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# LEADERSHIP OF INTEGRATED HEALTH AND SOCIAL CARE SERVICES

## Abstract

This research explores the lived experience of those individuals charged with leading the integration of health and social care services in Scotland. The research was primarily qualitative in nature – comprising of a qualitative survey of front-line managers of integrated health and social care services from a single partnership area. The survey explored the management and leadership tasks and activities expected of those leading health and social care teams. The research uncovers a sense that these new leadership positions are both overwhelming in the scope of tasks required and lack clarity in how these tasks should be undertaken. This highlights a need for coordinated support and training for staff who are charged with leading integrated health and social care teams. Three key recommendations have been drawn from the findings of this research: more support should be provided to managers working within these complex integrated systems; a joint training programme should be developed for managers across both partnering organisations and finally relevant policies and procedures should be compiled into one reference resource for managers of integrated services.

## Key words

Leadership, health and social care, collaboration, integration, Scotland

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## INTRODUCTION

The development and implementation of Health and Social Care Integration in Scotland has been found to be a distinctively different approach to that adopted in the rest of the UK (Hudson, 2007). In part this is influenced by the wider Scottish Approach to public services (Cairney, 2016) which has been described as a strategic form of government that emphasises partnership working and adaptive forms of leadership (Elliott, 2020a). The role of individual managers is key to facilitating integration (Pearson and Watson, 2018) yet little to date has been written on the direct experiences of these managers. The role of individual managers is particularly significant given the recent widespread changes and innovations particularly around collaboration and boundary-spanning activity. The nature and context of health services themselves also poses particular leadership challenges (Bovaird, 2007; Joshi and Moore, 2004; Sousa *et al.,* 2015; Wikström and Dellve, 2009). Therefore, this research provides the first in-depth exploration of the impact of these innovations on those staff served with delivering greater collaboration.

The aim of integrated health and social care systems is to formalise the joining up of local services with healthcare, to end siloed working and competition between providers and improve population health which are place-based (Alderwick *et al.,* 2015; Ham and Alderwick, 2015). This is an attempt to address the increasingly complex health needs of an aging population, whose experience of care in a fragmented, uncoordinated, and under-funded system of services has been left wanting (National Collaboration for Integrated Care and Support, 2013; Baird *et al.,* 2016; Maybin *et al.,* 2016; Gilburt, 2015). In spite of three decades of planning, integrated care systems are failing to deliver on improvements to health outcomes or efficiency due to a lack of commitment by national bodies and service providers, as well as structural and policy limitations.

Along with this significant change in the governance of community health and social care services comes increasing expectations of integration of service management and leadership and therefore accompanying further changes in the nature of the task of the managers and leaders of these services. Managers and leaders of services are increasingly expected to manage across the traditional boundaries of individual professional disciplines, traditional team roles, and indeed organisational boundaries. This has significant implications for how people manage their own professional identity in the context of integrated teams (Best and Williams, 2018).

Part of the focus at the system level of integrated provision is in providing system leadership. This involves a transition from the focus on individual organisations to the provision of leadership across systems (including housing, education, employment), and towards a focus on place, population, communities, and social connectedness, rather than individual services. Indeed, the selection of pilot sites for Integrated Care Systems in England was based partially on the strength of leadership evident in those areas. These shifts in emphasis require a significant shift in managers' activities and accountabilities as they move from leading organisations to leading systems, and a greater reliance on collective and distributed leadership to engage multiple stakeholders.

There are continuing tensions between the statutory framework, which focuses on organisations and their roles and accountabilities, and the growing emphasis placed on systems which prioritises partnership working through strengthening relationships and trust. This tension naturally creates an ambiguous working and learning environment for managers, who are learning about system working on the job and what this new basis of working means for their performance metrics and sense of professional identity.

Across the UK public sector training and development budgets have fallen dramatically (Elliott, 2020b) and, particularly in local government, many aspects of job quality are under increasing threat (Gibb *et al.,* 2020). Within this context of whole system change in health and social care services it is important to understand whether managers and

leaders of these integrated services are being provided with the right training, support and skills to effectively undertake what is clearly a significantly challenging task (Dickinson, 2014). Much has changed in the past five years around the governance and planning of health and social care services (Audit Scotland, 2017). However, research suggests that the organisational training and competence frameworks that support managers and leaders in their roles have not been revised to ensure staff competence aligns with the new organisational challenges and associated outcomes:

> …*traditional leader-centric development programmes with tenuous links to organisational outcomes have continued to dominate*. (The Kings Fund, 2015, p4).

This research therefore explores the experience of leadership in public services; leadership roles in integrated health and social care; and defined roles and duties of health and social care leads.

## LEADERSHIP IN PUBLIC SERVICES

Despite the difficulties of defining leadership (Woods, 2004) there is an expectation, within the context of public service organisations, that leadership does exist (Grojean *et al.,* 2004) and that it is *de facto* a good thing. Within the public service context ideas of leadership stem back to the origins of public administration and Woodrow Wilson's founding ideas of the political-administrative divide. Traditional public administration was based on ideas of Weberian rational bureaucracy, hierarchical structures and top-down leadership based largely on positional power. Thus we continue to have many leadership functions prescribed in statute, for example in UK local government there are statutory officers. These statutory officers are senior management positions who have specific responsibilities as set out in legislation: Head of Paid Service (Chief Executive); Monitoring Officer; Chief Financial Officer and Chief Social Work Officer.

New Public Management gave greater impetus to the professionalisation of leadership as a function of public service organisations by emphasising management (and business) training and comparing leadership remuneration with private enterprise in order to attract and retain ‘talent’. In particular it fetishized transformational leadership as an essential component of public service reform (Hartley and Allison, 2000) as demonstrated in the Fresh Start and Sure Start schemes (Newman, 2005). At the same time the language of business permeated the public sector (Russell and Sherer 1996), there became increasingly a revolving door between public and private sectors, and a greater reliance on management consultants referred to as the Consultocracy (Hood and Jackson, 1991).

Increasingly these ‘great man’ models of leadership have come under question (Mangan and Lawrence-Pietroni, 2019). Cases of public service failure have highlighted issues around hubris in leadership, dark leadership, destructive and / or toxic leadership. At the same time critical discourse has raised issues related to gender studies, intersectionality and diversity in relation to previously lauded models of leadership. All the while social inequalities have widened and many so-called ‘wicked issues’ remain unresolved. All this has given fuel to debates around New Public Governance (NPG). Whilst there are ongoing debates around the nature of NPG and to what extent it represents a significant shift from New Public Management it is clear that there is an increasing use of integration and collaboration (Buick *et al.,* 2019; Dickinson, 2014) and community empowerment (Elliott *et al.,* 2019).

The context of public leadership is recognised as involving complexity, systems thinking and boundary-spanning work (Buick *et al.,* 2019; Mangan and Lawrence-Pietroni, 2019; Nooteboom, 2013; Williams, 2013). This has been defined as VUCA (volatile, uncertain, complex and ambiguous) (Bennet and Lemoine, 2014; Van Der Wal, 2017; Mangan and Lawrence-Pietroni, 2019). In particular it is noted that collaboration has become “the new normal” (Sullivan, 2014) and so different skills and different mindsets are required (O’Flynn *et al.,* 2011; Buick *et al.,* 2019; Bardach, 1998). The leadership task is now recognized as something that can be a distributed, i.e. one that takes place among all

people and at all levels within an organisation, rather than just at senior levels (Gronn, 2000).

As Bardach (1998) has noted, the role of middle managers is particularly significant in partnership working. Partnership working leads to new roles and responsibilities but the local context of partnership working is also significant in how these roles develop (ibid., 1998). This may also lead to a need for new accountability systems (Virtanen *et al.,* 2018). They also require new ways of working and organising within the workplace yet often existing management training and development processes are insufficient in supporting middle managers for these roles in integrated service systems, especially where systems require professionals to work in multidisciplinary teams (Hartley and Allison, 2000; Best and Williams, 2018; Warwick-Giles and Checkland, 2018).

Given that integrated leadership roles within public services do exist, and that public services actively recruit people to undertake these roles, it is important for public services to develop ways to support these staff members (Heifetz, 1996). The theoretical positioning of leadership in public service context has developed from 'heroic' models of leadership to more distributed forms of leadership (Mangan and Lawrence-Pietroni, 2019) particularly in health and social care settings (Currie and Lockett, 2011; Jonasson *et al.,* 2018). Yet many of the tasks and activities of managers encompass not just these new forms of boundary spanning leadership but also the crafting skills of traditional public administration (Rhodes, 2016) and transactional managerial duties also referred to as "craft and graft" (Dickinson, 2014).

[INSERT TABLE 1 HERE]

The theories listed in Table 1 could be said to apply to any sector yet, as discussed above, public service organisations exist within very specific contexts and therefore have specific leadership challenges (More and Ticlau, 2012; Bason, 2010). These contextual challenges are heightened in services such as health and social care provision as they are statutory in their nature, person-centred, and heavily regulated

with a wide range of authorised procedures, processes, and rules. Furthermore, these services have responsibilities in matters of life and death, and public safety. The challenge of health and social care leadership in Scotland has been summarized as follows:

> …the way that people access and use health and social care services across Scotland will need to change, services will need to be delivered differently, and there will need to be a significant change in how people manage their own health. It is not possible to stop or pause services while these changes are made and the scale of the task should not be underestimated. This is an exceptionally large-scale, complex change involving not just structural, but also significant culture change, for the people providing care and the public. (Audit Scotland, 2017, p8)

In order to consider how staff members are supported and developed in their roles, both leadership and management responsibilities need to be considered, otherwise there is a risk that the focus of the competency frameworks that they are trained to, and measured against, will focus only on one side of the 'coin' or the other (Day, 2001).

## LEADERSHIP ROLES IN INTEGRATED HEALTH AND SOCIAL CARE

The development of health and social care integration in Scotland has received significant interest elsewhere (Freeman and Moore, 2008; Pearson and Watson, 2018) and it is widely recognised that this is a distinctly different approach to that adopted in England (Hudson, 2007). This distinctive approach is part of a wider Scottish Approach to public services (Cairney *et al.,* 2016; Elliott, 2020a). Within this leadership roles have been identified as critical to the success of integration (Pearson and Watson, 2018).

In 2010 the UK Department of Health described integrated services as essential, not optional (Department of Health, 2010). This was followed in England, in 2013, with the

publication of a policy outlining the expectation that multi-disciplinary working will become the primary way of working over the following five-year period (Department of Health, 2013). In Scotland this was taken even further, into primary legislation through the Public Bodies (Joint Working) (Scotland) Act 2014. In this context, health and social care managers are increasingly asked to lead and manage groups of staff from backgrounds that they are not themselves qualified in, seeking access when required, to a framework of professional advisory staff in senior positions.

On the one hand, this structural arrangement reflects the aspiration for professional staff to be able to advance their careers without having to transition away from a professionally focussed job into a management role (Scottish Government, 2006). But, on the other hand, staff working within this relatively complex structure report that it also creates a tension in scenarios where there is a conflict, or a lack of clarity, around when and whether their work requires general management advice or direction, or is a matter of professional judgement. This may be particularly challenging given the extent to which public services have faced funding cuts under austerity. It has been shown that these cuts have had a detrimental impact on working conditions (Gibb *et al.,* 2020) and that training and development budgets have been particularly affected (Elliott, 2020b).

There is strong evidence to support the view that,

> … good leadership is key to successful integration, and should be distinguished from clinical or professional leadership. (Institute of Public Care, 2013, p5)

Whilst at the same time,

> … team management is different to, and should be separate from, clinical or professional management. (ibid, p5)

This highlights the extent to which the management and leadership roles are subsumed within the team leader position in integrated health and social care partnerships. Whilst the leadership and management role of the team leader is essential in this complex system, a framework to support managers to undertake the role effectively, which works

alongside and compliments the professional advisory structure, is clearly required. Yet, despite this, there is a paucity of evidence relating to workforce and integration (Institute of Public Care, 2013).

The underpinning assumption behind bringing multi-disciplinary teams together is described by Jackson *et al.* (1995) as offering the potential to achieve better outcomes by creating an environment in which diverse perspectives and opinions generate more effective approaches by having a more comprehensive and rounded understanding of the task at hand. This rationale is mirrored in the underpinning assumptions of integrated working in health and social care services in Scotland (Scottish Government, 2016). Yet Jackson *et al.* (1995) have also asserted that multi-disciplinary teams do not always produce desired results. Even when multi-disciplinary teams have fulfilled their potential, team members and the organisations have often experienced unanticipated negative side-effects, such as unproductive conflict and high staff turnover. Similarly, it has been found that envisaged benefits of multi-disciplinary team working in health contexts are only realised if the quality of team processes is high (Fay *et al.,* 2006). Again, this would suggest that job of the team leader in these settings must be not just to undertake an effective leadership role but also to attend closely to the tasks of the manager.

Jackson (1995) conclude that the challenges of managing teams across different systems can be sub-divided as follows:

- Issues arising from the lack of shared technical language and the misunderstandings that can arise as a result of this
- Issues of power and status
- The struggle to develop a sense of cohesiveness
- Managing relationships beyond the boundaries of the team itself.

These findings have been corroborated within healthcare settings by, for example, Abramsky and Fletcher (2002) and Cedrachi *et al.* (1999) - highlighting the challenges of how different technical and professional language can lead to misunderstanding and

poor outcomes. Others have shown how hierarchical power structures within healthcare settings can influence decision-making and dissuade others from challenging those in more senior positions (Fox, 1974; Hightower, 1986; Johansen, 2012). Likewise, in relation to team cohesiveness it has been found that members of uni-professional teams experience more positive affect than members of diverse teams (Levine and Moreland, 1990).

## DEFINED ROLES AND DUTIES OF HEALTH AND SOCIAL CARE LEADS

This research sought to explore how the role of health and social care managers has been defined through competency-based approaches and the experience of those within these roles. It is clear that the role of team leader requires aspects of leadership and management, and that one of the key challenges in the role of leading a multi-disciplinary team is that of managing the diversity that is inherent in the different systems of health care and social care. Yet at present, it is not known how the managers of these multi-disciplinary teams have experienced these areas, whether issues have presented themselves as the research suggests they might, and how well managers feel equipped and supported by their current organisational competence frameworks to manage these challenges.

What remains unclear is the extent to which the explicit duties of team managers, as documented in the competence framework, are aligned with the different roles expected of team leaders, including management, leadership and challenges in managing diversity and the lived experience of the team leaders themselves. This is illustrated in Figure 1 below.

[INSERT Figure 1. Roles, Duties and Experience Nexus]

## THE RESEARCH CONTEXT AND SETTING

The context in which health and social care services in Scotland have been delivered has evolved considerably over time and the task of managing and leading health and social care services has evolved with it. Traditionally health services and social care were delivered independently, with NHS Scotland responsible for health care and local government responsible for social work and social care. However, community health and social care services were brought together in planning and leadership terms under The Public Bodies (Joint Working) (Scotland) Act 2014, which came into force on 1 April 2016. This Act aimed to bring about closer integration of health and social care services in order to deliver better outcomes for the people who use those services, and their families and unpaid carers, in a more efficient manner (Audit Scotland, 2015). Thus, it significantly changed the governance landscape of health and social care services (Audit Scotland, 2017). Local authorities and health boards are now required to work together to delegate resources and planning responsibility for a wide range of, primarily community based, health and social care services, to newly formed Integration Authorities (Public Bodies (Joint Working) (Scotland) Act, 2014). This is a policy intention that has arguably proved difficult to bring about to date despite efforts on around a two to three yearly basis on average since 1999 including most latterly the 2010 'Reshaping Care for Older People Programme' and the 2007 'Better Health Better Care' approach (Audit Scotland, 2015).

The Public Bodies (Joint Working) (Scotland) Act 2014 prescribed that health boards and local authorities must work together to agree an Integration Authority for each partnership area. There are 32 Local Authorities, 14 territorial NHS Boards, 7 Special NHS Boards and 1 public health body in Scotland. For the purposes of health and social care integration Clackmannanshire and Stirling were amalgamated and so there are 31 Integration Authorities in Scotland. Of those a total of 30 partnerships, including the partnership covered in this research, have adopted a Body Corporate model (The Public Bodies (Joint Working) (Scotland) Act, 2014). This model sees all staff retain employment under either their original health board or local authority employer (as opposed to one health board or local authority taking a lead employer role and transitioning staff to a Lead Agency – arguably, a fuller form of integration), and

managers of these integrated services must respect the respective separate employing organisations' policies and procedures, operating both sets as and when required. This includes policies and procedures for managing staff, managing performance, setting expectations about appropriate levels of escalation and delegation based on different organisational hierarchical expectations.

The combined budget of the new Integration Authorities is in the region of £8 billion in 2016/17 (Robson, 2016). It is within this significantly changed and arguably complex health and social care governance landscape that staff managing and leading services now work.

## THE RESEARCH APPROACH

A qualitative methodological approach was adopted to explore with first line managers their views on different transactional and transformational components of their role, and whether they have experienced the challenges of managing diversity (Jackson, 1995) in 'systems' rather than singular organisations.

Staff were chosen for the study based on the appropriateness of their experience to contribute to understanding i.e. those who are leaders of integrated teams. Participants were therefore sampled purposively as they were selected for the specific characteristics they have (Kelly *et al.*, 2003) and because there were a limited number of people with the right experiences or perspectives who could contribute to the study (Saunders *et al.*, 2012).

The following characteristics, or parameters, were established for the identification of leaders to invite to take part in the research:

- Close experience of managing individuals in a diverse, integrated service
- Employed by a public body which may be either a health board or a local authority

- Working in a role that is relevant to health and social care service provision through a health and social care partnership
- Participants from more than one health and social care partnership area were sought in order to minimise the likelihood that findings could be attributed solely to a specific factor in a partnership area.

A semi-structured interviewing approach was chosen as it lends itself to scenarios where there is already a pre-existing clear understanding of the details of the subject (Cohen and Crabtree, 2006). In this case the challenges of leading and managing teams from both health and social care systems has been considered through the literature review and the core competencies of the employing organisations are already established, therefore there is a clear understanding of the basis for the research.

## OVERVIEW OF LEADERS' EXPERIENCES

Managers considered almost all of the 22 domains (Table 2) being asked about to be significant aspects of their management and leadership role. For the transactional components 9 out of 10 managers reported all 6 domains as significant aspects of their management and leadership time. For the transformational components 5 out of 10 managers reported all 12 domains as significant aspects of their management and leadership time. All ten considered at least eight of the domains as significant.

This experience reflects the nature of the complex environment within which these managers are operating. The following table shows a mapping of core transactional and transformational competencies and the four areas of complexity identified by Jackson (1995) against the core competency frameworks of the employing organisations for the post identified as relevant to this research.

[INSERT TABLE 2 Essential Leadership Components – First Line Managers of Multi-Disciplinary Health and Social Care Teams]

Considering these findings, managers relate to the vast majority of the key leadership and management tasks that the literature review indicated likely to be factors for their day-to-day time. Given that the mapping exercise (Table 2) indicated that 20 out of the total 22 domains could reasonably be mapped against the competence frameworks of both employing organisations, it can be concluded that at face value, based on the closed question section of the research, the competence frameworks of both organisations are focussed appropriately on supporting mangers to have the skills and abilities to lead their multidisciplinary teams.

However, reviewing the open question results showed that there were two themes that generated the greatest level of comment: 1) organisational process issues, which accounted for 24% of overall comments received, and: 2) issues to do with training that are internal to the organisation(s), which accounted for 53% of comments. Other themes that were not as significant included:

- Time / capacity issues
- Training external to the employing organisations
- Issues linked to managing resistance, personalities and personal challenges including changing roles
- Challenges arising from the difficult public services financial climate.

Further analysis of the two largest response themes showed a great deal of synergy in the comments. Looking further at the responses given in the two largest areas, there are a number of groupings of comments that can be further drawn out.

## ORGANISATIONAL PROCESS ISSUES

In terms of the responses which related to organisational process issues (24% of the total responses) there were two main feedback points within these comments: firstly internal process issues and secondly challenges that arise from inherent aspects of integrating health and social care services.

Comments related to internal process issues included the complications caused by having to utilise two different organisational sets of procedures, challenges associated with complexity of the systems and a sense that these were too process-driven rather than outcome focussed. Examples of comments are as follows:

> *Even in an 'integrated' system there is a lack of shared systems which causes issues. The manager has to apply different organisational rules and processes. The task is made difficult by practical things. (Participant 2)*

> *Although services are integrated there are still clearly two different organisations which creates the complexity of managing two different lots of processes. (Participant 5)*

Comments related to challenges that arise from inherent aspects of integrating health and social care services included the challenge of managing the different types of hierarchical approaches in each employing organisation and the challenges created by the generic management versus professional leadership structures within the services. Examples of comments are as follows:

> *Integrated systems create less security about the properness of any decisions… people outside the system don't realise this so assume the decisions are effective and robust whereas you don't have the guarantee at your own level that it is. (Participant 7)*

> *Decision making in [the] local authority is very hierarchical and time consuming. Observing this from an NHS background is interesting. (Participant 8)*

> *On the other hand, NHS systems seem very professionally hierarchically led. Interesting to see what it is that people consider valued in different organisations. (Participant 8)*

## TRAINING INTERNAL TO THE ORGANISATION(S)

Managers reported that although the employing organisations offered training in the form of making staff aware of the existence of the policies and procedures for managing staff and performance, they felt this training was too theoretical and that more practical support was required in processes of actually applying these policies effectively. Examples of comments are as follows:

> *Managers are expected to already know how to manage performance and use organisational policies. You have to draw on your past experience. It is not provided to you other than to make you aware of the policies in place. (Participant 4)*

> *You get training on the theory of managing staff and performance but you don't get practical training. You have to learn by doing it day to day. (Participant 1)*

Respondents offered several ways in which this could be provided, from formal training through to examples such as peer support – overall, the need for more support in this area was clear.

Managers also reported various issues with identifying what their training needs were, getting the right training at the right time, not too much, not too little, and the benefit of everyone having the same underpinning core training. Examples of comments are as follows:

> *A clear training programme would be beneficial. (Participant 3)*

> *A fixed suite of skills and tools should be trained on so everyone has the same / a consistent approach. (Participant 6)*

## OTHER LEADERSHIP CHALLENGES TO INTEGRATION

Five participants reported issues linked to managing resistance, personalities and personal challenges including changing roles. This reflects the findings of the literature review which emphasised the relevance of transformational theory to the leadership role. The points were raised fairly evenly across the transactional challenges, the transformational challenges, the challenges of managing diversity and the open question section. Examples of comments are as follows:

> *The scope of the modern integrated management task is so broad that it feels difficult to do a good job in any given area. (Participant 7)*

> *It can be difficult to motivate staff to keep to task and negativity gets in the way. (Participant 4)*

The nature of the comments in this category did not identify consistent themes but reflected a range of views of the general challenges faced by managers. Four research participants highlighted challenges related to time and capacity issues within the service, and matters related to training provided that is external to the employing organisations. In terms of challenges related to time, the comments made were almost identical in nature. An example is as follows:

> *You often don't have time to cascade the good practice and tools you learn on the training. (Participant 3)*

Having sufficient time to attend to the tasks of management and leadership is a recurring challenge in services that have to respond to increasing levels of demand (Worth, 2013). This was a clear and recurring theme in this research and is clearly a complex matter that should be considered alongside a wide range of organisational, workforce and financial matters.

In terms of matters relating to training provided outside of the employing organisations, the comments fell into two groups, two participants suggested that the training that is provided to students looking to enter health and social care should itself be more integrated and less professionally 'siloed'. Managers saw this as an effective way of preparing newly qualified staff for the real world of integrated work. An example is as follows:

> *At the training stage different disciplines that will work in integrated ways should have to learn each other's languages and train together. (Participant 2)*

The second type of comments was that challenges arising from a lack of shared technical language. This was felt to be most notable with newly qualified staff. However, these participants saw this as one of the natural challenges of new staff joining teams and easily overcome with some time.

**DISCUSSION**

The study presents accounts of managers of integrated services, focused on their day to day challenges and discusses whether the competence frameworks of their employing organisations are well aligned to equip them for these issues. This research presents a strong degree of consensus on the extent to which all 22 areas of leadership and management are a significant part of their role. The research has provided a greater understanding of the challenges and the theories that are most applicable to the current management and leadership tasks. Specifically, it has identified a need for greater support for team leaders in managing staff and staff teams; greater support in managing performance; lack for formal shared training across both organisations; and lack of clear policies and procedures for managers of integrated services.

Managers considered almost all of the 22 domains of transactional and transformational tasks, and the challenges of managing diversity in teams as identified by Jackson (1995), to be significant aspects of their management and leadership role. The mapping

exercise (Table 2) indicated that 20 out of the total 22 domains could readily be mapped against the competence frameworks of both employing organisations. This significantly adds to current knowledge on the nature of leadership in Public Service Organisations and more specifically within integrated professional teams.

It can be concluded that the competence frameworks of both organisations are set appropriately on the areas that would enable mangers and leaders of integrated services to have the skills and abilities to lead their teams. However, the open section of the research offered an opportunity for managers to expand on their views and offer some context and depth to the research questions. Analysis of these views offers areas for consideration by organisations in how they implement their competence frameworks. It particular the findings have added considerably to our understanding of the totality of the public services leadership task – especially in multi-disciplinary settings.

The two largest response areas to the open questions were in relation to training internal to the employing organisations and organisational process issues. In terms of responses relating to training internal to the employing organisations the most common feedback area was around the lack of practical training, support and assistance that managers receive to support them in undertaking the transactional management tasks of managing the performance of the staff team, or individual staff members within the team.

Although research participants described these challenges almost exclusively as being focussed on transactional tasks, it resonates with the concept of developing cohesiveness in the team, which is both a challenge in managing diversity (Jackson, 1995) and reflects the considerable and growing amount of time that managers now spend managing conflict and performance issues in teams (CIPD, 2011; 2015).

If Mintzberg's theory of leadership is used it enables actions that are relevant to transformational tasks, and transactional tasks to be given equal place in order to develop a balanced approach to public sector leadership development (Mintzberg,

1973). But it is clear from this research that such an approach to leadership development is not currently being practiced within this professional context. Research participants offered some suggestions as to how the employing organisations could support managers in the challenges they experience in their transactional roles. Suggestions included things that could be described as peer support, shadowing, formal training, and action learning set type supports.

In addition, several research participants highlighted that there is no agreed training framework that sets out expectations for managers and delivers a consistent set of skills and approaches across both employing organisations. It is therefore felt that more research needs to be conducted on how an agreed joint training programme for managers across both organisations in the partnership could be further developed to support the shared training that is already provided where possible.

Finally, in terms of organisational process issues, there were two key contributions to knowledge. First was a set of comments focussed primarily on the complications caused by having to utilise two different organisational sets of processes. Second were challenges that arise from the inherent nature of managing integrating health and social care services. These include managing the different types of hierarchical approaches in each employing organisation and the challenges that the generic management versus professional leadership structures now common in integrated services creates.

Both of these issues are intrinsic to the way in which integrated health and social care services have been established and can be considered together. As described above, The Public Bodies (Joint Working) (Scotland) Act 2014 required health boards and local authorities to establish Integration Authorities and 30 of the total 31 areas opted for the Body Corporate model which sees managers delivering integration by working within the employment frameworks of two different organisations simultaneously. A review of research on the effectiveness of integration of health and social care services at an international level undertaken by The Institute for Research and Innovation in Social Services (Petch, 2012) concluded that integration was not a single activity or outcome,

rather it could be understood on three different levels. At a macro level integration was about developing a single strategic approach at a population wide, societal level. At a mezzo level integration was about things that happened at a service and system level, and at a micro level integration was about the way services were organised for the experience of the individual service user. The IRISS review of research concluded that in integration, the structures that are chosen, and structural change i.e. the mezzo level aspects, do not make a significant impact on the outcomes delivered by the integrated services (Petch, 2012). In fact the research stated that:

> *There is clear evidence that structural integration does not deliver effective service improvement.* (ibid, p3).

However, this research highlights that at the mezzo level, the daily experience for managers of integrated teams has been made more difficult by the structural arrangements that are currently in place, i.e. the need to continue to operate within the structures and processes of two separate organisations. This experience challenges the assertions of the IRISS review (Petch, 2012). This research has demonstrated that the decision to maintain a complex multi-agency structure can impact negatively on the day-to-day experience of those tasked with leading the integrated services. It is reasonable to assume that management time spent on dealing with these complexities directly takes away from management time available to drive forward integrated service change and development.

Whether this issue is best resolved through reconsideration of the Integration Authority arrangements at a local level or whether it should be addressed by further primary legislation will need further exploration. At present managers in the participating partnership area are obliged to continue to operate two different sets of organisational policies and procedures for the management of the staff in their teams. There is no single handbook bringing together the relevant policies and procedures of each organisation and few single system approaches, for example, for matters that are locally

designed and agreed. This demonstrates the heightened complexity of the environment within which leads of integrated services operate.

## CONCLUSIONS

Health and social care integration represents an aspect of what has been described as the Scottish Approach to public services (Cairney *et al.,* 2016). This is seen to be a strategic approach to government which includes a commitment to partnership working and community empowerment (Elliott, 2019; 2020a). Yet this research demonstrates some of the key operational challenges in ensuring effective integration of health and social care.

This research identifies that employing organisations in health and social care partnerships should consider providing more support to managers. Specifically, this support should focus on operating the policies and procedures related to managing staff and performance in each organisation. Consideration should be given to using techniques such as peer support, shadowing, formal training, and action learning set approaches. From a theoretical perspective it is recognised that models which see management and leadership as intertwined roles (e.g. Mintzberg, 1973) remain current and appropriate in health and social care services. In particular it was found that both transactional and transformational tasks are important aspects of the overall manager role in health and social care settings.

It is also found that employing organisations in health and social care partnerships should consider how an agreed joint training programme for managers across both organisations in the partnership could be further developed to support the shared training that is already provided. This is a particular challenge given reductions in funding and the increasing focus, especially in local authorities, on statutory services which have influenced a significant reduction in training and development budgets.

Employing organisations in health and social care partnerships should bring together the relevant policies and procedures of each organisation into one reference resource for managers of integrated services. In addition, active consideration should be given to making use of single system approaches wherever possible i.e. for matters that are locally designed and agreed, rather than for matters that are fixed or externally imposed.

Finally, it is acknowledged that further research should be undertaken across a cross section of partnerships in order to understand whether the findings are specific to the participating partnership or whether they represent lessons learned across the wider health and social care partnership landscape.

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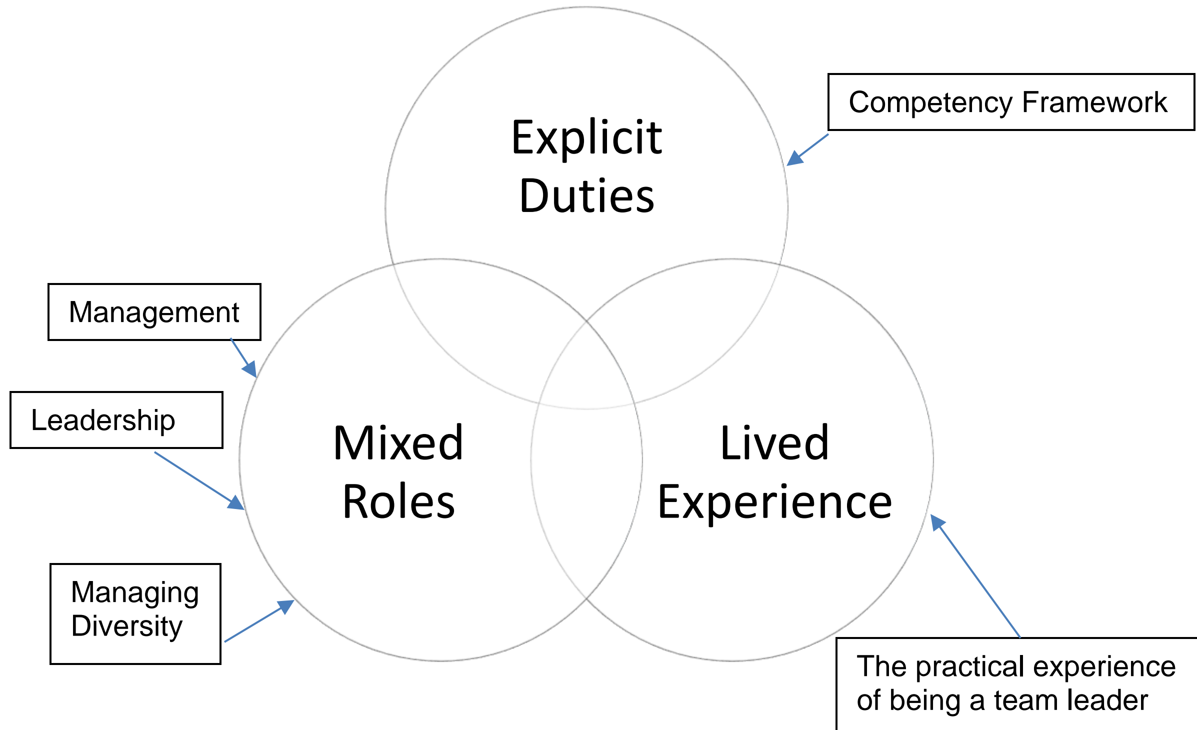


**Figure 1.** Roles, Duties and Experience Nexus.

**Table 1.** Theories of leadership.

| Theory | Key proponent(s) | Definition |
| --- | --- | --- |
| Trait | Carlyle (1841) | Leadership defined by inherent personal characteristics such as intelligence or personality. |
| Behavioural | Blake and Mouton (1964) | Leadership as a learnable skill based on developing certain traits |
| Situational | Vroom and Yetton (1973) | Leadership approach based on the context and situation of the time |
| Transformational | Burns (1978) | Leadership as role modelling, inspiring and motivating others and encouraging the commitment of followers. |

**Table 2.** Essential Leadership Components – First Line Managers of Multi-Disciplinary Health and Social Care Teams.

| Essential Leadership Component | Reflected in Competence Framework of Local Authority 1 (N) | Reflected in Competence Framework of Health Board 1 (N) |
|---|---|---|
| **Transactional Components** | | |
| Goal setting | 2 | 4 |
| Keeping staff to task | 4 | 6 |
| Giving feedback on performance and managing any under performance | 4 | 13 |
| Working to increase service efficiency and effectiveness | 5 | 15 |
| Ensuring established routines and procedures are followed | 1 | 13 |
| Standardising practice | 1 | 7 |
| **Transformational Components** | | |
| Emphasising intrinsic motivation and positive development of followers | 3 | 7 |
| Raising awareness of moral standards | 1 | 4 |
| Highlighting important priorities | 2 | 9 |
| Fostering higher moral maturity in followers | 1 | 3 |
| Creating an ethical climate (share values, high ethical standards) | 5 | 8 |
| Encouraging followers to look beyond self-interests to the common good | 2 | 6 |
| Promoting cooperation and harmony | 5 | 10 |
| Using authentic, consistent means | 0 | 0 |

| | | |
|---|---|---|
| Using persuasive appeals based on reason | 3 | 6 |
| Providing individual coaching and mentoring for followers | 0 | 0 |
| Appealing to the ideals of followers | 1 | 4 |
| Allowing freedom of choice for followers | 1 | 2 |
| **Challenges of managing diversity (Jackson 1995)** | | |
| Issues arising from the lack of shared technical language and the misunderstandings that can arise as a result of this | 1 | 2 |
| Issues of power and status | 1 | 2 |
| The struggle to develop a sense of cohesiveness | 4 | 9 |
| Managing relationships beyond the boundaries of the team itself | 4 | 2 |