Article

Developing Effective Collaborations: Learning from Our Practice

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Abstract: In this article we explore the challenges inherent in developing effective interorganizational relationships in the context of supporting the integration of health and social care in Scotland. We begin by outlining the context of health and social care integration and the nature of the program. We then describe the theories that underpinned our approach and outline in detail how the approach worked in practice in one area. We go on to discuss our reflections on six practices participants found helpful in creating the conditions necessary for effective collaboration. Finally, we end by reflecting on our learning.

Keywords: collaboration; leadership; integration; shared purpose; accountability

1. Introduction

Health and social care integration has been underway across Scotland for the past 3 years. It involves a wide range of large and small, public sector and voluntary organizations working together in ways which are completely new for them and throws up a wide range of interorganizational dynamics. The authors are partners in a small business (Animate) specializing in supporting interorganizational and intraorganizational work. In this article we have chosen to focus on a large contract supporting health and social care integration across Scotland. We start by exploring the context, then describe our overall approach, focusing in detail on how we worked in one area as illustrative of our practice across the whole. Finally we clarify our learning about six practices, which we have found to be at the heart of developing the kind of interorganizational relationships which enable organizations to truly collaborate. We know that collaborating is not easy; by exploring the learning from our own practice, we hope to support other collaborations to achieve their potential more easily.

2. The Context

In 2016 the Scottish Government legislated to bring together health and social care in to a single, integrated system, joining up services and thereby improving the experience for those using support. An ageing population and the impact of austerity on health and social care budgets introduced another driver for collaboration—a decline in financial resources, which looks set to continue.

Although new integrated boards were created in 31 areas across Scotland with responsibility for large parts of the health and social care budget, the original National Health Service (NHS) Boards and local authorities, with statutory responsibility for social care, remained, and most staff are still employed by them. So, health and social care 'integration' is in fact mostly a process of (multi-party) collaboration by which two large organizations, made up of many different departments, and large numbers of smaller organizations, attempt to work together to provide a better and more seamless service to people with health issues; in effect, almost the whole population.

The Scottish Government realized that developing interorganizational relationships to enable such collaboration would need support, and as part of that support, funded three national health and social

care organizations, NHS Education for Scotland (NES), the Scottish Social Services Council (SSSC) and the Royal Scottish College of General Practitioners (RSCGP), to design a support and development program, Collaborative Leadership in Practice (CLiP) which drew heavily on their own experience of dialogue, coaching and action research methodologies and practice. They contracted with Animate, and another consultancy organization, similar in size and approach, to deliver it.

Through CLiP, we were commissioned to support collaboration in 10 partnership areas. Two members of our team, Jo Kennedy and Ian McKenzie, and one associate, delivered the interventions, whilst the third member of our team, Joette Thomas, supported our learning. The exact nature of the interventions we delivered was determined in collaboration with the partnership itself but it always involved either team coaching or facilitation.

3. Using an Action Research Approach

The program was managed by leadership development practitioners or project managers from the three national agencies, to whom we reported regularly in action research meetings, facilitated by a 'learning partner', who supported us to use an action research approach[1]. The idea was that we could encourage those who were part of CLiP to see what changes they were experiencing in themselves and their teams as they began to develop interorganizational relationships, which then resulted in changes across the wider organization(s) or system resulting in improvements for people in communities.

This action research approach meant that as we took action, we sought to understand the impact of that action together. It also worked on a number of levels. Firstly, and most importantly, it helped us to articulate a theory of change. This was that working on one's own attitudes, behaviors and assumptions about the other, and subsequently on our relationships with our fellow practitioners from other agencies, spreads better practice in our teams, changes the relationships between our organizations and ultimately can lead to positive outcomes for those using services. This theory of change made sense to practitioners. We used graphic tools to map it quite specifically, and practitioners then felt more legitimized in spending time exploring their own assumptions, their own understanding of collaboration and their role in relation to it, rather than immediately rushing to action. Secondly, it helped us to define a sense of common purpose, identify the changes we were seeking and evaluate whether we were achieving them. Furthermore, it helped us to track small changes over time in relation to the overall change we were seeking.

4. Developing Our Interventions

In all honesty, before writing this article, we had never considered in any depth, how our intra-organizational approach differed from our inter-organizational approach. We just knew from feedback from our clients, and from evaluating the impact, that the approach worked in both contexts.

Writing this article forced us to ask the question: how do we determine the interventions we use to support interorganizational collaboration? We also revisited the theoretical underpinning of our practice, which could best be described as eclectic. We draw on a range of organizational development theories and have trained in systems, psychodynamic and gestalt approaches to working with groups and organizations. When we began working interorganizationally we drew on many of the same theories and approaches we used in our intraorganizational work. We learned over time that there were three sources which made most sense to our clients, in the interorganizational collaborations in which they are currently working. The work of Heifetz (2009) on adaptive leadership helps us to support people to: navigate complexity by taking the time to stand back and look at the whole; be more comfortable with not knowing the answer straight away and understand the value of bringing different views and different approaches to an issue and indeed the absolute imperative to do that

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[1] For further information on the approach we used to learn and on action research more generally c.f. www.research-for-real.co.uk.

when faced with 'adaptive challenges' (Heifetz et al. 2009). Interorganizational collaborations, like health and social care integration, are set up to address 'adaptive challenges', like how do we improve the health and wellbeing of Scotland's population; the answer to which is not within the 'gift' of any single organization. We find that making the distinction between a technical fix and an adaptive challenge, language pioneered by Heifetz, is very useful for the practitioners we work with, who are extremely familiar with the pressure to provide quick solutions to complex issues, without taking the time to consider who needs to be involved, and how, in developing a new approach.

We have found Wilber's Integral Theory equally useful. The simple four quadrant diagram which we discovered originally in an article on Resistance Free Change (Klein 2009) supports us to explain the aspects of intraorganizational and interorganizational working, systemically. In his book on Integral Psychology (Wilber 2000), Ken Wilber defines Network Logic as follows: "A dialectic (dialogue) of whole and part. As many details as possible are checked; then a tentative 'big picture' is assembled; it is checked against further details, and the big picture is readjusted. And so on, indefinitely with ever more details constantly altering the big picture—and vice versa. The 'whole' discloses new meanings not available to the 'parts', and thus the big picture will give new meaning to the details that compose it." We do not go into such depth in working with practitioners, but we do highlight how easy it is to pay attention to the 'objective' and tangible systems, processes and competencies within an organization or between organizations, and ignore the 'subjective' aspects which are less easy to see, such as values and beliefs, individual hopes and aspirations, culture, informal working practices and unwritten rules. When explaining it we often cite the old adage 'culture eats strategy for breakfast' attributed to Peter Drucker. This often elicits a weary laugh from the practitioners we work with, who are used to multiple strategies, plans and protocols which are never embraced or enacted. Explaining how paying attention to the 'whole system' including individual aspirations, values and beliefs and the cultures which have grown up in teams as well as the more familiar external process in organizations, can provide a way to move forward and makes sense to practitioners in both intraorganizational as well as inter-organizational contexts. However, in interorganizational contexts it is even more meaningful. Practitioners are used to starting with developing new structures, new roles and new job descriptions, to promote interorganizational working, rather than seeking at the same time to explore how to make it possible for individuals and teams to work in completely new ways, ways which often threaten their sense of identity; and to understand and value the approach taken by another organization, without feeling threatened by that difference.

Finally, Kegan and Lahey's (Kegan and Lahey 2009) work on Immunity to Change, enabled us to provide practitioners with a way of seeing resistance as something to be understood rather than something to be overcome. The Immunity to Change process introduces the idea of the 'hidden competing commitment' which could be underlying the resistance to change and needs to be both honored and understood. It also challenges practitioners to explore the assumptions they make about what might happen as a result of making a change and encourages the testing of such assumptions. This process, again is useful in a wide range of contexts, not just interorganizational working, but we have found it particularly useful in that context, because interorganizational working always necessitates change and often provokes fear, which leads to untested assumptions about what might happen as a result of that change. The Kegan and Lahey approach gives practitioners a simple process to help them really understand their own and others' resistance, rather than deny it, ignore it or fight it.

Being eclectic in our theoretical approach sometimes makes it hard to explain exactly how we work in both an intraorganizational and interorganizational context. So, over the past two years we have done some internal work to try to clarify and define our distinctive approach, and have come up with a working approach, which we are calling 'Stretch'. Stretch is not based on our understanding of Heifetz, Kegan and Lahey and Wilber. Instead it draws on a whole range of theory which has influenced us and is firmly rooted in the learning we are generating from our current practice. As such, it is a work in progress rather than a finished product. Currently, it has six elements (or imperatives) which as consultants we try to adopt ourselves and to use to support the development of intraorganizational

and interorganizational relationships. The elements are be curious, be appreciative, be proactive, be courageous, be thinkers and be communicators.

We use Stretch when working within organizations and between organizations; but we find that in our work on interorganizational collaboration, particular elements come to the fore namely: curiosity, courage and communication.

Working interorganizationally necessitates being able to tolerate a high level of difference without finding it threatening or overwhelming. We know that from our own experience and from our coaching practice, that raising individual's levels of awareness and insight into the impact of their own behavior, particularly when fearful or under threat, can have a transformative impact on groups and organizations. We know from our psychodynamic training that, as individuals and groups we are naturally threatened by 'the other' and often find ways of excluding them. We seek to raise awareness of this in our interorganizational work by exploring the assumptions which naturally arise about 'the other' and examining the ways in which we both consciously and unconsciously exclude. Encouraging curiosity is one of the most accessible ways we have found to express this. To support curiosity, we use 'light' psychometric processes in the room to enable people from different organizations to gain more insight into themselves and others, and to grow in understanding of their own 'working style'. Sometimes, we consider the 'working style' which might be dominant in their own organization and encourage them to be curious about the working style that might be dominant in other organizations too.

Drawing on our understanding of the work of Kegan and Lahey in particular, we encourage individuals and groups to identify their assumptions about others and about the work they are doing, and to ask more questions of themselves and one another. Some of these questions involve taking risks. We acknowledge and support differences and potential conflicts to emerge, drawing attention to them in the room and opening up the space for conversations about them. These conversations often take courage on all sides. Clearly courageous conversations are necessary within organizations as well as between organizations, but we find that interorganizational working requires a particular kind of courage, which often means people stepping outside their 'comfort zone', being willing to question their own professional identity, taking the risk to share resources and sometimes giving up working practices or aspirations which have been dearly held.

Finally, we spend a lot of time exploring how and what to communicate both within and outside the room. Again, this is as necessary within organizations as it is between organizations, but it is even more complex interorganizationally. Organizations develop their own ways of communicating internally through formal and informal systems, which are often impenetrable to those from other organizations. The same words may be used to mean different things in different organizations. Rather than just examining communication systems, as we would when we work intraorganizationally, when we work interorganizationally we support both informal and formal communication processes to be dismantled and rebuilt to suit a new entity and a new purpose.

Running through all the Stretch elements is a relational, purposeful approach. This means that we work hard to get to know our clients as human beings, and we prioritize giving them the time to get to know one another too; believing this knowledge will support them to take up their roles more purposefully and effectively together. We focus on defining purpose at every stage, from every perspective, and try to keep the purpose at the forefront, seeking to clarify it throughout our intervention.

5. Interorganizational Working in Practice

As part of our work on one of the national programs mentioned earlier, our team has worked with ten health and social care partnerships across Scotland, over the past two years, all at different stages of integration. All face the same challenges, which can be summarized as: greater demand, which has to be met with fewer resources. The pressure just to 'get things done' is huge and mitigates against the time it takes to establish a common vision, clear roles and truly effective working practices.

To describe the context of all ten would mean getting into a level of detail, which is beyond the scope of this journal article. However, our approach, although tailored to the individual context, was broadly similar in all of them. So, the description of the one below gives an impression of our work across the whole. Names have been substituted to protect anonymity. The consultant working in the site was one of the three authors of the article.

Beston is a small town on the edge of a large city in Scotland. It was chosen by the Health and Social Care Partnership (HSC) as a site in which to launch an inquiry involving practitioners from across disciplines. George, the 'strategic program manager' asked Jo, a consultant with Animate Consulting, to attend a startup meeting with him, and several other senior health and social care managers, to scope out an approach to promote better joint working for the benefit of housebound elderly people. The initiative was seen as a way of trying out 'locality working' in practice, with the aim being that we could devise a process, which other localities could learn from.

General Practitioners (GPs) are the first point of contact for many patients; they are also the most likely to be working in isolation. The HSC partnership decided to focus the project around two GP practices. They invited the GPs to attend six meetings with other health and social care practitioners who were also supporting housebound elderly people. The intention was to see how together, the group could improve the lives of elderly housebound people by ensuring that they received more of the right kind of services at the right time. Crucially, the HSC gave Delia, the 'integration manager' time to support the initiative, inviting people, organizing rooms and following up actions in between meetings.

Meetings were held monthly over a six month period. Each meeting lasted three hours. Fifteen–twenty people attended each meeting. No one (except Jo) attended all six meetings, although most people were present for at least four out of the six meetings. They included: two GPs (from different practices), district nurses, a social worker, a day center manager, a mental health specialist, a community librarian, several people from voluntary sector organizations who were providing community support or support to carers, a pharmacist, an occupational therapist, an IT specialist and one or two senior managers. In all, 10–15 organizations were represented. Jo's role was to design, facilitate and support the inquiry process.

Setting up the first meeting required courage on the part of Delia, who issued the invitations. It was an unusual meeting because: it was long; there was no fixed agenda; it took place in a community setting and the practitioners had different levels of experience and of status within their own organizations. What they had in common was a clear intention to work together better to support housebound elderly people in their geographical area. The first meeting began with a focus on communication. Jo invited people to say who they were and why they were there. The GPs in particular found this useful. They had not met most of the other practitioners, and they were immediately curious about all the support that was available from the voluntary sector organizations. Already many people in the group were beginning to question the assumptions they made about those who worked in other organizations being in some way 'less skilled' or 'more informed'. Almost everyone found it strange: hardly anyone had had the 'luxury' of three hours to sit together and discuss how to tackle the issues they had in common. They started by considering what worked currently about the way they worked interorganizationally, taking time to get to know one another (rather than just read each other's name badges) and getting clear about the purpose of their work together.

They were invited to identify the kinds of changes they wanted to see as a result of this process. Aspirations included: more trust, stronger relationships, more community involvement, better use of technology and a stronger focus on personal outcomes. During the second half of the meeting we focused on four stories of real people who were using support in Beston. Four small groups worked to distil the learning from each of the stories. Several interesting conclusions emerged: Three out of the four people receiving services were overwhelmed and confused by the amount of support they received from different organizations; people were afraid to change their 'care packages' in case they could not get them back again if their needs increased and information recorded by one practitioner in one organization was inaccessible to others in a different organization.

Telling stories of the present engendered a desire for immediate action and practitioners highlighted things they wanted to do (like sharing information) or questions they wanted to ask (such as 'what is a wellbeing clinic and how might it work?') before they met the following month. During that first meeting one of the nurses was visibly angry and upset, fed up with the ever-increasing volume of work, and the inefficiency of the systems and structures. Jo encouraged her to speak out and the group members respected the courage this took by listening to her. By the end of the meeting she had agreed to take a lead on researching the wellbeing clinic. Although Jo did not explicitly use Wilber's integral theory she was encouraging people to think systemically, drawing on their own values and aspirations, considering the culture of their organizations, examining the systems they used and most importantly beginning to create a new interorganizational entity to support housebound elderly people better.

In between every meeting Jo met with Delia, to debrief, discuss progress and plan the next meeting. Delia communicated with individual group members between meetings and nudged actions. She was always able to keep Jo abreast of what was going on, highlighting underlying issues and ensuring that the agenda was really focused on moving forward. Jo and Delia quickly developed a format for the meetings, which encapsulated an action research approach. Each meeting began with a short recap, using a visual plan which was pinned on the wall, and an update on actions in the whole group, which took the best part of an hour. This was followed by an in-depth focus on two or three key areas, in smaller groups, which led to agreement on actions in the large group. They always finished by checking out how people were as they left.

The second meeting began with more introductions as new people joined. By this time the existing members of the group were able to explain that the group provided 'an opportunity for trial and error in a safe environment, a place to share enthusiasm and frustrations, energy and honesty, a place where we can learn, a chance to identify and talk about the big issues'. They caught up on progress in relation to the actions identified in the previous meeting. In addition, they focused on three areas: tapping into the lived experience of users and carers; medication and information sharing.

During the third meeting Jo used a visual scenario planning tool to identify the future they wanted to create, where they were now in relation to that future, and the key areas they wanted to work on. That provided them with six clear priorities to focus on. By this time the group was appreciating the distinction between technical fixes and adaptive challenges (Heifetz). They identified some 'quick wins' such as telling pharmacists which of their patients attended the day center so that they could drop off medicines there, to avoid getting overwhelmed by some of the more intractable issues, such as integrating different information systems. At the end, group members reported that the meeting generated 'lots of little things that will make a big difference' and provided 'a forum that works towards integration that we can't find in the day to day'.

And yet, Delia and Jo were beginning to get impatient themselves, and were sensing that group members might be too. Group attendance was irregular and actions agreed at the meeting were not always being carried out between meetings. They were struggling even to get started on developing integrated systems across agencies, because the individual systems were not functioning themselves. Some practitioners had competing priorities and were not able to give the work the attention they wanted to, and others, found the cross-sector approach threatening to their sense of identity and professionalism, and stopped attending. The GPs were attending but were still skeptical and although positive in meetings were struggling to prioritize taking action in between.

During the fourth meeting they talked about some of these difficulties, using the Kegan and Lahey insights on resistance to examine what was underneath some of the barriers. The group had still not managed to identify how many housebound elderly people the GP practices supported. Nor had they managed to coordinate support around them. Getting to the bottom of who was 'housebound' and considering how to surmount the legal obstacles to sharing information, was tedious and taxing work. Having had the courage to acknowledge this, they recharged their energy by turning their attention to making the best use of the voluntary sector day center. They developed ideas for 'small tests of change', expanding its use by statutory sector agencies. By the end of the meeting the GP was

commenting: 'I am learning more about how other organizations work—these small tests of change are very important—I see my role as information sharing—I will ask the district nurses to pop into the day center'.

Delia and Jo were conscious that there were only two meetings left and during the fifth meeting they focused on what group members felt should become 'business as usual' in the HSC partnership, with a particular focus on developing flexible care packages for people (so that they did not feel the need to hang on to any support they were offered) and devising efficient ways of sharing information between agencies.

Delia and Jo met with senior managers to consider the results of the initiative before the final meeting. They were both anxious, aware of how slow progress had felt in relation to some of the key issues they had identified at the outset; however, the managers were very positive. They recognized a strong foundation for future collaboration. They saw that giving staff time away from the frontline had been valuable. Four ways to continue the work were identified: monthly multi-disciplinary team meetings in each GP practice, focusing on particular patients; continuing to work on far more flexible review process which really put the person at the center; developing the role of the voluntary sector day center and continuing to tackle the obstacles to information sharing.

During the sixth and final meeting they agreed plans to take forward the four initiatives. We ended by checking back against the outcomes agreed at the beginning. Group members identified that they had improved communication and understanding of each other's roles, made new partnerships and found out how to help one another to provide better services. They spoke of practical integration on the frontline. One member said 'we have gained traction' whilst another spoke of 'inspiration, enthusiasm and commitment'.

6. The Six Practices

The Beston story typifies our approach to supporting interorganizational collaboration. Using the three elements of Stretch: be curious, be courageous and be communicators, helped us design our interventions. We invited all the relevant partners to be in the room together; we took time to get to know one another, and one another's roles; we agreed a shared purpose, which mattered to all of us; we acknowledged diversity and recognized and worked on frustration; and we tried out small tests of change, building those that worked into 'business as usual'. Although it worked well enough, we only really scratched the surface in terms of being able to talk openly about some of the tensions and power imbalances between partners. This was largely because the group was fluid as most practitioners could only afford the time to attend some of the meetings. Prioritizing time to think remains very hard for practitioners delivering services, which means that developing adaptive solutions to complex issues is a real challenge.

However, Stretch really only defines our approach. The group created practices together which enabled their interorganizational relationships to develop and true collaboration to take place. These practices were facilitated by Stretch, in particular the support of courage, communication and curiosity and most importantly a clear and unequivocal focus on purpose and outcomes for people using services. In the rest of this article we explore the six practices, adopted in Beston, and in other areas, which for us have become the hallmarks of interorganizational collaboration. We identified the practices through reflection. Jo and Delia reflected first, in between each meeting in Beston, discussing what they had learned from the meeting, which interventions had worked well and what could be improved, and designed the approach to the next meeting together.

The authors also reflected as a team, telling stories from Beston and the nine other partnerships which made up our part of Collaborative Leadership in Practice, and drawing learning from our practice, using a reflection cycle and with the support of our learning partner.[2]

The practices are:

- Suspending disbelief;
- Defining a shared purpose which everyone can sign up to;
- Developing accountability to a shared purpose;
- Exploring diversity and building trust;
- Designing purposeful structural change;
- Supporting courageous and systemic leadership.

6.1. Suspending Disbelief

Many of those in health and social care have experienced a lot of change throughout their working lives. They have not initiated much of this change, and sometimes it has not led to better outcomes for themselves as practitioners or for those using services. Integration requires a suspension of disbelief. It means taking the risk to set up a new system in which professionals take up new roles and do things they are not accustomed to doing. It requires some give as well as some take, and it will take some time to see whether the risk will pay off.

> "Will our patients get a better service at the end of all this? I can see it is a massive amount of work to make it all join up." (GP)

We saw some practitioners willing to suspend disbelief and take the risk. We saw other practitioners, and particularly those who have little experience of interorganizational working, reluctant to take the risk, and quite deeply entrenched in their own system. Sometimes this related to power. Those with the most power, were often the most reluctant to collaborate, because it meant sharing it. Those with the least power, had little to lose by collaborating.

What we found helpful in encouraging people to suspend disbelief and take the risk to establish interorganizational relationships, was to foster a sense that something had to be done, both by looking at what worked currently, but also by exploring honestly the failings in the current system and how they impacted on particular people, both patients and practitioners. This created urgency.

What practitioners valued most in almost every workshop we ran or every event we facilitated was the chance to understand what each other did. As soon as they began to explore each other's roles and each other's organizations in any depth, they almost always found ways of helping one another in very practical ways. These turned into what are commonly known as 'small tests of change'. For instance, GPs began changing their prescribing practices so that home care staff did not have to visit so often, and housebound elderly people could go out to a local lunch club rather than stay in so that a worker could visit them and support them to take their medication. This meant the GP having to spend more of their budget on medications which could be given twice a day rather than four times a day, but they were willing to do it because they could see what a difference it made to the quality of life of their patients. These small practical experiments in doing things differently began to add up to a conviction that maybe things could be better through collaborating across and between organizations.

Suspending disbelief was facilitated by the three elements of the Stretch approach: curiosity, courage and communication.

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[2] We use a variety of reflection cycles but they all start with us individually telling stories of our experience and then going through a cycle which includes observing, reflecting, planning and identifying actions (ORPA designed by Research for Real and based on the work of Yolande Wandsworth).

6.2. Defining a Shared Purpose, and Getting Everyone to Sign Up to It

Health and social care integration aims to evidence high-level outcomes, which are achieved for society as a whole and not just for the participating organizations.

The pressure to produce these outcomes as a result of integration is intense and unrelenting. The Scottish Government are expecting more for patients and people who use services, at a lower cost. At a societal level, there is a real reluctance by politicians, and the general public, to accept that the present system is unaffordable and health and social care services will need to be rationed in some way.

In practice this means that difficult decisions about where to ration are left to local health and social care leaders and managers again requiring courage. As well as improving services, health and social care practitioners are tasked with improving public health overall (as a way of reducing demand), and mobilizing as yet undefined, community resources. Given this context it is no wonder that the task can feel overwhelming and produce both a sense of hopelessness and embattlement. This is compounded by media coverage, which is mostly hostile.

Within this context, we commonly found that people were inclined to 'get on with the job' without beginning with curiosity or communication which could lead to establishing meaningful tasks, roles and responsibilities. Developing a shared purpose enabled practitioners to explore their own role in relation to delivering that purpose and to explore what felt new, different and challenging about it. This makes it sound as if the purpose was fixed and immutable. In Beston it was not. As issues were explored, short term and medium term goals like encouraging the nurses to visit older people whilst they were at the lunch club, rather than in the homes, which meant they had to stay in all day, were constantly revisited and refined in the light of new knowledge. The long term goal of improving the wellbeing of housebound elderly people through improving their services, remained the same.

Ensuring that those who would be working towards the purpose were part of defining it was crucial. We saw several plans written by consultants or managers, which felt at best meaningless and at worst dishonest, to those working on the ground.

6.3. Developing Accountability to a Shared Purpose

Health and social care partnerships are accountable to the Scottish Government for delivering targets. These targets are often imposed from above, can be controversial, are often resented by practitioners on the ground and little understood by the general public. Instead we attempted to develop a sense of accountability to people who were using services and putting them at the heart of the shared purpose was fundamental to this. The ideal way to do this was to get them in the room as part of defining this purpose. However, this was not always possible. So, we encouraged practitioners to bring their stories into the room and started with those, trying to ensure that those closest to people using services had a strong voice. This worked well in Beston, where we started the process by focusing on 4 case studies of older 'housebound' people; creating in those in the room a sense of wonder, that people had so much unnecessary and conflicting support, a sense of frustration both at the waste of resources and the distress caused to the recipients of the services and an urgent desire for change and improvement.

6.4. Exploring Diversity and Building Trust

Schruijer points out that "successful collaboration means being able to work with diversity . . . diversity which in itself gives rise to distrust, stereotyping and conflict" (Schruijer 2006).

Providing health and social care services to the whole population naturally entails a huge range of diverse specialisms and skills. Interdisciplinary working adds another dimension to interorganizational working. It is at its most effective when these specialists can work well with one another across organizational boundaries. For instance, when a GP (who works within her own small partnership business) knows enough about an older person's support at home, that she can prescribe medication

to be taken at a mealtime when a home carer (who works for the local authority) is likely to be there to administer it.

Exploring diversity could be both an affirming and exciting experience in groups when they began to realize the potential of what was on offer. However, they could also experience it as threatening, particularly when their own specialism was under threat and when their organizations were competing for scarce resources.

In several interorganizational groups we experienced a real reluctance to talk about the painful and threatening aspects of working together. This manifested itself in conflict avoidance, which resulted in simmering frustration, or at the other extreme a refusal to talk to or work with people from different organizations. Both these behaviors naturally enough resulted in unproductive collaborations in which a lot of time and effort was wasted in either avoiding difficult subjects or not being able to get the right people in the room to talk about them.

Good solid working relationships are at the heart of collaboration. Building these relationships across organizations takes time, commitment and a willingness to take a risk to notice areas of disagreement and explore difference.

We have noticed two attitudes to relationship building. The first is the assumption that they are already built, which made us wonder whether participants were 'colluding' in avoiding the discomfort and conflict, which might be inherent in going a bit deeper and working towards meaningful change.

We experienced this phenomenon strongly in one partnership in which we worked, where a real discussion of difference was seen as very threatening. We were constantly told that relationships were good and therefore coming together was a redundant activity; managers just needed to be left alone to get on with their work in their way. All difficulties were blamed on budget cuts and poor leadership.

This entrenched sense of powerlessness and being victims of forces beyond their control, was the view of a minority of group members, but they had a strong voice, and other members of the group found it impossible to challenge them. When we challenged them, we felt more like school-teachers, than facilitators or consultants.

Over time this changed. Two years later, those most resistant to change have moved on, managers have begun exercising their power in more constructive ways and difference is being confronted more openly. However, there is a deep-rooted power imbalance between the two main parties, health and social care. The split in the senior leadership team is acknowledged but entrenched, so progress is both slow and frustrating.

The second attitude we encountered was that it is not worth taking the time to build relationships because we need to get on with the work. What we have found is that taking the time to explore what matters to people, individually, what their work experience is, and what their values are, provides a strong foundation for developing a common endeavor, as is demonstrated in the Beston example detailed earlier. It enables people to overcome their instinctive fear of 'the other', and to challenge their assumptions about the other's motivations. It leads to the development of working relationships which are based on respect rather than assumptions; where each partner recognizes the value in, and the contribution of the other. It enables the development of trust, where each partner is confident that the other is committed to the same end; and will put that end before their own organizational or individual interests.

It does not avoid conflict but it does create the conditions in which difference can be addressed constructively, rather than explosively or covertly. Ultimately it leads to getting the job done quicker and more effectively because there is less chance of miscommunication and misunderstanding.

When people have the courage to name either their fears or their suspicions, it often had a transformational effect on the group, who were then able to work together in a far more meaningful way. Sometimes this could be as simple as someone saying they felt overwhelmed and unsupported, as the nurse did in the Beston example. That was an experience others could relate to, and it felt true enough that the group immediately understood that we were there to work on the real issues.

Creating safe enough conditions for groups to work in this way was often challenging. Trust takes time to develop and can only be sustained if all parties demonstrate through their actions as well as their words, that they are working towards the same goals. Open and transparent leadership, which modelled a strong collaborative approach was key and is discussed later.

6.5. Designing Purposeful Structural Change

> "I might have had this almost mystical belief that the structures and processes we are putting in place will lead to integration, when the hallmark of integration will be relationships and dialogue. It needs to be built on that solid foundation, otherwise nothing else will work, whatever procedure you type up and circulate." (social work team manager)

New structures bridging organizations were often created, before purpose and working practices had been explored, before relationships had been developed and before a new culture had even been discussed let alone defined. The urge to act quickly and concretely without real forethought was strong. One practitioner commented:

> "Health and social care integration is not about new structures, but about how we make services work locally. When you make it real and concrete through relationship and dialogue, it makes sense." (participant)

Part of the hopelessness and disaffection we encountered in our work in integration came from a mismatch between the aspiration and the reality epitomized by structures, which were impeding rather than facilitating collaboration (this was particularly true in IT where it is very difficult to share data). Structures were also failing to hold people to account for poor performance and to enable and reward good practice.

The most effective structural changes followed a clear agreement on what would support working to purpose and were facilitated by good relationships. This meant that even when structural change meant people either losing their jobs or being redeployed, they could see the rationale and justification for it in relation to the wider outcomes for those benefiting from the collaboration.

> "We deliberately didn't focus on structural moves at the beginning—our focus was on working together ... structure would come later and is still coming, we are trying to get the best fit at this point in time, structural changes create huge tension, leave all of us feeling insecure." (leader within a health and social care collaboration)

6.6. Courageous and Systemic Leadership

The biggest common denominator for successful collaborations was courageous and systemic leadership, at different levels of the organizations. This meant having leaders at the top who were willing to take the risk to challenge the targets imposed on them by government. It meant leaders who showed that they were willing to look beyond their own and their organization's interests to the wider interests of the collaboration.

It meant leaders who were willing to try new ways of working, knowing that they might fail. It meant leaders who took the time to listen and try to understand the whole picture rather than become immersed in one part of it. It meant leaders who were willing to create a structure for the long term rather than something which suited their interests in the short term. One leader spoke about this as designing a collaboration that would work for the next generation of leaders, rather than for himself or his colleagues.

It meant leaders who were willing to listen to the dissenting voices and acknowledge where they were right rather than trying to shut them down.

It meant leaders who were willing to give themselves and others the time needed to explore the underlying issues and complexity rather than reaching for immediate and short-term solutions.

We saw plenty of examples of this kind of leadership. It added up to systemic leadership, which moved from blaming one party or another to a real understanding of how the current conditions had been created and what needed to be done to address them.

We also saw plenty of examples of failures in leadership where leaders modelled putting themselves before the interests of the collaboration often in quite concrete ways. One leader sought a pay rise whilst arguing that he did not have the finance to set up permanent collaborative roles. Whilst there were undoubtedly good reasons for the pay rise it had a devastating effect on the morale and credibility of the collaborative venture.

Although modelling good leadership at the top of the collaboration is crucial, good leadership at every level is at the heart of making a difference on the ground and delivering positive outcomes for people in communities. One leader commented:

> "Empowerment of staff helps to get things happening from the bottom up. There are things happening that they don't tell me these days. It is not out of control but good innovation, it's a trust thing."

7. Final Reflections

Through reflection we came up with the six practices any interorganizational collaboration would do well to adopt. Taking the plunge and suspending disbelief was fundamental to getting started on collaboration in the context of health and social care integration. Defining a shared purpose and developing accountability to one another for working towards that purpose gave an impetus and a clear direction to the collaboration. Taking the time to build relationships, explore diversity and tackle the difficult dynamics inherent in difference, ultimately facilitated faster and more purposeful action. And finally, modelling courageous and systemic leadership at every level renewed energy and motivation.

What we have learned is that good intentions are not enough. For collaboration to be effective there needs to be a very clear purpose which is foreground and center all of the time. Even with that clear purpose, effective collaboration takes time, effort and commitment, so finding real ways to notice the difference it makes from the outset is crucial. These differences do not have to be large. For practitioners to commit themselves they just needed to see small improvements in the lives of their patients, which ignites their hope that working together could be far more productive than working on their own or in their own silo.

The work of Heifetz, Wilber and Kegan and Lahey has proved useful both to us in developing our thinking and our approach as facilitators and consultants, and to participants in interorganizational collaborations when we have used it directly. We are still discovering which elements of our Stretch approach work best in the interorganizational context. Encouraging curiosity, developing new ways of communicating and providing conditions in which people can be courageous have definitely worked, but undoubtedly there is more that we can learn about this. Senior leadership came to endorse the value of spending time together to work on developing relationships and exploring roles and purpose before plunging into action. It was not without frustration but it did allow us to explore pain and frustration in a meaningful and ultimately productive way.

The last words come from participants in the Beston collaboration who have continued to meet and address their common issues in smaller configurations:

> "I feel really energized, the openness has been really encouraging—this work could have such a big impact." (Occupational Therapist)

> "I am sensing real enthusiasm from our different roles—this work is really important— and it is about aligning needs with support rather than having an agenda about cutting services." (service manager)

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