Contexts and Complexities: A Realist Evaluation of Integrated Care System Leadership

Abstract

Purpose

This paper presents a realist evaluation of leadership within an Integrated Care System (ICS) in England. It examines which aspects of leadership are effective, for whom, how, and under what circumstances.

Design/methodology/approach

Realist evaluation methodology was utilised, adopting prior realist review findings as the theoretical framework to refine explanations of how and why leadership within an ICS is effective. Between January and November 2023, 23 interviews with ICS leaders took place, alongside 7 meeting observations and documentary analysis. The Realist And Metanarrative Evidence Syntheses: Evolving Standards (RAMESES) guidance informed the study design, conduct, and reporting.

Findings

The findings highlight two overarching infrastructural contexts influencing leadership in ICSs: 1) the impact of the post-COVID-19 pandemic legacy and 2) the differences between health and social care regulatory and financial environments. Findings demonstrate that ICS leaders identified a strong sense of purpose as crucial for guiding decisions and creating a psychologically safe environment for open, honest discussions, fostering calculated risk-taking. Whilst a shared vision directed priority setting, financial pressures led to siloed thinking. Leadership visibility was linked to workforce morale, with supportive leadership boosting morale amidst evolving ICS landscapes and confidence in data-driven decisions supported prevention activities. However, financial constraints hindered responsiveness and innovation in addressing health inequalities.

Originality

By examining ICS leadership post-COVID-19 and amidst varying regulatory and financial environments, this study contributes to the emerging literature on systems leadership and offers practical guidance for leaders navigating the complexities of integrated care.

Keywords: Integrated care systems, leadership, realist evaluation, health and social care integration

Introduction

Integrated Care Systems (ICSs) in England represent a transformative approach to delivering health and social care, aimed at fostering collaboration across health and social care sectors to improve population health outcomes and reduce inequalities. Leadership within these systems is pivotal to their success, requiring a understanding of complex, evolving contexts and the ability to drive collective action towards shared goals. This paper explores the effectiveness of leadership within an ICS through a realist evaluation, providing insights into the mechanisms that underpin successful leadership and the contexts in which they operate.

Background

A rapid review (Author et al, 2024) highlighted the need for ICS leaders to commit to a clear vision, as this helps partners align their actions with ICS goals, whether working collaboratively or independently while minimising miscommunication (Aufegger et al., 2020; Aunger et al., 2022; Harlock et al., 2020; Kozlowska et al., 2020; MacLeod et al., 2019; Martin, 2021; Miller and Stein, 2020; Round et al., 2018; Sims et al., 2021; Urtaran-Laresgoiti et al., 2018). The importance of involving all stakeholders, including the public, in setting local ICS priorities, especially in the early stages of integration was also identified. This broad involvement supports key ICS goals, such as improving population health, preventing illness, and reducing health inequalities (Bell et al., 2022; Gordon et al., 2020; Harlock et al., 2020; MacLeod et al., 2019; Martin, 2021; Miller and Stein, 2020; Mitchell et al., 2020; Nicholson et al., 2018; Round et al., 2018; Urtaran-Laresgoiti et al., 2018).

Developing strong relationships through shared goals and frequent interactions is crucial for nurturing trust, supporting collaborative decision-making, and resolving tensions. Recognising historical power and resource imbalances between sectors is vital for fostering these relationships (Gordon et al., 2020; Martin, 2021; Chang, 2022; Sims et al., 2021). Finally, fostering a shared learning culture was essential for encouraging innovation and continuous improvement. Leaders play a key role in creating conditions that support innovation, manage risks, and facilitate learning from both successes and failures, which is crucial for effective service redesign (Sims et al., 2021; Gordon et al., 2020; MacLeod et al., 2019; Martin, 2021; Miller and Stein, 2020; Mitchell et al., 2020; Round et al., 2018; Urtaran-Laresgoiti et al., 2018).

National guidance and policy advocate a systems leadership approach to ICS leadership, emphasising collaboration, shared purpose, and collective learning to drive systemic change (Dreier et al., 2019). However, there is limited empirical research in this area, with no clear agreement on ‘what system leadership amounts to and which attributes, qualities and styles are most suitable to system leadership’ (Kaehne et al., 2022: 24).

This evaluation aims to enhance empirical and practical understanding of leadership in ICSs, building on previous rapid realist review findings (Author *et al.*, 2024) by evaluating leadership in an ICS to explain how and why leadership works within this context. The rapid realist review offered four initial programme theories for leadership in ICSs, explaining that leadership in this context works when i) ICS leaders hold themselves and others to account for improving population health, ii) a sense of purpose is fostered through a clear vision, ii) partners across the system are engaged in problem ownership and iv) relationships are built at all levels of the system as outlined in Table 1:

Table 1: Initial programme theories of effective ICS leadership (Source: (Author et al., 2024)) utilising Doing Things Differently: Rethinking Leadership Behaviours as an organising framework (NHS North West Leadership Academy, 2021).

Being	Effective ICS Leaders communicate a clear vision, fostering a sense of purpose across the system regarding the achievement of agreed ICS outcomes.
Leading & Visioning	Effective ICS leaders have a clear vision that promotes a sense of mutual accountability, providing opportunities for others to develop, make decisions, and take ownership of problem-solving through the engagement of all partners in the reduction of health and social care inequalities
Relating & Communicating	Effective ICS leaders build relationships at all levels of the system, they promote partnership and collaboration. Leaders encourage a collective agreement about what needs to be achieved and communicate openly about how and why decisions are made
Delivering	Effective ICS leaders hold themselves and others accountable for improving outcomes for the local population. They use available intelligence to take actions that support targeting and prioritising local communities. Effective ICS leaders support and encourage learning, curiosity, and calculated risk-taking, enabling innovative approaches that lead to service improvements.

Methods

Realist approaches are considered to be 'of particular use when exploring a concept as fluid as leadership' (Harris et al., 2020, p. 2). More specifically, realist evaluation provides a framework for recognising and exploring the complexity inherent in ICS leadership. Realist evaluation assumes that 'contexts interact with mechanisms to produce outcomes' (Greenhalgh and Manzano, 2021, p. 585) and attempts to unearth these mechanisms to make causal claims about a phenomenon.

Study findings are presented as programme theories that describe how, why, and in what contexts leadership in an ICS is effective (Marchal et al., 2018, p. 83). Programme theories are based on CMOCs that outline which mechanisms and contexts lead to which outcomes (Pawson, 2013a; Pawson and Tilley, 1997), with individual CMOCs provided in Supplementary File 1.

A qualitative case study design was used to develop explanatory accounts of how and why questions (Yin, 2018, p. 15). Realist evaluation focuses on causal mechanisms to explain what works, for whom, and in what contexts, enabling confidence that similar conditions will yield the same outcomes (Punton et al., 2016). Therefore, the development of programme theories supports generalisation beyond the confines of the case selected (Pawson and Tilley, 1997).

Realist evaluations support a multi-method approach to data collection (Pawson, 2013b) to support data triangulation when developing and testing theories (Mukumbang *et al.*, 2018). Therefore, a multi-method qualitative data collection approach was adopted, including documentary analysis, meeting observations, and interviews. Purposive sampling allowed for interview participants to be selected based on their knowledge and experience of leadership in an ICS (Emmel, 2014; Hunt and Lathlean, 2015). ICS guidance and policy documents were also purposively selected for inclusion in the study. Leaders were recruited from the core leadership team within the ICS, including Integrated Care Board members and Place leaders.

Throughout the data collection period, non-participant observations of governance meetings took place, which were used to complement emerging evidence from other sources, 23 participants were interviewed, 8 documents were collated, and seven meetings were observed. As meetings were live-streamed and recorded for the public, meeting transcripts were retained. Data collection began in January 2023 and concluded in November 2023. Ethical review and approval were obtained via the authors' institutional protocols.

Data Collection and Analysis

Interview, meeting observation transcripts, and documents were imported into data management software (Atlas.ti) to support a realist analysis (Manzano, 2016). A retroductive approach was adopted, whereby the researcher utilised and moved between inductive and deductive analysis (Greenhalgh *et al.*, 2017). Deductive analysis was utilised with pre-established codes based on the IPTs, while inductive analysis allowed space for additional CMOCs emerging from the data. Dalkin et al.'s (2015) framework provided a useful framework to support the CMO coding in this study by separating mechanisms into distinct resources and reasoning. This is presented as M (Resources) + C - M (Reasoning) = O based on the assumption that 'intervention resources are introduced in a context, in a way that enhances a change in reasoning. This alters the behaviour of participants, which leads to outcomes' (Dalkin et al., 2015, p.4).

Initially, data sources were read to re-familiarise the researcher with the findings and informally identify where chunks of data (sentences or paragraphs) were linked to other chunks in the transcript or documents (Shearn, 2017). Codes were established for the four IPTs (Being, Delivering, Relating & Communicating, and Leading & Visioning). Following this, mechanism resources were inductively sought, by reviewing each transcript or document line by line to identify the mention of a resource (Abrams, 2023). Evidence was sought for associated contexts, reasoning mechanisms, or outcomes if a resource was identified. As associated evidence did not necessarily appear within the same chunk of text but could be observed in different sections of a transcript or document, coding took place across different mechanism resources at a time, and further relevant chunks were coded as data sources were examined.

These mechanism resource datasets were then transferred to Word documents to support further analysis through narrative writing and notes, as Abrams et al. (2023) suggest. This provided an overview of the dataset per programme theory and facilitated exploration across all data sources to allow patterns to emerge. Coding was specific to identified contexts, mechanisms, and outcomes, but no connections were made to create CMOCs at this stage. Connections were made with contexts, mechanisms, and outcomes, as Jackson and Kolla (2012) suggest, and connections were then made with contexts, mechanisms, and outcomes. These connections often started as dyads where two CMO elements were initially coded (i.e., CO, CM, MO) (Jackson and Kolla, 2012). Finally, evidence was amalgamated when it appeared to be related, and utilising retroductive reasoning, connections were made between different contexts, mechanisms, and outcomes. The analysis process was iterative and developed as a greater understanding of the data was obtained through each programme theory dataset being analysed.

Findings

Data extracts provided within this section are presented based on their source, participant interview excerpts are noted as 'P', ICB meeting transcripts are noted with the month and transcript line, and strategy documents include the date of production and page number.

Context

Context played a significant role in this study, adopting a dual role of supporting and hindering leadership aspects within the ICS. The findings highlight two overarching infrastructural

contexts that influenced all PTs: 1) the post-COVID-19 pandemic legacy impact and 2) the differences between health and social care regulatory and financial environments, including the historical legacy of these environments as they joined to become an integrated system.

There was a clear recognition that the COVID-19 pandemic significantly impacted health and social provision, including workforce wellbeing and retention, funding regimes, and public/patient experience. Often, the overwhelmingly negative impacts of the pandemic were noted, such as increased elective care waiting lists and backlogs, staff morale and levels of stress alongside significant impacts on mortality and morbidity within the community.

"The staff have just been through a pandemic, and there's a level of exhaustion and challenge that they're facing as a result of that."

P2/20

However, increased collaboration between partners was also noted as a positive outcome of the pandemic. As partners had a shared history of cooperation and mutual aid, this influenced contemporary partnership work within the ICS.

"What we saw during the pandemic was some pretty unprecedented levels of cooperation and collaboration and mutual aid".

September 22/L69

Participants identified the structural differences between health and social care as barriers to a shared culture and purpose. Some participants emphasised the regulatory requirements passed down from central regulators, such as the Department of Health and Social Care and NHS England, as restricting their ability to focus on the ICS's longer-term aims.

"I think all the things that come down from NHS England, the Department of Health and Social Care, and wherever else are to respond to the now. You know, it doesn't matter whether it's hospital flow, general practice access, or wider determinants stuff; it's like, what are we doing now? rather than, you know, where are we going in 12 months, so I think that really hinders."

P2/12

In addition, NHS services' ability to forecast a deficit budget and overspend was juxtaposed with local authorities' inability to do so for social care provision. This resulted in a sense that the NHS could respond to needs regardless of financial deficits, with local authorities required to 'cut their cloth' to the allocated budget.

"Local Authorities will never consider us a partner until we get our act together on finance. I used to have a budget: you underspent or spent it; you couldn't overspend it; it was impossible. You've got to sit back and look at what impression that gives them that we're not equals."

P2/9

Programme Theory One: Being

The following section presents the final programme theories (with associated CMOCs provided in Supplementary File 1). The final programme theory emphasises the importance of clear leadership and vision in ICS formation and development. However, the evaluation findings indicate that inspiring partners towards a shared and communicated vision was a means to enable mutual priority setting and decision-making. The final programme theory introduces patient stories as a mechanism to remind ICS leaders of the real-world impact of their decisions, helping to facilitate more patient-centred discussions and decision-making within ICS governance meetings. The role of shared accountability among ICS partners in supporting

challenging conversations around outcomes and delivery is also included, alongside open and honest discussions among leaders that demonstrate an acceptance of failure.

All participants felt a sense of purpose in improving population health and residents' experience as leaders in the ICS. However, they also noted that sometimes their focus could be drawn to more immediate issues affecting the system, such as patient access issues ('right to reside', for example) or financial pressures. The use of patient stories, which were presented via pre-recorded video at ICB meetings, was noted to remind ICS leaders of the real-world impact of their decisions and shift their focus from national targets to longer-term population health interventions.

"At each meeting there's the patient's story and we get to hear real people and talk about people's lives and, and you are constantly reminded and so, this links back to people's health and wellbeing and quality of life and that drives you forward".

P2/01

Participants felt that ICS partners shared accountability for ICS objectives, which supported them in challenging conversations around outcomes and delivery. This facilitated a feeling of mutual respect where all opinions were considered of value, resulting in a psychologically safe environment.

"I think I can have quite honest conversations with them to say, look, I'm now challenging you about your delivery".

P2/20

"If you look at our committees, we're having quite open honest and candid conversations… I've never felt like 'I want to ask that question, but I don't feel I can'".

P2/10

Findings demonstrate that when leaders engage in open and honest discussions with partners who demonstrate an acceptance of failure, trust that the response to failure will be supportive and learning-focused develops. Leaders are more likely to take calculated risks focused on long-term outcomes when this occurs within a psychologically safe environment.

"you've got to accept things will go wrong, but you're going to be able to support people when that happens".

P2/22

"I think what we've started to do, is take calculated risks. So, you know, actually assess situations and instead of going super, super safe, that might not change anything, actually put a bit of a mix in there".

P2/9

"There's that psychological safety aspect isn't there? There's that trust in the relationship needs to be there in order to you know, start doing some of that learning".

P2/12

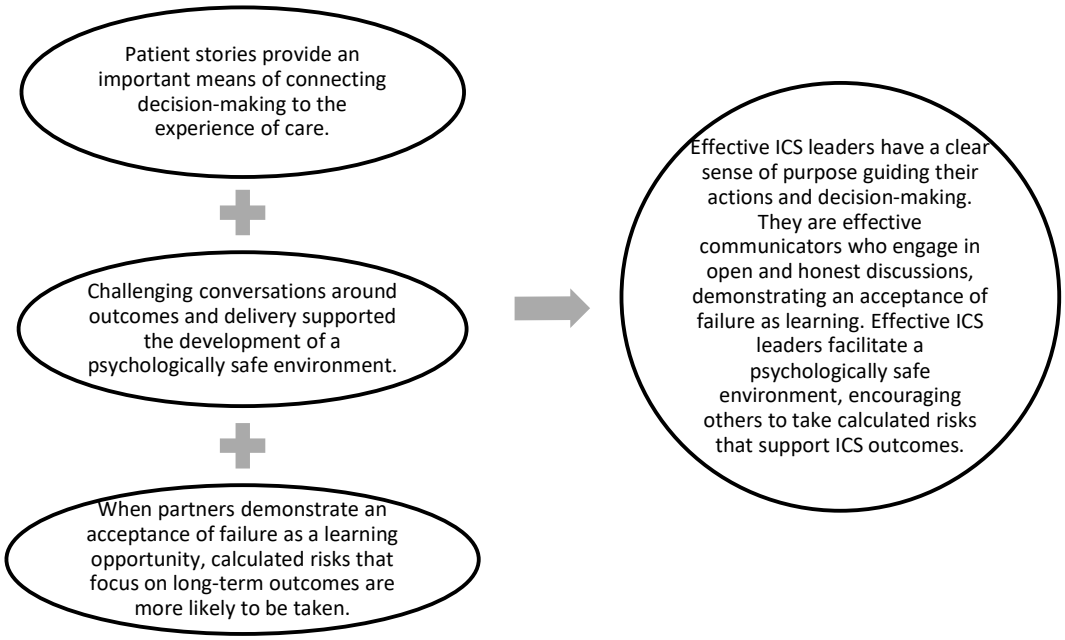

Figure 1: Programme Theory One (Being)

Programme Theory Two: Leading & Visioning

The IPT (*Author* et al., 2024) proposed that when determining and measuring ICS priorities, the transparent and democratic engagement of clinical and care professionals, non-health partners, and local communities should promote mutual accountability and a focus on population health and wellbeing. Participants agreed that the democratic engagement of partners and stakeholders was important. However, the proposed mechanism shifted from engagement of partners to inspiring partners towards a shared vision, with the complexities of differing organisational cultures and resource scarcity providing the context. Participants also highlighted the contexts of financial pressures and fragmentation, leading to siloed thinking and a retreat from collaborative efforts, contrasting sharply with the IPT's emphasis on mutual accountability and engagement. The engagement of clinical and care leadership was determined to be an important mechanism that highlighted the role of senior leadership and governance structures in facilitating and committing to clinical and care leadership.

Participants recognised the importance of a shared vision to improve health outcomes and reduce inequalities within the ICS. They also highlighted cultural differences and organizational priorities as potential barriers to effective partnership working.

So, I think the vision is non-contestable. I think it's there…I think the challenge we've partly got, though, is how do you implement the strategy or the vision into a strategy'

P2/15

Participants described the fragmented nature of the health and care system, highlighting the challenge of working, which impedes effective integration and decision-making. The transition from multiple organisations and the financial deficit across the system exacerbates these challenges, leading to organisational retrenchment and siloed behaviours rather than collaborative approaches to achieve system-wide financial balance.

"I think it's the complexity of the agenda. They're not linked together. So the fact that you know, we look at finance in a silo and we look at workforce and so we look at population health in a silo"

P2/18

"So what do you do when money gets tight? You just retreat to organisations"

P2/17

Findings emphasised the importance of integrating clinical and care professionals into the decision-making processes at all levels of the ICS. There was a stated commitment to investing in clinical and care leadership, ensuring that professional and clinical leaders are given protected time and resources and are centrally involved in setting and implementing strategy. However, there was an acknowledgement of the need for improvement in care leadership.

"on clinical and care professional leadership: the care bit not so good yet. on clinical, I think it's definitely improved..we have now got a clinical leadership structure that has clinical leads at place... We need to do better for care"

P2/21

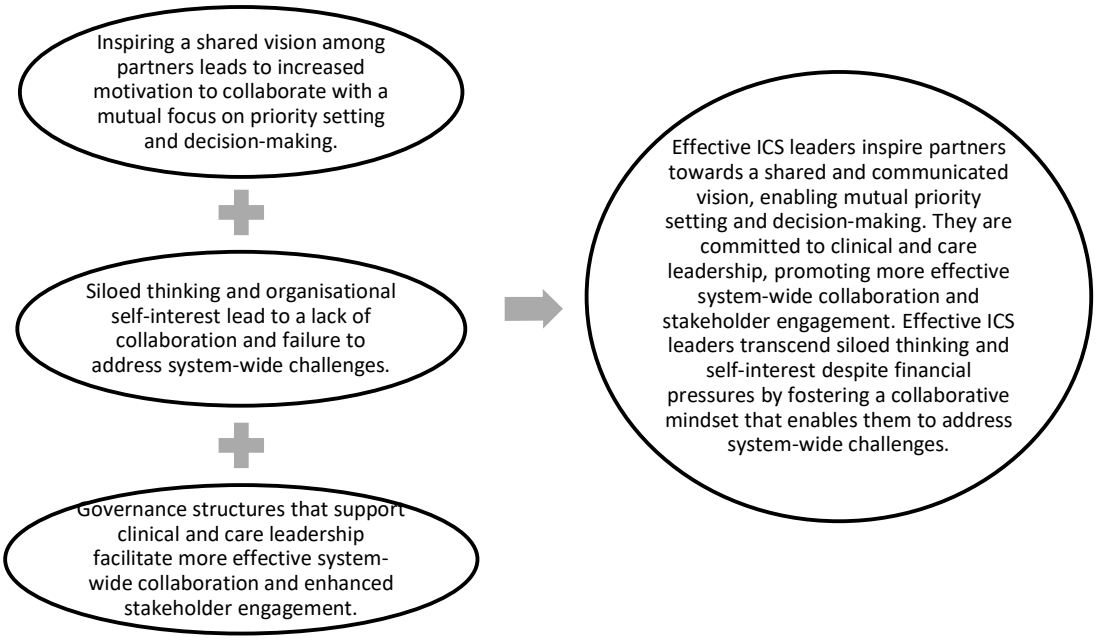

Figure 2: Programme Theory Two (Leading & Visioning)

Programme Theory Three: Relating & Communicating

As described in Figure 3, the final programme theory extends the contextual scope of the IPT beyond the initial integration of health and social care organisations to encompass the evolving landscape of ICSs and place-based partnerships. It identifies various mechanisms, including strategic partnerships, community and public engagement, and the visibility of leaders. Thus expanding the programme theory to reflect a more complex and varied understanding of the challenges and successes inherent in integrating health and social care, including the impact of

leadership visibility on workforce morale, recognising that visible, supportive leadership's presence (or absence) can lead to improved (or reduced) morale.

Participants agreed that the relationships between partners were important, but this formed the context for strategic partnerships working in and across existing health and care system structures. Within the evolving landscape of ICSs, where existing relationships exist, this partnership creates collaboration to achieve system transformation.

"The best and most effective way of working in partnership and collaborating is to have longitudinal relationships, you know, relationships that endure for long periods of time."

2/4

All participants supported the intention of community and public engagement. However, despite this, significant gaps in effectively engaging with the community were recognised. Participants considered the current approaches, such as public meetings, needing to be revised to foster constructive dialogue and genuinely incorporate the public's voice into decision-making processes.

'we've got to get better ways of talking with people. It's great that they can see it in action, but we're a long way from actually having constructive dialogue."

P2/13

'On wider public engagement, I'm not sure that we've done the whole thing…So the public can put questions in and we'll write back to them, but there's something about seeing to engage.'

P2/12

Findings highlighted the pressure the wider workforce was under, which included struggling with the need for efficiencies, staffing changes, recruitment gaps, and challenging working conditions based on increasing demand for services. Participants also recognised the value of leaders engaging the workforce through communications, direct contact, or specific initiatives to support their well-being and demonstrate affiliation and insight with their experience, fostering a sense of inclusion and value and, therefore, increasing morale. Conversely, when leaders were not engaged with the workforce through communications, direct contact, or specific initiatives to support their well-being, they did not foster a sense of inclusion and value, leading to perceptions of decreasing morale.

"There is something fundamentally important to acknowledge for our frontline staff and the people who manage those services that we know that they work in a difficult operating environment at the moment, and we know that there are significant challenges to being able to deliver the type of care that they want their patients to receive and that we want their patients to receive"

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"We have loads of communication that goes out and, and, and I get the impression that the staff as a result of that feel valued."

P1/3

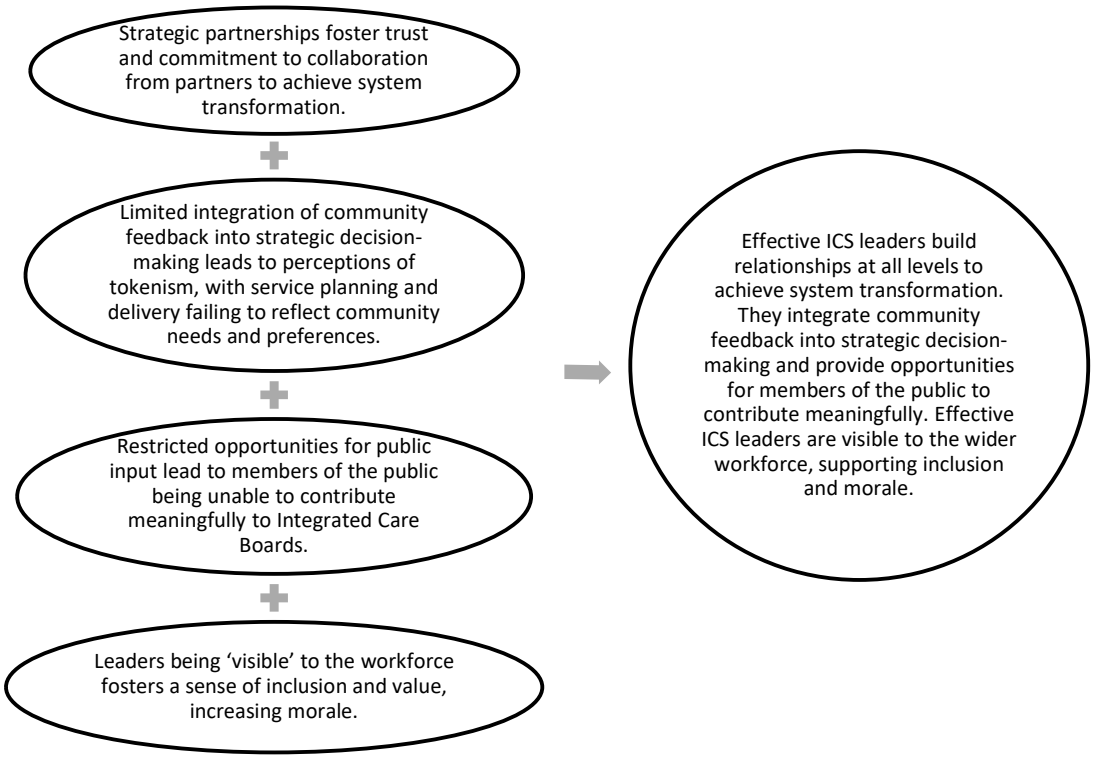

Figure 3: Programme Theory Three (Relating & Communicating)

Programme Theory Four: Delivering

Findings from this realist evaluation supported aspects of the IPT but also added and extended elements presented in the final programme theory in figure 4. Participants supported data-driven decision-making, suggesting a focus on prevention and addressing health inequalities through robust data. The final programme theory emphasises leaders feeling confident and empowered to make data-driven decisions, focusing system priorities on groups and individuals with the greatest needs where the aim is not only to improve access but to do so in a way that directly confronts health disparities rather than a specific focus on service access.

"I believe it's the right approach to have when you've got limited resources…to focus your time, attention and resources on the people who have the most need where we can have the greatest impact.'

P2/3

Disempowerment of place leaders limits their ability to respond effectively to community needs. Conversely, this reduces central ICS leaders' perceptions of risk associated with delegating finances and supporting resource allocation across the system to achieve financial balance.

"I think there's quite a strong command and control arrangement between the [central ICS team] and the place … it will get more difficult simply because the resources become tight. My experience is centralisation becomes more dominant".

P2/7

Participants agreed that the complex environment in which leaders and system partners operate influences innovation within an ICS. Whilst the IPT identified the positive impact of a

collaborative and supportive environment, the findings outline that leaders are confronted with operational challenges when exploring or implementing new ways of working. This leads to a heightened perception of risk and uncertainty and reduces support for innovation or improvement activity.

"As a system it's not stable enough yet to understand how to try innovation, and then think about how you scale that up across the system."

P2/2

"if we're going to starve organisations with the money that they need to survive and to thrive, then it's going to be really challenging to change them and to alter them."

P2/10

ICS leaders face challenges due to the risks associated with maintaining operational stability in the acute sector, which is of significant public interest. This context also influences the funding flows and performance metrics mechanisms, which limit leaders' ability to plan for and implement population health strategies.

"It feels like we are shuffling public service delivery cash around and not thinking through how we develop something more fundamentally different…I think we're NHS service centred in what we're looking at. We're not community or individual-centred. We're not going to change much unless we get out of that."

P2/2

"The real focus on prevention, and upstream and health inequalities and the wider determinants of health still feels like it is a rhetoric rather than something that has the weight and the might of the system behind it the way that elective recovery has the weight of the system behind it... if we reported on it differently you know, if we were made to look at deprivation figures and elective recovery figures that that were based on postcode and ethnicity, if we make it that that board were made to look at them every month, that that might change the conversation a little bit."

2/21

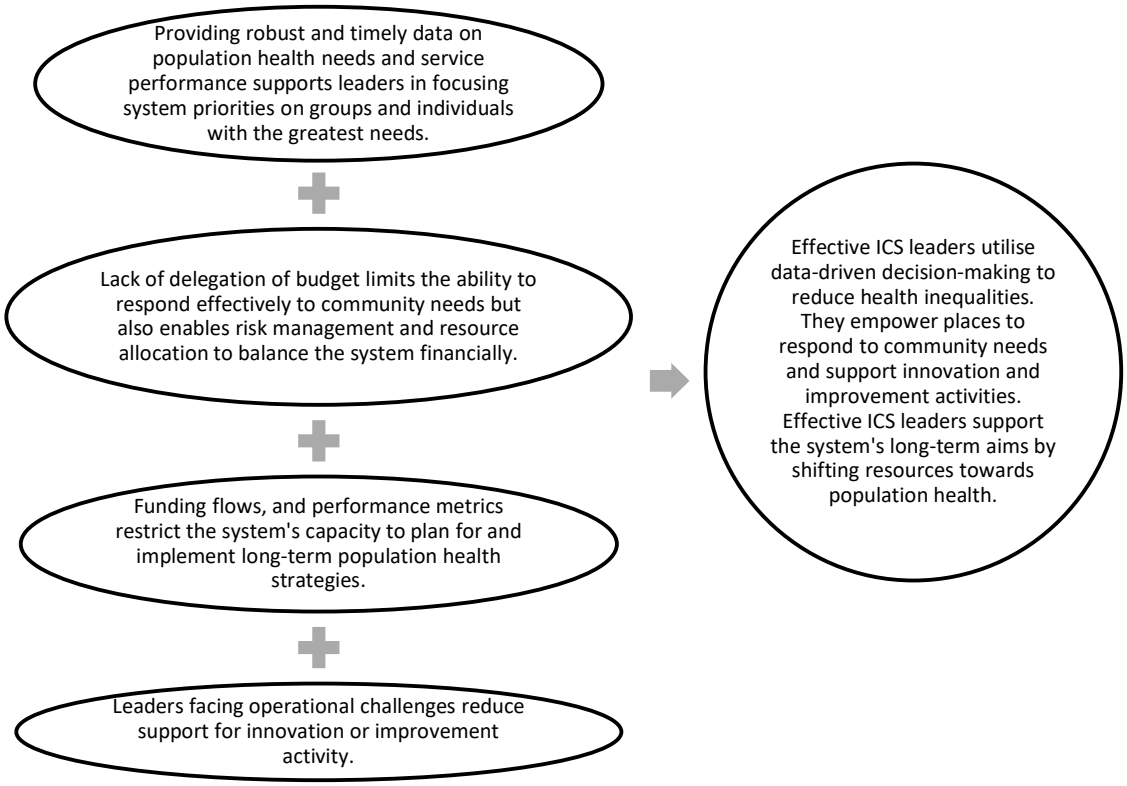

Figure 4: Programme Theory Four (Delivering)

Discussion

This study aimed to evaluate leadership in an ICS to explain how and why leadership works within this context. Realist evaluation encourages the use of existing substantive theory to explain how programmes (in this study, leadership within an ICS) work (Astbury, 2018). Therefore, to situate and discuss the final programme theory within the existing substantive theory, this section utilises system leadership theory to situate programme theory findings and provide generalisability (Marchal et al., 2018).

Programme theory one emphasises clear leadership and vision offering insights and mechanisms, such as patient stories, shared accountability, and acceptance of failure. The clear sense of purpose guiding ICS leaders' actions and decision-making aligns with systems leadership principles; as such, the findings from programme theory one support and extend systems leadership theory. Systems leadership theory argues that when leaders are intrinsically motivated and aligned with the system's goals, they are more likely to contribute to the collective effort and drive change (Senge et al., 2015). Findings demonstrate that effective ICS leaders are strongly committed to the overarching goals of integrated care and population health improvement. However, they also suggest a stronger focus on leaders' purpose linked to system aims of improving population health, with patient stories acting as the mechanism to shift leaders' focus from performance targets back towards patient-focused decisions. This finding adds to systems leadership theory by providing empirical evidence of the importance of a purpose-driven approach in the context of ICSs. The utilisation of patient stories as a tool to shift the focus of healthcare leadership from abstract strategies to real patient outcomes can be viewed from a systems theory perspective as an intervention that employs feedback loops to align system behaviour with values and outcomes (Ramage and Shipp, 2020).

Findings on the importance of open and honest communication, including accepting failure as learning, are consistent with systems leadership theory's focus on fostering a culture of transparency and continuous learning (Weberg, 2012). The findings suggest that effective ICS leaders create an environment where open dialogue and learning from setbacks are encouraged, which is crucial for adapting to the complexities of integrated care (Naylor and Alderwick, 2015). By fostering psychological safety, ICS leaders enable others to explore new approaches and take risks that can lead to improved outcomes (Edmondson, 2018).

The findings from programme two align with key themes identified in the extant literature and several key principles of systems leadership theory whilst extending systems leadership theory in the specific context of ICSs. The importance of a shared vision and mutual priority setting is consistent with the literature noting that effective ICS leaders inspire partners towards a shared and communicated vision (Aufegger *et al.*, 2020; Bell *et al.*, 2022; Harlock *et al.*, 2020; King and Mendez-Sawyer, 2021; Martin, 2021; Round *et al.*, 2018; Sims *et al.*, 2021; Urtaran-Laresgoiti *et al.*, 2018). This finding is consistent with the systems leadership principle of creating a shared vision (Senge et al., 2015). A shared and communicated vision helps to align stakeholders and facilitate collaborative decision-making, which is crucial for the success of ICSs (Naylor and Alderwick, 2015). This alignment between the findings and systems leadership theory provides empirical evidence of the importance of a shared vision in driving effective outcomes in complex systems.

The need for effective ICS leaders to transcend siloed thinking and self-interest by fostering a collaborative mindset despite financial pressures demonstrates the application of the systems leadership concept of 'system stewardship' (Timmins, 2015, p. 41). System stewardship involves balancing the needs of individual organisations with the wider system's interests, which is essential for addressing system-wide challenges in integrated care. Whilst systems leadership theory provides a framework for understanding the importance of interconnectedness, these findings provide insights into the practical challenges of managing conflicts and power-sharing arising from this interconnectedness within the ICS setting. Moreover, findings are aligned with the literature on effective ICS leaders fostering a collaborative mindset to address system-wide challenges (Deffenbaugh, 2018; Harris et al., 2022; Miller and Stein, 2020) and echo the concerns of Sims et al. (2021), who identify the persistent barriers to integration posed by entrenched organisational boundaries. This complexity reinforces the need for leaders to navigate these barriers effectively, a theme that aligns with previous findings on leadership in dynamic and resource-constrained environments (Eckert *et al.*, 2014; NHS Confederation, 2019).

Enhancing clinical and care leadership within ICSs reflects the broader advocacy within the literature for engaging clinical and care professionals in leadership roles (NHS England, 2019). This also aligns with the argument presented by Jones & Fulop (2021), emphasising the critical role of clinical and care leaders in driving systemic improvements and fostering collaborative cultures within healthcare systems. The findings contribute to this discourse by providing empirical support for national guidance regarding the value of clinical and care professional involvement in leadership and governance structures. Similarly, the literature supports the commitment to clinical and care leadership promoting system-wide collaboration (Nicholson et al., 2018; Embuldeniya et al., 2018; Martin, 2021).

Programme theory three demonstrates the need for genuine engagement with communities and the public, highlighting a gap between intended and actual engagement practices. This distinction between intended and actual engagement echoes the wider literature's discussion on the necessity for co-creation and co-production in the design and delivery of health services (Charles et al., 2018; Deffenbaugh, 2018). The empirical literature further supported this

finding by noting the need for the involvement of all partners, including the public, patients, and local communities, in determining ICS priorities (Bell *et al.*, 2022; Gordon *et al.*, 2020; MacLeod *et al.*, 2019; Martin, 2021; Miller and Stein, 2020; Round *et al.*, 2018; Urtaran-Laresgoiti *et al.*, 2018).

Programme theory three aligns with systems leadership emphasis on the importance of collaboration and partnerships across organisational boundaries, highlighting how strategic partnerships work within and across existing structures to support the development of trust and shared commitment between partners (Dreier *et al.*, 2019). Systems leadership theory stresses the importance of engaging diverse stakeholders, including community members, in decision-making processes to ensure that the system is responsive to the needs and preferences of those it serves (Senge et al., 2015). Findings indicate an incongruity between a stated commitment to public and stakeholder engagement and the practice of integrating community feedback into strategic decision-making. This contrast highlights a potential gap between the ideals of systems leadership theory and the challenges of effectively implementing community engagement in practice.

Systems leadership theory also acknowledges the need for leaders to adapt their approaches to the system's specific context and challenges (Senge et al., 2015; Dreier et al., 2019). The findings highlight the evolving landscape of ICSs and the various contextual factors, such as existing relationships, workforce pressures, and public accountability, as enablers or barriers to outcomes, underscoring the importance of context-specific adaptations and the need for systems leaders to be responsive to the unique challenges and opportunities within their systems.

Programme Theory four introduces the concept of risk perception and its impact on innovation; when leaders face operational challenges, their perception of risk and uncertainty increases, potentially reducing innovation or improvement activities. This is an important finding given the need for ICSs to approach health and social care differently, nurturing learning and innovation (Sims *et al.*, 2021) and creating space for experimenting or trying out new ideas whilst balancing risks (MacLeod *et al.*, 2019). These findings align with systems leadership theory by reinforcing the need for systems leaders to foster collective learning and adaptation (Senge *et al.*, 2015).

Providing robust and timely data on population health needs and service performance supported the prioritisation of needs within local communities. However, the mechanism was leaders' confidence in generating data-driven decisions, ultimately focusing system priorities on groups and individuals with the greatest needs. Previous findings have stressed the need for real-time data sharing across partners but acknowledged that this was limited by a lack of shared systems or information governance agreements (Embuldeniya *et al.*, 2018; Pearson and Watson, 2018). The use of shared data systems to support delivery to local communities is therefore important to support leaders in utilising intelligence to prioritise those with the greatest needs (Bell *et al.*, 2022; Gordon *et al.*, 2020; Mitchell *et al.*, 2020; Nicholson *et al.*, 2018).

Whilst the findings support a focus on governance and resource allocation, they foreground the role of financial constraints and lack of delegation of budgets to place as a mechanism to either achieve a financially balanced system or a limited ability to effectively respond to community needs depending on the reasoning of actors. For ‘central’ ICS leaders, a lack of delegation to place reduced their risk perception associated with delegating finances, whilst place leaders felt disempowered. Previous findings have stressed the need for clear and collaborative governance systems (Bell *et al.*, 2022; Gordon *et al.*, 2020; Sims *et al.*, 2021).

Strengths and limitations

The iterative approach to theory-building was a key strength; using prior programme theory as both the theoretical and coding framework for analysis supported methodical testing of mechanisms and CMOCs. Including the ICS leader's perspective provides contemporary empirical findings on the leadership of ICS, and this study provides actionable insights for ICS leaders, policy-makers, and those responsible for leadership development within health and social care settings. While findings were derived within an English setting and within one ICS, we anticipate they will be broadly applicable given the shared purpose and focus of integrated governance and delivery systems and the study's use of systems leadership theory to explain and scaffold findings. However, as this study focused specifically on the views and experiences of senior leaders in an ICS, future research could explore the impact of this in further detail through the experiences of both the wider workforce and local communities. In addition, testing these programme theories in another ICS would be particularly useful to identify additional contextual factors supporting effective leadership.

Conclusion

This realist evaluation has identified mechanisms that underpin effective leadership within ICSs, which will ultimately influence the functioning and success of ICSs themselves. The study highlights the importance of a clear, shared vision to drive alignment among ICS partners, guiding their actions and decision-making processes. When ICS leaders effectively communicate this vision, it fosters a collective sense of purpose and mutual accountability, enabling more coordinated efforts towards improving population health outcomes. The development of a psychologically safe environment, which allows leaders to engage in open, honest discussions and take calculated risks is particularly effective in contexts where there is a strong sense of trust and shared responsibility among ICS partners. The findings also highlight the contextual landscape that challenges leaders: financial pressures and differences in regulatory and financial environments between health and social care can hinder the development of a shared culture and purpose, leading to siloed thinking and reduced collaboration. Within this context, the mechanisms that support effective leadership are disrupted, making achieving long-term health improvement goals more difficult.

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