



CEO Appointments: The Mystic and the Measurable

Our Canterbury branch hosted this year's Institute AGM at the Christchurch Botanic Gardens Café, Christchurch. A venue those of us in the North can only envy. Ample free parking, good sight lines (a necessary fire) and delicious drinks and nibbles supplied by our sponsor Medirest. As an added enticement, Graham Ewing addressed us on an intriguing subject, on which most of us have at times mused about. *CEO Appointments - The Mystic and the Measurable*.

Graham is well placed to provide an insight into the appointment process. He has been involved in high profile executive search and recruitment for more than 20 years. Assignments have involved the appointments of Company Directors, Executive Directors, Chief Executives, Senior and Executive level management. These appointments have been spread across a broad number of industry sectors and include large and small private companies and government owned enterprises. In the public health sector Graham has been involved in the appointment of Chief Executives to most of the District Health Boards nationally.

Graham's consulting style reflects his personal involvement with all assignments, working closely with the client at all stages. With his extensive management and commercial experience, Graham is suitably experienced to advise clients on appropriate organisational development strategies. Leveraging his strong network of relationships at senior executive and governance level, Graham provides ongoing advice to a number of organisations at Board and senior executive level.

Graham began by noting that the points he would make in his presentation were not directly related to recent appointment processes in which he has been involved.

The process for any successful appointment has to start with a clear understanding of the performance of the organisation. The key is to predict the future performance of an individual in the given setting that they are going to work in. Therefore, it is important for the recruitment consultant to work with the Board to get an understanding of what the key goals of the organisation are and whether they are being achieved. There is a need to understand how the organisation is currently resourced; its performance, capability and capacity (people, culture, technology, facilities, and learning). From Graham's perspective it is really important to spend quite a bit of time meeting some of the senior people and taking a little longer in getting the selection cycle underway. Fully understanding the setting is critical and in some ways it can be compared to trying to organise a marriage, in the sense that you have got to ensure that it is the best thing for both parties.

The process starts and ends with talking with the Board to determine: what the critical things are that have to be got right over the next one to two years; what are the issues that they can not afford to get wrong? What are the things that are going to put them at greatest risk with the Minister, with their clients, with the PHOs, with the funder, with whomever? Those things need quite a lot of clarification at the outset because later on in the process the consultant needs to ensure that those areas of criticality are dealt to.

The measurable elements used in any selection process incorporate three broad areas: past

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Graham Ewing

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performance, assessment processes, and the whole area of presentation by the candidate. So from a measurable perspective, the whole process is the using of various windows to gather and interpret information with none of those windows standing on their own.

With many years experience in the business Graham believes that, particularly for senior roles, the best indicator of future performance is understanding what a person has achieved in the past as it is more than likely that they will continue to behave in a similar set of patterns. While a whole range of assessment tools are used in the selection process, their validity as an indicator is not high – even though they are used widely. So it is important that they are not used on their own.

These days CVs all look much the same. Candidates should not write a letter that repeats what is in the CV. Some people write huge bibliographies at the back of the CV on what they have published and what conferences they have been to. Then they put 5 or 6 pages at the start, a summary based on the latest management book, where they do an evaluation of how wonderful they are. That is out. A CV should be very much a historic document of where you have been and what you have done and stating the facts.

At the outset of the recruitment process, when gathering information about the candidates past, CVs are important. A lot of people seem to forget who will be reading the CV and how it will be used. They assume a lot of things – for example, they do not describe their employer, what their business is, what its size is, what its structure is, what it is focused on and particularly dimensional things to allow the consulting firm to make comparisons.

The interview process is about creating impressions and telling stories. Telling stories is important – whether it be a story describing your performance review process, whether it is looking at the history of your organisation, about your team leadership, or whatever it is; being able to tell stories and put them together in some sort of order of reasoning or understanding.

Graham's practice uses a wide variety of assessment tools. While he uses them he acknowledges that their validity is not great. They are quite low as a predictor but useful in identifying areas

which should be pursued further. The complexity of the health industry means cognitive assessments are critical for senior health management roles. Certainly the ability to think quickly, critically and rationally are important indicators of an ability to perform at a senior level in a complex organisation. From where Graham sits, he sees nothing worldwide that rival health management for complexity.

Referees are becoming more important in the selection process and are being used quite extensively. A very important part of the process is the opinion and judgement that your referees bring. It is very important that you select relevant referees that you have worked with. Brief them well and tell them about the job. Make sure you select ones that are articulate – some referees have very little to say about people because they only see them in one area.

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More damaging is the circulation of second or third hand stories spread in advance. Inevitably, an impression gets around that someone is a hopeless manager and no-one should touch them

Sector gossip is becoming quite damaging. The sector gossips far too much. We are only a small country and Graham is often told by people – even before he has been asked to do the job – that they know he will be doing it, who will get appointed and even who is on the short list. More damaging is the circulation of second or third hand stories spread in advance. Inevitably, an impression gets around that someone is a hopeless manager and no-one should touch them. This can get through to a Board and when they see someone's name on a short list they already have an erroneous impression about them.

It is good fun to talk stories but it is very damaging to the professionalism of the sector. Gossip has escalated in the last two or three years and it makes it quite difficult to be objective or to support people to step up and be quite honest about others because

they are aware of the negativity being put about.

When you are being short listed or interviewed by a Board, think about what knowledge or understanding those Board members bring to their roles as Board members. What they understand about the sector, what they understand about the role of the Chief Executive, what they understand about the DHB and what their expectations are.

It is important to take some time to understand those people, be aware of their individual expertise and expectations. Graham's experience has been that other stakeholder groups; be they Clinical Board / Management; PHOs; senior staff; or various user groups and providers having some input into senior appointment, have been well set up and worked well in having some input into appointments.

In interviews with Boards you really have to reflect on how your audience is going to assess you and what it wants to see, feel, hear, and think. By this stage your past achievements are accepted and almost forgotten. The question is what now? How do you stand out and impress on the day. The first impression is critical.

Most likely they have determined that, technically, you can do the job but a lot comes down to their perception. Take the audience into a future they can understand and cope with. Give them a 'wow factor' with substance. Prepare well, know what you know and know it very well. Know the key information about the organisation. Some go along to CEO interviews and are asked fairly fundamental questions that are already in the statement of intent and are freely available on its website and they sit there and say, "I don't know that." That is fatal.

Some people do not bother to do their homework. If you have forgotten something you have to handle it better than that. Everyone is in strategic planning – just in different sizes. Everyone is saying the same things – just double the numbers if necessary. Be quick witted. Don't allow them to eliminate you because you admit to something you have not read or can not recall.

If they get you to do a presentation make sure it is of real sharp quality. Keep to the allotted time – go over and they will turn off – only give three or

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four key points – don't give thirty or forty, they won't remember them. Use hand outs, not power point. You only need to have a technical problem and you will have lost it. Their key job in the interview is to communicate – communicate – communicate. It has to be passionate – that is telling the story, showing that you have got energy. Be clear, avoid industry jargon. There will be people on the Board who will not understand. They will not say anything, but you will intimidate them a bit and it will come out later on. Be concise. The cleverest people can say an awful lot in very few words. That can be very telling in that sort of environment where they will be seeing three or four people and it is a long day for them.

You have to work really hard in an interview. People are far more sophisticated at it now but at times it feels like you are a dentist. It is like pulling teeth. People will just give short answers and say yes or no. You have to be on your absolute top performance. Work hard. Give them a good time so they go away thinking I would love to see that person again. Engage with each one of the interview panel. Make sure they have all had a chance to ask a question. It is really like being on the stage for an hour or for how ever long it is. Expect a lot of routine questions relating to things you deal with every day. You should have really convincing responses ready to those things.

Post the decision; be professional in your response. Remember that only one person can be appointed. Be gracious in defeat. You will be remembered more kindly by the recruitment consultant and they will be more comfortable about giving you

feedback on the reasons you missed out. Often Boards do not say a lot about the people they do not wish to progress with. They very quickly move on to the one or two they want to progress and not a lot is discussed so it falls back on the consultant's interpretation of what went on. Boards don't normally go through and so no, no, no, for these reasons; or the reasons they give do not add any value for you the candidate. Remember the Board wants to make the correct decision – even if it has not gone your way.

When we come to the CEO role we always talk about the key to it all being leadership. So how do we define what are the qualities of a leader. Courage, initiative, proactive, energy, flexible, open, imagination, are some of the qualities required of a leader. These qualities are key in any management position in today's workforce. They don't just attach to a leader. In a senior role, leadership requires all of the above, and more:

There is a need for cognitive ability for complexity of tasks in what is a very complex industry.

A sense of value for management and leadership of others – which is about a motivational factor; a wanting to manage, a wanting to lead to take people somewhere.

Appropriate knowledge of management practices and having a lot of experience and skill in its use around the processes of management and administration.

Also having a necessary wisdom about people and "things". It is not having wisdom about this and that – like intellect, things is difficult to define, but when you know it when you come across someone who has that element of wisdom.

Having a stable and non disruptive temperament.

Graham suggests that these are the aspects that will differentiate a person who will be successful as a leader. All are open to development, except cognitive ability. People are not born leaders. It does not come naturally. Everyone who genuinely wishes to do so is born to lead given the necessary conditions. Leaders have vested managerial authority, but they also must be able to win the willing and effective collaboration of subordinates.

On to the Mystic & Measurable. Is the selection process effective? Is too much made of the fuzziness of personality traits and qualities, and emotional makeup and relationships? Graham suggests that perhaps as yet we do not value enough aspects around strategy, structure, management competency and managerial practices – the other necessary conditions that are critical for a manager to be successful. He questions whether the focus is too much on the "good feel factors" and not enough on the "necessary conditions?"

To summarise:

Past performance is the best indicator of how you are going to deliver as a senior executive.

Referees are really important.

The interview process is critical in how you handle yourself – be like an actor on the day.

Think about the leadership qualities and talk about the managerial processes that are involved.

Finally, appointments involve quite a lot of fact and a huge amount of persuasion.

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by electronically
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or e-mail the Editor for more information at admin@nzihm.org.nz

Getting the best from Knowledge Workers

In Management 101 we all learnt about how in the early – and even quite recent – industrial age, men in white coats trotted around factories with watches and clipboards measuring the time it took workers to perform specific tasks. These “time-and-motion” experts set out to measure labour productivity, and thence to improve it. The sort of jobs they were measuring, however, no longer enjoy such a premium in the places where they measured them: today in the workforce, manufacturing jobs struggle to reach double digits. .

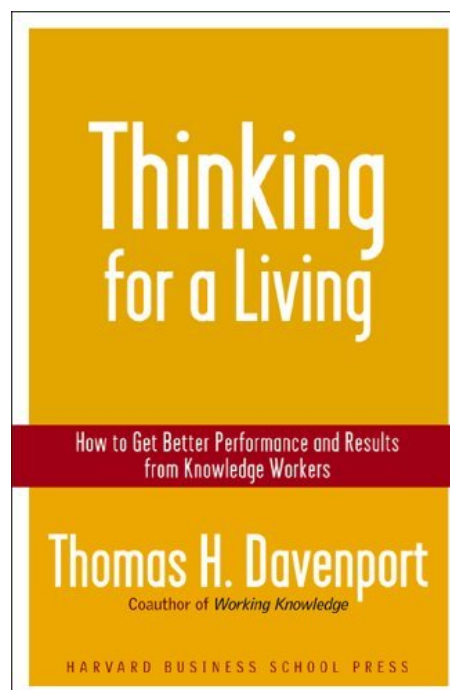
Workers are now employed largely in service industries, where they are paid for their brain rather than their brawn. Many of them can be called “knowledge workers” - between a quarter and a half, estimates Thomas Davenport, who is a long-time observer of the species.

Knowledge workers, he says, are those whose “primary tasks involve the manipulation of knowledge and information.” These people are the creators of wealth in western economies today, yet scarcely anybody is measuring their output and seeking ways to improve it. Somebody should, Davenport argues. Finding ways to improve the productivity of knowledge workers, he says, is “one of the most important economic issues of our time”. He is not the first to say this. Peter Drucker, who invented the term “knowledge worker” more than 35 years ago, said then that “management's new role” is to “make knowledge more productive”.

Little has happened in the intervening time, partly because this is not an easy task. There are no time-and-motion studies that can measure how many thoughts go through knowledge workers' heads or the value of their creative output. Does that therefore mean that companies must (as most of them have until now) leave these valuable assets entirely to their own devices, to work as each of them sees fit while they, their employers, merely stand and wait?

Davenport shows that the answer to this question does not have to be yes. Some companies have tried to make their knowledge workers more productive. Hewlett-Packard, for instance, was one of the first to create a sort of electronic “yellow pages” directory of experts inside the company, together with their expertise. Research has found that the computer programmers with the biggest offices are the most productive, and that e-mail is a better medium for complex negotiations than instant messaging. Whether that translates to the health industry might be hotly debated.

By looking at the ways in which different workers use knowledge, Davenport begins to build a framework within which companies can start thinking about how to make the process more productive. It is not yet—and may never be—a very tidy framework, and it ranges from the best technologies that gather and disseminate information which knowledge workers



need, to the sort of workspace best suited to people who are very mobile and who, by definition, need to concentrate a lot. But it is a bold attempt to address a pressing issue. On the down side, the author or his editor felt the need to conform with management book formula and end each chapter with a “summary” and a number of bullet point “recommendations”. Knowledge workers don't like being patronised; he should know that.

McMorland paper now available on-line

Members will recall Judith McMorland's excellent presentation at our July seminar on “Are you big enough for your job and is your job big enough for you?”. A summary of her presentation was published in Inform 33.

Judith's paper, from which her presentation was drawn, has now been published in University of Auckland Business Review and can be downloaded from: uabr.auckland.ac.nz/issues/article-detail.cfm?ArticleID=103

Putting Engineering to Work in Health Care

The health care system's ability to deliver care to patients—smoothly, safely, and efficiently—didn't receive much attention until a few high-profile medical errors in the mid-1990s brought health care quality and patient safety to the fore. The Institute of Medicine (IOM) reports *To Err Is Human* (2000) and *Crossing the Quality Chasm* (2001) followed shortly afterwards, documenting the problems and recommending needed changes.

Most recently, cost pressures have prompted calls for the use of engineering tools—which have long proven useful in other service industries—as a solution for some of the health system's problems. The National Academy of Engineering (NAE) and IOM report, [Building a Better Delivery System: A New Engineering Health Care Partnership](#), released in June, builds on this momentum, concluding that it is high time for health care professionals and engineers to start working together.

The goal of the plan is to transform the U.S. health care sector from an underperforming conglomerate of independent entities into a high-performance 'system' in which participating units recognize their interdependence and the implications and repercussions of their actions on the system as a whole. The difficulty is knowing how to do it.

Health care professionals typically operate with some degree of autonomy and without a clear hierarchy of control. "It makes it harder to implement change when you have a lot of independent agents trained to deliver care as individuals," says Proctor Reid, Ph.D., lead editor of the *Building a Better Delivery System* report and director of the NAE Program Office.

The adoption of engineering tools also has been slowed by the need to cross disciplines to implement systems thinking in hospitals and other health organizations.

"Engineers don't understand the health care delivery system and the medical profession doesn't understand engineering," says Dale Compton, co-chair of the committee that produced the NAE/IOM report and a professor of industrial engineering at Purdue Uni-

versity in West Lafayette, Ind. "We haven't been talking the same language."

Executives at Denver Health, an integrated, safety-net health system, have learned first hand that engineering ideas need to be adapted to work in health care. As part of the "Getting it Right: Perfecting the Patient Experience" project, a hospital operations redesign launched in 2004 with a grant from the Agency for Healthcare Research and Quality (AHRQ), three engineers have been hired as full-time hospital employees to apply systems thinking.

There is no ideal system for paying for health care.

- ✓ The European social-insurance model is in even more trouble than Britain's tax-based model.
- ✓ The rising cost of publicly-financed medical care threatens America's fiscal health

But the translation of concepts, such as the role of clinical judgment within standardized processes, can be a challenge. "The engineers would say, 'We can do this, we can apply this tool,'" says Paul Schyve, a member of the project's external advisory steering committee and senior vice president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "Then there would have to be some discussions between the health care managers and engineers [to determine] exactly how do we apply this here? There's this dialogue that goes back and forth as they are translating these ideas from engineering to health care."

Denver Health recently hired Simpler Consulting Inc., to help adapt "lean" operating principles to its system. (Lean principles are also referred to as lean manufacturing, lean production, and the Toyota Production System. "[The consultants] have translated

manufacturing examples into health care examples using lean principles and tools," says Sheri Eisert, Denver Health's director of health services research. "They have learned what waste is in the health care system compared to manufacturing; and what are the value-added and non-value-added activities in health care, compared to manufacturing."

Statistical process controls, queuing theory, modelling and simulation, and human-factors engineering, as well as more technology-intensive tools from the fields of supply-chain management, financial engineering and risk analysis, and knowledge discovery are among the tools that have been or have potential for adaptation to health care delivery.

Tools 'Ready to Apply'

The NAE/IOM report includes recommendations to transform the health care sector into what it terms a "high-performance system." These include adoption of engineering tools that focus on the design, analysis, and control of complex systems. "There's a set of tools engineers use all the time that are ready for application in the health care system right now," says Compton. "There are also a number of areas for which more research needs to be done to make the tools more useful to health care providers."

For example, using queuing theory—an engineering tool that accurately predicts the flow of customers based on historical data—to help hospitals better manage patients moving through their systems instead of treating every day as a new event. Queuing theory makes it possible for hospitals to appropriately staff the emergency department on busy Friday nights, just as grocery stores and restaurants have used this technique to schedule sufficient cashiers and wait staff to meet demand on their busiest days and nights.

Purdue University is working on appropriate scheduling with an inner-city clinic, where 40 percent of patients don't keep their appointments but fail to cancel them. The goal of the project is to identify factors affecting pa-

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tient turnout, such as weather and transportation, and then use this information to under-book staff resources when patients are unlikely to show up for their appointments. "[Once] you know the root causes, you can effectively plan for them," explains Compton.

Another theme that appears in the report is the need for information on health system performance. If you don't measure the system's performance along a number of different dimensions—quality, safety, efficiency, and so on—it's hard to get any fraction of interest in bringing these tools to bear on the problem.

Information technology is considered the "backbone" necessary to support the report's other recommendations, adds Jerome H. Grossman, director of the Harvard/Kennedy School Health Care Project. "But information systems aren't enough," he says. Human factors engineering tools, which were used to redesign airplane cockpits, are needed to define the entire care process, including the way that providers interact with the information available to them. (This approach generates information about human requirements and capabilities and uses it to optimize performance during system operation, maintenance, and support.)

Tools for Change

The report also calls for education and research, in part through the creation of 30 to 50 multidisciplinary centres that bring together people from engineering, health care, and other disciplines to address the quality and productivity challenges in the medical system. "The reason we call for these centres is to accelerate the change, to catch up and really adapt things that have gone on in other industries to health care delivery," says Grossman.

One such multidisciplinary centre, the Regenstrief Center at Purdue, was created this year through a grant from the Regenstrief Foundation. "Our mission is to do projects on the sub-systems of health care with the hope of understanding the big picture," says Joe Pekny, a professor of chemical engineering at Purdue and interim director of the centre. The centre focuses on patient-centred health care; improved environments for health care professionals; flows of patients, professionals, information, and funding

in health care organizations; supply chain of the U.S. health system as a whole; and the effects of federal and state policies on performance.

The centre currently has 60 ongoing projects, including mapping processes in a hospital's emergency department, analyzing operating room scheduling systems, increasing caregiver time at the bedside, and designing patient-centred care environments. It has found that the areas with the most resistance to bringing disciplines together often hold the most potential for improvement.

"We have a saying from our last year of operation: 'To be effective it's as much about culture as it is about technical engineering,'" says Pekny.

Attracting the attention of current

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We don't have people who know both and this is a huge problem."

students, in addition to encouraging crossover among professions, is critical. "Operations management methods known in other fields frequently can not be applied directly to health care," says Eugene Litvak, director of the Program for Management of Variability in Health Care Delivery at the Boston University Health Policy Institute. "They have to be modified and to be modified you need to know both operations management and health care. We don't have people who know both and this is a huge problem."

Accreditation bodies, which have long been interested in applying systems thinking to health care, will likely continue to lead in this area. JCAHO has published two books on systems analysis: [Failure Mode and Effects Analysis \(FMEA\) in Health Care: Proactive Risk Reduction](#) and [Root Cause Analysis in Health Care: Tools and Techniques](#). "We've gone through the work of trying to apply and adapt some of the concepts and language so people can use it in health care," explains Schyve.

Also, the Joint Commission requires organizations to report sentinel events, adverse occurrences that result in patient injury or death, and complete a root cause analysis for those that occur as part of the accreditation process. Within the last few years, it also started requiring organizations to pick certain areas where something could go wrong and prospectively apply the FMEA process to them.

Most of the impetus for use of engineering tools, the report and others say, will likely come from changes in reimbursement that encourage providers to invest in systems engineering. "At the very least, we need to redesign our reimbursement systems so that they don't create what can literally be disincentives to using new, better approaches," says Schyve. Ideally, they should reward the adoption of processes that lead to safer, more effective systems.

Cost Savings?

Although systems engineering tools have improved productivity and performance in other industries, there remains considerable debate about their ultimate financial impact on health care. While they will provide important 'one-off' or one-time savings, they may or may not provide strategies that reduce the growth rate in spending, and there is a need to do both of these."

However, these tools are not important for their cost savings alone but for their potential to increase revenues and enhance the care experience through, for example, reducing patient waiting time for appointments. Further, experts say that it is imperative for health care to adopt these strategies, if only for their potential to improve the safety of patient care.

"With the wrong management decisions, I can do as much harm to the clinical outcome as I can do with [the wrong] clinical decisions," says Litvak. "So, we are also talking about life and death when we're talking about management."

NZIHM AGM 2005

President Trisha Ross set out to get the business through in record time at this year's Institute AGM. An attentive group of members, with their taste buds distracted by the Medirest nibbles awaiting them were happy to advise.

Trisha's report had earlier been made available to all members.

Council Vice President Michael Aitken and Secretary Michelle Branney have resigned from their offices and were thanked for their service to the Institute.

Our 2005—2006 Council is:

Trisha Dunn President
David Rankin Vice President
Debbie McDean Secretary
Stuart Francis Treasurer
Fiona Ritsma
Anthea Penny
Peter Reynolds
Phillipa Heads
Shelly Park
James Chal

We welcome Shelly and James to the Council.



Be a 2006 Health Innovation Award Evaluator

The NZIHM conference 2006 will be held in Wellington in June 2006 in conjunction with the 2006 Health Innovation Awards. Thinking of coming to the conference and would like to be associated with the Awards? Then read on.

The awards are about identifying and recognizing new and exciting innovations in the health sector. A key part of the awards process is the evaluating of award applicants innovations by a team of their peers.

The call is out for doctors, nurses, physios, radiographers, management and others who may be interested in becoming evaluators.

All evaluators will be professionally trained over two days by the NZ Business Excellence Foundation. Using prescribed guidelines they then work in cross sectional teams to evaluate a range of applicants.

Evaluators will need to commit up to 100 hours to this work in February, March, April and May. Lots of hard work, but the excitement of innovators and their innovations make it all worth while. And then there is the extra skills the Business Excellence Foundation gives you at no cost

The good news is that all evaluators are invited to the gala dinner at the awards event in June 2006. It really is a good night out.

Having been an evaluator, I thoroughly recommend the experience.

For more information about the Health Innovation Awards check out the website www.healthinnovations.co.nz.

Nominations, which close on November 25, should be forwarded to Clare Gregory at the New Zealand Business Excellence Foundation

Earlier expressions of interest would be appreciated. For that or any questions you may have, email: clare.gregory@nzbef.org.nz or contact Clare on 09 489 8791.

Bruce Parkes



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Inform Editor Bruce Parkes

Health Leadership Programme 2006

Following the success of the New Zealand Institute of Health Management's National Health Leadership Programme in 2004 & 2005, registrations are now open for the 2006 programme.

The programme will cater for up to thirty health managers, clinicians and health professionals from a range of middle to senior levels in health care settings from throughout New Zealand.

Some of the class of 2005 attended the Institute AGM. They were enthusiastic about the programme and believe it has been beneficial to both themselves and their employers.

The programme commences in April 2006, and is comprised of four separate modules held at two-monthly intervals and concludes in October 2006.

For further information and to register please go to <http://www.rhpennytd.co.nz> or email r.a.penny@xtra.co.nz for further information and a registration form.

Seminar Programme

November 9th

@ Brightside Hospital,
Brightside Rd, Epsom
5:30p.m. for 6p.m.

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Taking control of your career and taking it in a direction of your choosing is important. Attend our November seminar and learn some tips and techniques that you can apply to ensure that you have a sound basis for making your own career decisions.

Our presenter Reece Notton is the Managing Director of DBM New Zealand

DBM is a global human capital management services firm. Each year they help more than 7,000 organizations and 250,000 individuals manage difficult and important business and career changes. Some of these changes occur because of whole-organization change; others happen on an ongoing basis as people enter, leave and take on new positions within an organization, or as they manage their careers.

This is our last seminar of the year. Take the opportunity to be well informed before you muse on your career opportunities while lying under a crimson pohutakawa tree at the beach on your summer vacation.

Members, don't just come on your own. Treat a valued colleague to free seminar

