COLLABORATIVE LEADERSHIP ACROSS SOCIAL CARE

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Over the last six months I have been teaching and facilitating sessions with various parts of the health and social care system across the East Midlands.

In my work,I have found that all the key stakeholders across the health and social care system recognise that they must work together in new ways to transform and integrate health and social care.

The challenge they face is how to change the system whilst simultaneously working full-on to meet today's pressing demands on the healthcare system. Their challenge is how to balance working 'in' and 'on' the business, when 'in' the business challenges often top-trump longer-term work to transform the system.

To unlock this logjam, leaders from across the system recognise the need for skilled collaborative working professionals, grown within their health and social care system. These will be the 'trusted individuals' to champion and support the NHS, local authorities, GPs and community service partners as they work together to deliver the service integration required.

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In relation to this, I wanted to share with you some of the key support papers and materials that evidence the challenges for doctors and CCG senior managers when they enter into the collaboration space.

Many of the challenges will be familiar to SSAs from across the public sector. However, some are more specific to the structure of the health sector and require specific styles of support and tools.

Ten lessons we can learn from…

In 2010, The King's Fund, The Nuffield Trust and Hempson's solicitors created a very helpful toolkit for working on the creation of confederations[1].

The team worked under the guidance of a steering group from the Royal College of General Practitioners and an external reference group that included front line practitioners working within federations as well as other senior staff from across the NHS.

From an assessment of the evidence, ten key lessons were distilled that are still particularly pertinent to those embarking on the development of a primary care federation.

1. **The motivations for practices to federate vary**, and include: a response to a perceived threat in the external environment; a desire to gain economies of scale in (often specialised) service delivery; to share risk in healthcare purchasing or commissioning; …through to undertaking clinical governance activities.

[1] Kings Fund et al (2010) *Toolkit to support the development of primary care federations.*

2. **Function affects form** – the size and legal entity will depend on the purpose for which the primary care organisation has been developed. For example, for running out of hours or other urgent care services, or a larger organisation with sophisticated risk sharing arrangements services.

3. **Independence from the statutory sector accords longevity**. A key question for practices thinking about a federation is whether they want to join together in an entity that protects their independence, or as some form of state/health system network.

4. **Involving doctors is relatively easy – it is harder to be more inclusive**. Most primary care organisations tend to be doctor initiated/led and, even where they seek to be more inclusive, they rarely seem to involve nurses, allied health professionals and others in a significant or strategic manner.

5. **Primary care organisations are good at planning and developing services within primary care and community settings** – those services that are closest to the concerns of GPs and practice staff. Practice based services, prescribing, and intermediate care are most commonly reported as objectives…There is much less evidence about groups' effectiveness in relation to commissioning secondary and specialised services.

6. **Primary care organisations are more likely to make substantive change where they have direct control of budgets** and where there are direct financial incentives for professionals.

7. **Clinical leadership and engagement are essential** to the development and success of primary care organisations, and require constant nurturing and attention.

8. **High quality management and infrastructure support is critical** to the success of primary care organisations, and its importance and scale are typically underestimated at the outset. It takes time to establish a fully functioning federated organisation, typically at least two years.

9. **Primary care organisations increase transaction costs within local health economies** – there is a cost to federating practices, providing management support, and engaging primary care professionals in activities beyond their practices. Such costs have to be weighed against anticipated and actual benefits…

10. **Major service transformation will require highly organised primary care as a bedrock**. Whilst policy in many countries calls for shifts of care from hospital to community settings, along with improved care for people with chronic illness and reductions in avoidable hospital admissions, there is little evidence of such service shifts happening in a significant manner within the NHS. Research points to the need for highly organised (and appropriately incentivised) primary care as a prerequisite for this.

What does the BMA have to say?

Building on the King's Fund toolkit, in October 2013 the BMA's General Practitioners Committee published a *Collaborative GP Alliances and Federations Guidance for GPs*[1].

The BMA set out the context and challenges for collaborative working as…

The Health and Social Care Act 2012, which came into effect on 1 April 2013, brought about the advent of clinical commissioning groups (CCGs) and new procurement and competitive tendering rules. Whilst presenting traditional General Practice with

[1] BMA (2013) *Collaborative GP Alliances and Federations Guidance for GPs.*

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considerable challenges, this also gives rise to some significant opportunities.

The demands from the UK governments, including the 2013/14 contract imposition in England, have not only increased the workload of already over stretched practices but have also reduced investment in the GMS contract.

In England, many practices, already operating at the limit of their resources, will soon find themselves under additional pressure to adapt to equitable funding changes.

The 19-page report unpacks, through helpful case studies, a range of collaborative models, which GP practices could adopt for different purposes:

- Simple alliances/formal and informal joint ventures
- Joint premises
- Partnership mergers
- GP co-operatives

It also provides suggestions on legal vehicles that these arrangements may fall under:

- Traditional GP partnership agreement
- Private companies limited by shares
- Community interest companies and social enterprises
- Charity or charitable incorporated organisation
- Limited liability partnerships (LLPs)
- Private companies limited by guarantee

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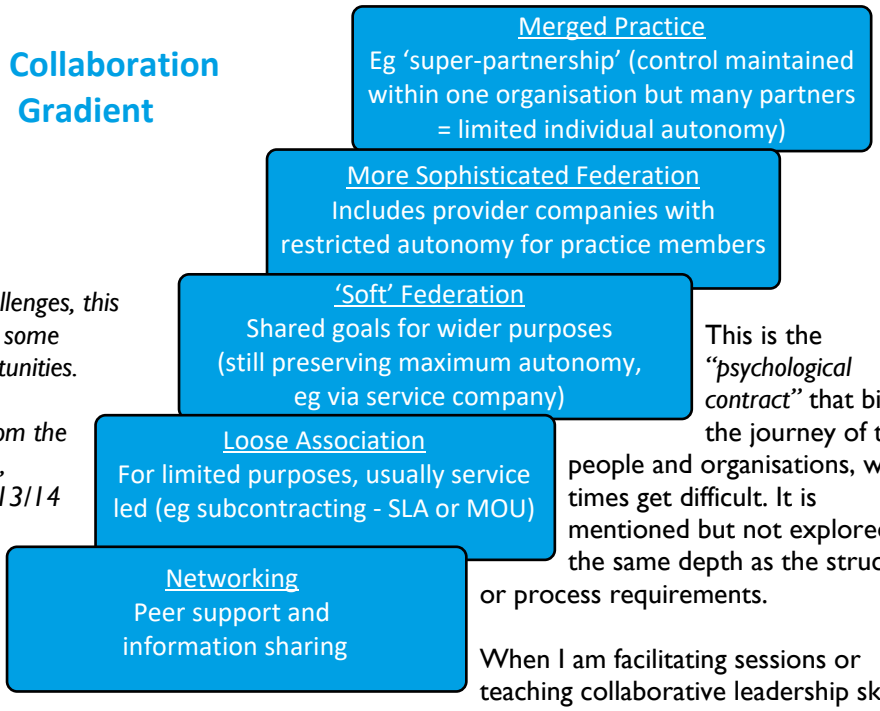
The Collaboration Gradient



This is the *"psychological contract"* that binds the journey of the people and organisations, when times get difficult. It is mentioned but not explored in the same depth as the structural or process requirements.

When I am facilitating sessions or teaching collaborative leadership skills, a key message the students learn is that collaborative working is 75% about the relationships at both personal and organisational level, and 25% about the deal (structural or process).

This is brought out in detail in the November 2014 Primary Care Development Centre's Paper *Inter-Practice Collaboration*[3] to which I contributed. The paper talks about the Collaboration Gradient, focusing on the depths of relationship between the organisations…

It is important to emphasize that there are many forms of collaboration, which do not involve federations or other formal structures and, while we see benefits in collaboration generally, we are not suggesting that one form is better than another, or that there is an ideal structure to which all should aspire. There is no "one-size-fits-all". There is in fact a continuum of collaboration which we have chosen to illustrate diagrammatically in what we call the collaboration gradient.

Within this context, the PCDC working in collaboration with Beyond Consultants and Shared Service Architecture will pilot a new type of GP leadership development programme.

The pilot will bring together both the DEAL: the *'how to initiate'* GP collaborative models of working, and the RELATIONSHIP aspects of trust building and collaborative working: *'how to be'* a collaborative leader.