Chapter

1 The Heart of the Matter

Real national unity sprang from the things which we had in common; the greater that common interest, the stronger the nation in peace as well as in war.

(Clement Attlee, 1941)

Between 1946 and 1948 the UK's 'social contract' was transformed. A programme of legislation ushered in what has come to be known as our Welfare State. The country was emerging from a long, bloody and destructive war. The population was facing daunting psychological, social and economic challenges and was desperate for change. The new laws were a paradigm shift: a radical change in the funding and organisation of health and social care and the support of those in need.

For centuries, poverty and hardship had been dealt with under the Poor Law. These laws dated back to Tudor times, but had been reinvented in 1834, with the setting-up of the dreaded 'workhouses'. Further reform gathered pace in the early twentieth century, with a range of liberal welfare laws, and the development of friendly societies and trades unions. These reduced the risks of penury, neglect, suffering and death for the poor, disabled, old and sick. But importantly, help was still haphazard and stigmatised. And fear of the workhouse cast a long shadow.

The wartime coalition government of 1941 had set up an inter-departmental committee to review Britain's health, social insurance and allied services, as a way of boosting morale and the war effort. Its report, written by the economist William Beveridge, was probably the most widely read government report of all time and has been referred to by his name ever since. It famously identified five Giant Evils in society: squalor, ignorance, want, idleness and disease (Beveridge, 1942). In 1945 the Labour party won the post-war election on a platform that promised to address these Evils. Clement Attlee's new government then began the work that led to the NHS and the modern Welfare State.

Three laws – the National Insurance Act (1946), the National Health Service Act (1946) and the National Assistance Act (1948) – embodied a radical new approach to organising care. The people of the nation took on formal responsibility for the welfare of each other. We all now *shared* the risks of accident and illness, of unemployment, disability, dependency and poverty. In giving new responsibilities and powers to government, we took on, collectively, the challenges of identifying need, developing strategy,

allocating resources within limited budgets, and organising and deploying staff and services to deliver on our behalf.

This was more than an expression of *duty*, more than the embodiment of a moral obligation. True, the aftermath of war, with the death, injury, loss, social disruption, need and expectation of a populace that had in so many ways risen at great cost to do its duty, meant that we owed each other mightily. Those 'in power' embodied – and no doubt many of them felt – that obligation. But perhaps war had reinforced something else. Perhaps we were ready to accept that we needed each other, that the welfare of the one depended on the welfare of all. Perhaps, however dimly, we recognised that investing our resources through taxation and national insurance into the work of promoting universal welfare was in everyone's interests. The introduction of the Welfare State can be seen as a remarkable expression of *kinship*, an idea we will explore in some detail in this book. And it continues to be a project – far from perfect – that invites society to attend to, and value, its deepest interests and connectedness.

There is always a but. This fine idea, this commitment to fostering the health, happiness and wellbeing of the national family, had to be *implemented*. This 'best laid plan' required decisions about how much and whom to tax, how much to invest in national welfare, how much to pay to those in need. We had to decide just how to organise and deliver the financial benefits, healthcare and social services involved. Having a wonderful vision is not enough: the devil lurks in both the overall translation of that vision into reality, and in the complex detail of the systems and practices involved. The arrangements made have time and again been deemed to be failing, insufficient, inefficient or outdated. They have been changed, or 'reformed', with varying degrees of honesty, intelligence and sensitivity, at least as often as governments themselves have changed.

Moreover, the nature of society itself has changed: slowly at first, and then with increasing pace. Longevity has increased, partly as a result of the efforts of the Welfare State itself. Along with this have come previously unimaginable increases in chronic conditions. At the same time, scientific progress has made effective treatment of once thought incurable illness possible. All this means the costs and complexity of care, in all its forms, have escalated.

Social inequality, having initially lessened, has risen massively, between geographical regions, but also within individual communities, along with increased social fragmentation, isolation and division. As the nature of the UK economy has changed, partly through the effects of globalisation, so the nature and availability of work has changed. Economic crises, such as the financial crash of 2008, have disrupted confidence, will and investment. Technical developments, business activity, advertising and consumerism have raised citizens' expectations, and thus the cost of living 'satisfying' lives. Social media, while facilitating connections between people across the globe, have led to fragmented communities of the like-minded, to increased hostility between differing groups, and to overt and covert manipulation of participants.

Partly as a result of these wider changes in society, there have been enormous increases in mental health difficulties, child abuse and family breakdown. The number of children taken into care has risen steeply. Alcohol and drug abuse, and its effects, have steadily escalated. In some parts of the country unemployment

and its effects have scarred whole communities for years. At the same time in-work poverty has also become a problem. The Welfare State has become a big part of British family life. In 2013, 20.3 million families were receiving some kind of benefit (64 per cent of all families), about 8.7 million of them pensioners (*The Observer*, 2013). Homelessness – perhaps the most visible barometer of the welfare of a society – grew significantly in the 1980s and 1990s, with significant numbers of women and families living on the streets for the first time in decades. The sharp decrease in public spending during the government's 'austerity' programme from 2010 made a further impact. Homelessness in the second decade of the twenty-first century is so prevalent that some worry it has become institutionalised; a row of people huddled in sleeping bags outside expensive department stores – some of them very young, some of them employed – an unquestioned fact of life.

For a long time, British social attitudes to people in need have been, to say the least, ambivalent. The benign – and, as we will argue, vital – recognition of the importance of investing in the welfare of all has wobbled on rough seas of public opinion, scepticism and political ideology. Certain sections of the press regularly turn out stories about 'scroungers' and 'benefit cheats', feeding the notion of the 'undeserving poor'. Should 'dependency' be encouraged, or people left 'to create their own destinies'? What levels of need justify public help, and what should be expected instead from families, neighbours and communities? Are there indeed 'deserving' and 'undeserving' people?

Should the state deliver all, most, or nothing of what such people need, or should a mixed economy within an allegedly trustworthy and benign ecosystem of market forces be promoted? Is taxation a 'rip off' of 'hardworking individuals', an inhibitor of business creativity, or a civilised way for us all to contribute to what society needs? Should we invest as much per capita in health and social care as other developed nations? How do we guarantee that our money is being spent wisely, efficiently, effectively and safely?

All along the way of course, we have had to contend with other, less appealing, human realities. Greed and competition for resources, the will to possess and dominate, and to reject or exclude, have always disturbed our productive cooperative relationships. People have broken the rules, been lazy, aggressive, and pursued their own interests, at all levels of society.

We need to accept from the start that no approach is perfect. Individuals do have to face limits on what the state, husbanding limited resources on our joint behalf, will and can fund – whether it be new drugs, benefits or more staffing. A universal, comprehensive system requires steering, commissioning, regulating and managing on a grand scale. The system can foster unhelpful dependency and a lack of personal responsibility. Citizens, including public servants, can develop a sense of passive (and sometimes aggressive) entitlement to services or ways of working.

Priorities are often hard to agree upon, and even harder to reconcile locally. They can be skewed by public panic, the interest groups who shout loudest, ideas about most (and least) deserving groups, media campaigns, stigma and denial. Our public investment in health, social care and welfare can be vulnerable to wider events – war, recession, crime and the costs of other public priorities such as leaving the European Community.

Even those in tune with the values underpinning the Welfare State question whether it is possible to adapt the system to the nature of modern society. Critics such as Hilary Cottam argue that its institutions and services reflect the era of mass production in which

they were designed and suggest there is a fundamental lack of fit with twenty-first century issues. Like many others, she despairs of the relentless attempts to 'fix' the Welfare State, believing that it is the underlying philosophy of the system that is the problem.

> *While we focus narrowly on how to patch and mend our post-war welfare institutions our attention is diverted from the bigger social shifts and transitions that are taking place. The world that surrounds our welfare systems is very different. When we ask our questions and start our innovations from within – standing inside the institution and wondering how they can be fixed – we miss the mismatch between what is on offer and what help is required. And crucially, we also overlook the potential that surrounds us: the new ideas, resources, inventions and energy that we could bring to the problems at hand.* (Cottam, 2018, p. 28)

Where Now?

The approach in this book is both practical and pragmatic. We are where we are, and, to be frank, the problems being so immense, it is not where we would want to start from. Nonetheless, we believe that the NHS is the best way of providing professional healthcare for all, and that collectively investing in financial support and social care for those in difficulty is in everyone's interests. Whilst we would concur with many of the criticisms of the Welfare State from Cottam and others, we also know – and indeed have experience of – centres of excellence, and services within state-funded health and social care that encourage constant improvement, welcome new ideas, inspire creativity and energise both staff and service-users.

In short, we believe that the Welfare State, despite its many flaws, is the best and most practical way to go about securing the health of a civilised society: and that making this model work well should be a priority for us all. Politicians should be articulating this clearly and powerfully to the people, and we the people should in turn be campaigning for it.

Facing and struggling with the inevitable complexities and shortcomings in its delivery has to be worth it. The NHS, in particular, despite it being commonly agreed to be at crisis point, was still, in 2018, the most valued institution in the UK, a prime element of our social capital, with 61 per cent of us happy to increase our taxes to pay for it (National Centre for Social Research, 2018).

It is, however, of concern that so little attention has been given to understanding and promoting what we see as central to the Welfare State: its embodiment of kinship. There seems to be a failure to understand and value it, a paucity of positive rhetoric, a lack of pride, a loss of historical narrative. This becomes more pressing as the generation who are old enough to remember the hardships and anxiety before the Welfare State was part of our landscape are no longer with us. Programmes of reform are more likely to be effective if we are able, as a society, to reconnect to, and so rehabilitate, the idea that pooling resources and sharing responsibility for each other can be good for everyone.

One important aspect of this kinship is its expression in the compassionate relationship between skilled practitioners and the people they are trying to help. To fail to attend to the promotion of kinship, connectedness and kindness between staff and those they assist is to fail to address a key dimension of what makes people do well for others. Such failures can sometimes be no more than minor irritations, but they can also lead to appalling systemic abuses, neglect and maltreatment.

This dark reality is evidenced in the reports of a succession of inquiries. These have covered shortcomings and abuse in the care of the elderly, people with intellectual disabilities, and in several acute healthcare trusts, child protection and residential care. Such scandals raise disturbing questions in the public mind about how compassion can fail. But, disappointingly, these questions receive far less attention than they deserve when subsequent corrective action is taken.

As well as prompting concern about the nature of care, sagas of abuse and neglect trigger doubts about the whole enterprise of the Welfare State. Of course, abuse and neglect can, and do, occur in all health and social care systems, both public and private, and in all parts of the world. Our exploration in this book seeks to shed light on some of the factors leading to such failures, in our particular time and place. More importantly, we hope to illustrate how such failures may be minimised, and how services can be helped to achieve what our commitment to them deserves.

Ideas to Guide Us

The dictionary definition of 'rehabilitation' includes both 'the action of restoring to health' and 'the action of restoring someone to former privilege or reputation after a period of disfavour'. Both are needed. Since the 1970s, the very idea of the Welfare State has been denigrated, with its champions easily appearing apologetic and defensive, and impractically idealistic. Meanwhile, those ideologically opposed to the underlying concept of socially funded health and welfare simply cut funding and disparage the services. As neglect becomes more common, services deteriorate and highly trained staff choose to leave.

As to kindness: kindness is generated by a thought and felt understanding that self-interest and the interests of others are bound together. In professional roles, we have a range of knowledge, skills and tools. When we work with intelligent kindness, we intervene with an understanding of the likely meaning, effects and value of what we do for the other as a person.

When the way we relate to the other is shaped by such intelligent kindness, the quality of their experience, the effectiveness of our intervention and the efficiency of our efforts are all improved. We will lay out evidence for this argument, examining ideas relating to the challenges for the individual, the team, the wider system and society when they try to make this real.

If we were to apply this understanding to the way things are run, we believe that our public hopes and expectations for the service would be far more likely to be met. It may be unavoidable that we have, some of the time, to consider and frame what we do in a transactional, commodified, industrial and value-for-money perspective. But we will argue that it is dangerous to undervalue attention to ways in which the work is a commitment to the skilled and effective expression of fellow feeling and kindness. Neglecting this will lead to waste and poor performance, to low morale and poor service-user satisfaction, to continued shameful abuses. The loss of valuable staff will continue.

The great majority of people who choose to train and practice in health professions, social work and wider social care do so with at least some such fellow feeling. Everyone has received help from another. Everyone knows, on some level, that the value and effectiveness of such help, however technical or practical, has depended on the capacity of the helper to connect with the other personally. Everyone knows that help, whatever else

it involves, is fundamentally *relational* and that good results emerge from the quality of the *collaboration* between the helpers and the people helped.

Intelligent kindness begins with deliberately directing our attention to connecting with the other person. It then involves allowing their needs, experience and personality to influence us, to prompt our imagination and knowledge to shape a response that will help and reduce suffering. To undertake this task, we must be alert to, and manage, feelings that distract us, that push us away from responding kindly, even that tend towards unkindness or cruelty. We must also look after ourselves and our colleagues.

Perhaps reassuringly, many readers will see what we have to say as just common sense. Conductors and theatre directors, sports managers, coaches and psychologists all recognise the crucial 'edge' given by addressing the psychology of the individual and the group. They practise, rehearse, analyse their players' collaboration, and work to promote confidence and intuitive teamwork. More broadly, sports pages, theatre and music reviews all recognise as crucial the issues of attitude, commitment, morale and the mutual attunement of players. When the 'giant killers' in football, Leicester City, rose to win the Premiership in 2016, Leicester developed into a city of excited football analysts. The success of the team became the focus of conversation in pubs and corner shops. Everyone competed to explain how the club led the field in committing resources and skill to the health, fitness and psychology of their team. Where are the conversations that show similar understanding and passion when it comes to the services that meet our deepest needs?

During the men's football World Cup in 2018, Gareth Southgate, England's new manager, rapidly became a hero, admired for his emotional intelligence and his understanding of his team, both as individuals and as a unit. One of the many stories around was his decision that they spend a week with a group of Royal Marines, knowing that the training of our armed forces is particularly focussed on fostering strong relationships. The team spoke warmly of what they had learnt from this experience, even the fact that mobile phones were expected to be turned off at meal-times, and conversation encouraged! If only the same amount of attention was paid to these matters across health and social care.

Human beings have great capacity for kindness, but also for destructiveness and violence. This book is not about sentimental 'niceness' or simple altruism. When we speak of people acting with intelligent kindness, we expressly do not mean that they feel only warmth and goodwill towards another. Life is, of course, a great deal easier when we feel nothing but kindness for another person. But all of us can be tired, selfish or impatient. We all have competing and conflicting motives and priorities. All of us have darker feelings. Any politician or other leader who strives to create a vision of national wellbeing, whether it be the 'Big Society', the 'Good Society' or a rejuvenated Welfare State, will need to apply their intelligence, and adequate resources, to managing potentially destructive feelings and processes, at the same time as encouraging enthusiasm for the idea.

Particularly when undertaking complex, emotionally-laden human work, simply requiring people to be compassionate and effective will have little effect unless the systems, and the culture, within which they work, are organised and managed in ways that support the humanity of their members, their relationships with each other and the people they aim to help. Staff at the front-line work within teams, institutions and

cultures that will either support or undermine them as human beings, as intelligent practitioners.

At times we will talk about 'genuine' or 'authentic' kindness. By this, we mean, a spontaneous, informed, improvisation arising from the particular nature and circumstances of the person one is with. This is not the same as the barista in the coffee shop automatically asking everyone she serves if they've had a nice day, because that's what the firm have taught, indeed ordered her to do, with 'mystery shoppers' ensuring she complies. True kindness involves a sense of agency.

Nevertheless, the difference between authentic and inauthentic kindness is far from clear-cut. Acting kindly while feeling reluctant or resentful is no bad thing in itself – indeed, it can be valuable hard work. But if it becomes mechanical or habitual rather than guided by an awareness of the other person, this is another matter.

There is a substantial body of knowledge to illuminate what kindness is, and what managing to be kind is about. This knowledge relates to the attitudes and behaviour of individuals, to teams and groups, to organisations and to society. It also illuminates our understanding of why things go wrong, of why people behave unkindly; and also what conditions promote kindness and effective action to restore wellbeing. It shows direct links between kindness, effectiveness and positive outcomes. It suggests virtuous circles that affect the recipient of help, the worker and the organisation.

The Task in Hand

Let's say we put a fraction of the effort that has gone into organising, regulating and industrialising public services into cultivating what helps and hinders this sort of way of working. It would have enormous impact on effectiveness and efficiency as well as on staff morale and the experience of the people receiving services.

We are not suggesting yet another evangelistic 'national programme'. Nor are we proposing some sentimental crusade. We do not advocate a 'technology of kindness'. But what if this body of knowledge were to be used to develop our understanding about how to reform, improve and ensure the quality and value for money of our services? What if we understood better how to bring out, nurture and protect kindness and its related attentiveness to what others need? What if people were educated, trained and supported in bringing this understanding into practice, whether as policy makers, managers or practitioners? And here's a radical thought: what if all aspects of the Welfare State – skills, technologies, procedures, research, where money is spent, how people are recruited and managed – were considered through the lens of intelligent kindness?

This book is an experiment with this approach. We hope to help those who work in the Welfare State to consider how to manage themselves, as they labour on society's behalf in stressful, anxious, often traumatic situations. We will offer ideas to help them think about how to integrate the technical aspects of their task with sensitive and skilled relational practice. The book addresses and attempts to help policy and opinion makers, leaders and educators come to grips with what will genuinely improve services. People who are patients or service-users, especially those active in trying to influence the system, may find some or all of our observations helpful. However, all of us who live in, and rely upon, the Welfare State need to think about and reconsider its value, and how we can nurture it. This book is for everyone who cares about that.

We, the authors, have worked in the NHS and in social care for many years. We have cared for people, supervised and trained staff, managed budgets, delivered savings and reshaped services. We have developed strategy and managed change. We have made mistakes in our work, and also done things we are proud of. We have been patients, needing care from many parts of the healthcare system at different times in our lives. We have supported children, friends and elderly relatives through health and social care at times of vulnerability, illness and dying. These experiences have been of variable quality – sometimes apparently due to 'the system' and sometimes because of the attitudes and skills of staff. It has often been difficult to tell the difference.

We have found the work gruelling and gratifying, enriching and draining; deeply satisfying but raising profound questions about our humanity; a treasured privilege that comes at a cost. Like millions of others, we have tired of the frequent 'reforms' and ever-increasing entanglement with bureaucracy. Like thousands of others we have had to struggle with disillusion and cynicism whilst also being aware of the dangers of idealising the past. As our frustration has grown, so has our conviction that there must be a better way of organising things, a way that brings out the best in people, a way that connects us to each other and to the inspired vision that prompted the formation of the Welfare State.

There have been times in history when kinship could be taken for granted. At other times it has been under threat, and needed attending to. Often it has only reasserted itself after traumatic disruption: it is as if, without such disruption, people may have grown complacent. There are enough indicators that the Welfare State – indeed the UK's broader social contract – is currently under serious threat, for us to want to put forward arguments that might contribute to its rescue, its 'rehabilitation'. We hope that all readers, whoever you may be, will be prompted to think more about what is really needed to ensure the vision of 1948 is realised in the face of new and increasing challenges, and how we can all re-discover a sense of kinship. This is the heart of the matter. Now we need to think more about kindness.

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