LEADERSHIP IN THE NHS: CONNECTING FOR THE FUTURE

Julian Hartley
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2005 Geoff Scaife Memorial Lecture
Julian Hartley, Chief Executive, Blackpool, Fylde and Wyre Hospitals NHS Trust
Geoff Scaife was killed tragically in a car accident in 2004, aged 55. Described by former Health Minister Lord Philip Hunt as “one of the four or five best managers of his generation”, he held a number of senior leadership posts within the NHS including Chief Executive of Avon, Gloucestershire and Wiltshire Strategic Health Authority, Chief Executive of Birmingham and the Black Country Strategic Health Authority, and Chief Executive of the NHS in Scotland, and previously worked at 10 Downing Street.

Geoff made an enormous contribution to the NHS in England and Scotland, and was very committed to improving public services. Sir Nigel Crisp, formerly Chief Executive of the NHS, said that Geoff was a great man and a great leader: “His personal qualities, his depth of experience and his wisdom meant that he made an enormous contribution to the whole of the NHS.”
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We are proud to introduce this paper, the adapted text of the inaugural Geoff Scaife Memorial Lecture, delivered at the 2005 NHS Confederation annual conference by Julian Hartley, then chief executive of Tameside and Glossop PCT.

In this paper Julian Hartley’s overall theme is the importance of building stronger connections between managers, staff and patients, and of engaging both staff and patients. Julian reflects on the kind of leaders the NHS will need in the future; the huge, ever-changing agenda they face; and the character and courage they need to deal with it.

The focus on results, targets and star ratings in the NHS in recent years, Julian argues, has led to a limited definition of leadership to the deficit of other important aspects of leadership such as personality, work processes and style.

The Geoff Scaife Memorial Lecture was created as a tribute to Geoff Scaife, who died tragically in a car accident in 2004. Geoff had a long and successful career in the NHS including seven years as chief executive of the NHS in Scotland and then as chief executive of Avon, Gloucestershire and Wiltshire Strategic Health Authority.

Following his death a memorial fund was launched under the auspices of the NHS Confederation and the Nuffield Trust. Many individuals and organisations gave generously to this fund, which allowed the establishment of the annual Geoff Scaife Memorial Lecture. In recognition of Geoff’s passion for developing others, the lecture is designed to give a young health manager a platform for airing their views on an NHS leadership topic. The lecture will be given each year at the NHS Confederation annual conference. The 2005 selection panel, chaired by Sir Nigel Crisp, selected Julian Hartley’s submission as the most outstanding of those received.

This first paper is being published to coincide with the formal launch of the NHS Institute for Innovation and Improvement.

Anyone interested in delivering the next Geoff Scaife Memorial Lecture, on the theme of the future development of health and health services and the role of good leadership and management should contact Gill Morgan, Chief Executive, the NHS Confederation, on 020 7074 3200.
LEADERSHIP IN THE NHS: CONNECTING FOR THE FUTURE

I was honoured to be asked to prepare this lecture. I never knew Geoff Scaife personally, but I knew him by reputation. That was as a highly effective NHS leader, a manager with drive, determination and integrity.

Having spoken to several colleagues who knew and worked alongside Geoff, I now have a sense of his belief in nurturing the next generation of NHS leaders, his commitment to teamwork, to encouraging and developing those he worked with and his ultimate passion for excellence in healthcare management. Without doubt, one of the abiding features I have come to recognise, albeit second-hand, about Geoff Scaife is his strength of character and his courage. Character and courage are rare commodities.

Leadership is about many things, but it is certainly about character and courage. I want to explore what kind of leaders the NHS needs now and in the future, and what qualities we need to develop. What kind of behaviours and values do we need to equip us for one of the most challenging management jobs in modern society? And what lessons can we learn from our past to shape our future?

Off-the-shelf leadership

We all bring our own character to bear on the challenge of leadership and we all do it in our own way. Yet there is no shortage of literature, advice, guides and definitions of leadership to help us along the way.

While preparing this lecture I searched around for ideas about what leadership would be required by the NHS for the future. At one point, while waiting for a meeting at the strategic health authority, I found myself in WH Smith in Manchester Piccadilly. Looking for inspiration, I wandered over to the ‘management’ section of the shop.

I was surprised by how many books were on offer, each offering its own recipe for success and its own answer to the question of what makes a successful leader. It was almost as if I only needed to buy one, read it between the station and my appointment and I’d take the meeting by storm and be recognised as a great modern leader.

Then I read Francis Wheen’s book, How mumbo-jumbo conquered the world, and found my thoughts echoed. In it he considers the same type of bookshelf and says: “The essential ingredient of these books is lists. Following the distinguished example of God, who condensed the laws of righteousness into ten easy-to-understand instructions, the authors seek to persuade their readers that the secrets of success are finite and can be briefly enumerated.”

Dale Carnegie was the pioneer, offering ‘seven ways to peace and happiness’ and ‘four good working habits that will help prevent fatigue and worry.’ Stephen Covey went even further in a book whose chapter headings include:
  • ‘Three resolutions’
  • ‘Six days of creation’
  • ‘Six conditions of empowerment’
  • ‘Seven deadly sins’
  • ‘Seven chronic problems’
  • ‘Eight ways to enrich marriage and family relationships’
  • ‘30 methods of influence.’

We all bring our own character to bear on the challenge of leadership and we all do it in our own way.
Anthony Robbins has discovered the ‘five keys to wealth and happiness’ and ‘seven lies of success.’ More ambitiously, his book, Giant steps, provides no fewer than ‘365 lessons in self-mastery.’ Lesson 364 in its entirety says: “Remember to expect miracles… because you are one.”

With the former Modernisation Agency’s excellent Top tips for service improvement series in mind, the point is that reliance on so-called gurus or books that make great claims to transform our individual, or organisational, fortunes needs to be treated with some caution, and they rarely provide the real answers to the questions we have about leadership.

They did not help me much with answering the question: “What kind of future leadership does the NHS need?”

When confronted with the agenda we all face, Robbins’ suggestion to expect miracles is apt. Our agenda includes:

- transforming the NHS
- offering choice
- empowering patients
- delivering higher quality services and value for money
- implementing major pay reform
- new IT infrastructure
- shifting services closer to home
- offering local access to key hospital services
- delivering major capital schemes
- engaging local communities
- managing the politics.

In truth, no easy list from a book off the shelf will help us with this agenda. We need to provide the answers ourselves and these will always come back to the qualities of character and courage.

Avoiding past mistakes

The NHS is at a critical stage in its development. For my generation of NHS managers this has a particular resonance. I joined the NHS in 1991 at the start of the then ‘internal market’. It was an interesting time to be a trainee manager in the NHS. I remember my first exposure to a management meeting involved a contract monitoring discussion between the health authority and the local hospital or DMU (directly managed unit).

There were some perfunctory introductions between the unit general manager and his chief accountant, and the health authority contract manager and finance manager. I was in ‘shadowing’ mode. The discussion took place almost entirely over a spreadsheet which gave that quarter’s activity and financial details. What seemed odd to me was the intensity and length of discussion over extremely limited subject matter. There was no discussion about what the activity figures represented in terms of patient experience, the quality of treatment provided, the number of complaints, or any clinical indicators giving a clue to how hospital treatment and care at the hospital compared with others in the region.

I am sure thousands of similar meetings took place around that time as managers tried to make the internal market fly and many used the information available – often just activity data and some notional costs – as the sole means of driving it.

During the early 1990s, which stand out for me as a time when management behaviours in the NHS veered from highly defensive to nakedly aggressive, we sometimes lost touch with the patients and communities we serve. I think the NHS, and NHS management, has moved a long way from this period, but it is worth remembering what it was like to work in the service at that time when the language of contracts, the internal market and binding arbitration established a distance from the real business of improving the quality of patient care.
As the pendulum which swings between central planning and a devolved market in health moves back towards the latter, it is critical we do not repeat the mistakes of the past. It is critical to avoid any disconnect between management behaviours and values and those of patients, staff and clinicians. The best organisations manage to align these values and constantly remind themselves they are there to serve the patients.

Defining leadership

So, what are the values, behaviours, skills and attributes required by NHS leaders to take the NHS through its next phase of development?

Leadership is difficult to define and any definition is unlikely to do justice to the complex human processes that it involves. People, including managers, researchers, and world leaders, disagree about it. One interesting approach is from Keith Grint in *Leadership: limits and possibilities*. Grint addresses the problem of defining leadership by asking:

- Do we define it on the basis of the person – is it who you are that makes you a leader?
- Do we define it by the process – is it how you get things done that makes you a leader?
- Or is it the position – is it where and when you operate from that makes you a leader?
- Or is it all about results – is it what you achieve that makes you a leader?

I suspect we would all offer different views about the weight we would attach to each of these four components, but there is a resonance for the NHS in terms of the last definition – results.

Defining leadership purely in terms of results, targets and star ratings excludes the other elements which define the leadership role.

A drive for results alone – like a single beam which illuminates only a narrow channel of darkness – offers only partial direction and never lights up other avenues, other opportunities. In order to understand the leadership role in these terms, it is worth offering two examples that are strikingly similar in their techniques.

The first comes from Shakespeare’s *Henry V* and takes place when Henry rallies his troops before they go into battle against the French:

That he which hath no stomach to this fight,  
Let him depart; his passport shall be made  
And crowns for convoy put into his purse:  
We would not die in that man’s company  
That fears his fellowship to die with us…  

This story shall the good man teach his son;  
And Crispin Crispian shall ne’er go by,  
From this day to the ending of the world,  
But we in it shall be remembered;  
We few, we happy few, we band of brothers;  
For he to-day that sheds his blood with me  
Shall be my brother.

Henry’s tactic of developing a vision of how the day will be remembered in years to come is highly effective. It sets up a
heightened sense of mission and purpose and also asks his followers to make a choice between those who ‘have no stomach for the fight’ and will be paid to depart and those ‘happy few’ who will be remembered for posterity and glory.

This technique of looking back on a critical event and giving it a significance and place in history was used by Don Berwick in his address to mark the 50th anniversary of the NHS in 1998, published in the BMJ.5

In it, Berwick imagines he is celebrating the 75th anniversary of the NHS and looking back to the time we are now in. He says:

More than any other, the principle that patients and families can be their own care givers transformed the cost and outcomes and shape of the NHS. Not only do you know technically how to give patients the knowledge you need, you have also given them more control over their own care. By the early 21st century the NHS was becoming a truly patient-centred care system. Shared decision-making incorporating every patient’s values and circumstances is now the norm.

Leadership engaging people

Both these examples highlight the importance of leadership engaging people, offering a vision of a better future and motivating people to be part of it. Neither one focuses exclusively on results or performance targets, but rather they build the vision which drives motivation and can lead to extraordinary performance and results.

Don Berwick’s example has a real resonance as we attempt to give patients more choice, control and influence over their care. His own example of ‘back to the future’ was overly optimistic. We cannot yet say that shared decision-making incorporating every patient’s values and circumstances is now the norm, and we are probably still a long way from it. But this is where our collective leadership role matters. And certainly our efforts to deliver a patient-led NHS rely on embedding this value in our leadership approach. The fact that Ken Jarrold in his paper, Servants and leaders6, puts patient leadership as the first point in his manifesto for leadership in the NHS is also no accident. This is a powerful and important message for all of us that is worth remembering.

My most recent reminder captures the importance of patient leadership. The following quote comes from Ian Kramer, a patient experience consultant at the former NHS Modernisation Agency’s Clinical Governance Support Team.

The system is, I think, overly swift to suppress information that it considers might undermine trust. There should be no perfect trust in an imperfect human enterprise. ‘Trust me, I’m a doctor’ excludes patients and their carers from playing a valuable role as co-guarantors of safe and effective care.

That role is not only valuable but necessary: patients and their carers provide the great bulk of care within the NHS, it is we who first identify symptoms, and we who must comply with medication schedules. Yet the system makes very little investment in providing us with the information we require to perform that role, and often fails to regard us as reliable witnesses and historians of our own lives.7

The last phrase – ‘reliable witnesses and historians of our own lives’ – carries a particular weight for patients and the public in my PCT patch, which covers Hyde, where Harold Shipman practised. One of Shipman’s tactics to cover his murderous trail was to alter his victims’ medical records so his explanations of their untimely deaths seemed plausible.

This was a marker not only of the way Shipman manipulated the truth and deceived those around him, but also of the power imbalance between Shipman and his patients. Information is power, and Ian Kramer’s point emphasises the need to give patients the information to redress that power imbalance.
One of the most inspiring local initiatives, partly as a consequence of Shipman’s falsification of records, has been the development of electronic patient-held records by a local GP, Dr Richard Fitton, who has put the information his patients need into their hands in a portable, electronic format. This record of their entire medical history can only be altered with their consent and involvement.

Holding their own records prompts questions from patients about medication, conditions and treatment regimes; Dr Fitton offers all his patients a fully equipped resource room with access to information online and from library and reference material, to help answer their questions. He no longer acts as the sole custodian of medical information and knowledge – his patients own it too and are building up control of their health and healthcare.

This is patient leadership in action. These patients are reliable witnesses and historians of their own lives. I believe this is a key leadership skill for the future of the NHS – leading the NHS to help patients lead their own care.

This is surely part of a transforming agenda that replaces old-style patient or professional transactions (usually one-way) with joint ownership and patients and carers as co-guarantors of safe and effective care. How much more powerful will patient choice be when informed by real knowledge and control on their part?

Connecting with our communities

If connecting with the needs of patients to lead their own care in a meaningful way is the first key leadership skill required of us, then connecting with our communities follows closely behind. One of the challenges working in a National Health Service is making national policy work in every locality. There are real and increasing differences in our society.

PCTs are interesting proxies for these differences. We are all genuinely different in terms of the populations we serve and their ethnic, socio-economic and political profiles. Yet we are all in the business of implementing national policy and priorities and delivering on national targets.

It feels increasingly important that if the NHS is to thrive and prosper into the rest of this century, we need to engage our local communities in new and effective ways. The enormous public health challenges we face, the development of foundation trusts and the role of members, the engagement of the voluntary sector, and closer working with local authorities all entail a much stronger local presence and role for the NHS.

A new localism is required. If we are to support the engagement of patients then we must also engage our local communities to act as champions for health improvement and use new methods and techniques, learning from other sectors. How many foundation trusts will get as close to their members as a Premier League football club? How many PCTs will change children’s eating habits as effectively as Jamie Oliver? Community engagement needs real local leadership and the courage to get out and understand the local communities we serve.

There are some useful lessons from fairly recent history about the need to engage closely with local communities and indeed about how the wheel of decentralisation to centralisation and back to decentralisation turns over time. Consider the following account:

If the NHS is to thrive we need to engage our local communities in new ways.
I start my fact-finding mission by visiting a cottage hospital at Much Wenlock, and the Beeches, a long-stay hospital for the elderly, both of which have been threatened with closure. What I find is a revelation. Here are two hospitals who know the value of the service they offer their local community, and who are determined to stay open. Staff, who ten years ago had no concerns beyond their role as carers, have suddenly discovered all manner of latent entrepreneurial talents.

After seeing the work at Much Wenlock, I have real doubts about the policy of shutting down a lot of cottage hospitals. It seems certain that cases which used to be dealt with at small hospitals like Much Wenlock will simply be pushed on to one of two large county hospitals where they are bound to cost more, and which will be less convenient for the patients.

I am surprised by the buzz of ideas surrounding the place. The hospital wants to continue providing a service to local people, and to solve its funding problems it is exploring, completely off its own back, ways in which it could raise additional money. The staff are talking about letting the second floor to Nuffield, the private hospital group. And there is the idea of getting a developer to build some sheltered housing in the very lovely hospital grounds where the hospital could provide nursing care.

This was written in 1989 by John Harvey-Jones when he visited Shropshire District Health Authority as part of his Troubleshooter series.8

Another key message from his visit was the need for the then health authority to connect with its stakeholders, patients and the community at large. The tendency to centralise services at the expense of local access has been highly problematic for the NHS for at least the past 20 years. Nothing energises public opinion and action like a planned closure, a rumour of planned closure or, not even closure, but modest changes to services.

Accountability matters

My experience of acute service reconfiguration in North Tees and Hartlepool taught me how critical local support or opposition is to success or failure. The old NHS strategy of just forging ahead really does not work. There is a clear need for the NHS to get smarter at a local level in terms of implementing change, using more sophisticated campaigning methods to connect with local people and engage in the frontline of public opinion, or risk ending up in the High Court.

The leadership response to these issues requires courage but it also requires the development of skills to enable NHS organisations to connect locally with people and for NHS leaders to be visible and credible local leaders, championing health and health services to their communities.

Part of this skill includes the sometimes difficult task of putting yourself in front of lots of people and explaining why changes are needed. In some quarters it has been called a ‘masochism strategy’, and sometimes it feels like it, but the old-fashioned public meeting still has its place and often it benefits the process of change in terms of finding more innovative solutions to seemingly intractable problems.

The skills and qualities needed by NHS leaders for the future development of the NHS include:

- leading to empower patients
- leading to connect with local communities acting as champions for health and health services locally

Leadership in the NHS: connecting for the future

Now, in a time of shifting services into primary care settings, the market entry of private sector providers to deliver NHS services, and the pressure to keep health services local, it looks like Harvey-Jones’ prescription for the NHS back in 1989 has been vindicated.
• being visible and credible with local stakeholders
• regularly explaining and discussing health issues with them.

Each of these leadership behaviours is underpinned by the qualities of courage and character. These are also the behaviours which will give us the best chance of transforming the NHS, by mobilising and empowering patients via better information and choice; by involving our local stakeholders and communities in the development and improvement of health services; and by putting ourselves out there as local leaders accountable for the health organisations we lead.

Accountability is also an essential aspect of leadership. There is no hiding place from the status of ‘accountable officer.’ This is particularly so when faced with difficult inquiries or Healthcare Commission investigations. I referred earlier to Shipman and, while I was not in Tameside at the time of his arrest and trial, once appointed to the PCT I had to pick up the baton of facing Dame Janet Smith at the Shipman Inquiry. Nothing quite prepared me for the experience of a day’s worth of grilling on the role of PCTs in monitoring, appointing, disciplining and appraising GPs.

Even the advice I received prior to my appearance about not worrying about the appendices to my statement proved wanting. The counsel for the inquiry fixed me with a steely glare and said: “Mr Hartley, I’d like to take you to Appendix 14 which deals with the regulations on the appointment of general practitioners to single-handed practices. Please would you explain the process to the inquiry?” There followed several hours of detailed interrogation, under oath, on the intricacies of Red Book arrangements and subsequent changes. What the experience brought home to me was the importance of being accountable for your organisation in all respects. There is a very real responsibility within the accountable officer statement and it can propel us into a range of arenas where we are called to account for our organisation’s performance, role or actions.

It is unlikely that the exposure of accountable officers to scrutiny and examination will diminish, particularly given the range and complexity of contracts we are now entering into with the private sector to deliver services.

I would emphasise the importance of understanding and living up to the accountable officer status as part of the leadership role in the NHS. Again, this will mean courage and character, as well as a willingness to answer for the decisions we take, sometimes at the highest levels. But this should not mean we are cowed and defensive.

For some managers a successful career is one which avoids any major controversies, with the guiding principles of ‘keeping your head down’ and ‘steady as she goes.’ It is unlikely that such leadership, or rather management behaviours, will transform the NHS.

But if leaders are able to be bold and fully exercise their status as accountable officers without fear, then support and backing from the Department of Health and from senior politicians is critical. However engaged or involved local people may be, difficult decisions to sustain and improve health services will need to be made now and in the future.

This is where local leaders ultimately need help from senior colleagues to help deliver the goods. Transforming the NHS to be fully patient-led will need support, commitment, courage and character from regional and national as well as local leaders.

Transforming the NHS to be fully patient-led will need courage and character from regional and national as well as local leaders.
Why do we seek to lead?

Francis Bacon recognised the paradox of leadership in one of his essays, which says:

> It is a strange desire to seek power and to lose liberty; or to seek power over others and to lose power over a man’s self. The rising unto place is laborious, and by pains men come to greater pains, and it is sometimes base, and by indignities men come to dignities. The standing is slippery, and the regress is either a downfall or at least an eclipse, which is a melancholy thing.9

Bacon wisely points out that being a leader, or as he puts it, ‘rising unto place’, can itself be restrictive and confining, while inhabiting this great place is slippery and uncertain. So why do we do it?

I think we do it in the NHS to make a difference, ultimately to people’s lives. Leadership in the NHS is a privilege and one which we need to embrace with courage and character. If we are to transform the NHS together, to effect real and lasting culture change, we need to reward and value the leadership behaviours that will take us there. For me, these are:

- leadership that develops and delivers real patient-power and real choice
- leadership that is involving, engaging and connects the NHS with our communities, and embeds and aligns its values with those of local people
- leadership that is up-front and ready to engage, explain, defend and ultimately decide on a range of difficult issues, always with a clear sense of our accountability to the community and the patients we serve
- leadership for change, supported and valued by those above us, giving us the authority to act locally and the backing to see the changes through, rewarding innovation, change and challenge to the status quo.

Overall, this recipe for a patient-focused localism rooted in NHS leadership is, I believe, necessary for us to take the next steps forward in a complex and changing environment. This must be underpinned by courage and character if we are to live up to all our roles as leaders, and indeed if we are to live up to the memory of Geoff Scaife.
ACKNOWLEDGMENTS

I would like to thank several people for their views and thoughts in preparation for this lecture: Neil Goodwin, Ken Jarrold, Mike Farrar, David Cain and my wife, Karina. I would also like to thank Gill Morgan for the opportunity of delivering it.

Julian Hartley

Leadership in the NHS is a privilege and one which we need to embrace with courage and character.

2. Covey, S. 1999: Principle-centred leadership. Simon and Schuster

3. Robbins, A. 2001: Giant steps: small changes to make a big difference. Pocket Books


7. Kramer, I. Quoted in In view (NHS Modernisation Agency Leadership Centre) issue 5, March 2005


THE AUTHOR

Julian Hartley joined the NHS in 1991 on the General Management Training Scheme (GMTS) following two years teaching after previously studying at Durham and Cambridge Universities.

Julian’s training was largely based in the North East of England but also included three months in the Punjab, India, working in a busy hospital. Following GMTS, Julian worked in a range of jobs around the North East, including South Tees Acute Hospitals Trust, Northern and Yorkshire Regional Office and Newcastle Upon Tyne Hospitals before being appointed as Director of Acute Services, Planning and Development at North Tees and Hartlepool NHS Trust.

Following this, Julian moved to the North West to become Chief Executive of Tameside and Glossop PCT. After three years leading the PCT, Julian returned to the hospital sector in late 2005 to take up post as Chief Executive of Blackpool, Fylde and Wyre Hospitals NHS Trust.
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Geoff Scaife, who died in April 2004 aged 55, was Chief Executive of Avon, Gloucestershire and Wiltshire Strategic Health Authority. He was formerly Chief Executive of Birmingham and The Black Country Strategic Health Authority, Chief Executive of the NHS in Scotland, and previously worked at 10 Downing Street.

The Geoff Scaife Memorial Fund was established to support an annual lecture on the theme of health leadership; the lecture would be delivered by a young NHS manager. The lecture is to be delivered each year at the NHS Confederation annual conference. The NHS Confederation and the NHS Institute for Innovation and Improvement will be publishing an adapted version of each lecture, with the aim of reaching the widest possible audience.

The first lecture, adapted here, from Julian Hartley, now Chief Executive of Blackpool, Fylde and Wyre Hospitals NHS Trust, eschews what Julian calls ‘off-the-shelf’ leadership and sets out to explore the leadership behaviours required to effect real and lasting change in the NHS. Amongst these, he says, are courage and strength of character – qualities also possessed by Geoff Scaife.