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MANAGEMENT DEVELOPMENT FOR CHIEF OFFICERS IN THE NHS

Maureen Dixon & Alison de Metz

Report of a survey

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

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Report of a Survey

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1 Introduction

This report contains the findings of a survey of chief officers on management teams in the NHS in England and Wales. The survey, carried out in 1981, was part of an initiative by the King's Fund to develop a management education programme for the most senior officers in health services.

The initiative was started in the early 1970s (DHSS circulars HRC(73)37, HSC(IS)47, HSC(IS)189) and was given a focus by a study of management training in the NHS carried out by Professor John Thompson of Yale University in 1973.[1] Among his other recommendations Professor Thompson identified the need for an **education** programme catering for the long term requirements of senior administrators, nurses and community physicians. As these professions are so closely bound within the Service, he felt that anything other than multidisciplinary preparation for the responsibilities of the reorganisation in 1974 could not be considered. Indeed, professional education 'precludes meaningful consensus management among peers all of whom are concerned with the effectiveness of the overall health service delivery system'. Furthermore, the principle of a common core with some shared and some separate electives was seen as a valid basis for planning joint educational programmes for the key officers of the National Health Service of the future. It was hoped that this training would facilitate changes from within the health service and would avoid traumatic implementation.

A working party was set up in 1975 sponsored by the King's

[1] Thompson, John D. Training and Education for Health Service Administration in England and Wales. Unpublished report, 1974.

Fund and chaired by Dr Bryan Thwaites, Principal, Westfield College, University of London and then Chairman, Brent and Harrow Area Health Authority. The working party reported in 1977 and again highlighted the relative absence of management development opportunities for the most senior health service managers.[2] This gap had been identified and documented elsewhere both before and after the publication of the findings of the 'Thwaites' working party in, for example, a report by the Business Graduates Association[3], a discussion of the role of the Chief Administrator in the reorganised Health Service[4], *Thoughts on Thwaites*[5] and the National Training Council's report on *Management Education and Training in the National Health Service.*[6]

During the late 1970s, Masters programmes in health service management or allied areas of study were introduced in a number of different universities. Courses at the Administrative Staff College, Henley and the two business schools were also increasingly attended by senior NHS staff, with DHSS support. However, the numbers of chief officers involved in such programmes were, and remain, relatively small.

In 1978 the King's Fund gave financial support for two regional administrators to attend the Harvard Program for Health Systems Management in order to gain experience of this particular approach to the development of senior health service managers. The Harvard Program provided an experience that was of value in many different ways, particularly in

[2] The Education and Training of Senior Managers in theNational Health Service – a contribution to debate. King Edward's Hospital Fund for London, 1977.

[3] Education for Senior Health Services Management. London, Business Graduates Association, 31st March 1975.

[4] The Chief Administrator in the Reorganised Health Service, a discussion document. Association of Chief Administrators of Health Authorities, Wessex Branch, June 1977.

[5] Payne, Leslie. Thoughts on Thwaites: a commentary on management training in the National Health Service. King Edward's Hospital Fund for London, 1979.

[6] Management Education and Training in the National Health Service. National Training Council for the National Health Service, 1979.

giving an opportunity for managers to broaden their managerial skills and analytic capacity. Although the content was not directly related to the National Health Service, the two participants felt that 'senior administrators of all disciplines would benefit from a course that employed the case study method of teaching and created the intense pace and commitment demanded by the Harvard Program.

The King's Fund therefore decided to develop a corporate management programme on an experimental basis, aimed particularly at chief officers and those likely to move into chief officer posts in the near future. The major architects of the development process during this period were Geoffrey Phalp and Pat Torrie, then respectively Secretary of the King's Fund and Director of the King's Fund College. Detailed planning began in October 1980, the main methods of enquiry being a series of workshops with the major professional groups (administrators, community physicians, nurses and treasurers), consultation with health authorities, the DHSS and national education and training bodies, and this survey.

The survey was intended to gain information on chief officers' opinions on the importance of selected 'knowledge areas and skills' which may be relevant to their jobs. Chief officers were also asked about the length and design of the Programme and these questions were aimed at finding the most appropriate format. In addition, demographic information and details of previous NHS experience, educational and professional qualifications and management development courses attended were also sought in order to compile a profile of information on this section of health service personnel.

The primary purpose of the survey was to ensure that the new Programme should be designed with the needs and preferences of senior health services managers in mind. The findings were therefore fed directly into the development process and the first Corporate Management Programme, which started in January 1982, reflects many of the survey

findings. For example, in accordance with the survey findings, the membership is multidisciplinary, the Programme is residential, members select from a variety of topics within the curriculum and undertake a practical project which is carried out after the formal sessions have taken place. As a result of the survey, the curriculum was changed to include a full Option on Personal and Inter-personal Skills and to cover Social and Cultural Aspects of Health in the Opening Core. Reflecting the almost equal preferences for a modular versus a continuous Programme, the format of the first Programme is modular but the second Programme will be organised as one continuous block of six weeks. A description of the structure and content of the first Programme appears in Appendix A.

The 1982 reorganisation of the NHS took place after this survey was carried out but before the production of this report. The content therefore refers to the NHS structure that existed between April 1974 and March 1982; hence the references to the area level. However, it is not likely that this timing had a significant effect on the survey responses apart from some individuals' uncertainty about their futures and a large number of vacant posts.

Much of the information gathered in the survey is likely to be of interest to a wide health service audience. Hence the production of this report, giving a picture of chief officers in the NHS seven years after one major structural reorganisation and a year or so before the next.

2 Chief officers on management teams: a profile

At the time of this survey, the organisational framework of the NHS was the one introduced in 1974 – three tiers of region, area and district in England and areas and districts in Wales. The survey involved chief officers on the management teams at each of these tiers, 1162 posts in total; 889 chief officers (76.5%) returned completed questionnaires.*

During the period since the 1974 reorganisation, there had been numerous studies of the management teams but little was known about the people filling the posts on the teams in terms of their age, experience, professional background and training for management. In order to be able to look at the relationship between these variables and management development needs, the first section of the survey was devoted to filling in this picture. (The questionnaire is reproduced at the end of Appendix B.)

The survey findings show that by 1981 there had already been considerable turnover in these chief officer posts since the 1974 reorganisation (Table 1).

We do not know how many of the posts were filled for the first time during this period. But more than half of the officers had been in their posts for less than 7 years at the time of the survey and the average annual turnover rate since 1974 was 7.4%.

* When interpreting the findings in this report, it should be borne in mind that chief officers at regional level inevitably comprised a small proportion of the respondents – 6.3% compared with 34.5% (area) and 59.2% (district), and that in the professional breakdown of the respondents (regional) works officers constitute only 1.5%. Full details of the survey population and the response rates are given in Appendix B.

Table 1 Time in present job: chief officers on management teams

	%
Under 1 year	6.2
1 – 2 years	8.8
2 – 3 years	8.8
3 – 4 years	9.3
4 – 5 years	6.9
5 – 6 years	3.6
6 – 7 years	8.5
7 years and over	47.9

Sex and age

Of the 885 respondents who gave their sex (4 missing cases), 711 were men, this in spite of the predominance of women in the nursing posts.

Table 2 Sex of respondents by job category

	Female	Male
District administrator	0	139
District community physician	22	98
District nursing officer	84	50
District finance officer	2	131
Area administrator	2	71
Area medical officer	4	68
Area nursing officer	57	21
Area treasurer.	0	80
Regional administrator	0	10
Regional medical officer	1	10
Regional nursing officer	10	1
Regional treasurer	0	12
Regional works officer	0	12

N = 885 Missing cases = 4

Even though nurses comprised 82% of the female respondents, 32% of the chief officers in nursing were men. By comparison, of the total number of nurses on the register/roll in England and Wales, 8% were men (General Nursing Council figures at 13.2.81).

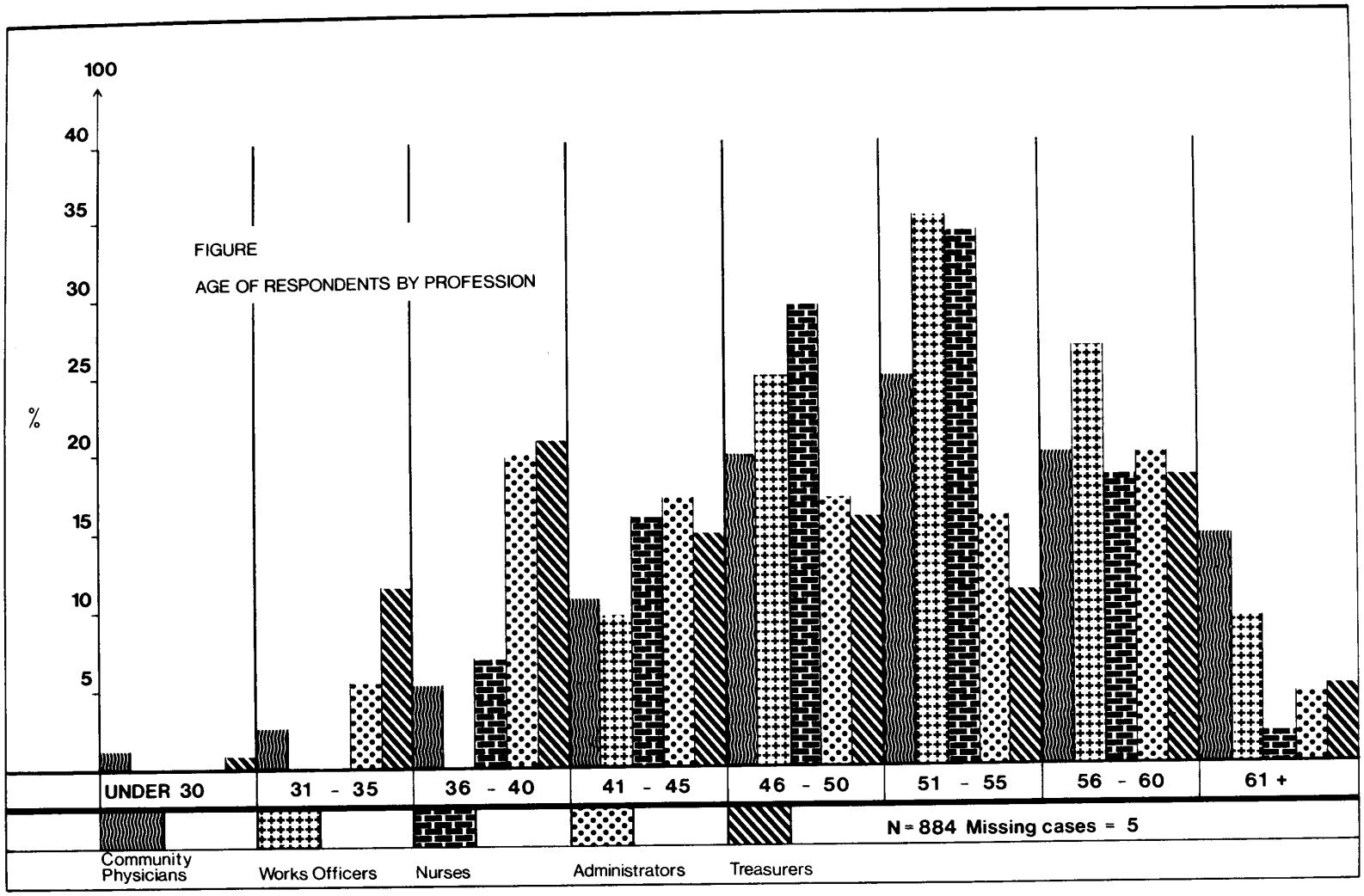
Although the male and female respondents had mean ages of 49 years and 51 years respectively, the age of chief officers differed significantly by profession (see Figure: Age of respondents by profession, page 16).

On the assumption that most chief officers will stay in senior NHS roles for the rest of their careers (and begging the question of the effects of the 1982 reorganisation of the NHS), it appears that relatively few chief officer finance posts will come open during the next 10 to 15 years, 65% of the treasurers being under 50 years of age. The community physicians' age distribution was skewed in the other direction – 62% were over 50 years of age and 36% will reach retirement age in the next 10 years. Nursing and administration showed more even age distribution with 18% of the nurses and 26% of the administrators due to retire in the next 10 years. Of the 12 regional works officers, one third will reach retirement age in the next 10 years.

When the ages of chief officers at the three levels in the NHS were compared, the following picture emerged.

Table 3 Mean age of respondents by profession and level in the NHS

	Administrators	Community physicians	Nurses	Treasurers	Works officers
Region	51	48	49	53	53
Area	50	52	48	51	–
District	48	53	45	49	–


100
40
35
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%
20
15
10
5
FIGURE
AGE OF RESPONDENTS BY PROFESSION
UNDER 30
31 - 35
36 - 40
41 - 45
46 - 50
51 - 55
56 - 60
61 +
N = 884 Missing cases = 5
Community Physicians
Works Officers
Nurses
Administrators
Treasurers

Previous NHS *experience*

When we look at the previous experience of chief officers on management teams, two pieces of information from the survey are relevant – the number of previous NHS jobs held and the number of years experience in the NHS prior to present job. In both instances, there were some striking differences among the professions.

Table 4 Number of jobs in the NHS prior to present job

	Administrators	Community physicians	Nurses	Treasurers	Works officers
	%	%	%	%	%
None	0.9	11.9	0.0	9.6	25.0
1 – 4 jobs	14.6	31.9	8.1	54.5	50.0
5 – 9 jobs	75.7	46.5	65.6	35.9	25.0
10 – 14 jobs	8.4	9.2	24.0	0.0	0.0
More than 15 jobs	0.4	0.5	2.3	0.0	0.0

N = 864 Missing observations = 25

Table 5 Number of years NHS experience prior to present job

	Administrators	Community physicians	Nurses	Treasurers	Works officers
	%	%	%	%	%
None	0.9	11.4	0.0	8.9	25.0
1 – 9 years	2.1	20.7	1.8	28.2	16.7
10 – 19 years	43.4	27.5	16.6	33.9	50.0
20 – 29 years	42.5	31.2	66.8	26.3	8.3
More than 30 years	11.1	9.3	14.8	2.7	0.0

N = 878 Missing observations = 11

Note For these analyses, medical and nursing posts with local government have been included as NHS employment.

Measured by these two indicators, nurses were the most experienced of the professional groups. Administrators were comparable to nurses in terms of years of NHS experience – 97% of the administrators and 98% of the nurses had 10 years or more previous experience – but the administrators had held fewer NHS jobs than the nurses.

By comparison, the treasurers and the community physicians were less experienced in the NHS, with 63% and 68% respectively with 10 years or more experience. For 11% of the community physicians and 9% of the treasurers, their present job was their first in the NHS.

If we compare the previous experience of chief officers at the three levels in the system, it seems that area officers tended to have longer NHS experience than their regional or district counterparts. Of the area officers, 58% had over 20 years previous experience compared with 49% for regional officers and 48% for district officers.

Educational and professional qualifications

Respondents were asked to give details of degrees, diplomas, certificates or similar educational or professional qualifications held. It was thought that the answers might show interesting differences among the professions and among the three levels in the NHS which might be related to different expressed needs for management training. Many different qualifications were reported and for purposes of analysis it was necessary to group them as shown in Table 6. The chief officers in the survey had received a total of 2541 educational or professional qualifications. (No data for this question were collected from 12 respondents, either because they did not give the information or because they had received no qualifications.) The earliest received qualification was in 1930 and the most recent in 1981.

Community physicians tended to be the most highy qualified of the professional groups in terms of both academic and

professional qualifications. This does, of course, reflect the career structure of community medicine in that, unlike the other professions, the basic professional qualifications are degree-based.

Table 6 Number of educational and professional qualifications held by profession

Qualification	Administrators	Community physicians	Nurses	Treasurers	Works officers	Total
Doctorate	0	29	0	1	0	30
Masters	23	24	9	6	2	64
Bachelors	75	176	10	18	4	283
Diploma*	52	177	63	14	2	308
Certificate	9	8	146	6	1	170
Registration	0	1	212	0	0	213
Professional Fellow	73	82	5	70	9	239
" Member	12	165	2	142	4	325
" Associate	149	3	1	105	6	264
" Licentiate	2	42	0	3	0	47
" Other	0	7	4	1	0	12
Other	1	2	0	0	0	3

In analysing the major fields of study in which the qualifications were obtained, it was again necessary to group the responses under arts, science, social science, health management, general management and professional studies (Table 7).

For our purposes, the most interesting finding here is that administrators had the largest number of qualifications concerned specifically with management. Of the 315 respondents with at least one qualification in health services management, 63% were administrators. Of the 135 respondents with at

Table 7 Major field of study of qualification by profession

Major field of study	Administrators	Community physicians	Nurses	Treasurers	Works officers
At least one qualification in:	%	%	%	%	%
Arts (n = 63)	79	8	6	6	0
Science (n = 31)	23	58	3	10	6
Social science (n = 63)	63	5	17	13	2
Health management (n = 315)	63	2	19	16	0
General management (n = 135)	47	7	7	37	2
Professional field of study (n = 637)	3	31	33	30	2
Other (n = 3)	67	0	33	0	0

least one qualification in general management, 47% were administrators. It is recognised that some professional qualifications include a component of management topics – the postgraduate qualifications of the Faculty of Community Medicine for example – but it would have been misleading to classify these professional fields of study as primarily managerial in content.

An analysis of qualifications held by level in the NHS (district, area, region) revealed no striking findings. A slightly higher percentage of regional officers held at least one qualification than their area or district counterparts and the lowest percentage was at district level. However, this picture is consistent with the rising age gradient from district to region shown on page 15.

Only 47 (5%) of the respondents were actively working towards an educational or professional qualification, of whom 15 were administrators, 11 were community physicians, 10 were nurses and 11 were treasurers. Expected dates of award of qualification ranged from 1981 to 1988. As might be expected, a greater percentage of district officers were studying for a qualification (6%) than area (4%) or regional officers (2%).

Management training experience

During the development of the Corporate Management Programme, it was argued by some that there were already ample opportunities for senior health service managers to pursue studies in management and that yet another programme, albeit different in focus and level, would be superfluous. It therefore seemed important to look at the pattern and type of management training that chief officers had experienced.

Since 1950, 744 of the respondents had attended a total of 1527 management courses of more than five days duration (Table 8); (145 or 16% of the respondents had no such management training). The figures show the huge increase in management training during the 1960s and 1970s.

Table 8 Number of management courses attended 1950–1979

1950 – 1954	18
1955 – 1959	32
1960 – 1964	99
1965 – 1969	323
1970 – 1974	745
1975 – 1979	244

Missing cases = 17

Note These figures do not include management training resulting in a degree, diploma, certificate or other educational or professional qualification.

By far the most active period was around the 1974 re-organisation of the NHS. The decline in management training for chief officers during the second half of the 1970s is continuing, with only 26 courses attended in 1980 and 13 in the first half of 1981. Table 9 shows where the courses were provided.

For purposes of further analysis, the various management

Table 9 Number of management courses by institution/agency

Institution/agency	Number of courses
NHS training centres:	
King's Fund	270
Nuffield Centre for Health Service Studies, University of Leeds	150
Health Services Management Centre, University of Birmingham	47
Centre for Health Services Management, Leicester Polytechnic	32
Health Services Management Unit, University of Manchester	21
NHS Studies Centre, Harrogate	15
General management centres:	
Henley Administrative Staff College and London and Manchester Business Schools	199
Civil Service College	17
Other universities:	
in UK	363
In North America	17
Regions (RHB, RHA)	123
Other polytechnics	68
Professional association or institute	44
Other colleges	42
Other	96

Missing cases = 23

courses were grouped under 5 headings: senior, middle and first-line management, the National Administrative Training Scheme (NATS) and specialised management. (The types of courses included in each category are shown in Appendix B, page 62. It should be noted however that the large number of courses provided around the time of the 1974 NHS re-organisation have been categorised as 'specialised management courses'.)

Table 10 shows the percentage of each profession that had attended at least one non-degree management course.

Table 10 Management course attendance by profession

Level of courses attended	Administrators n=225	Community physicians n=203	Nurses n=223	Treasurers n=225	Works officers n=13
	%	%	%	%	%
At least one senior management course	74	36	87	44	38
At least one middle management course	25	14	52	17	15
At least one first line management course	4	0	17	1	0
NATS	14	0	0	1	0
At least one specialised management course	35	56	36	20	31
At least one other management course	2	1	1	1	0

A higher percentage of nurses had attended at least one senior, middle or first-line management course than the other professions although the difference decreases for higher level courses. Community physicians, on the other hand, were the least represented in terms of attendance on senior, middle or

first-line management courses. However, a higher percentage of community physicians had attended at least one specialised management course than the other professions. (The Hunter Courses and courses on clinical aspects of management accounted for a large proportion of those specialised management courses.) This indicates that community physicians saw their training needs to be in more specialised areas rather than in management and reinforces the data in Table 7 on page 20 which show that community physicians comprised only 2% of the respondents with at least one educational and professional qualification in health management, and only 7% of those with a qualification in general management. Of those with at least one qualification in a professional field of study, 31% were community physicians.

When the data are analysed by level in the system, as in Table 11, it appears that there was a lower take-up of management training opportunities by regional chief officers compared with their area and district counterparts.

Table 11 Management course attendance by level in the NHS

Level of courses attended	Chief officers at region n=56	Chief officers at area n=306	Chief officers at district n = 527
	%	%	%
At least one senior management course	46	60	62
At least one middle management course	14	26	29
At least one first line management course	2	5	7
NATS	4	3	4
At least one specialised management course	48	39	33
At least one other management course	2	0	2

With the exception of the National Administrative Training Scheme and specialised management courses, the management training experience of the respondents was greatest at district level and lowest at regional level. The higher take-up of specialised management courses by regional officers was accounted for by their relatively high attendance on specialised, professional courses (for example, health care planning, industrial relations, information, computers), and on courses related to the 1974 reorganisation. It seems likely that this pattern was again related to the rising age gradient between district and region and to the kinds of activities carried out by the regional officers – less concerned with operational management and more concerned with planning and technical functions.

The percentage of chief officers who are ex-NATS was interestingly even throughout the system.

3 Chief officers' management development needs

A major objective of the survey was to obtain information on which to base the design of the Programme curriculum. The planning workshops had produced a good deal of information on what the particular professional groups thought should be covered in the curriculum and studies of other comparable programmes had provided additional information. But the survey was an opportunity to obtain much more comprehensive information from the practitioners themselves.

Problem areas

The first question, aimed at establishing general areas of need for management development, asked – What are the greatest difficulties or problem areas in your present job? Respondents were asked to list no more than 3 problem areas. Ninety-four per cent of the respondents listed at least one problem and 52 specific problem areas were mentioned in total. The problem areas were grouped for analysis as shown in Table 12.

Managerial problems were the most frequently mentioned and constituted 25% of all the problems listed. The main area of concern was lack of time and respondents felt that too many demands were made of them and that there was too much paperwork. A second specific difficulty was team work and covered areas such as consensus decision making, corporate management and inter-professional boundaries. Managing and achieving change were also mentioned. No doubt the problems listed reflected the climate of the NHS at the time,

Table 12 Problems or difficulties identified

Problem areas	Percentage of problem areas listed
Managerial	25
Financial	21
Staff/subordinates	17
Relationships	16
Policy and planning	11
Other	10
	100

affected by the forthcoming reorganisation and relatively recent changes in management structure.

Financial problems were the next most frequently mentioned area (21%). The most commonly reported problems were a shortage of financial resources, cash limits, financial constraints and the application of the RAWP formula.* Linked to this were the problems of resource allocation and the achievement of an equitable distribution of resources with no clear policy on allocation. A small percentage of comments (2%) referred to the poor quality and lack of up-to-date financial information.

Staff/subordinates and related problems accounted for a total of 17% of all the problems listed. Within this category, 27% of comments referred to the low calibre of support staff in terms of inadequate qualifications and training and the inability to delegate. Twenty-two per cent of the comments in this category mentioned the lack of commitment and low morale, the difficulty of maintaining the motivation of staff and the impact of reorganisation on these problems. Of all the com-

* Great Britain, Department of Health and Social Security. Sharing Resources for Health in England: report of the Resources Allocation Working Party. London, HMSO, 1976.

ments made, 10% indicated that the limits on establishments, presumably for financial reasons, and the resulting shortage in staff were the cause of the problems in this area.

Relationships with individuals and organisations both within and outside the National Health Service made up 16% of the difficulties listed. The most frequently mentioned relationship was that with team members. This echoes the reported difficulty with team work and consensus decision making mentioned above under managerial problems. Doctors received some criticism in this area; 14% of the comments about difficult relationships related to the lack of support from the medical profession and the possibility of conflict. Relationships with other staff and the inadequacies of the present structure were also listed as being problem areas.

Policy and planning was the area which gave rise to the least number of problems or difficulties (11% of all problems listed). Within this category changing government policy on the NHS was cited as being the most important problem (24%), followed by the setting and conflict of priorities. Finally, planning in general was mentioned as a cause for concern in 17% of these cases.

Knowledge areas and skills

The second and more specific area of enquiry into management development needs was structured around 9 areas of knowledge and skills (KAS). These areas had been derived from a study of the literature and other programmes for senior managers and from curriculum areas suggested at the five planning workshops. The 9 areas were:

Health Policy and Politics
Social and Cultural Aspects of Health
Economic Factors in Health Services
Financial Management
Planning
Analytical Methods and Skills

Organisational Analysis and Design
Industrial Relations
Personal and Inter-personal Skills

In each case illustrative sub-topics or subjects were listed which might fall within these broad areas – see Questions 8 and 9 on the questionnaire, Appendix B.

Respondents were asked to score on a five-point scale each of the 9 KAS from two points of view – importance for successful performance in their present **job** and their **personal** need for further education and training in that area. The purpose of structuring the question in this way was to distinguish between the relatively impersonal demands of the job in terms of knowledge and skills and the particular needs of those in the jobs at the time.

Mean scores for each KAS were obtained and these were then arranged in rank order, 1 being highest and 9 being lowest. It is important to note that in some cases the actual difference between mean scores for two or more of the KAS is not very great.

It is most useful to examine the findings regarding **successful job performance** first in order to give some background to problem areas discussed on pages 26–28 and to provide a basis for comparison with personal need for further education and training. The answers given highlighted some interesting differences among the professions, levels and jobs within a profession (Table 13).

Overall, Personal and Inter-personal Skills was ranked as the most important KAS for successful performance in the present job. Among the professions this was ranked highest by the administrators, nurses and works officers and relatively low by the community physicians. Conversely, Social and Cultural Aspects of Health was the most important KAS for community physicians and the least important for all the other professions except the works officers. In general, the community physicians' ranking was the most different from the population as a whole. It is rather surprising that administra-

Table 13 Rank order of knowledge areas and skills – importance for present job by profession

	Administrators	Community physicians	Nurses	Treasurers	Works officers	All
Personal and Inter-personal Skills	1	5	1	3	1	1
Planning	3	3	5	4	5	2
Economic Aspects of Health	6	6	4	2	2	3
Health Policy and Politics	2	4	3	6	6	4
Financial Management	7	8	2	1	3	5
Analytical Methods and Skills	8	2	8	5	7	6
Organisational Analysis and Design	5	7	7	7	3	7
Industrial Relations	4	9	6	8	7	8
Social and Cultural Aspects of Health	9	1	9	9	7	9

tors ranked Financial Management and Analytical Methods and Skills so low – 7th and 8th respectively.

When we look at the same data analysed by level within the professions the following picture emerges.

Table 14 Administrators' rank order of knowledge areas and skills – importance for present job

	PIPS	HP&P	PLAN	IR	OA&D	ECON	FM	AM&S	SCAH
District	1	4	2	3	5	6	7	8	9
Area	1	2	3	5	4	6	7	8	9
Region	3	1	3	6	7	2	5	9	8
All administrators	1	2	3	4	5	6	7	8	9

PIPS – Personal and Inter-personal Skills; HP&P – Health Policy and Politics; PLAN – Planning; IR – Industrial Relations; OA&D – Organisational Analysis and Design; ECON – Economic Aspects of Health; FM – Financial Management; AM&S – Analytical Methods and Skills; SCAH – Social and Cultural Aspects of Health.

Administrators as a profession ranked Health Policy and Politics higher than other professions and within the profession it was ranked 1st by regional officers, 2nd by area officers and 4th by district officers. On the other hand district administrators ranked Personal and Inter-personal Skills, Planning and Industrial Relations higher than the other KAS and higher than area or regional officers ranked them. Economic Aspects of Health was also more important for regional officers than for district and area officers.

Table 15 Community physicians' rank order of knowledge areas and skills – importance for present job

	SCAH	AM&S	PLAN	HP&P	PIPS	ECON	OA&D	FM	IR
District	2	1	3	4	5	6	7	8	9
Area	1	2	3	5	4	6	7	8	9
Region	1	6	4	2	5	3	8	7	9
All community physicians	1	2	3	4	5	6	7	8	9

Community physicians attached much more importance to Social and Cultural Aspects of Health for successful performance of their jobs than the other professions and this was common to all three levels. As with the administrators, Health Policy and Politics was relatively more important to the regional officers than to those at area and district, whereas the converse was true of Analytical Methods and Skills. Industrial Relations was ranked 9th (last) by community physicians at all levels, presumably reflecting the fact that, unlike the other professions, they do not have responsibility for extensive managerial hierarchies.

Personal and Inter-personal Skills was ranked highest by the nurses although those at region ranked it only 4th. Financial Management was ranked second overall with less discrepancy among the levels. Health Policy and Politics, and Economic Aspects of Health were seen to be more important

Table 16 Nurses' rank order of knowledge areas and skills – importance for present job

	PIPS	FM	HP&P	ECON	PLAN	IR	OA&D	AM&S	SCAH
District	2	1	5	7	3	4	5	8	8
Area	1	2	3	4	5	6	7	8	9
Region	1	1	3	3	6	5	7	8	9
All nurses	1	2	3	4	5	6	7	8	9

to regional officers but, as with the administrators, those chief officers at the district attached more importance to Industrial Relations and Personal and Inter-personal Skills. Organisational Analysis and Design was also more important to district and area officers than those at region.

Table 17 Treasurers' rank order of knowledge areas and skills – importance for present job

	FM	ECON	PIPS	PLAN	AM&S	HP&P	OA&D	IR	SCAH
District	1	2	3	4	5	6	7	8	9
Area	1	2	3	4	5	6	7	8	9
Region	1	1	3	3	6	5	7	8	9
All treasurers	1	2	3	4	5	6	7	8	9

For the treasurers, level in the system had little effect on the importance of the various KAS; treasurers' rankings were much more similar through the three levels than the other professions. Financial Management and Economic Aspects were rated 1st and 2nd respectively but Analytical Methods and Skills was rated only 5th.

(There is of course no analysis here of the works officers' responses since the works officers in the survey were all at regional level.)

The second area of enquiry concerned the same knowledge areas and skills (KAS) according to the respondents' own **personal need for further education or training**. Again, mean

scores were obtained and these were then arranged in rank order. When we compared the responses to this question to the responses on importance for present job, some interesting differences emerged.

Table 18 Knowledge areas and skills – importance for job and need for further education and training

	Importance for job		Need for further education and training	
	Mean score	Rank order	Mean score	Rank order
PIPS	4.58	1	3.05	3
PLAN	4.40	2	2.95	4
ECON	4.36	3	3.21	2
HP & P	4.35	4	2.74	8
FM	4.22	5	2.91	5
AM & S	4.17	6	3.50	1
OA &D	3.99	7	2.85	6
IR	3.77	8	2.77	7
SCAH	3.68	9	2.56	9

Apart from the different rank orders, the mean scores for 'need for education' were consistently lower than those for 'importance for job', but it is difficult to draw any conclusions from this. It could be that chief officers felt that they were relatively well prepared to meet the demands of their jobs. But we do not know what assumptions the chief officers made in responding to the question on need for further education. In view of the impending reorganisation, it may not be reasonable to assume that they answered with their present job in mind. We do know, from comments added to the questionnaire, that some respondents did not answer this question or scaled their responses low because of the unstable situation or their impending retirement.

Analytical Methods and Skills was the area in which re-

spondents felt they had the greatest need for further education and training and yet this ranked only 6th in importance for the successful performance of their jobs. On the other hand, Personal and Inter-personal Skills, which was ranked the most important for successful performance in their present job, was ranked 3rd in terms of need for further education and training.

The same inverse relationship applied to Planning and Health Policy and Politics. Respondents may have felt sufficiently proficient in these areas already or they may have seen these subjects becoming less important in their own futures.

In view of the considerable differences among the professions in level and type of qualification, in experience of management training and in the importance of the various KAS for their jobs, it might have been expected that they would also report rather different **needs for further education and training**. But when analysed by profession (Table 19), there was a remarkable consistency among the professions in their KAS rankings in terms of need for further education and training. The works officers did show a somewhat different

Table 19 Rank order of knowledge areas and skills – need for further education and training by profession

	Administrators	Community physicians	Nurses	Treasurers	Works officers	All
AM & S	1	1	1	1	ė	1
ECON	3	2	3	4	1	2
PIPS	2	3	8	2	ė	3
PLAN	8	4	4	3	5	4
FM	5	5	2	9	4	5
OA & D	4	6	6	6	ė	6
IR	7	9	5	5	9	7
HP & P	6	8	7	7	ė	8
SCAH	9	7	9	8	ė	9

ranking but the very small numbers in this group could explain the difference.

Within administration, area and district administrators appeared to have remarkably similar needs for further education and training, whilst the needs of the regional administrators were quite different.

Table 20 Administrator's rank order of knowledge areas and skills – need for further education and training

	AM&S	PIPS	ECON	OA&D	FM	HP&P	IR	PLAN	SCAH
District	1	2	3	4	5	6	7	8	9
Area	1	3	2	5	4	7	6	8	9
Region	2	9	1	6	4	3	6	8	4
All administrators	1	2	3	4	5	6	7	8	9

Another interesting comparison is with the data shown in Table 14 on page 30 (Administrators' rank order of KAS – importance for present job). The most striking difference here was in the area of Analytical Methods and Skills; this subject was ranked 8th in terms of importance for present job but 1st in need for further education and training, perhaps reflecting the way in which administrators see their responsibilities in the future. On the other hand, the areas of Health Policy and Politics and Planning were ranked high on importance for job but low on need for further education, the implication being that administrators felt already well prepared in these areas.

In the case of community physicians (Table 21), again there was a degree of similarity between district community physicians and area medical officers but these rankings were less different from the regional level than in the case of administrators.

Table 21 Community physicians' rank order of knowledge areas and skills – need for further education and training

	AM&S	ECON	PIPS	PLAN	FM	OA&D	SCAH	HP&P	IR
District	1	2	4	3	5	6	7	8	9
Area	1	2	3	5	4	6	7	9	7
Region	4	1	2	7	3	7	5	5	9
All community physicians	1	2	3	4	5	6	7	8	9

As might have been expected, Health Policy and Politics was more important to regional medical officers and they reported a greater need for further education and training in this area than district and area officers. All community physicians ranked Economic Aspects fairly high in terms of need for further education and training and yet area and district officers ranked it 6th in importance for their present job. Social and Cultural Aspects of Health was ranked 1st for importance to the job but was ranked only 7th for need for further education and training, again implying that community physicians felt well prepared in this area.

Area and district nursing officers reported quite similar needs for further education and training overall and in the areas of Analytical Methods and Skills, Financial Management, Economic Aspects and Organisational Analysis and Design, these needs were similar to those of regional nursing officers. However, regional nursing officers ranked Planning and Industrial Relations lower than their area and district counterparts and Health Policy and Politics, Personal and Inter-personal Skills and Social and Cultural Aspects of Health all ranked higher.

The nurses also ranked the KAS quite differently on need for further education compared with importance for job – 1st and 8th respectively for Analytical Methods and Skills, 8th and 1st for Personal and Inter-personal Skills and 7th and 3rd for Health Policy and Politics.

Table 22 Nurses' rank order of knowledge areas and skills – need for further education and training

	AM&S	FM	ECON	PLAN	IR	OA&D	HP&P	PIPS	SCAH
District	1	2	3	4	5	5	7	8	9
Area	2	3	1	4	4	6	7	8	9
Region	2	3	1	7	9	7	4	5	5
All nurses	1	2	3	4	5	6	7	8	9

Treasurers reported a low level of need (9th) for training in Financial Management although this area was the most important for their job. They reported however a high level of need for training in Analytical Methods and Skills. Unlike area and district officers, regional treasurers ranked Personal and Inter-personal Skills low, as they did Economic Aspects. However, Social and Cultural Aspects was the area in which regional treasurers reported most need for further education and training, whereas area and district officers ranked this KAS 8th.

Table 23 Treasurers' rank order of knowledge areas and skills – need for further education and training

	AM&S	PIPS	PLAN	ECON	IR	OA&D	HP&P	SCAH	FM
District	1	2	3	4	6	5	7	8	9
Area	1	3	2	4	4	7	6	8	9
Region	2	8	4	7	4	6	2	1	9
All treasurers	1	2	3	4	5	6	7	8	9

Of the works officers included in the survey population (works officers on regional management teams) the response rate was high (93%). However, as mentioned on page 13 and shown in Table 30 on page 59 of Appendix B, (regional) works officers constituted only 1.5% of the respondents and

this small percentage must be borne in mind when considering the statistical validity of any analysis of these data.

Table 24 Works officers' rank order of knowledge areas and skills – importance for present job and need for further education and training

	PIPS	ECON	FM	OA&D	PLAN	HP&P	AM&S	IR	SCAH
Importance for job	1	2	3	3	5	6	7	7	7
Need for further education and training	2	1	4	2	5	6	6	9	6

Comparison of works officers' rank order of KAS in terms of importance for present job and need for further education and training shows a high degree of consistency, in contrast to the whole population – see Table 18 on page 33. Again, mean scores for need for further education and training were consistently lower than scores for importance for present job. When compared with the rank order of the other professions at the regional level ('importance for successful performance in present job'), Health Policy and Politics and Planning were ranked relatively lower (5th and 6th respectively) and Organisational Analysis and Design and Personal and Inter-personal Skills were ranked relatively higher (3rd and 1st respectively). These same differences appeared when a comparison was made on the basis of 'need for further education and training'. These data suggest that works officers saw their management development needs differently from the other professions represented on the management teams.

A comparison with the problem areas identified earlier does provide a rough indicator of the significance of these findings. To some extent, the KAS rank order on need for further education and training does reflect the reported problem areas. For example, the kinds of problems grouped under

the heading of managerial problems which were the most often reported would be addressed by the 1st ranked KAS Personal and Inter-personal Skills. On the other hand, financial problems were the 2nd most often mentioned yet Financial Management was ranked only 5th in terms of need for further education and training. Economic Aspects was ranked 2nd suggesting that chief officers perhaps saw the resolution of their financial problems lying more in better understanding of extrinsic economic factors than in improved financial management within their organisations.

But if we take the findings at face value, the general picture emerging from this area of enquiry is:

considerable variation in importance of KAS for present job among the different professions and at the different levels

little variation in expressed need for further education and training in the KAS among the different professions

a tendency among the professions and at the three levels to identify a **high** need for further education and training in KAS which are judged to be relatively **unimportant** for present job.

If these findings are valid, the implications for management development are considerable. They suggest that, other things being equal, a multidisciplinary format with the same content being provided for all the professions may be quite appropriate. But it also seems that if education and training are concentrated in those areas where the greatest need is reported, there is likely to be relatively little pay off in terms of more effective job performance.

Additional knowledge areas and skills

Respondents were given an opportunity to suggest additional knowledge areas and skills which they felt were important. One hundred and seventy-seven respondents (20%) men-

tioned at least one additional KAS which were grouped under eleven broad headings as shown in the Table below.

Table 25 Additional knowledge areas and skills

Areas identified	Percentage of total additional KAS listed
Communications skills, public speaking, committee practice, conduct of meetings	17
Any specific or general KAS related to particular professional discipline (for example, treasurers – CBA, ZBB; nurses – nurse education; community physicians – preventive medicine, epidemiology)	13
Monitoring, evaluating, controlling	9
Managing change, implementing policy	7
Allocation of own priorities, use of time, delegation, judgement, balance of work	7
Computers in the NHS	7
Politics, influencing, political acumen	5
Training, staff development, training subordinates, training in the NHS	5
Law, medical ethics, legal aspects	4
International comparisons, comparative health systems	3
Other	23
	100

4 Programme design

To assist in the development of the Corporate Management Programme, the survey also sought information on various aspects of the Programme design. These included aspects which are the subject of great debate in the field of management education and which had been discussed in the planning workshops.

Programme characteristics

The first set of questions asked about respondents' preferences with regard to some basic characteristics of the Programme. The results are summarised in the table below.

Table 26 Preferences on programme characteristics

Question	Responses % Yes	% No	% Not important
Do you think the Programme should:			
have a multidisciplinary membership?	87.9	7.0	5.1
be residential?	82.2	3.0	14.8
allow members to select from a variety of topics?	68.7	17.8	13.5
incorporate a practical project?	51.0	19.8	29.2
result in a degree, diploma or other qualification?	13.6	31.9	54.5

It seems that the current emphasis on multidisciplinary, residential, non-qualifying courses is in line with the prefer-

ences of the clientele. The support for the Programme to allow choice of topics and to incorporate a practical project, although significant, was not so strong. This may suggest that the arguments in favour of choice within curriculum and project work are usually educational arguments put forward by the management educators rather than by the clientele.

When these data were analysed against the various variables, the following differences emerged.

Age did seem to have some effect on preferences. The younger and older age groups tended to be more in favour of a multidisciplinary programme than those in the middle age groups. Those in the age group 36 to 40 years were also less in favour of a project element than the other age groups. Age was also associated with preference on the Programme resulting in a degree, diploma or other qualification; with the exception of the 41 to 45 age group, the older the respondent the more likely he/she was to think that the Programme should not result in a qualification.

Profession appeared to be related to preference on the question of a residential programme, community physicians and works officers being less in favour of a residential basis than the other professions. With regard to selection from a variety of topics, the nurses and administrators were strongly in favour, the community physicians and treasurers less so, and the works officers showed least support for this idea. On the other hand, treasurers were most strongly in favour of a project element in the Programme. Of the five professional groups, nurses were most in favour of a multidisciplinary membership, closely followed by treasurers; administrators were least in favour and community physicians fell in between the treasurers and administrators.

Level in the NHS seemed to have little relationship to preferences apart from a slight tendency for regional officers to be more in favour of a residential programme, the selection of topics and the Programme **not** resulting in a qualification than their area and district counterparts.

Length of programme

The second area of questioning on programme design concerned how long the Programme should be, bearing in mind the demands of the job and impending changes in the NHS. Responses to this question ranged from one week to one year, the mean length being 5 weeks. (Seventy-five people failed to answer this question although 225 chose to expand on their answer pointing out various problems, particularly those likely to be caused by the impending NHS reorganisation.)

The preferred lengths of the Programme by profession (expressed as means) were nurses 5.8 weeks, treasurers 5.1 weeks, works officers 4.9 weeks, administrators 4.8 weeks and community physicians 3.6 weeks. It is interesting to note that this pattern was consistent with the amount of management training that the chief officers had received (see Table 10 page 23). So perhaps preferred programme length is not so much a function of profession *per se* as of amount of previous management training experience.

There was a distinct tendency for the desired programme length to decrease as age, years of NHS experience and number of jobs in the NHS increased.

Programme format

The aspect of programme design about which there was, and continues to be, most debate is the format for the Programme: should it be organised in a single, continuous block of time or should it be separated into sessions, or modules, of one or two weeks spread over a period of some months? The educational principles, much argued in the management development field at present, concern the virtues of intensive, concentrated work in a setting where the day-to-day realities of job and family cannot intrude versus the benefits of alternating periods of study and normal work, thus deliberately blurring the distinction between theory and practice. The single block, intensive model is extant in many centres of

management education such as Harvard and the business schools whereas the modular format is being tried out in the Nuffield Centre and the Birmingham University Health Services Management Centre.

Fifty-four per cent of those who responded to this question felt that the Programme should be of a modular design and 46% felt that it should be organised in a single continuous period; 28 people did not answer this question. There does appear to be a relationship between age and profession in this respect; 100% of those 30 years or younger and 75% of those aged 31 to 35 preferred the modular design, compared with an average of 52% in the other age groups. Among the professions, there was not much variation in the percentages preferring a modular design, the exception being the works officers, 75% of whom thought this design was preferable.

The final question gave chief officers the opportunity to make any further comments. Forty-seven per cent of the respondents made at least 1 comment and these were categorised under 4 main headings as listed on page 65 of Appendix B. Within these broad headings, 14 more specific areas were identified. Of the comments made, 58% concerned the Programme and were expansions of answers given to previous questions; (questions 8, 9, 10, 11 of the questionnaire in Appendix B – survey instruments). Five per cent of the comments specifically supported the purpose, design and philosophy of the Corporate Management Programme and 5% referred to the irrelevance of the Programme because of the individual's closeness to retirement (see page 33).

5 Summary of findings

A survey of chief officers on management teams in the National Health Service in England and Wales was conducted in April and May 1981. There was one main and very specific purpose, namely to find out about chief officers' management development needs. Along with the results of other developmental work in this field, the information formed the foundation for the content and design of the King's Fund Corporate Management Programme.

At the time of the survey, there was relatively little provision of management development programmes for the most senior officers in the NHS. In designing a programme aimed specifically at this group, it seemed sensible to ask them directly what they felt they needed. Little was known about this group as a whole so the survey was also an opportunity to obtain basic information on chief officers on management teams.

Chief officers on management teams: a profile

At the time of this survey, the organisational framework of the NHS was the one introduced in 1974 – three tiers of region, area and district in England and areas and districts in Wales. Since 1974 there had been considerable turnover in posts, and more than half the chief officers had been in their jobs for less than 7 years, the average annual turnover rate being 7.4%.

Of the respondents who gave their sex, 80% (711 cases) were men, in spite of the predominance of women in the nursing posts. The mean age of chief officers differed signifi-

cantly by profession; for example, 65% of the treasurers were under 50 years of age whereas 62% of community physicians were over 50 years of age. This age distribution has obvious implications for retirement and replacement. For all professions except community medicine, the mean age of the respondents rose from district to regional level. The pattern was reversed in the case of community physicians.

Previous experience in the NHS was measured by both the number of jobs held and the number of years NHS experience prior to the present job. Measured by these indicators, nurses were the most experienced professional group, 98% having had 10 years or more previous experience, compared with 63% of treasurers, the least experienced professional group. For 9% of the treasurers their present job was their first in the NHS. When comparison on the basis of level was made, area officers were the most experienced.

Community physicians were the most qualified group, in terms of educational and professional qualifications, although administrators had the largest number of qualifications concerned with management. Slightly more regional officers held at least one educational or professional qualification than their area or district counterparts, but this was consistent with the rising age gradient from district to region. Similarly, a greater percentage of district officers were currently studying for a qualification (6%) than area (4%) or regional officers (2%).

Since the period of the 1974 NHS reorganisation, there has been a declining trend in chief officers' attendance on management courses of more than 5 days' duration. A higher percentage of nurses had attended at least one management course than the other professions whereas more community physicians (56%) had attended a course on a more specialised subject (for example, clinical aspects of management, Hunter Courses). Fewer regional officers had attended a management course compared with area and district officers, although the regional officers were more highly represented

(48%) in the take-up of courses on a specialised subject (for example, the reorganisation in 1974, personnel, computers).

Chief officers' management development needs

Chief officers were first asked to list up to three difficulties associated with their jobs. Twenty-five per cent were management problems such as lack of time, too much paperwork, consensus decision making and managing and achieving change. Financial problems constituted 21% of the problems listed and difficulties associated with relationships with staff and subordinates made up 17% of the problems.

Chief officers were then asked to score 9 selected knowledge areas and skills (KAS) according to the **level of importance for their present job**. These were analysed in terms of the rank order of the mean scores and some interesting differences between the professions and levels were highlighted.

Overall, Personal and Inter-personal Skills was ranked as the most important KAS for successful performance in the present job. Among the professions this was ranked highest by the administrators, nurses and works officers and relatively low by the community physicians. Conversely, Social and Cultural Aspects of Health was the most important KAS for community physicians and the least important for all the other professions except the works officers. In general, the community physicians' ranking was the most different from the population as a whole.

When these data were analysed by level in the NHS, differences among regional, area and district officers did emerge. Regional officers' rankings were the least consistent with the population as a whole, highlighting the different demands of regional *vis-a-vis* district/area posts. However, for the treasurers, rankings were much more similar through the three levels than for the other professions.

The same 9 selected KAS were scored by the chief officers according to the **level of need for further education and**

training. Again, the mean scores of the KAS were analysed in terms of their rank order. Apart from the different rank orders, the mean scores for 'need for education' were consistently lower than those for 'importance for job'.

Analytical Methods and Skills was the area in which respondents felt they had greatest need for further education and training and yet this ranked only 6th in importance for the successful performance of their jobs. On the other hand, Personal and Inter-personal Skills, which was ranked the most important for successful performance in their present job, was ranked 3rd in terms of need for further education and training. The same inverse relationship applied to Planning and Health Policy and Politics. Respondents may have felt sufficiently proficient in these areas already or they may have seen these subjects becoming less important in their own futures.

In view of the considerable differences among the professions in level and type of qualification, in experience of management training and in the importance of the various knowledge areas and skills to their jobs, it might have been expected that they would also report rather different needs for further education and training. But when analysed by profession, there was remarkable consistency among the professions in their KAS rankings in terms of 'need for further education and training'. The works officers did show a somewhat different ranking but the very small numbers in this group could explain this difference.

When comparisons within each profession were made by level, there was a degree of similarity between district and area chief officers' rankings and these rankings tended to be quite different from those of regional officers. However, there was little similarity among the professions at regional level.

Comparison of works officers' rank order of KAS, both for 'importance to present job' and for 'need for further education and training', showed a high degree of consistency.

This was in sharp contrast to the whole population, but it must be remembered that the works officers constituted only 1.5% of the respondents to the questionnaire. These data suggest that works officers saw their role as fundamentally different from those of the other management team members.

The rank order of KAS did to some extent reflect the problem areas mentioned earlier. However, three main factors emerge: there is

considerable variation in importance of particular KAS for present job among the different professions and at different levels

little variation in need for further education and training in the KAS among the different professions

a tendency among the professions and at the three levels to identify a **high** need for further education and training in KAS which are judged to be relatively **unimportant** for the present job.

These findings imply the suitability of multidisciplinary management development opportunities with the same content being provided for all the professions. In addition, if education and training are concentrated in those areas where the greatest need is reported, there is likely to be little pay off in terms of more effective job performance.

Programme design

Chief officers tended to prefer multidisciplinary, residential, non-qualifying courses but were less in favour of being able to select from a variety of topics and the incorporation of a practical project.

With the Corporate Management Programme specifically in mind, chief officers were asked about the preferred length of the Programme and the desired format. The mean preferred programme length was 5 weeks, although quite large differences emerged when comparisons by profession were

made. These differences reflected the varying amounts of previous management training experience. However, when considering the two programme formats put forward – one single continuous block of time versus sessions of one or two weeks spread over some months – the differences in opinion were very small. Fifty-four per cent of the respondents felt that the Programme should be of a modular design and 46% felt it should be organised in a single continuous period.

Forty-seven per cent of the respondents made at least one further comment. Of these, 58% of the comments referred to the Programme, and more specifically, were expansions of answers to previous questions. The number of other comments made about the Programme, the clientele, the individual or the questionnaire was too small to be analysed statistically.

Appendix A The first corporate management programme

The first Corporate Management Programme, run on a modular basis, started in January 1982 and over a period of seven months includes a total of six weeks in residence at the King's Fund College. The objective of the Programme is to increase the effectiveness of corporate managers in the complex and uncertain conditions that characterise health service management. To meet this basic objective and to accommodate the different individual and professional needs, the Programme enables members to

develop knowledge and skills in areas with which they are relatively unfamiliar

apply these knowledge areas and skills in analysis of practical issues and problems

manage their own professional and corporate work more effectively and thus direct the development of their organisations.

The Programme is distinctive in that it combines

a focus on the health services specifically, informed by reference to other public and private sector activities

a concentration on corporate and strategic aspects of health services management

a modular structure, requiring only short absences from work and allowing the immediate practical application of the knowledge and skills applied

each member choosing from a variety of areas of study and influencing the topics to be covered within these areas.

The initial two-week Core session has been followed by a series of one-week Options on particular aspects of health service management from which each member has selected at least three topics. A further one-week Core session will be held in July 1982.

The 16 members on the first Programme are drawn from nursing, finance, community medicine, administration and personnel. Thirteen of the members are from the NHS, of whom 11 are now chief officers. One member is from DHSS and the other 2 members work in health services in Saudi Arabia and Iceland.

Throughout the Programme the emphasis is on tailoring the content to meet individual needs. Much of the work is in small group settings. The purpose of the initial two-week Core session was to develop an understanding of the generic issues involved in corporate management in health services and to lay the foundation for the later, more specialised components of the Programme. The 3 main themes of the Core were the environment, principles of management and corporate management in health services. In addition, Option previews were held and members developed individual learning plans so that they could get as much as possible out of the Programme.

Based on the survey findings, the Option topics are:

health policy and politics

organisational analysis and design

analytical methods and planning

economic aspects of health

personal and inter-personal skills

financial management.

Case studies and other practical exercises are used where appropriate and Option programmes are kept as flexible as

possible to allow groups of members to pursue topics of particular interest.

During the course of the Programme members are encouraged to identify a practical project to be undertaken after the formal sections of the Programme have been completed. The project should be in an area of particular interest to the members and should aim to integrate the various topics and to test the relevance of the knowledge gained during the Programme. An important part of the second Core is the development of plans for the project. Project advisers will be identified to work with members who will be encouraged to consider publication of their project work.

The first Programme is being studied by an external team of experienced evaluators in order to test out different ways of evaluating an educational experience of this kind. The evaluation study, funded by a grant from the Office of the Chief Scientist, DHSS, will be completed and written up towards the end of 1982.

The first Programme has been taking place alongside the current reorganisation of the NHS and it is difficult to know precisely what the effects of the unusual prevailing conditions have been. It could be argued that such turbulent times were not the best in which to launch a new management programme and the organisers and no doubt the members of the first Programme have some sympathy with this point of view. But inauspicious as the timing may have been, it does seem likely that the Programme will be subjected to a more critical evaluation by officers and employing authorities than might have been the case in more affluent and settled times.

Appendix B Survey methods

The survey of chief officers on management teams in the NHS was carried out between April and May 1981. The questionnaire and other survey instruments are reproduced at the end of this Appendix. The conduct of the survey was based on a similar survey of health service managers in Canada in 1977 and 1978, undertaken by a study team from the University of Toronto's Department of Health Administration.* In particular, W R Mindell advised on the questionnaire design, coding, programming and analysis of the data.

Survey population

The questionnaire was sent out to 1162 chief officers on management teams – region, area and district – in the NHS in England and Wales. This number included equal numbers (287) of administrators, community physicians, nurses and treasurers and 14 regional works officers. (The very small number of works officers should be borne in mind when interpreting the statistical information given in this report.)

Of the total population of 1162, 70 were at regional level, 392 at area and 700 at district. Throughout the analysis, chief officers in single district areas have been included in the area category.

Wales accounted for 88 of the total population and is shown separately in any analysis by region.

* Hastings J E F, Mindell W R, Browne J W and Barnsley J M. Canadian Health Administrator Study. Canadian Journal of Public Health Vol, 72 Supplement One, March/April 1981.

Questionnaire design

A draft questionnaire was designed and pre-tested in February 1981 on a 23% selected sample of the population plus 50 colleagues in the field of education and training. Pre-testers noted their comments on the draft questionnaire and on an evaluation form. The questionnaire was revised in the light of these comments.

Knowledge Areas and Skills The topic areas and specific subjects listed in the questionnaire were identified as those most relevant to the training needs of chief officers on management teams. Prior to the survey, a series of workshops was held for the major professions represented at management team level and these were attended by practitioners both in the health service and in academic institutions. Among the issues discussed at the workshops was the question of programme content and the results of these discussions formed the basis of the list of Knowledge Areas and Skills.

In addition to the workshops, an extensive analysis of the curricula of comparable courses both in the UK and abroad was carried out and meetings were held with interested individuals in the health service and other organisations. This information was combined with that gained from the workshops and refined to give the final list of Knowledge Areas and Skills. On the questionnaire, respondents were asked to score the nine subject areas according to the level of importance of that subject for successful performance in their present job and their level of need for further education and training. The scale ranged from 1 (not important, no need) to 5 (very important, great need).

A number of questions was also asked to help establish the programme design. Such questions were whether the membership should be multidisciplinary or not, if the course should be residential, whether members should be allowed to select from a variety of topics, if the programme should incorporate a practical project and result in a degree, diploma

or other qualification. In addition, the respondents were asked how long they thought the programme should be in weeks, and whether it should be organised as one single continuous period of time or separated into sessions of one or two weeks spread over some months.

A final open-ended question allowed the respondents to make further comments.

Judging by the satisfactory response rate and the consistency of the responses, the questionnaire was effective in obtaining the information required. The only slight problem arose with questions 8 and 9 where respondents were asked to give a single score on a five-point scale for each of the main headings under Knowledge Areas and Skills. Some respondents pointed out that they would have liked to give different scores to the individual sub-topics listed as illustrative of the main headings. In fact, this format was the one in the pre-test questionnaire, respondents being asked to score each sub-topic. This produced an extremely long and daunting list to be scored and was generally criticised by the pre-testers. It was therefore felt necessary to simplify the questionnaire and reduce the time required to complete it, recognising the consequent loss in precision.

Distribution of questionnaires

The survey was conducted by post and all questionnaires were sent on 14 April 1981. In addition to the questionnaire the survey package included a covering letter signed by the members of the Project Team, an explanatory note about the survey and a self-addressed envelope for the return of the questionnaire. The first postal follow-up, on 5 May 1981, when the response rate was 48%, contained a questionnaire coded in a different colour from the original questionnaire, a covering letter, the explanatory note about the survey and a self-addressed envelope.

A third follow-up, by phone, was started on 18 May 1981,

but was not completed as the response rate was already over 70%.

Responses to the survey

Of the 1162 questionnaires sent out, 889 (76.5%) were returned completed. The response rates by region are shown in the table below.

Table 27 Response rates by region

Northern	83.9	
Yorkshire	78.3	
Trent	80.6	
East Anglian	71.1	
North West Thames	84.1	Apart from the low response rate
North East Thames	79.4	from Wales there appears to be no
South East Thames	72.9	obvious geographical pattern in the
South West Thames	78.1	response rates, the four highest
Wessex	84.2	being from Wessex, North West
Oxford	71.1	Thames, Northern and Trent
South Western	77.3	regions.
West Midlands	71.5	
Mersey	73.6	
North Western	72.9	
Wales	64.8	

The response rates calculated on the basis of level in the NHS were: regions 81.4%, areas 78.6% and districts 75.3%. By profession the rates were: works officers 92.8%, treasurers 78.7%, administrators 78.7%, nurses 76.6% and community physicians 71.1%.

In general, the response rates were acceptably representative of the actual distributions in the survey population. (Table 28).

Table 28 Representativeness of responses by region

Region	% population (n = 1162)	% respondents (n = 889)	Difference
Northern	7.0	7.6	+0.6
Yorkshire	8.3	8.5	+0.2
Trent	8.0	8.4	+0.4
East Anglian	3.9	3.6	−0.3
North West Thames	8.7	9.6	+0.9
North East Thames	8.3	8.7	+0.4
South East Thames	7.3	7.0	−0.3
South West Thames	6.3	6.4	+0.1
Wessex	4.9	5.4	+0.5
Oxford	3.9	3.6	−0.3
South Western	4.6	4.6	nil
West Midlands	9.4	8.8	−0.6
Mersey	4.6	4.4	−0.2
North Western	7.3	7.0	−0.3
Wales	7.5	6.4	−1.1

Again, there was no clear regional pattern in the representativeness of the response rates, apart from a tendency for Wales and the central and north western parts of England to be under-represented (Table 29).

Table 29 Representativeness of responses by level in NHS

Level	% population (n = 1162)	% respondents (n = 889)	Difference
Region	6.0	6.3	+0.3
Area	33.7	34.5	+0.8
District	60.3	59.2	−1.1

It is perhaps surprising that the area tier was the most over-represented in terms of response rates, since the forthcoming reorganisation of the NHS might have been expected

to have the greatest negative effect on officers at this level. It may be that the inclusion of the 41 single district areas in the area category compensated for this potential effect.

Table 30 Representativeness of responses by profession

Profession	% population (n = 1162)	% respondents (n = 889)	Difference
Administrators	24.7	25.4	+0.7
Community physicians	24.7	22.9	−1.8
Nurses	24.7	24.8	+0.1
Treasurers	24.7	25.4	+0.7
Works officers	1.2	1.5	+0.3

When the representativeness of the responses by profession was calculated, the most striking finding was the under-representation of the community physicians compared with the slight over-representation of the other four professions (Table 30).

It may be that the community physicians saw the survey as less central to their professional interests and jobs than did the other groups. But another factor was the relatively large number of community medicine posts which were vacant at the time or being filled by someone with another role elsewhere in the system.

The non-responses are analysed in Table 31, page 60.

Chief officers on district management teams (DMTs) comprised the largest sub-group in the survey population (700 of 1162) and there was only one DMT from which no responses at all were received. Only one response was received from 6 DMTs, 2 responses from 38 DMTs, 3 responses from 75 DMTs and in 55 DMTs all the four chief officers responded.

Coding of the questionnaires

A coding manual was developed initially containing only those codes for fixed choice questions. Responses were coded

Table 31 Reasons for non-response by profession

Reason for non-response	Non-respondents (n = 273)				
	Administrators	Community physicians	Nurses	Treasurers	Works officers
	n	n	n	n	n
Reason unknown	38	61	43	51	–
Vacant post	2	7	6	3	–
Refusal:					
no reason given	8	8	1	–	1
no time	–	–	2	–	–
imminent retirement	1	–	4	–	–
acting in role	2	1	–	3	–
because of NHS reorganisation	2	–	2	–	–
Dual role	2	5	4	3	
Away, on leave	3	1	1	1	–
Questionnaire completed by wrong person	1	–	1	–	–
Questionnaire returned too late	3	1	–	1	–

onto specifically designed coding sheets and Project Team members made random checks on each other's coding. In addition, regular discussions took place to ensure that consistent coding practices were being followed. The coded data were keypunched onto cards and later transferred to magnetic tape for the first analysis. Codes for the open-ended questions were developed later and incorporated into the code book. The same coding procedure as for the fixed choice questions was followed and these data were merged with the initial data for final analysis.

Analysis of data

Data processing and analysis were performed using the Statistical Package for the Social Sciences (SPSS) at the University of London Computer Centre. The analysis was not intended to be exhaustive but to provide basic descriptive information consistent with the objectives of the study. The

data for fixed choice questions were analysed first to give the basic demographic details and information on choices of Knowledge Areas and Skills. Those analyses consisted of a comparison of profession and job categories and a comparison of choices of Knowledge Areas and Skills on a number of variables and a description of the differences which existed. It was not thought worthwhile to carry out more complex analyses, such as regression, aimed at identifying the variables which might explain the differences.

For all the variables basic frequency distributions were prepared. Further analyses, controlling for specific variables, were then carried out. In all analyses, the main independent variable was profession, although the number of works officers (n = 12) was really too small to justify any detailed analysis or breakdown.

Other comparisons were made on the basis of the following variables:

length of time in present job

years experience in the NHS prior to present job

number of previous jobs held in the NHS

age

sex

Educational qualifications Respondents were first asked to note if they had no educational qualifications at all, then to give details of educational qualifications held. Twelve codes were used to cover academic and professional qualifications for all five professions covered in the survey.

Six main codes were used to cover the major field of study of each qualification and subjects were grouped as follows:

arts for example, history, English

science for example, chemistry, maths, biochemistry, physiology

social science for example, economics, sociology, politics

health management for example, hospital administration, health administration, health policy, health planning

non-health management for example, public administration, personnel, secretarial practice, company law, public policy

professional studies for example, law, finance, accountancy, nursing administration.

Comparisons were made on the basis of job, profession and level in the service. The same codes were applied to qualifications currently being sought.

Respondents were asked about management training (courses of 5 days or more) that did not result in a degree, diploma, certificate or other educational or professional qualification. In the coding, five broad categories of courses were identified:

senior or top management training for example, Senior Management Development Course, Experienced Senior Managers Course, international seminar, management courses for district management teams

middle management training for example, hospital secretaries course, matrons course, departmental management course

first line or supervisory training for example, ward sisters course, Administrators Development Course

National Administrative Training Scheme

specialised management training for example, 1974 reorganisation courses, clinical aspects of management, Hunter Course, courses for personnel officers, catering officers, finance officers, courses on planning, information, computers, industrial relations

regional courses

Again, comparisons on the basis of job, profession and level in the service were made.

As mentioned in the body of this report, Chapter 3, page 26, chief officers were asked to list up to 3 problems or difficulties they had encountered in their present jobs. It was hoped that this question would help the respondents to focus their attention on the 9 selected KAS. Analysis of the answers indicated some 52 specific problem areas which were grouped under 5 main headings:

financial for example, resource allocation, RAWP, constraints, and lack of information and control

relationships for example, with the health authority, region, areas, other districts, CHCs, DHSS, local authority, team members, other professions, coordinative role of the administrator and the inadequacies of the present structure

staff/subordinates for example, quality and quantity, motivation, recruitment, IR, career development

management for example, consensus decision making, balancing workload and demands, divided loyalties, quality control, technological developments, role definition, managing and achieving change

policy and planning for example, changing government policies, priority setting, strategic planning, manpower planning.

The above categories are quite broad but they were developed after a fairly detailed analysis of the problem areas mentioned in a sample of questionnaires. Indeed, some of the codes were developed after this analysis as different kinds of problems were mentioned. The analysis of these data was done for the population as a whole and then compared with the analysis of the rank order of KAS which was done first.

The analysis of choice of Knowledge Areas and Skills (KAS) was by job category, profession and level in the NHS. Mean scores were prepared and these were then arranged in rank order, 1 being most important and 9 being the least important. The additional KAS that were given were analysed after the fixed choice questions. Again, codes were developed which covered the KAS given by a sample of respondents with later modifications as necessary. The additional KAS groupings are listed below.

any general or specific KAS related to a profession or discipline: for example, epidemiology, zero base budgeting, nurse education

allocation of own priorities, judgement, delegation and the use of time

communications skills, public speaking, committee practice, conduct of meetings

law, legal aspects, medical ethics

computers

international comparative health systems

politics and political acumen

managing change and implementing policy

monitoring, evaluating, controlling

training and staff development.

The questions regarding preferred programme characteristics were analysed by all variables (age, sex, job, profession, level, previous NHS experience etc) in order to get the widest cross-section of answers. The mean programme length in weeks and most favoured programme format were also extensively analysed for the same reason.

Analysis of general comments was approached in the same way as the other open-ended questions. Four main types of

comments were identified: comments about the programme, the clientele, the individual, the questionnaire. Within these groups a total of 14 specific comments was identified. Again, although some of the nuances of the comments may have been lost, the relatively small numbers justified the groupings for statistical purposes. Analysis was not done by specific variables, but for the population as a whole.

Survey instruments

A complete set of survey instruments follows, including an explanatory letter dated April 1981, an explanatory note about the survey, the survey questionnaire and a follow-up letter dated May 1981.

King Edward's Hospital Fund for London

King's Fund College
2 Palace Court
London W2 4HS
Telephone 01-229 9361

April 1981

Dear Colleague,

King's Fund Corporate Management Programme:
Survey of Chief Officers in the NHS

A new Corporate Management Programme designed to meet the needs of chief officers on management teams in the NHS is being developed under the aegis of the King's Fund. As part of the preparation for the Programme, we are carrying out this Survey of chief officers to find out what they see as the needs in this area.

Enclosed are an explanatory note 'About this Survey' and the questionnaire. We need your cooperation in the Survey and will be most grateful if you would devote a few minutes of your time to completing the questionnaire.

A code number appears on the questionnaire so that we can keep track of those returned. Please note that each response will be treated confidentially and no individual answers will ever be identified or made known to others.

The results of the Survey will be written up in a report which will be available in the summer.

Could you return the completed questionnaire in the prepaid envelope provided, if at all possible by April 30.

Thank you in advance for your assistance.

Yours sincerely,

Maureen Dixon BA MPhil
Associate Director

Alison de Metz BSc
Project Coordinator

King Edward's Hospital Fund for London

King's Fund College
2 Palace Court
London W2 4HS
Telephone 01-229 9361

KING'S FUND CORPORATE MANAGEMENT PROGRAMME

About this survey

You may already know that the King's Fund is developing an experimental Corporate Management Programme. The Programme is intended to fill a gap in the existing provision of management development opportunities for senior health service managers which was identified in the Thwaites Report*. The distinctive quality of the Programme will be its emphasis on corporate and strategic aspects of health services management and therefore chief officers on management teams in the NHS are seen as the primary clientele.

The Fund intends to launch the new Programme in the autumn of 1981. The DHSS is fully aware of this development as are the National Staff Committees and the National Training Council. The Programme is being developed in close cooperation with the NHS management education centres and with other relevant organisations.

This Survey is being carried out as part of the preparation for the Programme. The questionnaire is being sent to all chief officers on district management teams, area management teams, area teams of officers and regional teams of officers. A large part of the questionnaire is devoted to obtaining your opinion on the importance of selected 'knowledge areas and skills' which may be relevant to your job; this information will be used in the identification of the Programme content. There are also questions about the length and design of the Programme which are aimed at finding the most appropriate format.

It is important to achieve a high response rate in the Survey in order that the Programme can be directed to the real needs of corporate managers in the NHS. Your cooperation in completing the questionnaire will be greatly appreciated. All responses will be treated with the strictest confidence.

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* The Education and Training of Senior Managers in the National Health Service: a contribution to debate. King Edward's Hospital Fund for London, 1977.

King Edward's Hospital Fund for London

KING'S FUND CORPORATE MANAGEMENT PROGRAMME:
SURVEY OF CHIEF OFFICERS IN THE NHS

King's Fund College, 2 Palace Court, London W2 4HS April 1981

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1. What is your present job title?_____

How long have you been in your present job?_____ years_____ months

How long did you work in the NHS prior to your present job?_____years

How many jobs in the NHS did you have prior to your present job?_____ jobs

2. **Age:**_____ years

3. **Sex:** Female ☐ Male ☐

4. List below any degrees, diplomas, certificates or similar educational or professional qualifications which you have received.

If you have not received any such qualifications please tick this box ☐

Qualification	Year Obtained	Major Field of Study	Institution or Agency Granting Qualification

5. If you are now actively working towards any qualification please list below.

Qualifications Sought	Expected Date	Major Field of Study	Institution or Agency Granting Qualification

6. Have you ever had any **management** training that did not result in a degree, diploma, certificate or other educational or professional qualification (for example, senior management development course)? *Indicate below, omitting courses of less than five days duration.*

Description or Title of Training	Year of Training	Institution or Agency Giving Training

7. What are the greatest difficulties or problem areas in your present job? *List up to three below.*

1. _____
2. _____
3. _____

The following two questions ask about the knowledge areas and skills which you consider important in your present job and in which you may need further education or training.

8. Using the scale provided, please circle below the level of **importance for successful performance in your present job** of each group of knowledge areas and skills. *(Circle)*

9. Using the scale provided, please circle below the level of **your own need for further education or training** in each group of knowledge areas and skills. *(Circle)*

KNOWLEDGE AREAS AND SKILLS

	Not Important ... Very Important		No Need ... Great Need
HEALTH POLICY AND POLITICS e.g. policy analysis ... the politics of health ... government policy and health services ... policy development, priority setting and implementation ... consumer and community involvement in health services ... the law as it relates to health care ... the relationship between health services and local government	1 2 3 4 5		1 2 3 4 5
SOCIAL AND CULTURAL ASPECTS OF HEALTH e.g. concepts of health and illness ... the doctor-patient relationship ... health promotion and prevention of illness ... ethical and moral issues in health care ... socio-economic and environmental factors in health ... health care in other countries ... the impact of technological innovation	1 2 3 4 5		1 2 3 4 5
ECONOMIC FACTORS IN HEALTH SERVICES e.g. methods of financing health services ... public expenditure survey and the Treasury role ... equity in health care distribution ... economic definitions of health status and the measurement of health ... value judgements and economic analysis ... economic appraisal (for example, cost benefit analysis)	1 2 3 4 5		1 2 3 4 5
FINANCIAL MANAGEMENT e.g. allocation and redistribution of financial resources ... preparation and analysis of budgets ... financial control (for example, public accounts committees, regional and local systems) ... accounting principles and methods ... control of capital schemes ... analysis of financial information ... financial management techniques	1 2 3 4 5		1 2 3 4 5

Not Important				Very Important		No Need				Great Need
1	2	3	4	5	**PLANNING** e.g. theories of planning applied to the NHS ... operational and strategic planning ... central government planning and the NHS ... joint planning and collaboration ... manpower planning ... information for planning ... public participation in planning	1	2	3	4	5
1	2	3	4	5	**ANALYTICAL METHODS AND SKILLS** e.g. understanding and interpretation of statistical data ... operational research and systems analysis ... computer applications in health services ... evaluation methods (for example, of services or quality of care) ... understanding and interpretation of epidemiological information ... problem solving and decision making ... research methods	1	2	3	4	5
1	2	3	4	5	**ORGANISATIONAL ANALYSIS AND DESIGN** e.g. organisational theories applied to health services ... organisational design ... the impact of professionalism on organisation ... health authorities, members and their relationship to officers ... organisational aspects of working in groups and teams .. inter-organisational relationships ... achieving change	1	2	3	4	5
1	2	3	4	5	**INDUSTRIAL RELATIONS** e.g. theories of industrial relations applied to health services ... structure, government and policies of unions ... national and local negotiations and consultation ... negotiating ... the State and the politics of industrial relations ... closures and redundancies	1	2	3	4	5
1	2	3	4	5	**PERSONAL AND INTER-PERSONAL SKILLS** e.g. leadership, motivation and styles of management ... working in groups and teams ... dealing with conflict and stress ... delegation and control ... staff development ... self-assessment and self-development ... public relations and media relations ... use of time ... learning skills	1	2	3	4	5

There may be some knowledge areas and skills that are omitted from the above list and that you feel are important. *Please list these below and answer questions 8 and 9 for each.*

Not Important				Very Important		No Need				Great Need
1	2	3	4	5	________________	1	2	3	4	5
1	2	3	4	5	________________	1	2	3	4	5
1	2	3	4	5	________________	1	2	3	4	5
1	2	3	4	5	________________	1	2	3	4	5
1	2	3	4	5	________________	1	2	3	4	5
1	2	3	4	5	________________	1	2	3	4	5
1	2	3	4	5	________________	1	2	3	4	5
1	2	3	4	5	________________	1	2	3	4	5
1	2	3	4	5	________________	1	2	3	4	5
1	2	3	4	5	________________	1	2	3	4	5

To assist in the development of the King's Fund Corporate Management Programme, the following two questions seek your views on the design of the Programme.

10. Do you think the Programme should:

	Yes	No	Not Important
... have a multi-disciplinary membership?	☐	☐	☐
... be residential?	☐	☐	☐
... allow members to select from a variety of topics?	☐	☐	☐
... incorporate a practical project?	☐	☐	☐
... result in a degree, diploma or other qualification?	☐	☐	☐

11. Bearing in mind the demands of your job and impending changes in the NHS:

How long should the Programme be?________________ weeks

Which of the following do you prefer?

A. That the Programme is organised in a single, continuous period of time.

B. That the Programme is separated into sessions of one or two weeks spread over a period of some months.

A ☐ ⟵ *Please indicate preference* ⟶ ☐ B

12. We would welcome any further comments you would like to make. *Please attach additional sheets if necessary.*

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THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

<u>BE ASSURED THAT ANY INFORMATION PROVIDED BY RESPONDENTS IN THIS SURVEY WILL BE TREATED WITH THE STRICTEST CONFIDENCE.</u>

Please return the questionnaire in the enclosed prepaid envelope.

King Edward's Hospital Fund for London

King's Fund College
2 Palace Court
London W2 4HS
Telephone 01-229 9361

May, 1981

Dear Colleague,

A few weeks ago we sent you a copy of the enclosed questionnaire and explanatory note as part of a Survey of Chief Officers in the NHS. The Survey is being carried out to assist us in the planning of a new Corporate Management Programme for senior NHS managers. We also expect that the information gained from the Survey, which will be made available in a report, will provide valuable data for the planning and adaptation of NHS management development generally.

We have not yet received your completed questionnaire. We realise that this is a time when people take annual leave; or it may be that the original questionnaire did not reach you. So may we again ask for your cooperation in completing the enclosed questionnaire and returning it to us in the enclosed prepaid envelope by May 15th.

Thank you in advance for your assistance.

Yours sincerely,

Maureen Dixon BA MPhil
Associate Director

Alison de Metz BSc
Project Coordinator


048572 020000 04

MAUREEN DIXON is Associate Director, King Edward's Hospital Fund for London, with special responsibility for the development and coordination of the Corporate Management Programme. Following three years with Shell International, she has been continuously involved in education and research in the organisation and management of health services, working first in the Oxford Region of the NHS, then concurrently with the Brunel Health Services Organisation Research Unit and the King's Fund College. Latterly she spent five years on the faculty of the Department of Health Administration, University of Toronto.

ALISON de METZ is Project Coordinator for the Corporate Management Programme. After graduating from the LSE she joined the London Teaching Hospitals Management Services Unit as an Assignment Officer based in the Camden and Islington Area. After two years she joined the staff of the King's Fund College in the newly created post of Projects Officer, with special responsibility for the development and maintenance of planning projects and the Learning Resources Register. In October 1980 she started working on the development of the Corporate Management Programme.

£2.00