KF REPORTS

Number KFC 82/6

MANAGEMENT EDUCATION AND PRIMARY CARE

Report of a Workshop held at the King's Fund Centre on

Wednesday 21 October 1981

MAY 1982

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

Tel: 01-267 6111

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

The King's Fund Centre was first established in 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in developing solutions to problems of health and related social care and its now permanent accommodation in Camden Town has excellent facilities for conferences and meetings. Allied to the Centre's work is the Fund's Project Committee which sponsors work of an experimental nature.

Further enquiries about the work of the Centre and the Fund and requests for advice or assistance are always welcomed.

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Editors: DAVID HANDS and
PETER PRITCHARD

Rapporteur: BERYL MARTIN

FOREWORD

There has been considerable emphasis during recent years upon the development of primary care in the context of the debate about overall priorities within the National Health Service. However, although some broad goals have been set, little sustained attention has been given to the ways in which those goals can be achieved.

The King's Fund has been involved over the years in a variety of ways with General Practitioners and other professionals working in the primary care setting. This includes participation by primary care workers in research, publications, conferences, seminars and courses in many policy areas but, more recently, activities which are of particular relevance to the primary-care setting itself.

One vital issue is the capability of those working in primary care to manage effectively primary care services and the opportunities which are available to them for education to help to develop their management skills. Unless attention is given to encouraging imaginative management of primary care, it seems unlikely that the development and improvement of primary care services within the NHS will proceed as rapidly as many would wish.

We were therefore pleased to respond to a suggestion from Dr Peter Pritchard that the King's Fund should organise a workshop to bring together some of those who had worked in this field so that they could share and consolidate experience.

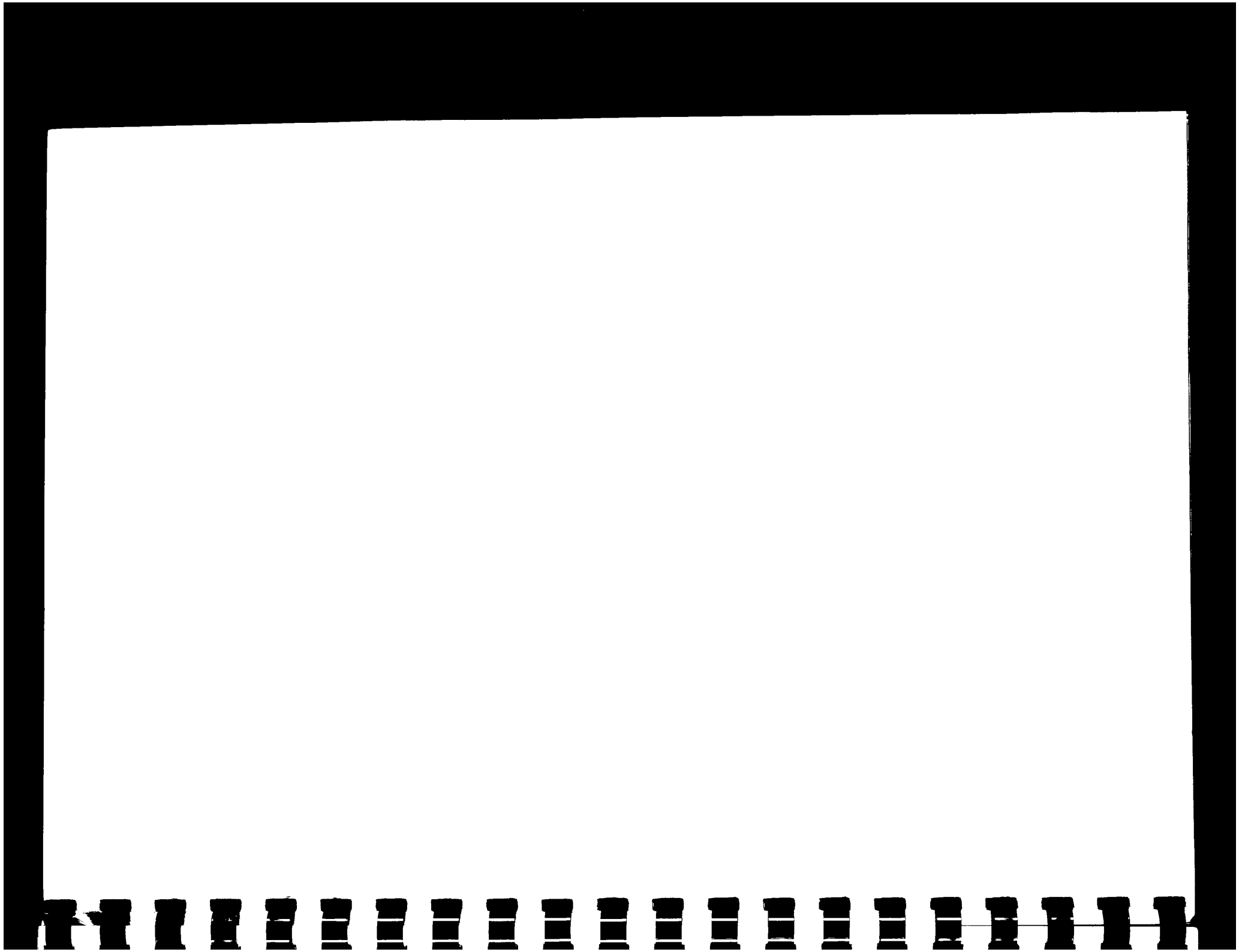
This report therefore makes a modest contribution to the task of bringing together some of the work which has already been done. It is hoped that it will also act as a stimulant to further development. It cannot of course be comprehensive and we apologise to those who have done similar work to that described of whom we were unaware and whose contribution could not therefore be acknowledged.

We would of course be interested to hear from anyone who, unknown to us, is already working in this field or who would like to begin doing so.

BILL FRASER - Senior Tutor, King's Fund College

DAVID HANDS - Assistant Director, King's Fund Centre

May 1982.



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WORKSHOP PROGRAMME

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10.20	Welcome and Background	David Hands
10.25	Introduction by the Chairman	Barry Reedy
10.30	Team Development	Graham Smith Jenny Blake Ken Low
10.50	Management Courses for General Practitioners	Bill Fraser Kathryn Evans
11.10	Training of Practice Managers, Medical Secretaries & Receptionists - Three Presentations:	
	1. Oxford Regional Courses	Peter Pritchard Wendy Pritchard Peter Havelock
11.30	2. Courses associated with AMSPAR	John Dawe Olga de Souza
11.50	3. Courses associated with ACHPA	John Yates Ellen Kemp
12.10	Resources for Management Education in Primary Health Care	Karl Sabbagh
12.30	Discussion	
12.45	Buffet Lunch	

Afternoon

1.45 - 3.00	Group Discussions: Where next ?	
	For this period, the Workshop divided into four groups to discuss in greater detail the presentations made during the morning and to decide on the action required to further develop work in this field. Groups were asked to include in their reports a list of three initiatives which should now be taken and to identify who should take them.	
3.00 - 3.45	Group Reports and Discussion	
3.45	Chairman's Summing Up	
4.00	Close	

INTRODUCTIONS

David Hands, Assistant Director of the King's Fund Centre, welcomed the participants. He explained that the idea of a holding workshop arose for a variety of reasons but, most specifically, from a meeting at the DHSS stimulated by Dr Peter Pritchard in July 1980 between officers of the Department who were interested in and involved with management and general practice, the King's Fund and Dr Pritchard.

The aim of the workshop was to identify some of those who were active in the field of management education in primary care so that they could have an opportunity to exchange views and experiences. He hoped that by using the resources present at the meeting, it would be possible to consolidate ideas and plan future initiatives.

He introduced the Chairman, Dr Barry Reedy, of the Health Care Research Unit, of the University of Newcastle upon Tyne, who had himself made significant contributions to this field during the past twelve years.

The Chairman, Dr Barry Reedy, emphasised that this was a very important occasion bringing together the diverse interests in this field. He introduced the speakers and described the design of the programme.

1. TEAM DEVELOPMENT IN PRIMARY HEALTH CARE

GRAHAM SMITH, JENNY BLAKE AND KEN LOW

GRAHAM SMITH, Regional Education and Training Officer, Wessex Regional Health Authority, set out the objective of the Wessex Team Development Project. This is to produce a 'Self Development Manual' which GPs can apply to their own Practice in order to improve their work effectiveness. The manual will cover a variety of factors including relationships with the community, administration and organisation, management methods and style within the practice, teamwork and personal relationships.

The stimulus for the project arose in early 1979, when the General Practitioner representative, and District Nursing Officer, from one of the Wessex Health Districts, approached the Regional Training Section for ideas concerning a problem that they had identified within the Community Health Service. This problem concerned the high turnover of qualified nurses in the Community, and it was felt that these nurses were leaving voluntarily because of frustration and low morale. Initial investigation suggested that the causes of this turnover included:

(i) lack of understanding and clarity about various roles in the Primary Care Team;

(ii) lack of communication within Teams;

(iii) ambiguous lines of responsibility;

(iv) issues concerning the extended role of the nurse.

After discussion, a number of actions were agreed to attack this nurse turnover problem. One major activity was an Organisation Development project designed both to develop teamwork in selected Practices and to provide the information upon which a self-development 'kit' could be produced. This kit could be applied by GPs and other staff, to their own Practice situation. It would help them diagnose their problems, suggest methods and processes to help them move towards a solution.

The Wessex Regional Education and Training Section decided to expand this project to cover the entire Region. The project was welcomed as the section wished to expand its work in the Community - having traditionally concentrated on hospital problems.

The first stage of the project was to collect raw data concerning the factors which led to effective working at the Primary Care level. The project proposal was aired with GPs in the Region through their District Management Team, and a number of Districts showed interest. Meetings were held with General Practitioners in these Districts, who were invited by their D.M.T. representative. 10-15% of GPs attended these meetings, representing at least 30% of Practices in each District.

Some of the comments at these meetings exemplified the problems which practices can face: "I really do not know what a Health Visitor does"; "I haven't spoken to my Community Midwife for 18 months". These comments represent a failure of the Health Authority to communicate with GPs. However, most of those who attended interest in the ideas and expressed commitment to taking some part in the project.

It may be that this method of generating interest amongst GPs may itself provide a problem in that the practices which were attracted were those which were confident enough to consider having organisational consultants working with them.

GPs expressed a number of reasons for taking part in the project which included:

- the feeling that they had got most factors right but had identified a specific problem (e.g. moving to new premises; division of non-clinical duties)

- a general belief that some improvements would arise from such a study

- altruism; adding to the pool of knowledge.

The project, now called 'Developing Teamwork at Primary Care Level' had three stages:- research stage - test stage - general distribution. GPs were asked whether they wished to be a Research Practice, where organisation development consultants would collect raw data whilst they worked with the practice. Or, they could be a Test Practice, who would, with a consultant present, test the first drafts of the kit on themselves.

Practices were not offered any inducements except the opportunity to participate in a change project and research simultaneously, confidentiality, improvement in internal processes, the opportunity to choose methodology (e.g. time commitment); and sharing ideas and systems amongst practices taking part. A written 'contract' was established between the organisation development consultant and the practice in each case. It was stipulated that the majority of staff (including administrators, nurses, therapists, social workers as appropriate) within the practice should be committed to the project, as they would all be involved and their work and relationships would be investigated.

The project involved working with five practices from three Health Districts. These include City, country and single-handed practices. Meetings were arranged between the organisation development consultants and the five research practices, to ensure mutual compatibility.

Five days observation and research were budgeted for each practice, usually as ten half days. This time was extended as consultants and practices found their relationship useful.

The draft kit or 'Manual' as it has become, is now available and is being discussed with the Research Practices. In the next few weeks it is hoped to move on to test it in a further selection of General Practices. As discussions with the Research Practices are not complete, it was not possible to explore the detail of the Manual at the Workshop. Its structure was presented and there was discussion of some of the problems discovered, and some of the fundamental questions which the two organisation development consultants found themselves addressing during the course of the project.

The Structure of the Manual

Three main categories of factors which help or hinder teamwork were identified from the researchers' observations and notes. These were aligned with each of seven areas of responsibility in the practices. The factors are:

1. Concepts or the 'philosophy' involved

2. Methods of measurement, policy guidelines and themes and

3. Practice (Hints and Solutions)

The above factors are then applied, in the Manual, to each of six areas of responsibility (or 'domains'), as held by

(i) the doctor

(ii) the doctor group

(iii) the primary team

(iv) the practice and its technology/business/ administrative systems

(v) the practice and outside health agencies (hospitals; F.P.C.; Health Authorities etc.) and

(vi) the practice and its relation to the community

By colour-coding the Manual, it has been possible to relate the factors to the domains, comprehensively, using a matrix system.

Several other sections are also provided in the Manual, including one on 'Managing Change' and another containing useful addresses and other information.

JENNY BLAKE, one of the organisation development consultants involved in the Wessex Project, described a number of themes which had arisen during the assembly of the data for the Primary Health Care Team Development Manual. In particular, she and KEN LOW, a colleague, wished to provide participants with an impressionistic rather than a 'scientific' account of their experiences. The two researchers went on to highlight the three dominant themes which seemed to be present in all the practices which were observed. These were:

1. The concept of 'teamwork' and its relevance to health care.
2. Patient participation - i.e. beyond a passive receipt of treatment.
3. Patient education - a practice responsibility?

1. Teamwork

This implies the bringing together, for the benefit of patients, complementary skills and can be

(a) for a very specific purpose such as the diagnosis and treatment of illness or accident;

(b) to ensure the continuing development of the practice as an effective work organisation, combining clinical and administrative tasks and responsibilities;

(c) to build links with other 'teams' be they other practices, clinics, hospitals etc.

There was no clear-cut definition of the composition of a Primary Health Care Team. The description of 'care team' may relate to the clinical staff (doctors, nurses etc) only or to the full-time employees in a centre or practice, including, say, the receptionists but excluding 'attached' staff.

There will be historical reasons for defining any particular team: what is important is that people who work together should be able to consider the most effective ways of ensuring that their skills and competences can complement each other.

The nature of the task and related skills will define membership of any particular team, rather than simply historical ideas about 'status'. The criterion is 'what is the work which has to be undertaken?' People who must work together, in 'ad hoc' emergency situations or throughout an extended period with its peaks and troughs of incidents, develop systems of 'values'. They can ignore or discuss ideas and views about the influences upon effective teams and their own team in particular: ideas about power, control, competence, status, roles.

The doctor, certainly, is a prime influence in any team, which is understandable given the accountability in law which he/she carries. Indeed the initiative to share and explore the most effective ways of working may stem from the doctors, but it is not their exclusive prerogative so to do. Ideas and practical suggestions about improvements also come from other people i.e. not only doctors can take initiatives about 'teamwork'.

Meetings are an obvious means whereby teams can confront issues and make decisions. The different categories include:

(i) Administrative meetings - perhaps with formal agendas and a chair person (e.g. the Practice Manager?)

(ii) Ad hoc meetings - about particular 'cases'.

(iii) Regular, specialist meetings - doctors sharing professional doubts and ideas ('cathartic' purposes too !)

(iv) Sub-group meetings - e.g. nurses, sometimes with one of the partners

(v) Occasional informal discussions - open-ended, over coffee, wine etc.

These meetings do not in themselves constitute 'teamwork' but they are an integral part of the overall pattern where sharing responsibility is an accepted norm.

2. Patient Participation

Patients as people who have other roles and experiences in life can be a source of ideas. How often, though, are views sought on the pros and cons of appointment systems; on the layout and decor of the waiting room; on the possibility of involvement as 'good neighbours' with fellow patients?

At a more personal level each patient is a participant in his/her own health care and therefore carries responsibility about behaviour in an active sense, not just as a passive recipient of pills or potions. Does the policy of a Practice or Health Centre encourage the sharing of responsibility between doctor and patient?

3. Patient Education

The answer to the last question will relate to the concept of a patient as someone who can learn. Does the practice, as a whole, consider its primary function to encourage the prevention of ill health? If so then each member of the team, clinical or administrative, can contribute to this end by the way in which they respond to each patient. How to use the services of Primary Care is an important lesson.

The most effective learning will take place in the consulting room where a specific matter is being discussed. H.E.C. posters distributed, sometimes haphazardly, around the waiting room, do not carry as effective a message as the doctor or nurse. The relevance to health of questions about weight, smoking, lack of exercise, diet etc. appears more real when it arises out of a specific consultation. Posters etc. cannot make an impact unless staff, too, use specific occasions to help patients learn.

Finally, if the team as a whole does value self-learning as one of its important duties to itself then patient education is more likely to be a natural development.

Jenny Blake saw the empirical observations made during the research, for example, raising certain general questions which are fundamental to the provision of primary health care. For example, what sort of message does a practice convey to the community in which it exists? How welcoming is the practice to patients? There may be differences between what the researchers called 'Practice Imagery' and 'Practice Reality' - for example is the message given that of a caring, happy place or not? Receptionists who are unsure as to how to respond to certain types of requests or who insist on answering the telephone in the middle of a patient's sentence can certainly be a reality. Again there is much reality in the recognition that a consultation can be an anxious process - often for the G.P. as well as the patient. Thus there needs to be a delicate balance between the aim of educating the 'user' and the requirement of developing the skills of those who work within the practice.

Confidentiality within a practice can also be the subject of mythology as opposed to reality. It may be important that many of the surgery staff do know 'confidential information', even about their neighbours; however, access to information and ideas in such circumstances demands the sensitive handling of such data. Thus the managing of the boundary between a practice and its community was an essential element in health provision and thus an important aspect of management education in primary care.

2. MANAGEMENT COURSES FOR GENERAL PRACTITIONERS

Bill Fraser and Kathryn Evans

Bill Fraser, Senior Tutor, King's Fund College, described the work done at the College.

In 1979/80 the King's Fund College held two workshops for general practitioners, with the support of the DHSS, to discuss their needs for management education. The principal conclusions established by the first workshop and confirmed by the second were included in reports, copies of which are available.

General practitioners have clear management training requirements identified as:

1. An introductory management course concerned with the organisation and management of a practice for newly appointed principals.

2. A second course for principals after five years in post to look at the organisation of general practice in the context of the management of the NHS. This would be designed particularly for trainers.

3. For general practitioners about to be involved in the management of the Service at district level, the course for new team members would continue to be of use.

As a result of their conclusions the King's Fund College organised a pilot course for recently appointed principals in co-operation with Dr Keith Bolden, Chairman of the Practice Organisation Committee of the Royal College of General Practitioners, and with the financial support of the DHSS. This course was split into two separate modules and it was hoped that participants would come to both parts (eleven out of fifteen did). The aim of the first module was to help members examine the effectiveness of the management of their own practices by sharing their experience with others and relating that experience to established principles of organisation and management with the help of organisation development experts (Miss W Pritchard and Miss K Evans), and experienced general practitioners.

Before they started the course, members were encouraged to keep an outline of how they spent their time and of any management problems they were encountering. A project, for discussion in syndicates, was designed to identify common management problems, approaches to solutions, resources needed, who has to be involved, and how outcomes were to be measured. (see Fig. 1).

In the report back session at the end of the course it became clear that members needed help most with managing change within their own practice. It was agreed that the second module would concentrate on this aspect of management and in the intervening weeks, each member would identify a change problem within their own practice and methods of tackling it. (see Figs. 2 & 3).

Members were asked to describe these briefly before the second module and also to identify what outcomes they were looking for from the workshop. The programme which resulted concentrated on dealing with the issues encountered in the interim and on a formal project relating a theoretical approach to managing change to practical problems. Within this structure, the approach was flexible, and time was made available to look at the problems of effective meetings and to discuss key management skills. At the conclusion, members identified individual action plans. (see Figs. 4 & 5).

It is anticipated that there will be a review and some further supporting activity based on an evaluation of the two modules.

Kathryn Evans, Senior Fellow, National Institute for Careers Education and Counselling, described her experience as a tutor on the courses. She discussed how to apply the lessons learnt, first in terms of content of the course and its focus on information and secondly in terms of the skills and competence which the participants had or needed in order to identify and deal with the problems in their own practices.

The second module concentrated on the management of change. The approach was flexible and practical. The starting point was the practice problem, to which theoretical input was related, rather than any planned instruction in management theory.

FIG. 1 GP Experimental Course

First Module

DIARY	How do you spend your time ?
KEY ISSUES	
SHAPING THE PRACTICE	Management - Staff - Workload - Money
INNOVATIONS	Computers
PROJECT	Problems encountered
NEEDS	Skills - Information - Resources Allies - Training - Style change Influencing
WHAT NEXT ?	

FIG. 2 GP Experimental Course

Second Module

ISSUES IDENTIFIED IN OWN PRACTICE
(Hopefully in advance)

ATTEMPTS TO SOLVE & LIMITATIONS

BASIC MANAGEMENT & INFLUENCING SKILLS

MANAGING GROUP DISCUSSIONS

ACTION

FIG 3 Second Module: Initial Objectives and Problems

BEING A TRAINEE AND SELLING NEW IDEAS

INTEGRATING PRACTICE IN NEW HEALTH CENTRE

REASSESSING ROLE OF TREATMENT ROOM
(in new Health Centre)

SETTING UP COMMUNICATION NETWORK
(in new Health Centre)

WORKLOAD: One doctor seeing fewer patients

DATA BASE FOR PLANNING

CHANGE WITH 7 SINGLE HANDED DOCTORS
BUT COMMON ANCILLARY STAFF

NEW BUILDINGS

NEW STAFF

"POWER BASE"

SLOW CORPORATE DECISION MAKING

NOT ENOUGH SUPPORT STAFF

FIG. 4 Objectives at end of Course

MORE EFFECTIVE MEETINGS

MORE EFFECTIVE INTERVIEWING

ASSESS MANAGEMENT STYLE

DELEGATION PARTICIPATION

MANAGE TIME MORE EFFECTIVELY

EDUCATIONAL SUPPORT FOR STAFF

EXAMINE FINANCIAL PROCEDURES

GO on a MANAGEMENT COURSE

PLAN FOR A COMPUTER

ANTICIPATORY CARE

PREVENTION

HEALTH EDUCATION

RE-EXAMINE ROLES HEALTH VISITORS

COMMUNITY STAFF

TAKE A PARTNER ?

SELF - AUDIT

FIG. 5 Five Year Plan

1981 - 1985

PARTNERS

STAFF EMPLOYED

STAFF ATTACHED

SYSTEMS

OUTSIDE APPOINTMENTS

CLINICAL WORK

EQUIPMENT

TRAINING

COMMUNITY HEALTH EDUCATION

AUDIT

RESEARCH

3. TRAINING OF PRACTICE MANAGERS AND SENIOR PRACTICE STAFF

There were three presentations on this topic from Peter Pritchard, Wendy Pritchard and Peter Havelock

Dr Peter Pritchard, a general practitioner, described two courses which he had organised for practice managers and senior practice staff in the Oxford Region in 1980. He called attention to more detailed handouts which were available at the workshop or which could be obtained from him.

The starting point was the team development project carried out in eight practices in the Oxford Region in 1979* which showed a substantial and unmet demand for management training at all levels. As a joint initiative of the local faculty of the Royal College of General Practitioners and the Oxford Regional Health Authority, two courses were run for practice managers and senior staff in the region. There were about 100 applications, and 90 places were made available in two residential courses, each of three days.

The plan was to hold residential courses as a first stage at Regional level, to try to assess training needs; find out about the job which they were actually doing; and to try to bring about change. The initiative was part of a wider strategy which is set out briefly in FIGURE 6:

* Pritchard, P and Pritchard, W (1981) Team Development in Primary Health Care. A Pilot project in the Oxford Region. Available from King's Fund Centre.

FIGURE 6

REGIONAL MANAGEMENT TRAINING STRATEGY

COURSE PROGRESSION

STAGE	
1	REGIONAL PRACTICE MANAGERS' TRAINING COURSE. RESIDENTIAL. Using outside Management Consultants. Little factual input.
2	DISTRICT-BASED DAY-RELEASE COURSES FOR PRACTICE MANAGERS & SENIOR STAFF, using a variety of tutors. More factual input.
3	DISTRICT-BASED DAY-RELEASE COURSES FOR RECEPTIONISTS, as 2.
4	DISTRICT-BASED RECEPTIONISTS COURSES, run by Practice Manager/Teachers, with some receptionists as teachers.
5	RECEPTIONIST TRAINING BASED ON THE PLACE OF WORK. (Introductory and In-service)

It was originally planned only to do the first stage.

The second and third stages are already under way in the region. Later stages need to make use of practice managers and receptionists with teaching skills who are beginning to emerge, though none are trained to teach so far. Audio-visual material etc. will also be needed for teaching in the individual practices or health centres.

Involving general practitioners is important. They have a key role in management and also feel threatened by all these 'outside' influences being brought to bear on 'their' staff. So the GPs whose staff were attending were invited for a half day. The views of attending staff, attending GPs and non-attending GPs (whose staff came) have been collected in a questionnaire study. A summary of this is available as a handout, prepared by Jenny Blake *. The time sequence is shown in FIGURE 7 (also prepared by Jenny Blake).

Pre-questionnaires were completed by all participants and a summary of replies is also available on request.

Some of the results of the pre-questionnaires are shown in FIGURES 8 and 9 which indicate the formidable experience of the first course attenders. On the second course they were a little less so. Those on the first course were from slightly larger practices. FIGURES 10 and 11.

General practice will have to change to meet the very serious problems facing health services as a whole partly from financial stringency but mainly from demographic and social changes. It will only be able to change if it has an effective and flexible management structure.

A number of issues were raised by these courses, some of which are being followed up, for example:-

What is the Practice Manager's job ?

What training does he need for it ?

How can this best be provided and by whom ?

Is some joint training with GPs (or co-tutoring) desirable and feasible ?

What is the best balance between group work and more didactic teaching ?

What is the GPs role in management ?

Can the joint role be extended to provide more effective health promotion and preventive services ?

* available on request

FIGURE 7

Time sequence of courses

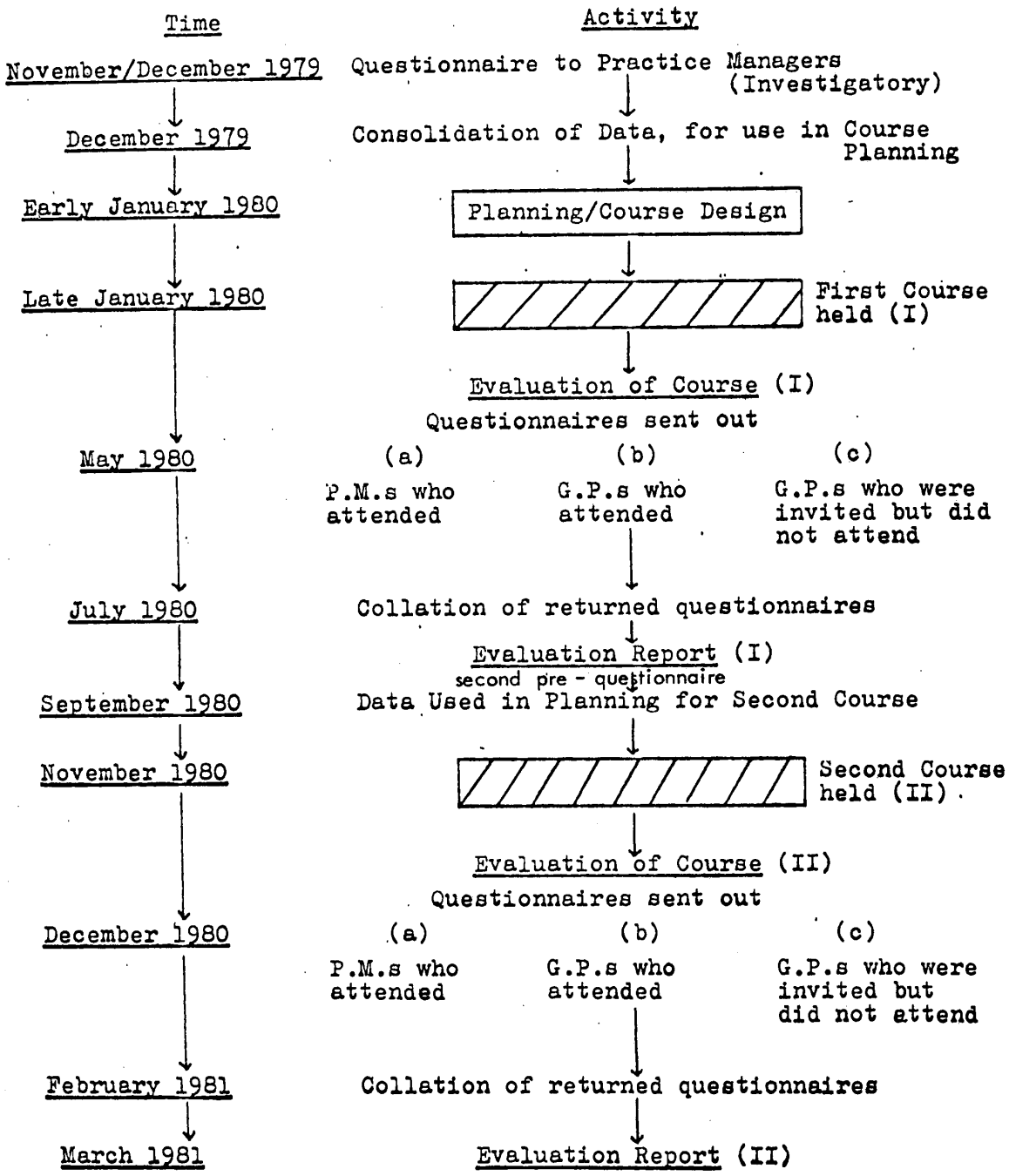


FIGURE 8

First Course

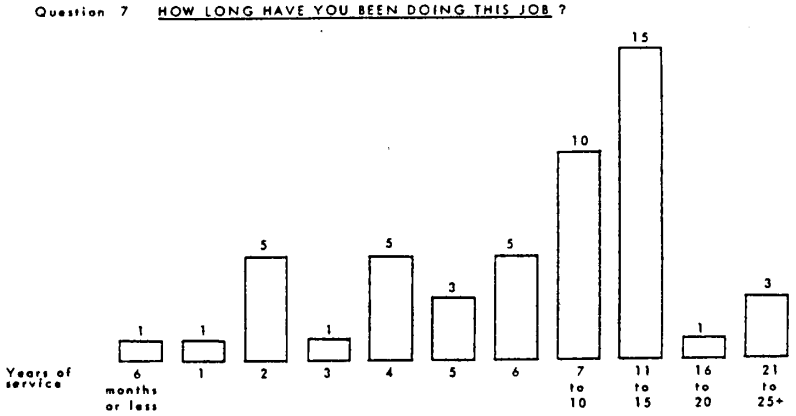


FIGURE 9

Second Course

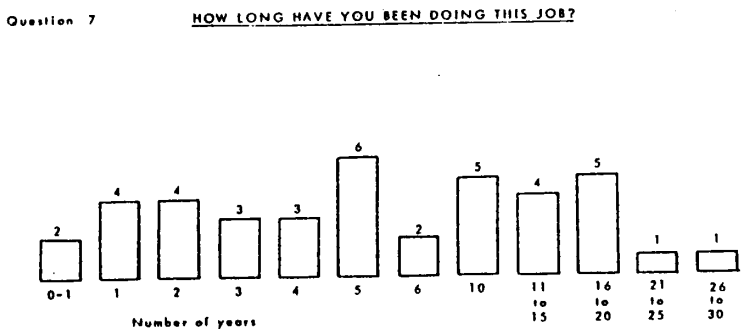


FIGURE 10
First Course

YOUR PRACTICE

Question 1 HOW MANY GP's IN YOUR PRACTICE?

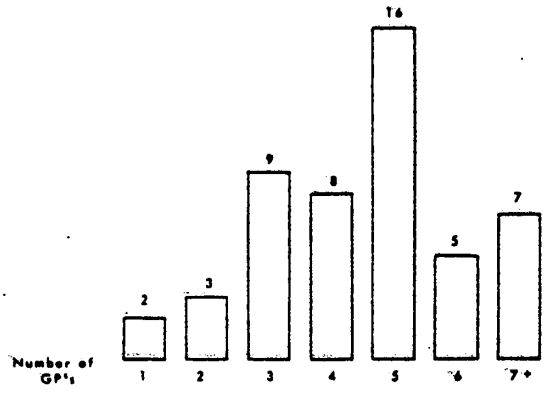
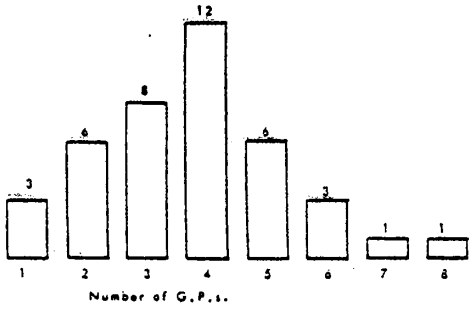


FIGURE 11
Second Course

Question 1 HOW MANY G.P.s IN YOUR PRACTICE?



Wendy Pritchard, Human Systems Development Adviser, Shell International Petroleum Co. Ltd, acted as a tutor on the courses and co-ordinated the work of the 'organisation development' consultants. She described the methods used on the courses.

Aims of Course for Senior Practice Staff

The aim of the Course was to contribute to senior practice staff carrying out the management aspects of primary health care, by helping them to look at their work and to develop ideas and plans for improving their own effectiveness.

Methods Used

It was known that participants on the course were likely to have a wide range of experience, skills and needs. This, combined with the belief that people learn more about their own effectiveness by active participation than by passive listening led the team to design the course on the basis of "discovery" or "experiential" learning.

This involved designing the course in such a way that the best use of the knowledge and skills of both participants and tutors could be made in the time available.

The ideas for the design came from three sources: a) the experience of the tutors; b) the results of the pre-questionnaires from participants; and c) the needs identified during the course;

Three main methods were used on the course itself:

(a) small group work with a tutor (s). This group remained constant throughout the course. As well as providing the means for people to discuss their particular work problems within their own group, the group itself and the way it worked could be used as illustrations of the way people work together. Each group planned its own time and priorities within the overall framework of the course;

(b) plenaries, which were used to exchange ideas and progress between the small groups, to summarise and draw out particular themes for the course as a whole and as a forum for films or any other general activities. These also gave individual participants practice in making small presentations or speaking up in larger groups. The difference between working in the small groups and the large group could be used to illustrate issues concerning organisations and people at work;

(c) informal time was provided so that people could pursue particular interests or problems with other participants or tutors which they initiated themselves, thus enabling people to take responsibility for managing their own learning and providing opportunities to make the most of the resources available. Sometimes small groups were set up across the other groups where people were interested in a particular subject.

Role of the Tutors

This was to ensure that sufficient structure was provided to reduce ambiguity without inhibiting flexibility; to act as facilitators and and catalysts in the small groups and plenaries and, to some degree, in the informal time; to draw appropriate lessons from the small group/plenary experiences; and to provide inputs on any relevant management theory as the need for this arose. Their role was not a traditional "talk-chalk" role. This sort of design does require tutors who are able to "think on their feet" and design and redesign according to participants needs as they present themselves. To this end tutors held regular meetings during the course to ensure that as far as possible the course was on track as it progressed.

Summary of Framework of Course

(i) The practice manager's job - what is it?
- particular difficulties and concerns

(ii) Managing people - particular difficulties and concerns (part of time with GPs present)

(iii) Problem solving and finding out, administration, finance, personnel, etc.

Peter Havelock, a general practitioner teacher and co-tutor on the second course, described his experience.

Co-training involved a Management Training Consultant and a General Practitioner "co-tutoring" small groups. The four GPs were members of the education sub-committee of the Thames Valley Faculty of the RCGP. All were experienced in small group learning/teaching but had little or no experience of management training. The GPs on the course had three aims:

1. To gain expertise in management training;

2. To bring some knowledge of general practice to the course;

3. To demonstrate to the practice managers a general practitioner working with another professional.

Before the course the difference in roles, status, training and expertise of the two professional groups had to be sorted out. The perceived image that a number of people have of doctors and GPs in particular had to be discussed and a working relationship between each pair of co-tutors had to be negotiated.

In the course it was demonstrated to the Practice Managers that GPs are not the source of all expertise about managing general practice and that there are often better sources of information and guidance.

Though the assessment of this course, compared with the first, was less favourable, Peter Havelock felt that co-training can be a great advantage; but if the pre-course work of negotiating a working relationship and continual reviewing of that relationship throughout the course, is not done, the effect on the group can prejudice the entire event

4. TRAINING OF PRACTICE MANAGERS, MEDICAL SECRETARIES AND RECEPTIONISTS

Courses associated with AMSPAR (The Association of Medical Secretaries, Practice Administrators and Receptionists) *

John Dawe, Director of Management Studies, Barking College, described the development of courses initially for medical secretaries and now also for receptionists and practice administrators which the Association has been pioneering since 1964.

There are now 118 colleges training medical secretaries and 15,000 have been trained to date and 4,000 are in training. There are 160 practice managers in training.

He stressed the importance of central assessment and examination and the need for nationally agreed standards, recognised by the DHSS, RCGP and BMA.

Though some 'discovery learning' was included in courses for practice managers, the main emphasis was on structured learning and an agreed syllabus.

Mrs Olga de Souza Course Tutor, Practice Administrators Course, Eastleigh College, described the half-day release course she has been running. She stressed the importance of providing a professional qualifcation and a career structure.

A summary of AMSPAR training schemes is appended.

* for address see Appendix 3

ASSOCIATION OF MEDICAL SECRETARIES
PRACTICE ADMINISTRATORS AND RECEPTIONISTS

SUMMARY OF TRAINING SCHEMES
FOR PRACTICE MANAGEMENT

Over fifteen years AMSPAR, having anticipated the potential needs of practice administrators, has endeavoured by every means at its disposal to initiate courses and has always involved the Department of Health and Social Security, the Department of Education and Science, the Royal College of General Practitioners and the General Medical Services as will be seen by the following summary.

1966 Following the doctors' charter which encouraged general practitioners to employ ancillary staff, the Association of Medical Secretaries anticipated the development of a formal structure to utilise clerical, secretarial and administrative personnel to its fullest potential.

1967 Senior members of AMS identified the situation based on their own experience that delegation of administrative tasks had become an integral part of their activities.

1968 AMS evidence to the Harvard-Davis Report led to consideration of the role of the practice manager and a discussion group was formed the membership of which included representatives from the Royal College of General Practitioners, practice manager members of AMS, Hammersmith Health Centre, Thames Mead Health Centre and Colleges of Technology. The first meeting of the group was held in .....

1969 On 19th February the Chairman of the Council of the RCGP said "there is an urgent need for trained administrators because more and more people claim to be practice administrators when in fact they have no valid claim to such a designation". A survey carried out by AMS revealed ten per cent of the membership at that time were already engaged in managerial tasks in group practices of three or more doctors and in established health centres.

1970 A Working Party was set up the membership of which included representatives from the Department of Health and Social Security, the Royal College of General Practitioners, the Department of Education and Science, the Principals of Colleges of Technology and practice manager members of the Association of Medical Secretaries.

At a meeting held in July of that year it was agreed that the basic Diploma in Medical Secretarial Studies would form the foundation of a 'brick-building' exercise by which additional subjects could be attained to reach a level of competence in management. (This concept has now been replaced by a separate course in Practice Administration. Nevertheless AMSPAR has always considered practice management training to be the natural progression from the Diploma and Certificate examinations).

1971 The Working Party met again to consider a course outline which was based on the results of the research for which the King's Fund had very generously given a research grant of £1,000. A pilot course was introduced at the Central London Polytechnic in November 1971.

1972 For the purpose of assessment and evaluation the course members re-assembled after six months of applying the principles taught on the course.

AMS and RCGP subsidized their member candidates on the course (13 practice administrators and 7 doctors).

Because of lack of financial assistance from the DHSS for a series of similar courses for practice administrators, officers of AMS met the Chairman and Secretary of GMSC and at their request submitted a report, following which a recommendation from GMSC went forward to DHSS that funds should be made available. RCGP added its support for further courses but expressed fears about the financial undertaking about which the Royal College would need assurance. Again the independent contractor status rendered funding complicated.

1973 The report on the content and evaluation of the pilot course was published in AMSPAR's Journal and copies sent to all interested bodies including the King's Fund.

In July 1973 in view of the frustrating lack of financial support AMS compromised by accepting the fact that the advanced course as piloted could not be mounted without such aid from the Department of Health. The view of the assessing committee that there should be a two-tier system of training for practice administrators - intermediate and advanced - was also accepted and courses mounted at selected Colleges of Further Education at intermediate level. These courses have been run at intervals ever since in some of the colleges and on a regular basis by Hammersmith and West London, AMS endorsing the certificates. The Hammersmith and West London College reported that candidates were enthusiastic and willing to travel long distances so as to participate.

1976 Further attempts to introduce a course at PCL at advanced level- with amendments to bring the syllabus in line with re-organisation of the NHS -were abortive because of the inability of medical secretaries and receptionists to meet the course fees without subsidy.

1977 Efforts to mount a course at advanced level during the summer vacation at Kensington College was again abortive because of Union objection to personnel exceeding teaching hours.

1978 A Joint Working Party was set up with the Royal College of General Practitioners to look into training courses for general practice personnel,covering all grades-Secretary, receptionist and practice administrator.

The terms of reference were:-

(a) to suggest a national syllabus from both organisations for basic and continuing training of secretaries/receptionists in relation to general practice.

(b) Co-operation between RCGP local Faculties and AMSPAR in the arrangement of local courses.

(c) Assessment of facilities.

1979 The Joint AMSPAR/RCGP Working Party considered a proposed syllabus for a course leading to a Diploma in Practice Administration which was introduced at six Colleges of Further Education in September 1980. The British Medical Association agreed to add a signature to the Diploma awarded to those passing the examination, carrying on the policy of this type of support as agreed when the first Medical Secretarial and Reception Certificates were introduced; the other signatury being that of AMSPAR's President, Sir Cyril Clarke.

Additional Colleges will commence the courses as from September 1981.

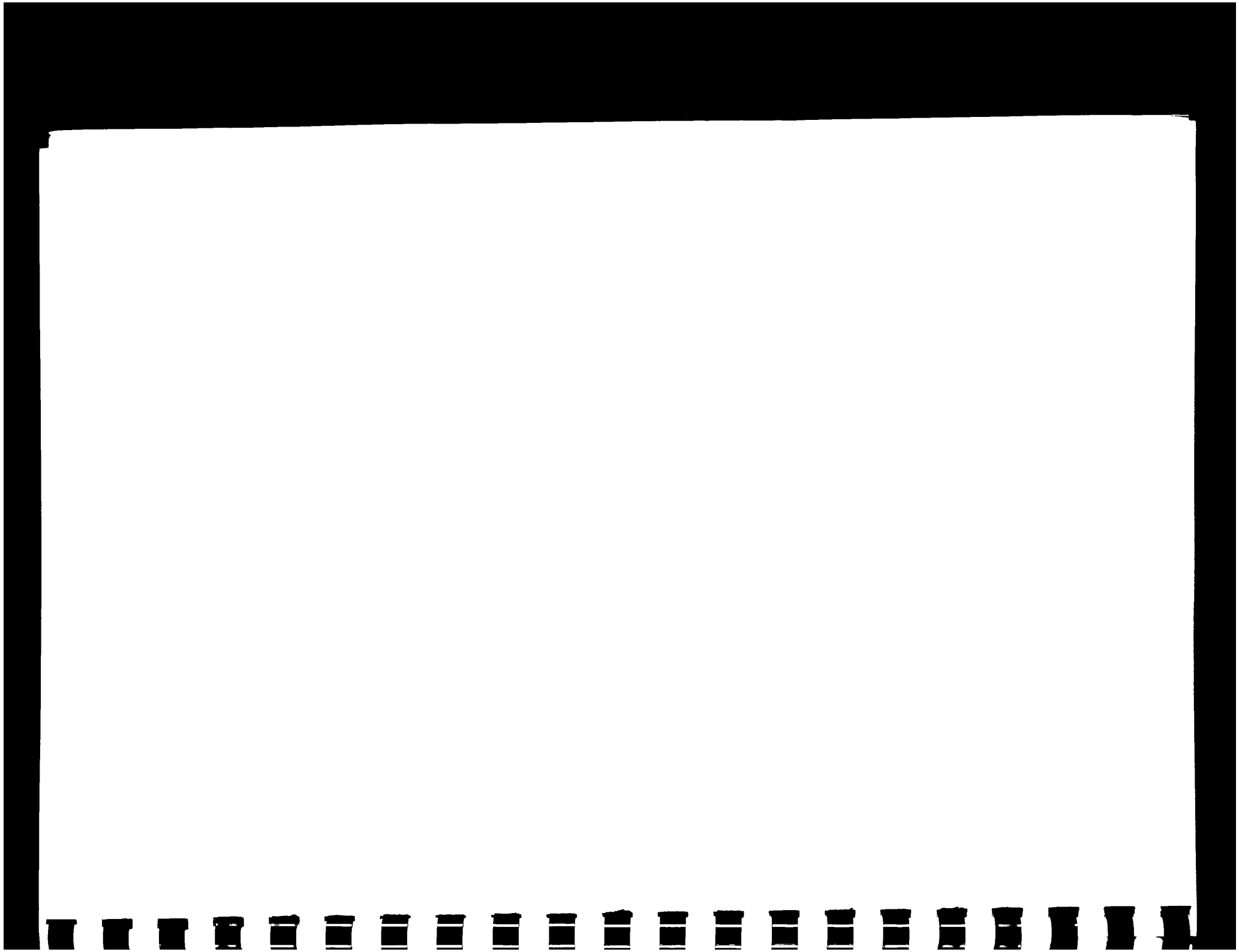
Now that re-imbursement is available for general practitioners releasing their staff to attend courses, there are many bodies interested in this field of training which has been persistently and professionally pursued by AMSPAR despite the fact that efforts have been thwarted by lack of financial support. It is felt the experience and expertise thus gained must provide an updated coverage of training requirements in practice management which was always thought to be the ultimate position in a career structure for medical secretaries and receptionists.

AMSPAR's AIMS AND OBJECTIVES ARE:-

1. To promote, encourage and support the education of and thereby the maintenance of high standards among persons (hereinafter called Medical Secretaries, Practice Administrators and Receptionists) who are or are to be engaged in employment as secretaries, practice administrators or receptionists with a medical practitioner or surgeon or in a hospital, medical research laboratory, nursing home or other medical establishment or otherwise connected with medicine or surgery and in particular either alone or jointly with any other body whether public, governmental, municipal or private to arrange, establish and conduct educational schemes, lectures and examinations.

2 To promote, encourage and support research into the administrative problems which arise in connection with the practice of medicine and surgery and the function that medical secretaries practice administrators and receptionists can perform in their solution.

AMSPAR has a clear obligation to fulfil its aims and has striven so to do unceasingly throughout the years of its existence and cannot abrogate this responsibility.



5. TRAINING OF HEALTH CENTRE AND PRACTICE ADMINISTRATORS

Courses associated with AHCPA (Association of Health Centre and Practice Administrators) *

Ellen Kemp, Education Officer AHCPA, described the professional isolation of the practice manager and the efforts which her association have made since 1975 in undertaking training and forming groups of practice managers in a locality to act as a mutual-help organisation.

John Yates, President AHCPA, described the changing expectations which practice managers have to meet.

As well as a shortage of practice managers, there was a shortage of people to train them in their unique role.

He has set out the educational functions of AHCPA and future expectations and objectives in the accompanying paper.

* for address see appendix 5

ASSOCIATION OF HEALTH CENTRE AND PRACTICE MANAGERS

The Association's chief interest is in the field of education for Practice Managers and Health Centre Administrators. It has an educational advisory board consisting of the following:-

Mrs J Mant	- R.C.G.P., Central Information Services
Mr A Phillips	- Principal, N.H.S. Management Training Centre, Harrogate.
Dr D Scott	- Regional Advisor in General Practice, West Midlands RHA
Dr J Sinson	- Regional Advisor - General Practice, Yorkshire RHA

The educational functions take four forms:-

(a) In many parts of the country there are branch meetings regularly. These meetings seek to reduce the professional isolation of practice managers whilst dealing with matters of primary care organisation.

(b) The national officers are available for consultation and advice to members and their practices.

(c) There is a small monthly magazine

(d) Courses are run in various parts of the country in association with Regional Training Officers, Advisors in General Practice, Area Health and Education Authorities.
These courses take the following forms:-

(i) Day Release Courses over several months covering the whole range of practice management;

(ii) Seminars on specific topics usually for one full day but occasionally linked for 3 or 4 days at suitable intervals. Topics are usually chosen to meet a specific local need, but occasionally a national experimental seminar is organised - e.g. Health Centre design and management for Architects and Administrators;

(iii) Weekend residential courses usually on a specific topic (e.g. 3 days on Medical Audit);

(iv) Residential Courses of 2/3 weeks on practice management.

Many members are active in education functions run by other groups especially Section 63 courses at Post Graduate Medical Centres and the Association is usually able to find speakers at functions organised by G.P.s

/cont.....

Given the following:

1. Public interest in, and expectations of, general practice is growing as evidence by the growth of patient participation bodies.

2. There is an acute shortage of trained practice managers and of managers able to train others.

3. The role of the practice manager is unique in the range of skills and knowledge required and the isolation in which he/she works.

4. There is sufficient knowledge following the work undertaken by various bodies in recent years for an informed judgement to be made about the knowledge and skills which a pratice manager should have.

5. Easier access to computers, interest in self-organised medical audit, pressure on public expenditure, discharge to the community and G.P. care of many previously cared for in hospital and increasing involvement of G.P.s in hospital care all add to the need for competent practice managers.

The following is required:-

1. The preparation of a statement defining the range of knowledge and skills which a competent practice manager should have. Such a statement to have the support of all the bodies currently working in this field.

2. The setting up of an experimental training course to improve the capability of experienced practice managers to train others.

3. A simplification of the present financial arrangements to encourage more activities for multi-disciplinary training of all practice staff.

4. Action to reduce the professional isolation of practice managers perhaps resulting in Post Graduate Medical Centres becoming a forum for the regular education activities of practice managers as so many do for GPs.

6. RESOURCES FOR MANAGEMENT EDUCATION IN PRIMARY HEALTH CARE

Karl Sabbagh, Director of the MSD Foundation, explained that this medical educational charity was set up three years ago with an annual grant from a pharmaceutical company.

The primary aim was to provide audio visual material for general practitioner training, but they were not limited to this.

The usual method was to produce video tapes or tape slide programmes with guidance notes for tutors and accompanying paperwork.

He summarised the work in progress which included a study of where video aids can help. The programmes were aimed at small groups who were not necessarily highly motivated so they had to be stimulating. Some programmes showing the content of general practice were aimed at practice staff as well as general practitioners.

A current 2-sessions programme is called "Mind Your Own Business" and covers some of the financial aspects of the general practitioner's work. It is broken up into a number of small sections with discussion breaks and project work in between. An example of this programme was shown.

Another approach is to teach the management of patients and their diseases in as realistic a way as possible. Many of these programmes involve team-working and so could be shown to primary health care teams in their own surgery or centre. With increasing numbers of people having their own video recorders, this becomes a likely area for development. An example of this second type was also shown.

A catalogue of visual material is available from the Foundation.*

* for address see appendix 3

7. REPORTS ON GROUP WORK

The four groups all had the same brief:

"To discuss in greater detail the presentations made during the morning and to decide on the action now required to develop this field further".

Groups were asked to include in their reports a list of three initiatives which should now be taken and to identify who should take them.

The "three initiatives" reported by groups are marked with a star *. It will not be a surprise to know that four groups produced eighteen starred topics not three each as requested !

Several issues were discussed by more than one group so the group reports have been merged.*

There were six broad categories of topic, though many overlapped. These categories were:-

1. Broad aims of management education and definitions
2. Initiatives in which a Regional approach was thought appropriate
3. Training for team-working
4. General practitioners and management
5. Teaching practice managers - Who ?, How ?, Where ?
6. The spread of information about management and education.

* The help of rapporteurs and note takers in each group is gratefully acknowledged.

1. Aims and Definitions

Management in primary care includes managing the business side of the practice and managing the delivery of health care. These are distinct though interdependent areas which need
* clarification. It was thought that managing the delivery of health care should receive a high priority in education if resources are to be used to their optimum.

If general practitioners, by prudent management, are given more time and space, how will they use it ? - More time for patients, for meetings or for golf ?

How can success be measured ? Is practice audit feasible and should patients be involved in this process ?

It was thought difficult for an individual to develop management education skills. Three groups of skills were needed - influencing skills, teaching skills and financial skills. When found and brought together there is still the problem of linkage and co-operation. This topic produced the prize neologism of the workshop - a "Synergy-network".

A definition of management in the context of primary care was sought but not found. The word has many meanings and clarification is needed.

2. Regional Initiatives

** A Regional role was thought to be essential for many of the initiatives discussed, though subsequent education could be undertaken at district, unit or practice level. The Regional training officer has the resources for and experience of management education but needs help in applying this to general practitioners and practice staff. The Regional Adviser in general practice was seen to have a key linking role.

Regional support for team working was clearly needed and it was suggested that the same agency could work both in hospital and primary health care teams, with the aim of producing better co-ordination.

Dissemination of information about management was seen as a regional task: this topic is considered in a later section.

3. Training for Team Working

The levels at which this training could take place were discussed
* in detail. Post basic inter-professional training was seen as the ideal, though long-term, aim. In the shorter term, inter-disciplinary courses, preparation of staff joining teams and
* training in the team all had a place.

A difficulty of joint training was the different educational backgrounds of team members.

* General practices differed so widely in their methods and their insights that a different style of team training was needed for 'high-flying' practices; for practices which recognised problems and were prepared to accept help; and for those who did not perceive any problems. How to motiviate the last group was discussed. It was thought that further study in this area - perhaps with the King's Fund support - was appropriate.

* The postgraduate medical centre was seen as the appropriate focal point for interdisciplinary training but practice staff do not all have right of access to it.

* Further development of problem-solving models and team-development kits was also considered.

4. Management Training for General Practitioners

Interdisciplinary training has been mentioned in the previous section but some separate training for general practitioners in their specific management role was thought to be appropriate. This too might have to be conducted at different levels, eg:-

* - Vocational trainees

- New and established principals

* - Trainers

- Management team and authority members

** There was strong support for further courses on the lines of the King's Fund College courses described earlier. The old problem of introducing new ideas on return to the practice might be overcome by training in the management of change and influencing skills.

5. Teaching Practice Managers and other Practice Staff

This field of action was discussed at length. Several of the topics in Section 3 on Team Training also applied here.

There was polarisation of opinion between those who favoured 'grass roots' experiential learning (learning by doing, discovery-learning) and those who favoured more structured courses, backed by a syllabus and leading to a recognised qualification. The value of the latter approach in improving the status of practice staff was appreciated. However the prevalent view seemed to favour a more flexible and experimental approach.

*** There was a danger that too early standardisation of training at national level could result in a lack of flexibility in training, which might not be so closely geared to the needs of the students, nor the realities of the job.

Clarification of the practice manager's role was needed: general practitioners should try to understand more about the job.

* Ideally, practice managers, trained in management and with teaching skills should be the teachers. The appropriate level seemed to be district with regional support.

* A scheme modelled on general practitioner vocational training was one suggestion.

6. Information

* The spread of information about management training in primary care was thought to be a crucial topic. This workshop had already seeded ideas. Locally-based informal networks of practice managers and general practitioners were needed to disseminate ideas and knowledge. Information was lacking on how these could be formed, sustained and cross-linked with each other. A start had been made but it remained sporadic.

An alternative but perhaps complementary approach was by teaching the teachers centrally to produce a cascade of information.

The medical press was seen to have an important part to play and regret was expressed that they were not present.

Discussion

In the brief open discussion period some points not reported by the groups were raised.

It was suggested that in order to influence the doctors who did not show interest in new developments, a lesson might be learned from pharmaceutical companies who took the trouble to visit them individually. This approach has been tried in London with a good response. The newly created post of "GP facilitator" in London may be the model to follow.

For research to be disseminated and used, it may first need to be popularised. This should not be denigrated by the purists. A suitable vehicle might well be the new "Times Health Supplement".

8. CHAIRMAN'S SUMMARY

The Chairman, Dr Barry Reedy of the Medical Care Research Unit, University of Newcastle upon Tyne, commented on a number of the themes which had arisen during the day.

A continuum of skills, learning and experience was evident. How can this information and knowledge of innovation best be diffused so that it is of greatest benefit to potential users ?

The present patterns of research is that much knowledge of research is not returned to the sponsors, not publicised and not used.

Practice managers need informal networks for sharing information. Do patient groups need this network too, and can the two networks be related to one another in any way ?

There is a general dearth of information about how innovation is diffused in general practice - in contrast to extensive knowledge about the take-up of new drugs.

How can we diffuse the information generated by this meeting ? The King's Fund will produce a report of this workshop to consolidate some of the work which has been done but further ideas, information and suggestions are welcome.

POSTCRIPT

Mention has already been made of the King's Fund College Courses for general practitioners (of which reports are available from Bill Fraser at the College). A further course for general practitioners on "Managing a Practice" is being held in 1982 (31st March to 2nd April and 6th-7th July).

As well as publishing the proceedings of this workshop it was suggested that a larger conference might be held a year later (with press invited) to report progress and consider future plans.

Another suggestion was for the King's Fund to sponsor a working party to study the training of teachers of practice management and the dissemination of information. Suggestions are invited and should be sent to David Hands at the King's Fund Centre.

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MANAGEMENT EDUCATION AND PRIMARY CARE

CONFERENCE - WEDNESDAY 21 OCTOBER 1981

List of those who were present:

DR R MacG AITKEN	General Practitioner	Spalding, Lincs
DR J B ASHTON	General Practitioner	West Malling, Kent
MR K BARNARD	Deputy Director, Nuffield Centre for Health Services Studies	University of Leeds
MS J BLAKE	Job and Organizational Design Consultant	Westbury, Wilts
MR M CUMING	Education Officer	The Institute of Health Service Administrators
MR J DAWE	Director of Management Studies	Barking College
MRS O DE SOUZA	SRN, Course Tutor Practice Administrators Course	Eastleigh College
MISS K EVANS	Senior Fellow	National Institute for Careers Education and Counselling
MR W J FRASER	Senior Tutor	King's Fund College
DR G GRIFFITHS	Senior Medical Officer	DHSS
MR J HALLAS	Nuffield Centre for Health Services Studies	University of Leeds
DR P B HAVELOCK	General Practitioner	Bourne End, Bucks
DR P J HOOK	Senior Medical Officer	DHSS
DR J HORDER	President	The Royal College of General Practitioners
MISS E M KEMP	Education Officer	Association of Health Centre and Practice Administrators
MRS S KILBY	Practice Manager	Swindon, Wilts
MR K LOW	Job and Organizational Design Consultant	Enstone, Oxon
MR T MAPPLEBECK	Area General Administrator	Sheffield AHA (T)
MRS B MARTIN	Manager	Oxford Community Health Project (Rapporteur)
MR R MAYNARD	Principal	DHSS
MISS A MURRAY	Deputy Director	Central Information Service for General Medical Practice

DR S F OLIVER	General Practitioner	Bury St Edmunds
DR D C OWER	Senior Principal Medical Officer	DHSS
DR G PAGE	Lecturer, Health Services Management Centre	The University of Birmingham
MRS A PLUMLEY	General Secretary	The Association of Medical Secretaries, Practice Administrators and Receptionists Ltd.
DR P PRITCHARD	General Practitioner	Dorchester on Thames, Oxon
MISS W PRITCHARD	Human Systems Development Adviser	Shell International Petroleum Company Ltd
DR B L REEDY (Chairman)	Senior Lecturer in the Organization of Health Care, Health Care Research Unit	The University of Newcastle upon Tyne
MR M J ROBERTSON	Staff Training Officer	Tayside Health Board
DR K SABBAGH	Director	The MSD Foundation
DR J SINSON	General Practitioner	Leeds
MR G SMITH	Regional Education and Training Officer	Wessex RHA
MR M WALTON	Training Adviser	DHSS
DR M WARD	General Practitioner	Swindon
MRS M WHALEN	Practice Manager	Edinburgh
DR A WILLIS	General Practitioner	Northampton
MR J YATES	Planning Officer	Gloucester Health District

The following people were also invited but, because of other commitments were unable to attend:

DR P ANDERSON	General Practitioner	Caversham, Reading
DR R BENNISON	General Practitioner	Bishop's Stortford
DR K BOLDEN	Senior Lecturer, Postgraduate Medical School	University of Exeter
PROF M DRURY	Professor of General Practice	University of Birmingham Medical School
DR J HASLER	Honorary Secretary of Council	Royal College of General Practitioners
DR W J D KcKINLAY	General Practitioner	Clitheroe, Lancs
PROF D METCALFE	Professor of General Practice	University of Manchester
DR G SINGER	Senior Medical Officer	DHSS

DR S SMAIL	Senior Lecturer in General Practice	Welsh National School of Medicine
DR R STEEL	General Practitioner	Worcester

KING'S FUND CENTRE

MR W G CANNON	-	Director
MR D HANDS	-	Assistant Director
MISS N DAVIES	-	Secretary to Mr Hands
MISS J HUGHES	-	Project Officer

APPENDIX 3.

USEFUL ADDRESSES

Films, Videotape and Tape-Slide Programmes

GRAVES MEDICAL AUDIOVISUAL LIBRARY Holly House, 220 New London Road, Chelmsford, Essex, CM2 9BJ.

M.S.D. FOUNDATION. Tavistock House, Tavistock Square, London WC1H 9JZ (01-387 6881)

VIDEO-ARTS LTD. Dumbarton House, 68 Oxford Street, London W1N 9LA.

ORGANISATIONS

THE ASSOCIATION OF HEALTH CENTRE AND PRACTICE ADMINISTRATORS (AHCPA)
Lord Lister Health Centre
121 Wood Grange Road
London E7 OEP. Tel: 01-555 5331

THE ASSOCIATION OF MEDICAL SECRETARIES, PRACTICE ADMINISTRATORS AND RECEPTIONISTS (AMSPAR)
Tavistock House South,
Tavistock Square,
London WC1H 9LN.

BRITISH MEDICAL ASSOCIATION,
BMA House,
Tavistock Square,
London WC1H 9JB.

BUREAU OF MEDICAL PRACTITIONER AFFAIRS LTD.
Francis House,
King's Head Yard,
London SE1 1NA.

CENTRAL INFORMATION SERVICE FOR GENERAL MEDICAL PRACTICE
(Mrs Joan Mant, Miss Anne Murray)
14 Princes Gate,
London SW7 1PU. Tel: 01-589 1251

HEALTH CARE RESEARCH UNIT,
The University of Newcastle-upon-Tyne,
21 Claremont Place,
Newcastle-upon-Tyne NE2 4AA.

HEALTH SERVICES MANAGEMENT CENTRE
The University of Birmingham,
Park House,
40 Edgbaston Park Road,
Birmingham B15 2RT.

INSTITUTE OF HEALTH SERVICE ADMINISTRATORS
75 Portland Place,
London W1N 4AN. Tel: 01-580 5041

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