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Ideas that change
health and care

The practice of collaborative leadership

Across health and care services

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Contents

Key messages

- Over the past 50 years, there has been no shortage of guidance describing how to structure cross-sector collaborations to improve health and care outcomes. Far less has been published about the behaviours, skills and leadership practices needed for health and care organisations to collaborate well. This report addresses this gap.

- Collaborative leadership actively promotes the need for leaders to switch from a focus solely on individual sovereignty to one of shared stewardship. In this report, we define a collaborative leader as someone who can create a safe, inclusive and trusting environment in which all can contribute fully and openly to achieving an agreed shared goal.

- Integrated care systems (ICSs) provide an organising framework to formally support collaborative leadership. However, promoting shared stewardship at the same time as retaining your own organisational leadership role will not be easy, especially after years of government policies in England promoting organisational independence and autonomy.

- Persuading others to participate and engage in collaborative working requires leaders themselves to practise and encourage collaborative behaviours. But this is insufficient on its own. Leaders also need to pay attention to six key areas of practice for effective collaborative leadership. These are:

  - creating a safe, inclusive and trusting environment in which everyone can contribute fully
  - building healthy relationships between all the parties involved
  - developing a shared purpose and shared group identity
  - actively managing power dynamics to enable the sharing of power
  - surfacing and managing any conflict quickly and fairly
  - promoting shared decision-making processes.

- More attention also needs to be given to developing staff across health and care organisations in the practice of collaboration. This style of working is hard and different from what has gone before.

1 ② ③ ④

1 Introduction

The traditional way of operating a health system, where you have your hospitals and your primary care and your social care separate… is not a system that works in a world where people are living a long time with multiple health conditions… Joining up the different parts is an imperative, both for improving health outcomes and for having a sustainable, affordable health and care system…

(Helen Whately MP, Minister of State for Social Care)

Across health and care in England, organisations are being encouraged and cajoled to work together to deliver more joined-up care for people (**NHS England 2023**). The need to join up different parts of the NHS and invest in cross-sector collaborations to improve health and care outcomes has long been recognised, and over the past 50 years in the UK there has been no shortage of guidance describing how to govern such partnerships (**Department of Health and Social Care 2021**; *Health and Social Care Act 2012*; **Department of Health 2011**; **Department of Health 2006**; Department of Health 1998; Department of Health and Social Security 1976). But little has been published on the behaviours, skills and leadership practices needed for health and care organisations to collaborate well.

Since the Covid-19 pandemic, there has been a greater urgency than before for health and care organisations to work together more effectively. The health and care workforce are tired and there are chronic staff shortages in many areas (**House of Commons Health and Social Care Committee 2021**). Also, the number of people with long-term diseases and co-morbidities (more than one disease or health condition) continues to increase, and many are experiencing difficulties accessing treatment and care (**Baker 2023**). Many of these problems are beyond the reach of existing institutions working alone – they require organisations and different sectors to collaborate. The current model of health and care therefore needs to shift, from a fragmented system dominated by hospital care, to a more preventive, integrated (primary, community, social and hospital services), sustainable and affordable model of care. Other health and care systems around the world are experiencing similar issues to those in England (personal communication).
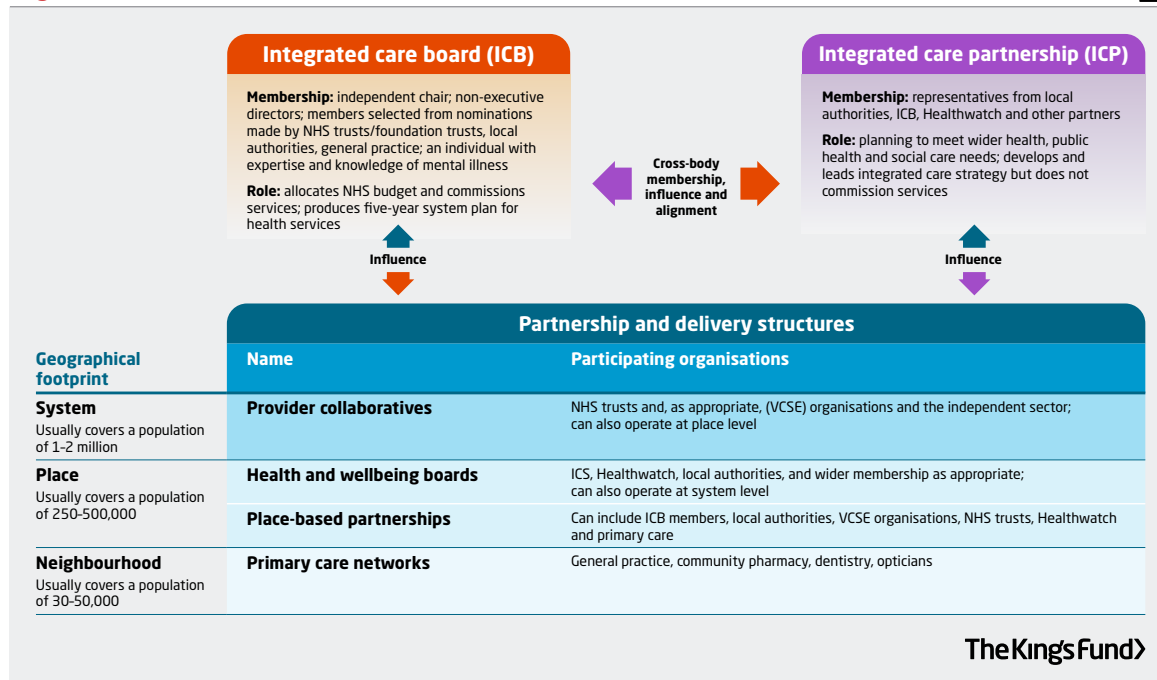
In England, the establishment of ICSs as statutory bodies (as a result of the Health and Care Act 2022) provides a new organising framework to support collaborative working across health and care services. ICSs are geographically based partnerships of varying sizes (covering populations of between 500,000 and 3 million people), designed to bring together local government, the NHS and a range of other organisations to improve the health and care of people who live and work in their area. They have four core purposes, to:

- improve outcomes in population health and health care

- tackle inequalities in access to services, experiences of services and outcomes

- enhance productivity and value for money

- support broader social and economic development.

If ICSs are to deliver on these core purposes, they will need to have sufficient resources and powers as well as a strong collaborative ethos.

Each ICS has a statutory integrated care board (ICB) and a statutory integrated care partnership (ICP) (*see* Figure 1). The ICB is the NHS organisation responsible for bringing NHS and other partner organisations together to plan and deliver integrated health services within the ICS. The ICP is the committee jointly formed between the ICB and the relevant local authorities within an ICS area. It also brings together a broad alliance of partner organisations. It is responsible for developing an integrated care strategy (as set out in the Health and Care Act 2022).

Figure 1 The structure of ICSs

Integrated care board (ICB)

Membership: independent chair; non-executive directors; members selected from nominations made by NHS trusts/foundation trusts, local authorities, general practice; an individual with expertise and knowledge of mental illness

Role: allocates NHS budget and commissions services; produces five-year system plan for health services

Cross-body membership, influence and alignment

Integrated care partnership (ICP)

Membership: representatives from local authorities, ICB, Healthwatch and other partners

Role: planning to meet wider health, public health and social care needs; develops and leads integrated care strategy but does not commission services

Influence

Influence

Geographical footprint	Partnership and delivery structures	
	Name	**Participating organisations**
System Usually covers a population of 1–2 million	**Provider collaboratives**	NHS trusts and, as appropriate, (VCSE) organisations and the independent sector; can also operate at place level
Place Usually covers a population of 250-500,000	**Health and wellbeing boards**	ICS, Healthwatch, local authorities, and wider membership as appropriate; can also operate at system level
	Place-based partnerships	Can include ICB members, local authorities, VCSE organisations, NHS trusts, Healthwatch and primary care
Neighbourhood Usually covers a population of 30-50,000	**Primary care networks**	General practice, community pharmacy, dentistry, opticians

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These new ICS structures are designed to promote an equal partnership between all participating organisations. This is no easy task. Different power dynamics will often exist between participating organisations. If collaborative working is to become a reality, organisational leaders in ICSs, whether at a system, place or neighbourhood level, will need to shift their focus away from individual organisational sovereignty towards shared stewardship (**Ham and Alderwick 2015**). Such a shift will not come easily to some, especially to NHS foundation trusts, which have been encouraged for more than 30 years to compete with each other and pursue their own interests (**Department of Health 1989**).

It can be argued that collaboration and competition are not always or entirely mutually exclusive, but in practice the tension between the two is very real and produces a range of challenges for leaders and staff. The Health and Care Act 2012 was designed to embed competition in the NHS. Newly established clinical commissioning groups became the purchasers of health care services, and NHS foundations trusts, and other service providers were encouraged to compete for resources. However, although this legislation promoted competition, the case for collaboration grew with the introduction of various national initiatives such as the Integrated Pioneer programme (**NHS England 2013**) and the new care models

programme (**NHS England 2014**). But like all collaborations, the broader political, economic and legal environments in which these initiatives were operating affected and shaped them.

The Health and Care Act 2022 aims to create an environment that is more supportive of collaborative working. Organisations and teams at system, place and neighbourhood level are being encouraged to combine skills and resources to improve health and care outcomes for local populations. However, after more than 30 years of competition in the NHS, collaborative working will not be easy, especially in a resource-constrained environment. These collaborations will also face other challenges, such as conflicting organisational goals, competing institutional norms and rules and perceived loss of power and status (**Alderwick *et al* 2021**).

To resolve some of these difficulties, a clear benefit for collaborating needs to be identified – that is, something needs to be achieved that any one of the participating organisations cannot achieve if acting alone. Once agreed, this 'collaborative advantage' needs to be communicated clearly and consistently across all the parties involved (Huxham and Vangen 2005). We argue that, in addition to clarity of purpose, different leadership practices and ways of working are also needed, otherwise a lot of time, money and energy will be invested in collaborations with little gain in terms of improved outcomes for local communities.

This report shares the learning and insights of health and care leaders who have actively chosen to adopt some different processes and behaviours to nurture more effective collaborative working. We have combined three data sources to produce the report:

- contemporaneous notes collected while working with various leadership groups over the past decade

- data from interviews with 15 senior leaders working in ICBs, NHS foundation trusts and local government

- data from a short online survey with more than 50 health and care leaders.

The interviews were conducted during the winter of 2022/23, as ICSs were being established and at a time of unprecedented pressures on the health and care system, including nurses and paramedics taking part in industrial action. While progress on the setting up of ICSs will have been made since our interviews, data from the short online survey conducted six months later, along with ongoing conversations with individuals and groups, suggest that the key issues highlighted in this report are where attention is most needed if the real potential of collaborative working in health and care services is to be achieved. Full methodological details are set out in the Appendix.

To summarise, the health needs of the population are changing and many people require more co-ordinated care, which in turn requires co-ordination and collaboration between services. ICSs present an opportunity for greater collaboration but seizing that opportunity is about much more than organisational structures, as it will require a shift in behaviours, skills and leadership practices. We hope that the research, experience and recommendations in this report will support leaders to implement – and reap the rewards of – more effective collaborative working.

2 What is collaborative leadership?

In 2011, The King's Fund argued that the dominant heroic model of leadership in the NHS, in which individuals almost single-handedly drove an organisation to success, was ill-suited to dealing with the complex issues the NHS was facing (**The King's Fund 2011**). The report promoted the importance of leaders working across boundaries and persuading others to work together to transform the way health and care services are delivered as more important than leading the cavalry charge on behalf of a single institution or organisation. Turnbull James (**2011**) viewed this post-heroic model of leadership as involving multiple actors who take up leadership roles (both formally and informally) and share leadership by working collaboratively across organisational and professional boundaries (**The King's Fund 2011**). This shared leadership model was more than numerically having more leaders as it placed an emphasis on relationships, connections and processes within and between different health and care organisations.

Over the past decade, there has been a proliferation of labels that have been used interchangeably in the NHS and the leadership literature to describe shared leadership. These include collective leadership, distributed leadership, system leadership and collaborative leadership. Although all these labels promote the concept of shared leadership, each places a slightly different emphasis on how it may be enacted, as the definitions in Table 1 illustrate.

Table 1 Definitions of shared leadership

Collective leadership	A leader or set of leaders selectively uses skills and expertise within a network, effectively distributing elements of the leadership role as the situation requires (**Friedrich *et al* 2009**).
Distributed leadership	Leadership is seen as being distributed away from the top of an organisation to many levels. This distribution takes the form of new practices and innovations, not just people at lower levels taking the initiative as leaders (**Turnbull James 2011**).
System leadership	Leadership is not vested solely in those who occupy positions of authority and involves sharing leadership and coming together based on shared ambition (**The King's Fund 2011**).

In contrast to other definitions of shared leadership, collaborative leadership actively promotes the need for leaders to switch from a focus solely on individual sovereignty to one of shared stewardship. This style of leadership may be deployed both in and outside of an organisation to support collaborative working. For example, leaders may need to incentivise collaborative working within their own organisation. The development of some shared goals may be a useful mechanism for unifying teams and diminishing various power struggles but, without individual leaders also practising and encouraging shared stewardship, such mechanisms will have limited value. Leaders may also choose to adopt a collaborative leadership approach when working with a group of peers. Promoting shared stewardship at the same time as retaining their own organisational leadership role will not be easy for leaders, especially after years of government policies in England promoting organisational independence and autonomy (*Health and Social Care Act 2012*; Department of Health 1989). But without such a shift, the collective action needed to improve the health and wellbeing of the population and transform the way health and care services are delivered will not be possible. ICSs potentially provide an organising framework to formally support collaborative leadership.

Chrislip (2002) neatly describes collaborative leadership as 'leading as a peer, not a superior'. This definition emphasises the need to share power with others. Another definition views collaborative leadership as the capacity to:

> ...engage with people and groups outside of one's formal control, and inspire them to work towards common goals – despite differences in convictions, cultural values and operating norms.
> (**Ibarra and Hansen 2011**)

Here, the emphasis is on working with a variety of different perspectives. Working with diverse views is challenging, especially in a resource-constrained environment, but if people are prepared to appreciate the differences and are willing to explore and learn from them, new more valuable insights may be generated. Davies (2016) views collaborative leadership as:

> ...a dynamic, interactive process that occurs between two or more people, the purpose of which is to facilitate decision-making and shared agreement on direction, alignment to goals, and commitment to action.

This definition emphasises the fluid and adaptive nature of this style of leadership and the need for leaders to focus on securing a decision and gaining commitment to act from all those involved.

Critically, if leaders are to successfully adopt a collaborative style of leadership, they will need to look at problems from perspectives beyond their own. This may involve abandoning existing interpretations and letting go of preconceptions or creating new or expanded interpretations of the problem to be addressed. This will in turn require leaders to be more open and trusting with one another so they can acquire information about each other's organisations. It will also require effective dialogue and a shared understanding of the problem. Collaborative leadership does not mean that individuals, groups or organisations need to reach a consensus on everything. Nor is it about abdicating responsibility. It is about actively connecting with others and working with a range of different views.

For the purposes of this report, we define a collaborative leader as someone who can create a safe, inclusive and trusting environment in which everyone can contribute fully and openly to achieving an agreed shared goal. They will also need to pay attention to the 'health' of the relationships between all those collaborating and design processes that are supportive of collaborative working. In the next section of this report, we examine these issues in more detail by reflecting on six key areas of practice for effective collaborative leadership.

To conclude, collaborative leadership should not be seen as the panacea for solving all the complex issues facing the NHS. Leaders will always need to use a range of different styles and approaches so they can be effective in a wide array of situations. There is a time to be collaborative and a time to be directive, as the Covid-19 pandemic showed. Sometimes leaders will adopt a collaborative leadership approach when working with their peers; in other instances, the emphasis will be on the leader creating the conditions so that others can collaborate well.

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3 Key areas of practice for effective collaborative leadership

Persuading others to participate and engage in collaborative working requires leaders themselves to practise and encourage collaborative behaviours. Role modelling and setting the tone for effective collaborative working are seen as critical. One interviewee illustrated this point:

> *…working collaboratively is much more to do with culture and expectations set by the exec team… moving beyond silo working undoubtedly needs to come from the top…*

Another, in a similar vein, suggested that it is:

> *…no good sitting around the partnership table and then going back to the organisation and bad-mouthing or not even talking about the partnership…*

In an environment where competition for both financial and workforce resources is still potent, health and care leaders may find openly demonstrating altruistic behaviours towards one another both in and outside of their organisation difficult. But showing that they are putting patients' needs and the needs of the local population ahead of any personal or organisational interests is critical. In general, those involved in practising collaborative leadership tend to put others ahead of themselves and they work in the service of others, as the quote below illustrates.

> *We're all trying to put the patient and the staff first as opposed to… putting personal and organisational goals first…*

Alongside this selflessness is an accompanying sense of leaders not elevating themselves above others. They demonstrate humility and this is reflected in their willingness to be open and share the challenges they are experiencing. In some cases, they actively reflect on and apply any learning to become more effective.

An individual's social conditioning, prior training, unconscious projections and motivations will all affect their willingness to collaborate, but if collaborative behaviours are rewarded they will become a learnt behaviour, as one ICS leader noted in the quote below.

> *...people will emulate the behaviours that are rewarded. It must start from the top – the mechanics need to be put in place to embrace collaboration. There is a need to demonstrate that this is the currency of today's leaders because even those leaders who don't do this instinctively... if the currency is about collaboration, they will have to... [and it will] become a learnt behaviour.*

However, behaving altruistically towards one another will be insufficient on its own to build collaborative capability. Our research suggests that there are six key leadership practices that will also need to be attended to. These are:

- creating safe, inclusive and trusting environments in which everyone can contribute

- building healthy relationships between all parties involved

- developing a shared purpose and shared group identity

- actively managing power dynamics to enable power-sharing

- surfacing and managing any conflict quickly and fairly

- promoting shared decision-making processes.

Each of these leadership practices is examined in more detail below. It should be noted that there are varying degrees of overlap between the six areas, and they should be viewed together (*see* Figure 2).

Figure 2 Key practices for effective collaborative leadership
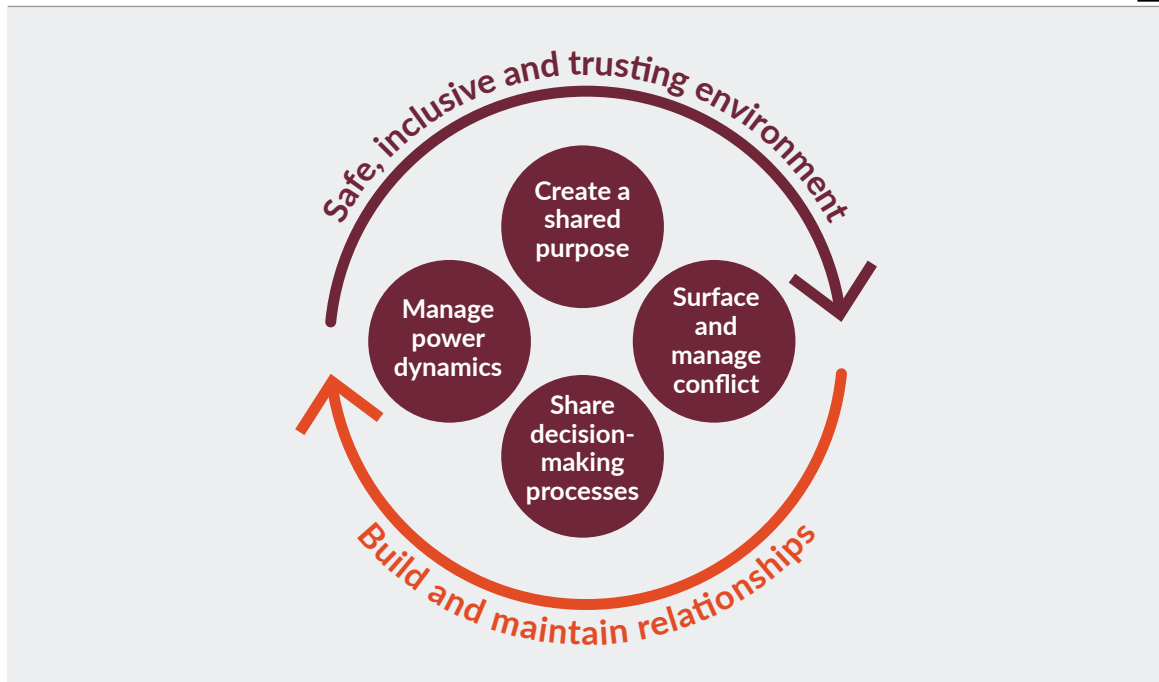
Practice 1: creating a safe, inclusive and trusting environment

One of the key reflections from the work the authors have conducted over the past decade is that when collaborative leadership is working well, people feel safe to speak freely and candidly without recrimination. As one interviewee noted, 'the relationships turned around when there was an open dialogue and a safe environment…'.

Another interviewee, in a similar vein, noted:

> It's easy for someone to say 'everybody share your thoughts', but people know if it's a safe environment or not. There has to be opportunity for challenge, for probing and questioning… collaborative means all parties have the opportunity to input.

Edmondson (2012) identified a safe environment as an important feature of collaborative cultures. If people do not perceive the environment to be safe, they will not raise questions or voice differing opinions and therefore it will be unlikely that any new or different solutions will emerge – for some, this is the rationale for collaborating. Working in an unsafe environment also means there is more likelihood of 'groupthink' (people just agreeing with one another rather than presenting alternatives), resulting in less creativity.

Processes can be designed to create a sense of safety. The quote below illustrates how this has been done in one ICS.

> [We]… did a range of different things to broaden out the networks, such as hosting our big breakfast between 8.00am and 10.00am. One of the VCSE organisations would host it and one of the statutory organisations would pay for it… they started off very informal with people getting to know each other. We might have a topic to discuss some issue… we began to call it the 'big think about x…', sometimes it was a bit reactive, but it always looked to the future how we wanted things to be… not a usual meeting.

This informal 'breakfast space' enabled different people with different views to come together in a relaxed setting, and this in turn produced some different types of discussion.

In contrast, another interviewee from a different ICS noted how they are continuing to work with the same organisations as they had done before:

> [We are having]… lots of meetings with the same health and care leaders… and we're having really similar conversations around multiple tables so quite a lot of duplication… and we're not all connecting with each other very well.

This interviewee went on to suggest that not enough attention is being given to enabling everyone to participate.
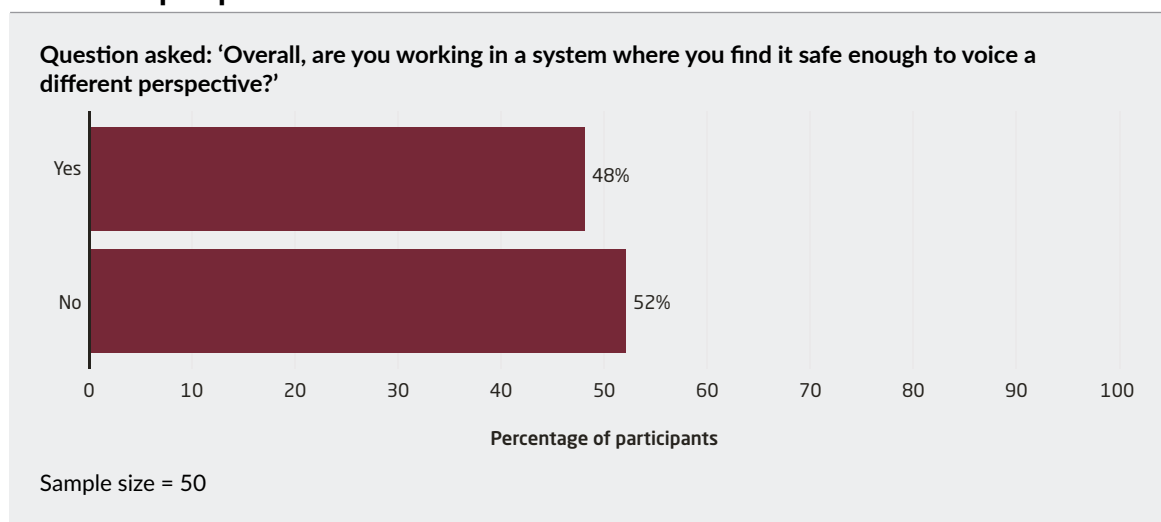
> …it feels like we're paying lip-service to their [the local authority's] involvement and it feels like they're attending when they have to attend, saying what they need to say, but I don't think they are very bought in or motivated…

Without carefully designed processes to maximise participation, there is a danger of 'pseudo' collaboration rather than true collaboration occurring.

We heard from interviewees that the 'shame and blame environment' that some NHS organisations are operating in means that some NHS leaders do not feel safe enough to fully participate in discussions. Half of our survey respondents stated they are working in a system where it is not safe enough to voice a different perspective (*see* Figure 3).

Figure 3 **Survey respondents' views on whether it is safe enough to voice a different perspective**

Question asked: 'Overall, are you working in a system where you find it safe enough to voice a different perspective?'

Yes	48%
No	52%

Percentage of participants

Sample size = 50

Interviewees also told us that this perceived lack of safety that leaders and teams are experiencing is producing some defensive behaviours. Leaders and staff are only looking at issues from their perspective and not investing the time to understand where other people or organisations are coming from. One interviewee noted the following.

> *Everyone… is on a state of high alert [in the NHS] … you are never going to get people at their best… [we need] to think of the enablers needed to help the system calm down and make people feel safer.*

There is a danger that people will continue to do more of the same if a safer environment is not created, with severe consequences, as another interviewee suggested in the following quote.

> *We need to slow down and pause... it's not all about system pressures, even though it might feel like it, because in 12 months' time, two years' time... we don't want to be in the same position, we need to look to the future...*

Shifting the collective focus away from solely responding to problems as they happen, to co-creating the future together, takes time and is a key skill of shared leadership (**Senge *et al* 2015**). Such a shift requires leaders to not just build inspiring visions with others but also add to create a trusting environment where the difficulties of the current reality can be clearly articulated so that everyone has a shared understanding of the problems that need to be addressed. Low-trust environments will lead to minimal knowledge-sharing and therefore partial understanding of the problems.

We heard from interviewees that intense operational pressures are also affecting levels of trust between leaders and staff in some organisations and this is not only producing defensive behaviours, but also leading to frustration, low morale and a reluctance among some people to collaborate with others. When our sense of trust is high, we are less fearful, less anxious, more confident and more optimistic. When trust is low, we experience a physical stress response (Eastwood 2021). This can be debilitating, and even when less severe it can affect our connection with others and may prevent us from working effectively with others.

Trust cannot be commanded or willed. It is a deep-seated primal calculation we make on evidence from our environment and how others relate to us. We are continually scanning our environment and judging whether it is physically and psychologically safe for us (Eastwood 2021). Trust is never fixed. It is highly contextual. It is always being calculated and recalculated based on the latest data. Trusting others puts us in an inherently vulnerable position. It is a calculated risk. Others in a collaboration may not have the same interests and, in some cases, people may let us down by not doing what they say they will do (Edmondson AC 2017).

The development of trust takes time and is only really built by working together or experiencing something together, as the following quote clearly illustrates.

> *We developed a level of trust [after meeting several times]… so people were not sitting back and thinking 'who are they to come in and make us do it this way [standardise assessments]' and I think that's why we're getting further faster than we might have even a year ago… and so we are now at a point where people are actually saying… 'we're okay to change that because we can see it's for the greater good'.*

Spending time together goes a long way to building trust – not just the words exchanged but also the experience of being physically together. Frequent personal contact, together with good-quality conversations, are critical in building trust between individuals. Such conversations provide signals of authenticity, loyalty and empathy. They also enable us to better interpret and understand each other and this, in turn, helps our ability to predict the behaviour of others.

Without trust, collaborative working will fail to achieve the benefits and possibilities we anticipate, as the following quote from an interviewee illustrates.

> *Without a foundation of trust, collaboration will be stifled because individuals will hold back and look upon proposals to collaborate with suspicion and apprehension. When people are wary of each other, and the processes of communicating and working together are superficial, collaboration doesn't have a chance.*

Structures and boundaries can provide people with a sense of safety and this, in turn, lowers anxiety and enhances trust. So, if staff are working across organisational or professional boundaries, they may require stronger relational support from others to reduce any fear and anxiety they are holding. Such an approach will increase conditions for building trust. Compassionate leadership is also a critical element of building trust – showing care, empathy and consideration to others (**West *et al* 2020**). Effective communication skills are also important if leaders are going to build trust and maximise participation from people with a range of different perspectives.

There are challenges associated with working with a range of different views, even within a safe and trusting environment – as one interviewee noted, 'it can get a little messy at times' – and it can take more time, especially at the beginning, when new perspectives are being brought in. Unclear gains of the potential benefits for working collaboratively will also hold back collaborations and waste energy and resources. For example, if there are lots of meetings and no demonstrable changes, staff may perceive this as an inefficient use of resources. A clearly defined shared purpose agreed by all those working together and communicated widely will potentially mitigate against this.

To summarise, bringing in and working with different views and perspectives is an important element of collaborative leadership, and this needs to be done within a safe and trusting environment so that all parties can fully participate. Diversity only has value if others appreciate the differences and are willing to explore and learn from them. It is only then that new insights or new solutions can be generated. The existence of trust can also provide the opportunity to change people's attitudes and beliefs and not just their behaviour. If leaders can together create a trusting environment where everyone feels safe enough to speak up, they will be creating a context that incentivises rather than undermines collaborative working.

Practice 2: building healthy relationships

Healthy relationships are important in collaborative working (Mashek 2023; Huxham and Vangen 2005). Relational exchanges can facilitate the building of trust and lower transactional costs, that is, the resources associated with contract management (**Unwin 2018**). The quality of a relationship can make or break the outcome of collaborative working.

Many health and care leaders are intentionally investing time and energy into building more personal relationships, recognising that true collaboration will only occur if healthy relationships are in place. In most cases, they are holding face-to-face meetings with one another to develop a better understanding of the people behind the roles. Some are meeting colleagues outside of the formal work setting, as the following quote illustrates.

> *I did most of my real work over a curry… [it is] so important to get to know people properly.*

Others are meeting for coffee or travelling to meetings together. In some cases, they are creating some different spaces within existing forums so that they can try to 'connect with one another on a more personal level'. As noted earlier, the more time groups can physically be together the more they will bond, and this will build trust and strengthen relationships. If people do not invest the time in getting to know each other as people and appreciating each other's goals and interests, connections and communications with one another will be limited and may affect how they work together.

Many leaders are working virtually to some degree, and although bringing together a diverse group of people is much easier online, many believe that the ability to build personal relationships is impaired. In some cases, people are experimenting with how they work online, to overcome some of these difficulties. For example, in one group they share different pieces of art with one another and talk about them for a fixed period of time before a meeting formally begins. Others have agreed on ways of working to increase participation and some are regularly holding 'coffee sessions'.

In many instances, the nature of the dialogue has shifted, as one interviewee noted in the quote below.

> *We have moved away from transactional relationships and holding people and organisations to account for performance... this has shifted the dynamic and the nature of the relationship.*

This shift away from transactional relationships over contracts and performance towards a more relational way of working based on humility, curiosity and trust has strengthened relationships.

Adopting a more relational way of working has also, in many cases, shifted the nature of the conversations to a deeper level where different contributions are valued. Some leaders are experimenting with holding meetings where there is no agenda and no papers. Attendees are invited to talk to one another; some have found this challenging, but most have become more comfortable with time and noticed that they have got much better at working through the complexity of issues and not coming up with a quick solution to the presenting difficulty. Others are creating 'open space' times within existing meetings. The creation of some

different spaces to hold more generative conversations appears to be strengthening collaborative working in some instances. In one example, those involved in the planning and delivery of urgent care across an ICS came together with no agenda, as the following quote illustrates.

> *[There was]… lots of energetic discussions, few actions [at this stage], but a really good conversation. There was a buzz in the air, and people left energised and saying that the time spent together was valuable, we need to do it again…*

This approach contrasts starkly with the workshop and meeting fatigue that others who took part in our research felt.

People are also using other spaces and processes – such as facilitated workshops, awaydays, offsite meetings or events, and local development programmes – to strengthen relationships. In some instances, they are using these spaces to generate new ideas; in other instances, they are using them as a forum to reflect on and learn about what is and what is not working. Senge *et al* (**2015**) suggest that specific interventions to support shared leadership can be helpful, but what may be more useful is creating an environment that fosters ongoing reflection so the work itself becomes developmental.

In some cases, past experiences mean there is a legacy of mistrust, and this needs to be addressed. The quote below illustrates how one ICS leader is tackling this.

> *We are developing a different relationship with our local authorities… there are elements of mistrust, some of that is history and some of it is a deep misunderstanding about how local authorities work… and that leads to blame…*

Others spoke about the mistrust between local NHS providers and how this is affecting the development of provider collaboratives locally. One interviewee shared how they are starting to rebuild relationships.

> *We've had an untrusting relationship for a while… we've thrown plates, had fights etc etc… now [we] need to step back and say 'we need to make this work, let's talk about it… what will make this relationship work?'.*

Where trust is low, organisations are adding more layers of bureaucracy to manage anxieties and fears. In effect, these organisations are returning to a more transactional relationship. When trust is not in evidence, or breaks down, it erodes people's ability to maintain relationships (Mashek 2023). Some interviewees noted that a lack of time to truly get to know each other was also affecting levels of trust and in some cases leading to anxiety.

Many interviewees saw the rebuilding of trust as a priority when it has been broken and are deploying various strategies to address this. For example, in one organisation, the director of strategy extended invitations to other people in the organisation to attend a future ICP meeting so they could understand both the bigger picture and have a better appreciation of what other parts of the system were experiencing. Other strategies include organisations and teams working on issues together to rebuild credibility and reliance in one another. When trust has been eroded it takes a long time to rebuild, and sometimes it cannot be rebuilt. In these instances, leaders are working around the damaged relationship or through someone else – at least for the time being.

To summarise, developing and maintaining healthy relationships in a collaboration is critically important. This will require sustained effort. Getting to know people and appreciating their different interests and goals are critical for effective collaborative working. Trust needs to exist, and, in some cases, this may need to be rebuilt or repaired after years of competing against one another. Showing care, empathy, respect and consideration for others is also important in developing relationships.

Practice 3: developing a shared purpose and shared group identity

It is important in a collaboration for people to have an agreed shared purpose for coming together, otherwise a lot of time, money and energy may be used with little gain. Health and care leaders who took part in our research accept this, yet many have not invested time in developing a shared purpose. One interviewee noted that '...we recognise that we shouldn't be doing everything together, and we need a common purpose that really unites us'. Another interviewee, in a similar vein, noted that:

...we may talk the language of tackling health inequalities but when all our time is spent on addressing urgent and emergency care... we really need to hammer down what we are going to do, what we are going to collaborate on... a shared aspiration that is going to bind us together and we can hold ourselves accountable to... collectively we know we need to do more around this...

In some cases, people have spent time and energy on developing a shared purpose but the result is a statement full of compromises that does not resonate with people, nor energise or motivate staff. In some cases, there is insufficient clarity.

Everyone agrees we need to make things better for patients but what that is and how we will achieve this goal varies...

If a shared purpose is not clearly stated, it becomes difficult to identify who needs to be involved in a collaboration. A shared purpose should succinctly capture the essence of why organisations or groups are working together. In the successful redesign of the health and care system in Canterbury, New Zealand, they used the following shared purpose: 'a connected system centred around people that aims not to waste their time or clinicians' time' (Dolan *et al* 2017). This shared purpose was clearly aligned to their overall vision and strategic objectives and actively applied.

When and how a shared purpose is developed also needs careful consideration so discussions between all collaborating parties are not closed before gaining a good understanding of any irreconcilable differences. Gaining a better insight into other organisations' expectations and aspirations for collaboration can also clarify how best to work with one another. Ideally, collaborative groups will spend time together to build a shared understanding of the problems to be addressed before defining a shared purpose. Research suggests that such mixed groups cannot rely on a shared understanding of the facts, so it is important to put time aside to hold discussions and develop a shared understanding of the problems together (Smith and Berg 1997).

Individuals from different backgrounds often reside in different 'thought worlds' due to differences in training, socialisation and expertise (**Baumeister and Leary 1995**). These thought worlds can create obstacles to effective communication and therefore undermine collaboration. Some leaders in our research acknowledge they are far more conscious of their language and the impact of their communication on

others, especially in mixed forums: '…[it is] so important we're not just getting stuck in NHS-speak'. Developing a shared language to frame some of the key issues can also avoid misunderstandings, as the quote below illustrates.

> [The]… *best test of collaborative behaviours is when your ops [operations] manager is talking to another from a local organisation – and they are talking the same language.*

Developing a shared identity across a collaboration can also be important especially if groups have a history of competition with each other, if the collaboration threatens their existence and/or if there are existing power differentials between members. Inter-group identity has important advantages over striving to create a shared collective identity as it allows groups or organisations to retain their own distinctiveness at the same time as creating a shared identity (**Hogg** *et al* **2012**). A shared inter-group identity can also be useful in creating a shared understanding of an issue and potentially in preventing any group or organisation from dominating. Members of such groups can also have an important boundary-spanning role, that is, these individuals have one or more relationships to other groups or organisations outside of the group. Such roles can create role models for others in working across boundaries. They will also have an important role in bringing facts and interpretations into the inter-group and back into other groups and organisations. Various mechanisms can be deployed to strengthen a mixed group's identity, such as building high-quality interpersonal relationships, developing some group rituals and using a shared narrative to describe why a collaboration is essential.

A shared narrative and consistency of messaging around an agreed shared purpose can also diminish any power differentials between groups or organisations. The value of a narrative is clearly illustrated in the quote below.

> *The narrative is about partnership and collaboration so if you are an outlier to that you quickly get noticed and you get picked on by people like X [the ICS leader]… It is the narrative to be seen to be working with even if people don't believe it, they still go with it…*

Sometimes when working in a mixed group it may be useful to attend to any history, especially if it is affecting behaviours between group members. But as the interviewee below illustrates, once this has been dealt with, things need to move forward.

> We are trying to create an adult–adult relationship and challenge each other when we are not living up to the values and also challenge one another when the history comes up. For example, this morning we had a conversation about emergency pressures and one of my colleagues talked about the history of the three local NHS providers not working together. We know that stuff… need to bust the myth, this is the leadership task rather than moving along with it. Leaders need to put a lid on that stuff… rather than letting it fester…

To summarise, it is important to identify the benefits of collaborating and develop a clear shared purpose. Once agreed, the shared purpose needs to be communicated clearly, and actively used with different groups. Developing a shared group identity may also strengthen participation. Developing a shared language to frame some of the key issues can also be useful and avoid any misunderstanding.

Practice 4: actively managing power dynamics

Power-sharing is a necessary ingredient for collaborating well and when it does occur it can be very rewarding, as the quote below illustrates.

> …sharing power is not about losing power, it is about growing power,… the power of the collective… it feels good to be working together rather than getting one over the other, like children…

Sharing power entails sharing responsibility and requires those involved in the collaboration to learn strategies of mutual empowerment and this, in turn, will often influence behaviours.

However, power-sharing is difficult and cannot be taken for granted. More than 50 per cent of our survey respondents felt that power was not being well shared across organisations in their local health and care system. This theme was also repeated in our interviews, as one chief executive noted in the quote below.

...underneath the wrapping paper I still need to be convinced there is genuine collaborative leadership going on... [I] don't think all the acute CEOs [chief executive officers] think the ICB is representative of the system. We have done a lot about shared goals and vision around the ICB table but because not everyone in the system is around the ICB table I don't think the shared vision and direction is shared by everyone...

In some cases, people defending various organisational, sectoral or professional interests are blocking collaborations and they are doing this in quite subtle ways. Frequently, the goal is to maintain the status quo, and for some NHS organisations this is about maintaining their independence, as one interviewee suggested:

...providers need to see themselves as part of the system rather than individual entities working in a system with partners...

The dominant voice of the hospital is still evident in many ICSs. One interviewee shared the impact of this:

...the perception is that the acutes [acute hospitals] rule the roost in the ICB and the community and mental health services are very much second tier in the pecking order... that's the perception and to deal with that we must band together to get better visibility and more power...

Power dynamics will need to be actively managed, otherwise pre-existing power differences between organisations and groups will remain, possibly in new constellations as the quote above suggests. Consideration may also need to be given to how collaborations are constructed, and how discussions are organised to diminish any power struggles. Bringing in service users will also require careful consideration if the power imbalances between professionals and service users are to be addressed.

In some ICSs, the power dynamics are shifting as local NHS foundation trusts come together to form a provider collaborative or a group model (where providers work together under a shared operating and decision-making structure). This may not necessarily be supportive of system working, as the following interviewee noted.

There is a chess game going on with some fairly big players not connected to the ICB, which is bizarre.

Not all organisations or groups will have the same capacity to access and use power. Resistance to shared leadership from years of cultural conditioning is affecting some of the power dynamics playing out. As one interviewee noted, '... some people are motivated by power... collaborative ways of working do not suit them'.

There are still many leaders who only believe in a singular model of leadership and phrases such as 'we have always done it like this here' and 'it has served us well' will need to be challenged and actively managed if the desired gains from collaborative working are to become a reality. Current processes available to ICSs are too limiting, as one interviewee suggested in the quote below.

> *NHSE [NHS England] do not have a mechanism of moving a CEO on unless there is a performance or quality issue, not if behaviours or values are wrong... we need to have a mechanism to move these people along as they could be a real barrier... [The]... duty to collaborate is very loose and you cannot use it to move people on...*

In collaborative leadership, power is used differently compared with a traditional model of leadership. It is not viewed as an instrument of dominance or coercion but more like a 'catalytic power' to mobilise joint action among all those involved. There is evidence from our work that some systems and places are creating more open and participatory environments so more people can hold and share power in collaborations. This shift from old power (leader driven) to new power (peer driven) does present challenges in traditional hierarchical (vertically structured) organisations such as the NHS and local government (Timms and Heimans 2018). In some places, however, hierarchical organisations are successfully co-existing alongside networks, as the quote below illustrates.

> *In [XX] we have a narrative about big and little dots. Most of us wanted equal-size dots and a network that holds them all together – you have a dot and you are held to account... people whose operating construct is all about power, and their organisation is king, find this way of working difficult – they see power resting in their organisation – ... it helps as the narrative in the ICS is about partnership working...*

Sharing power will be easier when leaders feel strong in their own power. A variety of factors will influence this, including:

- their degree of self-awareness

- where they are in their own career trajectory

- perceived risks to their team or organisation

- the availability of resources.

More established leaders may find it easier to share power, as one interviewee suggested in the quote below.

> *I reached a conclusion that the earlier you are in your career, the harder it is to let go of feeling in charge – personal power is important. Partnership has not got the same currency.*

The downside of a leader being flexible is that they can give all their power away, so they need to be aware of where they are in the system and what they and their organisation need.

To summarise, in collaborative leadership it is important to create environments and processes that are supportive of power-sharing. This may require actively managing or shifting some existing power dynamics. If power can be successfully shared across a collaboration, it will potentially mobilise joint action across the group.

Practice 5: surfacing and managing any conflict

In collaborations it is critical for the leader to draw out and use different views and ideas. Sometimes these differences will turn into conflict, and in these instances, it will be important for the leader to engage in practices that surface and manage the conflict constructively (**Hulks *et al* 2017**). If the conflict is not surfaced, there is a risk that trust will be eroded and this, in turn, will affect the nature of the relationships within the collaboration and potentially erode the collaboration itself. It is easier and less time-consuming to avoid conflict situations but rarely is this helpful.

Most survey respondents indicated they are surfacing and managing conflict (*see* Figure 4).

Figure 4 **Survey respondents' views on surfacing and managing conflict**

Question asked: 'What is your tendency (in the current climate) to surface and manage conflict?'

Sample size = 51
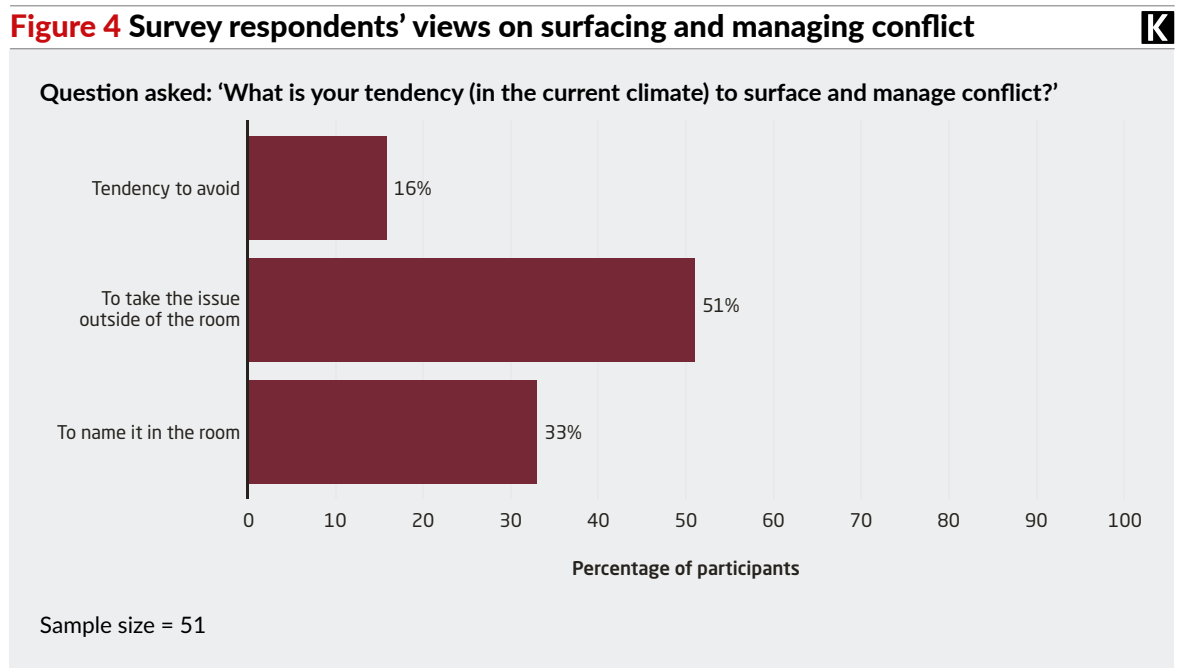
Increased scarcity of resources is causing conflict and, in some cases, this is preventing people from working together and they are retreating into their organisational silos. Survey respondents reported that, in the right circumstances, they are being candid and naming the issues in the room, but this is difficult and can be damaging to the individual(s) concerned unless done well. Others found that there was always too little time in meetings, or they did not have sufficient knowledge and/or information, to challenge one another. Some respondents are dealing with issues outside of the room and not allowing them to fester and undermine relationships. Again, this needs to be done carefully to avoid any repercussions.

In some instances, interviewees and survey respondents perceive that the environment is not safe enough for people to challenge one another. One ICS leader shared in the quote below how they have created the conditions so that others in the collaboration feel the environment is safe enough to do this.

We have spent a lot of time talking about how we [the ICB] want to work together and with our constituent organisations. We have agreed that we will be brave enough to challenge one another openly and in a respectful way so everyone... can carry on working together. When one or two partners feel strongly about not going in a specific way, we will take a different approach and explore their risks and fears... it may mean a bit of a compromise but we will have the conversations that need to be had. We must be able to challenge one another.

Meanwhile, some interviewees suggested that they need to challenge themselves more and look for more difference, as there is a danger that some forums are becoming too cosy. Co-creating some principles setting out how all parties need to behave towards one another can be useful, especially in managing conflict, if they are actively applied. There is a danger that without any agreed ways of working, everyone will work to their own rules and retrench into their own organisational silos when problems arise. In some cases, external facilitation is being used to support conflicting parties where there is a history of poor relationships.

In one ICS, three hospital chief executives have set out a deliberate plan to work together. In addition to protecting time to regularly meet and build relationships with one another, they have also embarked on some coaching together, 'to develop some frameworks that will help us get through the tough conversations...'. They recognise that they will need to make some difficult decisions in the future and although it is still early days, it is believed that the coaching has already helped them to have more open conversations with one another. They are beginning to name issues openly and use the safe space to voice any differing opinions, as opposed to apportioning blame and criticism to one another.

To summarise, the art of collaborative leadership is to include everyone's views and avoid putting one view in conflict with another. The key skill to surfacing and managing conflict is to understand where other people are coming from, to listen carefully and to have the courage to name any differences. Where conflicts do arise, there needs to be a commitment to resolving them quickly and fairly and to approaching them with an open and curious mind, rather than turning away from them. Conflict in some instances can be important as it can generate creativity.

Practice 6: promoting shared decision-making processes

Most problems cannot be solved by one person or one organisation. They require expertise, ideas, and support from multiple stakeholders including service users. Decisions with multiple inputs are generally viewed as of higher quality, largely because multiple perspectives have been considered.

Successfully securing service changes in health care often requires difficult and challenging conversations, involving multiple stakeholders who will sometimes need to compromise. Shared decision-making processes such as these require a different mindset and approach from those used in rational decision-making processes. Traditional problem-solving models frequently position participants as adversaries, pitting them against one another, and leaving them to operate with an incomplete appreciation of the problem and a restricted vision of what is possible. But finding resolutions to some of the complex issues facing health and care systems requires envisioning problems from perspectives beyond one's own. This requires effective dialogue and trusting relationships so those involved have a shared understanding of the impact of any decision on others.

The broad membership of some ICSs is bringing some challenges to decision-making. For example, the size of some ICSs means that it is not always possible to get genuine collective participatory decision-making within existing forums. In some cases, alternative spaces are being created so that people can talk through any potential risks and explore various inter-dependencies. Some ICSs are also actively exploring how they can design more inclusive decision-making processes. One ICS is developing a decision-making matrix that considers who needs to be involved in what decisions to ensure greater transparency. Potentially, an inclusive shared decision-making process can promote unity and trust across a collaboration if done well.

Any new decision-making processes need to be clarified and socialised between all parties involved. If this does not happen, there is a risk no decision will be reached, or decisions will take a lot longer as they go back and forth between the various groups, as the quote below illustrates.

> *It can all erupt again [at the ICB] as you have different acute and primary care reps on these groups who will say 'what on earth are you doing this for and where did you get this idea from?'... then goes back to the pathway redesign group.*

Lack of clarity around decision-making may lead to protectionism. Some groups or organisations may be concerned about potential losses of income, power or status. Individual attitudes, battles over 'territory' and individual career goals are other potential obstacles that will need to be considered when designing more inclusive decision-making processes.

Deputies being sent along to meetings without the delegated authority to make a decision is another challenge that some collaborations at neighbourhood, place and system levels are facing. To counter these challenges, some ICSs have agreed a principle beforehand that delegated decision-making powers are given automatically to whoever attends the neighbourhood, place or system meeting so that decisions can be made in a timely manner.

A potential downside to a more inclusive decision-making process is the time it may take. Also, the speed at which some decisions need to be taken means that, in some cases, not all groups are being involved, as one NHS foundation trust leader illustrated in the quote below.

> *...if you are not around the table even for 10% of the conversation that is relevant to you, decisions will be made that impact your organisation... sometimes decisions are not even made around the table, they are made in the next room...*

Some leaders also recognised that they are not being given sufficient time to reflect on issues and gather wider views and that, in some cases, this means 'good decisions are not always being taken'.

With multiple parties involved in decision-making processes, there is a danger that too many compromises are made, and the final decision may mean that the agreed shared goal is not reached:

> *We successfully designed a new intermediate care model together... this will solve a lot of out-of-hospital issues. We all agreed it and [at the leadership group meeting] we went around the table to secure commitment, [and] everyone said they agreed with the new proposed model but perhaps not x bit or y bit... by the end of going around the table the commissioning officer noted that we had only got one small thing we all agreed on... and this was not enough to proceed.*

On occasions, collaborative leadership requires 'a strong hand', as this quote suggests. A more directive approach may also be needed to ensure a decision is reached, especially if it is starting to impact on other things. In some cases, external facilitation may be required.

To summarise, in collaborative leadership it is important to establish inclusive decision-making processes. This may take longer but decisions with multiple inputs are generally regarded of higher quality. They can also promote unity and trust across a collaborating group. Developing a common vocabulary can also be helpful.

In conclusion

Collaborative leadership is grounded in the belief that a shared leadership model is more creative and effective than a leader or group of staff acting alone. A true collaboration will value difference and prevent any organisation or group from dominating. This may be difficult to achieve in health care systems that have traditionally valued some institutions or groups above others. However, the energy that can be potentially created from building an inclusive, safe and trusting environment in which all can contribute fully and openly to achieving an agreed collective goal – such as improving health and care outcomes for populations – should not be underestimated.

If the six leadership practices set out in this section are used with regularity and discipline, we suggest that the collaborative capability of any group, organisation or system will be greatly enhanced.

4 Where next?

Health and care staff are beginning to successfully work collaboratively across organisational and professional boundaries. However, after many years of policies promoting organisational independence, the switch from a focus on individual sovereignty towards shared stewardship is proving difficult even within the new organising framework of an ICS. The legacy of organisations and groups competing for resources and, in the case of the VCSE sector, still needing to do this, mean that the shift to more collaborative behaviours and mindsets is taking much longer than perhaps many had appreciated. In the future, expectations and timeframes for securing changes need to be realistic.

The environment in which ICSs have been born into is different from the one in which they were conceived (**Timmins *et al* 2022**). Interviewees described the environment as 'stressed'. Record numbers of people are waiting for treatment. There are big staff shortages in both health and social care. Inflation is hitting local government finances and eroding the real-terms spending increases that the NHS was meant to be receiving. The impact of these various operational and financial pressures means there is limited capacity for collaborative working. One ICS leader described the impact of the pressures on their role:

> *I came in with a brief to improve population health and improve patient care, yet we are utterly being driven by performance… it's very difficult to transform care when you've literally got stuff coming over your desk every single day that needs picking up and dealing with…*

Another interviewee noted the potential impact of the workforce and financial pressures on current collaborative working:

> *We are still a long way away from meaningful on-the-ground collaboration between health and social care. There are pockets of good work but when times are tough and there are a lack of resources, staff and leaders will revert into their organisational silos.*

Collaborative working is challenging, and even more so when there are resource pressures. If collaborative working is going to thrive across health and care services in such an environment, leaders will not only need to pay attention to the six key areas described in the previous section. They will also need to consider the potential gains of collaborating and how to build collaborative capacity across teams, organisations and systems.

Clarify the potential gains of collaborating

Going forward, systems, organisations and teams need to be more realistic and discerning about when to collaborate and when not to collaborate. Too often, people at the system, place and neighbourhood level are trying to collaborate on everything and are ending up in endless meetings, investing lots of energy and resources in discussing ideas with others and struggling to reach any decision. Therefore, time, money and energy are being consumed with little, if any, gain. Leaders may need to assume a stronger role in directing some collaborating groups or at the very least ensuring there is an agreed shared purpose aligned to a clear vision.

Building collaborative capacity

Many interviewees and respondents reported spending more of their time 'facing outwards' working and collaborating with other organisations, while at the same time as facing competing demands from their own organisation. In some instances, this has prompted changes within their organisations as the quote below illustrates.

> *It's a big challenge, trying to get a balance between internal focus for the organisation and external focus for the system. It's exhausting...there are increasing demands from the system...I was spending at least half of my time on system stuff last year...I am going to look at how the exec team is structured to mitigate the fact that I am now so externally focused...Going forward we need to accept this is a reality...and involve more staff'.*

In many ICSs, leaders are investing in development time together to build their own collaborative capabilities. There now needs to be a greater investment in developing other staff in the practices of collaboration. This style of working is hard and different from what has gone before.

Some leaders have already started creating opportunities for staff, especially those who have roles supporting 'the old world of contracting'. One ICS leader noted the following.

> *They need to get off the operational treadmill... and spend more time supporting transformational solutions... we need to help them to understand... the power of collaboration done well... also they need to be more externally focused... This group of staff are important...*

Commitment to collaborative working also needs to become more visible to staff, and collaborative behaviours need to be rewarded. If the collaborative capacity and capability of health and care organisations and systems is successfully strengthened, then the ideal outcome voiced by some of our interviewers may be realised – that we get to a point where organisations and people just step up and work together without needing to be asked or cajoled.

Looking to the future

Given the resource pressures and the pace of change and disruption needed to solve many of the problems facing our health and care system in England, we suggest that the notion of collaborative leadership is extended more widely. This is already starting to happen in some places, as the quote below from one ICS medical director illustrates.

> *...clinicians are working with asthma sufferers and instead of upping their asthma treatments, [they are] working with others from different organisations to sort out the damp housing causing the issue...*

This more 'civic' collaborative leadership approach is already being seen in some other international health and care systems, such as Montefiore in New York (**Collins 2018**).

Some ICSs are also creating joint leadership development programmes for current and future leaders from health, housing, education, the police and VCSE organisations. One of the aims of such programmes is to develop a deeper understanding of what is needed to improve local health and care outcomes. Such programmes will also potentially build the foundations for healthier relationships and broader collaborative working across organisations and sectors in the future. This approach builds on the recommendations of the independent review on health care leadership led by General Sir Gordon Messenger (**Department of Health and Social Care 2022**).

Future health and care leadership will be less about running the organisation or the business and more about shifting the power dynamics and walking alongside communities (**Lent 2023**). Councils such as Camden in London and Newcastle in the north-east of England are already starting to do this and have seen some transformational results in how services are delivered, as well as deeper engagement among staff and local communities (Gould and Lent 2023). There are still many unanswered questions about the effectiveness of this approach. But it has the potential to increase levels of public engagement and produce more shared responsibility between those providing care and those receiving it (**Wanless 2002**).

In this broader model of collaborative leadership, leaders will need to create the conditions for collaborative working with communities and staff. In the long term, various constraints may need to be removed, but in the short term, this may be about determining how to collaborate with the constraints that exist. Creating a sense of urgency through a strong narrative and shared purpose will be critical. Leaders will also have a key role in heading up the mobilisation of local assets and communities and will need to adopt the principles of system working. There will be less focus on plans and more attention given to demonstrating the values and behaviours associated with shared stewardship (Gould and Lent 2023).

Interviewee and survey respondents in our research were clear that NHS leaders need to be more outward facing and less internally focused going forward. They recognised that this will be difficult, especially in an environment of shrinking resources and multiple crises, as one interviewee noted:

Need to move to an NHS that is keeping people well rather than just treating illness...This requires a different type of leadership. It requires bravery and courage as you will be investing in something that may not show improvements for 10 years. It will require people to take risks. These risks will need to be managed across organisations. It will require leadership without an ego, and for some that will be really difficult. Success will come from partnership with others [and] a different leadership style that is more outward facing.

Adopting a more civic style of leadership will clearly entail having an even wider collaborative mindset as well as knowledge about the wider determinants of health. Such collaborations will fundamentally challenge some existing institutional processes and behaviours. But as people do not live their lives in service silos, there is an urgent need to redesign processes so that they are more rooted in the reality of local communities and people's lives. Collaborative leadership, with its emphasis on co-production, relationships, interorganisational connections and interdependencies, may well be an effective and practical approach to realise the transformations required for local people in our communities.

Appendix: Methodology

Our conclusions about the practice of collaborative leadership are derived from data collected from those practising collaborative leadership in and across health and care organisations.

Initially, we conducted a rapid review of the published literature on collaboration and collaborative leadership. Collaboration has been extensively written about, and contributions come from many disciplines, including sociology, management, public policy and psychology. Some of the literature focuses on the stages of collaboration, while some is concerned with the attributes, conditions or factors associated with success or failure. Taken together, the output of our synthesis provided a deeper understanding of the environmental conditions, leadership behaviours, skills and processes that influence effective collaborative working.

In developing our report, we have drawn on this literature review, together with our notes and observations from working with many different groups of leaders over the past decade. Most were participants on The King's Fund Building Collaborative Leadership (BCL) programme but, in some instances, we worked with senior leadership groups *in situ*. The overall aim of the BCL programme is to enable leaders to reflect on and question their practice of collaborative leadership so they can collaborate well and create the conditions for others to collaborate effectively. Consequently, our data is drawn largely from a population who are motivated to collaborate and, in many cases, hold a collaborative rather than a competitive mindset.

With each group, we worked together on the current leadership challenges they were facing, often sharing frameworks to offer new insights or potential ways of reframing their challenges. Sometimes new and unexpected insights occurred in these discussions that developed our own understanding of this style of leadership further. In effect, we adopted some of the principles of action research.

More recently, we also carried out in-depth interviews with 15 senior leaders drawn from a range of organisations, including NHS providers, ICBs and local authorities. The overall purpose of these interviews was to explore how leaders are practising collaborative leadership within ICSs. We had a good gender balance in the group and a third of the interviewees held senior clinical leadership roles. We conducted and recorded the interviews remotely. Participants were assured anonymity and their insights have been analysed accordingly. We triangulated all the data generated and analysed it thematically.

To build on the insights generated from the interviews, we also conducted a short online survey with more than 50 leaders drawn predominantly from the NHS, with a few respondents from local government and the VCSE sector.

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Acknowledgements

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Nicola Walsh is Assistant Director of Leadership and Organisational Development at The King's Fund. She works on a range of areas including health system reform, integrated care, population health and new models of health and care. She combines her organisational development skills with her health policy expertise. Her career has encompassed the charitable sector, academia, central government and the private sector. In previous roles, she has led national evaluation programmes and designed and delivered a range of postgraduate training and development programmes.

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Stephanie de Sarandy is an associate of The King's Fund and co-tutor on The King's Fund's Building Collaborative Leadership programme. She is a highly experienced facilitator and coach who works exclusively with senior leaders.

Stephanie has director-level experience, insight and knowledge of various industry sectors. Her business experience was gained through senior operational roles in Hewlett Packard and PwC and then as HR director for a start-up organisation. She draws on this business experience in her work. The organisations she works with are varied, crossing industry sectors, and public, private and not-for-profit organisations. Stephanie is also a visiting tutor at Cranfield Business School and a qualified coach.

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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In England, integrated care systems aim to realise collaborative working across health and care services, but after many years of government policies promoting organisational independence in the NHS, the switch to working together is challenging. How can leaders learn and practise the leadership behaviours, skills and practices that will mean integrated working becomes a reality?

The practice of collaborative leadership shares evidence insights from health and care leaders about how to collaborate well to build a stronger collaborative ethos across health and care services. The authors identify six key practices that underpin effective collaborative working:

- creating a safe, inclusive and trusting environment in which everyone can contribute fully

- building healthy relationships

- developing a shared purpose and shared group identity

- actively managing power dynamics

- surfacing and managing conflict

- developing shared decision-making processes.

Health and care leaders at all levels have a critical role in modelling and rewarding collaborative behaviours but this is insufficient on its own. Attention also needs to be given to six key leadership practices above. The authors also recommend health and care leaders extend the practise of collaborative leadership more widely to working more closely with local organisations, people and communities.