

Leadership in social work

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LEADERSHIP IN SOCIAL WORK: (and can it learn from clinical healthcare?)

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Foreword

As a profession, social work faces unprecedented pressures. Social care services, which social workers help to deliver, have been subject to many years of central government cuts. In addition, demand for services is rising, placing huge and difficult to manage burdens on social workers. Local authorities struggle to recruit and retain enough social workers, and the profession continues to suffer from negative public perceptions.

In this context, it is vital that we have confident and effective social work leaders - those who can inspire and lead teams and organisations in complex, multi-agency social care systems.

This paper's authors acknowledge these challenges facing social work, but contend that more could be done to encourage and support better social work leadership. They argue that compared to other relevant professions, such as nursing and medicine, there is an insufficient investment in leadership at all stages in a social workers' career; what they call the 'cycle of missing leadership.'

Yet good social work leadership is hugely important to the effectiveness and impact of social care services. In papers on strengths-based social work, Social Care Institute for Excellence (SCIE) discusses the importance of confident and skilled social work leadership to embedding strengths-based practice. In a tool for the What Works Centre for Children's Social Care, which SCIE is helping to establish, we identify excellent social work leadership as a vital feature of evidence-minded organisations.

This paper provides a helpful tour of a range of useful frameworks for conceptualising social work leadership, identifies ways in which social work leadership can learn from clinical leadership, and highlights gaps in the evidence and contributions to the professions' leadership development. The paper also presents a new and helpful definition of leadership in social work.

This paper makes an important contribution to the debate, but the authors are clear that it is just a first step in what is hoped to become a productive dialogue between academics, social workers, regulators and government. Certainly, at a roundtable chaired by SCIE's Chair Paul Burstow, used to inform the paper, the social work leaders in attendance were keen for the paper to spark a much wider debate.

The huge challenges facing social work, and social care more generally, are unlikely to abate in the near future. In this context, fostering excellent social work leadership will be more important than ever, and this paper kicks starts what we hope is a fruitful debate that leads to real change.

Ewan King, Chief Operating Officer, SCIE

Introduction

Leadership is recognised as an enabler of well-functioning organisations. Within social work, well-led services and professions will contribute to people, families and communities experiencing positive and enabling support that improves their life opportunities and wellbeing. Leadership is also highlighted in reviews of what has not worked well, either through focussing on the wrong objectives or being noticeable by its absence. Social work with adults, and with children and families, has professional status, designated legislative responsibilities, central roles in safeguarding the most vulnerable, and an institutional and democratically elected organisational home. Despite these foundations, social work in England often presents as a profession in crisis, unsure of its distinctiveness, strengths and contribution. This corresponds with social work being undervalued by other professions and overlooked by society in general. It is therefore crucial that social work has a strong sense of its purpose with strong leadership to develop and sustain the profession into the future.

This working paper seeks to add to debates about social work leadership within England. It begins by tracing out definitions, models and research evidence. It is noteworthy that much (but not all) of the social work leadership literature used in this paper originated from the United States of America, not the UK, raising questions about the significance given to leadership within the UK social work community and its researchers. The current context of social work in England is considered as the backdrop against which leadership must be realised. The core elements of leadership in social work are analogous to those in other professions (Sullivan 2016), and thus there are grounds to the argument that social work should not see itself as unique in terms of how leadership is conceptualised and enacted. This opens the door to learning from other sectors. Healthcare has recognised the potential benefits of leadership for many decades with active support from policy and practice. This paper concludes by highlighting the main areas for debate and setting out ways in which these could be positively addressed.

Leadership and Social work

Definitions of Leadership

Leadership in social work is poorly defined. This applies within England, the UK and further afield, both within children and families and adults fields, and with no coherent model or definition systematically employed or endorsed (Hafford-Letchfield et al, 2014; Sullivan, 2016; Lawler & Bilson, 2013). As Lawler (2007) states, 'we are still in the position of having no generally accepted definition of leadership or what it might be within social work' (p. 133). A further complication is that the knowledge base is mostly conceptual and lacks a robust empirical basis (Hafford-Letchfield et al, 2014).

Meanwhile, the importance of effective leadership has been highlighted by a range of scholars and reports, including the two most prominent reviews of child protection practice in England. Almost ten years ago Laming (2009) reminded us that serious case reviews consistently refer to the importance of effective leadership. In her seminal review of child protection, Munro (2011) stated that 'Leadership will be needed throughout organisations to implement the review's recommendations successfully, especially to help move from a command-and-control culture encouraging compliance to a learning and adapting culture' (p.107). These underscore the importance ascribed to leadership for improving social work practice.

However, the context of contemporary social work can be understood as inhibiting the development of confident and effective leadership, through managerialism, bureaucratic dominance, or cultures of fear and blame (Hafford-Letchfield et al, 2014; Rogowski, 2012; Lawler & Bilson, 2013; Sullivan, 2016). Confident and effective leadership is complex, daunting and multi-faceted; as a result, managerialism can be seen as a defensive response to such complexity and uncertainty, steering social work organisations towards expediency, efficiency and rigid structures (Lawler, 2007; Rogowski, 2011).

There is limited attention to leadership in social work education and a potential incongruence between education for frontline practice and education for leadership (Lawler & Bilson, 2013; Holosko, 2009; Perlmutter, 2006). The Social Work Task Force found that teaching on organisational leadership skills was largely absent from curriculums (Taylor, 2013). Social work education must, therefore, take some responsibility for the lack of progress in fostering healthy and effective leadership in social work (Holosko, 2009); as must the various governing bodies (which have been

in flux for the past decade). For instance, Colby Peters (2018) found that the Health and Care Professions Council proficiencies fail to mention the word *lead* at all.

These issues are exacerbated by pervasive recruitment and retention challenges, which contribute to staff shortages and, as a result, knowledge and expertise leaving the profession (Hopkins et al, 2014; Smith, 2005). For example, children and families' social work is confronted with high turnover of staff and vacancy rates, with experienced and committed practitioners amongst those leaving the profession (Baginsky, 2013; Collins, 2008). This cycle can encourage organisations to move practitioners into formal leadership positions without the macro-level knowledge and experience needed to fulfil the role (Bliss, Pecukonis & Snyder-Vogel, 2014). In addition, social workers can be placed in leadership positions and may not have the training or experience to be good leaders, holding the role because of years of service. This type of promotion suggests that they may not have developed the leadership skills necessary for the role (Iachini, Cross & Freedman, 2015; Sullivan, 2018).

These intersecting issues move social work away from leadership based on expertise and in-depth knowledge of practice, as advocated in healthcare (Goodall 2016; Goodall and Pogrebná, 2015). In fact, given the consistency of public enquiries, challenging regulator reviews, serious case reviews and media scandals, effective crisis leadership can be viewed as more necessary for social work in the UK (Lawler & Bilson, 2013) than leadership based on expertise.

Models of Leadership

There are different leadership models promoted in children and families and adults' fields, and between more specific practice areas. The following section presents several of these models, and considers them critically for their contribution to our knowledge base. For instance, the literature review revealed a surprisingly high proportion of leadership papers from the palliative care field (e.g. Blacker et al, 2016; Cullen, 2013; Davidson, 2016; Jones et al, 2014). These texts explore collaborative inter-disciplinary leadership, the benefits of specific leadership programmes and the importance of interprofessional leadership education. It conceptualises leadership in broad terms as an activity where practitioners influence the practice of others, not as a role or status limited to management or senior practitioners. It is perhaps noteworthy

that this area of social work is multi-disciplinary and entwined with health professionals and services.

Some scholars (Iachini, Cross and Freedman, 2015) have suggested specific types of leadership as more aligned to social work values. They considered how leadership is incorporated in social work education from a US perspective. They specifically cite the *social change model of leadership* as promoting the core values of social work. Furthermore, authors including Jones and Phillips (2016) and Blacker (2016) propose that, because of this value base, the social work profession is in a strong position to lead interprofessional education within health care.

Transformational leadership features heavily in the literature (Colby Peters, 2018; Hafford-Letchfield et al, 2014; Northouse, 2016). This model derives from business and utilises ideas of change and innovation, personal charisma, intellectual stimulation, and valuing and listening to followers (Northouse, 2016). This model's potential appeal to social work derives from leaders assisting transformation by valuing individuals and being accessible, inspirational and enabling (Lawler & Bilson, 2013; Martin, Charlesworth & Henderson, 2010). Furthermore, this type of leadership is associated with transforming staff perceptions, emphasis on collective action and commitment, and motivating practitioners to achieve both individual and organisational goals (Hafford-Letchfield et al, 2014; Sullivan, 2016).

Participatory or distributed leadership features prominently in the literature. This model is associated with developing shared purposes and values, collaborative cultures, continuous improvement and authentic shared leadership. In this model context is important, and leadership is understood as a practice distributed over leaders, followers, and their shared situation (Carpenter, 2015; Gibson, 2017; Spillane, Halverson & Diamond, 2004). Gibson (2017) describes that this model 'brings the situation to the fore, treating it as something more than a backdrop or container for leaders' practices, instead treating it as integral to defining specific leadership activity' (p. 38). Distributed leadership aligns closely with the social work value base, incorporating professional ideals of empowerment and egalitarianism as emphasised by the International Federation of Social Worker's *Global Definition of Social Work* (2014). This model focuses on leadership practice, as opposed to roles, and the development of common democratic working cultures (Hafford-Letchfield et al, 2014).

Client-centred leadership is identified as a preferred model by some scholars (e.g. Sullivan, 2016). This model is linked but different from distributed leadership, and could present issues of paternalism for a UK context, because the lack of consideration of the power imbalance between professional and client. This model is predicated on the client or service user as the preeminent focus, with the motivation and job satisfaction of practitioners merely acting as a means towards the desired end of meeting service users' needs and improving their life circumstances. Within this model the gap between leaders and service users should be minimal, with regular interactions between leaders and service users a key feature.

Communities of practice has potential relevance for the development of leadership in social work, given the concepts' focus on structuring social learning and promoting leadership through knowledge and expertise. Wenger, McDermott and Snyder (2002) define a community of practice as 'a group of people who share a concern or passion for something they do and learn how to do it better as they interact regularly' (p. 22). Communities of practice have three foundational elements. Firstly, identity is formed by a shared domain of interest; secondly, members build constructive relationships that enable them to learn from each other; and thirdly, members develop a shared collection of resources, tools, and problem-solving techniques to evolve high standards of shared practice (Wenger, 1998). The development of such communities could encourage a more communal, relational and knowledge-based approach to leadership, connecting with social work values of empowerment and collective action, while encouraging peer support and a common sense of leadership identity (Gray et al, 2010; Hafford-Letchfield et al, 2014; Wenger, McDermott & Snyder, 2002).

Adaptive leadership holds some relevance for social work, given the variety and speed of change in the sector. Its consideration of supporting people to manage change could be seen as a useful model to apply for social work contexts. Adaptive leadership conceptualises leadership through interactions between leaders and followers, recognising the mutual effects, and therefore opens leadership to those who are not in formal leadership positions. This model focusses primarily on leadership behaviours that are congruent with learning, innovation and adaptation. It recognises complexity in the workplace and advocates for leadership to support, rather than take control of, change and problem solving (Northouse, 2016; Heifetz et al, 2009).

Systems leadership has gained increasing prominence in recent years through the recognition in England and internationally that new forms of collaboration between professions, organisations and sectors are vital to respond to changing demography and poor outcomes due to continued fragmentations between services (Miller et al 2016, SCIE 2018a). Ghate et al (2013) define it as 'leadership across organisational and geopolitical boundaries, beyond individual professional disciplines, within a range of organisational and stakeholder cultures....to effect change for positive social benefit across multiple interacting and intersecting systems' (p13). It builds on previous thinking relating to the power of collaborations, the importance of diversity and the role of social movements to influencing complex adaptive systems (Welbourn et al 2012). Developing it in practice requires working not only with the leaders but also the system in which they operate to ensure that new innovative approaches can be adopted (Fillingham & Weir 2014).

There are some definitions of leadership (e.g., Holosko, 2009) that suggest it should include vision, a collaborative approach, problem-solving, the ability to influence the views and actions of others, and the ability to inspire and cultivate change. The development of leadership in social work could look to these ideas and peer externally for inspiration, knowledge and pertinent leadership models (towards healthcare in particular). As Sullivan (2016) proposes '...the task of a leader in a human service organisation is to create the context for professionals to perform in an efficacious fashion and to be a steward of a culture in which the client always comes first' (p. 559). As a result, perhaps leadership in social work can encourage improvement, innovation and the valuing of every individual in, or associated with, its enterprise, focussing on the desired effects of leadership as opposed to leadership as a status or specific role.

Developing Leadership

A recent review of practice frameworks for the West Midlands Social Work Teaching Partnership outlined practice development and leadership within the UK social work context (Gibson, 2017). It examined leadership development frameworks where professional practice was central. The review concluded that leadership should be based upon the pillars of distributed leadership, supportive practice environments linked to professional values and deliberate organisational and individual actions

aimed to improve practice. Furthermore, it suggested that leadership should be recast as a mindset and activity as opposed to a person or role, and that leadership should focus on practice development and innovation separate from administration and management (Gibson, 2017). Drawing on this review, Stanley and Kelly's (2018) work described the development of a practice leadership framework. They suggested that UK social work leadership should use the foundations of practice frameworks, sociological imagination, research in practice and IFSW principles. The strength of the model is drawn from its focus on the connection of leadership to social work practice and values. It discusses the role of the Principal Social Worker, concluding that after five years it seems unlikely to realise the stated aim of practice leadership focussed upon leadership as a bridge between front-line practice and strategic decision-making. It is important to note that this view is open to challenge.

There are examples of inventive practice, as evidenced by projects funded by the Children's Social Care Innovation Programme for example (McNeish et al, 2017). One programme being developed and delivered within children's social work is the Practice Supervisor Development Programme. It is funded by the Department for Education and jointly delivered by Research in Practice and specific universities. This programme is looking to 'educate' 700 practice supervisors by 2020. The programme will incorporate the KSS and support practice supervisors to develop knowledge, skills and values in their roles. Another is the Practice Leader Development Programme. Facilitated by practice leaders from a number of London based Local Authorities and the Department for Education, a central element of the programme is a coaching relationship with an experienced leader. The programme seeks to bridge the transition from learning into practice by maintaining this relationship for the first twelve months of participants taking up such roles.

Social Work Leadership – an ambiguous concept?

When considering the range of models and knowledge from the above section, what is striking is that there is no clear model of leadership that is promoted by the profession. This lack of clarity may create complications for the profession to develop its voice, to develop its knowledge base, and to respond to external threats. As a 'junior profession' in comparison to the more established medicine and law, these issues are

of particular concern. In the UK, social work has made a clear differentiation between itself and 'clinical' settings, suggesting that an approach that is more person-centred is preferred (to note, in other countries this is not the case). Whilst this is laudable, this may have removed social work from the supporting structures that healthcare provides, with its greater funding and more positive public perceptions.

What may be possible to be gleaned from the above, however, is that social work is likely to link closely with models of distributed leadership. This model presents clear alignment to social work values.

Context of social work practice

When considering social work leadership in England, it is important to consider not only the knowledge currently being developed, but the context in which the leadership is enacted. Social workers are employed in a variety of organisations, and work with a wide range of service users. Many work in local authorities, undertaking children and adults social care roles, but they also work in voluntary and charitable organisations (also called 'The Third Sector'). Because of the diversity, scanning across the workforce to make coherent suggestions is challenging. In addition, what might be suitable for one sector may be irrelevant or unhelpful for another. Social work in the UK is often portrayed as experiencing a state of near-perpetual change and, in addition to this turmoil, significant funding cuts have impacted children and families and adults' services alike (Rogowski, 2011; Cummins, 2018). Furthermore, practice is often described as dominated by organisational objectives, audit cultures and bureaucracy (Green, 2009; Morris, Featherstone & White, 2014). This context and issues likely hinder the development of confident leadership, and leading social work practice is often fraught and challenging (Aronson and Smith 2010; Stanley & Kelly, 2018).

Given these complexity, this section considers local authority social work in England. Given this boundary, there are a number of key elements to consider: contextual change; the political and public context of social work; the impact of inspections, scandals and serious case reviews; recruitment and retention of social workers (including changes to working patterns); effects of significant recent budget cuts; and social work profession's status and values.

Professional Reforms

Social work in England has experienced a decade of sustained and significant change including the formation of a Task Force and Reform Board (Social Work Task Force 2009a; Social Work Reform Board 2010, 2012), two high profile reviews of child protection (Laming 2009; Munro 2011), and two of social work education (Croisdale-Appleby 2014; Narey, 2014). The successive Labour, Coalition and minority Conservative governments have recommended a sweeping series of significant reforms, including the establishment and then abolition of the first ever College of Social Work (TCSW). These reforms have included: a new overarching professional standards framework in the Professional Capabilities Framework (PCF), previously

held by TCSW, and later by the British Association of Social Workers (BASW, 2018); the appointment of two Chief Social Workers (one for Children and Families and one for Adults) to give professional leadership and improve the influence of social work on policy; and the Assessed and Supported Year in Employment (ASYE). ASYE offers additional support to social workers in their first year of practice and, along with the PCF, provides a benchmark against which all new social workers' knowledge and capability can be objectively assessed at the end of their first year (Social Work Reform Board 2012). The Chief Social Workers have issued Knowledge and Skills Statements (KSS) for social workers working with children and families (Department for Education, 2014) and adults (Department of Health, 2014). In addition, Social Work England, the new professional regulator, has recently come into effect. There have been concerns raised about the speed and scale of these changes, suggesting that they do not allow changes to be embedded before further transformation.

The respective KSS for children and families and adults social work hold potential relevance and opportunities for leadership within UK social work. Within the children and families field there is a specific KSS for practice leaders, which aims to provide the basis for accrediting practice leaders within the field. It covers areas such as leading excellent practice, designing systems to support excellent practice and developing excellent practitioners (DfE, 2015). This KSS informs the practice leader development programme, which aims to facilitate leadership through learning in-role and experientially. There is no analogous KSS specifically for practice leaders in adults' social work. However, the KSS for social workers in adults does refer to leadership, if only briefly, in requirement 10 entitled 'professional ethics and leadership' (Department of Health, 2014).

There are some developments designed to encourage innovation in children's social care which are helpful to consider here. These include the *What Works Centre for Children's Social Care* and the *Children's Social Care Innovation Programme*. These two are interlinked, and examine the settings for social care, and how to improve the service. Of particular interest for this paper is the *What Works Centre's* definition of its remit:

'We will generate evidence where it is found to be lacking, improve its accessibility and relevance to the practice community, and support practice leaders (e.g. principal social workers, heads of service, assistant directors and

directors) to create the conditions for more evidence-informed practice in their organisations.’ (www.whatworks-csc.org.uk/)

The *Innovation Programme* also identifies the importance of practice leaders within its round one evaluation (DfE, 2018). In this document, the ‘Seven Enablers of Improvement’ can all be linked to leadership concepts discussed in this paper:

1. **Strategic approach** - Rigorous and forensic self-assessment; open and honest to external feedback; develop a vision and strategic plan that is right for the organisation.
2. **Leadership and governance** - Maintain the right, stable, focussed leadership at all levels; don’t rush into a restructure; establish effective, professional governance.
3. **Engaging and supporting the workforce** - Change the rhetoric and avoid the ‘blame game’; articulate high expectations and ambitious goals; stabilise the workforce; develop staff from within.
4. **Engaging partners** - Engage senior partners; align thresholds; review practices through multi-agency audits; remain outward facing.
5. **Building the supporting apparatus** - Maintain a secure front door; ensure the flow of cases reflects a child’s journey; know the business; develop routines to track progress.
6. **Fostering innovation** – Create a learning culture; test and pilot new ideas carefully; evaluate rigorously.
7. **Judicious use of resources** – Ensure strategic and financial planning are aligned; invest where it is needed; sustain investment until improvement is embedded; focus on long term priorities.

This evaluation links these *enablers* to *features of practice* and *outcomes*, and it suggests that this leadership is necessary to improve practice and outcomes. These outcomes align to government targets.

Diagram 1: Seven Features of Practice and Seven Outcomes (DfE, 2018)



Political and Public Context of Social Work

Working for local councils is a significant factor in the experience of social workers in modern practice. It is important to note that local councils are government entities with a great deal of autonomy, and that local councillors are elected officials. As a result, the oversight of the council by elected members has a significant effect on the daily working life of social workers. Elected local councillors provide strategic leadership and make decisions about budgets and priorities, with the senior management responsible for advising the councillors and implementing their decisions (LGA 2012). Changes in electoral response can have significant effects on the individuals in charge of budget- and target-setting, some of which can be influenced by ideology. The relationship between elected members and employed senior managers can be challenging, with the strategy-setting sometimes at odds with the needs of the local population.

A more uncomfortable consideration is the difference in public perception between the NHS and social care. Media stories often equate the NHS as a 'religion' (Field, 2016),

but the comparable perception is of an over-bearing and ‘failing’ social care sector. This has been considerably affected by a series of scandals, going back decades (Butler and Drakeford 2011), which have seen social work (which is closely aligned to child protection) repeatedly battered by media storms. It is important to identify that the ‘public inquiry and the media coverage of it were as much, if not more, an inquiry into social work as it was about child protection policy and practice and that social work was found wanting’ (Parton, 2011: 1216). These scandals, and the resulting inquiries, have resulted in very public shaming of social workers and senior managers, such as the televised sacking of a director, Sharon Shoesmith, by the Education Secretary, Ed Balls, after a council had a second high-profile child death as a result of child abuse. Whilst it is fair to suggest that social work should be scrutinised, and strive for high standards, it is clear that working in these conditions has a negative effect (Warner, 2015). Social workers suggest negative media representations of their work is a significant factor in them leaving the profession (RiP, 2015). The public perception of a scandal-ridden profession that is failing is a powerful part of the context for modern British social work.

Inspections and Serious Case Reviews

In addition to the political and public context, the inspection regime for social care is challenging and complex. Local authorities experience a combination of various evaluations from disparate inspectors. Currently the framework for inspecting local authority children’s services (ILACS) includes Joint Targeted Area Inspection (JTAI). The JTAI includes a range of inspections from several inspectors: Ofsted, Care Quality Commission, HM Inspectorate of Constabulary, Fire and Rescue Services, and HM Inspectorate of Probation (HM Government, 2018). These inspections have increasingly found more councils as ‘inadequate’ or ‘needing improvement’ and fewer as ‘outstanding’, and the negative judgments have a deleterious effect on staff morale and public perception (Impower, 2015; RiP, 2015).

These inspections rightly include a consideration of serious case reviews, which take place when a child dies or is significantly harmed as a result of child abuse or neglect. These *serious case reviews* have been consistently criticised as unhelpfully identifying individuals instead of systems as problematic (Munro, 2011), as well as for having repeated recommendations that are too general (Hyland and Holme, 2009). These

serious case reviews often garner strident media attention, and the effect of the outcomes has been found to be largely negative, without driving up standards of care (Frost, 2016). Because of the generality of the recommendations, the learning produced from these serious case reviews is difficult to embed into practice.

Recruitment and Retention of Social Workers

Related to inspections, as described above, the recruitment and retention of social workers has been problematic for at least 15 years. The average career for a social worker has been famously identified as lasting only eight years. This short career contrasts negatively with 16 years for nurses and 25 years for doctors (Curtis et al, 2010). The cost of training further generations of social workers with such poor retention has resulted in research to determine the reasons, with “heavy caseloads, burnout, poor pay and conditions, dysfunctional organisations, and low levels of training and support” all being suggested as reasons for the low retention (Baginsky, 2013, p 5). It is important to note that this issue is becoming more problematic, not less, with a rising number of councils experiencing recruitment and retention difficulties (LGA, 2017). These retention issues have a significant effect on the ability to support novice practitioners to gain expertise, since practice knowledge often develops when engaging with more experienced practitioners in a *community of practice* (Fenton-O’Creedy et al., 2005).

Recent changes in working patterns and employment expectations have also had an impact on social workers’ retention. Many councils have changed the office layout for social work teams, with a recent survey finding that almost 60% of social workers do not have their own desk (Community Care, 2017), which means they are ‘hot-desking’. This means social workers do not have their own workspace, and they are encouraged to employ ‘agile working’ techniques. A majority of social workers without their own desk believe that this has had a negative impact on their practice (Community Care, 2017). Social workers feel they have less privacy, and less space to consider complicated decisions, and these spaces are prone to interruptions (Jeyasingham, 2016). It is important to note that these spaces have been altered to suit the needs to organisations that have changed over time, including a reduction in budget and spaces.

Budget Cuts and Demand Increase

The reduction in funding for social work services has been both significant and sustained for the past 10 years. There are some startling figures published, such as a funding reduction of 49% between 2010-2018, but with a significant *increase* in demand for services (Bilson et al, 2017; NAO, 2018). 1 in 10 councils are experiencing financial difficulty (NAO, 2018), with suggestions that 'the current pattern of growing overspends on services and dwindling reserves exhibited by an increasing number of authorities is not sustainable' (p 11). There are several councils whose financial difficulties have garnered media attention, with Northamptonshire experiencing a £65m shortfall and government-appointed commissioners brought in to oversee the council's spending. As a result of these cuts, there have been risks to statutory services, which is where a bulk of councils' social workers are employed. Social workers find these cuts problematic, with 60% suggesting that the cuts have affected their practice effectiveness (Community Care, 2017). It is important to note that these cuts are in contrast to the NHS budget, which has generally been protected from real-terms reductions in funding (King's Fund, 2015). As a result of the rapid change to their budgets, it is impossible for councils to provide the same level of social care as they did previously, and many councils have increased care thresholds. The consequences are felt by the NHS, which has seen an increase in the use of A&E by patients believed to be in response to the rising council care thresholds (Crawford et al, 2018).

It is difficult to over-estimate the impact of the increase in demand for social work services, both in children and in adult's services. Children's social care has experienced an increase in referrals as a result of the 'Baby P effect' which has meant that referring services (e.g., schools, NHS) are more risk-averse and referring more often. There are concerns that the public scrutiny on social work services with children have resulted in a significant increase in the proportion of children investigated for child abuse and removed from their parents (Bilson and Martin, 2016; Bilson et al, 2017). With an aging population, adult social care is experiencing the same challenges as the NHS. During the period of the budget reductions described above, the proportion of older people rose by almost 9 percent (King's Fund, 2015). These issues

mean that, for different reasons, both children and adults' services are experiencing increased pressures, but with significantly reduced budgets.

Social Work Status and Values

The pressures described above are both short and long-term, but the stature of the profession pre-dates any of these concerns. The professional standing of social work is not as established as other professions, including medicine and nursing. The reasons for this differential status have their roots in the origins of the professions, and that status and power flow from one generation to the next along professional lines (Foucault, 1980, p. 92). This has an effect on recruiting to social work courses and posts, and on social worker's consideration of their own worth. It is helpful to note here that part of this status difference is the debate as to whether social work is a profession or a practice, a debate that has taken place for over 100 years (Flexner, 1915). These debates have an impact on the public perception, and the profession's ability to attract new generations of people to become social workers.

A further point for consideration in this debate is the gendered nature of the profession. Social work, along with other 'helping' or 'caring' professions such as nursing and teaching, have a high proportion of women. In the UK, 85% of social workers are women (Skills for Care, 2016) with this proportion likely to increase, as the ratio of men enrolling and completing social work courses has steadily dropped since the 1980s (Lyons *et al.* 1995; Schaub 2015). Whilst women are a numerical majority in social work, they do not predominate in positions of power. Social work experiences what has been termed the *glass escalator* (Williams, 1992), with men moving more quickly into positions of leadership and power than their women colleagues. This higher percentage of men in positions of power has been noted as a concern by a range of scholars (McDowell 2015; McPhail 2004; Simpson 2009). Given the close alignment of men to leadership and power, it seems important to consider how the gendered nature of the profession interacts with its engagement with leadership.

Finally, it may be helpful to consider a possible internal opposition to leadership that originates from the profession's value base. Social work values include empowerment, collaboration and collective responsibility (IFSW, 2014). These core tenets can conflict with leadership and management roles for some social workers and there may be a

stigma with moving into these roles (Hafford-Letchfield et al, 2014, pg. 147). Some social workers may feel these roles do not connect easily with their internalised professional values. The effect of radical social work theories on British social work should be considered here, which has been examined elsewhere in this paper. Essentially, the radical social work theories of community and collaboration may be an impediment to engaging with management and leadership roles and opportunities with the same ease or ambition as other, related, professions.

Modern British social work is undertaken in a complex and embattled context. The recent cuts to funding, accompanied by an increase in demand has meant a reduction in social worker's perceptions of effectiveness. Changes to working patterns have been significant. Social workers have shorter careers than other, relevant professions, and the status given to their profession is lower than medicine and nursing. Adding to this is the impact of a changing and demanding inspection regime and public vitriol resulting from scandals going back decades. The possible conflict between social work values and leadership is a further consideration, particularly given the effect of radical social work theories and a prominence of collaborative practice.

Learning from Health: the example of Clinical Leadership

Professional skills and knowledge have long been recognised as the heart of health care services. Patients rely on professionals for correct diagnosis and treatment, and the quality of interaction with professionals is central to patients' experience. Our reliance on these professionals at often our most challenging and difficult times has provided a status and a trust that is largely unparalleled by other professional groups. The additional value of health care professional also acting as 'leaders' has also been recognised for some time, and indeed has been embedded in the national health service since its launch in 1948 (and before). The concept of clinical leadership was developed to reflect the wider contribution that health professionals make to the shaping and running of health care services (Stanton 2010). *Formal clinical leadership* relates to health care professionals who take on discrete management or executive roles within a health care organisation. This can involve them moving away from more hands-on roles with patients, or combining management and direct care in hybrid positions. *Informal clinical leadership* relates to the influence professionals can have on their colleagues from either similar or different disciplinary background. This peer mentoring or, indeed, challenge is recognised as making a major contribution to the standard of care provided (DH 2007, Pepin et al 2010). As a consequence, clinical leadership is seen as a basic competence for practice and not only the responsibility of professionals in formal leadership positions.

Clinical leadership in policy and practice

The founding principles of the NHS – free at the point of use, available to those who need it, paid for out of general taxation, and used responsibly – are now embedded in norms of British society. Nye Bevan's leading role in the creating the vision for such a health care system is rightly praised from across the political spectrum. Less known is the battle that was faced by the Labour government in 1948 in relation to the opposition of the medical establishment. Prior to the NHS many hospital doctors relied on private practice for the majority of their income due to relatively low salaries within public and voluntary hospitals, and general practitioners ran their own private practices. They believed that a state-run system that employed doctors would threaten their main income source. There were also concerns regarding the potential for a loss of professional autonomy through managerial and central control over what treatments

could be provided. Faced by threats of strikes by the British Medical Association, and a recognition that the NHS was doomed without the support of the health workforce, Bevan was forced into a compromise in which general practitioners could maintain their self-employed status and hospital consultants would be able to continue with private practice. This resulted in the famous reflection from Bevan that he 'stuffed their mouths with gold'. Beyond the financial settlement, doctors were also ensured clinical autonomy. Klein (2006) describes the settlement as being a bargain between the state and medical profession – the government would decide on the overall budget, but the doctors would decide on the treatment for the patient and therefore how the budget was deployed. This was summarised at the inquiry into the behaviour of consultant psychiatry at the learning disability Normansfield hospital that:

'At the inception of the NHS, the Government made clear that its intention was to provide a framework within which the health professions could provide treatment and care for patients according to their own independent professional judgement of the patients' needs. This independence has continued to be a central feature of the organisation and management of health services.' (*DSS evidence to the Normansfield Report*: 11: pg. 424-5).

This clinical autonomy translated into operational arrangements in which NHS hospitals were run by doctors with the support of administrators. As a result, power was often held by medical clinicians. Over time 'consensus' management emerged where multi-disciplinary teams (doctor, administrator, nurse) jointly shared responsibility. These arrangements could be effective, but also meant that any decision could be vetoed if one member of the team did not agree (Ham *et al*, 2011). The inquiry into the management of the NHS by Griffiths in 1983 famously assessed that 'if Florence Nightingale were carrying her lamp through the NHS today, she would be searching for the people in charge' (Griffiths, 1983). This inquiry proposed that 'consensus management' should be replaced with 'general management' to ensure there was clearer accountability for decision making (including use of resources) and improve the standard of leadership within health care organisations. Whilst sometimes overlooked, the review also recommended that hospital doctors should be encouraged to accept management responsibility for resources and strategy alongside clinical responsibilities and freedom. Service areas were to be led by triumvirate of nurse manager, business manager and clinical (medical) directors; clinical directors continued their clinical duties (albeit reduced). McKee *et al* (1999) suggest that in practice, three types of clinical directorates emerged:

- ‘traditionalist’ (focus on operations with strong clinical collegiate networks and little opportunity for change)
- ‘managerialist’ (clinical directors were better connected with senior managers and showed greater involvement and influence on the overall organisational strategy)
- and ‘power-sharing’ (clinical directors worked as a team with nurse manager and business manager and across speciality boundaries).

There was an expectation that these strengthened managers would challenge clinical views regarding the prioritisation of resources but, in reality, managers seemed to have gained little more control. Amongst others, this lack of influence was reflected in the findings of the enquiry into paediatric heart surgery at Bristol (REF) where a culture of medical autonomy led to a lack of sufficient scrutiny and challenge.

By the late 2000’s, there were concerns that reforms led by New Labour had become too absorbed with centrally driven performance management, focussing on activity and targets. The NHS *Next Stage Review* (2008) was overseen by a clinician, the surgeon Lord Darzi, and considered what long-term reform was necessary for health (and care) services in England. A major focus of this review was how to improve the quality of health care, with the report concluding that there must be a strengthening of clinical involvement in decision-making at every level of the NHS. The report envisaged that “clinicians are expected to offer leadership and, where they have the appropriate skills, take senior leadership and managerial posts in research, education and service delivery” (REF). This translated into an expectation that health care professionals should not only be practitioners, but also ‘partners’ – collaborating with other organisations as well as taking responsibility for the management of finite resources – and ‘leaders’, working with other clinicians and managers to change systems where it will benefit patients, partners and leaders. This trio of roles built on the work by the US healthcare firm Kaiser Permanente, which is owned by doctors and sees their medical clinicians as ‘healers, leaders and partners’ (REF). The Darzi report described clinical leadership as the ‘neglected element of the reforms of recent years’ (REF) and recommended a range of initiatives to strengthen the competence of and opportunities for leadership by professionals.

The Medical Leadership Competency Framework was developed by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges (2008).

Responding to the expectations of the Darzi report, it describes the leadership competences that all doctors of all disciplines require to engage in the planning, delivery and transformation of health services. It recognised that different opportunities for leadership would develop throughout a medical career and therefore expected competences to be progressively demonstrated. For example:

- At qualification level - *Demonstrating Personal Qualities* and *Working with Others* at qualification,
- Pre-consultant level - *Managing and Improving Services*
- Consultant level - *Setting Direction*

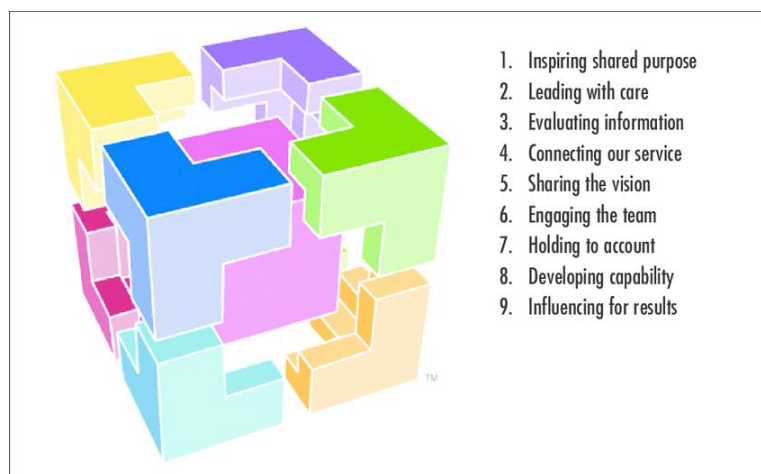
Diagram 2: Medical Leadership Competency Framework (NHSIII & AMRC 2008)



The Medical Leadership Competency Framework) complemented the NHS Leadership Qualities Framework (NHSIII 2006) produced as the benchmark for senior managerial leaders. These have subsequently been super ceded by generic frameworks which seek to accommodate both clinical and managerial roles, and formal and informal leaders (for example the NHS Leadership Framework (NHSLA 2011) and the NHS Healthcare Leadership Model (NHSLA 2013). Professional standards have placed increasing emphasis on the leadership competences both at qualification and at higher levels of clinical practice (Box 1) Reflecting the move towards more integrated care, these not only expect leadership across the same

profession but also an influencing role with those from different professions and disciplines. Teams are recognised as a central vehicle for delivery of single and multi-professional working and therefore important forums for leadership to be demonstrated. The GMC notes that initially post-qualification doctors will often act as followers rather than leaders, and this inclusion underlines that good followership also requires informed activity.

Diagram 3: NHS Healthcare Leadership Model (NHSLA 2013)



Box 1: Examples of leadership in healthcare professional standards

NMC 2018: All nurses must act as change agents and provide leadership through quality improvement and service development to enhance people's wellbeing and experiences of healthcare....work independently as well as in teams. They must be able to take the lead in coordinating, delegating and supervising care safely, managing risk and remaining accountable for the care given....work effectively across professional and agency boundaries, actively involving and respecting others' contributions to integrated person-centred care.

GMC 2018: Newly qualified doctors must recognise the role of doctors in contributing to the management and leadership of the health service. They must be able to: describe the principles of how to build teams and maintain effective team work and interpersonal relationships with a clear shared

purpose; undertake various team roles including, where appropriate, demonstrating leadership and the ability to accept and support leadership by others; identify the impact of their behaviour on others; describe theoretical models of leadership and management that may be applied to practice.

HEE (2017) Advanced clinical practitioners should be able to - Pro-actively initiate and develop effective relationships, fostering clarity of roles within teams...lead new practice and service redesign solutions in response to feedback, evaluation and need, working across boundaries and broadening sphere of influence.

Wider NHS reforms have reflected this interest in formal and informal clinical leadership. NHS Foundation Trusts must have Nursing and Medical Directors on their Boards and staff on their board of governors. Transforming community services (DH 2011) placed great emphasis on mutual models as means to encourage engagement by health professionals in the improvement of community health services. Clinical commissioning groups (CCGs) are membership organisations for general practitioners with a mantra of 'clinical perspective in everything it does, with quality at its heart' (NHS Commissioning Board 2012). CCG Boards not only include general practitioners, but must also have independent nurse and secondary care doctor members. Despite the emphasis on clinicians being at the heart of governance and delivery, the Francis Inquiry (2013) regarding the tragic failures in care at Mid-Staffordshire hospital discovered a health care organisation that was far removed from the quality focussed culture envisaged by Darzi. – 'as a result of poor leadership and staffing policies, a completely inadequate standard of nursing was offered on some wards in Stafford...poor leadership, recruitment and training.. led in turn to a declining professionalism and a tolerance of poor standards' (Francis 2013, P45). The Inquiry recommended a strengthening of leadership at all levels of the NHS and this include informal and formal clinical leadership. Good leadership was defined to include visibility, listening, understanding, cross-boundary thinking, challenging, probity, openness and courage. Principal among these was "the ability to create and communicate vision and strategy" (Francis 2013).

Learning for social work

Sustained investment and career paths are required

From the brief overview above, it is clear that the NHS (and indeed many healthcare services internationally) has invested hope, time and funding in the contribution of clinical leadership. Despite this investment, it appears that there is still some way to go before the vision of a context that consistently encourages such leadership and a professional workforce that has the competence to respond to this context. The Francis Inquiry (2013) is not the only recent review of the NHS to highlight fundamental weaknesses in leadership. For example, the Kings Fund commission reported that ‘one of the biggest weaknesses of the NHS has been its failure to engage clinicians – particularly, but not only doctors – in a sustained way in management and leadership. Individuals within the service, and its providers, need to be given both the ability and the confidence to challenge poor practice. Management and leadership needs to be shared between managers and clinicians and equally valued by both’ (Ham et al 2011 p.ix). This report found that clinicians who became chief executives saw themselves as ‘keen amateurs’ who had learnt (or not) on the job (Ham et al 2011). A recent review, by Lord Rose in 2015, came to similarly challenging conclusions in relation to the overall standard of leadership – ‘some see the NHS, both internally and externally, as full of people making excuses for poor care, passing the buck and shrugging off responsibility. Some people remain afraid to raise concerns fearing that either nothing will happen or that if something does there will be a negative consequence to it’. (p22). In relation to clinical leadership in particular, the Rose Review was clear that there was still insufficient focus in training on how professionals could contribute to the overall working of the NHS, and that there was a lack of career structure for those who wanted to follow the path of formal leadership roles. Those that do follow formal leadership careers commonly experience a sense of being in a ‘no man’s land’ between management and clinicians (Marnoch et al, 2000) and becoming separated from their peers (sometimes articulated as having ‘defected to the dark side’). Doctors may also be less financially rewarded than those who follow some clinical speciality roles, and enjoy less prestige than achieving academic success. More practical issues, such as how to fulfil the demands of clinical and formal leadership roles also restrict their ability to achieve both to a high standard (Dickinson et al 2013).

Lesson for social work: social work leadership will require sustained investment in learning from pre-qualification to advanced practitioner, the establishment of career routes, opportunity for social workers to remain as practitioners but earn more?

Despite investment it is hard to evidence positive impacts

Inquiries regarding failures in patient care often highlight that a lack of a clinical leadership has contributed to an unhelpful or, indeed, toxic culture where professionals were not working together in the best interests of people and communities. Clinical leadership can, in some ways, therefore be described as a 'hygiene' factor in the delivery of quality services, and its potential to be a negative force (*i.e.*, for charismatic but poor clinicians to have a destructive influence) seems clear. Evidence reviews of the impact of formal clinical leadership suggest whilst there is still much to be researched, there are indications that it can lead to improvements in both patient outcomes and organisational performance. For example, Sarto and Veronesi (2016), state: "the findings show a positive impact of clinical leadership on different types of outcome measures, with only a handful of studies highlighting a negative impact on financial and social performance. Therefore, this review lends support to the prevalent move across health systems towards increasing the presence of clinicians in leadership positions in healthcare organisations" (p85). Such positive indications do need to be balanced with a recognition that more research is required. Clay-Williams et al (2017) report that "There is a modest body of evidence supporting the importance of including doctors in the composition of hospital or organisational governing boards. Despite a large volume of published literature on the topic of whether hospitals and healthcare organisations perform better when led by doctors, however, there are few studies that have examined this topic in a robust way or directly compared the performance of medical and non-medical managers" p10

Lessons for social work: a need to be realistic about the impact whilst recognising that a lack of leadership contributes to poor care.

Leadership is now seen as an essential contribution of all health care professions, as is the importance of an inter-professional approach to respond to the needs of patients with complex needs and underlying determinants of health inequalities. Despite these aspirations there is no doubt that doctors continue to hold a particular status within healthcare that is unrivalled by other professionals. So much so in fact, that the terms 'clinical leadership' is sometimes used to refer to those from any professional background but often is assumed to refer to leadership by doctors. In their study of health care leadership, Dickinson et al 2013 reported that "Triumvirates exist on paper in most sites but in reality the duality of medical leader and general manager is perceived to be more important." (p16). There are both positive and more pragmatic reasons for engaging doctors in leadership. As highly qualified professionals who engage with patients and their families throughout their careers, they have practical experience, practice wisdom, and current knowledge of the day-to-day lives of people. On a more pragmatic note, doctors continue to hold considerable power within health care and it has extremely difficult (if not impossible) to introduce change without their support. Three factors appear to influence doctors supporting or seeking to prevent a change: will it impact on goals that they care about and, in particular, within their own clinical area; will it impact on their status or identity; and the political dynamics between those suggesting the reform and those who are sceptical (Nigam & Gao 2017). It is important to note that whilst doctors are often seen as the highest status leaders, other tensions exist. It is common for nurses to be the predominant profession numerically, and they also have a place on boards of providers and commissioners. This can result in allied health professionals such as therapists and pharmacists feeling dominated by a nursing influence.

Alongside these differences between healthcare professions are the continued difficulties regarding the relationship between management and clinician leaders. The tensions evident at the birth of the NHS regarding appear to still be present today. For example, Nicol (2012) highlights that despite a shared interest between clinicians and managers in the quality of healthcare they can begin at different points through a 'gulf in language and culture that exists between these two groups.' (Nicol 2012, p61). The Rose leadership review found that whilst cohesive relationships between managers and clinicians existed in well performing trusts, this was not the case in those who

were not doing well. ‘Despite the importance of clinical leadership, a gulf remains between clinicians and managers; it can be hard to get clinicians to sit around a table and be accountable for the organisation as a whole.’ (Rose 2015 P47). Nicol et al 2014 suggest though that the future cadre of doctors have a greater understanding of their role as organisational and system leaders which should enable more constructive relations with managers and politicians.

Lessons for social work: as the predominant profession in social care there is a danger that as social work develops its voice as a leader that it drowns out other professions such as occupational therapy and roles that are not formal professions as such. Management, and indeed political leadership, needs to interact positively with social work leadership.

Professional leadership can crowd out the perspectives of people and communities

Medical dominance has been observed not only in relation to health care colleagues but also in relation to the behaviour of their patients and the cultural assumptions held by society and its politicians. Whilst not as powerful as doctors, the other professions have considerable standing due to their expertise and role as health care providers which can result in their perspectives being more influential than that of people and the communities (Tenbensen 2005). Berwick (2016) describes the traditional relationship between healthcare professional and patient as being ‘era 1’, with governments attempting to reduce their autonomy through scrutiny, incentives and markets (era 2). This too was destructive by generating conflict rather than collaboration between stakeholders and largely reducing rather than increasing the voice of people and communities. He calls instead for ‘era 3’, which rejects ‘the protectionism of Era 1 and the reductionism of Era 2’ (p1329). This will involve a shift from professional ‘prerogative’ to ‘citizenship’, and moving from ‘what is the matter with you’ to ‘what matters to you’? This emphasis is also reflected in English health care policy. For example the NHS Five Year Forward View sets out a commitment to ‘engage communities and citizens in new ways, involving them directly in decisions about the future of health and care services.’

Translating this commitment to co-production of health services has still some way to go before it becomes commonplace. Research highlights that despite the recognition of the important contribution that patients can and should make to the design and

delivery of services this is far from the norm (Sharma & Grumbach 2017). Good practices do exist but as a group of 'change champions' involved in several of these reflected – “conversations revert easily to professional-centric priorities and professionals slip into providing healthcare service as a product—a quantum of advice, a package of evaluation and management” (Batalden et al 2015, p515). Alongside the shifting of professional paradigms to one which values the expertise of people alongside that of clinical judgement it will require investment in patient leadership including their training and development, installing robust feedback mechanisms that ensure that organisations listen, and developing an organisational culture of improvement (McNally et al 2015).

Discussion

The social work profession in England is then located in a complex, shifting and pressured environment. Despite arguably a greater need than ever for its skills and values it is a profession that struggles to recruit, retain and motivate its members. The importance of leadership in social work is recognised with underpinning models being adapted from other sectors. Evidence regarding their relevance, implementation, and impact in the field social work is though limited. Research focussed on an English context in particular is even sparser. The variety of models described in the opening section suggests a lack of a focussed leadership model that is adopted by the profession, in particular when considering practice knowledge and advanced practitioner status. This contrasts with a stronger conceptualisation and sustained interest within health care regarding the role of clinical leaders. Despite such investment, there continues to be challenges in health with consistent engagement of professions as formal and informal leaders, evidencing the positive contribution that clinical leadership can make, ensuring that all professionals are equally respected, and that the views of patients are not drowned out of the discussion. Healthcare therefore provides not only learning for social work but also questions to which social work may have the answer.

The mechanism of social work leadership oversight can be represented as a cycle of situations with leadership not receiving the attention that it does in other professions, and the below figure and sections outline the elements:

Diagram 4: A cycle of 'missing' leadership



Social work leadership needs a clear definition and relevant models of practice. Distributed, adaptive and collaborative leadership models would all seem to have some accord with underpinning social work values. These could potentially be combined with learning from clinical leadership models in healthcare to develop bespoke social work frameworks and approaches. In relation to a definition, this again needs to build on the distinct principles and purpose of social work, and to be relevant to social work in all the fields in which it is practiced:

Social work leadership: the use of professional credibility, competence and connections to positively influence others in response to the interests and aspirations of people and families. Achieved through coproduction with communities, collaboration with other professionals, and constructive conflict of

injustice and inequality, it can be demonstrated through formal roles and informal encouragement of colleagues.

Issue 1: are social work values in conflict with leadership?

Firstly, the concern that social work values are antithetical to leadership is a narrative that is widely understood, if not universally agreed, within the profession. This concern is not shared with the same fervour in nursing, arguably one of the closer of the healthcare professions to social work (it is also considered one of the 'helping professions'). These texts do not spend space considering whether nursing values are compatible with leadership attributes (*cf* Scully, 2015; Tomey, 2009). It goes without thinking that medical leadership texts do not expend space considering this. The concern about compatibility, therefore, is likely to be particular challenge with engaging with leadership. Going back to the origins of the nursing profession (Nightingale, 1858) there have been indications that leadership was an accepted element of nursing practice.

Issue 2. Is there sufficient engagement of academics in social work leadership?

The lack of a robust empirical foundation is a particular challenge for social work leadership (Hafford-Letchfield *et al*, 2014), with calls to improve this, even in the American context (Fisher, 2009; Perlmutter, 2006). Developing the knowledge base about social work leadership will help address concerns of knowledge being applied from outside social work (with the associated lack of social work values). It is important to note that other related professions have decades, if not a century, of knowledge to utilise. Similarly, there is a lack of leadership topics and training in social work education (Colby Peters, 2017), which does not assist with addressing the profession's oversight. The combination of the lack of an empirical base, and missing pedagogical content can be connected to other elements of social work practice, such as the inability to professionally advance without moving into management (Munro, 2011), and a lack of 'clinical leaders' to drive up standards. The

Issue 3. Is social work professional leadership supported by senior managers and elected members or seen as a threat to efficient local authority bureaucracies?

Social work in modern organisations, with their funding issues and increases in demand, require thought leadership to provide responses that address these modern challenges. These complications require leadership from within the profession, presenting solutions that promote social work values, in order for them to be grasped by social workers on a wide scale. It can be questioned, however if strong professional voices can align well with the election necessities for local councillors and the need to achieve organisational necessities for savings that are not in the interests of vulnerable people and communities. The experience from health is that clinical engagement is seen as an important aspect of transformation programmes through the professional insights and direct contact with individuals regarding their health and wellbeing. That said, the power of doctors in particular to block developments also leads to more transactional motivations to enlist their support.

Issue 4. Can social work combine strong professional leadership with an emphasis on co-production with people and communities?

Social work has a contribution to make to leadership, however, by drawing on its strong tradition and passion for service user empowerment and involvement. Social work programmes have had a longer, and more robust, connection with service users and carers than healthcare professions. This involvement is more involved than most of the PPI (patient and public involvement) programmes used in NHS organisations and healthcare professional programmes. This involvement, whilst still not perfect, includes service user contributions in a wide range of education settings, with some universities ensuring it is in every module, and every area of the programme (e.g., admissions, teaching, marking, employability). There are well-established areas of social work knowledge that consider how to approach and improve this involvement in both education (McLaughlin *et al*, 2018; Robinson & Webber, 2012) and practice (Beresford and Croft, 2004; Kemshall and Littlechild, 2000). This highly developed area of knowledge and practice is an important contribution that social work can make to conceptualisations of leadership for health and social care. An example could be developing the *citizen leadership* concept (see Beresford and Croft, 1993), which is gaining some traction in healthcare (*cf* Doherty and Mendenhall, 2006). Social work has an important tradition of applying the *strengths perspective* (Saleebey, 1992) in

many areas of practice, which can be used to address concerns of a paternalistic approach to care and has been included in the underpinning ideas of the *asset-based approach* (Skills for Care, 2014) an approach that is being implemented in many adults social care departments.

Conclusion

Continued austerity, growing inequalities and new threats to community cohesion mean that a confident and consistent social work contribution is more urgent than ever. New forms of integrated care are being considered in England and elsewhere which require the insights and challenge of social work to complement the skills and resources of health care professionals. Many of these integrated models are based on principles of strengths based approaches, of which social work and the wider social care community are at the forefront of thinking and practical development (SCIE et al 2018b). Leadership has a vital role in achieving this contribution through strengthening professional practice and shaping the cultures of its teams and services. Social work leadership must therefore be embraced by the profession, by its organisations, by its regulators and by its academics. A consistent definition, models of practice, and development opportunities throughout professional careers are the building blocks for success.

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