A Liberated NHS – But will it Lead Health and Social Care Together or Force them Apart?

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ABSTRACT

This article is based on a leadership seminar held by the National Skills Academy (Social Care) in July 2010 at which delegates representing local authorities, the independent social care sector, voluntary organisations, central government and academia considered the impact of integrated working on social care leadership. The views expressed in the article are solely those of the authors.

KEY WORDS

integrated care; health and social care; leadership; networks; whole system working

CONTEXT

A national crisis, a coalition government, and an urgent need to agree and implement a sustainable system for social welfare funding may seem like a unique policy context, but in fact the current circumstances in Britain mirror those that led to the publication of the Beveridge Report by the Labour–Conservative coalition in the 1940s (Abel-Smith, 2001). The current Coalition may not have set their sights on as radical an endeavour as a new welfare state, but there is no doubt that they are looking to introduce major changes. Health care, with the abolition of primary care trusts and the transfer of commissioning responsibilities to GP consortia and public health to local authorities, has perhaps been the most prominent policy area (DH, 2010), but most aspects of our national, regional and local government systems will be affected by the funding cuts, if nothing else. The Coalition has also stated an aim of redefining fundamentally the relationship between state and citizen, looking for greater individual and community-led action to address long-standing issues, with a corresponding decline in centrally led initiatives and control. This will be achieved by a ‘radical devolution of power of greater financial autonomy’ (Cabinet Office, 2010 p4) and an underlying philosophy of ‘those who can, do; and those who cannot, we always help’ (Cabinet Office, 2010 p8). Personalisation within adult social care can be seen as a
fore-runner to some aspects of this approach in its belief that giving individuals who receive services greater ownership and autonomy will lead to more efficient and effective support.

LEADERSHIP APPROACHES

This new political context is set in a social and health care landscape of rising demand, budget pressures, increased inequalities and a chequered history of relationships between the health and social care sectors. Against this background, there are four key elements of health and social care leadership that may become even more important in future than they are now.

VALUES AND THE ABILITY TO TAKE A WHOLE-SYSTEM PERSPECTIVE

In the past, some health and social care leaders seem to have operated with a competitive mindset, – the ‘my budget is bigger than your budget’ approach. Unchecked, this can lead to a series of negative behaviours at local level, competition replacing collaboration as the main way of operating. When budgets are tight, the temptation is to retreat back into organisational and professional boundaries, to focus only on core business, and to pass off as many costs as possible to the other ‘partner’. While partnership can sometimes seem to flourish in such settings, it can be because one agency believes it has something to gain by having influence over the other. This is a model of partnership on the basis of ‘putting mutual loathing aside in order to get your hands on the money’ (Alex Scott-Samuel, quoted in Powell & Dowling, 2006 p308) rather than one that leads to shared benefit. The current financial context could make such behaviours more likely – but this might well prove fatal. Instead, the only option may be to recognise that we are all in it together and that for individual and collective survival we have to find ways of making the best use of scarce resources that benefit all partners. This will inevitably require the ability to see the bigger picture, to compromise and to be willing to use resources and influence to help other parts of the system. Rather than more vigorous application of ‘more of the same’, we will need to recognise that it was ‘more of the same’ that got us here in the first place and that only something radically different will suffice.

DEVELOPING A NARRATIVE OF MEANING

Whatever happens, the reform processes under way in both health and social care imply significant complexity. Putting aside the centrally designed plans to re-organise the health service, the Coalition government has in general indicated a commitment to allowing local communities to find their own interpretations and solutions to both national policy and local difficulties. More than ever before, this will mean that local health and social care leaders have a key role to play in making sense (or meaning) of the changing context, and ensuring that they themselves, frontline staff and service users can engage with the implications. Prevailing models of leadership require the ability to simplify complexity, to tell a coherent story about the work we are all engaged in, and to help people make sense of what is happening. While communication and storytelling have always been key functions of leaders, they will become even more important in the coming months and years as the question of ‘what story’ and ‘who tells the story’ becomes a more integrated, shared endeavour. In a future ‘networked leadership’ context, leaders who clarify and simplify the message so that it can be easily communicated and turned into manageable performance tasks may find themselves inadequately equipped. The new leadership paradigm is one which requires leaders to embrace and work with complexity and to find ways to liberate and co-create the story of what the future might look like. Critically, leaders will be required to do so
in a network of relationships with diverse and competing stories, all of which are legitimate, even when they are contradictory! In this kind of environment, the capacity to make meaning which is sophisticated and responds to emergent complexity will become a necessary competence.

**INFLUENCING AND NETWORKING: LEADING WHEN WE ARE NOT IN CHARGE**

As proposed changes come into force, the health and social care landscape could become more complex and fragmented, with new GP-led commissioning consortia, social enterprises, employee-owned organisations, user-led organisations, personal budget holders and micro-enterprises. In practice, this could create a very diverse health and social care system at local level, with many fewer forms of direct control for local leaders. Whereas in the past those in positions of managerial authority might have been able to issue instructions that something should be done, they will have to operate now and in future by market development, influencing, networking, building consensus and building links with local communities. This will require an approach and skill set very different from those which have traditionally been valued in health and social care. High levels of political, emotional, social and technological intelligence will be vital to navigate through these new organising frameworks. The capacity to influence outcomes when you have limited power over others will become a much more significant leadership competence.

In an environment where authority has to be gained rather than conferred, future successful leaders will be those who can self-authorise and act with confidence. Social care leaders have often, historically, been less powerful partners in the health and social care relationship, but have often been more collaborative in their approach to working with service users and communities. Arguably this leaves social care leaders well placed to exercise a more co-operative, influencing style of leadership, but only if they can find the necessary personal and collective confidence.

**CIVIC LEADERSHIP AND LEGITIMACY**

Above all, health and social care leaders are going to have to make some very difficult decisions in the coming years. When this happens, we need to make sure that we are making the ‘right’ decisions (as best we can) – and, just as important, that we make them in the ‘right way’ (bringing local people with us as much as possible, and building consensus and momentum). It will involve technical and data-based skills to make the ‘right’ decisions, and will also involve issues of legitimacy, involvement and engagement. Thus, the next time we decide we need to downgrade an Accident and Emergency Department or close a day service for people with a disability, we need to be in a position where local people and local newspapers either agree or disagree with the decision, but recognise that the health and social care leaders concerned are the locally legitimated people who are responsible for steering a way through these decision-making processes. This isn’t just a technical issue about whether the A&E needs to be closed or the day service promotes independence. It requires the additional skills and knowledge needed to operate complex local governance, and a deep understanding of the nature of community and citizenship; it’s about civic leadership, identity and place.

**LIBERATION OR CHAOS?**

In the past, national guidance sought to ensure that local health and social organisations worked together to plan and deliver services. This aspiration for integration was not always replicated in central government silos, but the frameworks did generate the expectation of co-ordination and partnership. The new Coalition government has promised a substantial scaling-down of centrally
driven policy and target setting, and has already scrapped key waiting-time targets and monitoring bodies such as the Audit Commission. Instead it will be for local communities to find their own solutions, and to decide which ideas and approaches they wish to adopt from other areas (Clark, 2010). The Government is also seeking to empower public sector clinicians and professions and see voluntary organisations having a greater role and influence. This new approach may provide a unique opportunity for greater integration, but the lack of co-ordination and strategic direction may also lead to fragmentation and single-agency responses. It will be the task of health and social care leaders to ensure that ‘freedom’ does indeed lead to better integration, efficiency and person-centred focus, and so a better life for the vulnerable of our society.

REFERENCES


