

Addressing both national and local accountabilities: effective relationships between SHAs and PCT boards

Introduction

Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) are relatively young NHS organisations and have roles that they have explored and developed in the period since they were established. All account for their performance to the Department of Health (DH) and also have separate, legally constituted Boards. As the accountability to the DH runs from the PCTs through the SHAs and there is a natural tension between addressing issues of concern to local Boards and those prioritised nationally there can be friction between SHA and PCT Boards which is often described as a lack of trust.

Talking about lack of trust in this way can seem accusatory and unhelpful, and so, over the winter of 2004-5 a short series of conversations was held between a small number of PCT and SHA chairs¹ to explore how accountability for delivering the agenda of a democratically elected government for its highest profile public service can be married with the freedom to address local priorities.

We realised very quickly that these issues were not exclusive to the relationship between SHA and PCTs and that the learning from exploring this particular set of dynamics may be germane to others.

Is trust important?

These conversations responded to feelings of lack of trust, but first we considered whether trust is indeed important. We decided that it is, using the following reasoning.

We could consider that the primary role of the public services is to deliver the agenda of a democratically elected government and with good will, honesty and integrity. We could also suggest that public services have another important responsibility which is to represent to the government their understanding of the complex realities they are dealing with, thus enabling the government to set an agenda that is appropriate and deliverable. In a large organisation like the NHS, for these processes of enacting and determining policy to work well, NHS organisations (and in particular their Boards) need to be able to trust the other organisations with whom they interact to behave with good will, integrity, and competence. If this trust is lacking, both the policies themselves, and their implementation, will be less effective.

What do we mean by trust?

There are many accounts of trust to be found in the literature, and the one we thought the most relevant in this context is that of interpersonal trust, between individuals or groups, where trust is an outcome of an assessment of the trustworthiness of the other. Using this definition, trust is not something we *choose* to place or not, it is a response to our perceptions of others. We can then

¹ The membership consisted of three PCT chairs, two SHA chairs, a member of the DH performance directorate, an observer from the centre for clinical ethics at Oxford university (ETHOX) and the facilitator/author.

choose to act as though we trust when we do not, but the level of trust itself can be influenced only by the trustworthiness of the other or by our perception of it. We can see straight away, then, that simply calling for increased trust is inappropriate, in that increasing levels of trust without a commensurate increase in trustworthiness is actively dangerous.

If we are to increase levels of trust we need to understand when it is valuable to trust and when it is not. Using this definition, trust is valuable when:

- the trust has been wisely and well placed, by people who are able to make sound judgements about trustworthiness,
- the recipient of the trust is trustworthy in that they have stable dispositions to behave in particular ways,
- and those stable dispositions are to behave in ways we value.

Conversely trust can be damaging if:

- potential trusters are gullible or credulous, overly suspicious or cynical, lazy in obtaining evidence, or poor at distinguishing relevant from irrelevant evidence,
- potential recipients do not have stable dispositions but change their behaviours arbitrarily or whimsically,
- or those stable dispositions are to behave in ways we disvalue.

So if we do want to increase levels of trust, and in particular if we want to encourage people to trust us, we need to behave in trustworthy ways and proactively provide credible evidence that we are doing so.

What is trustworthiness?

The literature suggests that trustworthiness always involves honouring commitments to act, and honesty (making claims that are true). Also that the trustworthiness is limited to a particular area of activity over which there must be agreement between truster and trusted, and within that area of activity there must be a reasonable level of technical competence. Thus, to take a small scale example, a home owner might trust a plumber to fix a water tank (but not to make financial investments or look after children), and to do so competently. The plumber would be trustworthy if in addition he arrived when he had committed to, and represented the costs of replacement copperware honestly. However there appeared to us to be another element to trustworthiness and that is the values underpinning decisions made within the area of activity. So, if a decision had to be made about which replacement tank to choose, we might want to be sure that the criteria used to make the decision were the ones most important to the homeowner, perhaps reliability and capacity rather than ease of fitting and cost.

Trustworthiness thus appears to consist of:

- honesty
- honouring commitments
- agreement about the area of activity
- a reasonable level of technical competence within that area of activity
- values, or criteria that underpin decision making.

There is also a view that the motivation to be trustworthy, and therefore trusted, arises when an ongoing relationship is seen as being in the interest of the trusted party. Where this is not the case trustworthiness is less likely.

Trust, trustworthiness and the organisations of the NHS

The NHS

The context in which SHAs and PCTs operate has a direct impact on their roles and relationships, so it is worth describing some relevant features.

The NHS, as perhaps the highest profile public service, will inevitably attract a high level of involvement from politicians, both those in government and those who would like to be. It is worth thinking about the nature and priorities of politicians. On the whole they are people who like to act to resolve problems, and as Ministers are bound to introduce initiatives and be impatient with the pace of change, they will also be impatient with people they perceive to be obstructing change, and intolerant of what they perceive to be excuses. They care about the levels of service both personally and politically, so they want to see good things happening, and for them to be seen to be happening. They will all (regardless of party) want to increase, or at least justify, the productivity of a government run service, and the quality of its outcomes. The corollary of this is that bad news about the service will cause them immediate and great concern, and the level of concern will depend on the amount of political capital at risk rather than the size or significance of the incident itself. They are given a lot of advice from many directions, and they have little direct knowledge of the service themselves. They develop a 'big picture' of the service they want to see, and deliver the broad brush strokes in the form of policies, they rely on the detailed paintwork to be undertaken by the service. They will not be aware of how all their policies interact, because these interactions occur at the more detailed level (and also because the expectation that these interactions are fully possible to anticipate is flawed²).

We should therefore expect that there will be many policy initiatives that do not all support each other, and a pressure for evidence of efficiency and quality. We can also expect that any organisation creating 'noise'³ can expect a high level of direct interference, with the level of noise determining how much interference, and not the severity or significance of the incident that prompted it. These are all an inevitable part of our democratic process and a government run service.

It is therefore fundamental to the role of all NHS organisations that they are able to respond both to these policies and these pressures. As organisations of the NHS are interdependent and rely on the performance of others to be able to perform themselves, it is clear that the work of enacting government policy, and of informing government of difficulties in so doing, is a collective responsibility in which all have their part to play. In this setting, talk of individual NHS organisations being autonomous can be misleading. While organisations are legal entities and have legal accountabilities of their own, they are not entirely masters of their own fate and rely critically on the performance and choices of other organisations for their own success.

Placing trust

As trust is the outcome of an assessment of trustworthiness then, if organisations are to place trust wisely they need the skills and opportunities to make judgments about trustworthiness (i.e. honesty; honouring of commitments to act; and competence and similar values exercised within an agreed area of activity)⁴. When it is the trustworthiness of an organisation (rather than an individual) that is being assessed there are at four components to consider: personal, organisational, strategic and structural.⁵

² And is based on linear thinking that does not take account of what we know about complex systems.

³ Media coverage that is unfavourable

⁴ ⁴ One participant also observed that their reputation with their SHA was 'not a sign that I am doing a good job, I think it is a sign I am managing the relationship'.

⁵ OD Partnerships Network and the NHS Confederation recently explored the relevance of the work of Robert Galford and Anne Seibold Drapeau as set out in their book '*The Trusted Leader*' (Free Press, 2002) and in their Harvard Business Review article '*The Enemies of Trust*' (February, 2003). In these publications they suggest three kinds of trust:

Personal Trust, exists when a CEO is trusted as an individual and as a leader. When this type of trust is in place, people believe that the CEO (i) is honest; (ii) will do what they say they will do; (iii) will treat them fairly; and (iv) will make an effort to look out for their well-being. **Organizational Trust** exists when not only the CEO is trusted but people also trust the CEO's organisation. They trust for example that the organisation's policies will be honestly and fairly administered and implemented as stated. **Strategic Trust** exists when people have trust in and support the organisation's mission, and in how the organization will execute and deliver on that mission.

In practice this involves contact and interaction between individuals and between different levels of the organisations, with good mechanisms for feeding back perceptions and considering evidence. Organisations in which members are encouraged to engage with colleagues from other organisations by meeting them and conversing directly with them, rather than by exchanging pieces of paper, will be better able to gather the impressions and other evidence on which to base their judgments. This is true for non-executive board members as well as for executives, so opportunities for non-executives to meet their counterparts at regular, frequent intervals will repay the time invested.

Judgments will also be informed by the relationships and perceptions of people in other organisations, so members of all NHS organisations should expect that their reputation will be a subject of discussion. Organisations which encourage their members to share perceptions constructively rather than through malicious gossip or the opposite (politically correct but insincere support) will be able to make these judgments more perceptively.

An initial and continuing openness of mind will be more effective than either cynicism and suspicion, or credulous enthusiasm. An acknowledgment of the importance of making judgments about trustworthiness, in the form of an explicit agenda for doing so, allows due effort to be put into the gathering of impressions and evidence.

In practice trustworthiness is often gauged, in relationships of any kind, by one party taking a small risk, of acting as if they trust the other with regard to something small. If the trusted party demonstrates their trustworthiness a greater risk is taken, and so on. In our conversations we came across examples of where the early placing of trust led to very constructive relationships, and others where stereotyping and suspicion frustrated their development.

Increasing trustworthiness

We have said that a person, or collection of people, is seen as trustworthy if they are honest, honour their commitments, and demonstrate competence within the area of activity that we entrust them with, adopting values or criteria for decision making with which we are in accord. All of these elements benefit from further description.

Honesty

It goes without saying that in their dealings with each other PCTs and SHAs will not lie, that they will tell the truth, but in the context of trustworthiness we need to develop a picture of what 'telling the truth' looks like. It includes, for instance, telling all of the *relevant* truth, and telling *uncomfortable* truth. Both of these will involve an amount of research and assessment so that the facts presented are known to be true, and that they fairly represent a situation. This means that both parties gain a sense from the other of what is really happening, without exaggeration – neither undue optimism, nor defeatist pessimism.

For PCTs presenting information to SHAs relevant truth will include giving a realistic assessment of their likely performance against financial and performance targets, and this will depend on an accurate judgement about the performance of the acute trusts (ATs) with whom they are contracting. This latter judgment is another example of a level of trust and needs to be undertaken with as much skill and energy as described above. Similarly the SHA will, as part of the relevant truth, be clear and unambiguous about what is required in terms of performance, and prepared to share with a PCT its judgement of the PCT's ability to deliver. Again this latter involves all the skills and effort described above.

ODPN and the NHS Confed have identified a further kind of trust : **Structural trust**. Lack of structural trust occurs where one organisation or CEO will incur greater penalty for a collaborative initiative that goes wrong than will their partners.

The truth also involves uncomfortable truth. All the factors that impinge on performance need to be 'on the table' even if this causes discomfort. This requires a level of bluntness and straightforwardness that has not historically been rewarded within the NHS. It requires that when a decision is to be made that involves a number of people and organisations, they are all encouraged to express their genuine views even if these are not flattering to others, in their presence. This is a reversal of the usual pattern: of being polite when meeting together and then complaining about people afterwards.

Uncomfortable truth also includes giving a realistic description of the difficulties of implementing a policy or directive, to those who are closer to having drafted it and being held accountable for its implementation. This will involve SHAs faithfully reflecting the views of those closer to the ground (PCTs) where they are convinced of their trustworthiness, it therefore again requires a wise assessment of this. It also requires phrasing the truth in ways in which it can be heard, and some 'rules' for giving bad news to higher layers in a hierarchy are included as an appendix.

Honesty then requires time and effort and also courage. There are ways in which honesty can be encouraged and these include:

- rewarding honest and sincere behaviours and penalising those who are manipulative or game playing.
- recognising that it is possible for two people to disagree and both be right
- moving away from point scoring, position and power broking to exploration and solution
- exchanging the accusatory 'how can they say that!' for the exploratory ' why are they saying that?'
- taking care with environmental factors such as size of rooms and shape of tables.

Language is important too when we are talking about honesty. Where different groups are using language in different ways, or have a different understanding of a term or idea, then this does not allow honest exchange of views. Honesty therefore requires the use of concrete examples that discourage listeners from being able to project their own meaning onto terms being used.

For people to feel able to express themselves sincerely they need to be sure that they will be heard in the same spirit, so if PCTs or SHAs are tempted to complain that the other is behaving cavalierly or manipulatively rather than honestly, it will be worth the complainer examining the way in which they are responding to statements made to them.

It can be seen then that honesty of this kind will itself require a level of trust, or at least a decision to risk acting as though trusting.

Honouring commitments to act

Failure to honour a commitment results in immediate loss of trust so commitments to act need to be made sparingly, and in full awareness of the implications of the commitment. Wherever we are suspicious that a commitment has been made without this awareness we are wise not to place our trust.

During the conversations, reference was made to the values and behaviours articulated for the SE London NHS community and these are listed as appendix 2. One of the behaviours explicitly states '*An agreement is an agreement. There is no going back on agreements. Any concerns must be raised in the initial discussions. once these agreements are made they are final*⁶.' This can clearly be seen as one form of honouring commitments to act. If such agreements are to be honoured in this way then there is a need for reasonable time to be allowed for them to be reached. There is thus an onus on both PCTs and SHAs in relation to this element, and where reasonable time cannot be given then

⁶ Of course as circumstances change then sometimes agreements have to be revisited, so the principle here is that people and organisations enter into agreements with the genuine intention, and with the organisational competence to deliver them.

ways need to be explored for sharing the risk of non-delivery between them. Here again we can see that trust will allow this exploration, and also be nurtured by it.

There were several references, during the conversation, to people and organisations behaving in ways that were disappointing, and many of these could be seen as failing to live up to values that had been stated, or policy rhetoric that had not been lived out in practice. We could consider these to be instances of failing to honour commitments to act.

Another of the SE London values is *'to lead and not blame'* and this could be seen as another, broader, form of honouring a commitment. In this case a commitment to act with integrity and responsibility. Gandhi advocated *'be the change you want to see in the world'*, Stephen Covey talks of *'being a light not a judge, a model not a critic'* and these are perhaps other formulations of this. *'We are the people we have been waiting for'*⁷ is yet another. So *'honouring commitments to act'* needs to be understood in this fullness.

A specific example of where SHAs have the right to require PCTs to honour commitments to act is that of taking targets (financial and performance) seriously.

An example of PCTs' legitimate requirements of SHAs might be that of living out expressed values about e.g. caring for staff.

Agreement over the area of activity

The area of activity is the area of influence, authority and accountability. It is their area of operation within which the SHA has a right to expect the PCT to deliver, and vice versa, and to demonstrate a reasonable level of technical competence.

It was clear from the conversations that much of the area of activity is clear to both parties, but also that some of it is disputed. So it seems that, if trustworthiness is to be achieved, the area of activity needs to be *agreed* by both parties, to be made *explicit*, and to be seen by both parties as legitimate.⁸ Thus an ongoing conversation between PCT and SHA needs to clarify the area of activity for each, and below we suggest aspects of that area of activity that are pertinent.⁹

A PCT and their SHA might agree that the PCT will:

- Work purposefully towards the government's agenda. Specifically:
 - Working within financial limits
 - Taking targets seriously, by aiming to improve underlying service configuration and processes, rather than short term cosmetic or fudging exercises.
- Keep 'noise' to a minimum, to reduce levels of interference from politicians
- Take responsibility for working with the wider system, and develop constructive relationships with acute trusts and independent sector organisations, in order to do this entering into and monitoring contracts, and prompting and leading service reconfiguration.
- Be honest with the local population and work constructively to ascertain and meet local needs, in the context of a national agenda.

⁷ Heard by one of the participants from the Bishop of Bath and Wells

⁸ Again the SE London behaviour rules refer to this:

'Collective and individual targets are set, reflecting what we want to be known for. Achievement of these gives people a licence to operate in other areas.'

⁹ Clearly the area of activity of PCT and SHA must be agreed in the context of relationships with other NHS organisations also (DH and ATs for example)

- Build local partnerships outside the NHS to deliver the *health* agenda
- Develop a credible, feasible local strategy to undertake all of this, that recognises that government policies and priorities will change and that the organisation must be able to respond to these changes.
- Develop people and processes that are flexible and can deal with the present, the planned future and the future not yet articulated, or in other words: be able to maintain the momentum of existing change initiatives when the change agenda itself changes. When these changes in priorities happen, help staff to see them as different moves in the same direction rather than swings or reverses. In order to do this, (perhaps in conjunction with the SHA) to scan the horizon, make use of intelligence from other organisations (e.g. the DH), identify trends the government is likely to respond to, and generally think ahead.
- If, after a genuine and competent attempt to implement policies, find policies conflict or are not delivering the results anticipated by their originators, reflect these difficulties upwards.

A PCT and their SHA might agree that the SHA will:

- Have two roles: a performance management role on behalf of the DH, and a role supporting and adding value to the Trusts within their area; and that they will keep these roles separate and distinct. Within the first role they will monitor financial and activity performance against targets, in ways that are clear, transparent, and fair. In the second they will see their role as another vital piece of the jigsaw, and not as superior to the trusts in their area.
- Interpret the government's agenda for their area, and assist trusts in doing so more locally still.
- Assist PCTs in prompting reconfiguration of local services, by offering expert assistance in modernising techniques, by facilitating exchange of ideas and good practice, and by fostering good relationships between organisations.
- Support trusts who behave constructively in their relations with others, and remonstrating with trusts who do not. Make ongoing careful assessments of the trustworthiness of their trusts, as described earlier.
- Where trusts are behaving well protect their star ratings at the end of the financial year by moving money into and out of accounts.
- Develop a sector wide strategy that delivers all of this, in conjunction with the trusts.
- Understand that policies may not interact productively and take a genuine interest in how things are working out at frontline level. Reflect any difficulties upwards, using the rules in appendix 1.
- Help their economies anticipate the change agenda, encouraging them to see the challenge 'not as a story but as an adventure'.

Technical competence

Technical competence encompasses the attitudes, skills, structures and processes that together enable an organisation to fulfil the role and responsibilities agreed as the area of activity, and in the discussions between SHA and PCT about the area of activity they will also cover the nature and level of technical competence expected.

The technical competences that might be agreed as appropriate for a PCT could include:

Attitudes:

- Perceiving and handling the financial position and performance as one and the same thing.
- Working collaboratively with other organisations, believing that ‘we really cannot succeed on our own’ and recognising that it is not possible to take unilateral decisions without discussing and addressing the concerns and impacts on partners.
- Giving proper priority to good communication / relationships with MPs.
- Leading by example in engaging with clinicians.
- Being proactive and advising in advance when things are going wrong.
- Asking for help, taking responsibility even when things seem insoluble, rather than going over past history. ‘What can we do to help now?’ rather than ‘Whose fault is it we got into this position?’
- Anticipating the future: believing that addressing the agenda of a democratically elected government is legitimate, and approaching new initiatives constructively.
- Being prepared to work with uncertainty; happy to work towards solutions without knowing exactly what they will look like or how to get there.
- Seeing the big picture without getting pulled down into ‘we can’t do that’ ‘we’ve tried that before’...
- Staying focused on the high level purpose whilst being opportunistic.

Skills:

- Collaborative and facilitative working: ability to work with people with different thinking and communication styles, to build on ideas, to understand and use the levers that will encourage engagement.
- Technical expertise in aspects of commissioning: needs assessment; evaluating alternative service providers; understanding cost drivers, negotiating and monitoring contracts; all the associated data analysis and coding etc....¹⁰
- Working with GPs and others to encourage demand at appropriate levels.
- Engaging all stakeholders (MPs, AT managers, AT clinicians, patients and public ...) in service reconfiguration.
- Thinking ahead, predicting the future, constantly shifting, moving, redistributing capacity to be able to respond rapidly and effectively to new initiatives.
- Anticipating noise: keeping aware of sensitivities of local communities and groups, and the factors that may lead to disproportionate levels of noise.
- Alerting the SHA without alarming them.
- Managing their reputation with other key players
- Being flexible – if something doesn’t work, understanding why and doing something different.

The technical competences that might be agreed as appropriate for a SHA could include:

Attitudes:

- Working towards co-leadership of their sector, working together with all the NHS organisations within it, and encouraging a climate of trust and trustworthiness.
- Perceiving role as helping the organisations in their sector to perform, and also to give the DH confidence in their ability to do so.
- Happy with constantly shifting reality, people and systems, and therefore not passing on anxiety but encouraging a ‘how shall we deal with this?’ stance.
- Willingness to invent the future before it is imposed.

Skills:

Skills in fostering a working community of NHS organisations:

¹⁰ This expertise is then available for the PCT to *facilitate and support others (e.g. practices and/or localities) in tasks such as commissioning, clinical governance etc*

- creative skills, envisaging the future, developing ways of engaging PCTs and ATs around an area of policy
- assimilating information quickly, structuring the debate about key issues, then facilitating and leading.
- collaborative idea generation, well researched sensitivity analyses and the ability to talk them through, open mindedly with leaders in the sector.
- understanding of what does and doesn't motivate different people and organisations to succeed.

Skills in relating with the top team:

- political skills.
- telling people things in ways they can hear it.
- getting people to see situations in dynamic, non-linear ways.

Skills in anticipating change and helping others to do so:

- Keeping abreast of trends that will influence government policy.
- Good links into DH so aware of trends and climates of opinion.
- Knowing what work is in the pipeline and the impact this will have on budgets, strategies etc.
- Asking the questions that will prompt good strategy decisions.

Skills in assessing performance of organisations in sector:

- Making sound judgements about where financial problems are arising (e.g. recurrent v underlying deficits, over performance v inefficiency ...)
- Choosing appropriate ways of dealing with performance so that good performance is rewarded and poor performance is not.

Values

Where one partner does not share the values espoused by the other, or believes the other partner is using different values, then they will find it difficult to have confidence in the decisions made by the other. Values can be included in the discussion about area of activity and technical competence.

It may be possible to agree, for example, that decisions made by both parties will be guided by the following principles:

- Responsiveness to patients: the local population will have ready access to services that meet their needs and wishes, and different patient groups are treated fairly
- Staff at all levels are managed competently and treated fairly
- Ministers are enabled to develop sufficient confidence in the performance of organisations across the sector that interference is minimised / a good degree of autonomy is permitted
- Good performance is rewarded and poor performance is not
- All those concerned (members of the public, patients, staff) are treated as worthwhile individuals with relevant views.

Relationship seen as valuable

Where either the SHA or the PCT does not perceive an ongoing relationship to be in their interest they will not make the effort to be trustworthy. So where an assumption of 'command and control' pervades and structural accountabilities are assumed to be more important than the development of an effective relationship then trustworthiness (and hence performance) will be a problem.

Acting to build trust

This paper sets out to explore how trust and trustworthiness can be increased and has already indicated a number of ways of doing so. In our conversations we highlighted the importance of an acknowledgement of interdependence, a focus on the goal of responsiveness to patients, and processes for reaching agreement that are seen as fair by all concerned, and we suggested that all of these are more likely if individuals from the Boards involved know each other and have developed

relationships with each other. This suggests that contact and regular and frequent interaction between individuals at Board level is highly important.

This may have implications for the size of SHAs. It may be that size should be determined by the ease with which individuals can foster contact, interaction and engagement, and that this could be different in different parts of the country to reflect differences in geography, in density of population, in boundaries of other agencies, etc.

It may also have implications for the ways people perceive the family of organisations within each SHA. One SHA in the conversation aims for the SHA and Trust Chairs to see themselves as the board of a holding company. In this model everyone has a role in relation to their own organisation and an additional one relating to the corporate whole, 'working together and doing difficult things together, and sharing responsibility for the whole enterprise'.

There may also be implications for the kinds of people appointed to non executive and executive positions. For instance the SHA Chair would need to be able to handle, convince and win over chairs of their Trusts and be respected both locally and by the Top Team. Trust Chairs would need an ability to see their own organisation in the wider context, and a willingness to work for the good of the sector, recognising that this will allow their own organisation and its work to flourish. NEDs, local clinical leaders and the senior executive staff would also need to be sympathetic to the idea of working within a community of organisations, and Boards generally would need to include among their members people able to work in an open and learning culture.

Concluding thoughts

One of the participants observed that 'When you are in an SHA you realise that "you cannot do it for them" and when you are in a Trust you learn "there is no point in expecting the SHA to sort it out". This describes an environment in which operating through trust, and hence trustworthiness, is the only way. We hope that our conversations and conclusions are of use to others in helping to promote these.

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Appendix 1.

Some initial thoughts on rules for giving bad news to the next level in a hierarchy:

You *can* control what the next level knows by ensuring they hear it first from you. When you alert them you *must* have all the facts, including detail as this gives confidence, what you *cannot* control is events thereafter.

When you inform the next level of the problem, inform them at the same time of what is being done to resolve it.

You can reinforce their confidence in the effectiveness of your action by providing unsolicited, frequent and regular progress reports

If you want assistance make sure (a) you are clear what it is that you want and (b) it is in the gift of the next level.

In relation to finance it is worth noting that:

- It is a waste of time telling people you have a problem
- Explanations appear as excuses
- You must have a credible plan for addressing the problem.

Appendix 2.

The values and behaviours articulated by SE London SHA ,
which are presented more attractively on their website.

Values based leadership

To lead not blame

To work together not undermine each other

To look for answers not give excuses

Collective and individual responsibility - three simple rules:

1. What we want to be known for

Collective and individual targets are set, reflecting what we want to be known for. Achievement of these gives people a licence to operate in other areas.

2. An agreement is an agreement

There is no going back on agreements. Any concerns must be raised in the initial discussions. Once these agreements are made, they are final.

3. We speak well of each other

Differences of view around the table are encouraged and debated when decisions are made. There is then no place for undermining comments to others.