

# Leading and Learning

## Hári Sewell

*Director of Social Care and Drugs and Alcohol Services, Camden and Islington Mental Health and Social Care Trust*

## Peter Gilbert

*NIMHE/SCIE Fellow and Professor of Social Work and Spirituality, Staffordshire University*

### Abstract

Two learning sets have been established for senior managers who are responsible for social care in what are traditionally health service organisations. For the future health and welfare of wider society and the economy it is vital that mental health remains part of the local authority agenda and that social perspectives, care and inclusion become an integral part of the 'health' agenda.

This article explores the value of the two learning sets, one supported by NIMHE and the second by SCIE, to its participants and the organisations that they serve.

### Key words

learning; integration; values; leadership; mental health; outcomes

This is an era of unprecedented change in public services. In a third term, governments tend to either lose impetus or attempt to rekindle momentum by pushing harder and faster. The latter is certainly the case now and, while renewal and reform are essential, constant structural change tends to create maximum disruption for minimal outcomes.

Over the past few years, this journal's stablemate, *The Journal of Integrated Care* has carried a swathe of articles around changes within the public sector, with particular reference to whether one raft of policies supports or submerges another (for instance, see: Hudson, 2005a; Jones, 2005; Hudson, 2005b).

As Hudson has articulated on a number of occasions (eg, Hudson, 2005a), *'Public sector services have been subjected to a range of modes of governments in the post-war period, each associated with service re-focusing and organisational upheaval'* (p7). Hudson identifies three phases as following in order: separatism, then competition and, in the early years of the New Labour agenda, partnership. Hudson's contention in the case of the Government's reaction to the Victoria Climbié tragedy, the Every Child Matters response, and the Children Act (2004) has been, not for one mode of working to replace another, but for them to be aggregated together and now vigorously stirred with the fourth element of whole-systems working.

The problem, which even the person on the Clapham omnibus can identify, is that if schools become increasingly independent and gain a form of foundation status, with a diminution of the local authority role and an overwhelming emphasis on academic achievement, the protection of vulnerable children could be detracted from, rather than enhanced.

In the field of mental health, there are also major tensions between partnership and inclusion and separation and segregation. In this article we examine one approach that has been developed, at the point of delivery as opposed to policy, to moderate some of the possible challenges arising from new structures and systems. The emergence of the **learning sets** for directors and senior managers with a designated lead on social care, social work and social inclusion is discussed.

Since the early part of this century, local authority social workers and social care workers have been more frequently working within mental health partnership trusts, or health and social care trusts (see Glasby & Peck, 2003). This is usually on secondments, but sometimes workers are directly employed by these various types of NHS trusts, on occasions having had their contracts transferred from councils under TUPE legislation. For a long time attention to mental health has been limited both in terms of profile and in the allocation of resources and service improvement. This is despite the fact that mental health, (as opposed to mental illness), is a vital element in both the well-being of communities and the future prosperity of the economy (see Layard, 2004; 2005).

Attention to mental health is emerging as a critical issue and not one to be addressed half-heartedly or grudgingly. Local authorities have a clear lead in ensuring that the broader social inclusion elements

of mental health development are given attention. The Association of Directors of Social Services (ADSS) and the National Institute for Mental Health in England (NIMHE) recognised this and produced a guidance document in October 2003 (ADSS/NIMHE, 2003) on positive approaches to integration. This gave a clear steer from these two organisations and quoted the Chief Inspector's Guidance to Directors of Social Services. It put out clear outcomes to be gained from the transfer of operational mental health service delivery to NHS trusts, and also the possible challenges to look out for.

The ADSS/NIMHE policy document pointed out that: *'Users and carers and, to some extent, voluntary organisations, have stated clearly that it is not important to them which agency their care and treatment derives from, as long as it is effective and empowering'*. The paper was clear about the advantages of integration, not least that management and service delivery could be more cohesive and congruent, and that there would be a recognised centre of specialist expertise. It also warned, however, that integration should never be *'an end in itself, but a means to achieve better outcomes and effective services'*. This point was reinforced by the doyen of health service managers, Ken Jarrold, in his recent speech, when he continually reminded the government, especially in the light of the recent PCT upheaval, that *'form should follow function'* (Jarrold, 2005).

One of the possible adverse consequences which the ADSS and NIMHE were keen to avoid, was the possibility of local government losing interest in the delivery of mental health services, and in mental health as a wider social and human rights issue. The converse of this risk was also highlighted, ie, that the new, integrated mental health NHS organisations regard social care and social inclusion as marginal activities – and that social

care was a particular intervention that could be ascribed to specific individuals to do.

When social services departments (NB, now most local authorities have separated children's departments and adult services departments) began to transfer their social work and social care staff into mental health partnership trusts and care trusts, most of the new organisations identified a lead on social care. This was usually a third tier post, in charge of the professional development of social care and social work staff. Unfortunately, not all placed social care leadership at a sufficiently senior level. A different, or perhaps, combined error was creating roles where the social care responsibility was forever becoming subordinate to other aspects of people's ever-broadening portfolios. What is certain is that these lead roles (generically referred to here as directors of social care) brought with them specific and explicit pressures.

- **Acting as intermediaries** – As Ken Jarrold pointed out in his recent speech, the NHS has struggled to learn how to be a partner, and in Jarrold's opinion: *'the most important relationship of all'* is *'between the NHS and local government'*. Directors of social care have had to nurture this delicate relationship within two very different, and sometimes antipathetic, forms of governance. At a time when economist and Government advisor, Richard Layard (Layard, 2004; 2005), is stressing the vital importance of mental health to the well-being of the economy and citizens, it is extremely short-sighted of local government, if they pigeonhole mental health as an NHS responsibility.
- **Acting as internal change agents** – Building new organisations, with a multidisciplinary workforce, and the melding of health and social care cultures, is an extremely complex business (see Glasby & Peck, 2003; Gilbert, 2005: Chapters

7 and 8) and requires leadership that is effective, humane and, what Su Maddock calls, 'adaptive' (Maddock, 2005).

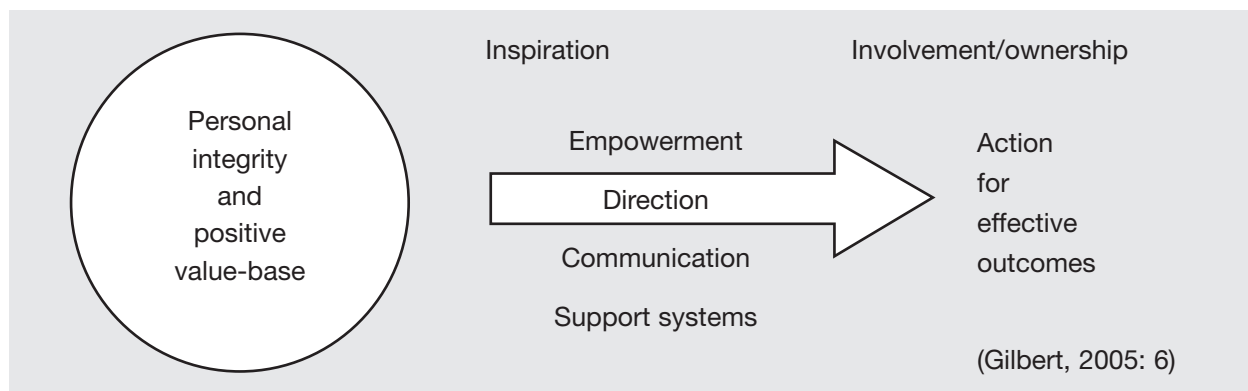
- **Defending the independent perspective in multidisciplinary settings** – The social work and social care workforce is relatively small, and is only one part of a multidisciplinary workforce. There are particular tensions for approved social workers, in carrying out their essential function within the Mental Health Act 1983, while avoiding the twin dangers of social work becoming purely a legislative instrument and ignoring its wider expertise in promoting social inclusion (see Gilbert, 2003).
- **Promoting social care which is counter-cultural** – Despite major changes within the curriculum for the education and training of psychiatrists, promoted by the Royal College, the medical model is still dominant in some places and there is also the danger in the British propensity to leave one dysfunctional paradigm only to cling to another, for an equally mechanistic cognitive model to take its place. Directors of social care and their deputies have to shape a whole persons and a whole systems approach to mental health.
- **Promoting experiential, value-based outcomes** – While supporters of performance management, both authors can see the downside of this culture. We would echo Jarrold's concerns about some of the *'behaviours in today's NHS'*, where *'the drive to deliver has become, in some places, an opportunity for inappropriate behaviour'*. The real challenge is to make leadership both effective and human (Sewell, 2004; Gilbert, 2004; 2005).

The tensions referred to above, combined with the newness of these relatively isolated roles, has required some mechanisms for learning, support

and benchmarking ideas and approaches. This is the importance of the learning sets. As one participant put it: *'The learning set helps me to recharge the social care batteries, because one is often in an NHS maelstrom. It provides some sense of sanctuary'*. The formation of learning set one, which commenced in February 2003, came out of a request from Hári Sewell (the then Director of Care for South West London and St George's Mental Health Trust) and Melanie Walker (Melanie

did not come from a social care background). The formation of the set was encouraged by Antony Sheehan, then chief executive of NIMHE, and Peter Gilbert became the Facilitator. Because of the need to support the next tier in social care, and with a concern around succession planning, a second set was sponsored by the Social Care Institute for Excellence (SCIE) and started life in May 2005. Both sets have grown rapidly in terms of participants and confidence.

**Figure 1:** Leadership - the essentials



**The aims of both sets are to:**

- (i) Provide a safe and stimulating learning environment for holders of leadership roles in mental health trusts, PCTs (which are providers of mental health services) and social care directors in adult services departments, who are likely to become managers of social care as the service transfers.
- (ii) Identify issues where a co-ordinated lobbying approach would be useful, and take action.
- (iii) To learn from each other's successes and challenges.
- (iv) Share expertise and jointly problem-solve new challenges.
- (v) Enable participants to gain knowledge of current issues in mental health (in its widest sense) and ascertain opportunities for positive change.

- (vi) Test out ethical and effective leadership approaches.
- (vii) Develop the concept of evidence-based practice in social care and its implications for integrated mental health services.
- (viii) Provide mutual support.
- (ix) Consider career development.

**Outcomes**

- Participants will gain the following outcomes.
- (i) Be supported during a time of considerable change.
  - (ii) Be better informed about what works, and how knowledge can be translated from one environment to another.
  - (iii) The above translated into better service outcomes for users and carers, with staff supported and developed.

Both sets meet on a bi-monthly basis. They are both facilitated by Peter Gilbert, who is the NIMHE/SCIE Fellow in Social Care (Policy and Practice) (complementing the work done by Nick Gould, Bath University, who is the NIMHE/SCIE Fellow (Research and Practice)). Usually the sets create and contribute on their own agendas, but at times there are outside speakers, eg, Edward Peck (see Glasby & Peck, 2003), from the Birmingham Institute of Health Management. Edward Peck is one of the foremost writers on structural change in Britain today, and the lead researcher for the Government on care trusts.

For the last two years, the two sets have gathered together for a residential in the autumn. The residential in 2004 acted as the precursor to the formation of the second set. In 2005, the focus of the combined set one and set two residential was on leadership and cultural change. The event had the benefit of input from Richard Humphries, the new Chief Executive of CSIP (Care Services Improvement Partnership) and theoretical frameworks lead by Peter Gilbert. These presentations were complemented by practical examples from set members. The residentials take place at a Benedictine Retreat Centre, Worth Abbey (BBC2, 2005). This is appropriate, as the guru of learning organisations, Peter Senge, (Senge, 1990) stresses the importance of the word *metanoia*, meaning a shift of mind. This is much used in issues around spiritual leadership, where there is a notion of awakening, leading to self-awareness, an increasing ability to lead effectively, and with integrity and humanity.

A number of the set members are also regional development centre leads for NIMHE on social care, and so the learning within the set is linked to the bi-monthly co-ordinating meetings of the regional social care leads, chaired by Nick Gould

and Peter Gilbert; and there are also links with the ADSS (Association of Directors of Social Services) Mental Health Strategy Group. Some of the set members have recently commenced on the leadership programme commissioned by SCIE.

Learning has always been an important part of leadership development. Perhaps one of the most famous stories within British culture, of leadership, is Alfred burning the cakes as he mused over how to save his people *in extremis* – an example of humility in leadership; and Robert the Bruce's equally famous learning from the spider and its persistent determination. Senge talked about the need, in a knowledge economy, to create organisations that were constantly learning from experience and putting that learning into practice. Lessem (1991) makes this point and Adair (2005) and Holbeche (2005) also stress learning and the importance of an ethical framework. Perhaps most importantly for the public sector, Beverly Alimo-Metcalfe and John Alban-Metcalfe, from Leeds University, writing on leadership in public sector organisations (2004), stress the requirement in the current climate for leaders to learn in challenging, yet supportive, peer group environments, because, in words that strongly echo Ken Jarrold's recent valedictory, the Metcalfes assert that:

***'One of the real dangers of becoming driven by targets, is that managers can become so target-focused that they behave in ways that can destroy the motivation and morale of their staff, which of course in turn deleteriously affects performance and leads to other costly outcomes'***

(Alimo-Metcalfe & Alban-Metcalfe, 2004: 174).

Feedback from the two sets has been overwhelmingly positive and numbers wanting to join are increasing all the time. The residential in 2004 had 10 members, whilst 2005 saw 24 in total. The feedback from members is qualitative and focuses on the extent to which the sets have equipped them to fulfil their roles more effectively. Their feedback might be grouped in the following areas.

- (i) **Support and development.** Members talk about their very 'isolated positions' as social care proponents in an overwhelmingly NHS organisation and having to hold together the twin horses of local authority and NHS, as they often strive to drag the carriage in different directions. Many people talk about the set enabling people to feel they are *'not on their own'* or even *'an oasis where you can re-charge batteries'*.

Because people are often ploughing a lonely furrow, members sometimes talk about the need to 'test out the reality' of their experience on other people in similar roles.

'Identity' is one of the biggest issues in multicultural Britain (Bauman, 2004), and one set member speaks of it being *'helpful to have reinforced my identity as a social worker and to have social care approaches validated as effective and useful'*. Managers with professional backgrounds need to retain those core values, while embracing a multidisciplinary perspective and managerial overview.

The importance of social care and social inclusion is sometimes differentially understood at different levels in the new organisations. One member commented that: *'Whereas social care is well respected across the organisation, at board level, I am often having to explain social care. (In one discussion about our service*

*principles, the medical director objected to the word 'citizenship', seeing it as too 'political')'*.

On the other hand, sometimes the importance of social care is well recognised at board level, as in one trust where its medical director is perhaps its greatest champion.

- (ii) **Learning from others within the set.**

Members bring examples and case studies of work undertaken, which provide fascinating insights into how leadership can be utilised, more often through influence than power, across geographical, organisational and interdisciplinary boundaries. These can vary from moving the whole social care agenda forward within a trust and its partner local authorities; to culture change within one part of the organisation; to introducing supervision policies which take into account both the need to keep people safe and promote good practice, and acknowledge the sensitivities of a variety of professional groups.

We all get institutionalised in some kind of shape or form, and members report that the learning set discussions, to quote one:

*'Test out the reality of your own, often cocooned existence, and gets you to think what else you can be doing'.*

- (iii) **The connection between the two sets,** the

shared minutes, and the residential for members of both sets annually, ensures that learning and leading at different levels takes place, and that board level managers don't lose touch with what is happening on the ground. As one said: *'It reconnects us with why we are doing what we are doing'*.

(iv) As the set grows, and covers a wider selection of organisations serving communities with very different needs, the sets are able to provide a steer to national organisations with responsibility for policy. Recently, a list of issues has been compiled for the ADSS, which may lead to a revision of the 2003 guidelines on integration, so members feel that they are making a difference.

The experiential feedback from learning set members is strengthened when the content of some of the discussions is considered. The sets are ruthlessly self-critical in justifying their time away from the office and the **outcomes** achieved at a local level as a result of involvement in the sets, are often explored. Learning set members have identified the following.

- A focus on succession planning to ensure progress is not lost. This is evidenced in the creation of learning set two.
- An immediate resource for benchmarking. Members have received prompt and numerous responses on issues such as contracts for ASWs, social care strategies, clarification of the social work contribution to mental health, etc.
- A combined meeting of learning set one and ASW leads enthused one of the latter group to establish a national ASW forum, which considers subjects such as the Draft Mental Health Bill.
- Arguments and strategies for promoting risk-sharing around social care budgets at the local level (in the interest of service users) have been rehearsed, enabling mature local discussions.
- A benchmarking exercise on integrated structures has informed the developments on new or reconfigured services at the local bases of learning set members.
- A series of four articles on social work leadership, published by *CareandHealth* magazine in 2004, was initiated by work led by Hári Sewell as a direct result of discussions in the learning set.

These are just some examples of how the time spent in the learning sets has provided, not only the critical function of enabling members to feel supported, but also real influences on social care are delivered in mental health partnership arrangements.

## Conclusion

It is clear from the emergence of the learning sets that social care is blessed with a significant network of dispersed leadership. The members of the learning sets have not relied upon external catalysts for their formation and continued meeting; they have anticipated the need for succession planning, and they have networked with influential individuals and organisations nationally.

In a world of fads, multiple structural changes and centrally-driven performance management, the learning sets have remained strong and grown of their own accord. It should have been clear that the new integrated mental health services, with new directors of social care, were going to require some mechanism to protect the investment. It is an endorsement of social care that the learning sets have demonstrated self-reliance and established themselves to do just that.

## Address for correspondence

Hari Sewell

Director of Social Care and Drugs and Alcohol Services, Camden and Islington Mental Health and Social Care Trust  
 2nd Floor, East Wing  
 St Pancras Hospital  
 4 St Pancras Way  
 London NW1 OPE

Email: Hari.Sewell@candi.nhs.uk or  
 pgilbert@gilbert88.fsbusiness.co.uk

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