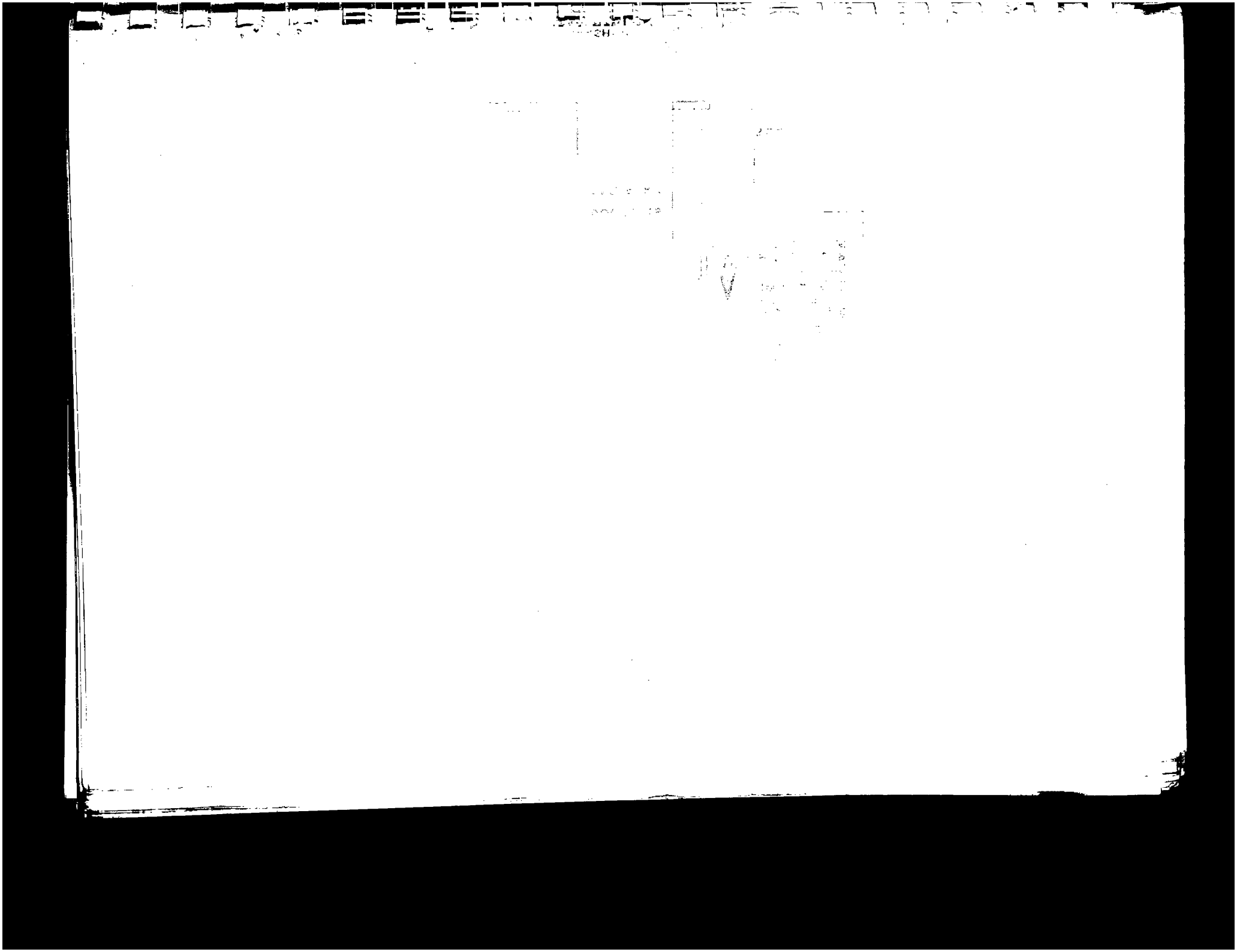
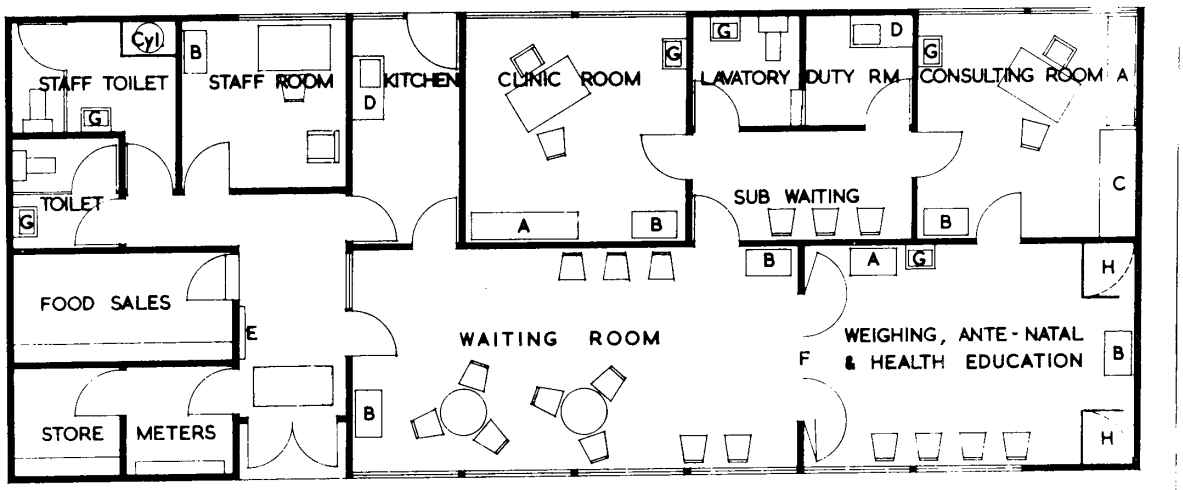
WEST RIDING



THE EXISTING D TYPE CLINIC

DOCTORS CAR PARK

KITCHEN ENTRANCE



PRAM SHELTER

KEY

	A	cupboard
	B	electric storage heater
	C	examination couch
	D	sink unit
	E	notice board
	F	folding doors
	G	wash basin
	H	foldaway dressing cubicles

Scale 0 10 FT

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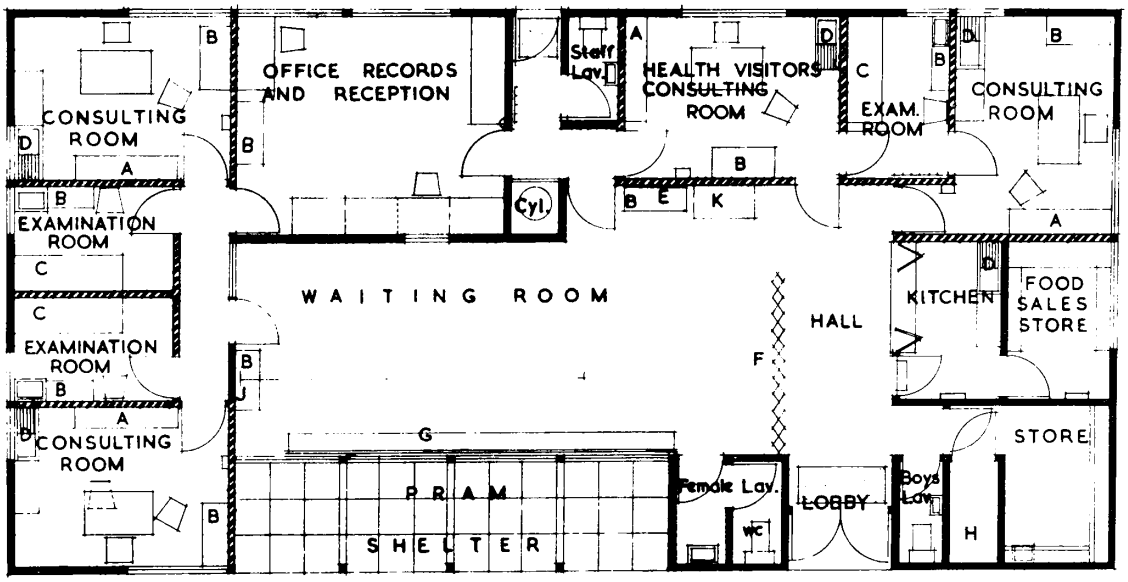
THE NEW E TYPE CLINIC

DOCTORS CAR PARK

DOCTORS ENTRANCE



A cupboard
B electric storage heater
C examination couch
D sink unit
E notice board
F folding screen
G bench
H meters
J eye test chart
K showcase

soundproof partition

Scale 0 10 FT

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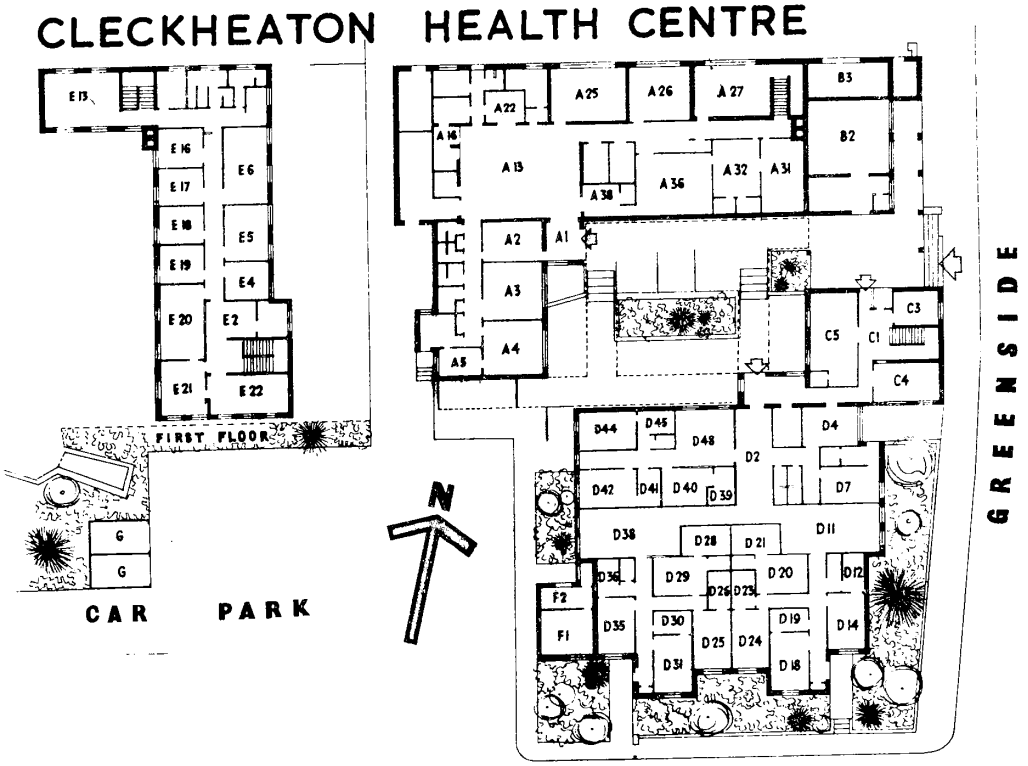
CLECKHEATON HEALTH CENTRE



Key to Ground Plan:

Block A — Clinic Wing

A1 Entrance lobby
A2 Dental waiting room
A3 Dental surgery
A4 Dental surgery
A5 Recovery room
A13 Waiting hall
A16 Welfare food sales
A22 Tea bar
A25 School health
A26 Special services
A27 Mothercraft
A31 Consulting room
A32 Dressing room
A36 Weighing and antenatal
A38 Duty nurse

Block B — Boiler House

B2 Boiler house
B3 Fuel store

Block C — Public health

C1 Entrance hall
C3 Chief inspector
C4 Office
C5 Office

Block D — General Practitioners

D2 Entrance hall
D4 Laboratory
D7 Minor surgery
D11 Waiting room
D12 Examination room
D14 Consulting room
D18 Consulting room
D19 Examination room
D20 Reception
D21 Dispensing
D23 Examination room
D24 Consulting room
D25 Consulting room
D26 Examination room
D28 Dispensing
D29 Reception
D30 Examination room
D31 Consulting room
D35 Consulting room
D36 Examination room
D38 Waiting room
D39 Dispensing
D40 Reception
D41 Examination room
D42 Consulting room
D44 Consulting room
D45 Examination room
D48 Waiting room

Block E — Divisional Medical Officer

E2 Waiting area
E4 Chief Clerk
E5 Divisional MO
E6 Conference room
E13 Health visitors
E16 Senior nursing officer
E17 Psychiatric social worker
E18 Assistant county MO
E19 Assistant county MO
E20 Welfare office
E21 General office
E22 School health office

F1 Registrar's office
F2 Waiting room

G Garages

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