

DEARDEN NEWSLETTER

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DEARDEN

EDITORIAL

Workforce Planning is a difficult art and rarely a science. The problem is that there are so many variables and that many of them are beyond the control of the people doing the planning! It is difficult to predict how the work will change. Government policy is also difficult to read as initiatives fall like the driven snow. The level of resource is crucial. The general economic situation is important because it determines how many opportunities outside the NHS are available to NHS staff many of whom have very marketable skills. Most difficult of all are the hundreds of thousands of individual decisions about when to retire, when to take career breaks for raising a family and other purposes, when to return to work, how many hours to work and where and when to move.

The degree of difficulty should not put us off. It is worth doing so long as we do not invest educated guesses with the solemnity of misguided certainty. It is worth trying to anticipate the future but foolish to believe that we can predict it.

The role of Foundation Trusts

There are few false notes in the Darzi/Tooke view of workforce issues but there are dangers in the approach to workforce planning. Workforce Planning is the business of employers. Of course PCTs have a role as the shapers of local services, as employers of important staff groups and as the organisations that work most closely with the GPs and other independent contractors. SHAs also have a role as the regional body responsible for bringing things together on a whole system basis. However the vast majority of staff in England are employed by Foundation Trusts – present and future. It is the Foundation Trusts that should have the opportunity and responsibility to lead on workforce planning at local level and NHS Employers, as a representative body, is well placed to lead on their behalf at national level. Medical Education England will also have an important role.

In Scotland the situation is even simpler given that almost all staff are employed by the integrated Health Boards. In Wales simplicity is rapidly approaching following the Minister's confirmation that

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new people

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“seven unified delivery bodies” will replace Trusts and Local Health Boards. In Northern Ireland, although the Regional Board and Shared Services organisation will be significant employers, the great majority of staff will be employed by the five integrated Health and Social Care Trusts.

Even in the days of devolution the UK dimension of workforce planning remains significant. The European and international dimensions must also be taken into account given the mobility of health professionals.

The responsibilities in the rest of the UK are very clear. However, in England, there is a real danger that Foundation Trusts will be put off their lead role in workforce planning by the Darzi focus on PCTs and SHAs. This would be a major error. Employers must lead on workforce planning and the Foundation Trusts are the most important employers. This is their business.

Foundation Trusts are also in a great position to begin to explore the potential of Health Innovation and Education Clusters [HIEC]. Academic Health Service Centres where established would be powerful sponsors. If Foundation Trusts work closely and creatively with Deaneries, and further and higher education, there is a real possibility of creating liberating structures that could do for education and training what Foundation status has the potential to do for service delivery. Local leadership and innovation, local bodies working together to show the way.

Ken Jarrold CBE



Adding value...

When responsibility for training and development of Chairs and Non-Executive Directors transferred from the NHS Appointment Commission to the NHS in April 2008, it seemed to take place with little fanfare. Under the new arrangements Strategic Health Authorities were given responsibility for actively supporting and developing Non-Executives, providing opportunities for them to learn and highlighting areas for their further development.

SHA's have a difficult balancing act; they need to provide Non-Executives with stimulating and stretching opportunities (so they will choose to attend) but they cannot design the development programme based only on what they enjoy taking part in. There must be a link to Non-Executive development underpinned by some form of assessment without suggesting that the process is in any way about assessing competency.

In NHS South East Coast, Dearden Consulting are working to provide all Non-Executives across the region with an analysis of their strengths and development needs against the SHA's six competencies for Non-Executive Directors.

Development programme

To deliver these objectives, we have designed a process including an on-line self-assessment questionnaire based on the six Non-Executive competencies and a one day development event plus face-to-face feedback and a written development plan.

The one day events will accommodate twelve participants, who will take part in a mixture of case studies, mock board to board challenge and scenarios based on current national and local issues. Each individual's

the development of Non-Executive Directors

contribution will be observed and assessed and reported back in a tailored development discussion between the Dearden observer/ coach and the Non-Executive. From these discussions and the results of their self-assessment there will be an agreement on individual signature strengths and development needs. Importantly, within their personal development report they receive, there will be no surprises as it will be a direct product of the face to face discussions and the conclusion will have been jointly agreed. Non-Executives will remain the final arbiter in what future training and development they participate in, but the outputs of our process will give them the

evidence to discuss their personal development needs with their Chair and agree how these will be met.

The output of the events will provide a rich source of evidence to underpin future investment in Non Executive training and development.

Intrinsic in the whole process is that it is completely confidential and that in any future analysis of training and development their result will be totally non-attributable.

For further information please contact Derek Emm on telephone: 07974 574917 or by email at derek.emm@dearden.co.uk

An example of Dearden Non-Executive Director Development Programme:



Clinical Leadership

are we asking the right questions?

Attempts to improve 'clinical engagement' and 'clinical leadership' have been made intermittently over the last decade with varying success and an extensive literature has developed on the subject. Lord Darzi's Next Stage Review¹ again emphasises the need for clinical leadership, 'fostering leadership for quality' and suggests a new professionalism with 'clinicians as practitioners, partners and leaders'. This latest and laudable attempt to involve clinicians in formal leadership roles also comes at a time when the evidence that doctors can influence organisational performance is growing².

Are clinicians difficult to engage and reluctant to lead?

But are clinicians, in fact, difficult to engage and reluctant to lead? There sometimes seems no shortage of candidates for senior positions in professional societies, the Royal Colleges and the BMA. Whether these individuals turn out to be good leaders is neither here nor there, they are clearly not reluctant to lead, and do get engaged in agendas that they find interesting or important to them. This raises an interesting set of questions about why professional leadership may be attractive to some clinicians but clinical leadership of a health organization or of the broader NHS may be less so.

- **What do we mean by clinical leadership?**
- **Are the skills and competencies of clinical leaders any different to those of non-clinical leaders in NHS organizations?**
- **Is the context in which those skills and competencies are displayed different for clinicians?**
- **Are the barriers to clinicians displaying leadership or developing leadership skills different to non-clinicians and, if so, what can be done to overcome them?**

To help answer these and similar questions, Dearden have been engaged by the NHS North West Leadership Academy to conduct a detailed and comprehensive study of the current state of and attitudes towards clinical leadership development in all the NHS organisations in the North West of England. Through a series of interviews, group meetings, questionnaires and large, multi-disciplinary open-space events, we are examining not only the 'transactional' aspects of leadership (skills, competencies, training and education, career development opportunities, etc) but also the broader organizational development factors underpinning it. Our hypothesis is that skilled clinical leadership is a necessary part of a successful organization but alone is insufficient. It must be practised in the correct receptive context, have a clear purpose linked to a proper understanding of the organization's (and wider NHS) goals and be backed up by professional managers that are not afraid to let clinicians into their world.

The implications of this are simple in concept but may require a fundamental shift in culture in some organizations.



NORTH WEST
CLINICAL LEADERSHIP

We are working with
the North West
Leadership Academy

Clinicians will need...

- to align their professional priorities and ambitions to organizational and service goals.
- help to overcome their previous reductive training to see the broader health picture beyond their specialist areas.
- help to change their perception of risk-management away from a perfectionist approach of wanting to do the very best for the individual patient before them to accepting that prioritization and compromise may be necessary.
- to accept financial responsibility for clinical decisions.

Managers will need to acknowledge...

- that the different knowledge base of clinicians may change organizational priorities.
- that clinicians will not be as influenced by central DH and political directives as career managers.
- that clinicians by and large will not have the basic managerial skills acquired by professional managers and will need significant support.

This agenda therefore is as much about engaging managers as it is about engaging clinicians. This could be challenging for a generation of managers, especially at Chief Executive level, who have become used to a different environment. It will require both professional groups to develop new behaviours, attitudes and possibly a new language to bridge the gap between existing cultures.

For all this to succeed, it follows that clinical leadership development must take place firmly in the context of the wider development of the organization; a message that Dearden have been promoting since its inception in 1989.

If you would like to learn more about the work Dearden are doing with the NHS North West Leadership Academy, or about other ways in which Dearden can help your organization develop its clinical leaders, please contact Dr David Dawson on telephone 07940 438988 or by email on david.dawson@dearden.co.uk

¹Department of Health (2008) *High Quality Care for All: NHS Next Stage Review Final Report*, TSO: London.

²Hamilton P, Spurgeon P, Clark J, Dent J, Armit K (2008) *Engaging Doctors: Can doctors influence organisational performance? NHS Institute for Innovation and Improvement: Coventry.*

Reflections on those huge career jumps

My grandmother has 17 grandchildren, so whenever we went to see her there were others there to play with. We loved to go to play in the 'river' (I have a feeling that if I were to see it now it would be little more than a wide stream). The water was clear and there were large stones in it. We liked to try to reach the other side by jumping from stone to stone. The last leap was huge and we would teeter on the final stone before trying to make that final jump to the other side. If you were lucky enough to make it to the other side you often found yourself there all alone. Some of the others had decided the jump was too big, some landed in the water...

I have been reminded of that game when working with applicants for Directors and Chief Executives over the years. The move from Assistant or even Deputy Director to Director is hard to prepare for and even more so the move from Director to Chief Executive. Those who have been on an SHA 'Aspiring Chief Executive' programme stand out. As well as having benefited from being on the programme, the selection process for the programme itself has done what it purports to do – identified latent talent.

There are very few organisations that are obvious first jobs for a Chief Executive. A small

single site Trust is, compared to many private sector companies, a complex organisation and a multi-site Trust or large PCT is more so. Selection panels often feel that they are taking a risk appointing a first time Chief Executive, so that those who have been a successful Chief Executive elsewhere have an advantage and it may seem that the odds are against you for getting that first post. A secondment or 'acting up' opportunity puts a candidate a little further up the track.

Obviously there are lots of other aspects that are probably more important than size. Is this a do-able job; are the finances basically sound; are the Chair and Board supportive; does the organisation have good relationships with stakeholders and partner organisations? As well as doing your desk research before applying, take every opportunity to meet the key people and get to know them a little. If this is not the right job for you, it is better you know before the interview than six months into the job. This is not scientific, but if it doesn't feel right, it's better to pass that one by and wait for the next opportunity.



If you would like to discuss the content of this article further please telephone Viv Walton on 07860 361252 or email viv.walton@deardenjobs.co.uk



Interim HR/OD Services from Dearden

Several NHS Organisations have or are benefiting from a decision to recruit an Interim HR Director. In some cases this gives the Chief Executive and Executive Team time to consider options for the future and in other cases it enables greater focus to be placed on a number of key workforce issues that the organisation is concerned about. Whichever benefit is sought, Dearden can provide an experienced interim service to suit what is required.

Recent experience of Interim HR Director work by Dearden indicates that NHS organisations can gain considerably from such an arrangement. Examples of work undertaken include:

- A complete review of the HR/OD function and subsequent re-positioning of the function as an integral part of both corporate and local service/business processes, instead of being peripheral to such activities.
- The development of HR/OD performance indicators through consultation with line managers and staff including leadership standards and competencies, productivity measures, staff satisfaction indicators.
- Improving understanding of how HR/OD activities add value to the business of healthcare delivery, and implementing measures to achieve this.
- Undertaking a focused review of pay bands and the distribution of roles in comparison with other organisations and recommending future actions.

- Preparing a comprehensive report on an organisation's workforce in terms of current indicators and the issues that need to be addressed over the next 3 to 5 years.
- Driving the KSF/annual appraisals process, ensuring robust systems are in place which act as a backbone to strategy, planning and performance management throughout the organisation, and embedding arrangements to ensure continuity including the simplification of the KSF.
- The implementation of service line management including a focus on clinical leadership and the infrastructure required to support such roles.

The projects described above are an illustration of what an interim appointment can focus on, as well as providing leadership and management of the HR function, whilst an organisation decides on its future plans.

If you think that Dearden may be able to help you please contact either Mark Gammage on 07966 330315 or Steve Griffin on 07771 947723. Alternatively email on either mark.gammage@dearden.co.uk or steve.griffin@dearden.co.uk

Dearden welcomes...

We welcome Dr David Dawson who joined us earlier this year and Sharon Colclough who will be joining us in early 2009.

Dr David Dawson

David has had 33 years experience of the NHS. He trained in medicine at the University of Bristol and then as a hospital specialist, being appointed consultant physician and gastroenterologist at the Northern General Hospital in Sheffield in 1988. Since then he has worked in a variety of senior clinical and management roles in acute hospital trusts, Trent SHA and the Department of Health. His last job was as Medical Director of the Mid Yorkshire Hospitals NHS Trust helping in its service, leadership and financial turnaround after it was placed on 'special measures' by the Secretary of State. He has particular interests in service improvement and re-design, emergency care (being responsible for clinical input to the Reforming Emergency Care strategy) and clinical leadership. He has reviewed over 60 emergency healthcare systems, has been a member of the Clinical Strategy Committee of the Healthcare Commission, a visiting Senior Fellow of the University of Lincoln and most recently chaired the Acute Episode Pathway group for the NHS Yorkshire and the Humber work on the Next Steps Review.



Dr David Dawson



Sharon Colclough

Sharon Colclough

Sharon joined the NHS in 1975 as a student nurse. She went on to also train as a midwife. Sharon has over 30 years of experience working as a clinician and a manager in the NHS, the private sector and at one point for the American Army in Germany.

Recently Sharon has been working as the Chief Executive of the Queen Victoria Hospital NHS Foundation Trust which during her two years there has achieved the Healthcare Commission rating of excellent/excellent twice, lastly on 16 October 2008. This Foundation Trust was the first in the Country to be placed on 6 monthly monitoring instead of quarterly because of its excellent financial track record. Sharon has also worked as the Chief Executive of a PCT in the West Country where practice based commissioning was cited as a national example of good practice. She has also spent time as a Director of Operations in one of the largest DGH's in the country, in Reading.

Sharon's expertise is in improving quality of care and organisational performance through clinical engagement. Sharon has an MBA from Henley Management College. She lives in Devon and in East Grinstead.



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