

## Research paper

# Administration and clerical staff perceptions and experiences of protected learning time: a focus group study

David Cunningham BA MPhil FRCGP  
Associate Advisor in Continuing Professional Development

Bridie Fitzpatrick MSc PhD  
Research Consultant

Diane Kelly MD FRCGP  
Assistant Director in Continuing Professional Development  
NHS Education for Scotland, Glasgow, UK

## ABSTRACT

**Background** Protected learning time (PLT) has become an established method of learning for many primary care teams in the UK. Considerable resources are used to provide protected time for practice teams to allow them to learn. There is little published evidence on how administration and clerical (A&C) staff learn within primary care generally and within PLT schemes in particular. The aim of the research was to explore A&C staff perceptions and experiences of PLT.

**Method** A qualitative community based study using three focus groups of A&C staff from semi-urban and rural general medical practices within three local healthcare co-operatives (LHCCs) in NHS Ayrshire and Arran, Scotland was undertaken.

**Results** A&C staff perceived that PLT was of benefit to them, and gave examples of how the team had learned from each other and from neighbouring teams. They wanted to use PLT more effectively, and wanted time that was focused on learning needs, relevant to their work. They wanted to learn more about their own team and its members, and how other local teams worked, as well as the wider workings of the NHS. They expressed concerns

about not being listened to, and felt that their needs were low in the priorities of the practice and the LHCC. They felt that PLT generally resulted in increased workload on the following day when they had to cope with the backlog of tasks generated in their absence during the PLT session. Some reported that they spent, or would prefer to spend, the PLT session working rather than learning.

**Conclusion** PLT needs to offer quality educational experiences. This could be achieved by following the learning process, i.e. learning needs assessment followed by designing and delivering appropriate educational methods and activities. Evaluation of this process is essential. The learning needs assessment should extend to A&C staff and not just clinical staff. This is a challenge as A&C staff have many varied roles within primary care. A&C staff are requesting greater consideration and involvement in team activities and want help to set their individual work in the context of overall practice and NHS activity.

**Keywords:** primary health care, team based learning

## Introduction

In the 1998 Chief Medical Officer report on general practice continuing professional development (CPD), he recommended making learning participative rather than passive, multiprofessional when appropriate,

based on personal and practice development plans to improve patient care and including the primary care team as a developing resource for patients.

Protected learning time (PLT) has become an established method of learning for primary care team members in many parts of the UK. Since its introduction to primary care with schemes such as TARGET (Time for Audit, Reflection, Guidelines, Education and Training) in Doncaster and other areas, and CREATE (Clackmannanshire Resource for Education, Audit and Teamworking) from central Scotland many primary care organisations have provided dedicated time for teams to learn.<sup>1-3</sup> Resources are used to employ on-call co-operatives and teams of bank district nurses to free clinical staff from service delivery.

Government recommendations have encouraged the use of team-based learning as a way of improving quality in health care.<sup>4</sup> It is suggested that protected time may give primary care teams an opportunity to learn from each other and from other teams, and make changes and improvements to service delivery.<sup>5</sup> It is acknowledged that practices have much to learn from each other, but there are cultural barriers within primary care that may reduce this opportunity.<sup>6</sup> Change may arise faster if primary care teams are able to explore new ways of working and learning, as identified from other teams. Learning may also be more effective when it is organised in a way that overcomes professional boundaries, hierarchical systems, and traditional ways of learning.<sup>6</sup>

It is known that primary care teams can learn and develop together and make changes that improve their ways of working.<sup>7</sup> In addition there is some evidence of improvements in clinical practice through participation in PLT schemes, and that PLT can give time to teams for problem-based learning.<sup>8,9</sup> Evaluations of PLT are generally positive.<sup>2,3,10-12</sup> There is less evidence that administration and clerical (A&C) staff have benefited from PLT. Research so far, has mainly focused on clinicians' learning or through evaluating learning of the entire team. There is therefore a need to focus on the perceptions and experiences of A&C staff towards PLT, in order to identify what changes are needed to improve this opportunity for them.

PLT commenced in NHS Ayrshire and Arran in 2001, and now involves all but two practices in the area. Unpublished evaluations showed that clinical staff generally valued PLT, but that A&C staff and practice managers valued it much less. The views of practice managers were explored in a companion paper in this publication. This study focuses on the views of A&C practice staff.

## Method

A qualitative method was chosen as the topic area was relatively unexplored. Focus group discussions were used to ascertain the perceptions and experiences of

A&C staff. An independent moderator unknown to A&C staff was employed to facilitate the discussions. The study design consisted of a sampling stage, data collection stage and finally data analyses by two researchers working independently. The research team and their roles are described in Box 1.

### Box 1 The research team

#### Chief investigator

Author of the paper and guarantor for ethical approval. The chief investigator was known to some of the A&C staff as he was a local general medical practitioner. He read and analysed the anonymised transcripts and discussed and compared the analysis with the independent researcher. He did not listen to the focus group audiotapes as he may have recognised certain individuals by voice.

#### Independent researcher

The independent researcher was acquainted with a few of the A&C staff. She listened to the audiotapes and read the transcripts. She analysed the generated data and compared the analysis with the chief investigator.

#### Focus group moderator

The focus group moderator was unknown to all the A&C staff. She had previous experience of qualitative research by undertaking in-depth interviews. She received training on focus group moderation. She recruited the participants and arranged the focus groups. She facilitated the focus groups and made contemporaneous field notes. She listened to the audiotapes and read the transcripts. She contributed to the discussion and the iterative process of the research.

## Study sample

Practices from all three LHCCs were identified, and those not taking part in PLT were excluded. A purposive sampling strategy was adopted aiming to achieve maximum variation of opinions and experiences. Practices were identified within Ayrshire and Arran from areas of varying deprivation (using the Carstairs scoring system). Practices were stratified by size, so that staff from large and small practices would be invited to participate. The moderator contacted selected practices by telephone and asked practice managers to discuss the project with their A&C staff, and invite one member to take part in the focus groups. Invitations stopped when the three groups reached a maximum size of nine participants.

Practice managers were the only available means of contacting A&C staff. The LHCCs did not hold a

database of A&C staff details, nor did individual A&C staff have email addresses that could be identified within the PCT email system. Practice managers' consent was sought to release staff to attend the focus groups, and to ensure that practices had adequate cover, as focus groups were held over the holiday period.

## Focus group discussions

A&C staff were given an information sheet with details of the aim of the project and the guarantee that their discussion would be anonymised. Each participant signed a consent form. A&C staff from each LHCC met together as it was felt this would encourage the discussion more as they would not only be more likely to be known to each other, but also to have shared experiences of some PLT activities. Venues were chosen that would be private and confidential, but also independent of the LHCCs and of NHS Education for Scotland (NES). Each meeting lasted between 60 and 90 minutes, and the conversations were audio recorded. The focus groups were facilitated by the moderator, who encouraged the discussion, and used open questions to seek opinions and views on PLT. Data collection followed an iterative process in that topics that emerged from one group influenced questions posed to future groups, and this iterative process continued into data analysis.

The moderator was given a small list of topics for the group discussions (see Box 2).

### Box 2 The topics for group discussion

- Expectations of PLT in relation to personal and team learning
- Experiences of PLT
- Views on which PLT events were successful and why
- Views on which PLT events were unsuccessful and why
- The value of PLT for the participants themselves and other A&C staff

Validation and analysis followed the same method as described in the companion paper.

## Results

Three focus groups were held of A&C staff with groups ranging in size from seven to nine participants. A total of 24 A&C staff took part in this study, representing 24 of the 58 practices (41%) in NHS Ayrshire and Arran that take part in PLT.

Seven main themes emerged from the analysis of the data generated. These are summarised in Box 3.

### Box 3 Key themes that emerged from focus groups

- 1 Learning from other primary care teams was valued
- 2 Team-building events were welcomed and appreciated by A&C staff
- 3 Learning about the wider NHS and other relevant organisations involved with health care was appreciated
- 4 Large centrally organised LHCC-wide meetings proved unpopular with A&C staff
- 5 Some A&C staff worked, or preferred to work, during PLT events
- 6 PLT generated a backlog of work for A&C staff
- 7 There was inadequate dialogue about learning needs with practice managers and LHCC PLT steering committees

## Learning from other primary care teams

Learning from other teams was valued by A&C staff. They appreciated learning about how other teams solved day-to-day problems. They wanted to share ideas about practice organisation and service delivery. This was particularly important for smaller teams:

'... because we are small and we don't have the interaction from other surgeries when it's in-house we would benefit a lot from joining a bigger practice.' (Group 2, participant 3)

A&C staff felt that they brought ideas and suggestions for changes back to their own practices as a consequence.

'Because you pick up things like when some practices do something one way and you do it another way, and you think Oh! You think that way might be better.' (Group 2, participant 5)

'I was round at yours [other participant's practice] the other week and it was great. Just even to see the layout, where things are done and how they're done. It was really good.' (Group 1, participant 1)

Although large centrally organised events were generally unpopular, A&C staff felt they gave them an opportunity to meet other colleagues in the area. This interaction was helped by facilitated small-group work, for example, when examining risk reduction and significant event analysis. These topics proved to be popular at large events where A&C staff could mix with other teams.

'... that's the good thing about coming to a large event because you can mingle.' (Group 2, participant 6)

'You feel as if you have actually achieved something ... spoken to different people.' (Group 1, participant 8)

'... and mixing the practices [at large events], I don't think we should be allowed to sit with our own colleagues.' (Group 2, participant 3)

This need to discuss, share and interact was replicated in the focus group discussions. Participants regularly left the subject of PLT and discussed practice organisation, appointment systems and electronic filing systems while in their focus groups. This phenomenon occurred in all three focus groups, strengthening the concept that A&C staff need to share information and learn from each other about their day-to-day activities.

## Team-building events

Some group participants valued in-house PLT sessions as it gave them time to get to know other members of the primary care team. They perceived team-building events to be a good way to mix with members they might not know well.

'It [team building event] gives you a chance to meet colleagues a wee bit better. At the end of the day you have to work together.' (Group 1, participant 6)

Team building events involving physical activity were appreciated as a way of getting to know each other better.

'We did a trip to \*\*\*, that was a day out. It was one of the doctors who is quite sporty and it was a four mile hike and you had to do it in a certain amount of time. You had so many questions to answer on the way round. It was just like an away day, but it was good fun, and everybody got split up so you were with district nurses. It was a good day.' (Group 2, participant 5)

'It was a team building event, and we really don't socialise, we socialise at Christmas and things with all the doctors. They socialise together themselves, so this was a chance for us; we went for lunch first and socialised with them and then we all went on the bikes and there was a bit of "right who is going to win!". Then we got the ferry home. It was our time, we stayed on I think we were over there until about six or half six. It was really really good, and it does, it lifts your spirits. You are not just seeing them as crabit. You are not seeing them as the doctors all the time, you are managing to socialise with them and see them as people.' (Group 3, participant 7)

Other group participants stated that they had planned an away day team-building event, but that a general practitioner (GP) had vetoed their plans and thus it did not occur.

'Well we wanted to do something like that, and were going to do it in \*\*\* and everybody was up for it, but one of the GPs said "that is not what PLT was for", so that got, you know, we didn't do it.' (Group 2, participant 6)

In some primary care teams, informal communication took place, with team members able to debate and plan what to do together. This was associated with a friendly atmosphere in the practice, where A&C staff felt free to express their ideas and thoughts on PLT sessions within their own team. This practice ethos or culture supported team-based learning. Other teams seemed to operate more rigidly and formally with A&C staff reticent to express their thoughts about the functioning of the practice to the rest of the practice, and staff referring to each other formally with titles and not by first name.

## Learning about the wider NHS and other relevant organisations involved with health care

Some participants described how visiting the local hospital laboratory had given them an appreciation of the wider NHS through helping them understand the importance of dealing with laboratory samples effectively.

'... it [visiting the hospital laboratory] lets you see what problems, what the labs are up against, and your GP practice, if you're not filling in your forms properly, it lets you see it from their point of view ... And you go right into the departments and somebody takes you over, and it's not a bother to them. And they are so busy as well. It is, it's really good.' (Group 2, participant 1)

Other participants mentioned meetings and presentations given by community drug agencies who gave a different perspective of drug addiction that A&C staff were not familiar with.

'... they were good. The drug people [local addictions counsellors] were really good. The two ladies who came, they came with a big suitcase with all the pieces of different drugs and things to see.' (Group 1, participant 5)

A&C staff also learned from other community agencies such as the police, and felt they gained some knowledge on how to protect themselves while working with the public.

'... we actually went to a police station and he took us around the police station and showed us how the CCTVs worked. Then he took us all into a room and showed us self-defence and that was fabulous. Two police officers, demonstrating how far you can go in defending yourself.' (Group 2, participant 1)

Other teams had visited a mortuary and an undertakers and stated that this had helped them understand the impact of death on recently bereaved relatives.

## Large centrally organised events LHCC-wide meetings

Although A&C staff welcomed large group meetings for the opportunity for mixing with and learning with and from others, the dominant perception was that they had little value educationally. A&C staff felt that the large numbers made education difficult to plan and prepare for, and as a result they were often in large groups or at lectures.

‘... at the bigger events you don’t get enough time either, because arranging 400 people or something in the afternoon and there are umpteen coffee breaks and lunch. Took too long for lunch and the time spent learning or training wasn’t enough. You know you get discussion groups which take so long to organise, by the time you sit down, find your room, sit down, get your topic, get your discussion going, it’s time to go back!’ (Group 1, participant 6)

There was a clear preference for in-house learning which was felt to be more personal and relevant to their jobs. The logistics of arranging education for large numbers of A&C staff to include small-group learning were perceived to present great challenges for most LHCC educational steering committees. Participants also felt that large events took little account of the considerable variations in the roles of A&C staff.

‘I went to a big event and I just thought that it was a waste of time. We just sat there among rows and rows with one person on the stage and we were back, back, back, and I just thought that was a complete and utter ...’ (Group 3, participant 7)

A&C staff also felt even when large events did include small-group discussion; the large numbers participating meant that small groups turned out to be large. A lack of group facilitators meant that A&C staff were reluctant to participate in small-group learning, and that as a result this was time wasted.

‘... huge [size of small groups]. We were sitting in a circle and you couldn’t hear what the person across was saying, you know, the circle, the groups were huge in that first one. I would say more than 80.’ (Group 2, participant 5)

‘In big groups nobody really wants to talk, they are all sitting, waiting on everybody else.’ (Group 2, participant 2)

## Working rather than learning at PLT sessions

Participants mentioned that at times little had been arranged for them at both in-house and large events, and as a result they worked through the events, rather than be involved in any education.

‘... well I remember one time in training we went through our entire filing system looking for missing files, and that’s what we did the whole afternoon.’ (Group 2, participant 4)

Some felt that working would be more useful to them as they were able to catch up with work while protected from interruptions from patients.

‘I mean the times I’ve walked away from dictation that is falling onto the floor to go and listen to my practice manager talking about things that really you feel; I wish I could get back to my desk and get my dictation done.’ (Group 3, participant 4)

## PLT generated a backlog of work for A&C staff

Other participants mentioned that for A&C staff there was no actual protected time, but that it was borrowed from the next day. Staff felt that clinicians had a mechanism which protected them from service delivery, but for A&C staff PLT delayed work until the next day.

‘Whilst we have this half-day and we are closed, we can be really snowed under with paperwork, things to catch up on, and on a Wednesday [the day after PLT] the phones ring constantly. We’re busier the following day when we close you know, that it is just, we just feel sometimes that not that it’s a waste of time but you are working twice as hard the following day to try and catch up with what you have missed in the afternoon previously.’ (Group 3, participant 4)

## Inadequate dialogue about learning needs

Several participants thought they were not being listened to if they did report their learning needs. Some had given suggestions that had appeared to have been ignored by their practice manager. In general, A&C staff felt that their needs were not taken into account when practice-based educational events were planned. They also thought that other members of the primary care team took the lead in decision making when planning and preparing both in-house and large PLT meetings.

‘We don’t get any of that, we don’t get to make the decision it’s “what I [practice manager] say goes”.’ (Group 1, participant 3)

‘We usually think about it two days before, and then they just hope something will turn up.’ (Group 1, participant 8)

This lack of voice or representation was expressed with regard to both practice teams and also the LHCC steering committees.

'... someone from the LHCC should actually sit down at a group like this and listen, you know, to what each person wants from it. There are so many topics that you could sit in a group like this, that the girls want to do and they are not being heard. Or they are being heard but not being listened to, you don't win.' (Group 1, participant 5)

'... but we're never important when it comes to training ... we have got good GPs but the other places that are doing all the organising never want to listen to what admin has got to say. A&C is always a way down the bottom when it comes to the topics and the training.' (Group 1, participant 5)

A&C staff also felt they were not listened to by LHCC educational steering committees.

'I went to the steering committee meetings with the PLT and then I stopped going because I could not go, but I had always suggested a receptionist forum. I had always wanted to go to an admin team of receptionists, like this to start that up but nobody listens.' (Group 1, participant 5)

Other participants admitted that they were not good at identifying their own needs or communicating those needs to their practice managers:

'So I think part of the fault's ours as well, and we should maybe say "well this is what we want" and if he [practice manager] says "well I don't know how to deal with this", I suppose we're all capable of picking up the phone and saying "well we can do it".' (Group 1, participant 1)

## Discussion

This study set out to explore the perceptions and experiences of A&C staff in primary care with regards to PLT and this has been achieved. This study from one Scottish health board area has identified various emerging themes that were previously unreported, from a group of staff not usually questioned. There are other strengths to the study. The sampling strategy recruited A&C staff from 24 practices in Ayrshire, covering all three geographical LHCC areas within the primary care trust, offering a wide spectrum of experiences. PLT was fairly well established in NHS Ayrshire and Arran, existing for five years before the study, and therefore focus group participants' perceptions were based on views developed over this period of time. The findings may be generalisable to other areas that organise PLT in the same way, and useful to others planning to introduce PLT.

The independent moderator who was unknown to the focus group participants along with the guarantee of anonymity allowed participants to talk honestly and freely about their perceptions of PLT. This is in

contrast to an earlier study which had raised concerns that A&C staff were reluctant to fully express their thoughts about PLT in case of the consequences of this.<sup>2</sup> Previous studies had only interviewed A&C staff in very small numbers, with limited data generated as a result.<sup>2,6,7</sup>

The study was further strengthened by having two researchers analyse the data, resulting in a greater breadth of themes without compromising the anonymity of the focus group members.

One weakness to the study is that it only covered one health board area and the results may not be generalisable to other areas that might organise PLT differently. Other issues affecting potential generalisability are that six practices were unable to release A&C staff to participate in focus groups because of practice commitments or a prevailing negative sentiment about PLT held by the practice managers involved. Two practices did not take part in PLT, and did not release staff to discuss with the focus group. Although focus group participants were asked to maintain confidentiality about what was discussed in the focus groups, it is possible that some participants may have been wary of being candid and honest about their perceptions, in case they were disclosed later to their practice manager.

This study does raise further issues for discussion around the topic of PLT and team-based learning. Some practices may not be ready for PLT and may find it difficult to use the time productively. When teams are hierarchical it is possible that a small number of key individuals are deciding on educational events for the team, which may be irrelevant for some members. There were clear insights into which members of the team decide what educational methods are undertaken by the rest of the team, and how one member of the team can control and restrict the learning activities of others. Often these members are GPs and practice managers. This goes against recommendations for team-based learning where all members of the team should be able to influence their learning. This attitude may also result in despondency among A&C staff, with a reduced potential for change with the teams involved.

In contrast some participants had been involved to an extent in the planning and preparation of team-building events or visits to other NHS and community services. They had enjoyed getting out of the practice premises and meeting people from the wider community. These events were well received, and staff felt they had learned from other agencies, and for some staff there was a deeper understanding not only of the roles of different groups involved in health and care, but also of how the quality of their own work impacted on other services.

The findings support previous research which showed that PLT can improve team working and learning from colleagues in other practices, and that care must be taken to meet the learning needs of both clinical and non-clinical primary care team members.<sup>10</sup> GPs are known to each other through a variety of means including postgraduate education groups and working together in on-call co-operatives. Similarly, practice managers and practice nurses have peer groups to share information with, both formally and informally. In contrast A&C staff rarely met with other colleagues from different primary care teams, and PLT provided a forum for interaction.

If education is to be useful and relevant for A&C staff, then it is important to base it on identified learning needs, and teams may need help with training to identify those needs, and with identifying educational resources and activities that meet these needs. The preference to work rather than learn may be a reflection on the provision of the quality of education and learning arranged for A&C staff. Other A&C staff appeared resentful that little had been arranged for them and they were not happy that they were working rather than learning. A&C staff did not benefit in terms of having dedicated PLT. Unlike clinicians, their workload during PLT was not undertaken by on-call services. The organisation of and possibly the resources dedicated to PLT should take account of the backlog of work faced by A&C staff when they resume practice activities on the following day.

A previous study reported the finding that non-clinical primary care team members may value PLT less than their clinical colleagues.<sup>3</sup> This study has gone some way in identifying the reasons why this may be, and also given some solutions that may improve PLT in the future. Other research has supported the use of PLT as a means of developing a learning culture within practices,<sup>11</sup> and PLT has been endorsed as one way of becoming a learning practice.<sup>5</sup>

## Conclusions

PLT has given time to practices to enable them to learn together and prepare for the challenges that face primary care. A&C staff make up a significant proportion of the primary care team, and their work has become more diverse and their role as part of the team increasingly recognised in recent years. This study has shown that it is important to identify learning needs of A&C staff and to plan and prepare educational events that take these needs into account. Practices may need to listen to A&C staff more if they are to develop to their full potential. Currently much of the planning and preparation of practice-based PLT events is

undertaken by practice managers. A&C staff perceive that clinicians have their needs met first, and that meeting these needs is the main focus of managers. More resources need to be spent on education that is fit for purpose for such a significant number of primary care team members. There is still considerable change needed before many practices can claim to be learning practices.

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#### ETHICAL APPROVAL

Ethical approval was received from Ayrshire and Arran Research Ethics Committee (05/S0201/8). Research management and governance approval was granted by Ayrshire and Arran PCT.

#### CONFLICTS OF INTEREST

David Cunningham is the chairman of North Ayrshire LHCC PLT steering committee.

#### ADDRESS FOR CORRESPONDENCE

David Cunningham, NHS Education for Scotland, 3rd Floor, 2 Central Quay, 89 Hydepark Street, Glasgow G3 8BW, UK. Tel: +44 (0)141 223 1400; fax: +44 (0)141 223 1403; email: [davidecunningham@wightcablenorth.net](mailto:davidecunningham@wightcablenorth.net)

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