NHSTA/KINGS FUND COLLEGE

REPORT OF A PROJECT TO INVESTIGATE THE TRAINING & DEVELOPMENT NEEDS OF FAMILY PRACTITIONER COMMITTEES

NHS Training Authority

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This report could not have been produced without the cooperation and commitment of the Administrators, Chairmen and staff of three FPCs chosen for this study. We thank their Administrators in particular for their frankness, interest and enthusiasm, and their willingness to have us move in and talk with people at all levels of their organisations. We hope that they derived as much learning and enjoyment from the work as we did, and that this report will lead to action that will enable them to foster further organisational innovation and learning.

JH/JMcC/SM/7/87

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In this report the following abbreviations are used:

DHSS	....	Department of Health and Social Security
FPS	....	Family Practitioner Services
FPC	....	Family Practitioner Committee
NHSTA	....	National Health Service Training Authority
HCHS	....	Hospital and Community Health Services
RHA	....	Regional Health Authority
RGM	....	Regional General Manager
DHA	....	District Health Authority
DGM	....	District General Manager
UGM	....	Unit General Manager
CHC	....	Community Health Council
LA	....	Local Authority
PPA	....	Prescription Pricing Authority
DEB	....	Dental Estimates Board
GP	....	General Practitioner
IPR	....	Individual Performance Review
IMT	....	Information Management and Technology
MED	....	Management Education and Development
DMS	....	Diploma in Management Studies
CMS	....	Certificate in Management Studies
IHSM	....	Institute of Health Services Management
ICSA	....	Institute of Chartered Secretaries & Accountants

SECTION A - EXECUTIVE SUMMARY

NHSTA/KINGS FUND COLLEGE

REPORT OF A PROJECT TO INVESTIGATE THE TRAINING AND DEVELOPMENT NEEDS OF FAMILY PRACTITIONER COMMITTEES WITH PARTICULAR REFERENCE TO THEIR MANAGEMENT DEVELOPMENT NEEDS

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1 INTRODUCTION

The Current Context

1.1 This report is presented in a turbulent post-election period for the NHS in general, and in particular for primary and community care services. The period of consultation on the Green Paper on Primary Health Care (1) and the Cumberlege Report on Neighbourhood Nursing (2), is now being followed by the Griffiths inquiry into Community Care.

1.2 The profile of general medical services in particular within the NHS has risen with changes in the demography of the population, in patterns of disease and in acute sector policy. Demands on these services are increasing, but research suggests that their response varies greatly in quality (Pendleton *et al* 1986). The current contract, drawn up over twenty years ago, does not seem appropriate to the contemporary needs of patients, general practitioners, or the State on behalf of the taxpayer (Pereira Gray *et al* 1986, Marinker *et al* 1986, and Maynard *et al* 1986).

1.3 Between the State and the independent contractor GPs stand 98 Family Practitioner Committees (FPCs), themselves almost as varied in their interpretation of their role as the contractors themselves. Their chief officers, the Administrators, have been in dispute with the DHSS concerning their own pay, while the Department's tight control of gradings and management structures has alienated many of them. The situation has been aggravated by a reduction in the administrative budget of some FPCs by 10 per cent, made with little notice, and it is claimed with the intention of spreading FPC resources more equitably.

1.4 FPC sensitivities run high. Chairmen as well as administrators we have talked with feel they have been short-changed, and not provided with the wherewithal to do the job given them in April 1985. Over the life of this project we like other investigators (Allsop & May 1986) came to share this view.

1.5 It might therefore appear impertinent to present a report on the management development needs of FPCs when we are only too well aware of the constraints on managerial action imposed by the centre and by lack of resources. We know however, that some FPCs, despite these constraints, persist in their attempts to change their culture from that of the archetypal bureaucracy to one of innovation, risk-taking, and pushing the boundaries of what is possible in influencing the availability and quality of family practitioner services. It is hoped that this report will generate debate on the nature of the managerial task and of managerial authority in FPCs, and result in action that will promote that broader-based change in organisational culture and leadership without which FPCs will be unable to fill the current managerial vacuum in primary health care.

Terms of Reference

1.6 In March 1986 the NHS Training Authority commissioned the King's Fund College to conduct a project to investigate the training and development needs of FPCs with particular reference to their management development needs.

1.7 The aims of the project were twofold:

(i) to identify the current and probable future issues facing FPCs;
(ii) to identify the consequent training and development needs of administrators and staff, chairmen and members, with particular emphasis on their management development needs.

Project Team

1.8 The project team comprised June Huntington (Director, Educational Programmes), then Fellow in Organisational and Professional Studies at the King's Fund College, with a background in research and management education and development in general medical practice; John McClenahan, Fellow in Management and Planning Systems at the College who had previously been involved in a study of FPC administration and computing while with Arthur Andersen & Co., Management Consultants; and Jeremy Webster, Training Consultant with the NHSTA who had considerable experience of FPC training and who had conducted a questionnaire survey of FPCs in 1984.

Project Advisory Group

1.9 An Advisory Group was established comprising King's Fund staff who were particularly well-versed in management development practice and in health services development work in primary health care in London and the chairman of an inner London FPC, two FPC Administrators, a Director of Planning from a Regional Health Authority, and a senior management representative of the NHS Training Authority.

2 WORK DONE

First Phase

2.1 During the first phase of the project a review of existing literature and unpublished reports of earlier FPC studies revealed that a considerable amount of knowledge already existed, not necessarily couched in terms of a management development needs analysis but certainly contributing richly to our own diagnosis.

2.2 This first phase included a review of previous NHSTA-funded surveys (Webster 1984) and Altenstetter (1985), FPC responses to the NHSTA's Training Strategy document, DHSS circulars and reports, Allsop and May's book in manuscript (published late 1986), FPC Annual Reports and strategy documents, many articles, and other sources; discussions with liaison officers in the DHSS, attendance at a Performance Review and at a meeting of London FPC chairmen who were presented with the findings of the Hay-MSL work in 5 FPCs; attendance at the Society of FPCs annual conference; and conversations with several FPC people who had shown interest in the project.

Second Phase

2.3 Three FPCs were selected for detailed work, after discussion with the Project Advisory Group. They were chosen to give a reasonable spread and balance of geographic location, size and type of FPC. All three FPCs face significant change, have relatively young administrators, and had indicated commitment to training and staff development.

2.4 The FPCs were:

- a large shire county relating to multiple DHAs, with a population of over a million;
- a large metropolitan district, relating to the two DHAs, with a population of 3/4 million; and
- a shire county relating to two DHAs with a population of just over 1/2 million.

2.5 The project team met with all senior managers in these three FPCs as individuals and as a group; interviewed a selection of staff throughout the organisations; attended meetings of the FPC itself except in one FPC, in which instead the Project Director attended with FPC senior managers a study day on the Green Paper and the Cumberlege Report held with DHAs and the local authority, the university department of general practice, CHCs and other organisations; attended in one FPC a Medical Practices Sub-Committee and in another a regular informal meeting of the Administrator, Deputy Chairman, and two CHC secretaries; and met with the three chairmen and some professional and lay members.

Interim Report

2.6 An interim report on the first diagnostic phase of the project was presented to the Advisory Group in November 1986 with proposals for a third phase of work individual to each FPC which would begin to help them address some of the needs identified. The Advisory Group challenged our proposals for the third phase, suggesting that we needed to pose the fundamental question 'better management for what?'. What would a well-managed FPC look like and what difference would it make?

Third Phase

2.7 After individual briefings with the administrators concerned, the Project Team attempted to address these questions in the third phase of the project, drawing on material from a workshop held at the King's Fund College for the three FPC Administrators and their Chairmen, though only one Chairman was able to attend;

and a workshop in Birmingham for the three Administrators and their senior officers. In addressing the Advisory Group's questions the team also drews heavily on Allsop and May's (1986) *The Emperor's New Clothes: Family Practitioner Committees in the 80s* which in its chapters on good practice in FPCs provides many answers to both these questions.

Final Phase

2.8 In the final phase, the team set their own experience of the project against their knowledge and experience of management education and development to produce this training and development strategy for FPCs.

3 FPCs IN THE 1980's

Role and Function

3.1 Prior to April 1985 the functions of FPCs were quintessentially administrative, in the sense that as organisations they existed only because family practitioner services were provided not by employees of the health service, but by independent contractors whose contracts with the NHS were financially and legally complex and open to considerable variety of interpretation. FPCs were, and still are, the statutory bodies responsible for 'administering the arrangements for the provision of family practitioner services (FPS) (which they formerly did on behalf of the District Health Authority (DHA) by which they were established)' (DHSS 1986c).

3.2 However, since being granted independence in April 1985, FPCs have found their expected role and functions to be deeply ambivalent and ambiguous.

3.3 The Departmental circular (DHSS 1986c) encourages FPCs on the one hand to be proactive, and to 'manage', but on the other hand the examples of 'management' which are given in the circular all relate to the management of their internal administration, not of FPSs. FPCs are 'responsible for ensuring that value for money is achieved in all aspects of their activities and that the best use is made of resources.' This might be taken

to refer to responsibilities in relation to administration of contracts, for example with regard to the work of some FPCs in encouraging takeup and monitoring use of ancillary staff in general practice, but the rest of the paragraph refers entirely to internal administration of the FPC itself.

3.4 The circular indicates ambivalence as well as ambiguity. In paragraph 32 it states that 'The Government seeks to bring about the maximum possible delegation of responsibility to health authorities (including FPCs) at local level', yet FPCs have to seek permission for capital spending beyond a sum DHAs would consider paltry, and for any increase or amendment to grading structures above scale 4.

Administration or Management?

3.5 The NHSTA's document'Better Management, Better Health' advocates the transition from an administered to an actively managed service, and we see this as vital to bringing better quality care into FPSs. We wonder whether others are as convinced. Chief officers of FPCs remain 'administrators' and not 'general managers' by title, while the recent Individual Performance Review circular was addressed to RHAs and DHAs 'for action' and to FPCs 'for information'. Those FPC administrators who are committed to managing are making this transition in a climate of ambivalence about the nature of the management task in FPCs. It is vital for the NHSTA to contribute to that debate as it affects FPCs or to support people who will contribute to it.

3.6 Those FPC administrators who wish to take responsibility for 'the direction, quantity and quality' of the FPSs often push the boundaries of their present managerial authority to the limits at their own risk. The BMA has brought strong pressure to bear on the Department regarding FPCs whose actions it construes as breaching the terms of their contract with independent contractors. We have also been quoted examples first-hand of administrators acting managerially in the sense of initiating the supply of a service to an under-doctored area and having their efforts blocked by the Medical Practices Committee.

3.7 *Better Management, Better Health* (NHSTA 1986) exhorts the service to make improvements in the quality of health care as the proper measures of managerial success and to 'co-operate with professional staff in setting and achieving high standards of care'. In order to adopt improvements in the quality of care as a measure of their success FPCs need help in conceptualising quality in FPSs, and in finding new ways of cooperating with independent contractor professionals in setting and achieving high standards of care.

4 THE WELL MANAGED FPC

4.1 Our ideal picture of the well managed FPC is described in the main report. It accords with, and is in part drawn from Allsop and May's book (1987). No FPC to our knowledge comes close to this ideal in all respects, although almost every aspect of it is already to be found in some FPC somewhere.

5 BARRIERS TO ORGANISATIONAL ACHIEVEMENT

5.1 Our field work suggested the following barriers to organisational achievement:

- lack of coherent vision of purpose, either from the centre or in most FPCs;
- an individually focussed 'training' culture, which does not link to the organisation's strategy (since this is generally not well defined, nor well communicated through the FPC);
- chronic lack of delegation;
- the existence of two types of work in FPCs (the traditional 'pay and rations' work, and the more managerial work now being demanded of FPCs), with different requirements for staffing, training and development;
- difficulty in absorbing new, better qualified recruits;

- lack of adequate support for computerisation;

- lack of corporateness in the FPC;

- lack of agreement as to whether the training and management development needs of FPCs can be met by programmes usually available to health authority staff and managers, and particular concern about the relationship of FPCs and their staff to the National Accelerated Development Programme (GMTS I, II, III).

6 ORGANISATIONAL DEVELOPMENT NEEDS

6.1 The picture we found is one of a wide range of organisational development needs in FPCs, covering virtually the whole spectrum of FPCs' traditional and newer responsibilities. In particular, the most pressing need is to develop the FPCs' capabilities for MANAGING OUTWARDS: initially to clarify its aims and purpose. We see the FPC's main purpose as being to seek improvement in the QUALITY and ACCESSIBILITY of FPSs (or even Primary Care services in some FPCs' views), for

- their populations and important subgroups of these populations;

- particular families and individuals;

- individual practices and practitioners;

and to take effective actions to influence improvement in desired directions.

6.2 While developing and extending their OUTWARDS management role, and indeed in part to make it possible and sustainable, FPC managers will need to strengthen their capabilities for MANAGING INWARDS (ie, within the FPS world).

7 MANAGEMENT DEVELOPMENT NEEDS

Chief Officers

7.1 The primary management development need of Administrators is help in defining the business they are in, the purpose of the FPC in its current complex and ambiguous context, the consequent nature of their own managerial tasks and the managerial authority required to address them.

Chairmen and Members

7.2 Ideally, the FPC administrator would address the training needs of his chairmen and members, not simply by providing seminars or short courses, but more importantly by ensuring that sufficient contact took place between chairmen, members and officers. Pairing of an officer and a member or a small group of members for purposes of further mutual education is one route, guided visits of members through the FPC is another.

7.3 The information base of lay members is particularly low, and we find that some of the educational events they have been offered have been pitched too high, the Administrators being unaware of members' lack of basic information about FPSs.

7.4 Administrators may be hesitant to meet the development needs of chairmen and members through fear of producing the 'pseudo-officer' syndrome. This fear could be tackled in programmes for administrators as part of their relationship to chairmen and members.

7.5 Developmental provision for chairmen and members can usefully be addressed across FPCs but requires an organisational infrastructure. London chairmen have met regularly over the past year at the King's Fund Centre and have appreciated this opportunity.

Senior Managers: Deputy Administrators & Function Heads

7.6 In the three project FPCs these were a very varied group, comprising males in their late 30s to late 40s whose careers had been spent in FPCs, and females in their twenties, one a graduate and former local government management trainee, and the other from commerce.

7.7 The older, mainly male group has profound needs for development of their understanding and competence in people management especially for those who have come up through registration and finance. This older group who have grown up in FPCs also need help in extending their vision of the FPC and its purpose.

7.8 The younger second-in-lines need help in people management of a different kind, that of managing people much older than themselves, and in working corporately within a management team that contains older men who have previously had to relate to women at work only as subordinates.

7.9 These young managers, often women, require considerable support from their chief officers, particularly in the form of support for their authority vis a vis older long-serving staff and of feedback on their managerial performance. They also need carefully structured opportunities to 'learn the business' in the shortest possible time.

7.10 This young group of senior managers, together with younger graduate entrants into middle management positions, frequently expressed their development needs in terms of what was missing *inside* the organisation, rather than as a need to go on external courses.

Middle Managers and Those in 'Staff' Positions

7.11 In all three FPCs several new appointments had been made relating to the introduction of new planning, personnel and training, and computerisation responsibilities. Again, many of these were graduate appointments of people with no previous FPC experience all of whom found the FPC world strange and anachronistic.

7.12 These younger managers are often quite confident in relation to computerisation. They may not be particularly competent, but they do not experience techno-fright. We feel they could be used more imaginatively in training of lower level staff and enabling them to overcome their fear of computerisation.

7.13 Their continuing development needs, like those of the second group, can largely be met within the organisation, simply by stretching them.

7.14 However,it should be should be emphasised that some of these staff have never been trained for the particular function they are filling, e.g. planning, personnel and training. Regionally-based planning groups have developed to meet some of these needs, but we wonder how developmental they are.

7.15 There remain many middle managers who have spent their working lives in the FPC, many of them women, some of whom feel that they have not progressed further because they are women. It has been particularly galling for some of these now to see younger women, albeit graduates, brought in 'over their heads'.

7.16 Lack of an effective IPR system affects these middle managers perhaps more severely than any other group, because there is effectively no arena in which they can air their confusions, resentments, and anxieties about the future. If their managers believe they can progress no further within the organisation, this should be made clear and the consequences explored. If there is doubt, they should be given the benefit of the doubt and a planned programme of management development instituted, but without effective IPR systems we doubt this will happen, and FPCs will continue to pay the price of a severely disaffected group within their organisations.

7.17 As with the senior management group, any external provision should be focused largely on self as manager, and on increasing people management skills, and information management skills, as this group is quite anxious about computerisation and its implications for their managerial role.

<u>First Line Managers</u>

7.18 This group needs to develop its supervisory and training skills, and to be given time within the organisation to apply these to the developmental needs of their staff who are largely engaged in routine, repetitive, yet very detailed work that requires high levels of accuracy. Currently this group is demotivated because its previous channels of promotion are now being blocked by recruitment of younger more qualified people. Theirs is also the work that will probably be most affected by computerisation.

Clerical Staff

7.19 The most appropriate response to the training needs of this group is for their immediate manager to take responsibility, given help by a more senior officer in the organisation who specialises in the training and staff development function, or from DHA or RHA training personnel, or from staff in local colleges. The greatest need of first line managers and staff is for greater awareness of the changed nature of FPCs and what this means for their own jobs.

Computerisation

7.20 We see computerisation as crucial to the transition from an administered to a managed service within FPCs, simply because of the base it will provide for proactive management in relation to contractors. The information capability it will give FPCs is also crucial for their credibility in relation to DHAs and local authorities. FPCs cannot offer money, and FPC managers and staff involved in the planning process are usually of a much lower grade in the service than health authority staff. All FPCs will be able to offer is information, at least initially. Once their information base makes possible more negotiation with contractors, then possibly at least some FPCs will be able to represent their contractors at the planning table in a more radical manner than currently.

7.21 All three project FPCs were in the throes of computerisation and we were concerned by the low level of support they were receiving from the local outposts of the Exeter unit.

8 A MANAGEMENT DEVELOPMENT STRATEGY FOR FPCs

8.1 Our strategy aims significantly to raise the capacity of FPCs to 'influence the direction, quantity and quality' of FPS (NHSTA 1986)within three years by a sequence of MED activity that begins with top managers, is largely FPC-specific, has built-in 'cascade' intent, and seeks more than one pay-off for a given investment.

8.2 At the commencement of the project we did not think we would end it by recommending FPC-specific MED activity, particularly for top managers.

8.3 Our experience suggests, however, that the strategic management development needs of FPCs are so great that any top manager development programme must be set in the context of FPCs rather than the NHS more widely.

8.4 We also promote an FPC specific top manager programme as our priority because of the current lack of central guidance on mission, despite tight control of management action. There is also no regional tier to contribute to articulation of purpose and strategy, and in its absence individual administrators need help in this task.

8.5 Our strategy aims to:

- enable top managers to develop and communicate a sense of purpose and direction throughout their organisations.
- link the training and development of individual managers to the organisation's strategy, to improve management performance, and ensure management succession for the organisation.
- develop general management attitudes, approaches, and competencies within FPCs.

9 POTENTIAL BARRIERS TO IMPLEMENTATION

9.1 One major barrier lies in the lack of a regional infrastructure. Six of the nine recommendations in BMBH's Action Plan involve RHAs as spearheads for implementation of the NHSTA's MED strategy in hospital and community health services. We suggest that the NHSTA review that section of BMBH in the light of our findings and ask whether MED effort can be placed creatively and productively in FPCs without a strengthened regional infrastructure for FPS.

9.2 The NHSTA may wish to initiate discussions with DHSS, the Society of FPCs and Administrators FPS, and other bodies to explore how the respective roles recommended to be undertaken by RHAs could be alternatively provided in the FPC context. The potential areas for support include:

- personnel and manpower
- management and training activities
- information and IT initiatives
- good practice guidance.

9.3 Without the introduction of IPR and the management focus and discipline that follows, much of our strategy will be ineffective.

9.4 A final potential barrier to implementation of an MED strategy for FPCs may lie in the age and career structure of the current chief officer group.

9.5 This situation makes imperative the need to promote secondments of FPC managers and their participation in the National Accelerated Development Programme, in order to enhance their chances of career mobility.

10 RECOMMENDATIONS

Top Manager Development Programme

10.1 We recommend that priority within our management development strategy be given to provision of a rolling top management development programme for FPC administrators.

10.2 Two programmes a year run for two years for 21 participants in each programme would enable the majority of FPC administrators to be included within three years from now.

10.3 The programme would enable participants, selected on the basis of their own analysis of their organisations, their managerial preoccupations, and themselves as managers, to work on the application of the principles adopted in *Better Management Better Health* to their own organisations, and to develop imaginative approaches to their task of influencing the direction, distribution, quality and cost of FPS.

10.4 Programme objectives would be to assist chief officers to explore the nature of their managerial task in view of:

- the continuation of the independent contractor status of the professionals whose contracts they hold;
- the continuation of the traditional pay and rations function alongside newer, more entrepeneurial functions;
- the containment of these within one organisation and consequent impact on staff selection and development;
- the management of environmental uncertainty and the interface with a range of other organisations;
- the impact of computerisation and of increasing information capability in FPCs on their internal structure and culture and their relationships with contractors and other significant organisations outside the FPC.

Collaborative Workshops

10.5 One outcome of the Top Management Development Programme for Administrators could be locally or regionally based collaborative workshops, sponsored by groups of administrators who had been on the programme, using the model developed in the project. This workshop brought together the Administrators and senior management groups of three FPCs, but a similar workshop could involve four or five FPCs, and could also include chairmen.

MED Programmes Not Specific to FPCs

10.6 In recommending an FPC specific top management programme, we are in no way suggesting that interested administrators should not attend programmes for NHS managers more generally, or indeed programmes for managers in business. These would be addressed to the individual's management development needs however, rather than to FPC organisational development needs, though the effect of a good programme would presumably flow through to the organisation. Attendance on such programmes would be particularly relevant and important for any administrator who wished to move out of FPCs, either temporarily or permanently.

10.7 Although a good number of administrators will retire

over the next three years, a considerable proportion are in their forties, some of them heading larger FPCs from which there is no promotion in the FPC world. Providing the NHSTA was assured that they intended to move into health authorities, there would be no reason why such administrators should not apply for bursary assistance for such programmes, as we know some already have. It would be helpful if the NHSTA could sustain such a bursary programme, though we realise funds are constrained.

Senior Managers: General Management Development

10.8 As most senior managers have grown up within their own functional specialities within the FPC, and as organisational development will require a more corporate view, we strongly recommend that in addition to participating in collaborative workshops of the kind described in 10.5, they may be encouraged to attend NHS-wide general management programmes aimed at developing a general management perspective and at developing themselves as managers.

10.9 Birmingham HSMC's middle management programme has regularly drawn one or two managers from FPCs, but on the whole FPCs have not drawn heavily on programmes offered by the NECs. We were told that was because of the expense of some of the longer programmes and because of FPC perceptions that those programmes are geared more to the needs of HA staff than their own.

10.10 There is an element of the vicious circle here. Until more FPC managers use NEC programmes, NECs will not gear their programmes to the needs of FPCs as well as HA staff.

10.11 The NHSTA may have to act as advocate here. Shorter issue-based programmes in Human Resource Development, Information Management, Strategic Management and Planning would also be relevant, not just the longer general management development programmes.

10.12 We were concerned to find a predominant commitment to 'classroom education' of the day release type, for these senior managers.

In that they award qualifications (DMS, CMS, IHSM, ICSA), they may boost the confidence of long-serving FPC staff and possibly protect them from encroachment of young graduates in the promotion stakes; at least there is a belief that they might do so. This may be quite fallacious if 'qualified' becomes synonymous with 'graduate' in FPCs.

10.13 Administrators should assure themselves that such programmes are manager-centred and offer ample opportunity to work while in the classroom on 'real' issues from the FPC, and that the FPC supports this by offering work experiences that help managers on such programmes develop their own conceptual framework for practice.

Senior Manager Development: Information Management

10.14 Senior managers in all FPC functions but particularly patient data services (Registration), should be able to receive much greater help in the area of computer technology and information management. We recommend intensive workshops in which the principles and techniques of information management are related to the FPC context, or in which there is an opportunity for FPC staff to work in a subgroup on their own issues.

10.15 Staff need to become much more critical of data and more able to analyse what they have in relation to what they need, or computerisation will result in management and/or data overload.

Senior Manager Development: Issue Based Development

10.16 We also recommend for this group of managers relatively short programmes particularly geared to finance officers, planning officers (or their equivalent) and joint events for patient data managers and planning officers. Such programmes should be centred on issues of immediate relevance to managers, and focus on their individual needs. They should build upon managers experience, and use different techniques to illustrate and illuminate the issues, rather than be presented as subject-based theories. If theory is presented, it should be accompanied by opportunity for practical application in realistic case exercises.

Planning Officer Development

10.17 Planning officers have already established regional planning groups, and we recommend that the NHSTA meet with organisers of these groups to explore ways of offering developmental support.

10.18 Planning officers should also be encouraged to attend local programmes on statistical methods, quantitative analysis, data presentation and interpretation; and should be encouraged to seek opportunities via short term secondments or short external programmes to learn about the planning processes of other organisations, particularly DHAs and local authorities.

10.19 We recommend also that planning officers, and patient data managers, should be offered the opportunity to attend shared workshops to learn what each needs and can get from the other;

10.20 These workshops should also cover the development of political skills - negotiation, persuasion, constructive PR and publicity.

First Line Manager Development

10.21 This group has the difficult task of motivating people who must maintain accuracy in the execution of detailed work, much of which is repetitive and routine. We believe this can only be achieved when first line managers are themselves fully aware of the overall purpose of the organisation and the way in which their own role and those of their staff fit in to this.

10.22 Enhancing this awareness is the task of high level managers, and we recommend that senior managers in FPCs take responsibility for the development of first line managers, either directly, or through groups of FPCs acting in consortia.

Chairmen and Member Development

10.23 We recommend that individual FPCs and consortia of FPCs take responsibility for the development of chairmen and members.

In keeping with the existing training culture of FPCs, previous provision by both FPCs and the DHSS tends to have been dominated by lecture or video as the means of learning, when opportunities for guided or accompanied experience and opportunity to reflect on that experience subsequently would be a much richer means of development in these roles.

10.24 This is particularly true of Service Committee work, but is also true of much of the FPC's work which can appear complex and esoteric to newly-appointed chairmen and members. We recommend attachment of new members to more seasoned ones, and attachment of small groups of members to specific members of staff within the FPC.

10.25 We also urge more careful targetting of member development effort, as there is little doubt that some members are more willing to become involved than others.

Secondments

10.26 MED programmes should be supplemented wherever practical by short term secondments of senior managers to other FPCs and (wherever this is practical to health) authorities. However, experience has indicated that the perception by Health Authority staff of the role and calibre of FPC managers make such secondments extremely difficult.

10.27 In view of this attitude, FPC managers will need to press for secondments for the benefit of their own professional development and the development of their organisations. We consider such secondments vital to the future organisational development of FPCs, and to the development of future career options for younger FPC administrators who already manage large FPCs.

10.28 We also recommend that secondments between the DHSS and FPCs be stepped up as a means of rebuilding a relationship which has become increasingly strained.

Management Development Advisors

10.29 Proposals are already under discussion for the expansion of the role of management development advisors within the NHS generally. We recommend that separate MDAs be appointed to work with FPCs since we

feel that Health Authority-based MDAs would probably "short-change" FPCs and may well have little or no background in FPCs.

10.30 From whatever source MDAs are recruited, they themselves will need support. We recommend that this should be established by either or both of the mechanisms of seconding high profile administrator MDAs to education centres, on a basis which could be quite flexible (for example, for a regular day or week a month, or for a certain number of days in a term or a year); or through the institution of 'learning sets' for one or more groups of MDAs working within FPCs. This could well form part of a larger programme of support for MDAs within which the FPC-based MDAs could form subgroups.

National Accelerated Development Programme (NADP/GMTS)

10.31 Some senior managers in FPCs should by now be expecting to take part in GMTS III, some middle managers in GMTS II, and some of the younger, bright graduate recruits to GMTS I.

10.32 We attach particular importance to the involvement of FPCs in the NADP, as in the medium to long term, it is one provision that could promote secondments and movement between FPCs and HAs, and a more effective collaboration between the two organisations. The potential benefits of FPC involvement in the scheme cannot afford to be put at risk.

Distance Learning

10.33 The NHSTA has made available to FPCs a booklet designed for members which could also be used for staff induction, and a series of new booklets since the completion of our project. These, like the Henley Distance Learning Package 'The Effective Manager' which was supplied to interested FPCs at a subsidised price, will not achieve their optimum impact unless they are 'placed' thoughtfully in a learning-conducive environment.

10.34 We recommend in future that distance learning materials be systematically piloted in a small number of FPCs before making them widely available, and that any

distance learning material, even the smallest booklet, be accompanied with a guide to extracting maximum learning from it.

10.35 As part of the project, we have developed a diagnostic instrument which Administrators and senior managers can themselves use to identify their own FPCs commitment in practice to management development. It can help them in selecting where to start on further development, and it gives suggestions for appropriate approaches to particular issues of MD which may be diagnosed. It is available from the authors of this report, and includes guidance for use.

SECTION B - MAIN REPORT

NHSTA/KING'S FUND COLLEGE

REPORT OF A PROJECT

TO INVESTIGATE THE TRAINING AND DEVELOPMENT NEEDS

OF

FAMILY PRACTITIONER COMMITTEES

WITH

PARTICULAR REFERENCE TO THEIR

MANAGEMENT DEVELOPMENT NEEDS

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1 INTRODUCTION

1.1 The Current Context

This report is presented in a turbulent post-election period for the NHS, and particularly for primary and community care services. The period of consultation on the Green Paper on Primary Health Care (1) and the Cumberlege Report on Neighbourhood Nursing (2), is now being followed by the Griffiths inquiry into Community Care.

1.2 The profile of general medical services in particular within the NHS has risen with changes in the demography of the population, in patterns of disease and in acute sector policy. Demands on these services are increasing, but research suggests that their response varies greatly in quality (3). The current contract, drawn up over twenty years ago, does not seem appropriate to the contemporary needs of patients, general practitioners, or the State on behalf of the taxpayer (4 - 6).

1.3 Between the State and the independent contractor GPs stand 98 Family Practitioner Committees (FPCs) themselves almost as varied in their interpretation of their role as the contractors themselves. Their chief officers, the Administrators, have been in dispute with the DHSS concerning their own pay, while the Department's tight control of gradings and management structures has alienated many of them. The situation has been aggravated by a reduction in the administrative budget of some FPCs by 10 per cent, made with little notice, and it is claimed with the intention of spreading FPC resources more equitably.

1.4 FPC sensitivities run high. Chairmen as well as administrators we have talked with feel they have been short-changed, and not provided with the wherewithal to do the job given them in April 1985. Over the life of this project we like other investigators (7) came to share this view.

1.5 It might therefore appear impertinent to present a report on the management development needs of FPCs when we are only too well aware of the constraints on managerial action imposed by the centre and by lack of of resources. We know however, that some FPCs, despite these constraints, persist in their attempts to to change their culture from that of the archetypal bureaucracy to one of innovation, risk-taking, and pushing the boundaries of what is possible in influencing the availability and quality of family practitioner services. It is hoped that this report will generate debate on the nature of the managerial task and of managerial authority in FPCs, and result in action that will promote that broader-based change in organisational culture and leadership without which FPCs will be unable to fill the current managerial vacuum in primary health care.

2 THE PROJECT: TERMS OF REFERENCE AND METHODOLOGY

2.1 Terms of Reference

In March 1986 the NHS Training Authority commissioned the King's Fund College to conduct a project to investigate the training and development needs of FPCs with particular reference to their management development needs.

2.2 The purpose of the project was twofold:

(i) to identify the current and probable future issues facing FPCs
(ii) to identify the consequent training and development needs of administrators and staff, chairmen and members, with particular emphasis on their management development needs.

2.3 It was proposed initially to combine a national questionnaire survey with a review of environmental issues and with diagnostic and development work in three FPCs, to assess those management development needs which required national initiative and those which could be met at local and regional levels.

2.4 Project Team

The project team comprised June Huntington (Director), then Fellow in Organisational and Professional Studies at the King's Fund College, with a background in research and management education and development in general medical practice; John McClenahan, Fellow in Management and Planning Systems at the College who had previously been involved in a study of FPC administration with computing while with Arthur Andersen & Co., Management Consultants; and Jeremy Webster, Training Consultant with the NHSTA who had considerable experience of FPC training and who had conducted a questionnaire survey of FPCs in 1984.

2.5 Project Advisory Group

An Advisory Group was established containing King's Fund staff who were particularly well-versed in management development practice and in health services development work in primary health care in

London; the chairman of an inner London FPC, two FPC Administrators, a Director of Planning from a Regional Health Authority, and a senior management representative of the NHS Training Authority.

2.6 The group met on four occasions, assisting the team to develop criteria for choosing the three FPCs to be worked with in depth, suggesting and reacting to the direction and focus of the work, responding to the initial diagnosis, identifying gaps and recommending shifts of emphasis as the work progressed.

2.7 First Phase

During the first phase of the project a review of existing literature and unpublished reports of earlier FPC studies revealed that a considerable amount of knowledge already existed, not necessarily couched in terms of a mangement development needs analysis but certainly contributing richly to our own diagnosis.

2.8 This first phase included a review of previous NHSTA-funded surveys (Webster 1984) and Altenstetter 1985), FPC responses to the NHSTA's Training Strategy document, DHSS circulars and reports, Allsop and May's manuscript (now published), FPC Annual Reports and strategy documents, many articles, and other sources; discussions with liaison officers in the DHSS, attendance at a Performance Review and at a meeting of London FPC chairmen who were presented with the findings of the Hay-MSL work in 5 FPCs; attendance at the Society of FPCs annual conference and converstions with several FPC people who had shown interest in the project.

2.9 Selection of FPCs

The first phase led to the development of criteria for selection of three FPCs. These were:

- geographical variation, with the recommendation that the three comprise one large metropolitan FPC with inner city features, one very large county with several DHAs, and one shire county;

preferably no previous management consultancy or research involvements;

commitment to change or currently facing objective challenges in the environment such as computerisation, change of premises, mismatch between primary care services and acute;

preferably administrators below age fifty;

some indication of commitment to training and staff development;

avoidance of a London and south-east concentration; and

size variation in terms of geography, population and staffing.

2.10 In July and August 1986 approaches were made to the administrators of three FPCs:

one a large shire county relating to multiple DHAs, with a population of over a million;

a large metropolitan district, relating to two DHAs, with a population of 3/4 million and

a shire county relating to two DHAs with a population of just over 1/2 million.

2.11 Second Phase

The project team met with all senior managers in these three FPCs as individuals and as a group; interviewed a selection of staff throughout the organisations; attended meetings of the FPC itself except in one FPC,in which instead the Project Director attended with FPC senior managers a study day on the Green Paper and the Cumberlege Report held with DHAs and the local authority, the university department of general practice, CHCs and other organisations; attended in one FPC a Medical Practices Sub-Committee and in another a regular

informal meeting of the Administrator, Deputy Chairman, and two CHC secretaries, and met with the three chairmen and some professional and lay members.

2.12 The aim of the second phase was to determine the current and probable future issues facing these organisations, as seen by the people in them, and the managerial and service responses they were currently making and would need to make to address these.

2.13 Individual interviews focused on the person's perception of the purpose of the FPC, of environmental changes, external and internal, the relationship of their own position to overall purpose, their work aspirations, their perceptions of their competence and confidence in addressing the demands of their current role and of any changes facing them in the future.

2.14 The granting of independence to FPCs in April 1985 and the imminence of computerisation in our three FPCs had produced an organisational environment of some turbulence in which people felt more aware than usual of potential tension, even conflict, between their own idiosyncratic orientation to work and the actual and potential changes in the organisations in which some of them had worked for over thirty years.

2.15 Interim Report

An interim report on the first diagnostic phase of the project was presented to the Advisory Group in November 1986 with proposals for a third phase of work individual to each FPC which would begin to help them address some of the needs identified. The Advisory Group challenged our proposals for the third phase, suggesting that we needed to pose the fundamental question 'better management for what?'. What would a well-managed FPC look like and what difference would it make?

2.16 Third Phase

After individual briefings with the administrators concerned, the Project Team attempted to address these questions in the second phase of the project, drawing on material from a workshop held at the King's Fund College for the three FPC Administrators and their Chairmen, though only one Chairman was

able to attend; and a workshop in Birmingham for the three Administrators and their senior officers (Appendix I). In addressing the Advisory Group's questions the team also drew heavily on Allsop and May's *The Emperor's New Clothes: Family Practitioner Committees in the 80s (7)* which in its chapters on good practice in FPCs provides many answers to both these questions.

2.17 The Advisory Group also reinforced the Project Team's doubts as to the value of the national questionnaire survey. By late 1986 the Team's own findings in the three FPCs were replicating those of Altenstetter (8), Hay-MSL, and Allsop and May (7). Both the Advisory Group and the Project Team felt the time would be more productively spent in continuing to work with the three FPCs and returning to these other sources of information.

2.18 Final Phase

In the final phase, the Team set their own experience of the project against their knowledge and experience of management education and development to produce a training and development strategy for FPCs.

3 FPCs IN THE 80s

3.1 Role and Function

3.1.1 Prior to April 1985 the functions of FPCs were quintessentially administrative, in the sense that as organisations they existed only because family practitioner services were provided not by employees of the health service, but by independent contractors whose contracts with the NHS were financially and legally complex and open to considerable variety of interpretation. FPCs were, and still are, the statutory bodies responsible for 'administering the arrangements for the provision of family practitioner services (FPS) (which they formerly did on behalf of the District Health Authority (DHA) by which they were established)' (9).

3.1.2 In April 1985 FPCs were granted independence from DHAs and became directly answerable to the Secretary of State across 'the whole range of their responsibilities' (9).

3.1.3 The management arrangements circular that accompanied independence defined the role of the FPC as:

> concerned with administering, managing planning, monitoring and investigating and adjudicating. In carrying out their duties, Committees are required to be sensitive to the needs of the community they serve; to collaborate with other bodies, particularly health and local authorities; as far as lies within their power, to enable practitioners to practise effectively and efficiently; to act within the Regulations governing arrangements for the administration of FPS; and overall to exercise rigorous regard to use of public funds, for example by keeping under review entitlement to FPS renumeration and compliance with contracts and to ensure value for money in relation to payments made, e.g. in respect of general medical practitioners' premises and staff costs.

3.1.4 Despite its inclusion of 'managing' as the second function listed in the role, the rest of the circular scrupulously confined this term to the FPC's relationship to its own staff. Any reference to the FPC's relationship to the contractors and their contract is defined as 'administering'.

3.1.5 A more proactive role for FPCs is proposed in paragraph 9 of the circular which refers to the 'statutory duty on FPCs and DHAs and local authorities to collaborate *to secure and advance the health and welfare of the people they serve*' Is this more proactive role to be taken only in collaboration with other and more powerful organisations?

3.1.6 Significantly, paragraphs 10 on finance and 14 on manpower contain similar ambiguities in their initial statements:

> Securing better value for money is a fundamental task of health service management. FPCs are responsible for ensuring that: value for money is achieved in all aspects of their activities and that the best use is made of resources ....

3.1.7 This might be taken to refer to responsibilities in relation to administration of contracts, for example with regard to the work of some FPCs in encouraging takeup and monitoring use of ancillary staff in general practice, but the rest of the paragraph refers entirely to internal administration of the FPC itself.

3.1.8 Similarly, under 'manpower-personnel' the circular states:

> Health authorities through the NHS are required to achieve the most effective use of manpower and the Secretary of State wishes FPCs to pursue this aim. Performance indicators, introduced in relation to FPC administration in 1983/84, provide one means whereby FPCs may begin to assess their administrative performance relative to that of other Committees of similar size and type'.

3.1.9 Again, the examples of 'achieving the most effective use of manpower' given after the exhortation relate to internal management of the FPC itself.

3.1.10 The circular contains ambivalence as well as ambiguity. In paragraph 32 it states that 'The Government seeks to bring about the maximum possible delegation of responsibility to health authorities (including FPCs) at local level', yet FPCs have to seek permission for capital spending beyond a sum DHAs would consider paltry, and for any increase or amendment to grading structures above scale 4.

3.1.11 Ambivalence is also present in paragraph 38 on accountability which states that the 'Government seeks to improve the accountability of health authorities and FPCs through a review process *aimed at ensuring that patients receive high quality services*'. This would seem to imply that FPCs carry managerial responsibility for this in the same way as health authorities, and indeed the senior staff in one of the three project FPCs stated their organisation's purpose as 'to promote the availability and quality of FPS and to influence provision of associated primary care services'.

3.1.12 The complexity and delicacy of FPC activity in pursuit of such a purpose is conveyed in paragraph 33 of the circular under its section on planning:

> The fact that FPS are provided by practitioners who provide services to the NHS on a contract basis means that the approach to planning by FPCs must differ from that of health authorities. But the themes of planning apply; ie establishing baseline provision; identifying local needs, opportunities and constraints; determining aims and policies and deciding (in consultation with other bodies) how these might be achieved; introducing and implementing proposals; and periodically reviewing progress. FPCs cannot require contractors to do things that are not part of their contractual obligations and the Committee's approach also has to take into account the fact that the MPC and, in certain cases, individual practitioners, take decisions which can affect the provision of services within their area. FPCs have a statutory responsibility for administering arrangements for FPS as a whole and, within their statutory limits, are answerable to the community and to the Secretary of State for developments in this part of the service, just as health authorities

are answerable in respect of hospital and community health services (HCHS). In seeking to define and implement their policies and plans, FPCs work through a process of information, consultation, persuasion and influence.

3.2 Administration or management?

3.2.1 The NHSTA's document '*Better Management, Better Health*' (10) advocates the transition from an administered to an actively managed service, and we see this as vital to bringing better quality care into FPSs. We wonder whether others are as convinced. Chief officers of FPCs remain 'administrators' and not 'general managers' by title, while the recent Individual Performance Review circular was addressed to RHAs and DHAs 'for action' and to FPCs 'for information'. Those FPC administrators who are committed to managing are making this transition in a climate of ambivalence about the nature of the management task in FPCs. It is vital for the NHSTA to contribute to that debate as it affects FPCs or to support people who will contribute to it.

3.2.2 Those FPC administrators who wish to take responsibility for 'the direction, quantity and quality' (10) of the FPSs often push the boundaries of their present managerial authority to the limits at their own risk, as the BMA has brought strong pressure to bear on the Department regarding FPCs whose action it construes as breaching the terms of their contract with independent contractors. We have also seen examples in this project of administrators acting managerially in the sense of initiating the supply of a service to an under-doctored area and their efforts being blocked by the Medical Practices Committee.

3.2.3 '*Better Management, Better Health*' exhorts the service to make improvements in the quality of health care as the proper measures of managerial success (10) and to 'co-operate with professional staff in setting and achieving high standards of care'. In order to adopt improvements in the quality of care as a measure of their success FPCs need help in conceptualising quality in FPSs, and in finding new ways of cooperating with independent contractor professionals in setting and achieving high standards of care.

3.2.4 Few FPCs as yet see the need 'to take more positive steps to understand and influence the behaviour and attitudes of the public to questions of health'(10) or see themselves as having the right' to promote demand from some groups and to discourage it from others'.

3.2.5 Some are beginning to do this in:

- reviewing and taking positive action on their relationship to their CHCs;
- lobbying for change in classification of areas to make possible higher improvement grants to GPs serving deprived populations;
- handling complaints more carefully and looking for trends or patterns over time;
- developing a higher public profile through attendance at health fairs, provision of a stand in a major shopping precinct.

FPC managers can stimulate consumerism in FPSs by making known the existence of the FPC and its legal duties and obligations so that the public can legitimately bring pressure to bear for change in the quantity, quality and direction of services.

3.2.6 Some FPCs are also becoming more active in the transition from institutional to community care of the mentally ill and mentally handicapped, and through their role in joint planning trying to ensure that people coming into the community are not concentrated in one area so that all the burden falls on one or two practices; and through lobbying the local authority and health authority to open their transition training facilities to GPs.

3.2.7 The more able and high-profile FPC administrators display a capacity to 'understand professional attitudes, together with an equal responsiveness to the needs and expectations of patients and the local community in general' (10). They are attempting,

within the current constraints of their authority, to begin to 'organise and integrate the diverse professional activities into coherent and stable health care programmes' (10) in the FPS sector, but change is slow and painfully incremental, especially as the unit of health care delivery in FPSs is so much smaller than in the DHA. Managerial influence on the quality of FPSs to date has been small because, at least up to now, most FPCs and their chief officers relate to individual practices.

3.2.8 This incrementalism is demotivating to some of the younger more recent graduate entrants who tend to expect greater and quicker pay-offs from their work efforts. FPC administrators themselves are more accustomed to this incrementalism, particularly if they have grown up within FPS. The efforts of two FPCs to attempt to negotiate minimum standards with their local medical committees may offer a breakthrough on this front. When an FPC takes this kind of initiative, it must have proven its managerial competence in the areas valued by the people it is trying to influence, namely the contractors, so that professionals have confidence in the managerial process within the organisation.

3.3 Administration and Management: Separate or Related?

3.3.1 Although most chairmen and chief officers we have talked to are troubled by the ambiguity and ambivalence they experience from the Department surrounding the essential nature of FPC work, they do feel that April 1985 marked a shift in the nature of FPCs as organisations, and that they are now expected to be more proactive and initiatory than in the past across the whole area of FPS.

3.3.2 This was evident in the role given to FPCs in planning health services provision, but also in the expectations laid upon them to ensure that independent contractors are fulfilling their contract to the letter, and complying with Departmental regulations on deputising and the limited list; and that patients get fuller information on services available and are enabled to make complaints more easily. FPCs are also expected to look for trends or patterns in complaints year on year, and performance indicators relating to

immunisation and vaccination when disaggregated to individual practices make it possible for FPCs to take up with contractors major discrepancies between practices.

3.3.3 Computerisation should make possible the further development of performance indicators that can at least offer a basis for managerial activity that is proactive and change-oriented. Increasingly, therefore, what has traditionally been seen as administrative work within the FPC *contains the germ of managerial work.*

3.3.4 The more forward-thinking FPC Administrators see this, and seek managerial oportunities signalled by the administrative work that is already being done in the organisation. One of the project FPCs for example:

> produces scattergrams of practice vaccination and immunisation rates available to practices in his area. GPs who receive these can compare their own practice's performance against those of others, and if they see a discrepancy will usually contact the FPC. The management of that contact is then crucial in helping the inquiring GP to analyse why his rates might be lower. Sometimes there is no practice nurse in the practice, or there may be no practice nurse because there is no room for one. Such discussions can lead to appointment of a practice nurse or to the GP applying for a development grant to extend his premises or a cost-rent application to build new ones.

4 THE WELL-MANAGED FPC

4.1 Allsop and May (7) classify the work of FPCs into four categories:

- The pay and support (administration) role;
- The regulatory, monitoring role;
- The adjudicating and resolving conflicts (between practitioner and patient) role;
- The service development and (discretionary) role.

4.2 The well managed FPC conducts its business in the first category with such effectiveness and efficiency that practitioner cooperativeness and goodwill is assured, creating a climate in which the other three tasks can be pursued effectively.

4.3 FPCs have long exercised a regulatory and monitoring role in relation to standards of premises and hours of availability, though they vary widely in the assertiveness with which they pursue this role. They have some sanctions, such as withholding of rent and rates if premises are not up to standard, though this is not as powerful a sanction as the capacity to withold resources necessary to work, as can a UGM or DGM in closing beds or wards.

4.4 Monitoring and use of sanctions, however, in the context of the independent contractor/FPC relationship is always a risk for the administrator, in that it can sour relationships with at least one practitioner and possibly others. The same applies to the FPC's adjudicating and conflict resolution role in relation to complaints. Actions in either of these roles can prejudice the relationship with contractors and make the service development role difficult to enter.

4.5 By contrast, the Administrator who ensures efficient performance of the pay and support roles, and fair and consistent performance of regulatory, monitoring, and adjudicating roles, will find it possible to enter the service development (including pursuit of quality) role when there is nothing in the regulations that *requires* him to do so.

For example:

> one of the project FPCs interviews all practices applying for a new partner: interviewing the prospective partner, looking at the clinical sessions proposed, and the services offered at the practice. Many FPCs consider they cannot influence applications for partnerships, but only appointments to vacancies created by a single-handed practitioner. This FPC involves itself on value for money grounds in that they would not support an application for a new partner if this was a way of doctors reducing their workload, in which case they would only pay half the allowance. This FPC has also tried to clamp down on 24 hour retirement by GPs, asking close questions about what the GP's contribution is going to be to the practice after the 24 hour period.
>
> This same administrator considers that the FPC itself should be prepared to bring complaints against practitioners. Again, this is a high risk policy, possible only when the majority of practitioners trust the integrity of the administrator. This administrator and his senior officers say that they have the full support of the majority of contractors. This confirms our experience in working with GPs in another context, that those with professional pride wish to see standards maintained and will support the FPC in its commitment to this aim.

4.6 The pursuit of quality in family practitioner services by senior managers of FPCs requires considerable managerial skills, in view of the sensitivities of professional autonomy, especially those of independent contractors. The more contact the FPC has with its contractors, the more its senior people are aware of the culture of particular practices, the more they are able to pursue their own purpose of promoting accessibility and quality of services.

4.7 The more managerial FPCs pursue this purpose in a number of ways:

- Increasing public knowledge and information available on FPSs;
- Ensuring accessibility;
- Improving the effectiveness and efficiency of practices;
- Managing complaints;
- Overall service planning and development.

4.8 Some examples of the FPC initiatives drawn from our own project and from Allsop and May's study are listed below in answer to the questions 'what does a well-managed FPC look like and what difference does it make?'. Many of these relate to improving accessibility as the 'bottom line' of quality. Unless a user can actually contact a service, she cannot begin to judge it on other dimensions. FPCs also have some clout as regards the accessibility dimension of quality, but none or very little in regard to other aspects.

4.9 <u>Increasing information available</u>

4.9.1 The Green Paper (1) signalled government's concern for increasing consumer choice in primary health care. It advocated dissemination of more information on what is available and increasing the ease with which patients can change doctors.

4.9.2 It is difficult to imagine this happening unless FPCs themselves develop a much higher profile. Several studies including a Consumers' Association Survey (11) demonstrate that less than one fifth of the public has heard of FPCs, under one tenth of patients know who represents their interests in the NHS, and only 18 per cent claim they know how to make a complaint.

One of the project FPCs has produced a video and booklet guide to the FPC and FPSs in its area, intended for educational institutions, health education units, CHCs, voluntary organisations, ethnic organisations, and others.

Its aim is to increase awareness of the public role of the FPC; the relationship between practitioners and

the committee, and the services provided; and to increase the public's capacity to use FPS effectively.

4.9.3 The video was made by the local Community Video Unit. We suspect that the more entrepeneurial FPCs would not find it too difficult to secure local financial support for such endeavours. This same FPC has taken a publicity stall at local health fairs and is negotiating a stand in a local shopping precinct.

4.9.4 Other FPCs have produced quarterly newsletters for staff, committee members, practitioners, the CHC and other related organisations, and have made these available in public places. FPCs are now required by the DHSS to produce strategy documents, and some have used these locally to raise public awareness of the FPC.

4.10 Ensuring accessibility

4.10.1 Some FPCs resist practice requests to stop running Saturday surgeries, insisting on a trial period initially, the onus then being on patients to ask for resumption of the service. Alternatively, FPCs may ask doctors to keep surgeries open until commuters get home from work. The more the FPC secures its own independent indicators or measures of consumer need, the more it can initiate requests of this kind. Some FPCs are beginning to conduct surveys of consumer need, but until more do so, their contact with the CHC is a vital source of information.

> One FPC reported by Allsop and May discovered people in one of its areas were remote from medical services. The Parish Council approached the FPC and asked for a surgery or branch surgery preferably with a chemist shop. The FPC found a site, negotiated with the Parish Council, the County Council, local medical and pharmaceutical committees, other organisations and following a practice breakup in another area encouraged the GP from that practice to come into the area and practise from a portakabin as a temporary measure, followed by preparation to build under

the cost-rent scheme. After 3-4 years the GP had a list size of 1600 and a chemist had also come into the area.

4.10.2 Other FPCs especially in the inner city have initiated services for people for whom GPs are reluctant to provide such as the homeless, and travellers, and have arranged for doctors of ethnic minority groups to be introduced into an area containing members of those groups.

4.10.3 Some vacancies due to retirement of single-handed GPs are not accompanied by premises, in which case some FPCs seek premises through exploration and negotiation with the local authority and other organisations. Others use retirement of single-handed practitioners to foster development of group practices that offer a wide range of services.

4.11 Improving the effectiveness and efficiency of practices

4.11.1 FPCs can influence practice effectiveness through:

- Promoting improvements to practice premises
- Encouraging takeup of ancillary staff
- Offering training for ancillary staff
- Being flexible about rates paid for ancillary staff (e.g. in London)
- Mounting study days for GPs and staff
- Promoting and supporting Associations of Practice Managers, Nurses and Receptionists
- Contributing to GP training
- Encouragement and support of practice managers who can often function as change agents in practices
- Helping practices produce practice leaflets
- Providing age-sex registers
- Arranging delivery and collection services, often through DHAs
- Supplying details of local consultants and their waiting lists

4.12 Managing complaints

4.12.1 This is a major and delicate area of work in FPCs.

One of the project Administrators not only carefully logs all 'complaints' as

such, but also explores requests to change doctors. This demands adequate inter-section communication within the FPC, as such requests would usually go to the registration section where the request can be dealt with 'technically' as part of the registration function or managerially as part of quality assurance.

4.12.2 All such requests are logged and reviewed over time to see if patterns emerge. If a particular doctor or practice begins to stand out, the Administrator will investigate more closely. Careful analysis of complaints over time also provides a useful stimulus to discussions with the local medical committee about quality of services provided; and what aspects of service provided seem most to trouble complainants.

4.12.3 The well managed FPC ensures that those in the FPC who handle complaints both informally and formally are well-prepared for the work. In the whole area of complaints the FPC acts as mediator between the patient and the practitioner. Lay people as patients may need considerable support and careful communication if they are to proceed with the complaint.

4.12.4 In view of the sensitivity of this area for the professionals involved, fine judgement is required to decide whether a complaint can be handled informally or must proceed to a Service Committee hearing.

> In one of our three FPCs the Chairman and in another the Administrator engage in conciliation work with complainant and contractor particularly when the complaint appears to be grounded in mis-communication and misunderstanding. The chairman or administrator, having gleaned the perceptions of both parties, is then in a position to bring them together with rapid resolution of the difficulty and a 'healed' doctor-patient relationship.

4.12.5 The capacity of the FPC as an organisation to learn from complaints, as negative indicators of quality, depends however on its capacity to reflect on the quantity and type of complaints it receives over

time and on its own processes of managing them. It is an area which also reflects the quality of working relationship between senior staff and members who staff the service committees. The well-managed FPC ensures that members serving on these committees are fully prepared for their role.

4.13 Overall planning and service development

4.13.1 The well-managed FPC builds up a picture of its population, in relation to existing services,

> identifying the needs and aspirations of consumers, practitioners, health authorities, the Department, and other interests, and any governing constraints; obtaining the views and advice of the local professional committees and formulating proposals for the distribution and development of FPS (7).
>
> One administrator discovered that surgeries were being built to current population levels without taking the future into account (a common experience recounted by GPs on management courses). His FPC now uses the County structure plan which breaks down information to ward or parish level then tries to assess the degree of developments taking place in each doctor's area (7).
>
> One of the project FPCs encourages practices to generate public meetings with their patients, and gave them money from its own administrative budget to do this on AIDS. This FPC also uses the cost-rent scheme to promote the development of primary health care teams, through development of larger and better-designed premises.

4.13.2 The effectively managed FPC will initiate discussions and negotiations with local representative committees to agree minimum standards for FPSs in their localities. Newcastle has published a paper on its work in this area, while

another FPC has approached us to see if we could help facilitate such discussions.

4.13.3 Two of the project FPCs have nurtured relationships with members of the Royal College of General Practitioners in their areas who are particularly committed to the pursuit of quality in general practice. This promotes the sharing of good practice at FPC and individual practice levels, and enables the Administrators to ensure that their concerns are disseminated among a young group of GPs who exert considerable influence on new principals and trainees.

4.13.4 Most of the above activities are discretionary on the part of the FPC, and involve genuine leadership on the part of the administrator. Yet they are evidence of bottom-up pursuit of quality in FPSs as distinct from top-down. While the Centre exerts tight control on FPC gradings and management structure, and while it may reverse some of the decisions taken by FPCs, it has not established any standards to be achieved or targets for services practitioners provide (7), though the Green Paper (1) signalled that these might become a basis for a good practice allowance or at least the basis of a more performance-sensitive contract.

4.13.5 This picture of the well-managed FPC drawn from examples of *several* FPCs, some from our project, some from Allsop and May's work, underlines the need for the present project, for as Abel-Smith commented in his foreword to Allsop & May's book .... 'all these things have actually been done by some FPC somewhere, but no FPC anywhere has done anything like them all'.

4.13.6 As yet there are considerable barriers to reaching that situation in which most FPCs approximate the picture we have drawn. Some of these barriers were clearly visible in our work with three project FPCs that is reported in Section 5.

4.14 Addendum

4.14.1 On reading this section in draft, a member of our Advisory Group commented that even 'the well-managed FPC' did not appear to be much involved with DHAs and local authorities. This is valid point and reinforces our own experience in the field.

4.14.2 There appear to be considerable barriers to closer collaboration between FPCs, DHAs and LAs, the first being historical. It was only in April 1985 that FPCs were made independent health authorities, and to some extent some of them still seem to feel the need fully to separate themselves.

4.14.3 Although they now have a statutory right to sit at the joint planning table, FPC staff often feel peripheral to its proceedings. They are of far lower status than HA and LA staff, they have no money to bring, and as yet precious little of the information DHAs expect of them. They often experience difficulty in seeing the relevance of much of the discussion to the development of FPS which is their major concern.

4.14.4 In April 1985 they were given responsibility for their own internal management. Centripetal force seems to dominate FPCs currently, pulling the available energy inwards towards management of new personnel functions and the introduction of computerisation.

4.14.5 In this report we have emphasised the need to support FPCs in 'managing outwards' and would expect them to manage outwards more actively once computerisation is complete and they have developed more confidence in managing inwards.

5 WORK WITH THREE FPCs

5.1 The context

5.1.1 We entered the project FPCs in the Summer and early Autumn of 1986, 16-18 months after independence. We quickly gained the impression that the early euphoria attached to independence was giving way to doubt and suspicion, particularly as a report commissioned by the DHSS from Touche Ross consultants had not only recommended no increase in grading for most FPC administrators but had suggested a reduction for some.

5.1.2 This, in addition to tightness of control from the Department and a perceived loss to FPCs of their own Training Unit and budget, contributed to a sharp drop in morale. Particularly among managers lower down the three organisations there was considerable anxiety about change, as perceived in impending computerisation and marked shifts in the pattern of recruitment to middle management posts, along with confusion and ignorance about the source of these changes.

5.2 Barriers to organisational achievement

5.2.1 Our field work suggested the following barriers to organisational achievement:

5.2.2 Lack of coherent vision or purpose with consequent lack of a clear strategy for pursuing purpose. Even when senior managers feel they are clear about purpose, this is not conveyed adequately throughout the organisation, with consequences for staff motivation and commitment.

5.2.3 Training and development is therefore not strategy-led, but focussed on individual rather than organisational need. There is heavy reliance on external provision, particularly of day-release courses whose relevance to FPC strategy cannot be assumed.

5.2.4 Difficulty in tackling strategic issues because of chronic lack of delegation throughout the organisation - from committee to officers, and from

chief officer down through various managerial levels of the organisation. People higher up need to free time to themselves to address purpose and strategy.

5.2.5 The existence of what appear to be two kinds of work in FPCs, the traditional pay and rations work being done by staff who have often been in the organisation for some considerable time, and other work that we call 'managerial' which is geared to influencing the direction, quantity and quality of FPSs. The existence of these two types of work has implications for staff recruitment, training and development. The increase in the new type of work is already resulting in new recruitment patterns which have consequences for staff retention and motivation.

5.2.6 New recruits are brought in to serve new functions of planning and personnel and training, and may be positioned in the organisation in such a way that they become locked into functional specialist roles, blocking their influence on the managerial process.

5.2.7 All three FPCs were preparing for computerisation and in two of them this was causing serious concern. FPCs seem to be receiving very little support in resolving both the technical and human relations aspect of this development, yet the capability it should give them is crucial to any transformation from an administered to a managed organisation of FPS.

5.2.8 A lack of corporateness, within the Committee itself and throughout the organisation. Senior managers may be trying to build corporateness within their own group ('the management team') but this can result in managers and staff below them feeling cut off and unable to influence the management process. Communication up, down and across the organisation is not good, and the overall climate of change and uncertainty brings problems of trust in work groups at all levels.

5.2.9 Lack of agreement as to whether the training and management development needs of FPCs can be met by programmes usually available to health authority staff and managers, and particular concern about the relationship of FPCs and their staff to the National Accelerated Development Programme (GMTS I, II, III).

5.3 Two types of work

5.3.1 The development of newer tasks since April 1985 has resulted in all three FPCs in an emerging split between two types of work: the first administrative, dominated by repetitive tasks, routine work, meeting of regular deadlines, work scheduling of high volumes of data processing much of which lends itself to computerisation; the second, managerial, relating to active development of services involving considerable people skills because of dependence on interpersonal influence, persuasion and negotiation to achieve aims.

5.3.2 Hay-MSL also referred to this division, and suggested that the two types of work tended to be done by two distinct types of personality.

5.3.3 Traditional functions of registration and finance are typically occupied by people with a constrained view of their function, attentive to detail and accuracy, and a concern to operate tightly within regulations. In one FPC we found that typically these employees had been there for years (over 20 in many cases), and valued the FPC because of the bureaucratic nature of the work, the security, and the fact that they need never move from the locality in which they lived their lives. To some extent these people selected themselves into the FPC world, and the traditional functions and modus operandi of FPCs reinforced their 'bureaucratic personality'.

5.3.4 These staff are threatened by the recruitment of younger more qualified staff, whom they feel have been brought in over their heads. To be hardworking and loyal ensured promotion in the past. The demotivation of such staff is problematic because even after computerisation a high proportion of tasks in FPCs will still require such staff to perform them.

5.3.5 We have also observed that younger graduate entrants to FPCs actively loathe this type of work, and want to move out of it as quickly as possible. Because of high unemployment, FPCs are now able to recruit graduate females into clerical positions, but they rapidly become frustrated. When given managerial positions the younger entrants find it difficult to manage in face of a culture that assumes that to manage a function you need to have performed it yourself.

5.3.6 New staff have also been recruited to planning roles and to personnel and training roles. In two of the FPCs those recruited to the planning function came from CHCs and have a very different orientation and personal style from that of FPC senior officers. This may explain why the development of real teamwork among FPC senior management groups is so difficult.

5.3.7 Many of the recruits to the newer specialist roles and managerial roles at senior levels are graduate or otherwise qualified women, some of whom are in their twenties and early thirties. FPCs can probably recruit more able women than men at the salary levels offered, but the introduction of these young women into organisations traditionally managed by a small group of non-graduate men, many of whom have spent their whole career in the FPC culture, requires sensitive management if people are to get the best from each other.

5.3.8 Chief officers and senior managers need help in developing strategies for managing the two types of work in their organisation and their implications for recruitment and staff development policies. Should the division be acknowledged and worked with in management decision-taking? If so, the implications for building corporateness are considerable. If the division is seen as a threat to corporateness, then ways may need to be found of ensuring that people experience both types of work in their career within FPCs so that they appreciate the impact of differences in the type of work on the people doing it.

5.4 <u>Lack of a development culture</u>

5.4.1 If FPCs are to change their organisational culture, their recruitment and staff development practices must support their strategy. We do not see as yet a development culture in FPCs in which those identified as having high management potential are given special opportunities to develop their talent through planned career moves and special investment in education and development. There was talk of this need, but less action to meet it.

5.4.2 None of the three FPCs had a performance appraisal system in place, though two expressed deep concern about this and were making attempts to begin the process. There were no systems in place to identify

and counsel people with potential, to identify posts which offered strong developmental opportunities as development posts, nor procedures for ensuring that people with potential occupied those posts and received specially tailored developmental and educational opportunities.

5.4.3 Our concern is that almost the opposite might be occurring in that as part of their commitment to change, the better FPCs are recruiting younger, graduate people who are keen to continue to develop. Because of the lack of a developmental culture and structure in the FPC the organisation seems unable to use what they have and are keen to offer.

5.4.4 Some of these new recruits have developed their own self-help groups on a regional basis, and we need to learn how best to support such groups.

5.4.5 FPCs are typified by a training rather than a development culture. The current training culture of FPCs contains the following components:

> You can only manage a department whose work you have grown up in.
>
> Do it (the task) like this. Training concentrates on how. The trainee is not expected to ask why, or to want to know the relationship between his task and the work of the organisation.

5.4.6 Surprisingly in an organisation which has traditionally been dominated by routine, repetitive operations, there is little use of protocols. Procedures are locked in people's heads. When they leave, knowledge, understanding and skill leave with them and have to be carefully reassembled in the newcomer's head.

> In one of our FPCs a young senior manager has compiled self-instructional handbooks, ring-bound for constant updating which facilitate the training of lower level staff and ease the burden on their supervisors.

5.4.7 The didactic mode dominates training and education. There is much reference to lectures and lecturing, when discussing in-service seminars and externally provided training.

5.4.8 Provision of external education and training is favoured particularly day-release for senior managers (DMS, CMS, IHSM, ICSA) and events laid on by the Dental Estimates Board or the Prescription Pricing Authority for lower level staff.

5.4.9 Training activities appear to be ad hoc and unconnected, and certainly unrelated to the strategy of the organisation.

5.4.10 So many of the training needs of lower level staff can only be met by their own managers, yet these managers complain that they are not given time to train their staff.

5.4.11 There is little evidence of the organisation making the effort to explore the impact of an external course on staff, or how best to use the new skills and knowledge acquired.

5.4.12 Training provides trainees with knowledge and skills to carry out *specific tasks*. What is needed in FPCs is far more developmental than this. FPCs need help on a variety of fronts to foster a development culture that includes chairmen and members, administrators, senior officers, and staff right through the organisation.

5.4.13 Staff development must become an integral part of FPC operations, a top priority for management as part of the implementation of performance review throughout the organisation. The training needs of staff will not be met without a major shift in the culture of FPC management, and without management's grasping the training and development implications of the April 1985 change in status. They have received very little help with this.

5.5 Level of general education and FPC careers

5.5.1 We have not seen statistics but we suspect that the level of basic education among FPC staff, including quite senior management is low, certainly in comparison with district health authorities or even units.

5.5.2 FPC staff at senior levels are becoming very conscious of this, which may have two results. First, it may produce a compensating anti-intellectualism which can block the free-wheeling ideas sessions so necessary to a future-orientation, and the articulation of purpose and strategy; and second, it may neutralise the contributions of recently appointed graduate staff, particularly when they are female.

5.5.3 We also became aware of a sense of stigma among FPC staff, again even at quite senior management levels. This may relate to non-graduate status, but it more probably relates to the confined nature of the FPC career, and the very real differences that exist between most FPC administrator's salaries and those of UGMs.

> One finance manager felt he would find himself out of his depth with chartered accountants or management accountants on a financial management course. He knows two qualified accountants who entered FPCs. One left saying he understood accounts but did not understand those in FPCs, as they were not accounts.

5.5.4 Even senior managers feel that their experience in FPCs does not transfer elsewhere. The implications for second-in-lines in their late 30s to early 40s are severe, for they know that appointments to chief officer posts are beginning to be made from graduate ranks and from outside the FPC world. The needs of these managers must be addressed or they will become progressively demotivated.

6 ORGANISATIONAL DEVELOPMENT NEEDS

6.1 The picture presented in the last section suggests a wide range of unmet *organisational* development needs in FPCs, covering virtually the whole spectrum of FPCs' traditional and newer responsibilities.

6.2 Managing outwards

6.2.1 The most pressing need is to improve the FPCs' capabilities for **MANAGING OUTWARDS**. In particular:

a. Each FPC will need to clarify its aims and purpose in its own terms, and largely in the absence of a clear process of strategic guidance or support from the centre. We see the FPC's main purpose as being to seek improvement to the quality and accessibility of FPSs, or perhaps even more broadly (in some FPCs' views,) Primary Care services for

- their populations and important subgroups of these populations
- particular families and individuals
- individual practices and practitioners

b. To be able to do this, FPCs will need to define in practical terms **QUALITY** and **ACCESSIBILITY**, how they might be measured or assessed, and what degree of influence (or in a few cases direct control) is available to the FPC to effect improvements.

c. FPCs will also need to learn how best to process existing data and in some cases gather and interpret new data which will help them to assess the quality and accessibility of existing services, and identify desirable directions for change.

d. Having established directions for change, FPCs will need to exploit known methods, and continually learn about and develop new methods to exert their influence effectively. They will have to do this within the constraints of their regulatory and statutory framework, and having regard to what they can obtain by way of resources. There is a very wide range of influence points and methods available, and an

important learning need is to share experience to discover what existing methods can work, and under what circumstances new methods seem worth trying.

e. They will also need to define the organisations that will be most salient to them in defining and implementing their strategy for influencing the direction, quantity and quality of FPS, and the most appropriate type and amount of resource to invest in the relationships with those organisations. Obvious examples will be the DHA, various departments of the local authority, local representative committees, and individual contractors and their practices.

6.3 Managing Inwards

6.3.1 While developing and extending their OUTWARDS management role, and indeed in part to make it possible and sustainable, FPC managers will need to strengthen their capabilities for MANAGING INWARDS (ie, within the FPS world). Managing inwards includes managing

a. DOWNWARDS - managing relationships with staff, including motivating them, communicating a sense of the organisation's overall aims, fostering a participative management style which can encourage them to give of their best, delegating effectively to free up time from routine tasks to allow for one's own longer term and strategic thinking, negotiating clear targets and appraising performance in the light of the organisation's strategy, helping other managers and staff to manage their own development and career, and linking these in to the organisation's own aims.

b. SIDEWAYS - including relationships with colleagues in the same FPC, other FPCs, and other FPS bodies such as the PPA and DEB, the Exeter FPS computer unit and so on).

c. UPWARDS - including relationships with immediate superiors (up to the Administrator), chairman and members both as individuals and as the Committee and subcommittees, and the DHSS and ministers.

7 MANAGEMENT DEVELOPMENT NEEDS

7.1 The organisational development needs of FPCs outlined in Section 6 cannot be addressed unless development needs of different groups of managers begin to be addressed.

7.2 Chief Officers

7.2.1 We have spent a large part of this report in outlining the ambiguities and ambivalence surrounding the role and function of FPCs. Currently these are experienced most keenly by the very administrators who are trying to take on board in their own work the principles outlined in *Better Management Better Health*.

7.2.2 We are told that when trying to act 'managerially' in the BMBH sense of trying to influence the 'direction, quantity and quality' of FPS they may find their decisions challenged by practitioners who then appeal to the DHSS. It is by no means unusual for these appeals to be upheld by the Department, which then undermines the authority of the Administrator in his own patch.

7.2.3 We are in no way implying that practitioners should not have the right to appeal, nor the Department the right to uphold that appeal. What we are saying is that currently Administrators entering the field of managerial rather than administrative action, enter a minefield and feel extremely isolated when they do so. They appear to us, for example, to be more isolated than an acute UGM who may be attempting to improve waiting times in out patient clinics.

7.2.4 The primary management development need of Administrators is help in defining the business they are in, the purpose of the FPC in its current complex and ambiguous context, the consequent nature of their own managerial tasks and the managerial authority required to address them.

7.2.5 Because of the current confusions about these questions, Administrators need to be able to address them in focussed and systematic fashion alongside other Administrators. Together they need to explore

the leadership demands upon them if FPCs are to contribute to the strategic management of primary health care.

7.2.6 They also need an arena in which to voice their uncertainty, vulnerability, and isolation, in their transition from a purely administrative to a managerial role; and their concerns about their own careers, particularly those who are in their late thirties and early forties and who are already running larger FPCs. They need help in exploring potential career movements, in evaluating these and developing the competence and confidence to make them possible.

7.2.7 If this is not offered, then many chief officer positions in FPCs will be occupied by their present incumbents for the next 20-25 years, with implications for motivation of the person in the role and even greater implications for young senior managers whose aspirations to a chief officer position will be blocked.

7.2.8 Significantly, when asked to discuss their own management development needs in a small workshop group, the project Administrators placed 'effective appraisal' first, and we shall argue in our Recommendations section that without the introduction of an effective IPR system within FPCs much other investment in MED will be wasted.

7.3 <u>Chairmen and members</u>

7.3.1 Chairmen are also confused about the nature of the management task and of managerial authority in FPSs, and where these lie.

7.3.2 Ideally, the FPC administrator would address the training needs of his chairmen and members, not simply by providing seminars or short courses, but more importantly by ensuring that sufficient contact took place between chairmen, members and officers. Pairing of an officer and a member or a small group of members for purposes of further mutual education is one route, guided visits of members through the FPC is another.

7.3.3 The information base of lay members is particularly low, and we find that some of the educational events

they have been offered have been pitched too high, the Administrators being unaware of members' lack of basic information about FPSs.

> One member in our study made the useful suggestion that information could be personalised in the sense of looking at how a doctor, e.g. gets onto the list, how he gets premises, how he gets his income.

7.3.4 Officers of the FPC could use their chairmen and members more productively, but only if they ensure that members are competent to discharge their functions particularly on important committees like service committees. When people feel competent they feel confident and more motivated. Most members will not develop competence from reading, however informative the booklets, the regulations, or the handbooks. People learn from experience and the opportunity to reflect on that experience.

7.3.5 Administrators may be hesitant to meet the development needs of chairmen and members through fear of producing the 'pseudo-officer' syndrome. This fear could be tackled in programmes for administrators as part of their relationship to chairmen and members.

7.3.6 Developmental provision for chairmen and members can usefully be addressed across FPCs but requires an organisational infrastructure. London chairmen have met regularly over the past year at the King's Fund Centre and have appreciated this opportunity.

7.3.7 As with all MED provision for FPCs, too much didactic presentation should be avoided at such events. They are more useful to participants if a facilitator works with them to help them diagnose their needs and develop a strategy to meet them. Again, like the administrators, they need the opportunity for guided reflection on their accumulating experience.

7.4 <u>Senior Managers: deputy administrators and functional heads.</u>

7.4.1 In the three project FPCs these were a very varied group, comprising males in their late 30s to late 40s whose careers had been spent in FPCs and females

in their twenties, one a graduate, and former local government management trainee, and the other from commerce.

7.4.2 The older male group is typically non-graduate, which may account for the popularity of part-time day release management courses leading to qualifications like the Diploma in Management Studies with this group. As these are offered in technical colleges and polytechnics close to work and home and require one day a week rather than a number of weeks away from the organisation, they are convenient for the FPC and the individual manager - and they result in a qualification. We would want to be assured that such courses were *manager*-centred and not simply management, i.e. subject-centred, and that there was opportunity within the course structure and process for the manager to take into the educational experience live problems from his own work within the FPC.

7.4.3 Those in the older mainly male group need to develop their understanding and competence in people management especially those who have come up through registration and finance. Because they have come up through the ranks and are often comfortable with the bureaucratic features of FPCs, they can demand tight adherence to tried and tested routines and offer little space for initiative to their subordinates. While these subordinates were the old-style FPC employees the consequences of this management style were simply stable (but inflexible) organisations.

7.4.4 Now that some younger FPC staff are better educated, more mobile, and not necessarily seeking an FPC career, they want work experience that can be assimilated as part of a package of growing competencies that have relevance across a range of organisations. These young people make demanding employees. If managed too bureaucratically, their capacity to offer new ideas, techniques, and modes of thought will be stifled and their contribution lost to the FPC before it is made. Older senior managers need a great deal of help in managing newer recruits to FPCs.

7.4.5 This older group who have grown up in FPCs also need help in extending their vision of the FPC and its purpose. They do not naturally think in strategic terms and need help in beginning to do this, particularly in relation to the external environment and its demands for greater collaboration. They

also need more opportunity to think through the demands of corporate management and the competencies required for effective teamwork.

7.4.6 Whether they begin to address any of these needs depends in part on the capacity and willingness of their Administrators to delegate more radically and to share some of the top management responsibility. Currently, administrators tell us that it feels unfair to them to do this in view of the relatively low gradings of some of their senior managers. Some administrators have applied for regradings for their senior managers without success.

7.4.7 The younger second-in-lines need help in people management of a different kind, that of managing people much older than themselves, and in working corporately within a management team that contains older men who have previously related to younger men (and more particularly younger women) only as subordinates.

7.4.8 These young managers, who may increasingly be women, require considerable support from their chief officers, particularly in the form of support for their authority vis a vis older long-serving staff and of feedback on their managerial performance. They also need carefully structured opportunities to 'learn the business' in the shortest possible time.

7.4.9 This young group of senior managers together with younger graduate entrants into middle management positions, frequently expressed their development needs in terms of what was missing *inside* the organisation, rather than as a need to go on external courses. They feel that the way in which they are managed inhibits continued development. They enter the FPC with qualifications but are confused as to their relevance to the needs of the organisation or to promotion possibilities. The development of performance review and appraisal systems would in part meet this requirement.

7.5 <u>Middle managers and those in 'staff' positions</u>

7.5.1 In all three FPCs several new appointments had been made relating to the introduction of new planning, personnel and training, and computerisation responsibilities. Again, many of these were

graduate appointments of people with no previous FPC experience all of whom found the FPC world strange and anachronistic.

7.5.2 As with the young senior managers, whether they can make an effective contribution to the work of the FPC, particularly its new work, depends largely on the freedom they are given to question long-standing routines and methods, the speed with which they can be introduced to the 'business' of the FPC, and the opportunity they are given to influence its management process.

7.5.3 Younger middle managers are often quite confident in relation to computerisation. They may not be particularly competent, but they do not experience techno-fright. We feel they could be used more imaginatively in training of lower level staff and enabling them to overcome their fear of computerisation. They would need help in managing the sensitivities of older lower level staff.

7.5.4 Younger people in middle management and 'staff' positions will not necessarily remain in FPCs, as they often have a mobile outlook that is at odds with existing FPC culture, but they offer a great deal to the organisation while they are in it, and our evidence suggests this is not always capitalised upon.

7.5.5 Their continuing development needs, like those of the second group, can largely be met within the organisation, simply by stretching them. However, it should be emphasised that some of these staff have never been trained for the particular function they are filling, e.g. planning, personnel and training. Two of our planners came into the FPC from CHCs, and fully recognise shortfalls in their own competence: in handling statistics and other areas of information management: in conducting surveys; in negotiating and persuading from a base of low status relative to others (in the DHA and local authority). Regionally-based planning groups have developed to meet some of these needs, but we wonder how developmental they are.

7.5.6 There remain many middle managers who have spent their working lives in the FPC, many of them women, some of whom feel that they have not progressed further because they are women. It has been

particularly galling for some of these now to see younger women, albeit graduates, brought in 'over their heads'.

7.5.7 Lack of an effective IPR system affects these middle managers perhaps more severely than any other group, because there is effectively no arena in which they can air their confusions, resentments, and anxieties about the future. If their managers believe they can progress no further within the organisation, this should be made clear and the consequences explored. If there is doubt, they should be given the benefit of the doubt and offered a planned programme of management development but without effective IPR systems we doubt this will happen, and FPCs will continue to pay the price of a severely disaffected group within their organisations.

7.5.8 This group is crucial in translating the strategic concerns of senior management into the main body of the organisation, and in identifying 'the germs of managerial work within the mass of routine administrative work' that we described earlier. Their grasp of the overall organisational purpose and strategy is of central importance in achieving a well managed FPC, and we found this to be poor in all three FPCs at this level. Many of this group's management development needs could be met within the organisation simply by increasing their contact with senior management, and more effective developmental delegation by senior managers.

7.5.9 As with the senior management group, any external provision should be focused largely on self as manager, and on increasing people management skills, and information management skills, as this group is quite anxious about computerisation and its implications for their managerial role.

7.6 <u>First line managers</u>

7.6.1 This group needs to develop its supervisory and training skills, and to be given time within the organisation to apply these to the developmental needs of their staff who are largely engaged in routine, repetitive, yet very detailed work that requires high levels of accuracy. Currently this group is demotivated because its previous channels of promotion are now being blocked by recruitment of

younger more qualified people. Theirs is also the work that will probably be most affected by computerisation.

7.6.2 Their capacity as first line managers and their enthusiasm for the developmental aspects of the managerial role is crucial, for they are the most appropriate people to address the training and development needs of their staff. To do this they need to be aware of the part played by their staff and department in achievement of organisational purpose in a rapidly changing environment.

7.6.3 With the coming of computerisation considerable demands will be placed upon them for effective deployment of staff over changing workloads and new technological processes. They will therefore have particularly acute needs for increased competence in the management of information processing.

7.7 Clerical Staff

7.7.1 The most appropriate response to the training needs of this group is for their immediate manager to take responsibility, given help by a more senior officer in the organisation who specialises in the training and staff development function, or from DHA or RHA training personnel, or from staff in local colleges. The greatest need of first line managers and staff is for greater awareness of the changed nature of FPCs and what this means for their own jobs.

7.7.2 There is currently considerable anxiety about the impact of computerisation and about the impact of new recruitment strategies. The need for both is illunderstood and this provokes schism between workers and senior management. In one of our FPCs the administrator recently held two half-day meetings for staff throughout the organisation at which he spoke about changes in FPCs. Staff said they had never heard about this and wished they had known about it before as it enabled them to make much more sense of the last 18 months in their working lives.

7.7.3 One indicator of a shift from a training to a development culture is that people are encouraged to locate their own work in the larger context of organisational purpose and strategy, and of their own expected career trajectory.

7.8 Computerisation

7.8.1 We see computerisation as crucial to the transition from an administered to a managed service within FPCs, simply because of the base it will provide for proactive management in relation to contractors. The information capability it will give FPCs is also crucial for their credibility in relation to DHAs and local authorities. FPCs cannot offer money, and FPC managers and staff involved in the planning process are usually of a much lower grade in the service than health authority staff. All FPCs will be able to offer is information, at least initially. Once their information base makes possible more negotiation with contractors, then possibly FPCs, some at least, will be able to represent their contractors at the planning table in a more radical manner than currently.

7.8.2 All three project FPCs were in the throes of computerisation and we were concerned by the low level of support they were receiving from the local outposts of the Exeter unit.

7.8.3 Current registration systems going in were relatively limited in their flexibility, particularly for analysis of geographic distribution of patients. FPC systems cannot yet use postcodes (if entered) for analysis, and the costs of entering them are very high. The practices register is said to have only a few, fixed, formats for printout. Finance systems were only just becoming available and were still very partial - the doctor payment subsystem will not be available for some considerable time, yet represents both a major part of the work of FPC Finance Departments, and a major part of the opportunity for capturing and presenting information.

7.8.4 FPCs visited could not show us good overview documentation describing current system capabilities, only relatively detailed operator instruction manuals (even these are having to be amplified by one FPC to form detailed procedural guides).

7.8.5 The Support Groups (Exeter outposts) were severely overstretched, available on site only one day per month we were told by one of our FPCs. Some of the Support Group staff were inexperienced in the Exeter system because of recent recruitment and were

therefore little more knowledgeable than FPC staff on many technical and procedural matters.

7.8.6 Development of the main existing systems (registration, cervical cytology, pharmacy payments and family planning payments) had been frozen by DHSSchaired steering groups until all FPC computers were up and running. This left FPCs who computerised early with what were said to be inadequate analytic tools which they were saying they would have to supplement locally.

7.8.7 There is a serious risk of inefficient duplication of effort in the short term and long term central maintenance support problems if (and when) different FPCs have different additions grafted on to the centrally provided systems. If these problems are not sorted out then FPCs may not be able to live up to DHSS and DHA expectations on information provision.

7.8.8 We understand the DHSS has recently received a commissioned consultancy report which set out a revised programme for Exeter which may affect the above points, but FPCs were not yet aware of its implications.

7.8.9 Currently, FPC staff suffer severe lack of investment in the development of their competence in information management and technology, yet that competence will prove critical in establishing FPC joint planning credibility with DHAs and local authorities, and managerial credibility with contractors.

7.8.10 One of the project FPCs had shown considerable ingenuity in preparing its staff for computerisation, using second hand PCs to train staff in keyboard skills and allay basic fears of the technology. Managers and first line supervisors had paid visits to fully computerised FPCs and staff had visited these FPCs in groups for acclimatisation days.

7.8.11 Nevertheless, as we completed our own report we were pleased to see a draft copy of the NHSTA's 'IMT Training Strategy' and would urge that FPC managers and staff have equal access to IMT training and development with HA managers and staff, particularly those in community units. As much of the demand for IMT training in HCHS was stimulated by

implementation of Korner, and Korner specifically excluded FPS, there is a risk that the IMT training needs of FPC managers and staff will be ignored or given lower priority.

8 A MANAGEMENT DEVELOPMENT STRATEGY FOR FPCs

The vital organisation is associated with high productivity, excitment, a sense of purpose, feelings of accomplishment, openness to change, and achievement of the nearly unachievable. In health terms, the vital organisation is able to release resources to be able to provide services to patients and clients that would not otherwise be available; or providing services to patients and clients sooner, or providing more of them.

An organisation's vitality is determined by the competence of all its employees and by their ability to put that competence creatively to work to meet the objectives of the organisation. This means that staff need to be very much alive to what the business is about, the opportunities and constraints that exist, what goes on elsewhere in the organisation. It also means that initiative and creativity is to be encouraged and rewarded as opposed to discouraged and penalised.

Much then depends on the line manager as trainer and on continued learning that is problem-solving centred and takes place on-the-job as well as off.

NHSTA: National Training Strategy
September, 1985.

8.1 We preface our strategy with a description of 'the vital organisation' to convey our vision of a potential future in the face of a present that falls considerably short of it. In FPCs today there is confusion of purpose, few feelings of accomplishment, resistance to change, and under FPCs are organisations whose competence falls short of what is now expected of them, whose staff are not 'alive to what the business is about' and to how their particular job furthers that business, nor are they fully aware of what goes on elsewhere in the

organisation. Initiative and creativity, if not discouraged and penalised, is somehow neutralised from organisational failure to assimilate and use it.

8.2 We have formed this picture not just from our work with three FPCs in which we have found individuals who are genuinely struggling to give birth to 'the vital organisation', but from wide reading, attendance at the FPCs annual conference, experience of Hay-MSL's presentation to London chairmen, and conversations with many people in and around the FPC world.

8.3 Some of those people believe the post-April 1985 FPCs were 'born to fail', and our work lends us to the view that unless a major investment of informed management education and development is made soon they may well be right.

8.4 *The process of change in organisations is an activity in its own right, quite different from that of managing the present: the associated systems require managerial time and effort. Frequently, the needed change systems are not established because the demands of the present are experienced as too pressing (11)*

This statement aptly describes current organisational reality in FPCs. The traditional work is omnipresent, and its inadequate performance would lead to rapid complaints from contractors, threatening the relationships necessary to form a base for more developmental work. It is also easier to ignore the managerial demands of change if many people both inside and outside the organisation profoundly do not want change to happen. This may also be true of FPCs.

8.5 *Unless proper provision is made to allocate resources to change management, the present always wins and hence the future never arrives (11)*

Many achievements made by FPCs in managing outwards have been made in spite of lack of support for change in the form of title shifts, restructuring, strategy-led MED, and extra resources. What appears to be demanded of FPCs is a genuine

transformation from the traditional pay and rations organisations to one that is far more developmental. This will require a major cultural shift, which will in turn require that administrators themselves undergo a corresponding identify shift from that of administrator to that of *manager-as-leader*.

8.6 By the nature of the changes being thrust upon them, FPCs are in the business of organisational development, and this demands effective organisational leadership (11-13). Unless FPC administrators are empowered to lead through a major attempt to address their management development needs, as those of newly appointed DGMs and UGMs have been and continue to be addressed, any hopes of their moving into the managerial vacuum in primary health care can be abandoned.

8.7 Our strategy aims significantly to raise the capacity of FPCs to 'influence the direction, quantity and quality' of FPS (10) within three years by a sequence of MED activity that begins with top managers, is largely FPC-specific, has built-in 'cascade' intent, and seeks more than one pay-off for a given investment.

8.8 At the commencement of the project we did not think we would end it by recommending FPC-specific MED activity, particularly for top managers. Our experience suggests, however, that the strategic management development needs of FPCs are so great that any top manager development programme must be set in the context of FPCs rather than the NHS more widely.

8.9 Such a strategy is quite in line with trends in management education and development over the past five years, in which the literature has featured numerous articles on the need to link MED activity more closely to organisational strategy.

8.10 We also promote an FPC specific top manager programme as our priority because of the current lack of central guidance on mission, despite tight control of management action. There is also no regional tier to contribute to articulation of purpose and strategy, and in its absence individual administrators need help in this task.

8.11 Chief officers of FPCs are so hedged about with legally delineated limits to their authority, that they need to develop both competence and confidence in large measure to engage managerially with their task. They themselves experience real need for management development, but this must be manager-centred, enabling them to reflect on the nature of their managerial task and their own capacity to meet it.

8.12 Currently, there seems to be no arena in which they can get together to envision the future, share current practice, reflect on it, and develop the capacity to spearhead major organisational change.

8.13 We have assumed that in order to change the training culture of FPCs to a developmental culture, we must start at the top. Without this, FPCs will be unable and unwilling to accept responsibility for their own organisational development, and for addressing the management development needs of their staff.

8.14 Our strategy aims to:

- enable top managers to develop and communicate a sense of purpose and direction throughout their organisations.
- link the training and development of individual managers to the organisation's strategy, to improve management performance, and ensure management succession for the organisation.
- develop general management attitudes, approaches, and competencies within FPCs.

8.15 <u>Potential barriers to implementation</u>

8.15.1 Before making specific recommendations for MED activity appropriate to the needs revealed by this project and other studies, we would urge the NHSTA to seek reduction of certain barriers to strategy implementation, without which return on a major MED investment might be less than expected.

8.15.2 One major barrier lies in the lack of a regional infrastructure. Six of the nine recommendations in BMBH's Action Plan involve RHAs as spearheads for implementation of the NHSTA's MED strategy in hospital and community health services. We suggest that the NHSTA review that section of BMBH in the

light of our findings and ask whether MED effort can be placed creatively and productively in FPCs without a strengthened regional infrastructure for FPS.

8.15.3 The NHSTA may wish to initiate discussions with DHSS, the Societies of FPCs and Administrators FPS, and other bodies to explore how the respective roles recommended to be undertaken by RHAs could be alternatively provided in the FPC context, for example:

a) <u>personnel and manpower support</u>

- providing constructive support and reinforcement to the process of introducing IPR within FPCs, and following up regularly and frequently on progress. Significantly the circular introducing IPR was sent to RHAs and DHAs *for action*, but to FPC *for information*, and none of our three FPCs have managed to establish effective performance review and appraisal systems, although all have said that they want do so - gathering information about the present age structure and qualifications of FPC Administrators Deputies and other senior managers, and the source and destinations of transfers in and out of the FPC world - giving career guidance and ensuring management succession within FPCs.

b) <u>support for management and training activities</u>

- providing MED support to groups of FPCs with similar requirements, geographically close to one another and providing support facilities ... for example in facilitating workshops, providing MDA input for local diagnosis, team building, and to develop general management approaches and skills

c) <u>support for information and IT initiatives</u>

- acting as a focus for supporting the successful implementation, use, and full exploitation of computerised information systems, and collaborative development of additional analysis and reporting capabilities which are not universally needed, and which cannot be provided or adequately supported from a distant national centre

d) <u>good practice guidance</u>

- acting as a focal point for collection and dissemination of good practice among neighbouring FPCs, which to be successful, must be felt to be 'owned' by the participating FPCs.

8.15.4 On making it happen BMBH states 'the Service will need the support and leadership of the two national Management Boards for England and Wales in endorsing policies and measuring performance in management development' (10, p11). The FPCs are currently outside the Management Boards, so who is to give the leadership in implementing BMBH for FPCs?

8.15.5 A further barrier to implementation is the lack of systematic IPR in FPCs. We have already pointed out that the IPR circular was sent to FPCs 'for information' and to health authorities 'for action'. We consider this unfortunate and are glad to learn that the NHSTA is now trying to engage FPCs in active IPR training and experimentation.

8.15.6 Without the introduction of IPR and the management focus and discipline that follows, much of our strategy will be ineffective.

8.15.7 If management development is to be tailored to the needs of the individual <u>and</u> the organisation, a regular review of 'fit' between individual and organisation is vital. Without this, MED activities can be (and we believe in the past have been in FPCs) random, inadequately informed, and lacking clear direction.

8.15.8 A final potential barrier to implementation of an MED strategy for FPCs may lie in the age and career structure of the current chief officer group.

8.15.9 The present age structure of administrators is not publicly known, yet impressions are that it may give rise to concern in the relatively near future. Many newly appointed administrators are relatively young.. in their early forties or younger. Some are already in large or very large FPCs, leaving little or no scope for further career development in traditional ways within the FPC world. This raises the question of whether they can or should remain in their present post until retirement.

8.15.10 Not only could their own opportunities for personal and career development be limited, but also they may block, or be perceived as blocking, promotion from below. More information is needed than was available to us on the national picture, and what may need to be done to widen the promotion prospects of FPC managers outside FPCs, both from posts as Administrators, and from senior and middle management posts whose present incumbents' prospects may be limited.

8.15.11 This situation makes imperative the need to promote secondments of FPC managers and their participation in the National Accelerated Development programme, in order to enhance their chances of career mobility.

9 RECOMMENDATIONS

9.1 Top Manager Development Programme

9.1.1 We recommend that priority within our management development strategy be given to provision of a rolling top management development programme for FPC administrators.

9.1.2 Two programmes a year run for two years for 21 participants in each programme would enable the majority of FPC administrators to be included within three years.

9.1.3 The programme would begin with a one-week intensive and residential module, followed by two further threeday modules spaced over 6-8 months, participants engaging in agreed work in their FPCs in the intervening periods. Participants being selected initially from FPCs that are already demonstrating an interest in and commitment to organisation and management development.

9.1.4 The programme would enable participants, selected on the basis of their own analysis of their organisations, their managerial preoccupations, and themselves as managers, to work on the application of the principles adopted in *Better Management Better Health* to their own organisations, and to develop imaginative approaches to their task of influencing the direction, distribution, quality and cost of FPS.

9.1.5 Ideally, participants should be selected so that small groups established within the programme could continue to meet in their own localities between modules, and continue meeting as a learning group after programme completion.

9.1.6 Programme objectives would be to assist chief officers to explore the nature of their managerial task in view of:

- the continuation of the independent contractor status of the professionals whose contracts they hold;
- the continuation of the traditional pay and rations function alongside newer, more entrepeneurial functions;

- the containment of these within one organisation and consequent impact on staff selection and development;
- the management of environmental uncertainty and the interface with a range of other organisations;
- the impact of computerisation and of increasing information capability in FPCs on their internal structure and culture and their relationships with contractors and other significant organisations outside the FPC.

9.1.7 A major aim of such a programme would be to produce a cadre of Administrators who could give leadership not only to their own FPCs, but to the FPS world in general, by stimulating management and organisational development activity in their own localities, within groups of FPCs, contributing to the development of more effective regional organisation of FPCs, and producing potential Management Development Advisers (see below).

9.1.8 A further aim would be to attempt to change the training culture of the participants' FPCs so that training needs are no longer confused with activities that effective managers would see as part of management, e.g. implementing performance review and appraisal, identifying career development plans for staff, particularly managers in the organisation, and gearing training and development to those plans.

9.1.9 We recommend that the education centre mounting such a top management programme should co-opt a high profile FPC administrator to assist with programme planning and execution. This co-option, like the MDA proposals made below, should contribute to the career development of high profile administrators in their forties who may be wondering 'where next?'

9.2 <u>Collaborative Workshops</u>

9.2.1 One outcome of the Top Management Development Programme for Administrators could be locally or regionally based collaborative workshops, sponsored by groups of administrators who had been on the programme, using the model developed in the project and which This workshop brought together the administrators and senior management groups of three FPCs. A similar workshop could involve four or five FPCs, and could also include chairmen.

9.2.2 It would be important for the NHSTA or the DHSS to provide funds that could be drawn upon by consortia of FPCs or interested groups of Administrators who wished to mount such workshops, to cover the costs of organisation and a facilitator if they considered this necessary.

9.2.3 The workshops held within the project were highly valued by all participants, and could be a more powerful learning vehicle if run for neighbouring FPCs so that relationships established within the workshop could be continued subsequently.

9.3 MED Programmes not specific to FPCs

9.3.1 In recommending an FPC specific top management programme, we are in no way suggesting that interested administrators should not attend programmes for NHS managers more generally, or indeed programmes for managers in business. These would be addressed to the individual's management development needs however, rather than to FPC organisational development needs, though the effect of a good programme would presumably flow through to the organisation. Attendance on such programmes would be particularly relevant and important for any administrator who wished to move out of FPCs, either temporarily or permanently.

9.3.2 Although a good number of administrators will retire over the next three years, a considerable proportion are in their forties, some of them heading larger FPCs from which there is no promotion in the FPC world. Providing the NHSTA was assured that they intended to move into health authorities, there would be no reason why such administrators should not apply for bursary assistance for such programmes, as we know some already have. It would be helpful if the NHSTA could sustain such a bursary programme, though we realise funds are constrained.

9.4 Senior Managers - General Management Development

9.4.1 As most senior managers have grown up within their own functional specialities within the FPC, and as organisational development will require a more corporate view, we strongly recommend that in addition to participating in collaborative workshops of the kind described in 9.2, they may be encouraged

to attend NHS-wide general management programmes aimed at developing a general management perspective and at developing themselves as managers.

9.4.2 The National Education Centres typically offer programmes that constitute 'short bursts of carefully structured education or training .... away from the workplace' (10). The King's Fund College in the past few months has had a London FPC Administrator on its Corporate Management Programme, a seven-week modular programme for top managers in the NHS, and on the Senior Management Development Programme, a four-week 'time-out' programme for NHS senior managers. The London administrator received some financial support from the Bursary Scheme operated by the NHSTA.

9.4.3 Both managers reported to us the value of attending NHS-wide programmes for extending their own horizons as NHS managers, and for learning more about the strategic and operational management of health authorities with whom they must now work more closely.

9.4.4 Birmingham HSMC's middle managment programme has regularly drawn one or two managers from FPCs, but on the whole FPCs have not drawn heavily on programmes offered by the NECs, reportedly because of the expense of some of the longer programmes and because of FPC perceptions that those programmes are geared more to the needs of HA staff than their own.

9.4.5 There is an element of the vicious circle here. Until more FPC managers use NEC programmes, NECs will not gear their programmes to the needs of FPCs as well as HA staff. The NHSTA may have to act as advocate here. If it were to make known to Centres that it was awarding bursaries to FPC managers who would be looking for NHS-wide MED programmes which specifically took account of the needs of managers in FPCs then there would be greater incentive for Centres to address those needs.

9.4.6 This could be achieved by the inclusion of FPC-specific case material and/or by encouraging or requiring faculty to engage in field development or research in FPCs, and/or by recruiting sufficient FPC participants to form a learning group within the programme.

9.4.7 We must remember that HA participants in these programmes would also gain from having FPC staff on them, as we have found that HA staff are frequently quite ignorant not simply of FPCs but of the organisation of FPS generally.

9.4.8 We would recommend that the NHSTA act as broker, bringing Centre programmes to the attention of FPCs and persuading Centres to take more cognizance of the MED needs of FPCs in designing and marketing their programmes.

9.4.9 Shorter issue-based programmes in Human Resource Development, Information Management, Strategic Management and Planning, would also be relevant not just the longer general management development programmes.

9.4.10 We were concerned to find a predominant commitment to 'classroom education' of the day release type, for these senior managers. In that they award qualifications (DMS, CMS, IHSM, ICSA), they may boost the confidence of long-serving FPC staff and possibly protect them from encroachment of young graduates in the promotion stakes; at least there is a belief that they might do so. This may be quite fallacious if 'qualified' becomes synonymous with 'graduate' in FPCs. Administrators should assure themselves that such programmes are *manager*-centred and offer ample opportunity to work while in the classroom on 'real' issues from the FPC, and that the FPC supports this by offering work experiences that help managers on such programmes develop their own conceptual framework for practice.

9.4.11 If day-release is to continue as a major training option for FPCs, we would recommend that the FPC as buyer of a programme build a close partnership with their providers.

> One of our FPCs has asked a local technical college's Management Studies Department to provide an in-house three-day management course for senior/middle management staff.
>
> One young member of staff has just commenced a DMS course in that department, and two of the staff who have contracted to provide the three-day programme have asked to spend

extra time in the FPC talking to staff, in order to increase the relevance of their day-release programmes such as the DMS to FPC staff. This seems to us to be a commendably entrepreneurial outlook on the part of the institution, and an attempt by the FPC to build a partnership with a particular provider.

9.4.12 We cannot think, however, that this type of day release programme is the answer to FPCs' MED requirements, and would argue that greater emphasis must be placed on positive developmental experiences at the work place balanced by short bursts of carefully structured education or training both at and away from the workplace (10, p24).

9.5 Senior Manager Development - Information Management

9.5.1 Senior managers in all FPC functions but particularly patient data services (Registration) should be able to receive much greater help in the area of computer technology and information management. We recommend intensive workshops in which the principles and techniques of information management are related to the FPC context, or in which there is an opportunity for FPC staff to work in a subgroup on their own issues.

9.5.2 We realise that these needs should be met if the NHSTA's draft strategy on IMT training is implemented, but as that work was precipitated largely by the demands placed on the service by the Korner recommendations, and as Korner explicitly excluded FPS, we fear that the IMT needs of FPCs could be neglected.

9.5.3 Staff need to become much more critical of data and more able to analyse what they have in relation to what they need, or computerisation will result in management and/or data overload.

9.6 Senior Manager development - issue-based development

9.6.1 We also recommend for this group of managers relatively short programmes in financial management and planning, and joint events for patient data managers and those with planning responsibilities.

immediate relevance to managers, and focus on their individual needs. They should build upon managers experience, and use different techniques to illustrate and illuminate the issues, rather than be presented as subject-based theories. If theory is presented, it should be accompanied by opportunity for practical application in realistic case exercises. These short programmes should ideally be organised by consortia of FPCs, enabling them to share perspectives and practice in addressing common issues.

9.6.2 Current issues for finance managers would include the establishment of management budgeting and reporting systems which will:

- promote more effective delegation and financial control over administrative costs within FPCs and which will

- illuminate differences in the spending patterns and activity rates of different practices and practitioners as a foundation for influencing the pattern and mix of services which they provide.

9.6.3 Current issues for administration managers who are charged with the personnel function are those of human resource development, the introduction of effective IPR systems, counselling, discipline, and career development. Personnel responsibilities came late to FPCs and there is a dearth of knowledge and experience, and considerable anxiety about these issues. The capability of senior managers to address the development needs of first-line managers and middle managers, will depend on increasing their competence in these areas.

9.7 Planning officer development

9.7.1 Planning officers have already established regional planning groups. As self-help groups these should be given every support, but we wonder whether their format is as developmental as it could be. We recommend that the NHSTA meet with the organisers of these groups to explore ways of offering developmental support.

9.7.2 Planning officers should also be encouraged to attend programmes on statistical methods, quantitative analysis, data presentation and interpretation which may already exist in local colleges; and should be encouraged to seek opportunities via short term secondments or short external programmes to learn about the planning processes of other organisations, particularly DHAs and local authorities.

9.7.3 We recommend also that planning officers, and patient data managers, should be offered the opportunity to attend shared workshops to learn what each needs and can get from the other; in particular, to focus on the issues of defining quality and accessibility, and development of indicators and measures of both of these.

9.7.4 These workshops should also cover the development of political skills - negotiation, persuasion, constructive PR and publicity.

9.8 First line manager development

9.8.1 This group has the difficult task of motivating people who must maintain accuracy in the execution of detailed work much of which is repetitive and routine. We believe this can only be achieved when first line managers are themselves fully aware of the overall purpose of the organisation and the way in which their own role and those of their staff fit in to this.

9.8.2 Enhancing this awareness is the task of high level managers, and we recommend that senior managers in FPCs take responsibility for the development of first line managers, either directly, or through groups of FPCs acting in consortia. We recognise that the needs of first line managers will only be met if their seniors have developed more effective human resource management skills.

9.8.3 The introduction of computer technology will reduce junior staff numbers and change patterns of working, both of junior staff, and of supervisors themselves. Supervisors will need help in adjusting to these changes, handling their own and staff uncertainties, and learning new rewards from encouraging and motivating their juniors instead of from their own greater knowledge and technical skills, which many seem to seek to reserve to themselves at present.

Some of these needs will presumably be met by the NHSTA's IMT strategy, but their personal development to accommodate these changes should be the province of their own managers rather than local college courses, though local colleges can be useful in offering bespoke in-house programmes.

9.8.4 In two of our FPCs turnover at junior levels is higher than it used to be. This places higher demands on induction programmes, which need to be revised and made speedier and more effective. One technique which may help in this is to make more use of simple self-instruction manuals for repetitive procedures along the lines used by one of our FPCs.

9.9 Chairmen and member development

9.9.1 We recommend that individual FPCs and consortia of FPCs take responsibility for the development of chairmen and members. In keeping with the existing training culture of FPCs, previous provision by both FPCs and the DHSS tends to have been dominated by lecture or video as the means of learning, when opportunities for guided or accompanied experience and opportunity to reflect on that experience subsequently would be a much richer means of development in these roles.

9.9.2 This is particularly true of Service Committee work, but is also true of much of the FPC's work which can appear complex and esoteric to newly-appointed chairmen and members. We recommend attachment of new members to more seasoned ones, and attachment of small groups of members to specific members of staff within the FPC.

9.9.3 We also urge more careful targetting of member development effort, as there is little doubt that some members are more willing to become involved than others. Although we did not have time fully to investigate the needs of chairmen and members, the conversations we did have with members suggested that the more competent they felt in their various FPC tasks, the more motivated they became. Again, we consider it vital that they be offered appropriate opportunity to debrief on their first few experiences in sub-committee work.

9.9.4 We understand that within the Chairmen and Members (Health Authorities) Project Team the NHSTA has been exploring the production of modules and packages for

chairmen and members of health authorities. With the recent co-option of an FPC Chairman and Administrator, the Authority is now considering the production of a sister handbook or package for FPCs. As we shall argue in our section on distance learning materials, the production and distribution of materials does not ensure their use. Their 'placement' within the system and appropriate guides to their use are crucial. Such materials are a richer means of learning if they are made the basis of workshops in which participants actively share their experiences of being chairmen and

9.9.5 We realise that most of our recommendations address the management development needs of the employed staff of FPCs, and particularly those of Administrators. We weighted our strategy and recommendations in this direction, rather than that of chairmen and members, because of their different time commitment and the duration of that commitment within the organisation.

9.9.6 The organisational change literature also suggests that the vision, capacity, and commitment of the chief executive is central in changing organisational culture. We do not deny the role of chairmen and members of FPCs in supporting and even pushing for change, but in our experience 'well-managed FPCs' are the creation predominantly of Administrators who possess a sense of purpose and the managerial identity and capacity to pursue it.

9.9.7 Chairmen of FPCs, unlike those of District and Regional Health Authorities, are not paid for their commitment, nor we found are they adequately prepared for the amount of time most of them discover they need to commit to their FPC role, and we cannot imagine that under these conditions they would be capable of producing the organisational change required without significant managerial development of their chief officers.

9.10 Secondments

9.10.1 MED programmes should be supplemented wherever practical by short term secondments of senior managers to other FPCs and wherever this is practical to health authorities. However, experience has indicated that the perception by

Health Authority staff of the role and calibre of FPC managers make such secondments extremely difficult.

9.10.2 FPC managers themselves consider that if they were seconded to a matching grade post in a DHA they would be doing far lower level work than in the FPC. FPC Administrators also feel that while in their own posts they relate as colleagues to DGMs, if they were to be seconded to a DHA they would probably go to a community unit GM post, and would then report managerially to the DGM.

9.10.3 There appears to be little motivation among DHA staff to be seconded to FPCs. We wonder if the DHSS realises how irrelevant many DHA staff even in community units consider the FPC to be to their own work. Most community unit GMs we have met in other contexts prefer to deal directly with the GP representative on the unit or district management board, or with the Local Medical Committee.

9.10.4 In view of this attitude, FPC managers will need to press for secondments for the benefit of their own professional development and the development of their organisations. We consider such secondments vital to the future organisational development of FPCs, and to the development of future career options for younger FPC administrators who already manage large FPCs.

9.10.5 We also recommend that secondments between the DHSS and FPCs be stepped up as a means of rebuilding a relationship which has become increasingly strained.

9.10.6 We recognise that the NHSTA has not authority to seek a resolution to the problems currently surrounding secondment, and can only hope that this report will serve to stmulate discussion of the issue between the two FPC societies and the DHSS at national level.

9.11 Management Development Advisors

9.11.1 Proposals are already under discussion for the expansion of the role of management development advisors within the NHS generally. We recommend that separate MDAs be appointed to work with FPCs since we feel that Health Authority-based MDAs would probably "short-change" FPCs and may well have little or no background in FPCs.

9.11.2 The proposed top manager programme for FPCs could and should be a recruiting ground for MDAs in FPCs. In the absence of regional structures in FPS, MDAs could be seconded to education centres around the country so that they were reasonably accessible to groups of FPCs.

9.11.3 We see the need to develop and implement FPCs' strategy to be so acute that we would want MDAs to focus initially on helping FPCs to address this issue. This would require a small number of MDAs of sufficient calibre and credibility to work with the chairmen and administrators, members and senior officers in individual FPCs or small groups of FPCs.

9.11.4 Although the establishment of an MDA service would be partially or predominantly funded from a levy or from central funds, we believe that FPCs should pay some fee element for the use they make of an MDA as an aid to encouraging their commitment to make effective use of the service.

9.11.5 At lower levels within the FPC organisation, or in specific functional areas, where MDAs may be able to help FPCs address their internal management problems there would be less need to ensure that MDAs had a background in FPCs, e.g. information, financial and human resource management.

9.11.6 From whatever source MDAs are recruited, they themselves will need support. We recommend that this should be established by either or both of the mechanisms of seconding high profile administrator MDAs to education centres, on a basis which could be quite flexible (for example, for a regular day or week a month, or for a certain number of days in a term or a year); or through the institution of 'learning sets' for one or more groups of MDAs working within FPCs. This could well form part of a larger programme of support for MDAs' within which the FPC-based MDAs could form subgroups.

9.12 National Accelerated Development Programme (GMTS)

9.12.1 Some senior managers in FPCs should by now be expecting to take part in GMTS III, some middle managers in GMTS II, and some of the younger, bright graduate recruits to GMTS I.

9.12.2 Our impression is that because RHAs play such a central role in the organisation of these

programmes, FPCs risk missing out on an NHS-wide MED opportunity. In our interim report we urged the NHSTA, as a matter of urgency, to review the relationship between FPCs and the NADP and we understand discussions are in progress currently.

9.12.3 We interviewed one FPC trainee from the National Management Training scheme and were concerned by what we found. Young graduates straight from university do not find FPCs exciting unless they are placed very carefully within the organisation and give ample project work. Young graduates tend to want to spend time at 'the sharp end' e.g. the acute hospital, and the equivalent of the hospital placement needs to be thought through for FPS trainees. The trainee we interviewed left FPCs and got herself a post in a hospital, and we understand that the trainee taken on in her place has since left.

9.12.4 We attach particular importance to the involvement of FPCs in the NADP as ,in the medium to long term, it is one provision that could promote secondments and movement between FPCs and HAs, and a more effective collaboration between the two organisations. The potential benefits of FPC involvement in the scheme cannot afford to be put at risk.

9.13 Distance Learning

9.13.1 The NHSTA has made available to FPCs a booklet designed for members which could also be used for staff induction, and a series of new booklets for staff induction since the completion of our project. These, like the Henley Distance Learning Package 'The Effective Manager' which was supplied to interested FPCs at a subsidised price, will not achieve their optimum impact unless they are 'placed' thoughtfully in a learning-conducive environment.

9.13.2 Such learning materials have a greater chance of being effective if they are part of a 'live' learning situation between two or more people.

9.13.3 Initially the Henley package was sent into each FPC expressing interest and in the three project FPCs we found them unused. In our interim report we recommended that the NHSTA review its use of this package, arguing that it was too daunting in size to

be undertaken by one individual in isolation. We recommended saturating a small number of FPCs with the package, with the recommendation that a senior staff member act as tutor/trainer to a group of interested managers who would work through the programme together.

9.13.4 We recommend that in future distance learning materials are systematically piloted in a small number of FPCs before making them widely available, and that any distance learning material, even the smallest booklet, be accompanied with a guide to extracting maximum learning from it.

9.13.5 The annual programmes and strategy documents now prepared by FPCs as part of their review process could also be used as learning materials in workshops.

9.13.6 In our section on barriers to strategy implementation we refer to the lack of any kind of good practice or learning resource exchange for FPCs, which relates once again to the lack of a regional infrastructure. We recommend that the NHSTA raise this in discussion with the DHSS.

9.13.7 If the NHSTA wishes FPCs to take greater responsibility for their own MED, it could supply them with a catalogue of appropriate learning materials. We considered for example that the exercises in the appendices to Turrill's book (11) on Change and Innovation could be particularly useful in running FPC-based workshops for chairmen, members, managers, or staff.

9.13.8 As part of the project, we have developed self-administered diagnostic questionnaire which Administrators and senior managers can themselves use to identify their own FPCs commitment in practice to management development. It can help them in selecting where to start on further development, and it gives suggestions for appropriate approaches to particular issues of MD which may be diagnosed. The questionnaire is available from John McClenahan at the King's Fund College, 2, Palace Court, London W2 4HS (Tel: 01-727 0581).

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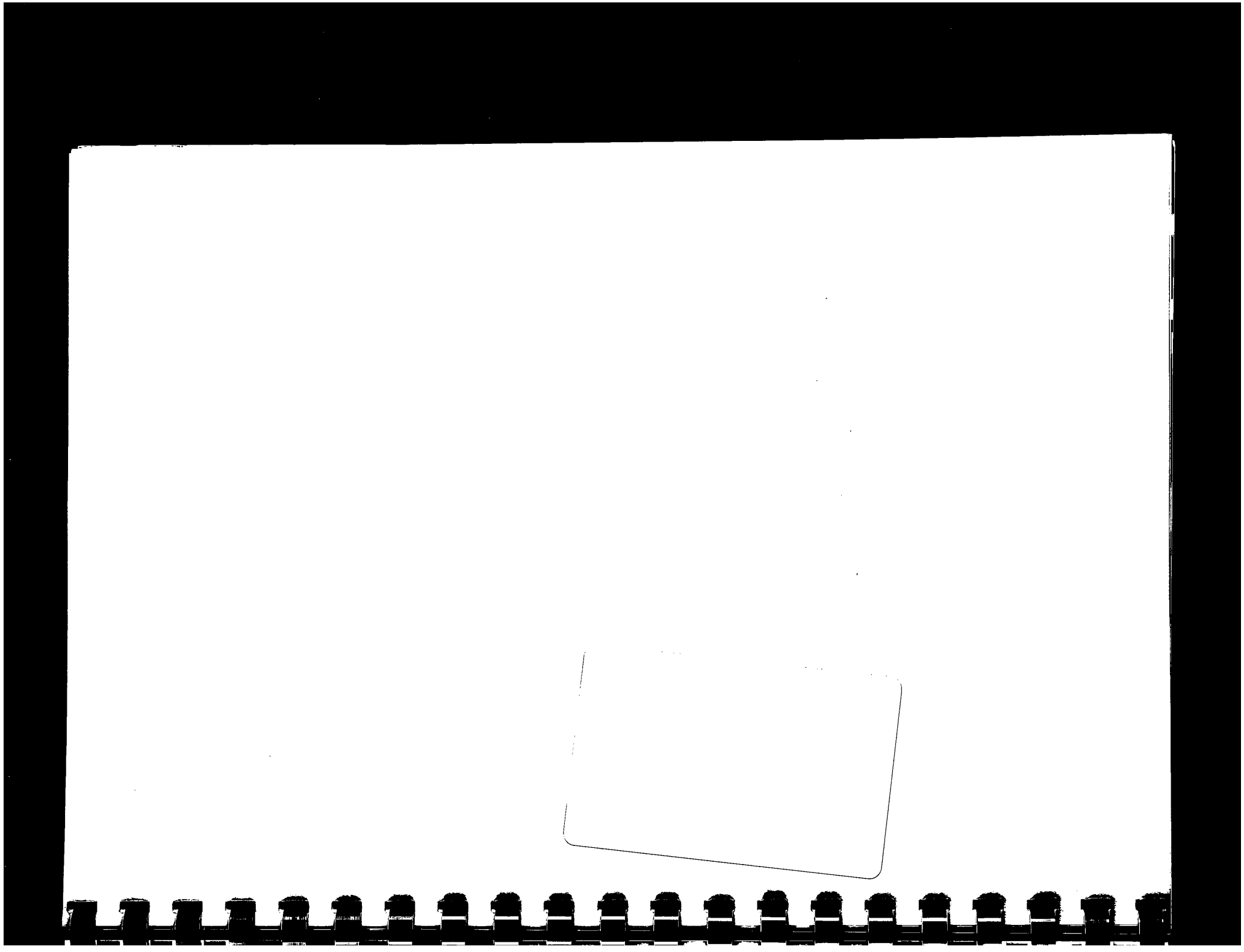

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