



discussion paper

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Putting our heads together: what makes senior joint posts work?

As the downturn begins to pressurise public services and an ageing population continues to exacerbate the burden of long-term conditions, many health and social care organisations are beginning to look afresh at how working together might be a solution. With the integration agenda rising in prominence once again, we surveyed some of the prominent figures who embody the strengths and challenges of closer joint working: senior leaders whose posts cut across the traditional boundaries between health and local government.

Based on these interviews, this discussion paper looks at the factors that help and hinder success in a joint post and what local and national leaders can learn from this.

Key points

- We surveyed senior leaders whose posts cut across the traditional boundaries between health and other local public services.
- Good joint working cannot be centrally mandated, but does need stronger national support.
- Joined-up services are not an end in themselves. They must be targeted at improving specific outcomes in that locality.
- Joint appointments, for all their advantages, also create new tensions.
- Enforced structural changes are counter-productive to joint working.

As their profiles on page 4 show, our contributors hold a variety of different posts, reflecting the many different forms of integrated leadership in use across the country. Their roles range in scope from managing all health and local authority services, to health and social care, health and well-being and in one case social care from within a primary care trust (PCT).

Although a small group, they represent a large proportion of senior joint health and local government posts in England, and therefore some of the most valuable expertise available on managing joined-up services.

Local, personal, evolving

The experience of working in a joint post, as expressed by all our interviewees, is an immensely positive one. While their time in such posts ranges from less than a year to almost a decade, they have all found that there is significant personal satisfaction that comes from having influence over much larger sections of user pathways than traditional boundaries allow for.

Our interviewees hold a firm conviction that closer integration between health, social care and other public services should be one of the ways we look to continue improving these services through the challenging times ahead. This

"I think the benefits of being able to have a say in things that start in prevention and end in acute care and to see the sense of the whole system is really empowering and very satisfying because you can make a real difference"

might involve joint leadership models, which offer the possibility of a broader strategic perspective; faster decision making on cross-boundary issues; and lower management costs.

Yet these roles also carry significant challenges beyond those of a traditional chief executive or director. The leaders we spoke to see the success of their work as dependent on them negotiating complex systems of public and personal accountabilities and interlocking networks of the people they manage. The roles also require significant support and nurturing from the organisations involved.

None of the group feels that their local joint leadership structures should necessarily be transplanted elsewhere. While they believe there is a need for greater urgency toward integrated services at the local level, as well as for stronger national support, they argue that good joint working cannot be centrally mandated. Each locality must therefore be allowed to develop its own solutions, with management forms following from what exists already at their front line. One size will not fit all.

Our interviewees have a strong local focus, yet there are several areas where we find their experiences have direct relevance beyond

their borders. Some of the themes around which consensus was most strong or most notably lacking are discussed below.

Us, not me

Asked how they are able to manage a considerably larger remit than most local public service leaders, and what motivates them to do so, our interviewees are reluctant to suggest personal traits which make them any more capable than others to fill joint posts. It was not the force of their personalities which enabled their jobs' creation and continuation, they say, but rather the skills and qualities of their wider teams, of which they are a component.

"Quite often people say it's about personalities. I don't think that's true because I don't think there's anything special about me"

None of the leaders feel that their remit encompasses too many areas for them to manage properly. There is often an 'induction period' of getting to know a service they had not worked in before, but with the right people to support and implement decisions anything can be led, they feel.

Ends, not means

One trait considered vital to successful leadership of joint services is a constant focus, instilled throughout their organisation(s), on improving outcomes. Our interviewees

"Integration is a process. It's something you do in order to achieve something, not an objective of itself"

observe that too often the process of integrating services and systems together is confused as an end in itself. Joined-up services, while they might feel inherently 'right', are only of value if they are targeted at specific, well defined needs in the population. The temptation to overlook this is powerful, but if forgotten they fear that years of work could result in neat organograms that make little difference to service users.

For this reason some of our leaders express scepticism of those who support closer public service integration because of political fashion. These trends tend to wax and wane and give too unstable a foundation for the long-term commitment that is needed to change culture as well as form.

Adaptive, not homogenous

There is no consensus on the best style of leadership for someone jointly managing health and local authority services to take. Some see a clear divide in the way in which one culture needs to be managed compared to the other, such as having to become fluent in two 'languages'. Others deliberately avoid this, instead working to create a distinct new language and culture for their organisation, based around shared values of public service or care. Some feel that the collaborative nature of the job requires a consensus-based style and minimum of ego, while others are more assertive in pursuing their area's vision.

People, not theory

Although support for greater integration nationally is unanimous among the group, none feel that the systems they have created are necessarily superior to others. The process of designing their joint management arrangements did not start with an ideal management form to work towards but with a matching up of the skills, relationships and personal fit of the individuals involved. This means that their own local solutions are idiosyncratic and still evolving, and that outsiders should be wary of trying to replicate these areas' successes by importing their structures – organisational theory, much like political fashion, has not been a significant driver.

Not without challenges

The leaders feel strongly that combined leadership has been instrumental in bringing improvement to health and other public services in their area and will continue to be an asset in the future. Yet none feel that they have developed a perfect organisational form. Joint appointments, for all their advantages, also create new tensions which the post-holder must be aware of.

The mismatch in the hierarchies of councils and PCTs has the potential to create confusion in the chain of command. Each type of post has its own tensions. For example, joint PCT chief executives / directors of social services work at director-level within the local authority but at chief executive-level within the PCT. In meetings between the two organisations it can therefore be unclear in what capacity they are present. For example, are they subordinate or peer to the council's

chief executive? This issue is seen as requiring a measure of diplomacy on the part of the joint leader, but is not seen as undermining their accountability.

This asymmetry in seniority can cascade down through the levels of staff below a joint post, with a risk that local authority staff may feel they have lost status by being put on the same level as their PCT 'equivalents'.

Middle management is seen as a crucial yet often problematic aspect of managing the change towards integrated services. Several of the leaders have experienced much greater resistance amongst this group than amongst senior leaders or front-line staff. They are perceived to be more protective of a silo mentality and can obstruct measures which they see as threatening their territory or job. Our group has differing experiences of navigating this. Several kept middle management structures separate to avoid disruption, while others, through either accident or design, saw a large number – in one case almost all – of their middle managers replaced during or soon after they started integrating.

“Some people can't cope with not knowing who reports to whom, but it doesn't work like that here, it's much more about what makes the most sense”

Time pressures are seen as more of a challenge in joint posts, but not because of a greater workload. While moving to an integrated post has not significantly increased the demands on most of the individuals we spoke to, there is a perceived problem with diary management.

Almost all of our interviewees note that the combined number of routine, but required, meetings of their council and PCT roles has constrained their flexibility more than previously. Having a greater proportion of each week taken up with recurring appointments, such as meetings with their boards, means that finding time for other business has become more difficult.

Nationally nudged, not enforced

Although they find integrated management beneficial to their localities, the leaders we interviewed oppose suggestions that a universal, integrated organisational form could be developed. Having multiple public services under their direction has made them more aware of how interwoven the network of boundaries within and between local organisations is, and therefore how no organisational form could bridge these boundaries perfectly. Health and social care tends to have the highest profile in policy discussions on joint working, but their view is that just as challenging is the need to navigate acute versus community, commissioning versus provision, adults versus children, care services versus housing and leisure, and more. Given this complexity, many of them ask whether it would be wiser

“Everybody thinks there is a perfect organisational solution to this. There isn't. Actually, keeping moving the boundary is the worst thing you can do. Decide on the model you want and leave it for ten years!”

Who we spoke to

Geoff Alltimes

Geoff is the chief executive of Hammersmith and Fulham Borough Council and the local PCT. After working for several years just as local authority chief executive, Geoff helped to drive the creation of a joint management team which began operation in May 2009. He now leads both organisations, though they remain separate entities.

Chris Bull

Chris is chief executive of Herefordshire's council and PCT. The first post-holder of this kind in England since 2007, he has led a joint management team for both organisations, though they remain separate entities. Prior to this he worked in Southwark where in addition to other roles he spent five years as chief executive of the PCT and director of adult social services in the council.

Peter Colclough

Peter has been chief executive of Royal Cornwall Hospitals Trust since February 2009. Prior to this he was chief executive of Torbay Care Trust for five years, having led the merger of social care and the PCT in 2004.

Jan Coulter

Jan is the director of health and social care at Knowsley Health and Wellbeing (a partnership between NHS Knowsley and Knowsley Council's Directorate of Wellbeing Services). She fills the statutory role of director of adult social services and reports to Anita Marsland, chief executive NHS Knowsley/ executive director of wellbeing services.

Anthony Farnsworth

Anthony is acting chief executive of Torbay Care Trust, an organisation responsible for health and adult social care in the area. His role means that he also fills the statutory post of director of adult social services. He has been in post since February 2009, prior to which he was director of commissioning for the trust.

Jane Lewington

Jane is chief executive of North East Lincolnshire Care Trust Plus, a post she has held since the organisation's creation in September 2007. Prior to this she was chief executive of the PCT from 2000. Her remit includes health and adult social care, with children's services provision and health improvement delegated to the council.

Rhona MacDonald

Rhona is the chief executive of Bath and North East Somerset PCT and is also seconded to the council as director of adult social services and director of housing. This arrangement has been in place since May 2009, prior to which the council posts were separate from Rhona's, but still sat within her management team.

Denise Radley

Denise is the director of adult social care for Peterborough with joint accountability to the PCT and local authority. She holds executive director positions in both organisations, supported through a series of matrix arrangements.

to focus energy on teaching local organisations and their leaders to work across service interfaces rather than seeking to reorganise where these lie.

Although our interviewees agree on the folly of seeking a one-size-fits-all integrated organisation, they do not appear to share a view on whether structural change to support joint working is important or not. Many recognise the achievements of areas such as Knowsley, which show that the benefits of integrated working can be achieved without significant structural change. Some of the leaders we interviewed conclude from this that such changes are an unnecessary distraction, or at least are not worth the investment required. Others, however, feel that structural integration has not been championed enough in recent years; so long as it is locally determined and built upon existing close working among front-line staff, being part of a single joint organisation can provide a valuable base from which to drive system change, they feel.

Despite the feeling that a top-down approach to joined-up services may not be very fruitful, the leaders we spoke to feel there is a lot more that central government, and particularly the Department of Health (DH), should do to champion integrated working more effectively. Work should begin close to home, with the DH seeking to understand what it aims to promote by bringing its own health and social care functions much closer together. A number of interviewees feel that the health and social care branches of the DH currently do not communicate or coordinate effectively, evidenced by the frequent release of policies that, viewed from the combined perspective of a joint post, are contradictory.

Transforming community services was consistently referenced by our interviewees as an example of this as it mandates the divestment of a PCT's provider side while leaving local authorities intact. This creates an imbalance in the functions and scope of councils compared to PCTs, constructs a new organisational boundary and makes integrating services all the more difficult.

"I think they [the DH] think integration is a good thing, but can't quite work out what it is"

Such divisions mean the DH is often not seen as a credible advocate for integration as it fails to set an example with which it can effectively challenge local organisations to do things differently.

Following from this, the DH should attempt to develop more policy streams that relate directly to integrated organisations. Currently, almost all of the work of synthesising national requirements on financial reporting and quality standards is borne at the local level by the integrated organisations themselves. This disincentivises many areas from integrating too closely as it would result in a significant extra burden of having to continue operating as two separate entities in many of the interactions with central government.

"It can be incredibly hard when you have to deal with two sets of performance monitoring and two sets of auditors"

Finally, policymakers should seek to create an environment more conducive to local integration by recognising that enforced structural changes, or the instability caused by their threat, are counter-productive to joint working. Integrating public service provision effectively requires established networks of trust between local leaders and, whether structural or not, a significant time commitment. Where there is a threat of one partner being split, merged or reorganised, this thwarts the development of the long-term planning necessary to bring services into better alignment.

PCT Network viewpoint

The insights presented in this paper provide valuable lessons for both local leaders interested in further joining up their public services and policymakers who wish to work towards this aim nationally. It is up to the reader to decide the extent to which these lessons hold weight, or are the views of a selective group of enthusiasts.

The desire of the leaders we interviewed to have greater local self-determination with which to plan and implement their long-term strategic visions is compelling. They give a clear warning that if national policymakers are serious about more joined-up services they need to rethink not just the way they promote integration at the boundaries of health, social care and other public services, but the way they direct the entire system. The frequent reorganisations of the NHS throughout the last decade are perceived by our group to have created instability which has undermined their attempts to develop locally relevant solutions. Future programmes of enforced

structural change on these organisations will continue to frustrate cooperation between local partners. For these messages to impact on policy, however, the DH would need to be willing to display a great deal more confidence in its local leaders, and be far more tolerant of the plurality of organisational forms that would result from this being granted. This, alongside focusing on better coordination with itself and other departments, suggests some new opportunities exist to provoke a step change in joined-up public services.

At the same time, one of the strongest messages from our interviewees is that it is not necessary for local leaders to wait for central government to work differently before action is taken. The experience of those in post is that

Points for further discussion

- What is preventing the wider use of innovative models of integrated working, such as joint posts?
- Should a greater degree of local freedom be allowed by central government or do NHS trusts and their partners first need to make greater use of the powers given to them already?
- To what extent would more joined-up central government departments better promote such working on a local level?
- If instability impedes joint working, should plans for national reorganisations be more strongly discouraged in future?

joint appointments can offer real advantages, either as powerful levers for change or as positive symptoms of closer working at the front line. Yet the fact that they themselves do not see joint posts as being the best option everywhere sets a challenge to other local leaders to

think for themselves what integrated working means for their own area and how it can achieve better outcomes. If central government is to be called on to allow greater plurality in the forms that NHS trusts and councils decide to take, then these organisations must also prove

that they know better than national policy-makers what will work for their populations.

If you have any comments on the issues covered in this paper or the points for further discussion, contact jonty.roland@nhsconfed.org

Further information

The future for community services. Primary Care Trust Network, NHS Confederation Briefing, April 2009
Transforming community services: enabling new patterns of provision. DH, Jan 2009

The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. The Network aims to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. Its ambition is a health system that delivers first-class services and improved health for all. As the national voice for NHS leadership, the NHS Confederation meets the collective needs of the whole NHS as well as the distinct needs of all of its parts through its family of networks and forums. The PCT Network is one of these.


For further details about the work of the PCT Network, please visit www.nhsconfed.org/pctn

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