

Sailors Don't Become Sailors in Calm Seas

Foreword

This action research is the result of thirty five years' experience working in the health system, first as a Community Nurse, then as a Staff Nurse, as a Counsellor and Therapist, Senior Manager and for the past six years a Management Consultant.

The research is also informed by extensive contact with a variety of health services, at all levels and across the sector. Working in other sectors such as Education, Justice, Social Services and Not-For-Profit has also proven beneficial, particularly in experiencing a broader range of services and to discover that the challenges within these organisations are similar. As a Management Consultant I have been privileged to be involved in supporting organisations to identify and implement solutions to a range of management issues. This has resulted in the development of a comprehensive toolkit that I share amongst all providers.

Sailors don't become sailors in calm seas.

That is true. Learning can be profound when the environment is more challenging. When you weather a storm and come out wiser you really are a better sailor and have no doubt learnt some great navigational skills for the future. However if navigating through the storm is so beyond your skills or understanding that you can no longer stay afloat, then generally speaking people will simply not survive. Calm seas are an opportunity to undertake formal learning, but challenging seas are the opportunity to learn by your experience.

Thank you to all the clients, patients, cleaners, chairperson(s) of board(s) and board members, the clinicians, the allied health staff, administrators and secretaries, Directors of Nursing, CEO's, Directors, Clinical Directors, Kaumatua and Maori Advisors, consumer and family advisors, techs (IT), storemen, HR Consultants, Risk Managers, Quality Managers, Accountants, the list is endless. Your expertise and specialist skills allowed me to develop as a generalist.

And thanks to one of the Clinical Directors I have worked closely with in the past for your testimonial to me:

“Diana is one of those very rare managers (in fact unique in my experience to date) who applies very effectively in her daily practice all those leadership, communication and empathetic skills and knowledge that are rarely evident outside of the text books and training workshops.”

Cost of staff turnover

All health services are aware of the significant cost of staff turnover. This is not a problem unique to health services and there is considerable research on strategies to manage it both in commercial world and government department settings. NZ Business released an interesting article in 2005 by Martin Price, HR Equations Limited. This article stated managing directors are seeing their mission critical concern is to retain good people, find talent and keep it. Suzanne Boyd, Executive Manager of Clayton Ford Recruitment Wellington also states something similar but cites David Rock, the founder of Results for Coaching Systems, who states there is a widening gap between how people want to be managed and how people are being managed and that reducing that gap is a critical success factor in retention of talent.

Both also agree that investment in training first level managers in this millennium's preferred management style (providing leadership and coaching) is a critical success factor. Those managers who provide opportunities for development of high performing staff (succession planning, reward, recognition, stimulation, inspiration, motivation), investment in informal learning and development (coaching, mentoring), role modelling, ability to give and receive feedback, ability to hold quality conversations, excellence in people management and relationships and an ability to inspire and motivate others are more likely to retain talent.

The College of Nurses Aotearoa (NZ) Inc has also recently commenced conducting research into staff turn over with a longitudinal study: *The cost of Nursing Turnover and its Impact on Nurse and Patient Outcomes*, by Dr Nicola North, Professor Frances Hughes, Dr Mary Finlayson, Erling Rasmussen, Dr Toni Ashton, Taima Campbell, Sharon Tomkins, School of Nursing, University of Auckland.

Although this report comes from a national survey of Directors of Nursing of District Health Boards and is not focused on Nurse Managers, it does raise some interesting points:

- *'Poor working conditions and opportunities have been identified as contributing to over 50% of NZ nurses ceasing active employment as Registered Nurses (RN) within 11 years of initial registration*
- *Turnover normally ranged between 12% and 25% with five DHB's having greater than 25% turnover. Negative impacts included bed closures, restricted elective surgery, reduced inpatient admission and ED service restrictions*
- *Generally, retention is seen as a major priority in reducing turnover*
- *The most frequent strategies used to improve retention and reduce turnover involved professional development, strengthening nursing leadership and addressing work environment concerns (a family focus,*

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flexible rosters, better parking and café facilities and addressing issues identified in exit interviews) and strategies connected to Magnet¹ hospital status and models of care

- *Nursing leadership has been shown in overseas studies to be related to nursing turnover*
- *The organisational climate affects employee satisfaction and turnover'*

There are many health services that are working with all or some of the criteria for Magnet Hospital Status but may not be gaining all of the desired outcomes from their investment. If we are to take a leaf out of the commercial world and couple this with experience in the health setting we would focus on closing the gap between how people are managed and how they want to be managed and utilise research based evidence to retain our limited pool of professionals. Improving the organisational culture would be one of the key strategies to move towards this goal.

Reports by the New Zealand State Services Commission provide a New Zealand context on using coaching for development and performance. The State Services Commission research resulted in the following two relevant reports being produced:

¹ *Key characteristics Magnet (The College of Nurses Aotearoa (NZ) Inc); The magnet hospitals shared certain organisational features that served to promote and sustain professional nursing practice. These features included:*

- *A flat organisational structure*
- *Unit-based decision-making processes – decision making was decentralised to the unit level, giving nurses on each unit as much discretion as possible for organising care and staffing in a manner most appropriate to the needs of their patients*
- *Influential nursing executives – the nurse executive was a formal member of the highest decision-making body in the hospital, which signified the high priority that hospital administrators placed on nursing*
- *Investments in the education and expertise of nurses*
- *The administrative structures supported the nurses' decisions about patient care*
- *Good communication existed between nurses and physicians*
- *Very high patient satisfaction*
- *Excellent RN to patient ratio*
- *A decrease in hospital acquired infections, falls/other injuries, and medication errors and related complications*
Very low RN turnover rate'

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- *Career Progression and Development Survey, 2000: Results for the New Zealand Public Service (CPS) which stated: “. . . the development and training opportunities most important to public servants are being able to demonstrate their skills and abilities, on the job training and gaining experience in a range of tasks.”*

- *The Report of the [Ministerial] Advisory Group on the Review of the Centre, January 2002, identified the following three interventions to improve work place performance:*
 1. *‘Coaching staff to manage and influence for better outcomes not just for their current roles but preparing them to play new roles in future, perhaps at higher levels, perhaps elsewhere in the State sector;*
 2. *Coaching managers, to be more effective in their people management roles – in providing performance management, training and development, mentoring and career support to their staff; and*
 3. *Coaching staff at all levels - not just managers - to provide leadership, including innovation, responsiveness, risk management, partnership and teamwork.*

The research went on to state: “Coaching is a means for enhancing good performance on the job and career progression”. ’

Providing appropriate, focused and integrated training based on experience within the health setting makes the training practical and real to the participants. The trainer must be able to coach, mentor, teach, educate, role model, give and receive feedback, be able to hold quality conversations, demonstrate excellence in relationship management and have experience of the complex setting in which these first line health managers are operating. Understanding the storms that managers find themselves in and supporting them in gaining skills and confidence in weathering the storms means more will survive and learn from their experience, becoming true and experienced sailors able to provide leadership to others.

Building the skills of first line health managers and leaders will result in retention of staff as everyone personally grows under a well developed and rounded manager and leader and staff loyalty is more likely to be secured.

INTRODUCTION

An organisation is made up of a group of people that includes individuals and sub-groups and, like the human body, an organisation constantly strives for a state of equilibrium. Homeostasis is described as: '*a state of equilibrium or a tendency to reach equilibrium, either metabolically within a cell or organism or socially and psychologically within an individual or group*²'.

Supported by multiple systems and processes that inter-link to operate as a whole, an organisation relies on system stability to operate effectively and efficiently. We only have to examine the results of poor change management to know the extensive cost (human, financial, loss of service, loss of stability, structure and infrastructure failure) that occurs when systems fail.

Clinicians (technicians³) know this theory and fully understand that stability may be achieved in a functional or dysfunctional way or anywhere along that continuum. Clinicians understand the process of adaption that occurs in the body when something upsets its equilibrium (in its most basic form; high temperature results in sweating to cool the skin).

As a manager their key task is to understand all of the components that make up the organisation (the system) just as they have done as a clinician. They need to have some understanding of what in the system is working (functional) and what in the system is not working and why (root cause), how the system responds to different events (process of adaption and manifestation of symptoms), how to effectively treat those events and how to ensure continuous improvement and learning (to avoid a reoccurrence of the same events in the future). On an even more important note it is also helpful if they have some insight into their own response to events and are aware of others and their response (emotional intelligence) because as a manager and leader we also have to deal with the 'human factor'.

During the past ten years I have seen significant improvement when managers, particularly new managers, are knowledgeable about the system they are working with and have access to the practical tools that assist them to be effective managers and leaders. The knowledge and skills they already have as clinicians need to be applied in the first instance to ensure a solid foundation of practical skills and knowledge is realised that already existed but that simply required transitioning.

This action research reflects areas that consistently come to my notice in the role of Management Consultant and as a coach, mentor and trainer. The results of the research are a reflection of what managers and leaders feel

² *Encarta Dictionary English (UK)*

³ *Where I have used the term 'clinician' throughout the paper this refers to allied health, technicians or any other health discipline and is interchangeable*

challenged by and then reflects the experience of developing appropriate, effective and successful strategies and solutions to overcome them. Over the past six years these strategies and solutions has proven to work well in developing effective first line managers and leaders in the health setting.

Creating breakthrough moments in learning

New managers and leaders in a health environment (or any other government or non government agency) become 'busy' shortly after appointment to this new role, often without a full orientation to the new role. This leaves little space for breakthrough learning or development of new skills. A comprehensive and formal orientation to a new role is a critical success factor for a new manager. Although on paper orientation looks like it has occurred, in reality many new managers are not well orientated to their new role.

Breakthroughs in learning come when we have time to stop and think (raise awareness). It takes time to understand, process and synthesise new information or consider old information in a new way. In other words learning occurs when we are focused but relaxed. Creating the right learning environment is critical to the success of new managers. Rarely will managers report their environment at commencement of the new role as 'relaxed'. It is more likely to be described by them as 'sink or swim' and it may not be long before they feel they are swamped by a storm with very little idea how they will navigate their way out successfully. As they feel the loss of control some will not survive; some will take the helm and use absolute control to stabilise; and some will 'do their best' under difficult circumstances at a personal cost. These strategies are rarely successful, unlikely to be sustainable and almost certainly are unlikely to result in retaining talent.

For the most part, as competent clinicians we run on 'auto pilot' (unconscious competence) as opposed to when we are learning a new skill where we tend to be consciously incompetent (we know we don't know, we are conscious of every step in a process and it takes longer to perform the associated tasks). This is similar to learning to drive a car. When we first start, we are very conscious of putting on the seat belt, arranging the rear vision mirror, starting the car, looking behind us for anything coming, slowly releasing the clutch at the same time as we accelerate and off we go. Within a short space of time we have mastered this and although we go through the same steps we are no longer conscious of each step involved in driving the car (we are now unconsciously competent). For a clinician transitioning into a new role as a manager it is like going back in order to go forward. In order to maximise current knowledge and skills and create an environment where new skills can develop we need to move away from unconscious competence and go back to conscious competence. Coming off 'auto pilot' and being conscious of processes takes more time. Consequently another critical success factor for a new manager is having the time available to transition in these early days and months.

Clinicians have a wealth of knowledge, expertise, experience and skills to call on as new managers. For the most part, however, they are unaware or do not have the time and space required to transition current knowledge and apply this to a new role. Frequently they report (in confidence) feeling out of their depth, however once this transitional platform has been built (and this can be completed within a few days' training) they can build on a more solid foundation of current knowledge that successfully underpins new learning and skill development. A new manager with some newfound confidence in their ability to manage the role, with the time available to process and synthesise information and who has undergone a comprehensive orientation (putting the resource in at the front end), will demonstrate positive results within the first six to nine months.

Coaching or mentoring nearly sixty one to one clients in the past six years, some of whom have had regular coaching and mentoring with me anywhere between a few months to those who have worked monthly with me for six years, will say that coaching is effective. Unlike many coaches/mentors Dynamic Leadership provides each client with a record of the session and these records have created the paper trail for this action research.

Alongside the one to one clients I have taken four interim management roles (often requiring a trouble-shooting role) and these have ranged from nine months through to a minimum of four months.

With over fifty contracts for management of projects, reviews, facilitating planning (strategic, annual, project, quality and risk) and service development the records from these contracts have contributed to understanding what is working well and what isn't.

To date I have also delivered over 35 training courses/ workshops covering a wide range of general management topics.

Dynamic Leadership Limited have developed a training course that has arisen from this action research: a programme known as S.T.A.R.T.:

Systems and Processes
Transferable skills, frameworks and knowledge
Awareness and emotional intelligence
Relationship Management
Transition and team work

FINDINGS

Whole Systems theory

Whole systems theory (the whole is greater than the sum of parts) is a foundation stone for any manager new or experienced – nothing works in isolation.

For clinicians this is a theory that is already well known to them but as clinicians this knowledge is based in a clinical paradigm. What is critical for a new manager is that they begin thinking about and building their knowledge in terms of the organisation as a system because their primary role now is to focus on this. It can be a complex system (depending on size and quality of the system as a whole) and although they have some understanding of it they are now looking through a new paradigm, that of general management. As a manager and leader they are contributing to meeting the goals of the organisation and the health needs of patients/clients, which is ultimately the purpose of good management in a health setting

Systems theory is also about how things are organised, that is organised in a precise and complex way. We can have all of the components of a car as individual parts but unless all of these components are put together in a cohesive way allowing them to interact and function as a whole, we still only have a lot of individual parts. Once the car is functioning as a whole we also have sub-systems: for example the cooling system or the steering system. One sub system may not be working well and will impact on the system as a whole. The car may also be part of a wider system, for example when the car is on the motorway. The car may be functioning exceptionally well but will also be affected by other cars in the wider system.

The health system is no different. A team (which can be based in an NGO, Maori or Iwi health provider or DHB provider etc) may function as a system in its own right, within a service, within a District Health Board (DHB) region and potentially across multiple regions such as in a Regional Service or an inter-DHB arrangement (a wider system). The more you know and understand the whole system and all of the components of the system the more successful you will be as a manager and leader.

Whole systems theory is also about stability. The size of a team makes a difference in terms of its ability to maintain stability. A large organisation of 3,000 people is generally structured into smaller sub-groups, as 3,000 people in one team would not be manageable (e.g. problems would arise in communication). Whole systems theory, as stated earlier, is a collection of parts that interact and function as a whole. This also requires making adjustments as one part of the system changes (e.g. the team grows beyond the ability of the current structure to ensure stability). In another example outside of health we can briefly examine the skill of riding a bike: The bike

alone is not stable; when a rider mounts the bike and pedals, the bike becomes stable and can function in a different way than it can when the rider is simply standing beside the bike; when there is a bump in the road due to road works the rider makes adjustments to retain stability. There are also several ways to stabilise the bike and yet get the same result. There is no 'right way' although some ways may prove to be more effective in gaining the desired outcome of stability.

Teams, services and health organisations are no different. If something changes in the system adjustments need to be made. This is yet another example of how the system links: in a health organisation it is the manager's role is to ensure the system stabilises but how it is stabilised may be subject to several possibilities. The decision making regarding the eventual solution implemented may rely on many parts of the system informing the decision; structure, authority, infrastructure (policy, guidelines), key stakeholders and/or finance to mention a few and in considering the human factor, may also be dependent on the emotional intelligence of the manager; best solution for the problem regardless of whose solution it was.

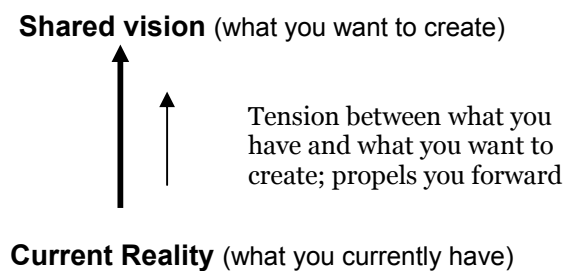
As stated earlier, it is a complex system that operates and it is this system that the manager requires knowledge about. In terms of the clinician transitioning to management it is important to understand the theory, learn everything you can about the system and all its components (a mission that is ongoing), how the components interact, what can and does go wrong in the system, what is working and what isn't and how to make adjustments to restablise the system in a functional way as it changes.

The facilitator/trainer who can support the clinician's transition to management fully through their own experience of transitioning themselves and through their extensive knowledge of the system can be extremely successful. The facilitator's experience and ability to provide real life examples that make sense to the course participants is extremely valuable. As the numbers of trained managers grow and complete the transition they are role modelling and coaching others and through this mechanism many of the key characteristics of Magnet are realised and the need for external training is reduced (train the trainers and coaching and mentoring becomes part of the culture).

Vision/current reality

The model used in this section is credited to the Centre for Leadership, Palmerston North.

Building on a whole systems approach this simple but effective model allows managers to understand and give meaning to the role of vision, values structure and infrastructure.



A vision is a powerful picture of what you want to create that is shared. It is more than a vision statement, as statements are open to interpretation. For example if there was a vision statement that we will 'build a house by the sea' the chances are that although we have a shared vision statement the picture is unlikely to automatically be the same for us both. I may envisage an old wooden cottage that I move onto the property and someone else may envisage a new three storey mansion. It would only be if we had a shared picture of the house by the sea that we could say we had a shared vision. Once there is a shared vision we will be moving towards the same picture at all times.

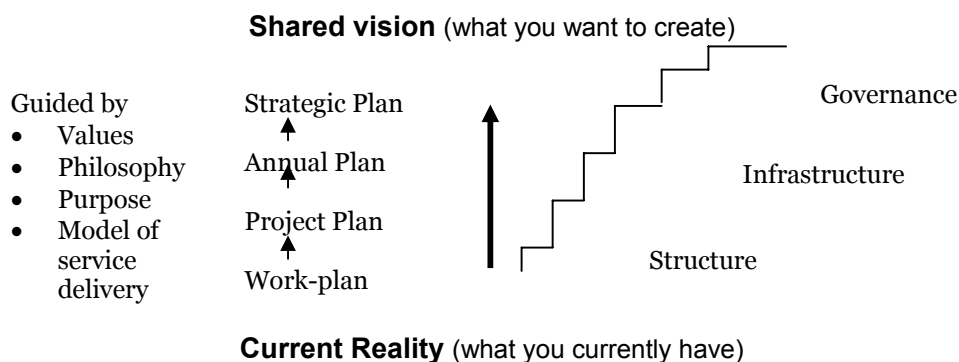
Being able to articulate the vision and the ability to motivate and inspire others towards the shared vision is a critical success factor for any manager or leader. Furthermore the vision is a good check-point. At any time anyone can come back to the shared vision and say "If we do this or take that action will that take us towards our shared vision". If an action would not take you towards your vision then you can ask yourself 'why are we doing it'.

Current reality is simply a realistic and honest assessment of what you currently have: a benchmark. Again this relies on emotional intelligence of the manager and leader. This is not about looking good, this is about a benchmark, a platform from which all your plans will be built. If you were building a house you would want a solid foundation. If you are building a functional service and system you will want something more than 'looking good'.

There is an inherent tension between what you have (Current reality) and what you want to create (Vision). This creates the momentum to drive you forward. However the tension needs to be managed. This is achieved through many mechanisms: structure and infrastructure, and guided by shared philosophies, values and agreed models of service delivery. Managers who can inspire a shared vision and an accurate and robust pathway from current reality to the vision are almost always successful.

Environment

Understanding the environment you are managing from a governance, structural and operational perspective is another critical success factor for a manager.



We would not expect our national rugby team to win the game if they did not have a game plan, were not aware of the rules of the game, if the goal posts or field boundaries kept shifting, if they did not understand the key purpose of the game, and nor would we expect them to remain safe without a referee. On the field and off the field the communication is constant, the information flows and everyone knows their role and responsibilities. There are coaches, managers, players, administrators and those that plan strategically at governance level. The health system is no different and the responsibilities the same. We can't win the game without excellence in governance, a well defined and functional structure, a clear purpose and a robust infrastructure for operational management. We can't expect managers to win the game in health if they are not given or do not understand the importance of the environment in its widest sense.

It is these aspects that guide us through as managers from current reality to our shared vision. It is critical for new managers that time is spent exploring this aspect of management ensuring they understand the true value of the environment.

Attitude and influence, key factors that also affect the environment, are discussed in other sections of this research paper.

Transferable skills, frameworks and knowledge

The concept that we can transfer skills, knowledge and frameworks has already been demonstrated in terms of understanding systems theory and homeostasis. We have also already explored in this paper how we can look at other paradigms such as a rugby game (structure, infrastructure, models etc). Transferring skills, frameworks and knowledge requires the art of lateral thinking.

ADPIE, the nursing process, is an essential framework for nurses in management roles to understand how to transfer (similar frameworks can also be used for other disciplines such as Social Work, Occupational Therapy etc).

The nursing process is a process by which nurses deliver care to patients, supported by nursing models or philosophies. The nursing process was originally an adapted form of problem-solving and is classified as a deductive theory. The nursing process is a patient centered, goal oriented method of caring that provides a framework to the nursing care. It involves five major steps of assessment, nursing diagnosis, planning, implementation/intervention and evaluating (ADPIE).

The nursing process is a cyclical and ongoing process that can end at any stage if the problem is solved. The nursing process exists for every problem that the patient has, and for every element of patient care, rather than once for each patient. The nurse's evaluation of care will lead to changes in the implementation of the care and the patient's needs are likely to change during their stay in hospital as their health either improves or deteriorates. The nursing process not only focuses on ways to improve the patient's physical needs, but also on social and emotional needs as well. The nursing process is;

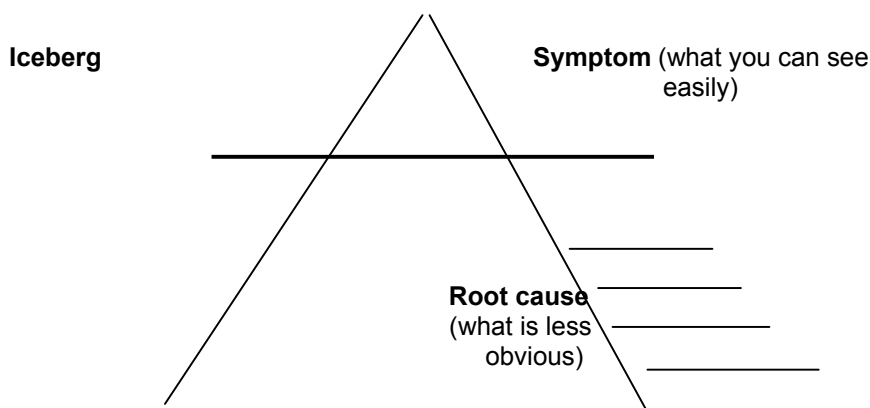
- Cyclic and dynamic
- Goal directed and client centered
- Interpersonal and collaborative
- Universally applicable
- Systematic

A key task for any manager is problem solving involving assessment, diagnosis, planning, implementation and evaluation. The nursing process is universally applicable and that includes problem solving general management or service delivery issues. Practising using the nursing process in another paradigm, the paradigm of management demonstrates clearly to the managers how to begin to transfer skills, knowledge and frameworks successfully. Telling

people how to do this is simply not effective, does not cater for difference in learning styles or preferences for learning and does not allow people to process and synthesise the information or practice using the skill.

One component of the holistic nursing process is **identifying and analysing the root cause** of a problem. Whilst we may need to treat the symptom (symptom management) part of diagnosis is about identifying the root cause. This is the same in management.

The iceberg is a simple visual model that has proven helpful for new managers. With an iceberg, what you don't see may be more of a problem than what you can see.



Managers know they are managing symptoms when they experience exhaustion or frustration by the experience of ongoing fire-fighting (problem after problem after problem); they find they have become so busy putting out fires that there is no time left for understanding what may be causing the fires and no time for planning ahead or carrying out the plans they had. Many clients of Dynamic Leadership have experienced symptom management and inadvertently internalise this as 'I am not managing'. It is a great relief when they can understand why they are not managing and that it is not about them personally.

Treating the root cause of the problem, on the other hand, is where sustainable change occurs. Unfortunately there is a Catch-22; analysis of the 'root cause' of the problem takes time and energy which a fire-fighter is short of.

In order to manage this problem managers have to be able to pick the fires to fight in the first instance because they have to free up

some time to identify and treat the root cause of the problem. Which fires can they ignore? The reality is some of the fires will simply burn themselves out. Which fires can they keep a watching brief on? These fires are going to be fine smouldering away but there needs to be awareness that they could gain momentum and a watchful eye is needed. Which fires must they put out because the damage they are going to cause is too great? These fires need to be actively managed while simultaneously working on the root cause (time consuming). Once managers know the fires they must put out and the ones they need a watching brief on more time and energy are available to work simultaneously on root cause analysis.

Root cause analysis has been widely accepted as a tool for analysing sentinel events. In recent times there is more of a focus on also using this tool for incident management however we need to teach managers to, wherever appropriate, minimise symptom management and use their time and energy on root cause analysis and sustainable change strategies. This skill provides managers with considerable success in managing services in a sustainable and functional manner more than any other strategy.

Root cause analysis is also linked to quality and closing the quality loop. Using the analogy of fire fighters, they go out to fight the fire and then analyse what caused the fire. The fire service has then taken this further by identifying that smoke alarms in residential settings would greatly reduce fatalities and they embarked on a major campaign to install and maintain smoke alarms. As a direct result of this they have reduced fatalities. They effectively closed the quality loop. This is similar to sentinel event reporting in a health setting and has the same rationale behind it. The most recent publication, Ministry of Health; *Quality Improvement Committee: Serious and Sentinel Events in New Zealand Hospitals 2007–2008* aims to do exactly that, close the quality loop.

There are many of these frameworks than can be easily transferred and that clinicians already have readily available to them; **the grief cycle** for example. This is a classic cycle that we see in change management when staff are negatively affected by change.

Grief is a normal process by which a person makes a healthy adjustment to any significant loss. The loss is defined by the person sustaining it, not by anyone else, and we can use several models to understand the stages of grief someone may experience. For example the Kubler Ross Stages of Grief:

- Shock stage: Initial paralysis at hearing the bad news.
- Denial stage: Trying to avoid the inevitable.
- Anger stage: Frustrated outpouring of bottled-up emotion.
- Bargaining stage: Seeking in vain for a way out.

- Depression stage: Final realisation of the inevitable.
- Testing stage: Seeking realistic solutions.
- Acceptance stage: Finally finding the way forward.

When we are looking at service delivery in an environment that simply is not conducive to 21st century models we can examine this within **Maslow's Hierarchy of Needs** (1970; Basic needs; Psychological needs; Self fulfilment needs). It will be difficult for the service to self actualise when perhaps the staff and patients are struggling to meet their physiological and safety needs. We can cite many examples of this in mental health settings in recent years with inpatient units simply not designed for the 21st century service delivery model.

Taking lateral thinking even further we can even use nature and transfer our knowledge into any setting. If we took a native fern, planted it in the direct sunlight and relied only on rainwater to keep it strong and thriving, it would in fact turn brown and is unlikely to survive. There is no problem with the plant, we simply put it in the wrong conditions and did not support it to grow and develop. People are similar. Right person, wrong role, inadequate support: there is nothing wrong with the person, we simply have recruited them into the wrong role or we have not given them the support they require. Or we can use our experience of parenting if we are parents. We don't leave the gate open for a two year old that leads to a busy road and hope they don't get run over. We shut the gate because we know developmentally they do not have the capability to manage a busy road yet and they do not have any tools available to them (look right, look left, look right again). Similarly in the workplace we close the gate for an inexperienced worker until we have built up their capability and given them some tools to manage with. We still expect them to make mistakes (as does the child that is learning to walk, falls but gets up again having learnt from the experience) and we support them to learn from them.

The possibilities are endless with transferable skills, frameworks and knowledge. Time is spent working through this aspect of developing new managers and experiencing transitioning frameworks and skills because it is here that confidence is built rapidly. Managers bring a multitude of models and frameworks to the role. The new manager and leader now realise they have significant knowledge available to them and indeed they do have a solid foundation to build on, and subsequently confidence increases.

Emotional Intelligence (EI), Relationship Management and Self Awareness

Once we have got whole systems thinking and awareness of the environment and participants are able to transfer frameworks and models, new information can be explored. The human factor, a key to relationship management, now needs to be considered.

Relationship management, which includes embracing the competencies for developing emotional intelligence alongside the ability to accurately self assess, is by far the most challenging set of competencies for managers to explore. In order to reflect on oneself and our own behaviour, trust is a critical success factor in any setting. Similarly trust is also a critical success factor in developing and maintaining healthy relationships in the workplace.

Emotional intelligence⁴ has five domains;

- Self Awareness: know your emotions
- Self Regulation: manage your emotions
- Self Motivation: striving to improve
- Social Awareness: know emotions of others
- Social Skills: understanding the relationship

As a Management Consultant considerable time is spent in all contract types (projects, coaching, interim management roles etc) in managing relationships where communication has faltered or broken down resulting in relationship issues. Invariably there is a need to focus in the first instance on ourselves (self awareness, self regulation, self motivation) prior to focusing on the other party (social awareness) and on understanding the relationship (social skills). Unbundling what has become an entangled mass of emotion is the first step to recovering the relationship alongside identifying any systems failures that contributed.

Numerous frameworks can be explored for working with emotional intelligence. The following list is a sample of some effective theories.

- Self assessment against EI competencies
- Self assessment of personal Strengths and Weaknesses
- Johari window (*Joseph Luft and Harry Ingham*): A model for understanding and training in self awareness, personal development, improving communications and interpersonal relationships and/or group dynamics; Also referred to as a 'disclosure/ feedback model of self awareness' or an information processing tool'
- Transactional analysis (*behavioural model, Eric Berne*): a philosophy and theory of personality
 - People are OK – (have worth and dignity)
 - Everyone has the capacity to think – therefore decide what s/he wants from life
 - People decide their own destiny and these decisions can change.

⁴ Reference: The Consortium for Research on Emotional Intelligence in Organisations

- A theory of personality: We learn how to behave from the people around us, the most powerful influences being our parents when we were children. Those early influences affect the feelings we can safely express, the values and beliefs we hold, the expectations we have about how families ought to behave and the actions we allow ourselves (especially when we're under stress). These feelings, beliefs, values and actions become habits, or life scripts long before we could analyse and decide in a rational way whether they were useful to us
 - A theory of interpersonal behaviour and communication: Transactions and games.
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- Drama triangle (*Stephen Karpman*): theory used for analysing interpersonal psychological processes or games – consists of three “dramatic roles”: Rescuer, Victim and Persecutor.
 - Values Based Practice (*Kim Woodbridge, Bill [K.W.M] Fulford, The Sainsbury Centre for Mental Health*): explores the role of values in relationship management and within the workplace.
 - Situational leadership (*Ken Blanchard and Paul Hersey*): a situational leader is one who can adopt different leadership styles depending on the situation. Blanchard and Hersey characterised leadership style in terms of the amount of direction and of support that the leader gives to his or her followers.
 - Role development: based in psychotherapy the theory recognises that we have many internal roles that we play out in different situations and some are more developed than others e.g. the authoritarian, the observer. Exploring what roles are over developed and what roles require developing is essential for carrying out situational leadership.
 - Communication models (*Transforming communication: Leading edge professional and personal skills, second edition, Richard Bolstad*): Listening skills/interpersonal skills/giving and receiving feedback/motivating and inspiring/compartmentalising/reasoning.
 - Conscious competence(*Gordon Training International is popularly considered to be the originator of the conscious competence model*) The theory states that people develop competence only after they recognise the relevance of their own incompetence in the skill concerned.
 - Five step process for coaching and mentoring: (*State Services Commission 2003: Coaching; Guidance for Managers and their staff on using coaching for development and performance*).

Building skills and competency for new clinical managers in regards to relationship management takes on a more individual perspective as one model or theory does not fit all. Personal history, personal preference and working on individual strengths means that manager's are more comfortable with using some models than others. However it is also essential that managers understand how their own history, preferences and strengths or weaknesses may lead them into transference and counter transference within relationships.⁵ There is no doubt that personal development leads to professional development and over time managers begin to see the value of self awareness in regards to relationship management in the workplace.

There is a need to exercise caution around working with personal issues both in the role of training facilitator and when in the coaching or mentoring role within the workplace. Performance coaching is an intrinsic component of a manager's role, however personal counselling and therapy is not. Managers need to develop the confidence to address personal issues that arise in the workplace that may affect performance including putting appropriate support in place (for example it is harder to perform well if you have a major emotional personal experience occurring in your life), but it is also essential that this discussion is contained appropriately. This skill involves all five of the domains of emotional intelligence: Self Awareness, Self Regulation, Self Motivation, Social Awareness, and Social Skills.

Managers invariably have to work within a grey area in terms of understanding the impact a personal issue may be having on professional performance (for the manager personally or for others as direct reports) and similarly where a workplace stressor is impacting on the employee personally. This ability and awareness of the manager is a critical success factor in managing relationships within the workplace. Developing the skills to address this

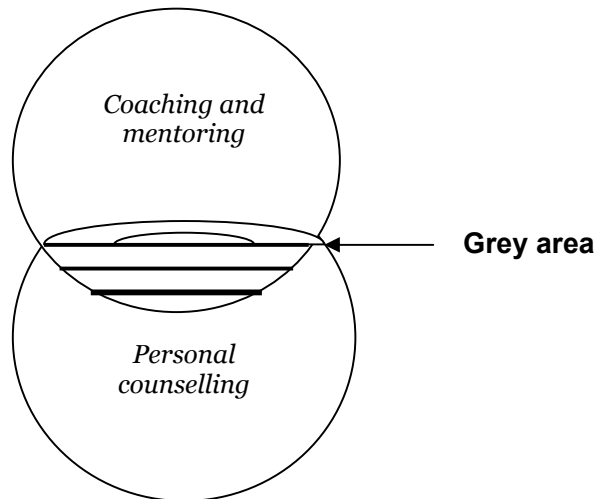
⁵ Michael G. Conner, Psy.D

***What is Transference:** During transference, people turn into a "biological time machine". A nerve is struck when someone says or does something that reminds you of your past. This creates an "emotional time warp" that transfers your emotional past and your psychological needs into the present. In less poetic terms, a transference reaction means that you are reacting to someone in terms of what you need to see, you are afraid of or what you see when you know very little about the person. This all happens without you knowing why you feel and react the way you do.*

***What Is Projection:** Some people refer to transference as a "projection." In this case you are projecting your own feelings, emotions or motivations into another person without realizing your reaction is really more about you than it is about the other person. In a life filled with transference, your job may be "the family reunion you are avoiding and you are forced to go to each day." In other cases of projection, your girlfriend may remind you of all the irritating things your mother did when you were growing up. Love at first sight is usually a projection – especially if it ends in disaster and you could have seen it coming.*

***Counter-Transference:** Therapists and other health care professionals can also have transference reactions while treating a patient. It's a two way street. Counter-transference is basically a therapist's "emotional time warp" around their patient's transference. In other words, counter-transference is a therapist's counter- reaction. That's why some therapists think they are falling in love with their patients.*

appropriately requires an ability to both raise the issue at the same time as contain the discussion. Personal counselling is not the role of a manager and this is best referred out (e.g. Employee Assistance Programme [EAP]), however being aware of what may be affecting a staff member's performance is the role of the manager. The manager has a responsibility to ensure appropriate support is put in place for the staff member to perform under these circumstances and to recognise if burn-out is a risk.



At an organisational level there are barriers and benefits to coaching and mentoring in the workplace and creating an environment that addresses and values these is necessary. Job satisfaction, improved performance against targets and better working relationships are some of the benefits. These cannot be realised, however, if the manager does not see coaching and developing others as a priority or if they are only focused on short term bottom line results. As noted under the section 'costs of staff turnover' and 'creating breakthrough moments in learning' the research demonstrates that developing employees for high performance is not short term bottom line strategy but the benefits in the longer term result in the organisation achieving high performance targets. Put the work in at the front end and the organisation, service or team is more effective and efficient in the longer term.

Developing emotional intelligence ensures there is respect for difference and the models and theories such as values based practice, Johari window, conscious competence, transactional analysis, Karpman triangle, role theory and communication models assist the manager in finding theories and frameworks in which they can better understand others and utilise to build relationships, trust and rapport.

Situational leadership relies on an ability to be able to change your style and therefore role development is often necessary for managers. Understanding

our preferred style allows us to actively manage what we can and can't achieve at any given time. For example if there is a fire we would like our fire warden to use an authoritarian style, this is not a time for consultation therefore the best person for the fire warden's job is one who under stress can use this authoritarian style easily. If there is a plane crash and the emergency department will be flooded with concerned families and relatives we want someone who is a good organiser, not authoritarian but has the ability to balance meeting the emotional needs of the families at the same time as getting the process of linking families with victims under way. There is no style that is good or bad, there are, however, styles that are better aligned to certain situations. We need to recognise that when we are under stress we will invariably revert back to our preferred style. Similarly looking at different learning styles and understanding how people learn assists managers to work with situational leadership.

When coaching and mentoring others, it is their preferred style, their values, strengths and weaknesses that are important, not the preferred style, values, or strengths of the coach. In order to deliver coaching to others you have to develop the ability to set yourself aside and this can only be achieved with emotional intelligence.

A strengths based model came out of the awareness that health and social services were saturated with:

- Problem focus
- Abnormality
- Deficit
- Victimisation
- Disorder
- Obsession with individualism, family and community pathology

The strengths model on the other hand focuses on:

- Uncovering someone's desires, aspirations, skills and talents and building on these
- Developing a sense of ownership
- Having options/flexibility
- Shared goal setting and planning
- Resource acquisition: 1) Availability – opportunities; 2) accessibility – what are the obstacles to resources; 3) accommodating the demand and balancing this with capability; and 4) adequacy – does the resource meet the need
- Ongoing collaboration, support, affirmation and learning

The strengths based model therefore fits well with what the action based research undertaken by Dynamic Leadership Limited has found to be effective. It also fits well with the State Services Commission research findings, what Magnet Hospital Status criteria require and the College of Nurses longitudinal

study have found, alongside Human Resource and Recruitment agencies research findings.

Working with the human factor as a manager is time consuming. Not managing the human factor is extremely expensive both financially and in terms of the "human cost" (physical, emotional, spiritual, cognitive and social cost). In order to transition clinicians to managers the importance of EI competencies and self awareness in regards to relationship management is critical.

Again we are not starting with a blank canvas; many clinicians will demonstrate a high level of emotional intelligence with patients/clients. However when it comes to the workplace environment working with colleagues and direct reports the EI competencies may not transition as smoothly (self regulation, for example, may be different with a direct report than with a patient or client; transference and counter transference issues will be different; understanding the relationship between nurse/allied health practitioner and patient does not necessarily equate to understanding the relationship between manager and direct report).

Transition and Team work

Armed with whole systems thinking, awareness of the environment, access to multiple frameworks, models and theories and with self awareness and emotional intelligence under way new managers are transitioning from clinician to manager and are now standing on a firm platform of knowledge and skill.

There are, however, several key skills and frameworks that managers will be required to know and understand in order to complete the transition and to improve the overall culture of the workplace. These relate to:

- Project Management frameworks (this framework has multiple uses for managers)
- Managing change (because change is inevitable)
- Understanding quality and managing risk (core component of service delivery)
- Creating a learning organisation and/or culture (Ministry of Health expectation)

Each of the above has a multitude of frameworks and associated theories that can be used and each requires a dedicated training session if managers are to become proficient in them. Nevertheless they are critical skills that managers need and come up often in consultancy when new initiatives or change initiatives have not been identified as a project and have not been managed in a robust way, resulting in systems or new initiative failure. Projects and change

are expensive to carry out and it is important that the time and energy put into these get the desired results.

As a consultant it is not uncommon to find quite significant number of projects under way without any framework around them and at time of implementation resistance abounds amongst the unidentified and identified key stakeholders. Systems become fragmented from deconstruction and poor reconstruction. The initiative may well have been an excellent one and the person managing the initiative highly skilled but the project fails not because it was a bad idea but because the process around it was inadequate.

Project management frameworks ensure that projects are appropriately scoped, have terms of reference, have allocated roles with clear responsibilities and authority (Project Manager, Project Sponsor [top line management support], Project Team Members, subject matter experts; right people, right skills for the role); have associated background information and a clear rationale for the project; clear objectives/goals are set (so you can measure against them); identifies any constraints or exclusions; milestones are set (and can be tracked); has clear deliverables (what you must deliver at the end of the project; project success); key stakeholders are identified and analysed; risk is identified and analysed and an impact assessment is carried out (if I change this what else will it affect, commonly known as the pebble in the pond – it is not just where the pebble lands, it is the ripples it subsequently causes).

Project management involves resources and these also have to be identified and analysed: a financial commitment (associated budget; cost benefit analysis), Human resource (means releasing staff or sub-contracting, attending project meetings as well as meeting tasks), technology requirements etc and it is important when the project comes across an unplanned problem that the Project Sponsor and Manager have previously identified what will take precedent in the project: time, quality or budget. If quality is identified as the most important factor then the timeframe for the project milestones will be extended so as not to compromise quality. If budget is the most important then quality may have to be compromised to keep to budget.

Projects also always involve robust plans, regular meetings, ongoing evaluation and measurement and a robust reporting system. There is also a phase called project close out or completion (evaluation).

Managers who identify when, what and how to use project management frameworks are more successful in managing their limited resource, meeting goals or targets, experiencing success in improving service delivery or implementing new initiatives and in developing team member confidence. As a consequence they themselves are more successful as managers and leaders. Success leads to success.

Change management is another key area that managers will inevitably become involved in and this requires skill in managing the 'human factor'. Despite change being part of life we have an innate desire to avoid it. Generally people like things to remain the same. During that transitional period of change people want to know how it will impact on them, may feel ambiguous, confused, experience stress, discomfort, anger and so on. Often, however, it is not what is changed, although this can cause some grief but it is more about how the change process is carried out that makes the difference. Project management is an excellent framework to use but change requires a greater understanding than just the framework for project management and the organisations legal responsibilities as employers.

Previously I have identified the grief cycle as one framework to consider when working with change. Another useful model is Prochaska and DiClemente's⁶ transtheoretical model of change. This model identifies that an individual passes through five "stages of change" before they are considered to have successfully adopted a behaviour

- Pre-contemplation – the individual does not exhibit the specified behavior, and has not considered adopting the behaviour
- Contemplation – the individual is considering adopting the behaviour, but has not dedicated any effort towards enacting it or preparing to enact it
- Preparation – the individual has started to gather information on the behaviour, with a view towards enacting it
- Action – the individual has begun to enact the behaviour regularly, but has not continued doing so over a long period
- Maintenance – once a behaviour has been regularly enacted for more than six months, the individual is said to have passed into the 'maintenance' stage for that behaviour.
- Transformation – at this stage, the change in behaviour has become part of the person's normal behavior. Sometimes referred to as the termination stage if the original purpose was to eliminate an undesirable behavior, sometimes referred to as the adoption stage if the original purpose was to begin a new behavior. This is seen as the

⁶ *The Transtheoretical model as proposed by James Prochaska, John Norcross and Carlo DiClemente (1994, Changing for Good, New York: William Morrow) originally only had 5 stages. A sixth stage, transformation, has since been added to this model.*

'final' stage – although there is much disagreement as to whether an individual ever moves beyond the maintenance stage.

This model, alongside motivational interviewing (a technique for moving people through the stages of change), is one of the most commonly used theories and frameworks for counsellors working with addiction (effectively a change process). There are different strategies to use at each stage of the cycle. By observing staff behavior (with your EI competencies) and actively interacting with staff (listening, problem solving etc) the model can assist managers to understand where individual staff are in the cycle of change (invariably staff are all at different stages at any one time). The manager can then put in place the appropriate strategy at each stage to move staff through the cycle, rolling with resistance and moving staff towards a state of optimism for the future and commitment to the change.

If managers attempt to drag people through change they will simply create resistance. The best strategy is to understand staff members readiness to change (where they are in the cycle) .The manager starts there not where the manager wants the staff member to be (taking them on the journey, not dragging them to the destination). You will have early adapters, late adapters, passive team members and some innovators who lead the change. Similarly the 80/20 rule applies. You need 80% of people on board with the change before you enact the change. You can drag a small percentage, some may decide they no longer want to remain in their role and a small minority may continue to resist, but with 80% on board you can successfully implement change.

The transtheoretical model is successful because it takes into account individual need so people feel heard and experience being supported through the change process at an individual level. There is no doubt that through this process a manager will maximise resource and knowledge of their team members and this input may result in making positive changes to the outcome (consultation, ongoing discussion). A team member's view may well contribute a valuable perspective that had not been fully considered. Some may still not like the outcome but may have come to understand that the change is necessary and experience the process as fair. They feel heard.

In managing change we also incorporate all of our previous learning regarding whole systems thinking (because the destruction and reconstruction of systems must be linked as a whole system), having a clear vision (future state in change) and accurate benchmark of current reality (current state), robust planning, infrastructure/structure, to move us forward and manage the tension (project management framework, communication plans, risk plans), emotional intelligence to manage the human factor, understanding situational leadership, the role of values and excellence in communication.

Managers who understand **quality** are able to close the loop and continuously improve their service. Wilson (1997) states that quality management “embraces all the multiple and various functions and activities” within an organisation that are required to ensure “quality maturity”. Again, as managers we are taking a whole systems approach here.

As a consultant and a Lead Auditor I am frequently surprised by the level of need for managers to further develop their skills in quality covering all aspects: quality management, quality assurance, quality monitoring, quality improvement, quality tools and establishing quality cultures. There appears to be a myth that quality is ‘over and above our day to day operations’ yet quality needs to be integral in all that you do. There is a saying ‘What you can’t measure you can’t control or improve’.

Interestingly enough quality can both identify and manage risk (not all risk but some risk) and these are intrinsically linked although separate processes. An effective quality management programme will integrate with the risk management programme and focus on the active management of issues that may endanger the organisation and its staff.

There are a number of basic models and frameworks that are useful in looking at quality that all managers require a fundamental understanding of:

- The role of Standards and Best Practice policies, pathways, procedures
- Benchmarking
- PDSA (Plan, Do, Study, Act) – performance improvement
- Tools: Data collection and analysis, Cause and effect tools; Fishbone or Ishikawa Diagram (invented by Kaoru Ishikawa); Root cause analysis; Flow charts.

Health services are inundated with standards, guidelines, performance indicators, targets and quality measures. Managers need to understand the basics of quality and fully embrace it by integrating quality into all that they do. New managers at least need to understand the value of quality management and quality assurance systems and processes and ideally embrace it and drive it.

A quality culture relies on four guiding tenets for management:

- Effective communication of the development needs of employees
- Encouragement of ideas that assist improvement
- Actively offering support and assistance and being seen to do so
- A willingness to admit that ‘mistakes’ are not uncommon and will be made

Openness – mistakes are seen as learning improvement opportunities

Ideas are shared – people are encouraged to speak their mind

Barriers are removed – the 'them and us' attitudes are eradicated

Listening – everyone is heard

Blame – responsibilities are recognised and blaming is recognised for the futile exercise that it is

A recognition of no end-point – no end-point can encourage a continuing commitment to learn, to improve, to improve learning and to learn about improving

Developing a quality culture, emotional intelligence, excellence in communication and whole systems thinking is also linked to creating a **learning organisation**. When we examine what is required for a learning organisation or culture we find four main categories:

- Communication and openness
- Inquiry and feedback
- Adequate time and
- Mutual respect and support

The term 'learning organisation' was coined in the 1980's to describe organisations that experimented with new ways of conducting business in order to survive in turbulent, highly competitive markets (Argyris and Schon 1996, and Senge 1990).

Peter Senge in his book *'The Fifth Discipline; The Art and Practice of Learning Organisations'* defined a learning organisation as *"the capacity of organisations to create the results they truly desire, where new and expansive patterns of thinking are nurtured and where collective aspiration is set free"*.

If we were to implement all of the findings of the action based research undertaken by Dynamic Leadership Limited (as defined by the many managers and leaders who contributed to the research through trial and tribulation) we would be well on the way to creating a learning organisation.

Robust **risk management** processes form one of the critical success factors for any organisation, commercial or non commercial and are an integral component of planning (strategic, annual, quality, project etc). There are many models and frameworks but the purpose is universal:

To identify, analyse, evaluate, treat, and monitor risk in order to:

- Minimise exposure to clinical and non-clinical risk
- Provide a safe working environment
- Protect the organisation's interests

Generally speaking risk management involves the following steps:

- Identify the risk
- Categorise the risk (there are usually categories in any framework or model)
- Analyse the risk
- Rate the risk (again this is part of any risk framework or model)
- Put strategies in place to minimise, eliminate or control the risk
- Assign responsibility and time frames
- Communicate the risk/reporting system
- Monitor and review

Many Dynamic Leadership contracts come about as a direct result of systems problems arising from change management, quality and risk issues. It may be that the systems and processes are within the organisation but the manager is not trained in these areas or is unaware of what is available. Other organisations simply do not have the systems and processes in place or they maybe fragmented and difficult to use. There are some organisations which have all the systems and processes but there is no compliance and no subsequent action when non-compliance occurs. In the first instance, however, there is an organisational responsibility to have both the systems and processes in place and all managers given the opportunity to undertake training in what really is core competency in general management.

Bringing together **a team** is also a very broad subject and of all the components to this research this would have the most variety of models available. There are two key areas to touch on however. These are:

- Developing human networks
- Understanding team development and ensuring 'right person, right place' (critical for any service)

Generally speaking we are surrounded by experts and developing our **human networks** as a manager becomes yet another critical success factor for us. What is interesting about human networks is it is not always the person in the designated role that you may learn from (e.g. there may be numerous people within an organisation who have a greater understanding than us in regards to quality and risk; it may or may not be the quality and risk coordinator or manager you network with). In fact if you overlay the formal structure with your human networks structure it may look entirely different. As a clinician we are constantly learning from others, yet new managers may simply not have considered the benefits of surrounding themselves with experts in each area of

responsibility they hold in terms of general management. Learning by osmosis⁷ is something clinicians do daily and maximising the resources available to you as a manager will contribute to your success. Surround yourself with experts internally or externally.

Similarly you are as good as the people around you, so recruit high performers. They are an asset not a threat. As a manager you are a generalist; if you want a high performing administrator recruit one who knows more than you do in terms of administration. They can also positively contribute as to how efficiently your office systems are working.

Team development models and frameworks, as noted earlier, are variable and often organisations will adopt a specific model appropriate for their organisation. Therefore it is wise to simply outline some of the core issues that create the most distress in a team when they are not present:

Boundaries: What is negotiable and what is not negotiable. Endless hours are spent on discussing things that are simply not negotiable or things that could be negotiable are controlled. For example:

- 1) Legislation is not up for negotiation. We don't debate it until it is time to put in a submission when it is up for review. Policy often reflects legislation.
- 2) If you have a task to undertake and you have so many days to complete it in and within a certain budget these become non-negotiable. How you go about completing the task is up to you (negotiable or self directed);
- 3) Roles and responsibilities need to be clear and authority must match responsibility. You can't take responsibility for something you have no delegated authority to manage.

Blurred boundaries appear to create more relationship issues than any other factor. This action research could come up with well over a hundred vignettes where blurred boundaries have created mayhem in the team. There must also be sufficient infrastructure to manage when team members step outside of the boundaries or the team becomes laissez faire.

Shared vision and goals; Everyone needs to be rowing in the same direction, as noted earlier under vision, and they all need to know and understand the goals (which need to be SMART: specific, measurable, achievable, realistic and timeframed). All team members want to be successful, so we have to be able to measure our success and celebrate it when we reach our goals.

⁷ *Encarta Dictionary English (UK): the gradual, often unconscious, absorption of knowledge or ideas through continual exposure rather than deliberate learning*

Individual goals and targets are set in performance appraisal and aligned to both team and service performance as well as career development.

Planning, carrying out the plan and evaluating the plan: We have already described why we need plans (to move us forward in a managed way from current reality to vision). This is a never-ending cycle (e.g. ADPIE: Assessment, Diagnosis, Plan, Implement and Evaluate). This is how we are constantly learning in order to continue moving forward. Quality and risk play a major role in planning and evaluation, measuring your success and making adjustments as required. There will always be tension as adjustment occurs but a certain amount of tension propels the team forward.

Communication: Teams must communicate and information must flow to the appropriate people. This occurs in multiple ways: meetings, reports, face to face, email, web based, hard copy, presentations; the modes for communication are endless. However communication must be meaningful and well targeted. For example, the sheer volume of information that comes to a team leader or manager in a health setting requires active management: essential for all (non negotiable, everyone needs to know about it); essential for some (identifying key stakeholders who require this information); non essential but nice to have (self directed and accessible to all).

How communication occurs and with whom is a critical success factor in leading a team. Information gives the power to act appropriately. Actively withholding information is a power play. Not receiving information for whatever reason results in poor decision making. In change management consultation is a critical step in the communication process. In managing risk communication is essential. Whatever the circumstances, communication is critical to the team functioning in a healthy way.

We know we have successfully communicated when both the sender and receiver have perceived the communication in the same way (involves active listening techniques); they may not agree but even if a difference of opinion is present, both have accurately heard and perceived the message in the same way it was intended leading to a greater mutual understanding.

Management of behaviour: All teams need to have the infrastructure to manage team member behaviour. This may be in the form of ground rules, robust policy and procedure, excellence in human resource expertise (HR department or expert) and excellence in EI competency. Once a team or a team member operates in a laissez faire manner a manager has to return to a structured approach. You cannot move from laissez faire to flexible. You have to go back to a very structured environment, re-establish clear boundaries and move to a flexible approach over time. It is far better to manage behaviour as and when it arises and maintain the boundaries the team has set than have to go back through this process of re-establishing boundaries.

Without clear boundaries conflict will arise. Without a shared vision and goals staff will not know what they are aiming for and may go off track easily. The plan keeps you on track and communication ensures excellence in team decision making as well as maximising your resources. Managing behaviour creates a safe environment where everyone knows what the rules are and there is assurance that each staff member will be held accountable.

In summary, to continue the transition for a new manager, new skills and frameworks are required. Project management, change management and quality and risk management are core competencies in my view. It is inevitable that a manager will be involved in these aspects of general management. A well managed project and change process builds the confidence of team members and contributes to a culture of trust, an essential component to team development. With our previous skills, our whole systems thinking and emotional intelligence we are able to develop our teams, give them clear boundaries and consequences and create a well planned service that team members can celebrate their success within as goals are measurable. With excellence in communication and appropriate management of behaviour everyone can grow and develop as individuals and as part of a team. The manager is surrounded by motivated and inspired staff, has access to a network of expertise and everyone succeeds. The culture is one of learning and mistakes are embraced simply as learning curves.

Self directed learning

The final component of this action based research is to examine what might inspire managers to continue learning in a self directed way, having successfully transitioned from clinician to manager.

There are many excellent courses out there to build on the platform each manager has built through a transition course. As noted earlier, further training needs to be undertaken in project and change management and in quality and risk management. However it is also important to capture that which sparks a new manager's enthusiasm and motivation for ongoing learning and to support this.

There is a model of self directed learning that I particularly enjoy. Personally I never read novels, but I do love to read books that inspire, motivate and continue my learning. I am passionate about it.

Richard E. Boyatzis, developed a theory of self directed learning⁸. The theory behind self directed learning as described by Boyatzis states:

⁸ *Unleashing the Power of Self Directed Learning* by Richard E. Boyatzis, 28 May, 2001

'Students, children, patients, clients, and subordinates may act as if they care about learning something, go through the motions, but they proceed to disregard it or forget it—unless, it is something which they want to learn.

Even in situations where a person is under threat or coercion, a behavioral change shown will typically extinguish or revert to its original form once the threat is removed. This does not include changes induced, willingly or not, by chemical or hormonal changes in one's body. But even in such situations, the interpretation of the changes and behavioral comporment following it will be affected by the person's will, values, and motivations.

In this way, it appears that most, if not all, sustainable behavioral change is intentional. Self-directed change is an intentional change in an aspect of who you are (i.e., the Real) or who you want to be (i.e., the Ideal), or both. Self-directed learning is self directed change in which you are aware of the change and understand the process of change.'

Boyatzis proposed that self directed learning began with a discontinuity: A need to discover our real self and a realistic view of our current self. The first two discontinuities are Real Self and Current self.

He then proposed that the first two discontinuities incorporated four major "learning points" in the self directed learning process:

- 1) *'Engage your passion and create your dreams*
- 2) *Know thyself*
- 3) *Identify or articulate both your strengths (those aspects of yourself you want to preserve) and your gaps or discrepancies of your Real and Ideal Selves (those aspects of yourself you want to adapt or change)*
- 4) *Keep your attention on both characteristics, forces or factors—do not let one become the preoccupation.'*

All of these learning points can be achieved by finding and using multiple sources for feedback about your Ideal Self, Real Self, Strengths, and Gaps.

Boyatzis identifies that a learning agenda focuses on development, whereas a performance agenda results in defensiveness. The third discontinuity is Mindfulness through setting a learning agenda: create your own personal learning plan.

The fourth discontinuity is Metamorphosis: experimenting and practicing new behaviors and desired changes, and the fifth discontinuity is about Relationships that enable us to learn. Boyatzis identifies that relationships and groups give us our sense of identity, guide us as to what is appropriate and 'good' behaviour and they provide feedback: a reference group. Boyatzis proposes that new reference groups are formed that encourage change and

March 09: Sailors Don't Become Sailors in Calm Seas: The research paper behind the S.T.A.R.T Training program for transitioning clinicians to management

development (recognising that some prior reference groups such as family and friends have a prior investment in them, potentially invested in staying the same versus change). The major learning points from the fourth and fifth discontinuity are:

- (1) *'Experiment and practise and try to learn more from your experience*
- (2) *Find settings in which you feel psychologically safe within which to experiment and practise*
- (3) *Develop and use your relationships as part of your change and learning process'*

In summary self directed learning occurs when there is a discontinuity:

- My Ideal Self and My Real Self, my Strengths and Gaps
- Building on the strengths while reducing the gaps
- Experimenting with new behaviour and ideas, thoughts and feelings
- Practising through to mastery.

Alongside the reference groups that managers may build for exploring the discontinuity, coaching one to one is also an excellent environment of trust where learning agendas can be identified, encouraged and supported.

Looking forward

It has not been possible in documenting the action research to identify all the detail and 'hot tips' that have come out of the experience. These will come to light in the next phase, writing a book(s) that will include vignettes and hot tips. These will give real life examples of what has occurred and the learning that has come from these events.

As noted at the beginning of this paper my sincere thanks goes out to everyone I have met in a variety of settings. You have taught me more than any formal training could ever hope to achieve and I am eternally grateful. It has given me the opportunity to share this knowledge with many, many people.

"Capture their hearts and their minds will follow"

*Carly Fiorina
CEO Hewlett Packard*