Leadership for personalisation and social inclusion in mental health

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Acknowledgements

Executive summary

This report is aimed at those involved in developing, providing and leading personalisation and social inclusion for mental health. It is also aimed at those developing the leaders of the future. It explores three key questions:

- What is at the heart of the personalisation and social inclusion challenge in the contemporary and future mental health context?
- What are the leadership challenges in transforming mental health social care to deliver more personalised support, inclusion and care choices?
- What, therefore, are the implications for the development of leaders and leadership?

Defining personalisation

Personalisation means thinking about care and support services in an entirely different way. This means starting with the person as an individual with strengths, preferences and aspirations. They drive the process of identifying their needs and aspirations and making choices about how and when they are supported to live their lives (see chapters 1 and 2). It requires a significant transformation of all adult social care services, including mental health, so that all systems, processes, staff and services are geared up to put people first.

The traditional service-led approach has often meant that people have not received the right help at the right time and have been unable to shape the kind of support they need. Personalisation is about giving people much more choice and control over their lives in all social care settings including those integrated with health. It is far wider than simply giving personal budgets to people eligible for council funding. Personalisation means addressing the needs and aspirations of whole communities to ensure everyone has access to the right information, advice and advocacy to make informed choices about the support they need. It means ensuring that people have services such as transport, leisure and education, housing, health and opportunities for employment regardless of age or disability.

Personalisation, mental health and integration

Personalisation offers the opportunity to further break down mental health stigma and institutionalisation through increasing self-determination, independence, choice and control for and with people with mental health problems themselves. But there are specific challenges of implementation within mental health. These include the need to manage particular types of risk, fluctuations in mental capacity and the mechanics of effective social care delivery within integrated NHS provider organisations.

Personalisation is already changing how entitlements to social care resources are determined and used. Over time, it will apply to health resources too and its full potential to transform mental health may be felt only when this integration occurs. This report focuses mainly on the issues for social care transformation within current and emerging forms of integrated mental health service systems (see Chapter 3).

Challenges and opportunities for leaders – a radical agenda

Personalisation implies a paradigm shift in thinking and practice at personal, political and developmental levels. This is potentially a radical agenda that will have many controversies to resolve, stretching present leadership norms and expectations.

These leadership challenges include driving a values-led service and systems transformation, whole-system workforce reform and a need for sustained and cultural change within and across organisations. All of this will need to be achieved within a period of public spending constriction.

This document explores these challenges and opportunities (see Chapters 4–6). Rising to these will require not only ethically sound and imaginative leadership, but also practical, energetic, humanised and available leadership across all parts of the mental health system.

Leadership will need to come not only from within formal structures of authority but also from people using mental healthcare resources, their families, friends and communities of interest, practitioners of all types and other stakeholders. Personalisation offers an opportunity to really rethink what it means to be a 'leader' in public service and what it means to create 'leadership' within systems.

Suggestions for leadership practice and development

This report offers ideas about how leadership might need to be exercised and developed in the future (see Chapter 4). It suggests that strategic, operational and grassroots leadership for personalisation is most likely to be grounded in relationship building, the development of shared values across systems, the encouragement of creativity, the capacity to influence others and 'hosting' and facilitating collective inputs and energies rather than 'directing' them. Modest but robust confidence and strong ethics – rather than thrusting heroic styles – may become more important in public services, with an emphasis upon the enablement of others. The importance of pursuing human rights, sound ethics and equalities will grow through this agenda.

New conceptions of good governance will be needed to maintain quality within this diversified landscape. Part of this good governance will be to effectively share leadership responsibilities whilst attending in new ways to the values-driven management functions needed to deliver effectively. Leadership may need to be a more dispersed activity than hitherto, founded on widely shared, common goals and values amongst many stakeholders and emerging out of new cross-organisational cultures and including more visible 'citizen leaders'.

Leaders and leadership will need to be developed in new ways if the benefits of personalisation are to be realised. Different people within the system will need to be offered opportunities to develop their confidence and skills.

While this report does not claim to offer all solutions to an emergent and complex set of leadership challenges, the following ideas are suggested as priorities for organisations and cross-organisational systems (see Chapters 5 and 6):

- Develop and demonstrate leadership that tackles stigma and promotes social inclusion.
- Create the conditions for citizens with entitlements to social care resources to be empowered to meet their personal aspirations and make real choices in care and support.
- Facilitate citizen involvement and leadership in determining the overall shape and delivery of mental health support systems.
- Facilitate effective cross-sector partnerships, including developing innovative engagement between councils and the NHS in relation to mental health.
- Lead to enable greater transparency, fairness and consumer satisfaction with the operation of systems of entitlements.
- Reform and develop the workforce.
- Ensure professional leadership of all relevant staff groups – including social work – is fit for purpose.
- Lead from a strong personal value base, bringing oneself explicitly and effectively into one's leadership practice.
- Open up new support and care solutions, including innovation for a more diverse and creative provider market.
- Create new formal and informal leadership development opportunities that will grow innovative new leadership across the system.
- Develop leadership strategies that expect pressurised public resources and can develop capacity in unexpected places.

1 Introduction

Personalisation is the current major driving force in public sector welfare reform in the UK. It proposes a new relationship between public authorities and citizens in which people take more direct control over – and more responsibility for – their own well-being and the services they receive. This new relationship moves us from a philosophy of care based on the provision of services and social goods as 'professional gifts', to resources being made available as a matter of citizenship entitlement and services being 'co-produced' through collaboration between citizens, public authorities and professionals.

Personalisation proposes that well-being is inextricably linked with social inclusion and active participation in civic society. Our health and well-being are strongly dependent on the extent to which we can work, learn, have meaningful relationships and contribute to, as well as receive from, those around us. Whatever our needs or disabilities, active citizenship is seen to be vital to individual and collective well-being. That is why this report draws together personalisation and inclusion; they should be mutually reinforcing in policy and practice.

Policy on personalisation has emerged from a number of pressures. It is foremost a response to rising expectations and dissatisfaction with public services on offer: we increasingly expect to choose more freely the type of support or social opportunity that we need, and how, when and where it happens. Personalised approaches should enable this. By focusing on what a person wants and aspires to, personalisation could transform our approach to mental well-being and mental health support systems. It could bring about the real end of institutionalised mental health services, 20 years after 'community care' was enshrined in law. Personalisation has the potential to further break down unhelpful distinctions and structural divisions between 'social' care and 'health' care, and enable a better balance between prevention, early intervention and 'upstream' crisis, emergency and restorative interventions.

Personalisation has also arisen as a policy response to the challenge of changing demographics, in particular, the ageing of the population. As people live longer, sometimes surviving longer with significant disabilities and illnesses, they want and need tailored support to maintain their independence. As the number of older people rises as a proportion of the population as a whole, social care costs will proportionately rise and new solutions will be needed to meet this social and economic challenge.

The changes implied by personalisation are not without dilemmas, challenges and some contradictions: balancing risk minimisation with positive risk taking, for instance and enabling individual support purchasing choice while ensuring reliable care and support providers can survive in a changing and competitive market. Perhaps most challenging in the coming years will be implementation in the context of reductions in public sector spending.

The realisation of the positive potential of personalisation will depend to a large degree on effective and tenacious leadership across adult services – leadership that can enable the benefits of personalisation to emerge out of uncharted territory.

Finding out what this will look like and making it happen is a challenge across all adult support, care and treatment services. As we go to press, the future funding and organisation of adult social care is up for debate following the publication of the adult social care Green Paper (DH, 2009) and the realities of public sector spending constriction in coming years are beginning to come clear. However, this report suggests that there is an ethical imperative for those involved in adult social care and specifically those working for mental well-being, to grasp and make the most of the opportunities and principles underpinning personalisation and social inclusion.

The focus of this report, then, is on three key issues and the relationships between them:

- What is at the heart of the personalisation and social inclusion challenge in the contemporary and future mental health context?
- What are the leadership challenges faced in transforming mental health social care to deliver more personalised social support, inclusion and care choices?
- And what, therefore, are the implications for the development of leaders and leadership?

2 Policy context: the journey towards personalisation in mental health

> Despite attitudes about sexuality, ethnicity and other similar issues improving, research shows that prejudice against people with mental health problems is actually increasing. ('Time to Change' National Anti-stigma Campaign, 2009)

This section outlines the story so far in the development of personalisation and social inclusion imperatives as they relate to mental health. It outlines the efforts of recent years to modernise approaches to mental health and then explores the four main dimensions of personalisation – *choice and control*, *building social capital*, *earlier intervention and prevention* and *self-directed support* – in the mental health context. It considers how these four dimensions relate to the recovery agenda which has developed within mental health somewhat in parallel to the drivers of personalisation, but which now needs to be understood as all of a piece.

The section ends by raising a key problem area for leadership resolution within mental health: managing the safeguarding and risk management agenda within transformed social care for mental health.

2.1 Modernising our understanding of mental health

It is well accepted that about one in four people will experience significant mental health problems in their lifetime (Rankin, 2005). Yet recent research evidence continues to suggest that public attitudes, while largely sympathetic towards mental health problems, have changed only a little for the better during the past 10–15 years and negative attitudes persist or are getting worse (TNS UK, 2008). Open acknowledgement of mental health problems may be becoming slightly less taboo, but there is no convincing evidence yet of widespread reductions in stigma and the discrimination that can follow from it. National policy efforts to de-stigmatise public opinion of mental distress and illness are relatively recent and remain a work in progress (see for example the 'Time to Change' National Anti-stigma Campaign; 2009, www.time-to-change.org.uk/).

Negative public perceptions of mental health problems and distress and the 'Cinderella' nature of mental health services have gone hand in hand over the decades. The Department of Health's 2001 document, *The journey to recovery*, reflected on inadequate progress in service quality over previous decades, as people moved out of long-stay institutions into 'community care' services and accommodation. The document went on to state the following:

> In a few areas innovative new services were introduced but, overall progress was patchy and poor. Services were not meeting needs comprehensively, and those that tried to do so often relied heavily on the commitment of a few pioneering individuals…. The community too often became a bleak and neglected environment for people with mental health problems. (DH, 2001, p 4)

The government made mental health one of its top three health priorities within the White Paper *Modernising mental health services* (1998), introducing the National Service Framework for Mental Health (NSFMH) the following year (1999), which drove reconfiguration of services around new types of team with functional roles, founded on contemporary evidence for effectiveness – assertive outreach, crisis and home treatment and early intervention in psychosis services in particular. The specifications for these forms of team have included both social care and health resources and staff.

The creation of the National Institute for Mental Health in England (NIMHE), launched in June 2002 (subsequently merged into the Care Services Improvement Partnership, or CSIP, in 2006 and succeeded by the smaller National Mental Health Development Unit, or NMHDU, in 2009), provided a new framework to support implementation of policy and innovation within mental health services. NIMHE's regional development centres linked national, regional and local perspectives and encouraged leadership by people at all levels within service systems and in wider stakeholder groups.

NIMHE/CSIP particularly supported Experts by Experience (people using services and their carers) to have direct influence over the direction of travel for mental health. Key parts of NIMHE's programme were: raising the profile of mental health as a mainstream public welfare issue; challenging myths and stigma; challenging inequalities and discrimination; and identifying and supporting necessary workforce changes. Key strands of NIMHE's work are now being carried forward through the NMHDU, which aims to support policy implementation through working jointly with strategic health authorities and other key organisations.

2.2   Mental health law reform and values-based alliances

A significant driver of debate and thinking in recent years has been the 10-year debate to amend the 1983 Mental Health Act up to its final enactment in 2007. This engaged a wide range of stakeholders in protracted but essential debates about (among other things): entitlements to services; attitudes towards people with mental health problems; public safety concerns; investment in mental healthcare; the success or otherwise of 'care in the community'; clinical consideration of what constitutes 'treatment'; and the extent to which professional roles could be taken up more flexibly by a range of practitioners.

The Mental Health Alliance (see www.mentalhealthalliance.org.uk), comprised of 75 diverse user-led, carer-led, voluntary sector, statutory sector and professional organisations, became a powerful voice which was opposed to certain proposals in early drafts of the legislation. It argued for a more enabling and human rights-based mental health act – something more consistent with the personalisation and inclusion approach. The Alliance concluded that the 2007 Act was a 'disappointment' and a lost opportunity, although an improvement on the previous Act.

One of the positive outcomes from the process of legal amendment was the adoption of a statement of principles within the new *Code of practice* (DH, 2008a) that was also given a higher status than the previous code, enabling ongoing

values-based influence on the interpretation of the new Act by groups such as the Mental Health Alliance.

The Alliance exemplifies the importance of different groups finding shared, positive values to collectively lead and drive improvements in approaches to mental health in the face of persistent public misunderstanding and mythology. The members of the Alliance included those who had experiences of using services, as well as professionals bringing a variety of evidence and values-based practice paradigms to their work. The integration of values-based practice with evidence-based practice may be seen as a key component of personalised mental health approaches, enabling the coming together of 'what is important to the person' – their subjective wishes, experiences and beliefs – with 'what the evidence from research tells us', as explored, for instance, in the work of Fulford and Woodbridge (2007).

Collaboration across organisational sectors around shared values also underpins the recent work of the Future Vision Coalition (2008) that has come together as the 10-year lifespan of the NSFMH comes to an end. This coalition of 11 organisations (Association of Directors of Adult Social Services [ADASS], Association of Directors of Childrens Services, Local Government Association, NHS Confederation – Mental Health Network, Mind, Rethink, Mental Health Foundation, Mental Health Providers Forum, Royal College of Psychiatrists, Sainsbury Centre for Mental Health and Together), coordinated by the NHS Confederation, advocates in its 2008 discussion document:

- An end to the dominance of the medical model and adoption of an 'integrated model' with an emphasis on the social determinants of mental health
- An emphasis on public mental health
- Services to focus on the goal of recovery of a good quality of life
- A shift in power relations enabling real self-determination for people using services over the direction of their recovery.

The advocacy of a values-based and holistic perspective on mental health in recent years by many organisations have significantly influenced the government's recent 'New Horizons' consultation (www.dh.gov.uk/en/Healthcare/Mentalhealth/NewHorizons/index.htm). This will form the basis of a national mental health strategy to replace the NSFMH. It aims to bring into focus public mental health approaches and prevention, stating that there is 'no health without mental health'. It has a vision to 'create flourishing and connected communities through the promotion of well-being and resilience and the reduction of inequalities'. It also aims to take to the next stage improvements in the accessibility and quality of services for those with highest needs. The consultation's guiding values are stated as equality, justice and human rights; reaching full potential; being in control; and valuing relationships. It makes explicit reference to personalisation as a fundamental opportunity to change how resources are used. It also suggests a future where mental health solutions are not seen to be the preserve of public spending on discrete services but something that must arise out of communities' actions and the coming together of initiatives from a range of sectors. The tone and philosophy of the document is a long way from the policy drivers behind the NSFMH.

2.3 Key elements of personalisation and social inclusion for mental health

In 2007, *Putting People First* (DH, 2007) laid out the transformation agenda for adult social care. It is an explicitly values-driven document that envisions independent living as a right for all, with whatever support is needed to overcome socially constructed disability. It stated:

> This landmark protocol seeks to set out and support the Government's commitment to independent living for all adults. (DH, 2007, p 1)

This short document, alongside the longer guidance contained in Local Authority Circulars (LACs) in 2008 and 2009, laid out the vision of transformation required across four key areas of adult care:

- Extending *choice and control*
- Building *social capital*
- Improving *universal services*
- Moving towards more *preventive and earlier services*

The key leadership challenges of each of these dimensions are explored below.

Personalisation has a variety of roots. These include: the campaigning and awareness raising by people with disabilities themselves, including the survivor movement within mental health (Carr, 2008);* public consultation on the government Green Paper, *Independence, wellbeing and choice* (DH, 2005) and the White Paper *Our health, our care, our say* (DH, 2006a); and the work of the Social Exclusion Unit (SEU) (www.cabinetoffice.gov.uk/social_exclusion_task_force.aspx) and influential public policy innovators such as Charles Leadbeater and the Demos think-tank (2004) and the New Economics Foundation (NEF, 2008).

A personalised approach takes valued citizens in their social contexts as its starting point and their self-evaluated outcomes as key measures of 'success' (Leadbeater, 2004). It is about enabling people to have optimal control over their support arrangements. Personalisation offers the opportunity for social perspectives on disability and equality to become a dominant framework for all mental health support systems. Within this approach, 'professional health' interventions play a vital but not necessarily a determining part in enhancing the quality of life of people using services.

Personalisation is also founded on sharing and 'co-creating' knowledge and from that, the 'co-production' (Leadbeater, 2004, p 10) of service delivery through active citizen participation. It provides the opportunity to draw together all those involved in mental health support – people who use support services, their families and carers, community leaders, practitioners, managers, policy makers, commissioners and executives – into more collaborative, beneficial and equal relationships and practical, innovative partnerships.

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* Quote from Carr (2008, p 10).

Within the mental health field, the effectiveness of personalisation will be particularly dependent on tackling the social exclusion and stigma that has been part of day-to-day life for many people with mental health problems and distress, and for their carers and families.

The National Social Inclusion Programme (NSIP) for mental health was developed alongside and in conjunction with the concepts and policies of personalisation. In 2004, the SEU report that underpinned NSIP's subsequent programme of work gave a vision of a future where people with mental health problems had equality of access to work and participation opportunities.

For some people, of course, mental health stigma is further compounded by other social discrimination. Recent evidence shows that people of black and minority ethnic (BME) background continue to receive measurably different and unequal access to appropriate support.* Gender, sexuality, religious background and age are other key sources of differential treatment within mental health services. Social inclusion and social cohesion concerns thus need to be integrated within personalisation if social inequalities are to be addressed, individually and collectively.

The transformation of social care services towards more personalised forms has been supported by transformation funding and policy guidance from the Department of Health (2008b). The transformation agenda recognises that systems, philosophies, resources and structures need to be ambitiously reformed if services are to be personalised (from Hari Sewell, personal communication). It will require greater sophistication in joint commissioning across health and social care. *Putting People First* (DH, 2007) highlights in particular the need for:

> Local authority leadership accompanied by authentic partnership working with the local NHS, other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high quality care system. (DH, 2007, p 2)

2.4   Choice and control

2.4.1   Recovery approaches

> **Example:** If we plant a seed in a desert and it fails to grow, do we ask, "What is wrong with the seed?". No. The real conspiracy lays in this: to look at the environment around the seed and to ask, "What must change in this environment such that the seed can grow?". The real conspiracy that we are participating in here today is to stop saying what's wrong with psychiatric survivors and to start asking: "How do we create hope filled, humanized environments and relationships in which people can grow?". (Deegan, 1996, p 3)

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* See for example results of the Healthcare Commission 2008 Count me in census on ethnicity of inpatient wards showing continuing overrepresentation of some BME groups in mental health.

A recovery approach within mental health services is increasingly being endorsed in various countries (for example CSIP/RCPych/SCIE, 2007; O'Hagan, 2004; USDHHS and SAMHSA Center for Mental Health Services, 2004; Ramon et al, 2007) by users, carers, professionals and policy makers, as a way of describing the positive personal journey a person with mental health problems or distress can make to achieve a better quality of life.

In common with personalisation, recovery promotes the expectation that people using services can and want to take as much control as possible over their own journey towards improved well-being. The recovery journey is *of* and *for* the person using services – it is not a service-defined 'care pathway'. It also represents a shift towards an approach to self-determination that is not predicated on the presence or absence of 'symptoms'. It is not about 'cure' but about people finding a better way to live. It has been characterised as being founded on optimism, hope and opportunity (Perkins and Repper, 2003), building on individual strengths. It provides powerful, galvanising concepts to guide how mental health services can do their work in the detail of day-to-day practice, in all parts of the mental health support system.

The key question for staff may be 'what am I doing that might get in the way of this person's self-defined recovery?'. The key question for leaders of staff and services may be 'what am I doing to ensure my resources promote recovery?' or 'what am I doing to create the environment/conditions in which staff can get on with the proper job of removing barriers to recovery?'.

2.4.2   Developing the provider market

The personalisation and self-directed support agendas in transformed social care – and their emerging equivalents in healthcare – provide great opportunities to bring material resources and the structural transformation of service processes to the benefit of individuals' recovery journeys. Through this, leaders and managers have the opportunity to create services that are provided *for* and *controlled by* people, with professionals '*on tap not on top*' (Shepherd et al, 2008).

The improvement in the quality of people's experiences and outcomes will in part depend on fostering more choice in the social support provider market. People needing and wanting support must be able to choose not from a fixed menu but from an a la carte menu, or to purchase the ingredients and means to create their own versions. This implies new approaches to commissioning by social care and health leaders and innovative leadership within the non-profit, commercial and statutory sectors.

As Ann James has put it:

> Growing the supply side of health and social care – the providers – needs to be shaped to match the changes we are seeing in demand. If we don't do that, we risk repeating the dreadful mistake of community care – closing long-stay hospitals and just expecting the market to provide. (James, 2008)

The challenges for commissioners across social care and health are immense – commissioning for difference and diversity rather than sameness and standardisation is a paradigm shift. How do they commission for a market to be available for individuals to choose to purchase while also commissioning to meet immediate 'duties of care'?

The challenges are just as great for the provider side which is comprised of players of all sizes and degrees of leverage with commissioners and which are differentially placed to be flexible and responsive in adapting the offers they make both to organisational commissioners and individual purchasers of support.

2.5   Building social capital

2.5.1   Participation, inclusion and 'co-production'

There is growing acceptance of the fundamental importance of meaningful connectivity and participation within communities for the overall physical and mental health, well-being and longevity of all of us. This broadly defines our 'social capital'. In the context of exploring the role of differential social capital in determining health outcomes, Morgan and Swann (2004, p 2) suggest:

> Social capital is an expansive concept, one that includes facets such as sociability, social networks, trust, reciprocity, and community and civic engagement. Morrow (1999) states that the fundamental principle behind the concept appears to be that social capital is constituted by the extent to which people are embedded within their family relationships, social networks and communities, and have a sense of belonging and civic identity.

In order for individuals to make more real choices about social support, how they want to live and improve their lives, there must be widened options for them within their communities; more places that are accepting and supportive and more and different opportunities for social participation than have traditionally been available for people with mental health needs and more genuine removal of social discrimination.

The 2004 SEU report, *Mental health and social exclusion*, set the agenda for NSIP's mental health programme. A particularly salutary and notable finding of the 2004 report was that mental health staff held particularly negative perceptions of people using services and had low expectations of what they could achieve. Changing this cultural and attitudinal problem of staff was and may remain a key leadership challenge.

The 2009 report on NSIP's achievements, *Vision and progress*, identifies 10 key messages for future improvement in social inclusion in mental health and elaborates the SEU's original ideas (adapted here for brevity from NSIP, 2009, p ii):

- *Social inclusion needs to be about more than access:* it is about *participation*.
- *The need to work across traditional boundaries:* inclusion requires integrated effort across government and non-government agencies at all levels.

- *Social inclusion is supported through partnership working:* to build the bridges required to support community participation, active citizenship and to build social capital.
- *It is not just about serious mental health problems:* social inclusion is about common mental health problems, prevention, mental health promotion, building resilience and community well-being.
- *The public sector duty to act on discrimination is an active duty, not a passive one:* statutory measures for equality are key to eliminating exclusionary barriers.
- *No challenge to exclusion can succeed without the full involvement of people with mental health problems:* a co-productive approach with people who experience mental health problems is essential across all delivery and development.
- *A sense of personal identity, aside from ill health or disability, supports recovery and inclusion:* services should support people to access the opportunities to contribute within the many communities to which they belong.
- *To promote inclusion we need pathways from segregated service provision into mainstream services.*
- *Healthy workplaces are necessary to mental health and well-being.*

The report details the leadership and workforce challenges and innovations of the NSIP, including the Developing Effective Local Leadership for Social Inclusion (DELLSI) programme involving three NHS mental health trusts (discussed further in Section 5 below). The report notes in the foreword (NSIP, 2009, p 1), as the programme comes to an end, that:

> … there is no finishing point. The challenge is continuing to effect cultural change, through the transformation of thinking and services across complex organisational boundaries. Whole person approaches demand whole system responses. This is neither simple nor short term.

Implementation of equalities duties by public authorities with regard to people with mental health needs is a crucial part of breaking down social, service and environmental barriers to inclusion. Another leadership challenge for personalisation and inclusion in mental health lies in finding ways to use equalities and rights legislation and knowledge to best effect within localities. Effective leaders and leadership will use legal leverage and innovative application of the law to reduce direct and indirect barriers to participation.

Through greater exercise of citizenship rights and responsibilities by people with social care needs and the whole community, a more personalised future will see the 'co-production' of services and support arrangements. This means that support and care will come not only from structures created and administered by large public authorities but also in partnership with small-scale local innovations, self-organising groups and community activism.

Co-production contrasts with public service delivery systems that position the user as a passive recipient of services designed and delivered by someone else. People who use services are seen as having assets and expertise that can help improve services. Starting from the assumption that those traditionally labeled as service users should play an active role in service creation, co-productive approaches can encompass new

relationships with professionals and new forms of peer support. Given the potential for resistance and conflict, frontline staff need to be trained in the benefits of co-production and confident to share power and accept service user expertise (Needham and Carr 2009).

2.6   Universal services, earlier intervention and prevention

Personalisation is also about improving universal public services: primary and emergency healthcare; adult education; leisure services; transport; and environmental services. Personalisation re-emphasises the importance of these and other universal services to the fabric of civic life and to public well-being that goes beyond the benefits of their direct usage. The common experience of using them binds communities and promotes cohesion across apparent differences. More cohesive and participative societies generally have better health and well-being outcomes.

Local councils and the NHS are expected to promote and enhance universal services and facilities. Their duty to promote equalities should ensure this includes those most socially excluded through disability, discrimination or social disadvantage. In the future, universal services should be able to act as more effective gateways to social care assessments and resources. Personalised adult care systems should have 'no wrong door' but easy access portals to the help that is needed. A particular leadership challenge in mental health is thus to reduce barriers between universal and primary services and specialist resources, minimising the long-recognised problem of people experiencing being passed 'from pillar to post'.

Smoothing the gradation and reducing the stigma between aspects of service is another dimension of personalisation. The enhancement of primary mental healthcare services – reducing the necessity for people to be referred into specialist secondary mental health services, speeding up discharge from secondary services and enhancing early and preventive interventions – are all important parts of the personalisation and inclusion agendas. However, this raises a particular workforce leadership challenge: *what roles, posts and services might be needed within primary care (and indeed, other universal services) to enable those eligible to access social care?* People in receipt of primary mental healthcare support have tended to be invisible to social care systems as the resources to assess all mental health-related eligibility for social care have been largely swallowed into integrated NHS trusts. If personalisation is about fairer and easier access to entitlements, NHS and local authority commissioners and leaders must address this.

Providing targeted, evidence-based, specialist earlier intervention services is another crucial systems-level change implied by personalisation. In mental health, providing effective early intervention for young adults and older teenagers with psychotic disorders and for people in the early stages of dementia are excellent examples of mental health leading the way in personalised interventions. Properly functioning early intervention in psychosis services enables young people to maintain participation in ordinary, age-appropriate life chances while tailoring evidence-based and timely treatments to the individuals.

The strategic leadership challenge of this emphasis on prevention is to ensure that those most disabled and most in urgent need continue to receive timely support while improving access to 'upstream' services that may reduce long-term dependencies and disabilities.

2.7   Self-directed support: personal budgets

As this report has so far described, personalisation and social inclusion are about much more than the targeted social care or secondary health resources. However, improving the way in which people with mental health problems access such targeted resources within transformed systems is a crucial challenge. Personal budgets are the key mechanism for delivering the personalised and self-directed support that can promote and empower a person's recovery journey. They are designed to give people much more control and choice over their social care and support.

The evidence base on personal budget schemes is explored elsewhere (Glendinning et al, 2008; Carr, 2009), but research shows that they can be of positive benefit to people with mental health problems. The findings of the IBSEN pilot study of personal budgets (Glendinning, 2008) found that people of working age using mental health services had the best quality of life improvements of any group. this relates in particular to increased choice - people availing themselves of a wider range of tailored options for support and enablement that were not available under previous systems. This finding and other reports on the benefits of direct payments for people with mental health problems indicate just how important it is for quality of services and better outcomes that self-directed support is implemented fully within mental health.

Personal health budgets are also being piloted for England. These will build on the experience of personal budgets in social care and test out ways of giving people with long term conditions, like mental health problems, greater control over the health services they use.

One of the issues that the IBSEN research into personal budgets highlighted was practitioner misconception about everyone who needs ongoing social care and support being given cash to buy their own services (Glendinning et al, 2008).

However, a direct payment is only one way to receive a personal budget. The following points are crucial for understanding how personal budgets work:

- 'Personal budgets should be focused primarily on funding ongoing support and care needs, and normally only considered after a focus on relevant preventative and enabling options
- Personal budgets can be offered as a direct payment, or as an 'account' managed by the council or a third party.
- Personal budgets should be implemented within the framework of self directed support. This involves self-directed assessment, 'up-front' allocation and support planning, to ensure maximum choice and control'.
  (DH/ADASS 2009)

Self-directed support also means that less in-demand services – within statutory or third sectors – will be decommissioned or will need to be differently commissioned. This challenges social care and NHS commissioners to maintain reliability of service availability in the short term while enabling the market to develop longer term. Thus, the *leadership* and the *management* challenges inherent in ensuring the effective implementation of personal budgets in mental health include:

- ensuring people using mental health services are fairly accounted for in the local RAS
- ensuring that those managing self-directed support systems within local councils understand the needs of people with mental health problems
- ensuring people using mental health services and their carers can exert appropriate and effective authority in local implementation and evaluation
- ensuring staff within all relevant services understand the practice and role design implications of moving from a 'care management' system to a 'support planning' system, including risk enablement approaches
- ensuring resources made available for the transformation of social care systems towards self-directed support up to 2011 are used in the service of mental health as much as for other groups in the community
- ensuring a safe and effective transition from block-purchased to choice-based commissioning of diverse providers.

2.8 Challenges for mental health: personalisation, managing risk and safeguarding vulnerable adults (SVA)

As people exert more 'choice' of support arrangements, they may be more exposed to unassessed risks. These may arise from, for instance, unregulated services and people taking decisions that are at odds with professional perceived wisdom. Mental health service provision is particularly associated – publicly, politically and clinically – with the amelioration of risk, sometimes doing so in the context of fluctuating need and fluctuating mental capacity. Mental health services also have to manage negative public perceptions of mental illness and inflated notions of the risks people post to themselves or others. This has brought about a very risk-averse culture within traditional mental health services.

SVA and personalisation may be understood as 'two sides of the same coin'; the former provides the framework to manage risks arising from the myriad of individual, personal choices arising from the latter. Increasingly, SVA may be the main framework for discharge of many statutory agencies' duties of care as they pass on the functions of direct provision to the third sector, unregulated support workers and private arrangements made by individuals, either using their own or public money. Over time, the limits and extents of the powers and duties that remain invested in public authorities to intervene and offer safeguarding protections, will be tested by cases where the relative ethics of 'autonomy' and 'paternalism' will need to be weighed.

This 'arm's-length' relationship between statutory providers and the support people arrange for themselves requires a change of culture and behaviour for local councils, partner statutory agencies and the leaders within them. Leaders

in mental health must find ways of taking new types of positive risk, locally leading of changing public conceptions of risk taking and championing freedom to choose and take control within mental health. Staff and managers will need clear leadership and support in this new ethical context.

3 Whole systems challenges: integration and beyond

... the more robust and sustainable benefits of the integrated approach have now been demonstrated.... (ICN/CSIP, 2008, p 9)

[Yet] Self-Directed Support seems to be a new paradigm with a consequent risk of an uncomfortable fit with existing ways of doing things.... The quest will be for a citizen-based model of integration. (ICN/CSIP, 2008, p 50)

This section lays out why some current approaches to health and social care integration may not be fit for purpose to enable transformed social care. It highlights the ongoing role of councils with the mental health agenda and indicates some of the different ways in which councils and the NHS are working together on mental health. The section presents some of the ways in which social care leadership and representation have been developed to date within integrated service systems – indicating some of the successes and weaknesses of these solutions. The section ends with reiterating the value of joined-up commissioning across social care and health.

A major – and strategic – reason why implementing personalisation within mental health may be particularly challenging, is the structural dislocation of statutory mental health social care resources, and management away from local councils and into integrated provider NHS trusts across England and Wales, via a variety of partnership agreement arrangements. This offers great potential to provide a strong foundation for integrated personalised social support, drawing together social care and health resources. But it also means that mental health issues may not be top of the list of day-to-day concerns of the local authority leaders and managers who are developing personalised social care processes.

The 'hosting' or integration of social care within NHS organisations also means that social care obligations are being delivered within organisations – now largely NHS foundation trusts (FTs) – which are propelled most strongly by health service and business concerns. Ensuring prompt and effective use of social care resources and ensuring robust SVA processes are in place are currently two areas of repeated concern within the proper operation of mental health partnership agreements between local councils and the NHS. While most service systems recognise the gains made through integration, there have recently been 'de-integration' moves by some local councils which have taken back direct management of social care staff and resources. For some councils, implementing personalisation is prompting a stock take on exactly *how* they want to collaborate most effectively with NHS providers and commissioners in the future.* The question is how to maintain whole system approaches while potentially disrupting 'taken-for-granted' integrated arrangements.

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* For example in Birmingham City Council in 2008 reviewed integration arrangements and NHS and Council mutually agreed to end the partnership agreement, move from an NHS hosted arrangement and go to a co-located, separately managed arrangement from health and social care staff and functions.

The delegation of duties from adult social services departments of local councils to the NHS also requires elaborate practical infrastructures – finance, information and eligibility systems etc – that can operate across often complex organisational boundaries. Leadership vision and tenacity – matched by effective management systems – will be required to work across social care, health and other sectors to make these complexities work *for* and not *against* people using services.

3.1 What have we meant by 'integration' up to now?

The value and meaning of social care and health 'integration' has been taken for granted within mental health policy for many years. Structural integration has been promoted as a means of improving access to statutory NHS and social care services by reducing multiple assessments, pooling resources to get better value and sharing core roles across traditional professional boundaries.

To date, integration has tended to be delivered through the delegation of social care duties to specialist NHS mental health provider organisations under the framework of legal partnership agreements. This process has helped to grow large provider trusts, sometimes covering several councils and NHS commissioning areas, sometimes coterminous with councils, the NHS or both. Commissioning of third sector services has occurred usually in parallel to and sometimes in competition with the integrated provider trusts, as both local authority and NHS commissioners seek to broaden the provider base. More recently, different funding streams have been drawn together through the plans and priorities of local strategic partnerships. The majority of social care funding for mental health, however, has continued to be managed by NHS providers.

Within provider mental health trusts, integration of social care and health functions has taken different forms on a continuum, including:

- parallel, co-located but distinct social care and health services
- multifunded teams with shared goals and tasks, usually with social care staff seconded to work under NHS management
- wholesale pooling of staff and resources to create 'one' provider, including transfer of social care staff to NHS employment.

NHS provider mental health trusts thus have dual accountability – to NHS local commissioners on the one hand, and to councils on the other. The latter is at once a 'commissioner' of which services are fully delegated and a 'partner' in the delivery of services for which the local council remains directly responsible, such as the making of direct payments, ensuring the sufficiency and approval of approved mental health practitioners (AMHPs) and discharge of guardianship powers under the 2007 Mental Health Act.

3.2 Integration in the future: the ongoing leadership role of councils in mental health

Whatever the local arrangements for delegation of social care delivery, the director of adult social services (DASS) remains responsible overall for the planning and

provision of social care in their area. The 2006 guidance on this statutory goal details the following responsibilities (DH, 2006b):

i)   Accountability for assessing local needs and ensuring availability and delivery of a full range of adult social services
ii) Professional leadership, including workforce planning
iii) Leading the implementation of standards
iv) Managing cultural change
v)   Promoting local access and ownership and driving partnership working
vi) Delivering an integrated whole systems approach to supporting communities
vii) Promoting social inclusion and well-being

The social care transformation and social inclusion agendas reemphasise and make ever more relevant the leadership now invested in the DASS for all groups in the community, whatever the delivery arrangements. As ADASS has stated:

> Over the last decade, many Councils have devolved significant areas of mental health commissioning and service provision responsibility to NHS organisations – increasingly mental health has been seen as a "health" issue ... we believe that social care's retreat from mental health has gone too far and that we need to re-assert the connections with the wider local government agenda and Local Strategic Partnerships so that people with mental health needs can have better access to housing, education, work, leisure. (ADASS, 2008, p 5)

The extent to which local councils behave as 'commissioners' and how much as active 'partners' within mental health systems – and how skilfully they manage the relationship challenges inherent in this complex legal and practical situation – has varied from area to area (ADASS, 2008). Where the ongoing engagement of councils in mental health service developments has been less effective or consistent, one contributory factor has been the loss of staff with strong mental health knowledge and experience into trusts, by transfer or secondment, leaving gaps in knowledge, confidence and commitment within some councils. Even where knowledgeable and confident senior staff remain within council social services departments, they may not have sufficient workload capacity and/or sufficiently effective performance management tools to maintain influence on the development of social care and inclusion within integrated trusts.

Councils and their social care and social work value bases and cultures have not been uniformly able to influence the culture of mental health integrated trusts such that social care concerns and perspectives become part of the day-to-day world of the provider environment. In their 2007 article, Robb and Gilbert reflect on Robb's experience of moving into an integrated mental health trust role for the first time. She expresses how the differences in language, organisational accountability, structure and the locus of power and respect (afforded to 'clinicians' more than 'managers') significantly impacted on her leadership role (Robb and Gilbert, 2007).

3.3   Ensuring embedded social care leadership within future integrated services

There is some empirical evidence that the variability in the engagement of councils and the provision of strong social care (and, indeed, social work) leadership within integrated provider organisations directly and negatively impacts on user outcomes. The Healthcare Commission (HCC) and the Commission for Social Care Inspection (CSCI) report *No voice, no choice* (HCC/CSCI, 2007), a joint review of adult community mental health services in England, highlighted the great variability in health *and* social care service quality across the country. But some of the specific areas of concern highlighted were distinct weaknesses in social care delivery, including the foundations for more personalised services such as poor uptake of direct payments. Other areas of weakness included lack of involvement of people using services in care planning and regular reviews of care, both prerequisites for the ambitions of self-directed support.

The *New ways of working for everyone* progress report (CSIP/NIMHE, 2007, p 115), drawing on a national survey of social care staff and managers and an opinion survey of social care leads in integrated provider trusts, also suggested:

> ... there is a lack of clarity about the leadership expectations and/or requirements of social workers [and that] ... leadership needs to be sustained and delivered in order to deliver priority outcomes of social care within mental health services.

The report also suggested that where identifiable 'leaders' for social care or social work within mental health had been established, they were sometimes the sole or main point of contact between two complex organisations. They often had to act as the holders of wisdom and expertise, answerable to two or more organisations on a very wide variety of issues. They sometimes felt they were without sufficient authority or support to gain positive leverage on either organisation and felt pulled in different directions.

> It's like everything from both organisations gets funnelled through me – I am at the point where the tips of two triangles, two funnels meet when what is needed is connectivity across the base of both triangles – across the departments and staff throughout all functions like HR [human resources], finance, governance, training etc. (member of the Social Care Strategic Network for Mental Health [SCSNMH],* personal communication)

A variety of approaches have been taken to creating roles to represent and improve leadership and management of social care performance and the social care/work workforce – and to influence the culture – within integrated provider trusts. These are evolving as more trusts attain FT status and take on new governance and public accountability configurations.

Some of the main approaches taken to date are described in Table 1 below.

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* SCSNMH is a professional association for those with a leadership role in mental health and social care in England and Wales.

Some organisations have created several of these types of role to create a sound governance and supervision structure. A test of the effectiveness of any of these single roles may be whether they are embedded in a network of supporting roles with clear (NHS and local authority) governance processes that enable them to function effectively and exert leadership authority. The question then becomes not only 'are there *leaders*?' but 'but are there sustainable systems of *leadership*?' in place.

Table 1: Range of social care leadership roles in mental health

Leadership role	Employer	Opportunities
Local authority head of service/ director on trust board	Local authority	Embeds local authority perspectives in trust strategy and decisions Develops commitment on both sides to establish effective working relationships and mutuality
Local authority councillor representation in FT Council of governors/ members	Local authority/ elected member	Enables local democratic representation to be a formal part of trust governance processes; brings political perspectives into the open Enables local authority influence to be in context of discussion with community, staff and other stakeholder representation
Board-level director of social care or social inclusion	NHS	Social care is part of regular work of the board and senior management teams; social care performance embedded within board reporting and scrutiny Enables visible professional leadership of social work at board level
Non-board-level director/head of social care or social work or social inclusion	NHS and/ or local authority	Social care is represented in senior management team strategy and operational decision making Enables visible professional leadership of social work at senior management level May allow for more flexibility and attention to diverse matters if not taking board-level responsibilities
Jointly appointed (local authority and NHS) senior operational and/ or strategic staff	NHS and local authority	Embeds dual accountability in day-to-day operations and governance of performance Gives access to decision making and influencing forums in both organisations
Head of social inclusion	NHS or local authority	Focuses attention away from social 'care' and on to inclusion – moves beyond 'services' to opening up access to sustainable and universal opportunities
Social work/ AMHP lead	Usually local authority	Close to practice; accessible and visible day to day; a role model Can scrutinise detail; provide immediate point of contact for practitioners requiring advice and assurance

Leadership role	Employer	Opportunities
Senior/principal practitioners	NHS or local authority	Close to practice; embedded in teams, providing credible day-to-day advice and guidance to multidisciplinary colleagues as well as social care staff; upholds social care values and perspectives within detail of practice
Manager of operational services with social care background	NHS or local authority	Embeds social care knowledge in day-to-day operational decisions
Can bring both sound knowledge of key social care priorities and best of social care management and leadership culture

The creation and maintenance of the SCSNMH, whose membership is drawn from these roles, has demonstrated that a new professional leadership practice has emerged out of these roles, spanning social care and health.

Not all organisations have created these leadership roles and systems, and not all organisations have developed the potential of the posts created. Some posts have been created then dis-established, and some have been overloaded with too many diverse responsibilities that diminish their strategic impact (CISP/NIMHE, 2007). Where they have been created with levels of authority commensurate with tasks and responsibilities, their impact has been well regarded (CISP/NIMHE, 2007), and they provide an important foundation for leadership of personalisation of social care going forward.

Creating dedicated roles and leadership structures does not necessarily equate to change of organisational culture and outcome. The service systems that are coming together to create a new 'coherent' entity or a seamless process are highly complex and inflexible in themselves or cannot be made to fit comfortably together. There are fundamental differences to be overcome such as charging for social care when healthcare is free at the point of delivery or harmonising expectations of management and supervision best practice which are different traditionally in councils and in the NHS. Agencies may sometimes be culturally, structurally and financially much more intransigent or dissimilar than expected. The effort and time associated with integrating different functions and cultures may be under-estimated or under-resourced.

As Glasby and Peck (2004) have suggested, local government and NHS local commissioners need each other now more than ever in order, specifically, for local government to achieve its aims of being a 'place shaper' and for NHS local commissioners to become more locally embedded and less subject to constant and disruptive reorganisation. They need broad relationships and collaborations that can accommodate – but are not reduced to – the mechanics of particular forms of contract, agreement and partnership structure. Rather they need broad, joint understanding of local needs, taken forward through joint strategic needs assessment, local area agreements and joint senior leadership appointments where appropriate. They need to learn from and share excellent commissioning practice.

To get beyond silo thinking and behaviours and to bring about real cultural changes in organisations, local government and NHS leaders need to keep focused on being

the joined-up enablers of real community engagement and voice to drive the shape of services as well as the joint custodians of shared public duties. Putting aside organisational 'egos' and enabling the release of the energy and leadership potential of others – particularly those using social care resources directly and their advocates – starts to define the new leadership challenges for the 'post-integration', personalised future. But this can only be truly effective if commissioning is strategically linked and effective across all social care and health sectors.

4 Making it happen: leadership for personalisation and social inclusion

Personalisation is about whole system change, not about change at the margins. It will require *strong local leadership* to convey the *vision* and the *values*, which underpin it and to reach beyond the confines of social care. It is essentially about a significant *cultural shift* and *management of change* for the wider social care and local government sectors. To achieve this, all stakeholders will need to work in partnership to construct a comprehensive delivery model, which works across social care and touches on the wider reforms within the NHS and in local government. (DH, 2008b, pp 5–6; emphasis added)

This section lays out key approaches to leadership that are implied by the challenges and opportunities explored in preceding sections. By contrasting the emerging and future service, workforce and philosophical approach with what has gone before, future leadership approach priorities are proposed. An evaluated social inclusion leadership programme is compared to this emerging list of priorities as a case example. The importance of workforce leadership and reform is emphasised, including the change implications for traditional professions, the future role of social work and the future of the non-traditional workforce, particularly Experts By Experience.

All the major reports into service development or service failures point to the need for sound leadership. This is not just a public sector or private sector issue; it transcends boundaries.

As public services continue to develop in complex ways and take on new forms, it seems that understanding of leadership and the performance of leaders must become increasingly sophisticated, and increasingly grounded in the abilities of leaders at all levels to work and engage in sense making across traditional boundaries. This needs a revitalised approach to leadership – and management – development.

Lord Darzi's final review report (DH, 2008c, p 66) states that:

Leadership has been the neglected element of the reforms of recent years. That must now change ... leadership will make this change happen [and facilitate] meaningful conversations that transcend organisational boundaries.

4.1 Leadership and management

Leadership is about vision – being able to make sense of and communicate the bigger picture within complex situations. But it is also about ensuring things happen and enabling practical innovation. In this, leaders need to relate closely to managers. Sometimes these are the same people with overlapping roles; sometimes they are different. If leadership provides and promotes the vision, management puts it into action through attention to the operations, processes and HR deployment needed.

Failures in organisations often stem from a lack of appreciation of the necessary synergy between leadership and management. Some organisations are keen to have very compliant people in management roles who will not 'rock the boat'. In these instances the organisation is unlikely to be able to respond to challenges. Conversely, some approaches may over-emphasise a transformational leadership approach without attention to the delivery mechanics of good management. Both leadership and management are necessary, and organisations need to ensure that they are there in the right measure. Inevitably it is not simply an either/or, and many of the aspects of leadership and management have overlaps, as in Figure 1.

Figure 1: Leadership and management combined
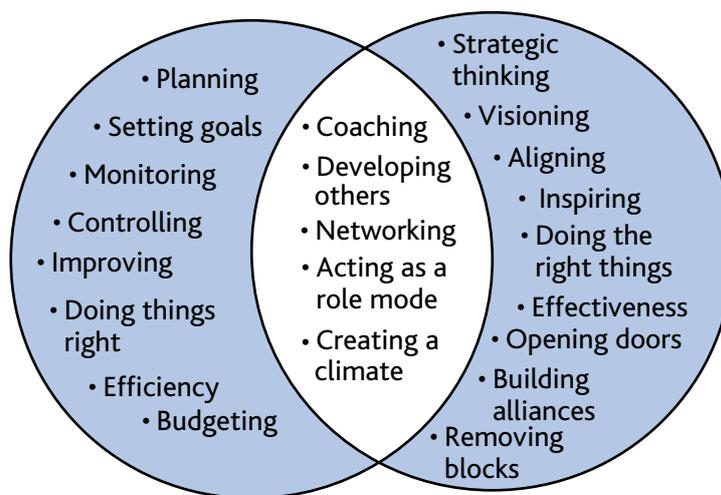
Source: Chris Lake, Roffey Park Management Institute (quoted in Gilbert, 2005, p 19)

At a time of tremendous change the joint leadership *and* management challenge is to ensure these 'building blocks' of effective organisations are sufficiently in place to keep enterprises in operation, while enabling it to transform and grow. Making personalisation a reality in mental health requires a renewed, robust evaluation of both the leadership and management resources and practices available within and across organisations, particularly at the interface of local government and the NHS.

4.2   Leadership fit for the times

Table 2 below suggests some of the main ways in which leadership has developed out of the culture, values and politics of different eras. Styles of leadership in mental health have fitted within the service forms and approach to people implied by these different phases in the development of mental health services. One of the ironies of leadership in the public sector is that it has often lagged behind cutting-edge thinking and sometimes tried to copy the outgoing management theories in the private sector. Coulshed and Mullender (2001) make the point that at a time when commercial and industrial organisations were bringing in more human and emotionally intelligent approaches (Goleman, 1996), public sector organisations were often reverting to a more mechanistic approach. Leadership of personalisation and inclusion may need to develop and deploy some of the most cutting-edge ideas to be successful.

There seems to be some congruence developing in thinking about public sector leadership at the moment that delivering benefits across complex systems demands leadership that is ethical, humanistic, facilitative and available. It needs to be founded on an ability to work creatively with relationships, out of which can emerge common understandings and shared energy. This type of collaboration is at no time more necessary than when resources are squeezed.

Table 2 suggests the following dimensions of leadership may be increasingly required within mental health systems in order to deliver personalised and inclusive outcomes:

- *Customer/consumer and Experts by Experience leadership:* the leadership that will come from the self-organised collectives, advocacy and community groups of people using services and their carers.* Also the de facto leadership that will come from the personal choices people make that will drive the shape of the market and the service system.
- *Cross-sector network leadership:* formal leadership positions within mental health service systems will need to be less tied to the delivery priorities of discrete organisations and more focused on leading across boundaries and against organisational self-interest for its own sake. Leaders in all quarters will need to have influence and collaborate to set directions across different parts of the system in partnership, sharing leadership responsibilities with leaders from other organisations and sectors. This implies a different perspective on the complex whole – allowing the shape of and vision for services and priorities to emerge in response to changing and fluid feedback.
- *Leading for choice through creativity and innovation:* creating new 'offers' and real choice in the social care (and health) provider market demands innovative, creative leadership and entrepreneurialism. But creativity and innovation need to be effectively led within the whole process of personalised support planning – from how self-assessments are assisted to how options are explored in detailed conversations, how support plans are put together and bureaucratic barriers overcome. Practitioner staff need leadership that creates a positive culture, valuing innovation and creativity.
- *Hosting, facilitating and mentoring leadership:* one of the implications of the above is that leaders may be more defined by their ability to bring people together, to release creativity and positive action and to provide the context for such things to happen. Simple exhortation to organisational authority is inadequate when bringing people from different disciplines, organisations, sectors, backgrounds and interest groups together to engage in a common vision or task and to release potential. In this context, leadership needs to:
  - give meaning
  - create community
  - allow humanity (Gilbert, 2005)

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* Within Foundation Trusts, which have characteristics similar to commercial companies in many ways, this influence can actually be better formalised through well functioning Councils of members or governors giving more direct local accountability.

Table 2: The long journey out of the institutions for mental health services and the implications for leadership

Approach to services	Theory base	View of people	Delivery systems	Roles	Knowledge/ power locus	Leadership approaches
1840s–1970s Segregated institutional care	Medical treatments Custodial and/or asylum-based	'Lunatics' cases, patients	Fixed sites: closed hospitals, asylums	Doctors, nurses, clergy, lay visitors	Doctor knows best	Charismatic Morally based Imperial Directorial and rigid Uni-professional reporting (medicine, nursing) Steeply hierarchical Containment and experimental treatment-focused
1980s–present day Community care	Multiprofessional/ multidisciplinary care and cure Organised duality of 'health' and 'social' care interventions	Clients and 'service users'	Multidisciplinary community teams, some hospitals, some cross-sector partnerships, some third sector provision	Multidisciplinary professionals	Professional knows best Manager knows best	Multidisciplinary team-based Leading for standardised quality outputs Transactional management across health and social care Heroic – transformational style of change Ethics of compassion towards people using services Activity and output-focused
Emerging future Recovery, personalisation and self-directed support	Overarching social model of disability Recovery approach	People/ citizens: with rights, control, opportunities and entitlements	Emerging forms of new service across statutory, voluntary, user-led and private sectors; more diverse sources of support; more evidence-based treatments offered where indicated	Educators Advocates Peer support workers Evidenced-based practitioners	Co-production of expertise between person and service provider	Customer/consumer leadership Leadership at points within networks across sectors Leading for choice through innovation and creativity Hosting, facilitating and mentoring leadership Public service leadership emphasis demonstrating human values Ethics of rights Governance-driven/outcomes-focused

Source: Adapted from Ruth Allen, Robin Murray Neil and Rachel Perkins (unpublished presentations)

McKergow (2009) suggests the metaphor of leader as 'host', someone who selects and prepares the venue, invites people who need/want to be together, oils the discussion, attends to people so they feel able to contribute, holds the boundary against intruders and creates more than the sum of the parts.

Mentoring and coaching approaches to leadership bring a focus on ensuring leaders are available for conversation, knowledge sharing and discussion with staff and others. This approach emphasises a positive perspective on the motivations and abilities of people that the mentor or coach seeks to release.

- *Leadership driven by public service ethics:* leadership in public services is purposeful and is about enabling the ethical delivery of social goods. Personalisation and social inclusion offer the opportunity to restate the ethics of public service – of 'servant leadership'. With a focus on enabling self-determination and end user benefit being more defined by the person themselves, leadership can become oriented to service rather than control.
- *Leadership that embodies human values:* leadership in mental health services needs to mirror the values-based approaches which have been changing services, as described in Section 3. Inculcating hope and valuing personal narratives are just two aspects of this. Leaders need to be meaning makers, weavers of stories into the pattern of everyday lives. Leaders in mental health also need to show their own humanity by demonstrating the acceptability of acknowledging their own mental health concerns, making it possible for others to be open.
- *Equalities and human rights-based leadership:* personalisation and inclusion demand a dogged attention to people's rights and entitlements. Whether protecting and enhancing the personal dignity of an older person on a high-dependency ward or enabling a young person diagnosed with schizophrenia to get a job or tackling the high compulsory detention rates of BME people in psychiatric wards – leadership needs to be underpinned by an understanding and commitment to the rights and entitlements enshrined in law, policy and best practice.
- *Outcomes and governance-driven leadership:* effective governance requires a full and strategic collaboration between NHS organisations, social care departments, the wider council, user and carer representatives and non-statutory organisations on strategic objectives. Glasby and Peck (2006) highlight the need to build governance arrangements on shared meanings across partners (for example shared understanding of the use of words such as 'governance' and 'board' and 'commissioning'), and alert us to the importance of recognising the symbolic rather than purely executive impact of partnership structures, such as partnership boards.

Figure 2 below, from *Social care governance: A practice workbook* (Simmons, 2007, p 8), locates leadership and management in the cycle of governance activities that can lead to meaningful engagement with, and valued outcomes for, service users and carers. It neatly encapsulates the place of leadership in a cycle of continuous improvement, with the achievement of high-quality services through meaningful engagement and effective outcomes for service users and carers at its heart. It perhaps demonstrates a particular 'social care' perspective on the importance of interrelated factors needed to ensure 'quality services' for users and carers. The other elements of the cycle are largely beyond the scope of this report, and the workbook

itself is an excellent resource for practically engaging with the issues described in the figure. These issues go beyond social care and are relevant across local health and social care systems. The focus of this report is the leadership required to enable local systems to properly engage in the processes described. It also helps to highlight the risks of not paying appropriate attention to leadership.

Figure 2: Model of social care governance
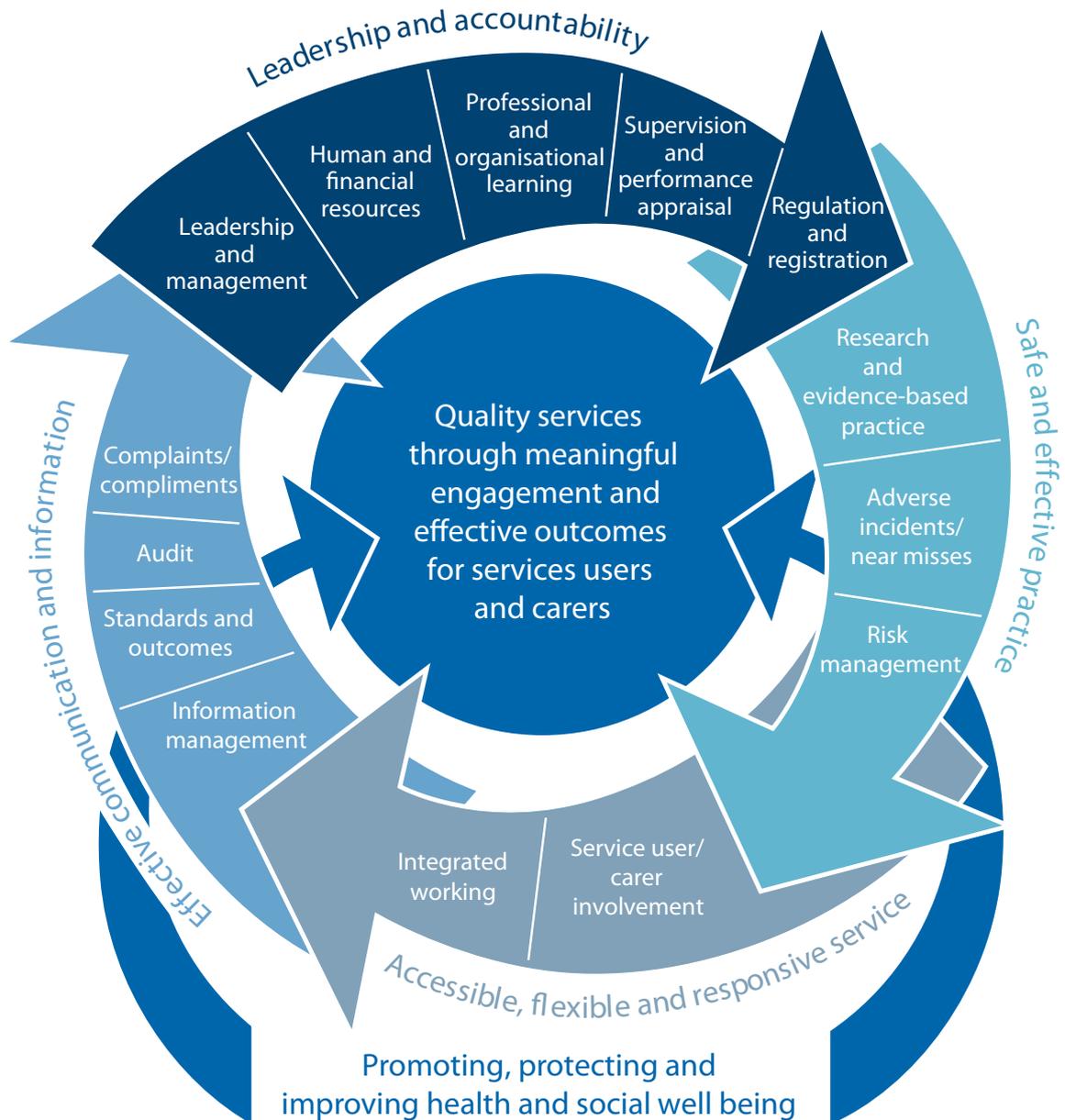
Source: Simmons (2007) (with permission)

4.3   Leadership for social inclusion: an evaluated project

In the box below are findings from the NSIP Delivering Effective Local Leadership for Social Inclusion (DELLSI) initiative (also discussed on p10). (NSIP, 2009, p 27)

which map well onto the leadership approaches for personalisation detailed in Table 2 above. The aim of the DELLSI initiative has been to facilitate the bringing together of leadership development and service improvement at a local level to promote social inclusion. To achieve this, three NHS trusts were recruited and took part in the programme between September 2006 and May 2008.

Findings from NSIP Delivering Effective Local Leadership for Social Inclusion project

Working with three integrated social care and mental health trusts to promote inclusion practice, NSIP's pilot leadership project found:

- The importance of adding value at a strategic level by alignment with organisational priorities, while avoiding reliance on a top-down directive approach to motivate participation. *Outcomes and governance-driven leadership.*
- The need to ground plans in a systematic assessment of what people using services say they want and need. *Customer and Experts by Experience leadership.*
- Engaging people who use services to communicate the project messages throughout the organisation. *As above.*
- Building from participants' own understanding and evaluations of social inclusion locally. *Host and facilitator leadership. Humanistic leadership.*
- Taking a team approach, so that different groups and individuals pursue their issues of concern and build from their strengths. *As above.*
- Maintaining a 'can-do' approach and remaining hopeful even in the face of resistance, apathy or events not going as planned. *Outcomes-focused leadership.*
- Using senior stakeholders to broker relationships on behalf of the team. *Host and facilitator leadership.*
- Being realistic about the time frame needed to achieve improvement and consciously promoting sustainability from the outset. *Outcomes and governance-driven leadership.*

The DELLSI initiative has been positively evaluated and work is underway with new partners to develop a second phase with twice the number of sites.

4.4   Professional and workforce leadership

Across social care and health there is a huge task ahead in enabling existing staff to make a significant journey of change. Some of the concepts associated with personalisation can sound jargonistic and unrealistic at first hearing. Professional and practice leaders need to find ways of explaining complex concepts and putting them into action with the right combination of learning inputs and standards setting for outcomes.

These challenges are amplified by the emergent nature of personalisation – professional and operational leaders need to give direction and strive for clarity while encouraging innovation in uncertain terrain.

Leaders of personalisation and inclusion practice may need to look for new tools that can support the change process, allowing creativity while delivering sufficient consistency and maintaining risk management governance. An approach such as the 'Plan, Do, Study, Act' (see for example NHS Institute for Innovation and Improvement, www.institute.nhs.uk) cycle of implementing change offers one such helpful, straightforward way of structuring practice change within uncertain and untested contexts. Emerging research evidence on 'what has worked' is becoming increasingly available (see for example Glendinning et al, 2008), and its implications need to be absorbed and well understood by professional and operational leaders and managers and translated into meaningful messages for staff at all levels. Practice and professional leadership is needed across sectors – for instance, engaging and mobilising resources and ideas across the health and social care boundaries and with third sector colleagues.

Staff of all disciplines are not only facing changes in practice. They also need to deal with the prospect of significant changes of role and job design. There will be changes for the *existing/traditional* workforce and also a change in the overall *skill mix and nature* of the workforce. Not all the tasks and roles for personalisation will be carried out by traditionally qualified professionals. The budgetary imperatives of coming years may accelerate moves away from widespread deployment of expensive traditional professionals towards greater roles for support staff and non-traditional staff of various kinds. The most expensive and highly formally trained staff may be much more reserved for the most complex assessment and risk management activities than has been the case in mental health in recent years.

This does not necessarily mean diluting the need for shared capabilities such as those laid out in the NIMHE document *The ten essential shared capabilities* (Hope, 2004). It also does not negate the need for a broad biopsychosocial understanding across disciplines and throughout the hierarchy of mental health organisations. But it may mean that technical skills are re-focused in order to improve the experience of people needing to use such services at defined points in time. This may mean, for instance, ensuring psychological therapies can be more efficiently offered if people with those skills are not overly preoccupied with generic or managerial tasks.

The leadership challenge in this – to move to new conceptions of integration and new conceptions of how technical skills can be deployed in more focused ways – is a significant shift. Mental health staff leaders have spent much of the last 10 years or so steering attention to the commonality of the knowledge and skills base across disciplines. Now, with choice coming to the fore in social care and health – and, thus, the need to enable people to understand what is on offer and make decisions within that choice paradigm – workforce leaders need to instil new clarity in staff roles, functions and the intended outcomes of their efforts. Staff and leaders need to be able to explain both the specificity of what different people and resources offer and have a more sophisticated way of explaining how everything fits together in potentially new forms of systems integration. Only by being able to explain this will staff be able to become facilitators of personalised choice.

This agenda clearly also challenges the team structures that have become the norm in integrated statutory mental health structures. However, there is an opportunity here to re-imagine and re-design teams in much better ways than currently. Evidence from the HCC NHS National Staff Survey for 2007 revealed that 94% of staff

responded positively when asked: 'Do you work in a team?'. However, this shrunk to only 42% when the survey explored whether the team in question fulfilled criteria for a well-structured team, that is, clear objectives, close working with other team members to achieve these objectives, regular meetings to discuss effectiveness and how it could be improved. The need to re-design teams for personalisation and inclusion outcomes may be an important opportunity for leaders to create teams that can function much better.

4.5   Role of 'peer support'

One of the most interesting possibilities in mental health is the potential to develop more peer support staff and volunteers – well trained people with lived experience of using mental health services and informal carers and family members, who may offer empathetic and hope-inducing support to people of a very different nature to traditional staff. The potential effectiveness of this approach has been evidenced in the work of organisations such as META (Ashcraft and Anthony, 2005) in the US where specialist, trained peer support staff make up 70% of the workforce in the city of Phoenix, Arizona.

This approach may offer a step-change for organisations in countering stigma and promoting recovery-focused practice. A peer support worker can offer an immediate role model and source of optimism about the future for people still using mental health services. They re-write the story of what mental health problems might mean in the future – from one of chronicity to one of change and progress. The presence of peer supporters – who can become valued colleagues and leaders in their own right – may also shift day-to-day organisational culture and language to reflect a more positive perspective on mental health problems. Peer support initiatives may, of course, develop outside of existing service paradigms, may compete for business in the new provider marketplace and may be part of the 'co-production' of services discussed above.

4.6   Some implications for social work

People value a social work approach based on challenging the broader barriers they face. They place a particular value on a social approach, the social work relationship, and the positive personal qualities they associate with their social worker. These include warmth, respect, being non-judgmental, listening, treating people with equality, being trustworthy, open, honest and reliable and communicating well. People value the support that social workers offer as well as their ability to help them access and deal with other services and agencies. (Shaping Our Lives, 2008, quoted in Carr, 2008)

The implications of all this for mental health social work are both exciting, and potentially anxiety-provoking. Over the past two or more decades, social work has become almost synonymous in adult mental health services with the approved social work (ASW) role created by the 1983 Mental Health Act. While the 2007 Mental Health Act has replaced this with the AMHP role open to different professions, existing ASWs have formed the core of the new AMHP workforce. The opening up of the AMHP role to professions other than social work will change that workforce over

time. Social work roles may become more focused on innovative practice to deliver personalisation and other statutory obligations including safeguarding people of all ages, working once more with families and communities rather than solely with individuals and advocating for people's rights using wider legislative powers.

Social work has the opportunity to bring the best of its facilitative, rights-based and humanistic culture and practices to new forms of personalised and inclusive support systems in highly relevant ways. The potential value of professional social work in driving forward personalisation has been identified in research and policy (see for example Ray et al, 2008). However, realising this potential will require authoritative professional practice and strategic representation and leadership, at national, regional as well as local levels.

4.7   What can professional social work bring to the emerging workforce for personalisation?

One of social work's practice development and leadership approaches of particular relevance is its approach to supervision and mentoring. Leadership through reliable tiered supervisory relationships has been central to social work practice development and is embedded in the training of social workers at qualifying and post-qualifying levels. Within these supervisory relationships – when they are effective – a balance of reflection, inquiry, quality assurance and mentoring can be modelled in some detail. At its best, it can model the effective and sensitive communication that social workers and other colleagues should bring to their interactions with people using services and their families and carers. It can be a model of personalised attention to what is important in terms of outcomes and the needs and potentials of the supervisee. Social workers and social work leaders have the potential to bring and explain the value of this into multidisciplinary environments much more than has been the case hitherto.

However, this hierarchical supervisory approach is itself open to innovation and modernisation. For instance, social work practitioners may benefit from more effective use of lateral networks of peer, supervisory or mentoring support to promote creativity and non-silo thinking. Enabling better use of information technologies to share ideas that evolve and elaborate quickly through multiple inputs, for instance, will enrich social work practice.

For a long time, the discourse around social work with regard to whether it should become more professionalised and, thus, more defined in its skill and knowledge base, has been unstable. Protection of title with registration, recent developments in training (the three-year degree minimum qualification level) and recent suggestions of the need for a social work college point towards greater formal professionalisation. But the enduring low public status of social work, its unclear career structures and its potentially diminished role in the total workforce mix being proposed by some adult social care services suggest it is not in line with other 'professions'. These anomalies need to be diminished and the role and status of social work clarified to capitalise on its potential to drive personalisation in all care services.

Social workers' knowledge and skills could also be better harnessed in leadership roles that go beyond their profession, leading practice and services across social care and health. To do this, more attention may need to be paid to social workers' professional and leadership development. This attention can be insufficient if neither an employing council nor a hosting or employing NHS trust fully embraces their requirement in their complex position between two organisational cultures and sets of priorities. This last point leads to the final section of this document: *what are some of the key issues in developing the leaders for personalisation and social inclusion of the future?*

5 Developing leaders

… it is not strategies that change things: it is people. (James, 2008)

This section considers in more detail what may need to happen and what is already being tried to develop the leaders of today and tomorrow. It focuses on how we might need the leaders of tomorrow to be – but always remembering the contexts that enable leadership and leaders to flourish or not. The last section lays out some examples of leadership development initiatives – for citizens, staff, formal and senior leaders – and concludes with suggestions about what might need to happen next if we are to create cohorts of people that can draw out the opportunities and potential for a truly deinstitutionalised and personalised approach to mental health in the future.

5.1   What makes a good leader?

Theories of leadership and what makes a good leader have evolved as society, politics and technologies have changed, and as the world has learned from the mistakes of previously lauded leadership styles.

Considering what makes formal 'leaders', Alban-Metcalfe and Alimo-Metcalfe (2009) offer a 'five-stage' summary of the main approaches to leadership and leadership development throughout the 20th and 21st centuries, which are further adapted here:

- 1930s: the concept of the 'Great Man' (specifically gendered), leadership based on innate character traits.
- 1950s: behavioural theories, competence-based management and leadership.
- Both the above were criticised for not taking account of situational factors leading to (stage 3) 'situational and contingency' models.
- 1970s and 1980s saw the emergence of leadership being about managing constant change, what Charles Handy (1995) has called 'never ending white water', with the leader's role being about 'defining organisational reality' (Bryman, 1996).

This fourth stage – which arguably has been dominant in social care and health institutions in recent years – has been subsequently criticised for tending towards over-reliance on 'charismatic' and 'heroic' approaches, located in few people and necessarily linked to formal, authority roles.

Thus recent thinking in leadership theory has moved away from 'thrusting', individualistic leaders towards valuing leaders who are engaged and rooted in real issues, part of networks of leaders and interested parties. This has been described by Alimo-Metcalf and Alban-Metcalf (2009, p 69) as 'nearby, post-heroic transformational' or 'nearby, engaging' leadership, emphasising the importance of accessibility and proximity to the people and the matters most affected by particular leadership challenges and practice.

Professor Beverley Alimo-Metcalf has developed a transformational leadership questionnaire that considers three main dimensions for the development of leaders within public service:

- *Personal qualities:* being transparent, acting with integrity; being decisive; inspiring others; resolving complex problems.
- *Leading and developing others:* showing general concern; empowering staff, being accessible; encouraging change and welcoming questions.
- *Leading the organisation/team:* networking and achieving; focusing team effort; building a shared vision; supporting a developmental culture; facilitating change sensitively. (described in Alimo-Metcalf and Alban-Metcalf, 2004)

Figure 3: Options for leader and leadership development approaches

Leader development – social capital

Open/emergent

Coaching

Community development

Whole system development

Action research

Action learning

Mentoring

Team coaching

360° feedback

Individual ← → Collective

Organisational/systems development

Psychometrics

Team training

Competencies

Leader development – human capital

Direct/closed

While leader*ship* development may build the collective social capital within the system, *leader* development builds the individual human capital to fill key roles. Iles and Macaulay (2007) provide a useful framework for considering leader and leadership development along dimensions concerned with whether the goals of the development process are *fixed and predetermined* or *open and emergent* in light of the needs of participants and constantly changing contexts. Their framework is schematised above (adapted by Professor Stephen Onyett for this publication), and gives a sense of the wide range of complementary activities that can be undertaken to develop leadership and leader capacity.

The extent to which a person can effect change in a leadership role is usually about the combination of their personal qualities (their 'human capital'), the 'social capital' within the system and the wider cultural and socioeconomic context in which they are operating. The effectiveness of a leader is thus about systems and cultures within and across organisations as well as individual behaviours and decisions. Effective leader and leadership development activities are thus likely to need to pay attention to all these dimensions.

5.2   Leading others through leading yourself

... to be a more effective leader, you must be yourself – more – with skill. (Goffee and Jones, 2003, p 17)

The NHS, in its leadership qualities framework (www.nhsleadershipqualities.nhs. uk/), has at the heart 'personal qualities', including self-awareness, personal integrity, self-belief and self-management. Surrounding the 'personal qualities' are two parts of the outer circle: 'setting direction' and 'delivering the service'. The leader, at whatever level, needs to know themselves, discern the signs of the times, scan the horizon and lead change through people. To lead people we have to lead ourselves, to gain trust we have to be trustworthy, to instil belief we have to believe in ourselves.

Figure 4: NHS leadership qualities framework
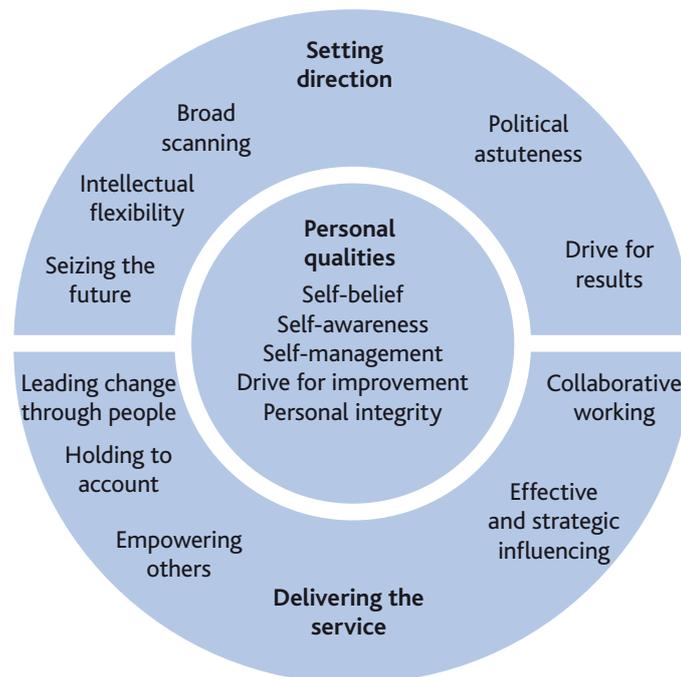
Source: www.nhsleadershipqualities.nhs.uk/ (developed on behalf of NHS England and used with permission)

At personal levels, effective leaders will have and demonstrate:

- personal and professional integrity
- values that are constantly demonstrated in their activities
- a sound ethical base for decision making
- an ability to be self-aware and self-developing
- a sound understanding of the situation
- personal conviction, 'groundedness' and self-belief
- empathy and emotional intelligence around others
- an authentic and distinctive voice (see Goleman et al, 2003).

This may be true wherever leaders are located in the system: at the top of a formal hierarchy, as senior practitioners, or leading from grassroots involvement in the main issues; effective leaders take authority appropriate to the situation rather than being given it.

Development approaches such as appreciative inquiry and work with a solutions focus specifically encourage the articulation of the core values of all – staff, managers, users, commissioners etc – and how they might offer their special contribution to visions of the future.

A core principle of appreciative inquiry is that human systems move towards whatever it is that is being talked about. It therefore becomes a key role of leaders to promote widespread exploration of what is going well, and to find and encourage the best values and motivations of the stakeholders in the improvement enterprise, to help everyone be more 'themselves' and be heard.

It is worth then developing our self-knowledge, for instance through assessments of our emotional intelligence and 360° assessments by others. However, Goffee and Jones (2006, p 11) warn against being overly introspective. They feel that modern approaches sometimes lead 'to excessive concerns with the inner drives of the leader'. They suggest that:

> Effective leaders have an over-arching sense of purpose together with sufficient self-knowledge of their potential leadership assets. They don't know it all, but they know enough.

This points to the necessity of pragmatic qualities that enable a leader to move beyond neurosis, keeping the goals and the horizon in view. It is often this pragmatic self-awareness and emotional intelligence rooted in real world experience – rather than a theoretically preoccupied self-assessment – that people who have used services or their families and carers particularly bring and which other stakeholders can bring if they draw imaginatively on their own real, emotional responses to life events in day-to-day practice.

Table 3: Some examples of leader and leadership development initiatives

Target group	Example: formal programme	Example: self-organised/facilitated network initiative
Citizen leadership	**National Citizen Leadership Training Scotland, 'We are all leaders':** developing the leadership potential of people who use social work and social care services, www.scotland.gov.uk	**Users In Partnership (UIP) West Midlands:** promotes the involvement of service users in the planning, delivery and monitoring of mental health and social inclusion services throughout the West Midlands, thus leading to service improvements, www.uip.org.uk/
Practitioner leadership	**Customised, in-house senior practitioner leadership programme:** South West London and St George's and Sussex Mental Health Trusts. Contact: Ben Bano, Telos training, www.telostraining.co.uk/	**AMHP leads network:** the lead AMHP professionals set standards and ensure local authority responsibilities are met in the provision of AMHP services. The network provides a collective voice and source of information and empowerment for practice leaders
Manager leadership	**Effective Team Working and Leadership Development Programme:** CSIP/NIMHE programme rolled out regionally across integrated social care and health community teams in mental health	**Integrated Care Network (ICN):** ICN provides information and support to frontline NHS and local government organisations seeking to improve the quality of provisions to service users, patients and carers by integrating the planning and delivery of services. Key to the role of the ICN is facilitating communication between frontline organisations and government, www.dhcarenetworks.org. uk/icn
Senior/executive leadership	**1. SCIE Social Care Leadership Development Programme** for senior leaders in children's and adults' social care in England, run in conjunction with the University of Birmingham, the Tavistock Centre and the King's Fund, www.scie.org.uk **2. Leaders UK senior development programme:** national School of Government/Ashridge/University of Birmingham. 'Leadership within organisations is important, but more important is the capacity to get things done across organisational boundaries', www.leadersuk.org/	**SCSNMH:** a self-organised membership organisation for people in senior social care leadership roles in mental health. Contact: scsnmh@aol.com

Table 3: continued

Target group	Example: formal programme	Example: self-organised/facilitated network initiative
Regional leadership	**1. London Expertise Exchange Programme:** organised by the London Joint Improvement Partnership to place senior staff in each other's organisations and then join an action learning set **2. Leadership for Innovation:** led by Improvement East under Amanda Reynolds, Deputy Regional Director for Social Care and Ann James CBE, Independent Leadership Consultant, the initiative is developing a cohort of leaders across the region with a multilevel programme of master classes in innovation, learning sets and mentoring. All DASSs are involved, together with selected assistant directors, plus health and other partners. The programme is designed specifically to support new solutions in social care. To do this it combines leading edge thinking and contributions with peer support and mentoring	**Joint Improvement Partnership:** promoting and coordinating the range of high-quality support available to organisations – mainly at no cost to the recipient – from existing agencies. Promoting the culture that seeking support to deliver better services for users is a sign of strength not weakness. Led by the regional deputy directors for social care in the regional government offices, www.jointimprovementpartnership.org.uk/
Cross-cutting initiatives	**Common Purpose leadership development:** 'We are committed to looking for leaders in unexpected places – and then exposing them to the information and the perspectives they need to be more effective. In the process, they meet new people, make new connections and find new ways of working with people who may not view the world in the same way', www.commonpurpose.org.uk	**Social Perspectives Network (SPN):** membership network organisation for anyone with an interest in social approaches to mental health, driven by people with lived experiences who are represented across the whole organisation, www.spn.org.uk

5.3   Leader and leadership development opportunities

> … if we consider leadership as a collective process rather than an individual property then we need to challenge the traditional approach of sending only senior management on leadership development programs, and encouraging others in the organisation to "follow the leader". (Bolden, 2005, p 7)

The effectiveness of structured leadership and leader development programmes is contentious (Bolden, 2005). Criticisms may come because people hold to the notion that leaders are 'born not made' or because leadership development programmes are often undertaken out of context and simply cannot translate into effective actions in the real world (see for example Mintzberg, 2004). Another level of criticism arises from the notion that any individualising programme of development is flawed because organisational capability arises not from individuals but from collectives. Day (2001, p 583) suggests:

> … each person is considered a leader, and leadership is conceptualised as an effect rather than a cause. Leadership is therefore an emergent property of effective systems design. Leadership development from this perspective consists of using social (ie relational) systems to help build commitments among members of a community of practice.

There is no simple truth of leader or leadership development: personal qualities, the context, the relations, the power distributions; the purpose of the enterprise; the political context – all have a bearing on what might be helpful at any given time. Diverse innovations – choice, plurality – in a leader and leadership development for personalisation and inclusion are thus needed to make change in different contexts. These options will need to be in both formal and informal leadership support and will need to be both funded and made available cost-free (for example through mutual exchange and peer mentoring arrangements) within a climate of tight resources.

The social care sector – from the highest levels to the frontline – has been paying more attention to leader and leadership innovations in recent years than latterly. Some types of leader and leadership development initiative are categorised (see Table 3) and some significant examples (with weblinks where possible) are given to illustrate the diverse options evolving to extend more voice and different types of leadership influence to more people.

5.4   So where do we go from here?

Practice and leadership development initiatives in mental health – particularly those supporting the detail of delivery and practice – have tended in recent years to come out of NIMHE which only latterly, when subsumed into CSIP, developed a strong social care impetus. These organisations have both now gone and in the future, other national leadership organisations in social care (and health) must clearly play a bigger part in taking forward leader and leadership development opportunities for mental health. Mental health needs to move towards the centre of the concerns of the national social care and social work bodies just as it needs to move back to the centre of local government attention.

The Social Care Institute for Excellence (SCIE), Social Care Association, General Social Care Council (GSCC), Local Government Association, Improvement and Development Agency (IDeA), deputy regional directors for social care within the regional Government Offices, ADASS and, most recently, the new National Skills Academy for Social Care, are among the most important players that need to be engaged in the challenges of mental health. The National Skills Academy has been established as the only welfare-related skills academy in recognition of the unprecedented challenges facing social care in coming years. It may have a particularly important role to play in developing 'top leaders' and leaders of practice in the new world, supporting diversified agencies to provide diversified options for people to use. It is talking of the need for a human and empowered approach to leadership at all levels – a focus on the quality and qualities of leadership practitioners wherever they are.

But what is also needed is strategic linkage across these organisations with development and leadership bodies in health and across the third sector for welfare and other relevant sectors. Perhaps of note in Table 3 is the fact that while some of these initiatives reflect the integration of health and social care systems and interests, others reflect the ongoing distinction between the sectors. While local government leaders are organising, for instance, through joint strategic partnerships, colleagues within NHS commissioning are organising often quite separately to deliver on 'world class commissioning'.

They also reflect that development initiatives (more so than networks) still tend to offer leader development according to formal authority and the role of participants. So, while people with experience of using services are supposed to be driving reform, formal leaders and citizen leaders rarely, it seems, learn to explore their leadership practice together.

What may be needed for personalisation and inclusion leadership in mental health to transform whole service systems will be more commitment to join leader and leadership development opportunities across *all* old silos and boundaries wherever possible.

Many of the most useful ideas for creating and changing public services in coming years may come from unexpected places. The co-production imperative within personalisation refocuses the ethos and functioning of public services away from provision to individuals towards making the relationship between that person and the professional or authority more effective and satisfactory. Communities need not be 'recipients' but co-creators of solutions.

This is an important philosophical and practical matter that could be in danger of being distorted by economic imperatives particularly as we face a period of public sector spending squeeze. However, just as the notion of recovery in mental health can transcend the details of diagnosis and causation, so the best aspects of personalisation and inclusion should transcend economic strictures. The role of leaders in personalisation must be to ensure whatever resources are available are used most effectively to support not only formal processes of support but also informal support and social networks.

6 Key messages: summary of the leadership challenges for personalisation and social inclusion

6.1 A paradigm shift

The challenge of personalisation and meaningful social inclusion in mental health should not be under-estimated. It will require not only visionary and imaginative leadership, but also practical, energetic and available leadership across all parts of the mental health system if we are to turn words into beneficial outcomes for people. It implies a paradigm shift in thinking and practice at personal, political and developmental levels for existing and future leaders. It is potentially a truly radical agenda that will have controversies to resolve that will stretch present leadership norms and expectations.

Strategic and operational leadership for personalisation will be rooted in creating new collaborations to create and promote vision and action for a better future – 'walking with people' on the journey. It is most likely to be grounded in relationship building, the development of shared values across systems, the flourishing of creativity and the capacity to influence and 'host'/facilitate collective inputs and energies rather than 'direct' them. The key leadership styles and approaches particularly emphasised by personalisation are thus:

- leadership of networks of relationships across sectors and geographical boundaries
- leading for choice through innovation and creativity
- hosting, facilitating and mentoring leadership approaches more to the fore
- greater prominence for an overt public service leadership style, rooted in positive, humanistic values
- leadership driven by the ethics of human rights and equalities
- governance-driven leadership with a focus on citizens' self-defined evaluation of positive outcomes.

The following list attempts to summarise some of the most evident and pressing leadership tasks we face. Readers may well find other key messages emerging from their own reading of this report.

Develop and demonstrate leadership that tackles stigma and promotes social inclusion, mainstreaming these in organisational and staff behaviours: future mental health leaders needs to be focused more than ever on carrying the double message that good mental health is necessary for a successful and cohesive society *and* social inclusion and cohesion promote good mental health. Leaders must explicitly challenge the differential disadvantages and discrimination affecting different social groups with mental health problems.

Create the conditions whereby citizens are empowered to meet their personal aspirations and make real choices in care and support: people who use mental health services, their families and carers want and need access to support which fits with their lives, their aspirations, their identities and the social systems in which they live and work. They want to have more control over the support they receive and to

work in collaboration with professionals. Leaders for personalisation in mental health need to focus on these outcomes in all they do.

Facilitate citizen involvement in determining the overall shape and delivery of mental health support systems. Facilitate the dialogue and create the conditions under which co-production of services can happen: personalisation is about the co-creation of ideas and the co-production of services between citizens and public authorities and professionals. This is achievable only if those directly using support resources and the wider community have real influence and take responsibility for the well-being, health and social care agendas in their localities and beyond.

Facilitate effective cross-sector partnerships, including developing innovative engagement between councils and the NHS in relation to mental health. Ensure systems of integrated, multisectoral social care and health are fit for purpose going forward: in order to deliver beneficial outcomes for people, local councils need to be active in their strategic leadership of personalisation in mental health. Councils need to work in renewed and reinvigorated partnership with the NHS and the voluntary and private sectors as well as developing their commissioning and market-making roles. For some councils, this means re-engagement with an issue left for some years to the NHS and voluntary sectors. New forms of service and organisations will need to emerge from personalisation, and current and future leaders are tasked with innovating new forms of service in a complex, evolving landscape. These changes will challenge current commissioning systems and current taken-for-granted forms of 'integration' across statutory health and social care and across the whole system of support and opportunity for people with mental health problems.

Lead to enable greater transparency, fairness and consumer satisfaction with the operation of systems of entitlements: leaders and managers will need to demonstrate the utmost integrity and clarity in their role as developers and administrators of systems of entitlements. They are charged with delivering equality of access to people with mental health needs while making realistic decisions about balancing prevention, early intervention and meeting severe needs. Engaging local stakeholders meaningfully in the process of setting local access processes is a vital leadership task within this.

Reforming and develop the workforce, including succession planning for leaders of the future and developing leader and practitioner 'Experts by Experience', taking all staff and stakeholders on the journey: new roles will emerge to fulfil the tasks demanded within new and existing services. These roles will be oriented towards opening up opportunities for choice and control and many may have more emphasis on knowledge sharing, supporting self-management of health and social support needs and brokering and navigating the system more effectively. These will change the roles and deployment of traditional professions. But there may also be new opportunities for peer support staff and the inclusion of more Experts by Experience – people who have used mental health services – transforming the traditional 'them and us' culture of mental health support services and changing power relationships. Leaders will need to understand and work innovatively with different organisational power relationships implied by a differently constituted

workforce. Existing leaders – within formal hierarchies and in informal roles – will need to develop themselves in this new context *and* develop leaders of the future.

Ensure professional leadership of all relevant staff groups – including social work – is fit for purpose for the workforce reforms needed and oriented towards the future: the value and values of all professional staff within integrated mental health services and teams should be better defined and properly supported to bring the best of enabling, empowering, rights-based social care and social work to the task of personalisation and inclusion. This should include enabling the workforce to change, develop new skills and demonstrate renewed relevance.

Lead from a strong personal value base, bringing oneself explicitly and effectively into one's leadership practice: with the anticipated breakdown of traditional structures, the personal integrity and identity of individual leaders becomes key as they hold the vision and the meaning for the service in transition.

Open up new support and care solutions, including innovation for a more diverse and creative provider market: commissioning leadership will need to be assertive and competent in its ability to encourage innovative new providers and enable existing providers to change. This will be needed while maintaining required, reliable continuity of existing support and care services where these are valued and necessary and steering a course that brings greater choice without losing useful systems interconnection and coherence.

Create new formal and informal leadership development opportunities that will grow innovative new leadership across the system: leaders in the emerging world of personalisation will be in uncharted territory much of the time. Traditional training will therefore have limited application and learning from each other will be crucial. This calls for new development opportunities to be created, opportunities that make fast and efficient use of personal networks, including digital networks.

Develop leadership strategies that expect pressurised public resources and can develop capacity in unexpected places: achievements in personalisation will need to come in the context of financial constraint and real reductions in spending. Maintaining a positive grasp on the principles of personalisation will be more, not less, necessary in this harsh context. Using partnerships, efficiencies, evidence and co-productive techniques with communities will be essential. Leaders will need to show the ability to remain positive, creative, resourceful and willing to seek unlikely or untried collaborations and approaches.

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Leadership for personalisation and social inclusion in mental health

This report is aimed at those involved in developing, providing and leading personalisation and social inclusion for mental health and those developing the leaders of the future. It explores three key questions:

- What is at the heart of the personalisation and social inclusion challenge in the contemporary and future mental health context?
- What are the leadership challenges faced in transforming mental health social care to deliver more personalised social support, inclusion and care choices?
- And what, therefore, are the implications for the development of leaders and leadership?

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