

Trustworthy Collaboration

Building trust across health systems

A report for NHS Employers



Contents

Section	Page
Acknowledgements	3
1. Executive summary and main recommendations	4
2. Literature review	11
3. Research methodology	18
4. Obstacles to trustworthy collaboration	22
5. Facilitating trustworthy collaboration	27
6. Recommendations	37
Appendix i: Royal Free London case study	41
Appendix ii: Stockport Together case study	47
Appendix iii: Somerset Symphony Programme case study	52

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Stockport Together

Somerset Symphony Programme

Royal Free London

1. Executive summary and main recommendations

Trust across complex and multiple systems. Easy to say but difficult to achieve.

The Vanguard programme in the NHS came out of the Five Year Forward initiative published in October 2014 by a partnership of the major NHS organisations: NHS England, the Care Quality Commission, Health Education England, NHS Improvement, Public Health England and the National Institute for Health and Care Excellence. This partnership initiated the programme in order to develop new models of care, using Vanguards to develop and test new approaches to improving and integrating services.

Now in its third year of operation there are 50 Vanguards, each developing and testing one of 5 types of care model:

- Integrated primary and acute care systems – joining up GP, hospital, community and health providers.
- Multispecialty community providers – moving specialist care out of hospitals into the community.
- Enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services.
- Urgent and emergency care – new approaches to improve the coordination of services and reduce the pressure on Accident and Emergency departments.
- Acute Care Collaborations – linking local hospitals together to improve their clinical and financial viability, reducing variation in both care and efficiency.

The Vanguard movement in the NHS is but one example of the Service innovating to promote cross boundary working. In part this is being encouraged in order to address the need to save what Chris Ham from the King's Fund has called "*eye watering amounts of money*". The Vanguards, and their successors the Sustainable Development Plans or STPs, require different providers within the NHS, Local Authorities and the private sector, to respond in an **integrated and collaborative way** to the challenges, some might say crises, in health and social care.

As a proposition it is hard to fault. The private sector and broader public sector are also being encouraged to embrace the advantages of collaboration. The leading management and leadership commentator Margaret Heffernan, in her book *The Bigger Prize*

published in 2014, extols the benefits of collaboration for business. At the same time, for instance, Higher Education Institutions are being encouraged to work in partnership with other universities whilst simultaneously being measured and ranked for their teaching, research and student experience on the basis of their individual institution.

In parallel there are calls across all sectors for a move away from traditional models of autocratic and command and control type leadership towards styles which emphasise the importance of establishing relationships – relational leadership. Professor Michael West in his King's Fund report, published in May 2017, extols the benefits of "compassionate leadership". However, as Ham, Alderwick, Dunn and McKenna point out in an earlier King's Fund report, February 2017, with the NHS currently under such pressure, "There is a risk that work to sustain services will crowd out efforts to transform care." (p.2).

The problem with both the idea of the Vanguards, and indeed, the Sustainability and Transformation Partnerships, lies not in the attractiveness of the destinations. Few could dispute that achieving effective and integrated collaboration across different health and care providers is a laudable aim. The problem lies in getting to that destination. It is the journey that is troublesome. As ever, managing the implementation of change remains far more difficult than setting strategy. It's a tall order to seek to change a whole regulatory and funding system within the NHS at the same time as expecting today's leaders to reengineer their mind sets away from the last 30 years' emphasis on competition and towards collaboration. This involves changing their routinized leadership styles and beliefs, plus their everyday managerial behaviours which in the past have been

moulded by politicians and regulators onto a course of competition. Requiring collaboration amongst the very organisations with whom they previously competed requires leaders to recalibrate all their routines and metrics towards a very different destination and way of seeing the world. As Heffernan observes about the world of collaboration:

“Collaboration is a habit of mind, solidified by routine and predicated on openness, generosity, rigour and patience. It requires precise and fearless communication, without status, awe or intimidation. It’s hard because it allows no passengers: everyone must bring their best. And failure is part of the deal: mistakes, failed prototypes, dead ends and clouds are a necessary and inevitable part of the process, to be greeted with support, encouragement and faith.”
p.373.

To say that working in collaboration requires a transformational change within individual NHS leaders, their organisational units and the whole Service’s system of regulation and legislation, is an understatement. Yet this was the challenge facing the top leaders of the partner organisations within the Vanguard movement. It was a very risky journey for all senior managers involved.

From earlier research conducted in the wake of the financial crisis, it had been established that highly trusted organisations and senior managers were able to lead their employees through significant often highly negative change whilst still retaining their trust (Hope Hailey 2012, 2014, 2014a). For the Vanguard movement then trust seemed an important ingredient for ensuring success. However, to kick start this change it was vital for senior leaders to swiftly establish trust with other leaders across multiple and complex systems. How they achieved this is the focus of this study. We go onto summarise our main findings and make recommendations. However, each of these main findings is supported by a much more in depth analysis within each of the chapters.

Chapter 1 of this report includes the executive summary and main recommendations. In Chapter 2 we review the research that has been undertaken within the area of inter-organisational trust, which formed the basis for our investigation. Chapter 3 describes the methodology we used, the access within individual Vanguards we used for case study data collection, and the chapter also sets out the implementation and analysis of the quantitative survey we conducted across all the Vanguards. Chapter 4 identifies the main barriers leaders identified in the process of getting Vanguards established whilst Chapter 5 describes in depth the senior leadership behaviours and practices that enabled trust to be

built over time and across different institutions. Chapter 6 sets out the recommendations from this research. The case study data is presented in the Appendices.

For the remainder of this introduction we summarise the main contents of those chapters. Readers should regard each subsequent chapter as providing further, in depth information about the subject under analysis. Some may wish to understand the existing research better whilst others may wish to look at individual cases in more depth. The choice lies with the reader. In summarising each chapter we can only attempt to present the main findings but we advise each reader to look at different chapters in more depth.

An overview of existing published research into trustworthy collaborations and leadership (Chapter 2).

In this chapter we review the literature on trust in horizontal collaborations or partnerships to establish what is already known within this area. Collaborations between organisations are outside traditional hierarchical mechanisms of control. Instead they are cooperative relationships negotiated through ongoing communication processes. In the initial stages, at least, this requires consensus building and partners being willing to make inevitable trade-offs. If trust can be established, the process of building collaboration will be smoother. Whilst a formal written contract can minimize the risk of entering into a collaboration, trust can maximize a partnership’s potential. Trust can act as an accelerant for the performance of partnerships.

How do we define trust? The most useful definition we have used is by Rousseau:

“A psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behaviour of another.”

As trusting someone means making oneself vulnerable, it is built over time as each of us go through cycles of learning about each other. As captured by the Dutch proverb: trust comes on foot but leaves on horseback. So, trust builds up slowly but can be lost suddenly if a violation occurs.

Thinking first about vertical trust relationships, within an organisation trustworthy leaders support others in building positive expectations about them by investing time in face to face interactions, making sure they are regularly visible to employees, and by being not only honest but also open. Trustworthy leaders are approachable. Trustworthy leaders do not conceal (Hope Hailey et al, 2014).

Yet across organisation boundaries there are many key differences. Senior leaders are also likely to spend less time in the partnership setting than they are in their own organisation. Yet it is through face to face encounters that one assesses another person's trustworthiness. Proximity helps trust. So, in a partnership situation the senior team may be comprised of leaders deemed highly trustworthy within their own organisations but they still face the challenge of establishing trust with their new peers. This is because of the absence of authority (and therefore supposed ability or competence) through hierarchy, the absence of rules and penalties for untrustworthy behaviours and the absence of a deep well of trust between them and their new peers, which in contrast with their employees has been built up through multiple observations over a long period of time.

What does it mean for leaders? It means that senior managers in collaborations have to bring very different additional leadership competencies to the top table to those associated with hierarchical "within organisation" trust building.



Reviewing existing research studies we used the established drivers of trustworthiness: ability, benevolence, integrity and predictability (Mayer et al, 2007; Dietz and Den Hartog, 2006) as a framework for comparing how these four drivers might manifest themselves in different ways from what we see in "within organisation trustworthiness" compared with "across organisations trustworthiness".

Within an organisation trustworthy leaders build and maintain interpersonal trust by demonstrating not only consistency but also competency. They demonstrate ability through their knowledge, skill and professionalism but a certain amount of ability or competence is often associated in people's minds with positions of hierarchy (Hope Hailey et al 2014). A senior manager in a hierarchical setting might be assumed by others to have ability or competence because of

their ascendancy to the top echelons of the organisation. This is not necessarily the case when working in leadership teams cooperating across different organisations and systems.

Across organisational boundaries there are many people involved in collaborative partnerships but some people still remain more important than others. Leaders acting as boundary spanners negotiating new ways of working in senior collaborative teams have a key part to play as powerful decision makers. Their position as decision makers has importance but they also act as role models for the practice of inter-organisational trust – they will be watched by everyone else lower down in their own organisation. Employees will, on the basis of what they observe in these senior leaders, assess their own personal commitment to any new collaborative arrangement before taking a risk by changing their working practices to make the partnership work.

Within organisations there are still many risks for employees in trusting a leader – a leader could damage your trust by knowingly taking advantage of your vulnerabilities. We share information with someone we trust on the basis we expect them to use it in good faith. Within organisations, as well as showing consistency and competency, trustworthy leaders therefore also have to demonstrate their benevolence by showing an interest and recognising the needs of their staff. They behave with integrity by not acting opportunistically and not taking advantage of another's vulnerability.

Across organisations research on collaborations suggests there are added complications in the form of certain behavioural barriers such as 1) interfirm and inter function conflict; 2) nonaligned goals leading to opportunistic behaviours; 3) an inability to share sensitive information. All three of these barriers threaten the development of trust in collaborations.

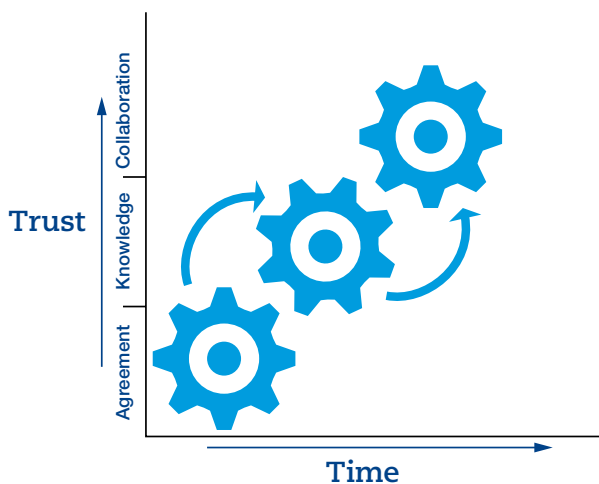
How should senior leaders practically plan a navigation route through this minefield of potential conflict and distrust amongst partners? Research published in 2015 suggests a cycle of increasing trust for collaborative partners involving 3 stages:

Stage 1 - agreement driven trust based on formal contracts and agreements;

Stage 2 - knowledge driven trust as parties become accustomed to each other; and then

Stage 3 - collaboration driven trust, trust that is built out of the willingness to take a risk because by this stage one has sufficient knowledge about the intentions of the other parties.

Although in the first stage the presence of a contract might provide a sufficient “entry” level of trust, once partners see benefits from the collaboration, and their knowledge of each others’ skills and competencies increases, trust in turn fosters cooperation (Pomponi et al, 2015).



This early level of vulnerability and potential for conflict means that sharing information in a collaboration can help to build trust in the second stage and prevent dissent. Research has also shown that “personal chemistry” between leaders can help partnerships move from a formal contract based form of trust towards the second stage of knowledge based trust. Similarly establishing aligned goals at the outset can help to reduce the potential for conflict and increase trust:

“Practices that bridge organisational boundaries – such as goal alignment, frequent and open communications, high levels of managerial interaction, the exchange of expertise and resources, and a willingness to share risks and rewards – are the essential elements from which a collaboration capability is built.”

In sum, the literature on inter organizational trust concludes that competing behaviours and avoiding behaviours between partners are unhelpful but collaborating and compromising (addressing the changing needs and finding solutions to meet all parties’ needs, or partially meeting all parties’ needs) can ultimately improve the performance of an alliance. In our data collection we examined these behaviours at a senior leadership level in more depth.

How we delivered the research project (Chapter 3)

Having conducted a review of existing research we then collected data within the three Vanguards, analysed the data and constructed case studies. Using the results from this qualitative piece of research, coupled with established validated scales from published research, we constructed a quantitative survey which was distributed across the Vanguard movement with the help of NHS Employers and NHS England. Having analysed the survey data and compared that with the case study data, we then held a workshop with leaders from the Vanguard case studies, NHS England and NHS Employers. They provided a reality check on our findings and a helpful extension of our ideas. The observations made within that workshop are reported in Chapters 4 and 5 along with the main findings from the qualitative and quantitative data.

We experienced significant difficulty in gaining access to Vanguards to collect qualitative case study data and in persuading the whole Vanguard movement to participate in the survey. Based on 30 years of management research, we can say that getting people to participate in this project has been more difficult than anything we have done before, and that includes several previous projects within the NHS. We observe that the pressure that people are experiencing within the NHS affected their availability for this research which is, whilst regrettable, completely understandable. However, with this health warning in mind, this research should be seen as a pilot project. We have managed to construct a broad brush description of senior managers’ perceptions of 1) their experience of participating at the leadership level of these Vanguards and 2) what it has taken to establish trust across different organisational boundaries.

Barriers to creating trust across systems – evidence from the data (Chapter 4)

Five key barriers were reported by case study participants: competition in the system; third parties, legislation and regulation; organizational reputation; organizational culture; and individual anxieties. Each case study at the end of this report has a more comprehensive description of the barriers reported in that specific

Vanguard. Results from the wider quantitative survey underlined these major concerns.

Many partners had competed in the past against each other either for budget, staff, to be a provider of a particular service or to be ranked better in particular performance metrics. In the broader survey a third of partners reported being in competition with each other whilst a further third reported the absence of competition.

Third parties, legislation and regulation were also seen as barriers in the case studies. Here the source of distrust was not between partners but from a shared sense of uncertainty about the future action of third parties such as regulators, NHS England or politicians: “What really will the Department of Health do or will NHS England really support us?” However, the wider survey showed that the average respondent did not believe that participating in a Vanguard would damage their own organisation’s quality or financial ratings.

The reputation of another party’s actions in the past could be the cause of distrust over their intentions and integrity or benevolence towards their partners in the present. Consistency of behaviour was key to overcoming this distrust.

Different cultures create a variety of mind-sets within the broad NHS and care system and there was often an expression of surprise at the existence of those different world views or worse a lack of empathy towards that difference.

The uncertainty, complexity and unpredictability surrounding the creation, operation and future of the Vanguards only helped fuel the personal fears of individual leaders as expressed in the case study data: “This is much bigger than anything I’ve been involved in.” Leaders feared ceding power and control over their working practices. Yet paradoxically it is only by “opening up” and sharing concerns with each other, that partners can move from a contract driven Stage 1 cycle to the knowledge based trust experienced in Stage 2. The broader survey responses showed that the average respondent agreed that parties in Vanguards would need to cede control.

Facilitating transitions – evidence from the data (Chapter 5)

Here we identify the major behaviours or actions that enabled leaders in collaborative partnerships to demonstrate their trustworthiness through their ability and competence, their benevolence, their integrity and their attention to reliable and consistent behaviours over time.

Ability: it is important to demonstrate ability by deploying relevant experts or expertise. This took the form of using people who had experience of cross boundary working in the health sector and/ or people who could use data analytics or logic to build a case for the partnership. The case study data revealed the importance of using clinicians to lead cross site communications. Ability and competence was also demonstrated by mobilising resources or removing blockages to implement “quick wins” to the rest of the organisations. At the same time it was as important to recognise the limits of people’s capabilities to effect change and, crucially, not to over promise. In the broad survey most respondents agreed that their partner had demonstrated early on their ability to make small changes and had used data or logic appropriately to build a case for partnership.

Benevolence: knowing the needs of partners was a way of demonstrating benevolence but this took time and energy on the part of leaders. This was relationship leadership in practice. Helping others out in difficult circumstances was very motivational – going beyond “formal partnership agreements” to support each other. Respondents in the broader survey agreed that their partners were benevolent.

Integrity was slightly challenging. There were good examples from the case data of the benefits of agreeing a shared vision or even a shared problem: “Do we fight or collaborate? We had done the fighting and realised an aggressive approach wasn’t getting us anywhere.” Case study respondents said that agreeing a shared vision was helpful but that really living the shared values of the partnership was problematic alongside delivering the everyday needs of their own organisational units. Furthermore, when faced with difficult choices, over a third of the broader survey respondents’ responses reported that sometimes their partners changed the facts slightly to get what they wanted. Deception is clearly not good for trust. What seemed to work better in the cases was an open and honest discussion of the dilemmas each party faced in standing by the partnership. In addition, inclusive decision making helped: “I get paranoid about not being aware of things and not being included.”

Predictability: frequency of contact and proximity breeds familiarity and promotes trust. Physical, tangible symbols were vital in the cases ranging from the creation of a “hub” type shared working space for partner organisations to a shared tea fund! The broader survey threw up a challenging result with 30% of respondents reporting that partners promised to do things without doing them later. Having ground rules for behaviours, regularity of meetings helped but sticking to them may be another matter.

Leadership behaviours underpinning all of the above included: influencing others, appreciating and challenging ideas. Thinking of yourself as a leader of a system rather than of a single unit helped as did investing time in dialogue with each other and understanding another's world view.

Recommendations

Recommendation 1 – There are differences between vertical trust relationships and the creation of trust across complex systems. Based on the research of the Vanguard movement and a review of related studies, there appear to be 3 distinct cycles within the creation of collaborative trust:

Stage One – Agreement driven trust

- In this initial stage of collaboration partners may draw up a written agreement which sets out the ground rules and objectives for the collaboration.
- Evidence based decision making should be used here, particularly with clinicians. Leaders need to show solid evidence, drawn from data analytics on other health and social care partnerships, that patient care and financial and operational benefits can be accrued. This also starts to build perceptions of ability and competence in the minds of stakeholders and partners.
- It is desirable for partners to start sharing information and concerns as this will start to build a “cognitive closeness” which in turn will propel the alliance through to the next cycle of trust.
- The formation of teams is important. The composition of these teams should ensure that leaders who have a natural propensity to collaborate should be included. Clinicians are also important in order to persuade medical staff of the desirability of the objectives of the partnerships.
- Leadership development programmes which develop collaborative behaviours amongst the senior leaders are a good investment at this stage. This support enables leaders to explore the personal change necessary to move from competitive mind sets through to collaborative mind sets.
- It is also important at this stage to be consistent in one's behaviours, particularly if any partner has a reputation for being untrustworthy in the past. Any slip will be read by others as a reversion to past motives and behaviours and a belief in the partner's integrity will start to erode.

- Investing time in the partnership and in understanding partners forms a benevolent foundation for the move to the second stage of knowledge based trust.
- Adaptive leadership styles are important at this stage to facilitate exploration and discovery about other partner needs and concerns.

Stage Two – Knowledge based trust

- Sharing key information and knowledge sharing is critical to this stage although it simultaneously increases the risk for opportunistic behaviour on the part of others.
- Partners need to honestly deepen their understanding and empathy of the concerns of others at this stage. They should explore their differences and try to understand the reason for those differences. Deeper knowledge about each other creates familiarity but also a willingness on the part of partners to try to solve others concerns. Knowledge moves from a cognitive understanding into a willingness to have a shared ownership of those problems.
- Objectives for the collaboration start to be seen as aligned goals.
- Documenting and sharing any successes across the multiple organisations influences the perceptions of others outside the partnership.
- Faster decision making starts to happen as the partnership builds a collaborative capability.

Stage Three – Collaboration driven trust

- The written formal agreements become less important as firm trusting relationships drive the collaboration.
- It is useful to accept and talk honestly about any trade-offs and dilemmas between the needs of your own organisation and those of the partnership.
- Do not over promise. Failing to deliver is worse than being modest in one's desired results and objectives.

Recommendation 2 – The NHS needs to heavily invest in the provision of leadership programmes which help develop collaborative behaviours amongst senior leaders. Helping leaders to manage uncertainties, develop emergent and adaptive leadership styles, demonstrate benevolence and integrity in all their decisions and actions.

Recommendation 3 – Leaders need a considerable investment of personal time and energy in order to move away from contractual agreements around partnership to collaborative trusting relationships.

Recommendation 4 – Attending to internal trust within one's own organisation remains important. There needs to be a congruence between the internal culture and the actions of senior leaders within that culture. In vertical trust relationships, leaders should build trust by being consistent in their behaviours, mindful of demonstrating their integrity and values, communicate openly and honestly, demonstrate concern for employees and share a collective vision and live the shared values of the organisation. These behaviours link to the four pillars of trustworthiness which are generally applicable to all interpersonal trusting relationships: ability, benevolence, integrity and predictability (Mayer et al, 1995; Dietz and Den Hartog, 2006).

Recommendation 5 – Maintaining the trust of external stakeholders by delivering the day to day needs of the single organisation is vital. Partnerships cannot ignore the wider context, recognising that keeping the existing NHS system happy is still part of their job. Recognising that this will throw up dilemmas and tensions helps.

Recommendation 6 - The following checklist sums up the leadership behaviours that will drive trust in partnerships across multiple complex systems:

- * Are you pursuing the goals of the collaborative alliance?
- * Do you and your colleagues avoid exploiting your partner's trust in you?
- * Who are the multiple stakeholders? What are their characteristics?
- * Are they willing to cooperate?
- * Have you defined ground rules?
- * Do you share information?
- * Have you reached an agreement?
- * Are you tracking and sharing benefits?
- * Do you nurture trust within your own organisation as well as the partnership?
- * Do you act as a trustworthy role model for others? Within and across organisations?
- * Do the leaders of the other partner organisations have a relationship orientation?
- * Do you reward collaborative behaviours within the partnership?

2. Literature review: Trustworthy leadership and trustworthy collaboration: an overview

In this chapter we explore research on trust which is relevant to the leadership skills needed to build collaborations across boundaries. Collaborations between organisations are outside hierarchical mechanisms of control; rather collaborations are cooperative relationships, negotiated in ongoing communication processes (Hardy et al, 2003; Heide, 1994; Lawrence et al, 1999; Milne et al, 1996), with consensus building and trade-offs (Ansell and Gash, 2008; Austin and Seitanidi, 2012). Partners in collaborations will bring different competencies as well as different assumptions about the sharing of risks and responsibilities (Gray, 1989).

Building trust is important for successful collaborations:

“Trust is foundational for the development and sustainability of collaborative alliances...Trust is an integral and enduring component at every stage.” (Henderson et al, 2015:1545)

Those involved in collaborations perceive the key benefits to be improved productivity and enhanced customer satisfaction (Fawcett et al, 2012). Research in the field of children and family services delivery in the USA found the perceived effectiveness of collaborative ventures was mainly based on the existence of processes for sharing resources and building trust between partners (Bin Chen, 2010).

In each of the following sections on trust we think about how it applies to leadership within the organisation setting, before asking how it applies to collaborations cross-boundary. As a study of public managers in the USA noted:

“The cross-sectoral environment in which many public officials must now operate differs greatly from a traditional, bureaucratic structure and therefore, as the literature suggests, may require different types of leadership behaviours.” (McGuire and Silva, 2009:35)

In this new context they noted leadership behaviours conforming to the definition of leadership employed by Yukl (2002:7):

“The process of influencing others to understand and agree about what needs to be done and how it can be done effectively, and the process of facilitating individual and collective efforts to accomplish the shared objectives.” (McGuire and Silva, 2009:38)

Trust:

“A psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behaviour of another.” (Rousseau,D., Sitkin, S., Burt, R. and Camerer, C., 1998: 395)

We take each of these three parts of the definition of trust in turn.

Positive expectations

Trust can build over time as we go through cycles of learning about each other (Mayer et al, 1995; but note Vanneste, Puranam and Kretschmer, 2014 on the moderators of trust building over time). In the workplace we can base our initial trust in a new manager on the knowledge that person could lose their job if they break the rules, i.e. early trust can be based on knowing the manager faces a penalty if they break our trust. Over time we interact with the manager and our trust can then be based on our experience of how the manager has behaved. If we work together for a long time, we could get to know each other sufficiently well to feel confident that we share the same values, i.e. we identify with each other.

Within an organisation, trustworthy leaders support others building positive expectations about them by investing time in face-to-face interactions; and by being not only honest but also open, i.e. willing to be honest about everything. They are approachable. Trustworthy leaders do not conceal. (Hope Hailey et al, 2014b)

Across organisation boundaries there are key differences: the absence of hierarchy and the absence of the rules and penalties

inherent in the organisation structures. Research published in 2015 (Pomponi et al, 2015) building on previous studies suggests an equivalent cycle of increasing trust for collaborative partners: agreement driven trust; knowledge driven trust; and collaboration driven trust. Although the contract might provide an entry level of trust, once partners see benefits from the collaboration and their knowledge of each other's skills and competencies increases, trust fosters cooperation. Trust, rather than the contract, becomes the basis for collaboration. The first cycle, agreement driven trust, is slightly controversial; formal contracts have also been found to hinder the development of trust (Malhotra and Murningham, 2002).

The following framework from Naesens, Kobe, Pintelon, Taillieu and Tharsi (2007) provides more detail on the elements to consider in the initiation stage and then in maintaining trust in horizontal collaborations, synthesising various models:

Phase 1: setting the stage: identification of stakeholders, common definition of goals, willingness to collaborate, characteristics of the convenor, availability of resources.

Phase 2: direction setting and problem solving: defining rules, information sharing, finding alternatives.

Phase 3: implementing and sustaining the partnership: rank and file, agreements, power imbalances, evaluating partnership.

Leaders can support the growth of trust across boundaries by attending to these elements, for example, partners are less likely to violate each other's expectations for positive collaboration behaviours when they take time to agree on ground rules and procedures (Gray, 1989).

Research on enablers of collaboration across boundaries suggests the need to reduce costs and raise service levels supports the initial push to collaborate (Fawcett et al, 2012). As the relationship then gets established, documenting and disseminating the benefits derived from collaboration could influence the future commitment to collaborate (Fawcett et al, 2012). There is an apparent link here to the expectation element of trust: it supports establishing trust on the basis of the experience of interacting with the partner.

Finally, while the above addresses the cognitive component of trust, i.e. making rational choices based on experience and interactions, there is also an affective component to trust, relating to emotions and the feelings people have for each other (Henderson et al, 2015; Sloan and Oliver, 2013). Emotion can derail decision making in collaborative partnerships so leaders need to be skilled at managing emotions and conflict resolution.

The intentions or behaviour of another

When we trust a leader we believe we can predict how the leader will behave. There are various potential outcomes: the leader could behave in accordance with our expectations; the leader could fail to meet our expectations; the leader could not only fail but also act in bad faith. While trust in a leader might recover from an omission made in good faith, it is highly unlikely to recover from a bad faith abuse of trust (Elsbach and Currell, 2012).

Within an organisation, trustworthy leaders build and maintain trust by demonstrating not only consistency but also competency. They demonstrate ability through their knowledge, skill and professionalism. Trustworthy leaders do not over-promise. They do not preach without observing those rules themselves; they walk the talk (Hope Hailey et al, 2014b).

Across organisation boundaries researchers have explored not only inter-personal trust but also inter-organisational trust. Put simply: there are more people involved; but some people are more important than others. In this context, boundary spanners have a key influence on inter-organisational trust. Recent research has simulated the emergence of inter-organisational trust from interpersonal trust through indirect reciprocity, i.e. when kind (or unkind) acts are returned by others (Vanneste, 2016; Gulati and Sytch, 2008). Cross-boundary we are looking at the intentions or behaviours of many people.

Indeed research on barriers to collaborations also emphasises the importance of leaders addressing the behaviours of their own people, i.e. paying attention to their own organisation as well as to the collaboration. Individuals tend to resist change because behaviour change is required. With regards to culture, managers in a recent study reported low trust within their own organisation, as well as cross-boundary, contributed to their unwillingness to take a risk by adopting collaborative behaviours, such as sharing information vital for decision making (Fawcett et al, 2012). The research concluded that a bias towards developing functional expertise leaves companies lacking collaborative capability. Manager commitment is critical yet power based structures and cultures lack the attitudes or skills to collaborate well cross-boundary. Collaborative leaders need to be both task and relationship oriented (from work on collaboration in complex teams, Gratton and Erickson, 2007).

Generating early buy-in and momentum to collaborate and documenting the benefits of collaboration may mitigate these barriers. Proactively changing your own structures and culture to

remove fear and reward collaborative risk-taking will support the building of collaborative capability.

Trustworthy leaders who demonstrate commitment to building trust within their own organisations can mitigate the resistance to any change required to generate collaborative capability. They can model collaborative behaviour.

To accept vulnerability

Trust reduces the unpredictability in a situation, enabling us to make the decision to take a risk. High trust relationships feature open communication and willingness to share information (Kwon and Suh, 2005). Acting on your trust in a leader involves making yourself vulnerable in a number of ways: a leader could damage your trust in them by naively demonstrating values which threaten your security; a leader could damage your trust by knowingly taking advantage of your vulnerabilities. When we share information with someone we trust we expect them to use it only in good faith. Employment relationships provide clear examples of situations in which ideally the employee can trust a team leader with personal information; yet that same information may provide the team leader with potential leverage over the employee.

Within an organisation, trustworthy leaders show an interest in and recognise the needs of their staff. They live the organisation values and maintain confidentiality. Trustworthy leaders behave with integrity and do not act opportunistically (Hope Hailey et al, 2014b).

Across organisation boundaries research on collaborations suggests there are added complications in the form of certain behavioural constraints (Eisenhardt and Martin, 2000):

Interfirm and inter-function conflict (Moberg, Speh and Freese, 2003; Barratt, 2004)

Non-aligned goals leading to opportunistic behaviour (McCarter and Northcraft, 2007)

Inability to share sensitive information (Kampstra, Ashayeri and Gattorna, 2006; Fawcett, Wallin, Allred and Magnan, 2009).

These three all threaten the development of trust. Conflict, for example, due to competition between partners, increases the difficulty in predicting the partner's behaviour and increases the uncertainty in the decision to trust. If the collaboration provides the partner with an opportunity to further their own goals at your expense, again the uncertainty increases. If the partners also cannot share sensitive information, ignorance of the other organisation can easily lead to inadvertent damage to trust.

While possibly making the organisation vulnerable, the benefit of sharing information in a collaboration is that it enhances the innovation and problem solving capacity (Edelbosand Klijn, 2007). Trusting collaborations are characterised by the sharing of information. Trust supports greater understanding and familiarity which in turn supports the cognitive closeness necessary for simpler, faster decision-making (Thorgren and Wincent, 2010; Karamanos, 2003). Trust in collaborations can be built in small steps, requiring commitment from stakeholders (Henderson et al, 2015). Conversely, failures in cooperation and coordination can lead to the breakdown of collaboration, resulting in disappointing results for the alliance (Gulati, Lawrence and Puranam, 2005). Trustworthy leaders pursue the goals of the collaborative alliance. They do not pursue local goals at the expense of their partners' interests.

Trustworthy leadership

Drawing together the 'Dos and Don'ts' from previous studies on leaders as trust-builders within an organisation (Whitener et al, 1998; Gillespie and Mann, 2004), we see that leaders should be consistent, behave with integrity (walk the talk), share control, communicate openly, demonstrate concern for employees, consult team members, share a collective vision and live the shared values. These behaviours link to the four pillars of trustworthiness which are generally applicable to all interpersonal trusting relationships (Mayer et al, 1995; Dietz and Den Hartog, 2006): ability, benevolence, integrity and predictability. The corresponding leadership behaviours for the pillars can be summarised as follows (Hope Hailey et al, 2012, 2014a, 2014b):

Ability: knowledge, skill, understanding basics, professionalism

Benevolence: showing interest, recognising individual needs, being approachable

Integrity: living organisational values, maintaining confidentiality

Predictability: walking the talk, track record, acting consistently

Practical steps which can help generate trust between leaders and followers include: proximity; strong personal relationships; identifying people with a propensity to trust upwards and downwards; avoiding excessive use of electronic monitoring; and continuously demonstrating concern for followers as people not just as employees (Hope Hailey et al, 2012).

"Trustworthy leadership" puts the emphasis on the leader; however leadership can also be conceived as a process (Hope Hailey et al, 2014b). Trustworthy leaders make relationships central, recognise and develop the unique talents of their staff, they appear as

real people and they share responsibility by not only accepting responsibility for their actions but also holding each other to account (Hope Hailey et al, 2014b). Trustworthy leadership takes time and courage. Trustworthy leaders are “human, personal and relational.”

These practices all help override the falling societal level of trust. Even before the recession, both private and public sector organisations were suffering decreasing levels of trust in senior managers (Hope Hailey et al, 2010). In some organisations this was exacerbated by HR systems for leadership selection which emphasised ability and were sometimes overriding senior management’s personal assessment of the benevolence and integrity of a candidate, both qualities which HR systems tended to be inadequate at measuring (Hope Hailey et al, 2014a). By fostering a sense of mutuality trustworthy leaders can counter these trends, to develop a bank of trust and goodwill through good times to be drawn on during a crisis (Hope Hailey et al, 2012).

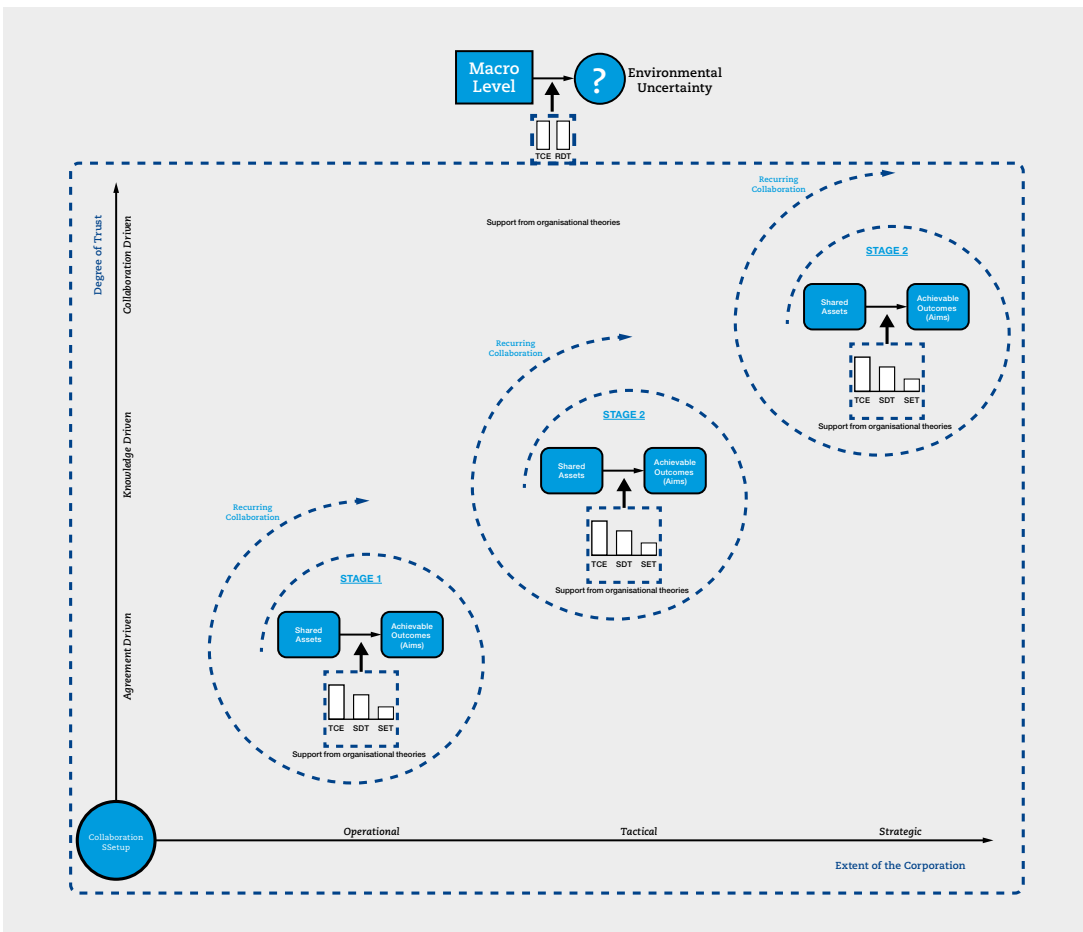
However we should also ask: what are the limits of trustworthy leadership? First, while the leadership behaviours noted above are significant factors in explaining trust in middle managers and senior managers (Hope Hailey et al, 2012) they do not explain all of the variation in these measures of trust. For example, the propensity to trust is also relevant. Second, senior leaders in both the public and private sector are increasingly expected to be able to develop collaborations across organisation boundaries. While the four pillars of trust are applicable to all trust relationships, the relevant behaviours are context dependant. We ask, therefore: what behaviours map on to those pillars in collaborations? We ask: what is trustworthy collaboration?

Trust and collaboration cycles

It is not always clear in studies of trust and collaboration which enhances the other. In practice we see they are mutually reinforcing. It will be apparent from the previous sections there is considerable overlap between studies of cycles of trust and studies of cycles of collaboration, albeit that trust is often cast as an impediment because the absence of trust can jeopardise efforts to collaborate. For example, the main impediments to cooperation, even in post-disaster relief logistics, are mutual mistrust and lack of transparency (Schulz and Blecken, 2010, as applied in Pomponi et al, 2015).

Recently Pomponi, Fratocchi and Tafuri (2015) developed a conceptual framework to show the evolutionary steps in a collaboration against two dimensions: mutual trust among partners and the extent of the cooperation. While this was developed specifically for implementing horizontal collaborations in supply chains, which concern collaborations between organisations operating at the same level of a supply chain, much of the reasoning is applicable to organisations collaborating within the NHS. The framework links incremental levels of trust (for example, Lewicki and Bunker’s (1995) calculus based, knowledge based and identification based trust) with incremental levels of collaboration (for example, Lambert et al’s (1999) operational, tactical and strategic level of partnerships). These levels of collaboration incorporate different levels of aims of collaborations, ranging from simple cost reduction through to innovation; and the sharing of relevant assets.

Figure 1: 'The proposed framework', Pomponi et al (2015), page 91, Figure 1



Key of abbreviations for Figure 1 with their key question for the collaboration:

TCE: Transaction Cost Economics: "people generally adhere to their commitments. However, the likelihood of selfish behaviour cannot be ignored (Williamson, 2008)" (Pomponi et al, 2015: 88). This suggests the use of controls and complete contracts to minimise uncertainties of behaviour by partners. These have most value in the first phase when trust is low, but their contribution is less in subsequent phases once trust grows, not least because early contracts cannot anticipate every eventuality. We see this links to providing the initial basis for an expectation of trustworthy behaviour.

SET: Social Exchange Theory: taking account of the role of personal chemistry and the social interactions between the parties; focusing on maximising the rewards of the collaboration rather than imposing/avoiding punishments. This grows in significance through the cycles. We suggest the emphasis on continuous interaction and reciprocal knowledge links to the importance of frequent, open and honest communication to build trust.

RDT: Resource Dependency Theory: taking account of power in inter-organisational relationships. This is at the top of the diagram to show it is relevant to changes in the environment in which the collaboration operates. Power can diminish trust and weaken collaboration (Kahkonen, 2014). Elsewhere trust in collaborations has been found to enhance performance where behavioural uncertainty is high, but to be counterproductive when environmental uncertainty is high (Krishnan et al, 2006). It links to work in the trust field on predictable behaviours enhancing trust but also entrenching rigidities, risking a failure to adapt to a changing environment.

SDT: Social Dilemma Theory: addressing conflicts between an immediate self-interest and a longer term collective interest; it is a choice between cooperative and non-cooperative behaviour. When is behaviour opportunistic and when is it seeking to satisfy both an organisation's aims and the aims of the partner? This is complicated in the NHS Vanguards because while we could argue the NHS has an overarching, unifying purpose, at the same time elements of it are set up as independent entities, for example, GP practices.

We are drawing attention to this framework because it helps to synthesise the practicalities of implementing collaboration, and we relate those practicalities back to trust. It enables us to take a holistic view of trusting collaboration. The complementary use of all these theories helps address the intricacies of horizontal collaborations. To illustrate this point, we return to the leader/follower trust example. While the trustworthiness of the leader certainly explains some of the follower's trust in the leader, other explanatory factors are relevant too, for example, the propensity of the follower to trust. In collaborations, it is often said that a contract can minimise the risks of entering the collaboration; trust can maximise the potential of the collaboration.

We would draw your attention to four elements of the Pomponi et al review at the micro level:

- **Initiation of trust:** Pomponi et al advise paying close attention to the initial stages of a relationship, to maximise trust. Drawing on Audy et al (2012) and Crujssen et al (2007) they advise the critical elements are the selection of cooperating partners and the management of the negotiation phase. They suggest 'personal chemistry' is relevant here. They do not otherwise expressly address the creation, as opposed to the evolution, of trust. We see this linking to work on boundary spanners in the indirect reciprocity of trust between organisations.
- **Competition:** where there is competition between collaborating partners in a supply chain, trust mirrors the level of cooperation (Cheng et al, 2008, as applied in Pomponi et al, 2015). Where partners are also competitors, Pomponi et al advise an added objective: developing a shared collaborative perspective. Other research has shown trust to be good for reducing behavioural uncertainty and used competition as a cause of behavioural uncertainty (Krishnan et al, 2006). Ansell and Gash (2008) advise that where the history of the partners is antagonistic, it will take time to repair trust; that time should be taken in to account as an investment when deciding whether to collaborate.
- **Identifying and sharing achievements:** drawing attention to successful experiences can enhance both collaboration and trust, increasing the familiarity and understanding of each other such that cooperation 'fosters itself'.
- **Sharing of information:** key information and knowledge sharing is critical to collaboration (Leitner et al, 2011). However, the greater the amount of confidential information shared, the greater the risk for opportunism on the part of the partner. Trust can grow by incrementally increasing the sharing of information.

"Practices that bridge organisational boundaries – such as goal alignment, frequent and open communications, high levels of managerial interaction, the exchange of expertise and resources, and a willingness to share risks and rewards – are the essential elements from which a collaboration capability is built." (Fawcett et al, 2012)

It has been proposed that leaders can benefit from actively managing the trust relationship throughout its duration; it is not necessarily easy to maintain and a balance must be sought to avoid slipping in to a 'blind faith' scenario in which underperformance goes unnoticed (Thorgren and Wincent, 2010). Although the pillars of integrity and predictability might suggest the need to always put the goals of the alliance first and to avoid suggesting you want to make any changes to the alliance, this needs a little more sophistication. As Thorgren and Wincent (2010) show, competing behaviours, avoiding behaviours and accommodating behaviours between partners are unhelpful but collaborating and compromising (addressing the changing needs and finding solutions to meet all parties' needs, or partially meet all parties' needs) can ultimately improve the performance of the alliance by avoiding rigidities without reducing trust.

We summarise our ideas from the literature review in Table X below.

A note on measuring trust

Trust changes but does not necessarily 'grow' over time. A meta-analysis published in 2012 of 39 studies describes the operation of several mechanisms affecting trust over time (Vanneste, Puranam and Kretschmer, 2014). First, the initial bias of pessimism or optimism about the relationship influences the initial trust levels and we see an initial bias correction over time. Second, the value of the relationship to one party may change. Trust is context specific so if the context changes, so does the trust. Third, if partners identify more with each other over time then trust increases. The faster identification is established, for example, when partners have frequent interactions, the more rapidly trust increases. Finally, with deselection of untrustworthy partners, the average trust in a portfolio of relationships will increase over time.

If partners are optimistic about the relationship, while the foundations for the trust will evolve, there could be little change in recorded levels of trust. When attempting to measure trust levels over time we do not, therefore, always see growth even when trust levels are good.

Table 1: A brief summary of the literature review

Rousseau et al definition of trust	“A psychological state comprising the intention to accept vulnerability...	...based upon positive expectations...	...of the intentions or behaviour of another”
General	The trustor is deciding to take a risk.	The trustor can base that expectation on the presence of a deterrent; or, after time, on their experience of the trustee; and possibly ultimately on an identification with the trustee.	The trustor expects certain behaviour. The trustee may meet those expectations; or fail to meet them through incompetence but in good faith; or fail to meet them in bad faith.
Vertical leader/follower behaviours for trustworthy leadership	Do you know the needs/ vulnerabilities of the people who you want to trust you? Do you behave with integrity with regard to those vulnerabilities - in line with organisation values; keeping them confidential?	Do you invest time in face-to-face communication? Is the content both honest and open? Are you approachable? Do you pay attention to relationships?	Do you behave consistently? Do you demonstrate competence – knowledge, skill and professionalism?
Behaviours to avoid	Don't act opportunistically	Don't conceal	Don't over-promise Don't preach without observing
Cross boundary differences	Are there any inter-organisation conflicts? Are the goals of both organisations aligned? Can you share sensitivities?	Absence of taken-for-granted structures and culture. The expectation can be based on an agreement, then over time on knowledge, and ultimately could be driven by collaboration.	'Another' becomes 'many others' Different mechanisms e.g. indirect reciprocity
Cross-boundary leader behaviours for promoting trustworthy collaborations	Are you pursuing the goals of the collaborative alliance? Do you avoid pursuing local goals at the expense of your partners?	Who are the stakeholders? What are their characteristics? Are they willing to collaborate? Have you defined ground rules? Do you share information? Have you reached an agreement? Are you tracking and sharing benefits?	Do you nurture trust in your own organisation? Do those operating cross-boundary have a relationship orientation? Do you model collaborative behaviours? Do you reward collaborative behaviours?

3. Research methodology

Our sources of data for this report were in qualitative and quantitative form. We first completed in-depth case studies in 2016 on three Vanguards: Royal Free London, Stockport Together and the Somerset Symphony Programme. These three Vanguards came from three of the five different care model categories. After coding the data from the case study interviews we then compiled a survey to explore further the issues raised in the cases across all 50 Vanguards.

The qualitative data for the three cases included:

- Face-to-face semi-structured interviews
- Telephone interviews
- Focus groups
- Documentary evidence available online.

The interviews lasted between 35 minutes and 100 minutes. We interviewed senior leaders working on the Vanguard project, including both management and medical professionals. These included board members and their immediate reports. As far as possible interviewees were purposively selected to cover the organisations participating in a Vanguard and a range of medical and managerial professionals in those organisations, but this was limited by the availability and willingness of individuals to participate.

The semi-structured interview protocol covered:

- Brief career information about the interviewee
- A description of the Vanguard (partners, purpose, duration, stage of development, etc.)
- Leadership in the Vanguard (guiding principles, methods of persuasion, communication, decision-making, etc.)

- Trust in the Vanguard (definitions of trust, benefits, vulnerabilities, barriers, etc.)
- Trustworthy leader character traits (ability, benevolence, integrity, predictability)
- Presence/absence of a trust fund in the Vanguard e.g. pre-existing trusting relationships
- Interviewee's experience of other trustworthy leaders in the Vanguard.

The focus group protocol covered:

- Definitions of trust
- Barriers and enablers to trust
- Trustworthy leader character traits (ability, benevolence, integrity, predictability).

The interviews were conducted by two members of the research team. Subject to gaining permission, all interviews were audio recorded and transcribed professionally. The same two researchers then coded the interviews using both open coding and codes drawn from the literature review. We used documentary evidence available online to support our analysis.

Table 2: Qualitative data summary

	Number of interviews	Number of focus groups	Number of people in the focus groups	Total number of people who contributed	Number of management professionals	Number of medical professionals
Royal Free London	4	1	4	5	3	2
Stockport Together	5	1	4	9	8	1
Somerset Symphony	4	1	5	9	9	0
Totals	13	3	13	23	20	3

The sample for the survey was derived from NHS Employers Vanguard contacts. We provided a link to the online survey and an invitation to take part; NHS Employers forwarded these to their contact in each of the 50 Vanguards; each contact was asked in turn to forward the online survey link to the senior leaders in each organisation in that Vanguard. We sought to increase the response rate by sending reminders. We also tried a second list of Vanguard contacts. We received 39 valid responses. While this response rate is low, these do cover Vanguards from all five care models, as shown in Table II.

Table 3: Number of valid responses by care model

Care Model	Number of valid responses from the care model	Number of Vanguards in the care model	Number of Vanguards in the care model from which one or more responses were received
Acute care collaborations	7	13	5
Enhanced health in care homes	3	6	3
Integrated primary and acute care systems	9	9	2
Multispecialty community providers	16	14	6
Urgent and emergency care	4	8	3
Total	39	50	19

When we combine the qualitative and quantitative data our findings in this report are based on data received from over 20 of the 50 Vanguards.

Measures used in the survey:

The respondents were asked to complete a series of scales. We used both published scales and factor analysis to create statistically derived composite measures. We used Cronbach's alphas to check the reliability of each scale.

Please note the low number of responses means the scales derived from factor analysis may be unreliable. Given the low number of responses we have taken a cautious approach and excluded scales in which we had any doubts and have used the survey results only in a descriptive way in the report.

Table 4: Overview of analysis to Cronbach's alpha stage for the scales used in this report, with mean, median and mode values

Scale name	Items	Cronbach's alpha	Mean	Median	Mode
Financial and Quality Rating	22, 23	0.832	2.4	2	2
Integrity behaviours	36, 37, 43	0.782	3.4	3.3	4
Competition	10, 11	0.894	3.2	3.5	2
Ability behaviours	48, 40	0.667	3.6	4	4
Benevolence behaviour	46	-	3.7	4	4
Aligned interests	19	-	4.5	4.5	5
Decision Making Process	51	-	3.9	4	4
Formal Agreement	52	-	2.8	3	2
Surrender of some control	16	-	4.0	4	4
Inter-Individual Trust	26, 27, 28	0.833	3.6	3.7	4
Inter-Org Trust	29, 30, 31, 33	0.736	2.7	2.7	2.8

We sought to measure inter-organizational trust using a 4-item scale derived from Krishnan, Martin and Noordehaven (2006) (the original scale has 5 items but the internal reliability for the scale on our data improved when one of the 5 was excluded); inter-individual trust using a 3-item scale derived from Fang, Palmatier, Scheer and Li (2008); barriers and enablers to trust reported in the literature; and barriers and enablers to trust reported in the case studies. Example barriers and enablers include inter-organisation competition, the degree of change involved in participating in the Vanguard, shared purpose, risks of participating, and agreement of decision-making structures.

Finally we gathered feedback on our developing ideas by presenting the draft results to a workshop comprising representatives from the case study Vanguards, NHS Employers and NHS England. This supported assessment of the validity of our analysis.

4. Obstacles to trustworthy collaboration

In this chapter we summarise the key obstacles the case study interviewees had come across in trying to build trust. We link these back to the literature review to gain insights on how these barriers operate to undermine trust. We also use the survey results to provide a description of how widely these obstacles were experienced across other Vanguards.

We have gathered these obstacles broadly in to three groups: systemic, organisation level and individual. The rationale for this is to support leaders recognising the sources of the obstacles because the response will, to some degree, be determined by the source. While leaders can seek to change their own behaviours to maximise the advantages of interpersonal trust, they have limited influence over the wider system and must work out how best to work within the NHS framework as it gradually changes.

Systemic obstacles

Leaders in all three case studies emphasised how the current competitive nature of the health care system and the existing legislative and regulatory frameworks were obstacles to trust.

Competition

The achievement of cooperation against a background of competition is difficult (Henderson et al, 2015; Erakovich and Anderson, 2013) and our case study data confirmed this. The historical emphasis on competition and choice in the NHS established a system where healthcare organisations were in competition with each other. This competition could take various forms: competing for resources, such as, limited budgets and staff; competing to be the provider of a service; needing to be better than the other providers to avoid interventions.

As a senior leader at Royal Free London (RFL) observed:

“Let’s not underestimate where we have come from. The NHS has been a competitive world of people wanting to do their best in their organisation, for their organisation, for their staff and for their patients, and that has to be put aside.”

At Stockport Together there was a significant change in direction, as described to a GP conference by the deputy chief executive of a hospital:

“Our job was to take as much money off you as we possibly could and build a huge business. We understand that is not a sustainable approach; our strategy now is to go the other way.”

Competition in the past or present creates a barrier to trust by increasing the behavioural uncertainty between potential partners. Do I feel confident you will not take this opportunity to exploit my position? How can I give you a basis for an expectation that I will behave with integrity and benevolence when I also compete against you? Where the history between the parties is antagonistic it takes a long time for trust to be initiated by interaction alone. One answer is to enter a contract with penalties for misbehaviour, or at least to sign up to a new way of working. The parties will need to develop a shared collaborative perspective (see following chapter for more detail). If these steps allow some working together to commence at an operational level (to get in to the first wheel of Pomponi et al’s (2015) framework – see Literature review chapter), a history of interaction can then be generated and ultimately trust and collaboration can grow through experience.

In the RFL case, North Middlesex University Hospital (NMUH) and RFL agreed a memorandum of understanding to provide a framework for discussions.

In the Stockport case, over a hundred clinicians, leaders and politicians representing the region and service users, came together for a two day congress to work out how to improve their system and what levels of joint working they could aspire to. Chief Officers of participating organisations signed a pledge stating “this is where we are, this is what we’re here to do,” creating the foundation of a common approach and a commitment to genuinely work together.

Wider picture: In our survey we sought to test the prevalence of competition as a barrier across the 50 Vanguards using a 2-item scale (Cronbach's Alpha .894), asking: had respondents competed against their Vanguard partners in the past; and whether they continued to compete against their Vanguard partners in other services. We had an almost even split of respondents "disagreeing" and "agreeing". Over a third of survey respondents reported competition with Vanguard partners. Only a slightly larger number reported no competition. This split may be explained by the differences between the Vanguard models; where similar organisations are collaborating there may be more of a barrier effect from competition between the parties, for example, between neighbouring hospitals or between neighbouring GP practices. Existing research suggests parties reporting competition will take longer to develop strong trusting relationships.

Third parties, legislation and regulation

The challenges raised by legislation and regulation varied. First, the unpredictability of initiatives from third parties such as regulators, NHS England or politicians was a perceived barrier to trust. Second, the philosophy behind the legacy regulations had more in common with the competitive model than with the Vanguard movement. Third, the procedures dictated by certain legislation undermined trustworthy collaboration efforts.

[In the RFL case we see the announcement of the North Central London Sustainability and Transformation Partnership part way through their work on the Acute Care Collaboration which resulted in RFL having to make sure the Vanguard could fit with the aims of the STP.](#)

[Also at RFL, although the new group model was expressly not about RFL "acquiring" all the group members, RFL leaders had to operate within existing legislation which stipulated that to expand a foundation trust you had to acquire the joining hospital. The requirement to go through an acquisition with the associated steps of due diligence, etc. undermined the leaders' work to create a collaborative relationship.](#)

[At Stockport Together leaders noticed that the pressure of a visit from a regulator could cause people to revert to negative behaviours such as blaming other organisations, when the solutions lay in working together rather than finding fault. Some also commented on how the wider NHS leadership could sometimes be a barrier to trust:](#)

"I think they are very short-termist and they don't realise how they destroy trust by doing that, destroy the long term success..... I cannot believe how little attention is paid to it (people side of change and OD) in what is a very big business."

Likewise in the Symphony Programme there was cynicism about the support they would receive from NHS England or the Department of Health:

"What really will the Department of Health do, or will NHS England really support us?"

[Yeovil noticed that barriers to trust were compounded when there were cuts in the Vanguard's funding, adding to cynicism about the track record of change in the NHS to date.](#)

How should we relate trust between collaborating partners to unpredictable changes coming from outside the collaboration? Ideas from transaction cost economics and resource dependence theory can shed light here on the challenges created for trustworthy collaboration: a change in the environment in which the collaboration operates could increase the risk faced by a partner continuing in the collaboration; and changes to, for example, commissioning regulations, could change the relative power of parties in the collaboration (see Pomponi et al (2015) framework in the Literature review chapter). Can I trust you to continue collaborating if the cost to you of doing so has increased? Am I still confident you will not exploit me even though your power over me has increased?

An approach for minimising the chances of third party changes is keeping the trust of third parties.

[In the RFL case the current senior management team were drawing on their past experience of acquiring Barnet and Chase Farm Hospitals in designing the Vanguard model. RFL leaders had demonstrated ability in its relations with the regulators during that acquisition by not overstating how quickly change could be achieved and being careful not to promise too much. They had managed the expectations of the regulators.](#)

This need for Vanguard leaders to pay attention to maintaining the trust of a regulator fits in to a wider theme in the feedback we received on the case studies when we presented them back to NHS England, NHS Employers and representatives from the relevant Vanguards. Sometimes the impact of building a Vanguard

was unexpected deterioration in relationships with certain parties outside the Vanguard. We recognise time and resources are limited but we suggest Vanguard leaders periodically assess the impact of the Vanguard activities on other stakeholders in the system and seek to maintain the trust of those outside as well as those inside the Vanguard, perhaps by making small adjustments to their communications.

Wider picture: It is difficult for a cross-sectional survey to assess the impact of potential third party intervention. However we sought to capture the impact of a legacy regulatory framework on the establishment of a Vanguard by exploring the concern held by some leaders in the case studies about the potential impact on their ratings from the regulator of participating in a Vanguard, and the consequences that might follow. We sought to capture the prevalence of this fear in the survey by asking respondents the extent to which they agreed or disagreed that cooperating in the Vanguard could damage (i) their financial viability, and (ii) their quality rating (2-item scale, Cronbach's Alpha .832). We are pleased to report the average respondent does not believe participating in a Vanguard will damage quality ratings and financial viability for their own organisation, so to this extent existing regulations are not causing problems for many Vanguard parties.

Organisation level obstacles

We now turn to two barriers reported at the organisation level: organisation culture and organisation reputation.

Organisation reputation

In the literature review we looked at the possible bases on which an expectation of trustworthy behaviour might be built. A complication of both interpersonal trust and inter-organisational trust in Vanguard collaborations appears to be the effect of organisation reputation on those expectations. Again, as with the competitive landscape, sometimes the parties are not starting from a neutral position of trust; rather they are starting from a position of distrust.

In the Royal Free London, potential Vanguard partners may have interpreted RFL's actions in the light of stories of the past acquisition by RFL of Barnet and Chase Farm Hospitals. The changes made to integrate the practices at the various hospitals had not been welcomed by all staff.

“Well they probably heard bad things about us from [some] Barnet colleagues – we know they have.”

Similarly, in the Symphony Programme, despite a more distant history of good communication between GPs and consultants, recent history had seen a narrowed focus on their own organisation's needs and many of them no longer knew each other due to reduced levels of contact. After the Hospital's acquisition of three GP practices, some thought they were actually trying to take over all GP practices.

Stockport Together leaders recognised their starting point was a position of distrust. Several people spoke of the disruptive force of hidden agendas, assumed and actual, and how a history of dysfunctional relationships at senior levels makes it hard for some partners to believe the benevolence at the heart of the Vanguard - a case of 'leopards don't change their spots'.

The barrier here is distinct to the systemic issues above. In those the source of uncertainty is whether the system is pushing the partner towards unwelcome behaviours; here the source of uncertainty is the partner organisation's previous activity, or reputed previous activity. As with the systemic issues above, developing a shared collaborative perspective and minimising risk by using a written agreement may help get the parties in to the first wheel of the Pomponi et al (2015) framework. The experience of collaborating at an operational level can then provide the basis for trust and collaboration to grow on the back of those experiences.

We would like to add the following theme developed with NHS England, NHS Employers and Vanguard representatives in the feedback workshop: it was observed that consistency in the adoption of new collaborative behaviours was important. Any slip-up would be seized on by the other Vanguard parties as proof that the organisation was following its old agenda (see also the organisation-level facilitators of trust in the next chapter).

Finally, history determines in large part the extent of any “trust fund” between two parties, in other words, the amount of trust that is already in the bank before entering into a collaborative partnership. Some partnership teams may be able to draw on an abundant fund; in others reserves might be quite low. Identifying and using your boundary spanners who already have trusting relationships at a personal level with their counterparties could mitigate this obstacle. We should also not underestimate the role of personal chemistry in initiating trust. As observed by a workshop participant, the arrival of a new CEO determined to build bridges with his counterparts can change the relationship between two organisations.

Some RFL staff had existing relationships with staff at NNUH, for example, one of the Deputy Directors at RFL had previously worked at NNUH. A number of clinicians worked for both organisations. Some network services had been delivered with NNUH for a number of years.

Wider picture: In inter-organisation collaborations there is the complication of leaders having to observe both their own organisation's and the collaboration's goals (Eisenhardt and Martin, 2000; McCarter and Northcraft, 2007). The perceived risk is reduced if partners' goals are aligned. We asked: did respondents agree that it was in the interests of all the parties to their Vanguard to make the collaboration work. The average respondent strongly agreed or agreed with this question. This is good news because it suggests successful goal alignment between the Vanguard parties participating in the survey has been achieved, which is one of Fawcett's (2013) enablers for successful collaborations.

Organisation culture

Cultural differences between partners were reported in all three cases. Strong organisational cultures create mind-sets with which people choose to see the world. Different cultures produce different mind-sets, resulting in people from different organisations viewing the same situation through different lenses. The results sometimes were a lack of empathy and understanding of a partner's perspective, creating barriers to trust.

Stockport Together noticed the various health care organisations had a limited understanding of political pressures faced by the Council and that the Hospital and Council had different perceptions of time, for example, what 'urgent' means. A key learning point for Stockport was that each organisation in the Vanguard operates from a different world view and holds stereotypical beliefs about the other three organisations, some of which are true, some of which are not.

In the Symphony Programme building trust between NHS organisations and GPs was challenging when GPs did not always see themselves as part of the NHS in the same way, and were sometimes more entrepreneurial, autonomous and able to make fast decisions (compared to a bureaucratic hospital).

Familiarity breeds trust. If we take Pomponi et al's (2015) framework as an inspiration for developing a concept of 'trustworthy collaboration', we see moving in to the second wheel on their evolution framework requires 'knowledge-based trust'. Listening to the case study interviewees highlighted a particular challenge

with cultural differences between health care organisations: sometimes you discover the differences by making the mistakes, the same mistakes which undermine trust. While there is, perhaps, an acknowledged divide between primary and secondary care, interviewees had sometimes been surprised by the degree of cultural difference between, say, a teaching and a general hospital. With this knowledge-based trust would come deeper cooperation, beyond mere coordination of operations. Partners would share more valuable information with each other to achieve new aims. We must ask: how can cultural differences be recognised rather than misinterpreted?

In Stockport Together they focused on understanding their position whilst also helping people see their own slightly different lens, overcoming difference by highlighting common ground. They used an independent third party to 'hold up the mirror' to help leaders learn about themselves and their partners.

In the Symphony Programme leaders invested time in 'educating' each other about the different systems and processes in their respective cultures, generating greater familiarisation between GPs and consultants.

Third, RFL had used cultural focus groups before the acquisitions of Barnet and Chase Farm to identify similarities and differences, to target their efforts at supporting familiarisation. The culture in a teaching hospital can be very different from that in a district general hospital. They kept the Trust's objectives consistent and continued to repeat them. RFL worked with Barnet and Chase Farm staff on the Values and the behaviours underlying those, creating "a common language" which "allows them to frame conversations". They planned to use similar OD techniques in the development of the Vanguard.

Individual level obstacles

A core component of trust is a willingness to feel vulnerable based on an expectation of the other person showing goodwill and positive intentions towards one's own interests. For NHS Vanguards to function well, people are expected to trust each other. Yet the uncertainty and risk inherent in this new approach meant senior managers rendering themselves open to a level of uncomfortable vulnerability. The vulnerability these senior people felt was made up of a range of fears coupled with the recognition that they were obliged to take decisions despite that uncertainty. The uncertainty, complexity and unpredictability of the situation exacerbated people's general sense of vulnerability.

Specific fears included losing one's job in any new organisational structure; the exposure of a team's poor performance when they were required to share information openly with partners; fear of a smaller organisation being dominated by a larger organisation; fear of losing control, status and power; fear of being out-manoeuvred; anxiety about personal competence to lead a Vanguard.

“This is probably much bigger than anything I've been involved in.”

“I get paranoid about not being aware of things and not being included.”

In the Symphony Programme, leaders spoke of the risk of leading new ways of working that were not tried and tested. Clinicians demanded evidence of effectiveness but the evidence lay in international comparators, not within the UK.

“Sometimes you say, “Well it's been done in the States before, but we've never done it - that's the whole point. We're going to test it and see if it does work.”

Stockport Together leaders recognised that for the Vanguard to progress, the leaders of each statutory body had to cede some power and persuade their own stakeholders that this was a path worth pursuing, so putting their own reputation and roles at risk. Leaders also made themselves vulnerable to the scrutiny of external regulators when they supported Vanguard partners by providing additional finance or people resource.

How do individual fears and anxieties undermine trust? The individual will be watching the trustee and assessing whether their intentions and behaviours are likely to realise the individual's fears. To avoid ignorantly exacerbating an individual's anxiety, the trustworthy leader needs to be sensitive to possible insecurities and make time to listen to the individual. We suggest opening up and explaining your concerns to a Vanguard partner will support achieving 'knowledge-driven trust'. Existing research suggests this will be an incremental process: for example, you share a small financial concern, see if the partners treat this information with integrity and then, hopefully, feel you can share more information. Greater knowledge about each other creates familiarity which can lead to smoother operating of the collaboration as trust grows.

It is worth noting the fears listed above are relevant to multiple trust relationships, for example, organisation-based trust, senior leaders-based trust and counterparty-based trust. Leaders tasked with building collaborations between organisations need to pay attention to these various relationships, for example, by being open with their own support service leaders about the possible job opportunities in a new structure; and remembering their counterparts may have similar insecurities too.

Wider picture: For leaders to successfully build trust across organisation boundaries they need to understand the risks and fears of the other parties. While these will often be peculiar to a given Vanguard, we identified a common fear which almost all respondents recognised. We used a single item to ask whether to make the Vanguard successful the respondent would have to surrender some control of their working practices. The most common response and the average respondent agreed with this statement. This suggests most parties to Vanguards will have to surrender some control of their working practices. Leaders can demonstrate benevolence to their partners by acknowledging this barrier to trust. We recommend support for implementing changes in working practices and allowing partners' sufficient time to help their staff through the necessary changes.

Conclusion

In this chapter we have looked at five key barriers reported by case study participants: competition in the system; third parties, legislation and regulation; organisation reputation; organisation culture; and individual anxieties. Each case study at the end of this report has a more comprehensive description of the barriers reported in that Vanguard.

Having described the obstacles faced by Vanguard leaders, in the next chapter we explore behaviours which facilitated trust in the case study Vanguards.

5. Facilitating trustworthy collaboration

In this chapter we ask what leaders collaborating with each other in the Vanguards can do to build trust across organisation divides. For this report we were asked to consider what trustworthy leadership might comprise across organisation boundaries. To underline the shift from intra-organisation to inter-organisation we are moving from using trustworthy leadership to using the term **trustworthy collaboration**.

We should highlight a distinction here. Where a Vanguard has democratic representation from multiple organisations, we see these individuals as leaders within their own organisations and collaborators in the Vanguard. There is also some structure within a Vanguard body itself and an individual appointed as chair or chief executive officer will have an additional leadership role within that body.

In this chapter we use three foci to organise the data: cross-boundary, organisation and self. We focus first on how to facilitate that cross-boundary trust in both individuals and organisations, before adding observations on what leaders need to attend to within their own organisations to support that trustworthy collaboration. Finally we report the individual leaders' reflections on how they have changed their selves.

Cross-boundary focus

In the literature review we mentioned the four pillars of trustworthiness (Mayer et al, 1995; Dietz and Den Hartog, 2006):

- Ability
- Benevolence
- Integrity
- Predictability.

The literature suggests these are relevant generally to trust relationships, whether between leader and follower, or between collaborators. The question an individual must ask when seeking the trust of another person is: does that other person see these four in me? In the Wider picture sections below we report the results of two measures of trust across the organisation boundary. Our results suggest that, of these four pillars, the weakest results were recorded for Integrity. We then give more detail on the examples we saw of each pillar, including adding detail on integrity.

Wider picture: inter-individual trust: We used a three-item scale adapted from Fang, Palmatier, Scheer and Li (2008) to measure inter-individual trust, that is, trust between representatives of

different firms assigned to the Vanguard. We use the scale to examine respondents' trust in their counterparts at the individual level. Overall trust scales combine items on predictability, ability, etc. to cover the whole construct. It is encouraging to report that from the frequencies, we can see that most respondents agreed with the statements: my counterparts from the other organisations and I are concerned about what happens to each other; when my counterparts from the other organisations and I share problems, we know that the others will respond with understanding; and my counterparts from the other organisations and I can rely on each other to do what we have promised (Cronbach's Alpha .833). This suggests the majority of respondents did already have some trust in their equivalent parties in their Vanguard partners at the time of collecting this data.

Wider picture: inter-organisational trust: Various validated scales for inter-organisational trust can be found in the literature. Here we used an adaptation of Krishnan, Martin and Noordehaven (2006). In contrast to the interpersonal trust measure we used, these items are reverse-coded. The items include: our organisation is generally doubtful of the information provided to us by our Vanguard partners; our Vanguard partner organisations have promised to do things without actually doing them later; sometimes our Vanguard partner organisations change facts slightly to get what they want; and, our Vanguard partner organisations are generally doubtful of the information we provide them (Cronbach's Alpha .736). The responses are very mixed across the full range of answers offered to respondents. The most mixed responses were to the 'promised without actually doing' and 'sometimes they change the facts slightly' items. This suggests Vanguard participants might want to pay attention to these weaker areas in integrity. The broken promise item is also relevant to predictability. The dishonesty item is most concerning because it expressly involves deception rather than omission. Deception is particularly destructive of trust. However overall across the whole scale the most common response was "disagree", suggesting some trust had been established.

Ability

More able leaders are better at building and repairing trust (Dirks and Ferrin 2002, Dirks 2006). A leader's ability helps reduce the vulnerability people feel when they place their trust in another to do what they say they are going to do. The ability component of trust is domain specific, so having professional ability as a GP will inspire trust from a patient, but does not necessarily mean people will trust their ability to lead system wide change.

In the case studies, we found themes linking to the ability component of trust included: using your experts, competence at delivering change; and recognising the limits of your own ability and capacity.

- **Using your experts**

The real or perceived ability of leaders is a particular challenge when leading in a first-time scenario where there are few answers to what exactly the future holds or how exactly to go about achieving the vision of integration. However, organisations identified and put forward their experts in two ways: people who had experience of cross-boundary working in the health sector; and people who could use data and logic to build a case.

A CEO in the Symphony Programme had past experience of working in an integrated model of care in a different region. It had focused on community health and social care which helped the CEO gain perspective on the wider system:

"I can see that ... often the problems in the hospital aren't actually all directly within the hospital's issues; they're issues that are happening outside the hospital but we've still got people coming in. So if we're really going to solve the hospital challenge we've got to also get a perspective on how we solve the problem outside."

The Royal Free London team working on the Vanguard model had learnt from their successes and mistakes from previous acquisitions (Barnet and Chase Farm Hospitals) and other collaborations around clinical services. By combining their experiences of running a shared services model and of building trust across boundaries, they created a Vanguard design which they hoped would appeal to future partners.

Vanguard partners recognised the importance of data and logic. As well as gathering the data to support their proposals they recognised the value in clinicians leading cross-site communications.

In RFL the clinicians were encouraged to lead the attempts to build cross-boundary channels of communication with NMUH.

In Yeovil they invested 18 months conducting patient level analysis to understand how much each patient was costing the whole system, whereas previously they would have leapt in and started to change things quickly:

"It showed us that 4% of our population were incurring 50% of the health and social care resources... approx. 4500 patients."

A typical observation was:

"It's important for people to realise we didn't dream this up on our own, there's international research behind it."

- **Competence at delivering change**

Leaders demonstrated their ability to make change happen by mobilising resources, removing blockages and implementing quick wins. They showed they could deliver on promises and meet their partners' expectations, providing a foundation for trust to grow. We draw attention here to 'delivering' rather than 'designing' change. A key part of this is making sure the people in your own organisation will be willing to implement a change. Partners would lose confidence in leaders who could not 'deliver' their own organisations. That could be failing to keep the confidence of their own board or failing to bring their people on the change journey. We provide some examples in 'Organisation focus' towards the end of this chapter. This also links to the 'Individual focus' section in that it is not just the leaders who need to adjust from a 'fortress' to a 'collaborative' mind-set.

In the Royal Free London, trust was built with Chase Farm when they delivered a new hospital which had historically been a long standing broken promise. They recognised the importance of people believing the RFL team could do difficult things, before they could place their trust in the RFL team.

"Staff still didn't believe us until they saw the diggers on site and now they can see the walls going up they finally do believe us."

Royal Free London also demonstrated their change management capability by not overstating how quickly change could be achieved, being careful not to over-promise.

In Stockport Together, a leader from the CCG and the Foundation Trust demonstrated removing blockages when they announced to staff:

‘We’re here to unblock anything. Please don’t worry about tariffs and prices. Do what’s right for patients. Make this better. ... You can come and just ask for up to five thousand here and ten thousand here to make that work.’

- **Recognising the limits of your ability and capacity**

While a leader’s ability can inspire trust, recognising the limit of that ability can also build trust. This is more than avoiding the pitfall of over-promising; it is knowing when to bring in external help.

Early on, leaders in the Symphony Programme built trust by admitting they needed more expertise on new models of care; external consultants brought international examples to support their thinking.

In Stockport Together, the leadership team scrutinised their history, current situation and future direction with the support of an external facilitator, who delivered honest and direct feedback to support the team’s awareness and development.

“You’re the leaders of this system, if that’s what it’s like you’ve set it like that. Your choice in this room now is to un-set it.”

Royal Free London built capability by forming strategic partnerships with three organisations in the USA: Intermountain for change management capability, Cerner for analytics and The Institute for Health Improvement to add improvement science capability.

Related to this is recognising the limits of your capacity. It is worth noting here we are talking about organisation as well as individual abilities and capacity. We are looking to generate both inter-organisational and inter-personal trust across boundaries. Dedicated resources were used to help keep vanguard projects moving when existing leaders did not have the capacity for the extra work.

RFL and NNUH had each appointed relationship directors to focus on the potential partnerships and transactions, working not only with potential partners but also with the regulator. The Royal Free appointee worked at both sites. He had facilitated the RFL Medical Director meeting senior clinicians and staff at the North Middlesex to talk about the group concept, gradually drawing a wider group of people in to the discussions.

In Stockport Together, despite having some infrastructure around the vanguard, such as a programme management office, people were sometimes diverted by business as usual problems in their own organisation. Their response was to create two Senior Responsible Officers to lead and trouble shoot across the system and unblock barriers.

Wider picture: Ability: For your Vanguard partners to trust that you will behave in accordance with their expectations, they will need to see you demonstrate the competence to deliver on your promises (Mayer et al, 1995; Dietz and Den Hartog, 2006). From the case study data we developed a two-item scale (Cronbach’s Alpha .667) to measure the perceived ability of leaders in the Vanguards: respondents were asked whether their partners had demonstrated early being able to make small changes; and whether senior leaders in the Vanguard used data and logic to build a case. Most responses fall in or towards “agree”. This is encouraging because perceiving your Vanguard partners to be competent at delivering what is needed will support cycles of trust building in the Vanguards.

Benevolence

Benevolence can be demonstrated by showing an interest in the other’s needs and taking those needs in to account. It helps to know the person you trust has your best interests at heart. An example of a leader demonstrating benevolence would be the leader going beyond what is required to accommodate the other’s needs. There are two steps: knowing the partner’s needs; and helping out.

- **Knowing the other’s needs**

To be able to do this you need to make time to understand other people’s perspectives, vulnerabilities and needs. Leaders in Vanguard organisations spoke of investing significant time and energy in understanding each Vanguard organisation. This called for a form of relational leadership where everyone’s success depended upon the strength of the relationships across boundaries.

Stockport Together took time to understand the current situation from different perspectives. This empathy enabled them to tailor their approach to building trust to different stakeholders, from GPs to Councillors.

“It’s a constant piece of work, you can’t underestimate the need to forensically assess the nature of what’s at stake for different stakeholders/people in the system.”

In the Symphony Programme, leaders recognised the importance of first understanding the other parties’ world view:

“We could damage it [trust] so easily if we made assumptions.”

At a practical level relationship building entails frequent interactions and time spent face-to-face. As one leader observed, you know you have got there when the other person starts confiding in you.

- **Helping out**

Benevolence was demonstrated when leaders actively supported their Vanguard partners when they faced challenges.

RFL had supported NMUH through a difficult period by providing staff to help out. Rather than pulling up the drawbridge and regarding the staffing issue as a problem for NMUH, RFL leaders got involved.

In Stockport, when one partner had an impending visit from the regulator, the finance directors from all partner organisations worked through the night to prepare and attended the meeting together in support.

“You would have no idea they were from different organisations working collaboratively completing this task. They understood each other’s positions totally.”

We suggest Stockport Together had progressed in to the second wheel of Pomponi et al’s (2015) framework (see literature review). Initially the finance directors had been reluctant to open their books to each other; now they were going beyond what might be expected to support their partner. In the second wheel we see ‘knowledge-based trust’ achieved through familiarity promotes a deeper form of cooperation, beyond merely coordinating operations.

While helping out in a crisis is a clear example of benevolence, there were some more subtle, long-term decisions which we suggest demonstrated a concern for the other’s anxiety, arguably going beyond what was needed to ‘seal the deal.’ Case study leaders paid particular attention to the composition and development of their Vanguard leadership team or board ensuring its members represented all Vanguard organisations and those with a clinical background took a prominent role.

The Symphony Programme recognised the vulnerabilities the GPs felt in participating in the Vanguard with the Hospital which was so much larger than them. They appointed 4 elected representatives of primary care to the Programme Board and appointed a GP as Chair. They acted to reassure the GPs.

Wider picture: Benevolence: From the case study data we took a single item to measure whether respondents perceived their Vanguard partners to be benevolent: did respondents think their partner organisations had taken an interest in their organisation’s

situation. Most responses fell in or towards “agree”. This is an encouraging result because if Vanguard partners perceive each other to be benevolent in their interactions with each other, it will support the virtuous cycle of building trust and encouraging collaboration.

Integrity

In the leader/follower relationship, integrity behaviours include living the organisation’s values and maintaining confidentiality. A person behaving with integrity would be honest and open; they would not deceive and conceal. In the Vanguard context, we add the complication of a second, possibly inconsistent, set of goals and values. Social dilemma theory would describe the resulting challenge for an individual as a choice between cooperative and non-cooperative behaviour, where you cannot satisfy both organisations goals at once. If we assume the goal of a Vanguard is the better operation of the health system, an example of integrity might be a leader putting the needs of the whole health care system before their own organisation’s financial gain.

To be able to demonstrate integrity in a Vanguard an individual needs to know and understand the guiding principles of their Vanguard, as well as those of their organisation. In the case study research, a relevant theme is therefore the creating and communicating of a shared vision for the Vanguard organisations. Second, how do the leaders demonstrate integrity when faced with conflicting duties? Third, we noted a concern to include all parties in decisions, to avoid any suggestion of parties colluding behind each other’s backs. Finally, we look at honesty and openness.

- **A shared vision**

Communicating a shared vision included making the case for change by articulating the shared problem. In our cases initially this was the burning platform of the unsustainability of the existing system going forward.

In Royal Free London, appealing to the bigger picture of NHS funding challenges helped leaders to articulate a shared platform because ‘you have to do something different’.

In the Symphony Programme, increasing demand and financial pressures, and a deterioration in the relationships between hospital consultants and GPs, meant the case for change was clear:

“It’s easier to rebuild some trust in adversity. The pressures on the system at the moment can help us to do this. We all know how things are now isn’t sustainable.”

Stockport Together faced broken relationships between senior leaders, a poor performing A&E and resources that did not reflect the population needs. A shared problem became a catalyst for change:

“Do we fight or collaborate? We had done the fighting and realised an aggressive approach wasn’t getting us anywhere.”

Unified in the face of enormous challenge, leaders articulated a shared vision of the future as a vanguard.

As a leader at Royal Free London observed:

“If it is clear as to what you are doing, what the purpose is, what the common good is, what the value add is and what the aspiration is, then you’ve got a message you can sell, and a message that’s attractive to others, and they want to be a part of it.”

Leaders in the Symphony Programme spoke of building system wide awareness of their vision to make ‘everyone’s lives better’. They repeatedly refocused people on the patient and their needs, reminding them of their shared, underlying motivation for working in the NHS.

“You need to lift people’s heads up to see this mutual, common purpose.”

The Programme Board created a charter outlining the ethos, values and the philosophy of the new organisation and asked GPs to embed it within their practice.

The Stockport Together programme used vision to bind all parties to a shared commitment and realisation that they stand or fall together, helped by defining what success would look like for the patient in precise and tangible terms, such as reducing A&E admissions by 30 per day.

“You’re trying to reconnect people to why they joined public service and came to make a difference, and to quantify it... to give people a story that they can relate to [and to] give them a number that they can measure success by.”

A hundred leaders working across the healthcare system agreed a shared vision of becoming one unified organisation, and Vanguard board members signed a pledge and defined the behaviours required for working collaboratively.

A benefit of a shared defined set of values is other people being able to see you observing the values. This is not, however, always straightforward.

Authenticity was a theme apparent in Stockport where leaders recognised that if their actions were values driven people were more likely to trust them, but not without challenges.

“I don’t doubt we’re living it, the challenge is others believing it, that’s when their defensiveness can get in the way.”

• Difficult choices

Faced with the dilemma of cooperating or not, when the goals of both organisations cannot be satisfied, one choice is to put the shared purpose first.

In Stockport Together, some courageous and highly symbolic acts conveyed integrity, such as when finance directors from different organisations openly shared their books with each other. Such openness publicly confirmed their commitment to putting the needs of everyone above their own, exemplified when one of the directors of finance said to their counterparts:

“If we had a single director of finance instead of three this would be a lot easier. One of them actually said that in a public meeting.”

In Stockport Together, leaders recognised that they sometimes had to give things up to move forward, a change from the win-win scenario often aimed for in negotiations.

A similar theme emerged from Symphony who recognised that they had to be ‘prepared to give a lot, give something away’, in other words to share the risk and the benefit.

However we noted above some weaker results on the integrity item in the inter-organisational trust measure: “Sometimes our Vanguard partner organisations change facts slightly in order to get what they want.”

The table below gives the results just for this item. Over a third of our survey respondents reported that sometimes their partner organisations changed the facts slightly to get what they wanted. We suggest this picks up on both honesty and the dilemma faced by an individual leader when trying to satisfy both the requirements of the Vanguard and the requirements of their organisation.

Table 5

		Frequency	Percent	Valid percent	Cumulative percent
Valid	2 Disagree	17	43.6	43.6	43.6
	3 Not sure	7	17.9	17.9	61.5
	4 Agree	14	35.9	35.9	97.4
	5 Strongly agree	1	2.6	2.6	100.0
	Total	39	100.0	100.0	

While deception is destructive of trust, there is research suggesting that over time partners in collaboration should not be afraid to raise issues they face. Preserving trust by always being predictable and consistent could entrench rigidities. Rigidities could cause the collaboration to fail to adapt to a changing environment. Clearly deception is not recommended; but open discussion of dilemmas may actually improve the performance of an alliance.

- **Honest and open**

Lastly, in the case study Vanguards integrity was demonstrated in honest conversations. Vulnerability and risk were noticeably present when people took steps to be open and honest with one another, perhaps for the first time, with much at stake.

The Symphony Programme described investing time in honest face to face communication to give people the forum to question and challenge each other. It also invested in systems to provide transparent data at all levels.

“The dashboard will show quality, patient experience, HR, turnover ... then every practice will have that dashboard... So, you’ve got that transparency and that cascade, from the front line to the board.”

- **Inclusive decision-making**

Leaders behaving with integrity do not conceal. In the case studies it was clear there was a concern to avoid suspicion of parties quietly agreeing things without including all Vanguard members.

“I get paranoid about not being aware of things and not being included.”

They adopted structures with, for example, equal voting rights for parties or positions for representatives from all parties on a new board. Leaders demonstrated the ability to design and implement new decision making structures to enable collaborative decision making with Vanguard partners.

In Stockport Together, they established clear governance around, and clarification of, the decision making authority of the Vanguard itself.

This agreement on decision-making processes and structures is also relevant to predictability.

Wider picture: Integrity: Acting opportunistically would leave your Vanguard partners feeling exploited. Demonstrating integrity in your interactions with your Vanguard partners supports them building a positive expectation that you will continue to behave with integrity in the future, enabling trust to build (Mayer et al, 1995; Dietz and Den Hartog, 2006). We tested perceptions held by Vanguard participants of their partners’ integrity with a three item scale (Cronbach’s Alpha .782) which looked at: whether respondents believed that the senior leaders all focus on the common purpose and set aside organisation goals; whether senior leaders are transparent and honest with each other; and whether senior leaders all consult with each other on important decisions regarding the Vanguard. In general, respondents do perceive their Vanguard partners to be behaving with integrity, but this is not a strong result. This is concerning because if partners perceive a lack of integrity, trust will fall and the collaboration is likely to be unproductive. We explore this further at the end of this cross-boundary section.

Predictability

Predictability is defined as ‘a regularity of behaviour over time’ (Dietz and Den Hartog 2006). If you can predict someone’s likely behaviour it can take away some of the uncertainty experienced by placing your trust in them. In the Vanguard case studies there were many examples of rebuilding the frequency of contact between organisations and different professionals, whether clinical or those in

central functions such as finance, whether informally to simply get to know each other or for more formal meetings. Frequency of contact breeds familiarity and can promote trust.

In Stockport Together curry nights were organised for hospital consultants and social workers:

“You can’t have trust unless people know each other and they won’t know each other in anything other than a professional way, which doesn’t engender trust, if you don’t invest a bit of time in making them feel relaxed with each other.”

In the Symphony programme their aim was to rebuild relationships between GPs and Hospital Consultants. Leaders recognised that despite having had closer relationships in the past, the growing complexity of the system had led to less informal interaction between them and weaker relationships. It was necessary for them to come together to discuss how to better manage the 4% of complex cases and how to break down siloes in the system.

“There is a mutual purpose in overcoming this problem and we are very fortunate that our immediate practices, GP practices, have had the open heartedness to engage and build this dialogue.”

“You cannot underestimate the amount of time it takes to build those relationships first with people.”

Participants attached value to steps which made the Vanguard tangible and we suggest these support a sense of predictability too. As well as regular events these included physical items.

In Stockport Together, they described creating tangible symbols of a new collaborative way of working between organisations, ranging from the large, for example a ‘hub’ shared working space for partner organisations, to a shared tea fund which was a small but potent symbol. They see the shared space as critical for ‘operating as a human being’ by avoiding false assumptions, conflict and email battles.

“The tea fund, it really brings people together... gives it a family feel.”

To be predictable you also need to demonstrate consistency.

Stockport Together interviewees referred to the importance of consistent messages coming from the Vanguard leadership team, and of the risks of this becoming inconsistent when under pressure:

“If you’re not consistent you appear dishonest. Being under pressure from multiple stakeholders is a challenge.”

The Symphony Programme discussed the importance of consistent leadership style and being consistently focused on collaboration, as opposed to:

“Being one minute very collaborate and the next reverting to “Oh I’m not worried about what you’re up to. We’re just focussed back on the hospital now.”

We noted at the beginning of this chapter a weaker result in the inter-organisational trust measure for an item touching on both integrity and predictability:

“Our Vanguard partner organisations have promised to do things without actually doing them later.”

Table 6

		Frequency	Percent	Valid percent	Cumulative percent
Valid	1 Strongly disagree	2	5.1	5.1	5.1
	2 Disagree	12	30.8	30.8	35.9
	3	11	28.2	28.2	64.1
	4 Agree	12	30.8	30.8	94.9
	5 Strongly agree	2	5.1	5.1	100.0
	Total	39	100.0	100.0	

Over 30% of respondents reported partners promising to do things without doing them later. This may simply be lack of capacity but we cannot exclude a selfish motive and that would be even more destructive of trust.

One step for avoiding surprises and facilitating predictability is agreeing some ground rules for the behaviour expected of Vanguard partners.

In Yeovil they specified what decisions the Vanguard could make and what decisions other teams could make on their own, and GP practices locally elected representatives so they could have a mandate on behalf of GPs to avoid over consulting all GPs.

Wider picture: Predictability: In collaborations there is an absence of hierarchical or market mechanisms of control (Hardy et al, 2003). The taken-for-granted processes within an organisation are absent at the start of a collaboration. Naesens et al (2007) recommend, inter alia, defining some rules to support direction setting and problem-solving. We used a single item scale to ask whether the respondent and their partners had agreed a decision-making process for their Vanguard. The average respondent agreed with the statement. This suggests those Vanguards have the ground rules in place to move to the next stage.

Naesens et al (2007) suggest in their next phase, which is implementing and sustaining the partnership, the parties should pay attention, inter alia, to agreements. We used a single item scale to ask whether the respondent had formalised their Vanguard agreement in a contract. Around 46% of respondents had not formalised their Vanguard; just under 30% had formalised it; and the rest were unsure. Thus while most respondents had agreed decision-making processes, fewer had formalised their arrangements in a contract.

Having explored the behaviours for facilitating trust across boundaries we now add observations from the case studies on topics leaders may wish to address in their own organisations, before adding leaders' reflections on how they changed their selves.

Organisation focus

While leaders are busy building trust cross-boundary they may also need to pay attention to a few items in their home organisations:

- **Processes counterproductive to trust**

In some instances support functions operated outdated processes that were counterproductive to cross-boundary trust. Leaders need gradually to update their organisation processes.

In one case a finance department expected a business case for investment to show outcome measures which were designed for a competitive health care organisation rather than an organisation operating in collaboration with other organisations. Finance would scrutinise budgets from one perspective whilst not considering the system wide changes of the Vanguard, e.g. increasing investment in primary care to save money in the rest of the system.

- **Keeping your own people informed and on board**

When the leader's focus is on collaboration it is easy to forget to pursue a programme of communications in the home organisation too.

RFL leaders had kept staff informed. They had circulated a film clip of the Chief Executive talking about the bid to become a Vanguard, shared the announcement RFL would be an Acute Care Collaborative, had an event to launch the Vanguard and used an external company called Credo to facilitate the group model design and clarity of communications, alongside internal teams.

Directors who were also clinicians had to lead the communications.

“They don't really care what the finance director says and I know that.”

However there was always more communicating to do.

“My counterpart in the North Mid ... she seems to know loads more about it than I do. How do I get up to speed?”

A new proposal may be very good but if the people who have to operate it have not been kept on board, they are unlikely to implement it successfully. An example might be consultants in a hospital. If they are still thinking with the 'fortress' mentality of the previous system and have not been taken on the Vanguard change journey, they will not want to implement plans which they see as damaging from the fortress perspective.

In Stockport Together, they were able to persuade consultants to allow GPs to call them directly to check referrals with the aim of reducing the referral rate. This risked reducing the income to the Hospital trust so they had to leverage relationships to do this. Their approach was to be honest when the consultants raised concerns and say 'yes it will', to listen to their concerns and to respond to them.

- **Practising collaboration within the organisation**

In the literature review we noted the obvious but significant change from inter-individual to inter-organisational trust: there are more people involved. If a person from your organisation were approached by someone from another organisation in the Vanguard, would they be able to demonstrate collaborative working?

Establishing a collaborative style of leadership within RFL would be a building block to achieving collaborative leadership across organisation boundaries.

“At every single level ... we really do have to role model being collaborative.”

To this end, development programmes within RFL were multi-professional and there was “inter-professional learning”. The aim was to train staff so “their mind-set is ‘how can I help this conversation go well?’”

This focus on training links to leaders’ reflections on their work on their selves.

Individual focus

Leaders acknowledged the need to expand their own self-awareness, adapt their mind-set and change their leadership style in order to effectively lead the change required to create a Vanguard. They recognised the need for this significant personal change if they were to successfully help others to change their own beliefs, perspectives and behaviours in order to operate differently in a new model of care.

Leaders articulated the principles they used to guide their approach to leadership in the Vanguard and how this was different to how they had gone about leadership to date. They spoke of a change of mind-set and the need for a different attitude to leadership:

“My leadership role isn’t just a leadership role within my own organisation ... I’ve got a responsibility to lead a system ... it requires you to perhaps have a different outlook.”

“We’ve all got to trust each other that we’re working in the best interests of the system rather than the individual organisation, and that can be quite a mind-set shift, when for years we’ve been encouraged to very much look at individual organisations.”

In addition to a changed attitude, leaders described a change in their leadership style.

Leaders in Stockport Together spoke of the need for an adaptive leadership style, being continuously aware and adapting to the situation as it unfolds, with day to day examples of being explicit in meetings about what they don’t know and the uncertainty in path ahead. They also recognised the need to move away from leading through authority towards leading through influence.

In the Symphony Programme, leaders spoke of an inclusive leadership style, of their role in building awareness across the system and of leading through influence and support rather than direct authority, empowering others to lead based on their ability to influence or their area of expertise.

“A dictatorial approach won’t work, each partner is used to making own decisions.”

Individuals were supported in these changes in various ways.

‘Holding up the mirror’ and ‘no surprises’ were phrases repeatedly heard in Stockport Together, reflecting the central role of honest feedback in their progress to date. The feedback was described as directed towards both the organisation and individuals, to highlight barriers to collaboration. People recognised the discomfort of giving and receiving direct feedback.

“There’s quite an infrastructure there where they’re all meeting regularly and talking regularly with some rich conversations, tense at times but that’s the nature of what we’re trying to do.”

Stockport Together used a leadership programme to support development of behaviours to lead through complexity and to lead from the middle, reflecting an emphasis on empowerment. The act of coming together also helped to build social capital and lubricate integrated working.

Table 7: a summary of how attitudes and leadership style were described as changing during the course of establishing and leading in a Vanguard.

From	To
Command and control, authority	Influence, appreciating, challenging
Organisation perspective	System perspective
Fortress mentality, protectionism	All in it together, share pain and gain 'area deficit focus'
Competition	Co-operation
Self interest	Perspective taking/empathy
Commercially sensitive information	Openly sharing information
Gaining and retaining power for self/ own org	Surrendering power for wider system / greater good
Fast change	Investing time in dialogue and understanding
Criticising other organisations, focus on difference	We need you with us, focus on common ground
Personal expertise e.g. nurse, clinician	Leader beyond ones area of specialism

Conclusion

In this chapter we presented the data on facilitating trustworthy collaboration around three foci: cross-boundary, organisation and self. We used the four pillars of trustworthiness to organise the cross-boundary data and drew attention to slightly weaker levels of perceived integrity and predictability in comparison with ability and benevolence.

There is an argument that our focus on the organisation could form part of 'ability': if you cannot bring your people with you on the journey, then it does not matter how passionate you are about trust and collaborating cross-boundary because the other organisation will find your people are not behaving in the same way. We, however, kept it separate to draw attention to the importance of it as a focus of attention for leaders.

6. Recommendations

Recommendation 1 – There are differences between vertical trust relationships and the creation of trust across complex systems. Based on the research of the Vanguard movement and a review of related studies, there appear to be 3 distinct cycles within the creation of collaborative trust:

Stage One – Agreement driven trust.

- In this initial stage of collaboration partners may draw up a written agreement which sets out the ground rules and objectives for the collaboration.
- Evidence based decision making should be used here, particularly with clinicians. Leaders need to show solid evidence, drawn from data analytics on other health and social care partnerships, that patient care and financial and operational benefits can be accrued. This also starts to build perceptions of ability and competence in the minds of stakeholders and partners.
- It is desirable for partners to start sharing information and concerns as this will start to build a “cognitive closeness” which in turn will propel the alliance through to the next cycle of trust.
- The formation of teams is important. The composition of these teams should ensure that leaders who have a natural propensity to collaborate should be included. Clinicians are also important in order to persuade medical staff of the desirability of the objectives of the partnerships.
- Leadership development programmes which develop collaborative behaviours amongst the senior leaders are a good investment at this stage. This support enables leaders to explore the personal change necessary to move from competitive mind sets through to collaborative mind sets.
- It is also important at this stage to be consistent in one’s behaviours, particularly if any partner has a reputation for being untrustworthy in the past. Any slip will be read by others as a reversion to past motives and behaviours and a belief in the partner’s integrity will start to erode.
- Investing time in the partnership and in understanding partners forms a benevolent foundation for the move to the second stage of knowledge based trust.
- Adaptive leadership styles are important at this stage to facilitate exploration and discovery about other partner needs and concerns.

Stage Two – Knowledge based trust

- Sharing key information and knowledge sharing is critical to this stage although it simultaneously increases the risk for opportunistic behaviour on the part of others.
- Partners need to honestly deepen their understanding and empathy of the concerns of others at this stage. They should explore their differences and try to understand the reason for those differences. Deeper knowledge about each other creates familiarity but also a willingness on the part of partners to try to solve others’ concerns. Knowledge moves from a cognitive understanding into a willingness to have a shared ownership of those problems.
- Objectives for the collaboration start to be seen as aligned goals.
- Documenting and sharing any successes across the multiple organisations influences the perceptions of others outside the partnership.
- Faster decision making starts to happen as the partnership builds a collaborative capability.

Stage Three – Collaboration driven trust.

- The written formal agreements become less important as firm trusting relationships drive the collaboration.
- It is useful to accept and talk honestly about any trade-offs and dilemmas between the needs of your own organisation and those of the partnership.
- Do not over promise. Failing to deliver is worse than being modest in one’s desired results and objectives.

Recommendation 2 – The NHS needs to heavily invest in the provision of leadership programmes which help develop collaborative behaviours amongst senior leaders. Helping leaders to manage uncertainties, develop emergent and adaptive leadership styles, demonstrate benevolence and integrity in all their decisions and actions.

Recommendation 3 – Leaders need a considerable investment of personal time and energy in order to move away from contractual agreements around partnership to collaborative trusting relationships.

Recommendation 4 – Attending to internal trust within one’s own organisation remains important. There needs to be a congruence between the internal culture and the actions of senior leaders within that culture. In vertical trust relationships, leaders should build trust by being consistent in their behaviours, mindful of demonstrating their integrity and values, communicate openly and honestly, demonstrate concern for employees and share a collective vision and live the shared values of the organisation. These behaviours link to the four pillars of trustworthiness which are generally applicable to all interpersonal trusting relationships: ability, benevolence, integrity and predictability (Mayer et al, 1995; Dietz and Den Hartog, 2006).

Recommendation 5 – Maintaining the trust of external stakeholders by delivering the day to day needs of the single organisation is vital. Partnerships cannot ignore the wider context, recognising that keeping the existing NHS system happy is still part of their job. Recognising that this will throw up dilemmas and tensions helps.

Recommendation 6 - The following checklist sums up the leadership behaviours that will drive trust in partnerships across multiple complex systems:

- * Are you pursuing the goals of the collaborative alliance?
- * Do you and your colleagues avoid exploiting your partner’s trust in you?
- * Who are the multiple stakeholders? What are their characteristics?
- * Are they willing to cooperate?
- * Have you defined ground rules?
- * Do you share information?
- * Have you reached an agreement?
- * Are you tracking and sharing benefits?
- * Do you nurture trust within your own organisation as well as the partnership?
- * Do you act as a trustworthy role model for others? Within and across organisations?
- * Do the leaders of the other partner organisations have a relationship orientation?
- * Do you reward collaborative behaviours within the partnership?

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Appendix I: Royal Free London Vanguard Case Study

Vanguard type: Acute care collaboration

Vanguard members: Royal Free London NHS Foundation Trust; Potential Vanguard members: North Middlesex University Hospital, Royal National Orthopaedic Hospital

Context

In September 2015 Royal Free London NHS Foundation Trust (RFL) was named as one of thirteen Acute Care Collaboration Vanguard sites.¹ At the time Royal Free London NHS Foundation Trust ran three hospitals in North London: Barnet Hospital, Chase Farm Hospital and Royal Free Hospital. Building on this experience, RFL had proposed the creation of a hospital group.

RFL believed that significant improvements in patient health outcomes and patient experience, as well as cost savings, could be achieved by bringing a number of hospitals together, connected by a single group centre. The initial proposals were for one or two trusts to join the group each year. The ultimate size of the group could be large, possibly ten to fifteen trusts if the model succeeds. Individual organisations would be able to join the group under a range of 'membership options', from full membership (where the member is fully owned) to 'buddying'.² This new organisational model (distinct from NHS Trust and Foundation Trust models) would offer economies of scale, by sharing centralised HR, finance and procurement functions. In December 2016 RFL was awarded £8million of funding by NHS England to support its work as a new care model Vanguard.³

The Creation of the Vanguard

RFL set out to design a group structure which would appeal to potential members. The design built on two elements: partnerships to optimise the group potential; and, RFL's recent experience of acquiring Barnet and Chase Farm Hospitals.

Partnerships to optimise the group potential

RFL formed strategic partnerships with various non-NHS organisations, from which new joiners to the group would benefit. Three of these were:

For change management capability: Intermountain, Utah

Groups of clinicians and senior management had been to Intermountain in the US to look at how they standardise care pathways and protocols on a grand scale⁴, thereby reducing clinical performance variation across hospitals, for example, designing protocols with trusted champions and clinical leaders. Clinicians work to those protocols but importantly are also encouraged to "act out of them if the patient is different." RFL was also seeking to learn from Intermountain's expertise in controlling the cost base through economies of scale.

For analytics: Cerner, US

Cerner was RFL's digital electronic medical record provider. Intermountain was one of Cerner's biggest clients. This partnership was therefore complimentary. The computer system could be developed to facilitate offering the same excellent standard of care across all member hospitals. The approach developed with Barnet and Chase Farm had been to appeal to the common purpose of patient benefit, while also sharing data to create a powerful evidence base to help achieve the common purpose.

For improvement capability: The Institute for Health Improvement, Boston

RFL wanted staff to be skilled in the tools of improvement science.

"We believe that improvement has to lie at the heart of everything that we do."

These partnerships would provide a common basis for operating as a group.

"If it is clear as to what you are doing, what the purpose is, what the common good is, what the value add is and what the aspiration is, then you've got a message you can sell, and a message that's attractive to others, and they want to be a part of it."

Building on previous experience

While sharing the benefits of these three partnerships, full member hospitals would retain their individual identities yet with one board with non-executives at the centre of the group, with the centre of the group running a centralised balance sheet and interfacing with the regulator. The centralised HR, finance and procurement functions would be an evolution of the structure tried and tested for these services following the acquisition of Barnet and Chase Farm. Clinical practice groups would cut across the individual hospital business units.

"I don't think the way that the Vanguard is set up is exactly [about] leading. It's more like influencing."

Members of the group that were not full members could use or join some of the services.

RFL leaders had recent experience of the challenges of building trust across organisation boundaries from both the acquisitions and other collaborations around clinical services, including a pathology joint venture with University College Hospital. The proposed model for the Vanguard does not seek to integrate new hospitals to the

¹ Although often listed with RFL in press reports, Salford Royal and Northumbria Healthcare NHS Foundation Trusts are not partners in this RFL group; rather they are setting up similar groups of hospitals.

² <https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/acute-care-collaboration/royal-free/>

³ <https://www.royalfree.nhs.uk/news-media/news/trust-awarded-8-million-vanguard-funding/>

⁴ RFL is already the fifth biggest Trust in the country but running a system of Trusts/hospitals will take it to a new scale.

same extent as in the acquisitions because this would repeatedly put RFL through “massive organisational change” but much of the expertise from the acquisitions is still relevant.

RFL had acquired Barnet and Chase Farm Hospitals in July 2014 when they had various performance issues, for example, with RTT (referral to treatment) times.

“We had a lot of learning from suddenly going from a hospital here in Hampstead, which employs about 5,500 people to suddenly pretty much doubling in size and spreading our footprint to another kind of [hospital and] half a million patients.”

Three areas in which they would learn from their successes and mistakes are:

Engagement

In the run up to the formal acquisition in July 2014 they had led engagement events for senior clinical staff from the various sites. These involved food and wine, discussion groups around tables, in a neutral location, all jointly led by the Chairman and Chief Executive. There had been a determination to listen to the new group to work out how best to work together and to recognise their anxieties. Also, senior operational staff had been included in the operational design so that it was clear from day one in July who was reporting to who. RFL leaders recognised the importance of investing time in face-to-face meetings to build trust.

Culture

RFL also used cultural focus groups before the acquisition to identify similarities and differences, to target their efforts. The culture in a teaching hospital can be very different from that in a district general hospital. The RFL Chief Executive and the senior management team did roadshows to be visible. The Chief Executive was regarded by colleagues as brilliant at walking the talk, being visible, talking to anybody, taking an interest in them and making them feel special.

All staff attended the same corporate induction. The senior team continued to work on being visible, for example, they visited Barnet on Wednesdays.

“We said ‘we’ll be up here every Wednesday’ and we keep going back every Wednesday.”

They kept the Trust’s objectives consistent and continued to repeat them. RFL worked with Barnet and Chase Farm staff on the Values and the behaviours underlying those, creating “a common language” which “allows them to frame conversations”. RFL leaders recognised the need to be sensitive to cultural differences in new members and a challenge going forward would be how to engage new members with shared values and behaviours.

Delivering promises

Finally RFL sought to rebuild trust in management and leadership in the new sites by delivering on promises, most notably delivering the redevelopment of Chase Farm Hospital.

“Getting the Chase Farm business case through ... is a real winner. The staff can see it happening.”

“Every new chief executive of that hospital had promised them ‘we’re going to get the building and the estate sorted out’ and nobody had ever delivered.”

This demonstration of ability appeared to have supported good relationships externally, for example, with clinical commissioning groups, and internally with staff who were reported now to be implementing the changes RFL had sought. RFL leaders promoted demonstrating ability in its relations with the regulators by not overstating how quickly change could be achieved and being careful not to promise too much.

Some initiatives went less well and they found that in a fledgling relationship mistakes could be interpreted as evidence of a hidden agenda. Mistakes, particularly in the language used in communications, created set-backs, even when “it’s cock-up, not conspiracy”.

“The language is important and that is actually how you get trust.”

However in spite of the setbacks they reported that performance measures for the new sites had improved over the two years since the acquisition.

By combining their shared services model with their expertise in building trust across boundaries, RFL leaders created a Vanguard design which they hoped would appeal to potential partners. The benefit to patients would be better care across all sites, the benefit to the hospitals would be lower costs and the benefit to staff would be the option to move around within the group.

Making it happen: initiating, negotiating, structuring, operationalising

At the time of conducting the research for this case study RFL leaders had developed an initial model for the Vanguard and negotiations with potential partners to develop it further were ongoing. A potential founder member of the group was North Middlesex University Hospital (NMUH). The Trust Board of NMUH formally endorsed entering discussions with RFL at a public meeting in May 2016.⁵ A memorandum of understanding provided a framework for discussions. In common with a number of NHS hospitals, NMUH faced significant funding challenges. Joining the

⁵ <http://www.northmid.nhs.uk/Portals/0/Trust%20Board%20M%202026th%20May%202016.pdf>

Vanguard would be a potential route to improving the performance and financial viability of the hospital in the future.

A second potential founder member was the Royal National Orthopaedic Hospital (RNOH). In contrast to NMUH which is a district general hospital on the outskirts of London, RNOH is a smaller specialist institution, with different objectives in joining the group. RFL is different again, being a large teaching hospital. While the potential members are all hospitals, the similarities between the hospitals should not be overestimated. RFL leaders had to understand the similarities and differences in potential members' aims and objectives.

Rather than presenting a fixed model, RFL leaders sought to engage potential partners in finalising the design of a model which would work for all. If successful they could create a template for this new way of working which could be replicated across the country. In the following sections we explore the experiences of senior leaders in RFL in seeking to build trust across organisation boundaries with NMUH.

Trust enablers

RFL leaders reported the following as supportive of building trust with NMUH leaders.

Existing relationship

RFL had supported NMUH through a difficult period, for example, by providing staff to help out at NMUH. Rather than pulling up the draw bridge and regarding the staffing issue as a problem for NMUH, RFL leaders had got involved. RFL benefited from neighbouring hospitals continuing to function well so this had been in their mutual interest but nevertheless demonstrated benevolence.

Some RFL staff had existing relationships with staff at NMUH, for example, one of the Deputy Directors at RFL had previously worked at NMUH. A number of clinicians worked for both organisations. Some network services had been delivered with NMUH for a number of years. RFL had experience in bringing together services across North Central London, for example the liver and liver transplant programme. As neighbouring hospitals NMUH and RFL also shared a number of patients.

A shared platform

The financial situation in the NHS means "you have to do something different." Appealing to the bigger picture of the funding challenges helped the leaders to build a common purpose for adopting the Vanguard.

Clinicians leading cross-site communications

For the early meetings RFL's Medical Director went to speak to clinicians at NMUH. The RFL Quality Director had also visited. RFL had then recruited a number of doctors to go out to have bilateral conversations with NMUH's clinical leaders.

"You get them to meet and look at their results."

NMUH's introduction to the Vanguard therefore had come via credible people with whom they could work through what it might mean and what the opportunities might be. Going there, being there, understanding their issues and finding common ground were seen as important for building trust. Previous collaborations suggested meeting "tens of times" rather than just "two or three" would be necessary for successfully coordinating any one medical programme. Meeting every two weeks for, say, 6 months would be hard but would allow time to work through the detail necessary for success. The first clinical practice groups (CPGs) would provide clinicians with examples of colleagues making it work, rather than examples from Utah.

Dedicated resources

At RFL the Chief Executive, Deputy Chief Executive and Medical Director were working closely to drive the Vanguard forward. The Deputy Chief Executive, who was also the Chief Finance Officer, was concerned to ensure the plan was coherent and coordinated. The Medical Director was driving the cross-site clinical practice groups and the partnership with Cerner. All three had been at RFL for a long time, providing "a stable CMT and its genuinely clinically led." RFL and NMUH had each appointed relationship directors to focus on the potential partnerships and transactions, working not only with potential partners but also with the regulator. The Royal Free appointee worked at both sites. He had facilitated the RFL Medical Director meeting senior clinicians and staff at the North Middlesex to talk about the group concept, gradually drawing a wider group of people in to the discussions.

In-house leadership training

RFL senior leaders had supported individual leaders by adopting a leadership development programme. Potential system leaders across the new model could access relevant training, for example, modules for clinical directors around vital conversations. The London Leadership Academy, a pan-London NHS leadership development organisation, was offering further training. Indeed, establishing a collaborative style of leadership within RFL would be a building block to achieving collaborative leadership across organisation boundaries.

"At every single level ... we really do have to role model being collaborative."

To this end, development programmes within RFL were multi-professional and there was "inter-professional learning". The aim was to train staff so "their mind-set is 'how can I help this conversation go well?'"

In-house communication

RFL leaders had kept staff informed. They had circulated a film clip of the Chief Executive talking about the bid to become a Vanguard, shared the announcement RFL would be an Acute Care

Collaborative, had an event to launch the Vanguard and used an external company called Credo to facilitate the group model design and clarity of communications, alongside internal teams.

Directors who were also clinicians had to lead the communications.

“They don’t really care what the finance director says and I know that.”

However there was always more communicating to do.

“My counterpart in the North Mid ... she seems to know loads more about it than I do. How do I get up to speed?”

Humility over hubris

RFL leaders emphasised the importance of being able to say “bear with us while we fix some stuff.” Trust would be lost quickly if the RFL were found to be all “fur coat and no knickers.” RFL leaders emphasised the value of open and honest conversations, including being able to say we “don’t know.”

Making time

To build trust with the executive at NNUH:

“We got a group of people and we went to the pub.”

Trust barriers

RFL leaders had identified a number of barriers to be overcome.

Competitive history

“Let’s not underestimate where we have come from. The NHS has been a competitive world of people wanting to do their best in their organisation, for their organisation, for their staff and for their patients, and that has to be put aside.”

“In London ... there is a huge amount of institutional rivalry and competition ... you’re bidding for business that belongs to somebody else.”

The emphasis on competition and choice during the previous few governments, manifested through the internal market, foundation trusts, payment by results, primary care trusts, and commissioner/provider splits, was the context in which collaborations would now be built. Individuals had to build trusting relationships with people they had previously battled in competitive processes.

Reputation

NNUH is geographically close to Barnet and Chase Farm hospitals. Stories of the changes in those hospitals following the acquisition by RFL were likely to have reached NHS staff in the area.

“Well they probably heard bad things about us from [some] Barnet colleagues – we know they have.”

While RFL leaders had worked hard to deliver progress at these sites following the acquisitions, for example, the approval to redevelop the Chase Farm site⁶, some Barnet and Chase Farm staff had objected to the changes and left rather than adapting to the new management structure and ways of working with RFL. People “wanted to keep doing things the way they had always done.”

“It’s also a bit about people wanting their own territory, their own freedom.”

While working for a larger group would appeal to some staff, others would not like it.

RFL directors were aware they had not always got the response they were expecting from NNUH to offers of help. An attempt to support might be interpreted as an attempt to take control, particularly when interpreted in the light of the acquisitions at Barnet and Chase Farm. Although the group model was expressly designed to be collaborative rather than acquisitive, the suspicion remained that RFL was attempting to repeat its acquisitions of Barnet and Chase Farm.

In these early stages, when the mechanics of membership had yet to be agreed, uncertainty also made it hard to get the pitch right. Individuals appeared wary of talking to their counterparts at RFL when they did not yet know the big picture plan. It was suggested appreciative enquiry could be useful in these circumstances.

Third parties

First, problems at a hospital could attract the attention of multiple parties, such as, politicians, regulators, patient groups and trade unions. RFL leaders had to gain and maintain the trust of these stakeholders as well as the potential partners. It could take years to add, say, 10 hospitals to the group so the trust of third parties would need to be maintained over a long period.

Second, new initiatives from third parties could draw attention away from the difficult project of building a group of hospitals.

“It might be that I agree something ... and then somebody else pulls the rug ... and that could be the regulator, it could be NHS England.”

In this case, the recently announced North Central London Sustainability and Transformation Partnership risked distracting the potential partners from working towards the Vanguard. The Vanguard had to work within the STP and demonstrate its ‘fit’ with the STP’s aims.

Capacity and capability

First, the staff capacity for the new project was limited.

⁶ <https://www.royalfree.nhs.uk/news-media/news/chase-farm-redevelopment-approved/>

“To get to know [people] takes time and space and it needs to feel safe ... and everybody is busy already in their day job.”

Second, those working on the Vanguard had to balance that project with their other responsibilities.

“You end up just collaborating; you don’t do any work.”

These were combined with a question of capability as well as capacity:

“Whether we do really have the skills and capacity, the operational capacity, to actually deliver the over-arching board and control of a huge big health system without losing control of what we’ve got already.”

Individual vulnerabilities

First, clinicians were open to the idea of improvement yet two services at neighbouring hospitals could each believe they were offering the best workable service available and would have entrenched ways of working. Conversations about how to standardise and optimise offerings across a group of hospitals needed to address this context. Appealing to a common purpose of improving patient outcomes could get you only so far if the clinical leaders disagreed about how to improve those outcomes.

Second, individual leaders in HR, finance and procurement roles had to meet to agree the steps towards becoming a group. They also wondered which of them would be senior to the other in the new shared support service structure.

“Where might I end up? Will I have a job in this Vanguard?”

This is a difficult setting in which to build trust.

Third, individual leaders felt insecure if they had no experience of similar projects.

“This is probably much bigger than anything I’ve been involved in ... my vulnerability right now is not knowing enough.”

Group vulnerabilities

RFL staff had seen the negative financial impact on RFL of the acquisition of Barnet and Chase Farm. Some hospitals interested in joining the Vanguard group would be financially vulnerable. In severe cases it was difficult to see how the group could absorb an organisation without jeopardising all the members.

“The money is a massive vulnerability for all of us.”

It was reported that as money got tighter in the NHS, people had to manage their cash flow. They stopped paying each other. That built mistrust.

Honest conversations and open disclosure were essential for re-building trust but hospitals could be wary of highlighting financial problems for fear of being put in to special measures by the regulator. RFL leaders were talking to the regulator about how the performance measurements needed to be changed if high performing hospitals were to be persuaded to join with failing hospitals.

Legislation

Although the new group model was expressly not about RFL “acquiring” all the group members, RFL leaders had to operate within existing legislation which stipulated that to expand a foundation trust you had to acquire the joining hospital. The requirement to go through an acquisition with the associated steps of due diligence, etc. undermined the leaders’ work to create a collaborative relationship. There were also competition law issues to be addressed.

The role of leadership in overcoming trust barriers

Two messages used by RFL leaders to persuade their own staff of the benefit of the Vanguard were: the economic case; and, the patient care case. One way to encourage participation was appealing to people’s pride by arguing they should share their excellence, while always prioritising the ‘collaboration not acquisition’ message. RFL leaders used repeated open, honest communication led by clinicians to maintain the trust of their own staff.

They also recognised the importance of allowing clinicians to lead the relationship-building across organisation boundaries. The stable and experienced leadership team at RFL facilitated the building of trust with NNUH by demonstrating benevolence, ability, predictability and integrity. By helping NNUH through a difficult period RFL leaders had demonstrated concern for NNUH. By always seeking to support their arguments with data RFL leaders behaved professionally. Indeed the strategic partnerships themselves had been skilfully chosen to support the generation of powerful data to guide decisions in the future. To counter any bad reputation from the acquisitions RFL leaders could point to the improved performance across the three hospitals in the RFL group and the delivery of the long-awaited buildings at Chase Farm. RFL leaders were careful not to over-promise and knew the value of delivering on any promises they did make. RFL leaders sought to be open and honest in their conversations with all parties, whether with in-house staff concerned about their future jobs, potential group members or the regulator.

RFL leaders had had the benefit of experiences with Barnet and Chase Farm, both good and bad, to hone their leadership behaviours. They were already applying these lessons in their discussions with NNUH. In the future they would look to reinforce cycles of trust-building by committing to the relationship in a contract and delivering on their promises, while always seeking to understand the other party’s position and cultural differences.

Conclusion

Building trust was fundamental to the success of this Vanguard model. For hospitals to want to join the group, they would need to believe membership would be better than the status quo.

“It’s crucial ... for our design of a group. People aren’t going to want to join with a set of people they don’t trust.”

By the end of the 2016/2017 financial year RFL wanted to have demonstrated the cost efficiencies and performance benefits which could be achieved by standardising processes in a couple of areas, for example, maternity, by getting groups of likeminded clinicians in service lines to work through their key patient journeys. This evidence would be important for re-enforcing trust between group members and inspiring trust in the Vanguard model.

Appendix II: Stockport Together Case Study

Vanguard type: Multispecialty Community Providers

Vanguard members: Stockport GP Federation, Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust and Stockport Metropolitan Borough Council; third party voluntary organisations.

Context

In 2014 Stockport's A&E was amongst the worst in the country, resources and investment didn't reflect population needs and the leaders of the different health organisations barely spoke to each other. The burning platform was even starker when the Council projected the consequences of the austerity programme; a shared problem became a catalyst for change:

“Do we fight or collaborate? We had done the fighting and realised an aggressive approach wasn't getting us anywhere.”

“If we don't work together then the system faces a catechism both financially but also in patient care.”

Some services were performing well, whilst others needed significant change. Over a hundred clinicians, leaders and politicians representing the region and service users, came together for a two day congress to work out how to improve their system and what levels of joint working they could aspire to. Chief Officers of participating organisations signed a pledge stating “this is where we are, this is what we're here to do” creating the foundation of a common approach and true integration, a commitment to genuinely work together. They pooled a 40-50 million budget for commissioning and created some infrastructure with a joint committee of the CCG and Council.

The Vanguard

Stockport Together is a Multispecialty Community Provider (MCP) Vanguard which intends to develop a new model of care that creates a more sustainable system, an integrated delivery model that pools resources and removes the boundaries and barriers of silo working.

“We've all signed up for something that can't work unless we all have our needs met. – there's a genuine sense that no one partner has more authority, partners are on an equal footing.”

Their vision started as a new model of care where each organisation has democratic accountability, and has evolved into a vision of working as one partnership, retaining a distinction between commissioner and provider. Specifically to create a small commissioning function with most of it managed by a care organisation with a single plan, a single set of commissioning intentions, a single budget and single integrated management team. All services would be delivered within an outcome and population based approach and a shift to a prevention focus that uses the assets of local communities.

“The local authority has re-configured its services and put the whole of public health and adult social care delivery into a pooled commissioning budget and the provider because it sees the future without that level of completely shared ownership as being too bleak to contemplate.”

The MCP draws on learning from a previous integrated, family support service. It offers significant leadership to GPs at a neighbourhood level and to the whole health and care system. They are quick to point out that the goal isn't the MCP itself, the MCP is just the vehicle:

“Like the cup that holds the wine of improved services and reduced inequalities, financial balance – it involves £450m being spent in a different way.”

Making it happen

Initiating

The Vanguard leadership team used a neutral party to listen to people's experiences in each organisation. They then reflected back to the leadership team what they'd heard, forcing an honest conversation about the difference between people realities. They received direct feedback from someone they trusted:

“You're the leaders of this system. If that's what it's like you've set it like that. Your choice, in this room now, is to un-set it.”

As a leadership team they appointed an independent chair, who continues to provide direct feedback and challenge, to ‘hold up the mirror’. They were told they weren't meeting frequently enough and then they met for a week, then every week for two hours, over six months, a significant shift. The external partner works with them to create their case for change and establish new processes.

“We did a lot of setting ground rules about how we'd work together”

Negotiating

Encouraging commitment to collaboration required a heavy dose of realism and perspective, a solid understanding of the current situation. They had to challenge perceptions and assumptions with direct messages:

“Let's all hold the mirror up. We're not that good at this are we?”

They also anchored the vision to people and patients:

“What we're wanting to achieve is for them and we need to use the money in the best way. That might be my organisation has to disappear.”

There was visible leadership and real honesty about the significant change in direction. A Hospital deputy chief exec attended the annual GP conference and said:

“Our job was to take as much money off you as we possibly could and build a huge business. We understand that is not a sustainable approach, our strategy now is to go the other way.”

Structuring

Structures were put in place to make sure there was a clear authorising environment so that people were empowered to work on the Vanguard as much as they were empowered to deal with their statutory duties. A project management office lead the planning phase, holding regular meetings with leaders and wider stakeholder groups, placing a huge emphasis on communicating proactively, for example via newsletters, staff briefings, so people want to be a part of it and to build momentum.

They were careful to strike a balance between focusing on setting up clear governance for decision making and OD aspects such as values and defining how we will work together.

Operationalising

4 key work streams will deliver the transformation plan; core neighbourhoods, borough wide services, healthy communities and acute interface; supporting these is an enabler work stream. People are empowered to make decisions as part of the programme:

“We did all the visionary this is what we need to do, do we understand our system the finance people going in rooms and really getting to grips and sharing data. Now that is the norm that is just the way we do business.”

Conflict management and empowerment have become important areas of focus - having informal conversations with people to enable them to share their honest views, and also pushing decision making down whilst allowing issues to escalate up.

“You’re looking to break down existing barriers and do things differently so people have to take a bit of risk almost that those that they move away from an established way of doing something.”

They used a leadership programme to help people to develop the behaviours to lead through complexity, to create the conditions for people to lead from the middle. Getting everyone together for this helped with working in a more integrated way.

Trust enablers

Recognising needs and vulnerability

A key enabler was using different approaches to building trust with different stakeholders, depending on their needs and the nature of their vulnerability. For example, some of GPs' needs could be met by centralising some of their administration, whereas the Council's needs centred around their mandate from the population to improve services. For the council, endorsing the new model of care could be the biggest decision they had made for decades about the structure of adult health and care, and would account for about half of their budget.

“It’s a constant piece of work, you can’t underestimate the need to forensically assess the nature of what’s at stake for different stakeholders/people in the system, their propensity to trust or distrust and actively work with that ... you have to look at the issue of vulnerability from a number of perspectives so it always has several dimensions and somebody, in leading the system, needs to make sure that we’ve done the exercise to work out what they are.”

Leaders work with people to surface their concerns, and use different tactics such as giving information, or getting different people together to build understanding and relationships. For example by holding a curry evening for hospital consultants and social workers:

“You can’t have trust unless people know each other and they won’t know each other in anything other than a professional way, which doesn’t engender trust, if you don’t invest a bit of time in making them feel relaxed with each other.”

They are also alert to when partners come under pressure recognising this is when vulnerability increases and their capacity to trust other partners in the system becomes strained.

“You have to be able to trust that people will follow the new rules of not passing the financial buck from one to another and at the same time you know support each other when the regulators come to town.”

Visits from regulators are a significant test of trust from which some of the most noticeable stories of partnership have emerged. When one of the Partners had a visit from a regulator, the deputy directors of finance worked through the night on the day of submission:

“You would have no idea they were from different organisations working collaboratively completing this task, they understood each other’s positions totally and were using language in the same way.”

Trust fund

They noticed that having a history of coming together and resolving issues together can help to build trust, they are ‘like markers in their history’. People described it as trust based on evidence, on a person’s track record, rather than blind trust or crossing your fingers.

“I think one of the reasons we’ve become more ambitious than other people is because the same people are in the system and they have got this ability to trust each other.”

For example, they were able to persuade consultants to allow GPs to call them directly to check referrals with the aim of reducing the referral rate. This risked reducing the income to the Hospital trust so they had to leverage relationships to do this. Their approach was to be honest and say ‘yes it will’, to listen to their concerns and to

respond to them. Holding some existing trust in their relationship helped them to do this.

Mobilising resources

Having the resources to put action behind words has also been an important enabler of trust. Being able to say to people 'we will unblock your blockages' demonstrates their commitment to change. Resources also enabled them to feel empowered and autonomous.

"If you need a mobile phone to do this clinic we can provide you with that and the trust came very quickly."

Face to face dialogue

The Vanguard leadership team and managers of the change programme used face to face dialogue to build trust with each other and colleagues in the partner organisations.

"People place a lot on it, they look at your face they watch your body language your whole persona, and I know I do the same and it's picking up on people how they come across and if I think of the people that are leading this change a lot of them the majority of them have a lot of credibility and that has made me trust them"

It's also a tool to foster debate, people want answers to their questions and to build their own understanding so they can lead their own teams through the transformation:

"I want the answers to my questions so I can feed that down, I need to understand it and unless I understand it then I will have an element of distrust"

"If I understand it then I'm quite passionate about it ... if I don't believe it then I can't sell it"

Honest feedback

'Holding up the mirror' was a phrase repeated by most people interviewed in Stockport, supported by the value of 'no surprises', reflecting the central role of honest feedback in their progress to date. Whether that's honest feedback from someone outside the system to the leadership team:

"It was pointed out to us helpfully by somebody outside the system that we had spent the last however many years ... passing the buck from one to another passing deficits and financial risks from one to the other..."

Or holding up the mirror to the system itself to highlight what's not working; or holding up the mirror to a team member who's behaviours don't fit with a new mind-set of collaboration. Most people appreciate receiving direct feedback and recognise the personal risk it takes to deliver it; it can make both the giver and receiver feel vulnerable.

"I'm giving you instant feedback unless we do something different we are going to go backwards not forwards."

"There's quite an infrastructure there where they're all meeting regularly and talking regularly with some rich conversations, tense at time but that's the nature of what we're trying to do."

Allowable weaknesses

If leaders can create a climate of allowable weaknesses it gives people more confidence. They are doing something new and no-one has all the answers, so this helps people to feel they can speak up when they are out of their depth and to ask leaders for help.

Trust barriers

The barriers to creating trust manifest across three levels:

Individual

Where a leader's style is based on fear people described a reduction in trust, for example a punitive system where teams are under pressure, results in people protecting their own position and blaming others.

In addition, people recognised that they themselves can become suspicious if they feel decisions have been made without their input, indicating that a top down approach to leadership undermines trust by triggering vulnerability:

"I get paranoid about not being aware of things and not being included."

Also, if people suspect leaders aren't being completely open with them it can reduce trust:

"I'd much rather have a debate and people be open and say it as it is between my eyes, I'm fine with that. Go round the houses and I'll look for what's behind it."

In addition, the stereotypes that people build up about each other can get in the way of relationships. People recognised that the truth can be twisted and rumours spread as a reflection of people's insecurity, vulnerability and uncertainty about the future in the face of funding cuts.

Organisational

Despite having some infrastructure around the Vanguard, such as a programme management office, people were sometimes diverted by business as usual problems in their own organisation. Their response was to create two Senior Responsible Officers to lead and trouble shoot across the system and unblock barriers.

External pressures, such as the scrutiny of regulators, sometimes leads people away from common ground and collaborative mind-set. Fear causes them to revert to past attitudes and behaviours such as finger pointing, when the solutions are in the working together rather than finding fault.

Support functions can be a barrier to progress when they operate under the past way of thinking, e.g. expecting a business case for investment to show the same outcome measures as in the 'old world' rather than reflecting collaboration between the organisations. Having separate financial interests and targets can be a barrier.

“There’s a perception (by support functions) that they may not be needed it’s not that they [are] not needed for the whole system but just not that component of the system.”

Systemic

A key learning point for Stockport was that each organisation in the Vanguard operates from a different world view and holds stereotypical beliefs about the other three organisations some of which are true, some of which aren't. They focus on understanding their position whilst also helping people see their own slightly different lens, overcoming difference by highlighting common ground. Moving people to a wider systems perspective can be constrained by their own sense of vulnerability; moving beyond this requires doing the homework to understand their perspective.

“There isn’t really a conspiracy against you, actually people see the world differently and the thing that you don’t find important they do.”

“We being the corporate organisation, can really get in the way if we don’t trust each other and make it easier for each other because we put barriers.”

Some commented on how the wider NHS leadership can sometimes be a barrier to trust:

“I think they are very short-termist and they don’t realise how they destroy trust by doing that, destroy the long term success..... I cannot believe how little attention is paid to it (people side of change and OD) in what is a very big business.”

The role of leadership in overcoming trust barriers

“One of the principles of leadership I was very explicit about was that we needed to be completely open and honest with each other about the nature of what our day job was and the nature of how hard the change process was going to be.”

Leaders focused on using a shared vision to gain everyone's commitment to collaborative working, binding them together with a shared realisation that they stand or fall together. They precisely and tangibly defined what success will look like for all staff, they defined outcomes to make change measurable, real, and always related to the patient, such as reducing admissions to hospital by 19 a day and admissions to A&E by 30 per day.

“You’re trying to reconnect people to why they joined public service and came to make a difference, and to quantify it... to give people a story that they can relate to give them a number that they can measure success by.”

A significant amount of their focus was on the behaviours needed to create a trusting and collaborative relationship, behaviours that help them to lead from the middle, a leadership style that is 'conversational, 'challenging, 'appreciative'. Behaviours that publicly confirm their commitment to a new way of leading, exemplified when one of the directors of finance said to their counterparts:

“If we had a single director of finance instead of three this would be a lot easier. One of them actually said that in a public meeting.”

After a lot of time and negotiation the finance directors of the different organisations actually sat in a room with each other and opened up all their books to each other. Considering how independent they were from each other before, that leadership act demonstrated courage and commitment to the new way of working.

“It took a big commitment from the very highest level and then a big commitment from the director of finance.”

Other leadership principles used to build trust during the transformation included:

Being values driven: Trust is at the heart living by values- they supported staff who were doing the right thing by the patient and recognised that sometimes involves knowing when to break the rules.

Authenticity: they recognised that people trust them when their actions are values driven and they do what they say they're going to do, are open and honest. Central to this is building trust through honest feedback. Confronting people who behaved inappropriately at first made for some uncomfortable meetings, but people are more comfortable now and are starting to change.

“You have to hold a mirror up and be brave enough to say actually there’s an issue here and we need to work our way through it ... it’s much easier to do that if you do it from an understanding and trust and there’s no way of short cutting that.”

Surrendering power: leading through influence rather than direct authority, and recognising that to work effectively in the system you must be prepared to surrender some power.

“There’s a fallacy that if you make changes, unless it’s win win it doesn’t go forward - so how do you create a sense of altruism so that some parts of the system can accept they might need to give something up thereby lose if the greater win is really worth it. So, keep pushing people to give stuff up because sometimes you have to give stuff up to move forward.”

Perspective taking: to take the time to understand and respect people's different positions, to understand the current system - how it felt, how it was working and what would happen if they allowed it to carry on as it was, and whether that was what they wanted. Some of this involves introducing new language and metaphors, such as a ballroom analogy where the leaders observe the dancefloor and dancers from a position on the balcony – to see the interaction from all perspectives.

Adaptive leadership: Building on this perspective taking, being continuously aware and adapting to the situation was recognised as important, for example being explicit about uncertainty in meetings:

“We cannot control the entire environment, we are going forward in a clumsy way. We are designing as we are doing. We have to learn when we bump into each other not to do it again or to minimise the impact when we do.”

They believe trust underpins everything in the Vanguard, so much so that they haven't called it trust but their approach closely fits the definition of trust....

“We spend what to the outside world might look like a disproportionate amount of time on simply building relationships, making sure people are seeing each other face to face and talking about their concerns.”

Conclusion

Implementation started in November 2016, so it's early to report measurable improvements, however for the first time in years there has been a reduction in non-elective admissions. Tangible change includes a new organisation infrastructure and a leadership team who are working in an integrated way which are all very visible signs that things are different. Vanguard leaders have noticed that when they do have trust they have open conversations, improved system decision making, the ability to make progress faster and deeper.

“You've got to give transformational change it's the green shoots you've got to nurture it you've got to get it organised I think and that takes time.”

“If you trust something you will engage with it ... you build that trust, you build that programme and people engage with it and then they commit to it.”

Stockport Together has brought together separate organisations which are all accountable to someone or something different, which all have different cultures, which are moving towards becoming one organisation form, something that is more ambiguous and harder to grasp. Whilst it's an ongoing challenge, there's a singularity of purpose and signs of truly integrated working and positive outcomes. New rituals and symbols of integrated working are emerging, there is a 'hub' workspace for people from all four organisations. What is clear is trust matters because of the

interdependency between the organisations, they all rely on each other, and where trust exists the outcomes are enticing:

“It's almost like a quantum increase in productivity we get when we have trust ... You get more bang for your buck because people go the extra mile”

“Trust helps us just to be more productive and to build care around the patient because what that means is we don't have 47 different professionals going into see the patient. So from the patients perspective it generates joined up care.”

Appendix III: Somerset Symphony Programme

Vanguard type: Primary and Acute Care

Vanguard members: Yeovil Hospital Trust, Primary care (19 practices), Somerset Partnership NHS Foundation Trust and Adult Social Care

Context

South Somerset was under significant financial pressure as a health system and leaders recognised that the only way forward was to work together and pool resources.

“We recognised that between 2015 and 2020 we’d have to have three new wards just to cope with the people who are otherwise going to be ending up in hospital”

Drivers for change included an aging and growing population, increasing demand and financial pressures, different parts of the system working in a disjointed way. In addition, workforce shortages and Primary care faced challenges attracting talented GPs to work in remote areas whilst existing GPs were demoralised by 8 minute slot appointments.

This all pointed towards the need for a greater level of collaboration and change, but deterioration in the relationships between GPs and hospital consultants over the years meant trust was limited from the start.

“It’s easier to rebuild some trust in adversity, the pressures on the system at the moment can help us to do this, we all know how things are now isn’t sustainable.”

The Creation of the Vanguard

The Symphony Programme was created in 2012 by the partners in South Somerset and Somerset CCG, drawing on the CEO of Yeovil Hospital’s experience of an integrated model of care in another region. They recognised they had to adopt a wider system perspective to overcome their challenges. When the Vanguard movement started it was a natural progression to establish a Primary and Acute care Vanguard, they decided to extend this to include voluntary sector and community groups, recognising their value. Their aim was to create an integrated health care system that supports patients and the community to be healthier and to do this by making best use of collective resources available in the NHS.

Making it Happen

Initiating

Their first step proved to be a catalyst for change. In 2012 they conducted an extensive data analysis of hospital, GP, community, mental health, social care at patient level. They spent over 18 months understanding the data and working with experts on international models of care to plan a care model that would manage their population differently. Whereas previously they would have leapt in and started to change things quickly, before taking action they invested time in analysing how much each patient was costing the whole system:

“...it showed us that 4% of our population were incurring 50% of the health and social care resources... approx. 4500 patients.”

They decided to focus on that 4% to pre-empt problems and reduce the duration of hospital stays. This evidence based approach using facts to explode myths, helped to build trust early on and create a foundation for change.

Negotiating

Next came a significant investment of time in face to face communication throughout the system; visiting all of the GP practices to talk about the challenges faced by the hospital but also the challenges the hospital could see were being faced by GPs. The tone was inclusive from the start:

“This isn’t about top down telling you how to do it’, it’s “come and work with us to help redesign the way you work, to make your life better in your surgery and improve the care you can provide to your patients.”

Primary care was positioned as central to the system; the Vanguard acknowledged a widely held view that historically the Hospital had been perceived to dominate the healthcare system. Their message was clear:

“We as a hospital need sustainable GP practices locally and you as GPs need a sustainable hospital locally, so wouldn’t it make sense to try and work on these challenges together?”

Their aim was to put GPs at the heart of change, to rebuild relationships between GPs and hospital consultants. They noticed that informal communication had slipped away, the two parties were more distant than ever before. They needed to come together to talk about managing the 4% of complex cases but also how the wider system could operate in a less siloed way.

“There is a mutual purpose in overcoming this problem and we are very fortunate that our immediate practices, GP practices, have had the open heartedness to engage and build this dialogue.”

They recognised different people’s concerns and needs and took action early on to build trust, such as offering GPs interesting work at the hospital and the opportunity for hospital consultants to hold surgeries in the GP practices. This enabled them to “move the medics as opposed to moving the patients”, build relationships and also provide more stimulating work.

Structuring

The Symphony Programme is overseen by a Programme Board which includes all the key partners including 4 elected representatives of primary care, and is chaired by a GP. At programme board meetings they review progress and challenges. They adopted an incremental approach to change “start things small, test them and refine them a bit”. Key strategies included:

- Establishing 'complex care hubs' with dedicated teams working closely with GPs to provide care for the most complex 4% of patients, providing better management of care by supporting them to manage their conditions, developing a single care plan, and ensuring they are aware of their whole treatment and the resources available to them e.g. community services such as weight watcher group. A practical approach to removing barriers to people improving their health.
- Identifying the 18% who are at risk of becoming as complex as the 4% and providing enhanced primary care to prevent further illness, a proactive, front loaded approach to health care. This involved health coaches in every practice who support people to understand their conditions, access support, and to live healthily, and the practice as a whole becoming outward facing and proactive, managed through a daily or frequent "huddle" of the whole practice team
- Establishing in 2016 Symphony Healthcare Services Ltd, a wholly owned subsidiary of Yeovil District Hospital. This provide practices who wish to with the option of integrating into a larger organisations and sharing resources more efficiently e.g. sharing specialist nurses across GP practices, sharing finance functions and HR. Both integrated and non-integrated practices are implementing the new care models.

Operationalising

Whilst still early in the operationalising phase, the Symphony Programme is starting to gather impact measures. Emerging hard measures are suggesting significant reductions in admissions to hospital for patients requiring complex care management and a reduced length of stay. Softer measures include GPs feeling more in control of their workload, increased job satisfaction and working more as a team in the practice.

"People are spending their time in more interesting work, patients are ill less, their lives are better."

"It's made us friendlier, we understand each other better, have a better awareness of patient life and understand the economics of health care."

Critically, trust has enabled dialogue helping people to explore all opportunities and to avoid hidden agendas, widely seen as one of the key barriers to trust anywhere in the system. Patients are more connected to their community and are less reliant on statutory services; they are more empowered to take control of their situation.

Trust Enablers

Whilst pressures on resources were driving the need for collaboration across boundaries, a number of leadership practices stood out as creating the conditions for different parties to trust each other as they transitioned to a new model of care.

Shared vision

A concern for the best interests of the system rather than individual organisations, a consistency of message, guided by shared values and philosophy, focusing people on patient needs. Refocusing on a shared concern for how the Vanguard could improve patient care.

"We've all got to trust each other that we're working in the best interests of the system rather than the individual organisation, and that can be quite a mind-set shift, when for years we've been encouraged to very much look at individual organisations."

Logic and rationality

Analysis of patient data acted as a myth buster for anyone who believed the current system was sustainable. Data was also used to evidence progress and build confidence in potential benefits.

Quick wins

Being prepared to give a lot and share the risk and benefits. Delivering on large and small promises, especially early on, helped to build belief in the leadership team's commitment to change. Being careful to 'under promise and over deliver' was a common mantra.

Offering resources

A multi-stakeholder, credible Vanguard board and full time Vanguard roles e.g. Project Director, acted as a clear demonstration of organisation commitment and helped to role model collaboration.

Inclusive leadership

Rather than top down leadership, listening and incorporating people's ideas on how to redesign the system, being prepared to compromise. Empowering others to work out the detail. Equal representation of all partners on the programme board.

Open dialogue

Investing time in honest and face to face communication, giving people space to question and challenge to break down historic barriers to trust. Taking time to have personal conversations. Transparent reporting on progress. Helping people to understand the wider system but also what change means for their job.

Empathy

Understanding and acknowledging the different identities, experiences and perspectives of stakeholders. Recognising their challenges, vulnerability and concerns, tailoring messaging and taking action to meet their needs.

“clinicians are used to scientifically proven guidelines, when we say we’re going to adopt a new model of care they want the evidence it will work “sometimes you say “Well it’s been done in the States before, it’s never been done in the UK ... So I suppose there’s a vulnerability there about the fear of the unknown.”

“You’re putting yourself into their shoes, they have to appreciate the challenges and pressures we face and we also have to understand their challenges and pressures.”

“The GPs have been so used to managing their own business, lifting them into this world where you’re talking about multi, multi million pounds of money and service, it’s quite a different – it’s quite daunting for lots of them.”

An awareness of cultural and decision making differences between small entities such as GP practices and larger organisation entities such as hospitals.

“Collaboration is understanding the other person’s environment.”

Relationship Management

The leadership team invested time in building relationships across the system, locally and nationally e.g. with NHS England and regulators to gain funding and support.

Decision making

Communicating the process for decision making and being transparent about the decisions made was a key focus, as was embracing collaborative decision making whilst also making a decision when needed.

Trust Barriers

Symphony Programme leaders were conscious of a number of individual, organisation and systemic barriers spanning the past and the present, which could undermine their trust building efforts:

Individual

Both leaders and followers had a fear of the unknown, of the potential threat to their own job security if the system became more integrated. There was a fear of losing responsibility, control or income, a fear of not having all the answers as a leader – no one’s done it before.

“There was a lot of suspicion about what were our true motives, but you have to show people that you are serious about it.”

Organisational

Building trust between NHS organisations and GPs is challenging when GPs don’t always see themselves as part of the NHS in the same way, can be more entrepreneurial, autonomous and able to

make fast decisions - compared to a bureaucratic hospital with very different processes. GPs are positioned as central to the solution, so leaders invested time in ‘educating’ each other about the different systems and processes in their respective cultures and building relationships:

“There’s an interesting dynamic of a small operating entity with three or four GPs and a large hospital with a multi-million pound budget and you’re trying to bring them together and build a relationship, when actually you can absolutely see why they feel threatened by that.”

Systemic

Cynicism about the wider system and external relationships, receiving less funding for the Vanguard than expected. Cynicism about the track record of change in the NHS. The legacy of a ‘fortress mentality’ which grew as leaders sought to protect the interests of their own organisation.

“What will really the Department of Health do or will NHS England really support us?”

“People are fed up with change so you need to connect them to a bigger sense of purpose.”

The Role of Leadership in Overcoming Barriers

Conscious not to be seen as the hospital telling GPs what to do, early on in the programme Yeovil Hospital appointed a GP to be an Associate Medical Director of the hospital. He also became chair of the Symphony Programme Board and another GP was chosen by the board as the Vice Chair. Aware of some suspicion about their motives, these appointments helped the Vanguard to be seen as a partnership.

The leadership team were acutely aware of the need to build trust to support such radical change in ways of working. They recognised the need to build system wide awareness of their vision to make everyone’s lives better, and yet they were also aware of some cynicism about this altruistic purpose. Their response was to repeatedly refocus people on the patient and their needs, tapping into people’s shared underlying motivation to work for the NHS:

“You need to lift people’s heads up to see this mutual, common purpose.”

“I keep repeating it (the vision) until they get it, until they are confident.”

“This doesn’t have to be drudgery, there can be more great moments.”

The Hospital CEO adopted a hands off approach to leadership by empowering and influencing others rather than directly telling people what to do. They focused on setting the context and then encouraging others to lead, acting instead as a support and a guide.

Personally they noticed a shift in their leadership style from what's required to lead one organisation to being a leader within a system, the different mind-set was required:

“It’s quite a mind-set shift to think well actually my job now is no longer just to manage a hospital, it’s about leading other people.”

The importance of trust in achieving their aims was clear from the start. Trust was seen as essential for improving patient care, for example by reducing the cost of duplication when clinicians repeat a test because they don't trust the test result:

“You won’t move forward on this sort of agenda unless there is absolute trust between all the people involved.”

“You can have the best programme plan you like and the best thinking, but it would only get delivered when people really, really work together and trust each other.”

Conclusion

The Symphony programme took time to plan the change before taking action, and used dialogue and transparent decision making to consciously build trust at every stage. They adopted an inclusive leadership style which sought to understand and work with the different needs of different people within the whole system and to unify them behind an overarching, common purpose. Leaders demonstrated benevolence in their words and actions. Trust was limited at the start, but they worked hard to build it, they have nurtured trust and not let it go. They were consistent and persistent in how they led the transition to collaborative working, and continue to work towards a longer term vision of establishing an integrated care organisation.

