



# Joint Appointments

The Operational Efficiency Programme, the Pre-Budget Report, the Smarter Government action plan, as well as the expectation surrounding the Total Place initiatives and the NHS integrated care pilots all suggest that “joined-up” government and public services are going to be a major part of the public sector’s response to the financial crisis. This paper looks at the challenges involved in the governance of joined-up government and public services. An increasing share of local leadership of the public sector will be undertaken collaboratively and this Board Paper suggests ways in which organisations can overcome organisational, processual and attitudinal barriers to secure long-term efficiency and outcomes gains through joint appointments, pooled budgets and collaborative service delivery.

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The various parts of the public sector have advanced at strikingly different speeds towards implementation of these policies: shared back-office solutions are reasonably well-understood and widely-used in local government; Whitehall Departments are widely held to be in dire need of more effective and more strategic procurement and estates management and PCTs are desperately scrabbling to develop commissioning skills in a race to secure better value for money as well as service quality.

Some statutory organisations, in areas where the politics are right, and relationships between the constituent parts of the public sector are harmonious, are coming together in a dance to the new music of collaborative strategic planning and thematic budgeting.

Joint appointments are on the rise, and in many cases these are emerging organically out of collaboration on shared services (as is the case in Waltham Forest, where the NHS and Council are recruiting a joint Director of Finance); it is also increasingly commonplace for Local Authorities and PCTs to jointly appoint a Director of Public Health – a trend that is certain to be accelerated and driven by

ring-fenced, population health budgets. Joint appointments in public health can afford opportunities to bring population health improvement right into the heart of Councils’ strategic planning in core areas like housing, environmental services and education, if the organisational attitude is right, and the individual post-holder is savvy and visionary enough to bring about real change.

The Improvement and Development Agency (IDeA) recently reported on the merits (in terms of improved efficiency) of the deeper integration of discrete Councils’ systems and operations which can be engineered through the nomination of a shared Chief Executive. Here, too, the impression is that having a shared management structure removes significant organisational obstacles to closer joint working and this sort of integration brings in its train considerable efficiency improvements through redesigned systems and services.

The model is being closely watched by managers, commentators and reformers. It seems to offer an easy way of getting round barriers to the sort of thematic, focused place-making efforts which are the subject of the much-vaunted “Total Place” pilots,





which are test-beds for the integration of planning and spending in areas of policy like worklessness, learning disability services and health inequalities.

All three of these latter are at the heart of the Knowsley Health and Wellbeing Partnership between NHS Knowsley and Knowsley Council, which has won laurels for its progress towards the integration of health and social care. Partnership here was seized as an opportunity for a clean break with the old ways of working; the partners have focused on the formation of multi-disciplinary teams, the development of patient/user-centred care and the involvement of clinicians and carers in decisions about how services are commissioned, tendered, designed and delivered.

The idea in Knowsley was to put in place a single, shared accountability structure, built around one executive management team and pooled budgets, to enable the development of integrated teams, working towards a set of key local outcomes. Beyond the Knowsley case, as the national programme of integrated care pilots progresses, it will provide more evidence of the ways in which the re-ordering of financial incentives of clinicians, carers and managers around outcomes can leverage innovation and better services, arranged around patients' real needs.

Regulation points this way, too: from the CAA, through the annual health check and the coming regime of periodic review by the CQC, to the ongoing evolution of the World-Class Commissioning assurance process, the concern is increasingly with assessment against specified outcomes.

Regulators and system-managers are increasingly looking for statutory organisations to identify and manage health and well-being risks in concert with their local planning and delivery partners. PCTs have generally welcomed this shift in emphasis – which looks certain to continue after the next election, whatever its result – but recent events in Basildon and Thurrock suggest that efforts to police the reporting

of performance against outcomes will have to be intensified, with a concomitant shift towards tougher independent assessment and impromptu inspection. As part of their response, PCTs and Local Authorities are developing collaborative working structures, to improve commissioning and leverage better value and quality from contracts.

In London, sectoral commissioning of acute care is well developed with the six Acute Commissioning Units. Attention is now shifting even more towards commissioning of community care. Boroughs and PCTs are in the early stages of establishing local joint commissioning units (actual or virtual) to undertake joint strategic needs assessments, public engagement, policy development and planning at Borough level, pool commissioning expertise (and, in some areas, budgets), to procure services and work collaboratively for the delivery of shared outcomes at Borough level.

Joined-up governance and decision-making should encourage stronger local collaborative commissioning, more closely focused on outcomes and directed at the shifting of the whole health and care economy towards care closer to the patient/service user, and away from acute settings. London Borough Councils and PCTs are also examining the possibility of greater integration of support and back office functions. With the development of joint commissioning structures for community services, the appeal of cross-Borough provider entities becomes concomitantly stronger. Closer working is inevitable, and the possibility of mergers has also been mooted.

In some areas - notably Blackburn and Darwen - statutory bodies are drawn to the Care Trust Plus model and the opportunities that it may afford to remodel care and to pool commissioning budgets to engineer the integration of services. Here, too, a single line of accountability for outcomes opens the way to the secondment or transfer of clinicians, carers, health visitors, and so forth, into multi-disciplinary teams, delivering more preventive care. Improvements in staff morale and motivation are an important

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benefit of this sort of change, since this tends to produce, in turn, innovativeness and willingness to experiment further with new working methods and integrated teams.

But joint appointments are risky; “cultural fit” is the sort of term that headhunters are perhaps overly fond of, but it does refer to a real-world problem. There are very significant differences between the two groups of organisations in terms of the way they approach service design and their relationship with their populations, beyond their variant democratic credentials. For one thing, PCTs spend the vast majority of their budgets on commissioned services, whereas Local Authorities tend to have much more mixed economies of provision.

Some joint appointments don't work because the inability to reconcile two different decision-making/governance cultures and organisational rhythms may stymie effective direction of merged functions, with oversight of commissioning and accountability becoming confused. Under such conditions, budget issues can become less clear, with responsibility for spending in areas of shared decision-making fudged and strategic focus lost.

There is also a danger that joint appointments may concentrate too much responsibility for strategic direction and oversight of two different organisations in one individual, who will (in the vast majority of cases) lack direct experience of managing and directing spending in one of the two cultures; an experiment with a joint HR appointment at one Local Authority appears to have come to an unhappy end for these sorts of reasons.

It is vital for both organisations to agree on a precise delineation of the scope of the joint role, and to have realistic expectations of the types of candidates who could take up the post. These joint posts are a relatively new feature of the public sector executive and recruitment landscapes – candidates with credentials and experience which precisely correspond to the requirements of both organisations and the specificities of the joint role will be extremely few.

At Odgers Berndtson, we have experience and reach across the whole economy and can accordingly deliver clients looking to appoint to a new joint position a diversity of candidates from different sectors with the ability and ambition to rise to the challenge of broader responsibilities. We have worked with all types of public service organisations, as well as social enterprises and education establishments, to recruit to individual and multiple vacancies, sometimes as part of wider organisational change and restructuring programmes.

High-quality, targeted search and our huge networks mean we are able to unearth a broad range of talented individuals, many of whom had perhaps never previously considered the transferability of skills and expertise gained in very different sectors.

Joint appointments provide an exciting opportunity for talented individuals to develop new types of strategic leadership, which leverage all the skills, experience and strategic planning resources of two distinct organisational cultures, and bring them to bear on the problems and opportunities of a whole health and care economy.

Local leaders, open to dialogue on aims and means but committed to deeper partnership and focused on the development of and delivery of shared outcomes, can prosper under these conditions; providing of course the local political backing is strong, public and committed. They will also need to quickly find and nourish themselves at sources of support in each organisation - good advice on managing organisational politics, building their profile and dealing with the right people at the right moment will be as gold dust for any new joint appointee. Getting a few quick wins - early successes in the form of concrete outputs - would also help reassure staff and stakeholders, and limit the danger of toes being trodden on as partners learn a tricky new dance.



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### ■ Beverley Steel

Beverley Steel is the Managing Director of our public sector business which covers Central and Local Government, Education, Charities, Healthcare & Life Sciences, Housing and Regeneration. She also oversees the Wales practice and is focused on board, Chief Executive and other senior executive roles. [Beverley.Steel@OdgersBerndtson.co.uk](mailto:Beverley.Steel@OdgersBerndtson.co.uk)

### ■ Nicholas Allen

Nick is a Research Analyst. Prior to joining Odgers, Nick worked as a Policy Officer in a consultancy representing the interests of public and quasi-public sector organizations in Brussels. [Nicholas.Allen@OdgersBerndtson.co.uk](mailto:Nicholas.Allen@OdgersBerndtson.co.uk)

### ■ Contact Details

Tel: 020 7529 1111

## England

**London**  
11 Hanover Square  
London W1S 1JJ  
+44 (0) 20 7529 1111

**Birmingham**  
Brindleyplace  
Birmingham  
B1 2HS  
+44 (0) 121 654 5900

**Manchester**  
Suite 16E  
Manchester  
International Office  
Centre  
Styal Road  
Manchester M22 5WB  
+44 (0) 161 498 3400

**Leeds**  
Springfield House  
76 Wellington Street  
Leeds LS1 2AY  
+44 (0) 113 386 8500

## Scotland

**Glasgow**  
Stock Exchange Court  
77 Nelson Mandela  
Place  
Glasgow G2 1QT  
+44 (0) 141 225 6320

**Aberdeen**  
7 Albert Street  
Aberdeen AB25  
+44 (0) 1224 218 999

## Wales

**Cardiff**  
13 Cathedral Road  
Cardiff  
CF11 9HA  
+44 2920 783 050