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### **Integrated Care System Leadership: A Rapid Realist Review**

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## Integrated Care System Leadership: A Rapid Realist Review

### Abstract

#### Purpose

Given the complex nature of Integrated Care Systems, the geographical spread, and the large number of organisations involved in partnership delivery, the importance of leadership cannot be overstated. This paper presents novel findings from a rapid realist review of Integrated Care Systems (ICS) leadership in England. The overall review question was: *how does leadership in ICSs work, for whom, and in what circumstances?*

#### Design/methodology/approach

Development of initial programme theories and associated context–mechanism–outcome configurations (CMOCs) were supported by the theory-gleaning activities of (i) a review of ICS strategies and guidance documents, (ii) a scoping review of the literature, and (iii) interviews with key informants. A refined programme theory was then developed by testing these CMOCs against empirical data published in academic literature. Following screening and testing, 6 CMOCs were extracted from 18 documents. The study design, conduct, and reporting were informed by the Realist And Metanarrative Evidence Syntheses: Evolving Standards (RAMESES) training materials (Wong, Westhorp, *et al.*, 2013).

#### Findings

The review informed four programme theories explaining that leadership in ICSs 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.

#### Originality

This review will be of relevance to academics and healthcare leaders within ICSs in England, offering critical insights into ICS leadership, integrating diverse evidence to develop new evidence-based recommendations, filling a gap in the current literature, and informing leadership practice and healthcare systems.

**Keywords:** ICSs, leadership, realist review, health and social care integration

## Background

By 2035, the number of people with four or more diseases is expected to double, with a third also having mental health conditions (NHS England, 2019, p. 2). The population is aging and becoming medically complex (Charlesworth and Johnson, 2018, p. 97). This demographic shift poses challenges for health and social care, traditionally designed for acute illnesses, not chronic conditions. Integrated care has emerged as a response, driven by financial and policy factors (Ling *et al.*, 2012, p.2). In England, health and social care services have adopted partnership working through Integrated Care Systems (ICSs), which became statutory bodies in July 2022, encompassing all NHS Provider Trusts (Hospital, Community, and Mental Health Trusts), Primary Care Services including GP Practices, Local Authorities, Care Providers, and Voluntary, Community and Social Enterprise organisations that are involved in the provision of health and social care.

ICSs, as complex systems spanning vast areas, rely on senior leaders to improve population health, reduce inequities, and maximise value. Leadership is crucial in these partnerships, often being the primary driver of large-scale change and ICS development (Bhat *et al.*, 2022).

The International Conference on Integrated Care (Stein *et al.*, 2023) emphasized the need for effective leadership in integrated care. However, in a recent review of system leadership in health care, Kaehne *et al.* (2022) found no empirical studies that examined the value of different approaches to leadership. Literature suggests that successful integration hinges on robust leadership and governance at the system level across health and social care (Asthana *et al.*, 2020; Dickson and Tholl, 2020; Erens *et al.*, 2016; Evans *et al.*, 2016; González-Ortiz *et al.*, 2018; Goodwin and Smith, 2011; Ham *et al.*, 2011; Maruthappu *et al.*, 2015). In Scotland, leadership qualities were deemed critical for integrating health and care services (Hutchison, 2015). Leadership ability, alongside organisational culture, workforce management, and inter-organisational collaboration, is pivotal in integrated health systems (Bhat *et al.*, 2022).

A leader's ability to transition from organisation-centred to a broader, multi-organisational focus is vital for ICS operation and sustainability (Charles *et al.*, 2018; Deffenbaugh, 2018; Tweed *et al.*, 2018; Wistow *et al.*, 2016), including developing partnerships across system members (Paice and Hasan, 2013; Social Care Institute for Excellence, 2018; Tweed *et al.*, 2018). The NHS Confederation advocates a 'collective' leadership approach for ICSs (Ham, 2022), with a consensus on the necessity of a 'systems leadership' style. Effective integrated care leaders are expected to communicate a shared vision, foster trust, and manage the workforce effectively (Charles *et al.*, 2018; González-Ortiz *et al.*, 2018; Thakrar and Bell, 2017).

Despite the recognised importance of leadership in ICS implementation and operation, research often focuses more on the identity of leaders rather than their actions (Sims *et al.*, 2021, p. 13), hindering the understanding and application of effective leadership practices. Additionally, there is an assumption that senior leaders can adapt their existing leadership styles to the new ICS structures (Chambers *et al.*, 2020), but a clear definition of 'systems leadership' and evidence for the necessary skills and attributes are lacking (Kaehne *et al.*, 2022, p. 7).

In summary, while the significance of leadership in implementing, developing, and sustaining integrated care is widely recognised, empirical studies in this area are scarce (Evans *et al.*, 2016). Research has often focused on the attributes and skills of leaders, rather than their actions and behaviours. Notably, empirical evidence on the leadership of Integrated Care Systems (ICSs) in England is particularly limited, despite their widespread adoption.

This rapid review aims to enrich both theoretical and practical understanding of leadership in ICSs. It seeks to elucidate how and why leadership works within these systems, aiding those

involved in ICSs to better comprehend and foster leadership development. The review employed a realist method, focusing on Context, Mechanisms, and Outcomes (Booth *et al.*, 2018). It involved reviewing ICS strategies and guidance, a scoping review of literature, and interviews with key informants knowledgeable about ICS leadership. These steps helped in formulating and refining programme theories about the functioning of leadership in ICSs, its effective contexts, and the reasons behind its success.

Accordingly, the objectives of this study are: (1) To create an initial rough programme theory (IRPT) based on a scoping review of strategies and guidance relating to the implementation and purpose of ICSs and initial stakeholder interviews with key informants; (2) To develop the initial rough programme theory into a refined programme theory based on empirical data published in the academic literature.

## Methods

This study utilises realist approaches to formulate theories for effective leadership in ICSs, focusing on desired outcomes (Pawson and Tilley, 1997; Wong *et al.*, 2017). Theories, termed IRPT, were developed using diverse sources, aligning with Realist And Metanarrative Evidence Syntheses: Evolving Standards (RAMESES) guidelines (Wong, Greenhalgh, *et al.*, 2013; Wong, Westhorp, *et al.*, 2013). The research process employed the context + mechanism = outcome (CMO) heuristic (Wong *et al.*, 2017), analysing literature, ICS strategies, and conducting interviews. Ethical review and approval were obtained via the authors' own institutional protocols. These theories were then empirically tested, refining the IRPTs as shown in figure 1.

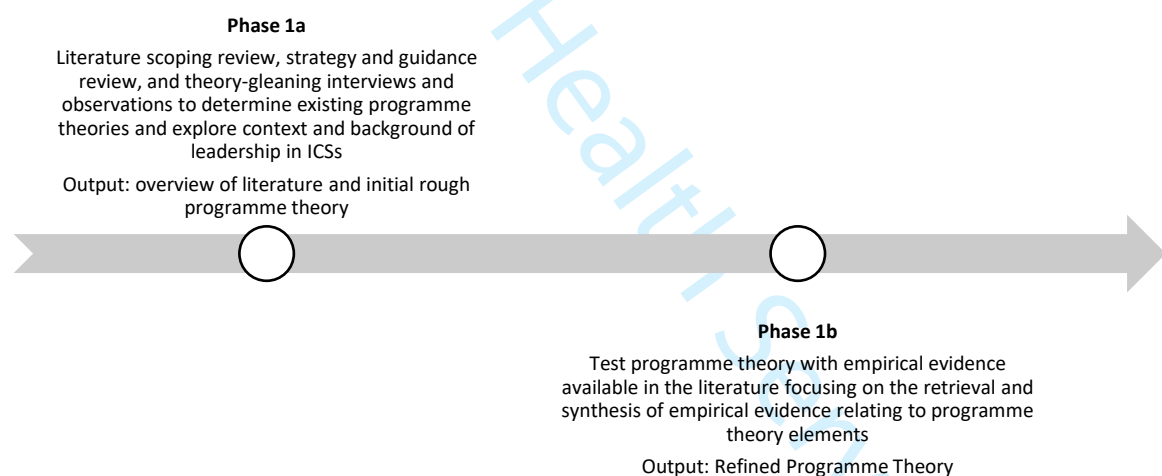


Figure 1: Phases in the Development of Initial Programme Theory

This study built initial rough programme theories by analysing ICSs policy documents, guidance, and key informant interviews, drawing on Pawson and Tilley's (1997) concept that policymakers' expectations offer a basis for testable theory. Thirteen policy and guidance documents, along with five semi-structured interviews with ICS senior leaders, were analysed to identify contexts, mechanisms, and outcomes of leadership in ICSs, leading to four programme theories and nine Context-Mechanism-Outcome configurations.

## Search

Adhering to RAMESES standards for transparency, this review targets literature post-2017, coinciding with the inception of England's ICSs. This timeframe aligns with the historical

1  
2  
3 evolution of ICSs and the pilot phase resulting in a rapid realist review, that uses realist  
4 processes within a limited literature set (Wong, Westthorp, *et al.*, 2013, p. 18).  
5

## 6 Selection and Appraisal

7  
8 In Phase 1b, two reviewers (LK, RG) screened studies by title, abstract, and full-text for  
9 relevance, addressing any conflicts. They evaluated studies' potential to affect leadership  
10 theories in ICSs, focusing on 'conceptual richness' and 'thickness' for meaningful contributions  
11 (Booth *et al.*, 2013; Dada *et al.*, 2023; Pawson, 2006a; Wong, 2018). The rigour of each study  
12 was assessed based on trustworthiness and relevance to testing initial rough programme  
13 theories, including robust data points from methodologically weaker studies as per realist  
14 methodology (Pawson, 2006b).  
15

## 16 Data Extraction

17  
18 Each paper's characteristics, including objectives, study location, design, and participants, were  
19 extracted. Focus was on identifying context-mechanism-outcome configurations and refining  
20 programme theory. Dalkin *et al.*'s (2015) formula: M (resource) + C → M (reasoning) = O, and  
21 operational definitions of context, mechanism, and outcome, as shown in table 1, guided  
22 mechanism-context delineation.  
23

24 *Table 1: Operational Definitions of Context, Mechanisms, and Outcomes*

	Operational Description
<b>Context</b>	A situation or condition that existed prior to the formation of ICS, or a situation or condition outside of the control of the ICS that is relevant to the leadership of ICS, and may change over time
<b>Mechanism</b>	Activities, processes, and actions related to ICS leadership (resources) and the responses or reactions of leaders, or other members of the system, that follow (reasoning)
<b>Outcome</b>	Result or consequence of ICS leadership (intended or unintended)

## 39 Data Synthesis

40  
41 Data extracts, including interview quotes, observation notes, and study excerpts, were compiled  
42 to detail contexts, mechanisms, and outcomes, forming Context-Mechanism-Outcome  
43 Configurations (CMOCs). Thematic organisation mirrored thematic analysis (Gilmore *et al.*,  
44 2019), with the realist review approach aiding in discerning relationships between elements  
45 (Rycroft-Malone *et al.*, 2012). This involved juxtaposing and reconciling evidence to refine  
46 theories and develop comprehensive CMO configurations, integrating data to clarify the  
47 interaction between context, mechanism, and outcome (Pawson, 2006c).  
48  
49

## 50 Programme Theory Development

### 51 Search Results

52  
53 After screening the initial 5,716 records by title and abstract, 99 records were screened by full  
54 text. 22 records were evaluated for relevance (Alonso and Andrews, 2022; Aufegger *et al.*,  
55 2020; Aunger, Millar, Rafferty, Mannion, *et al.*, 2022; Bell *et al.*, 2022; Chang, 2021; Elliott  
56 *et al.*, 2020; Embuldeniya *et al.*, 2018; Gordon *et al.*, 2020; Harlock *et al.*, 2020; Kozłowska *et al.*,  
57 2020; MacLeod *et al.*, 2019; Martin, 2021; Martin and Knowles, 2019; Miller and Stein,  
58 2020; Mitchell *et al.*, 2020; Nicholson *et al.*, 2018; Pearson and Watson, 2018; Robert *et al.*,  
59 2020).  
60

2022; Round *et al.*, 2018; Shand and Turner, 2019; Sims *et al.*, 2021; Urtaran-Laresgoiti *et al.*, 2018) and 1 was excluded (Alonso and Andrews, 2022) resulting in 21 being included for richness assessment. 3 studies were excluded following a review of richness (Elliott *et al.*, 2020; Martin and Knowles, 2019; Robert *et al.*, 2022), the remaining 18 papers were reviewed for rigour, considered trustworthy, and therefore included in the review. Contributions of included papers to final CMOCs is included in *Supplementary File 1*.

### Phase 1a: Literature Scoping

The initial literature search aimed at theory building and understanding the scope of literature on leadership in ICSs (Booth *et al.*, 2018, p. 154). This scoping review provided a contextual overview, contributing to the IRPT, later tested against empirical evidence in phase 1b.

#### ICSs Guidance and Policy

ICS policy and guidance documents informed the development of IRPT (RAMESES II, 2017). These documents often mirror the social, economic, historical, and political contexts of their creation, providing insights into the complex systems where programmes are developed and implemented (Miller and Alvarado, 2005). Thirteen documents were selected and analysed (Department of Health & Social Care, 2021; Department of Health and Social Care, 2022a, 2022b; National Audit Office, 2022; NHS Employers, 2022; NHS England and NHS Improvement, 2021a, 2021b, 2021c, 2022, 2021a, 2021b).

The scoping exercise highlighted essential elements for effective leadership in integrated health and social care, encompassing individual leader traits and structural considerations, detailed in Figure 2.

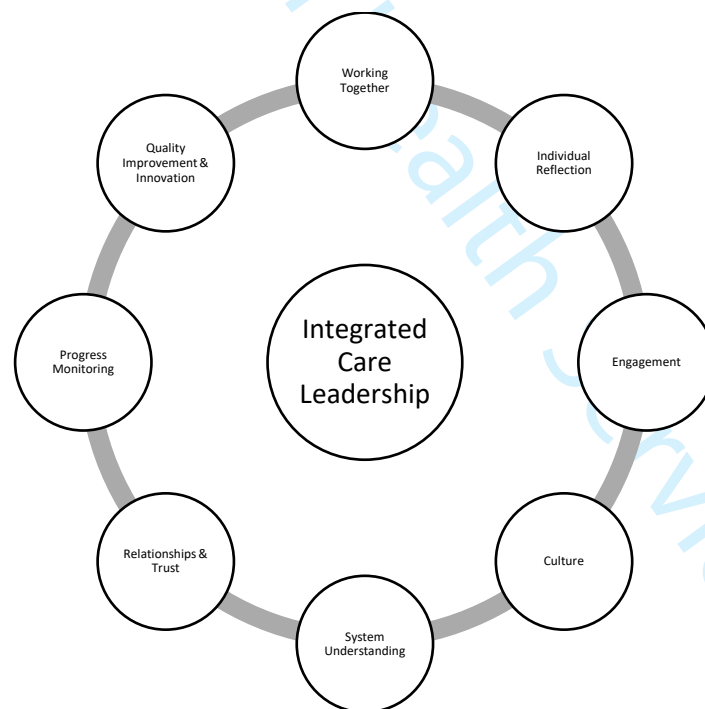


Figure 2: Literature Scoping Key Themes

#### Individual Reflection

Leaders need to reflect and develop their thoughts and feelings, changing as necessary (Baylis and Trimble, 2018; Sullivan-Taylor *et al.*, 2022). This involves continuous learning and fostering an adaptive learning culture (Charles *et al.*, 2018; Hendry *et al.*, 2021; Miller and



1  
2  
3 Stein, 2020), underpinned by emotional intelligence and self-understanding (Good Governance  
4 Institute and Coventry University, 2022; King and Mendez-Sawyer, 2021).

### 6 Working Together

7 Integrated care leadership involves tackling complex 'wicked' problems and managing conflicts  
8 (Hulks *et al.*, 2017; Social Care Institute for Excellence, 2018). Leaders must collaborate, share  
9 power, and use distributed leadership approaches (Aunger, Millar, Rafferty, Mannion, *et al.*,  
10 2022; Baylis and Trimble, 2018; Harris *et al.*, 2022; Miller and Stein, 2020). Clear governance  
11 structures and data sharing are crucial for managing risk and decision-making (Booth-Smith,  
12 2017; Cheng and Catallo, 2019; Harris *et al.*, 2022).

### 15 Relationships and Trust

16 Building trust within systems relies on strong relationships, effective communication, and  
17 managing power dynamics (Aunger *et al.*, 2022; Baylis and Trimble, 2018; Hulks *et al.*, 2017).  
18 Trust fosters collaboration and understanding of partners' motivations (Deffenbaugh, 2018;  
19 Ham, 2022; Harris *et al.*, 2022).

### 22 Culture

23 A shared culture is essential for collaborative working, facilitating common goals and a unified  
24 narrative (Bell *et al.*, 2022; Harris *et al.*, 2022; Urtaran-Laresgoiti *et al.*, 2018). Cultural  
25 alignment reduces conflict and supports shared values and vision (Cheng and Catallo, 2020;  
26 Nicholson *et al.*, 2018).

### 29 Engagement

30 Engaging with patients, communities, and the public involves co-creation and ensuring genuine  
31 influence in service design (Charles *et al.*, 2018; Ham, 2022; Sullivan-Taylor *et al.*, 2022).  
32 Leaders should partner with a range of organisations, including the voluntary sector, for a  
33 population-based approach (Alderwick *et al.*, 2021; Hendry *et al.*, 2021).

### 35 System Understanding

36 Leaders must understand the health and social care sectors and manage conflicts between  
37 organisational and system priorities (Deffenbaugh, 2018; Harris *et al.*, 2022; Miller and Stein,  
38 2020).

### 41 Progress Monitoring

42 Monitoring performance through agreed indicators is vital for evaluating progress and  
43 demonstrating impact (Department of Health and Social Care, 2022a; Martin, 2021; Round *et*  
44 *al.*, 2018)

### 46 Quality Improvement and Innovation

47 Leaders should foster a culture of improvement and innovation, empowering the workforce  
48 and developing quality improvement capabilities (Gordon *et al.*, 2020; NHS Confederation,  
49 2018; Turner *et al.*, 2018).

## 52 **Substantive Theory**

53 The phase 1a scoping exercise identified strategies and practices for effective ICS leadership,  
54 needing further organisation and coherence. Literature informed the use of substantive theories  
55 for programme theories, providing a bridge to existing research (Marchal *et al.*, 2018; Papoutsi  
56 *et al.*, 2018). Systems leadership theory aligned best with the findings.

### 59 Systems Leadership in Health Care



Systems leadership focuses on understanding and addressing interdependencies in health care systems (NHS Leadership Academy, 2013; NHS North West Leadership Academy, 2021). It involves engaging a wide range of stakeholders and navigating complex environments, though empirical research in this area is limited (Kaehne *et al.*, 2022). Whilst there are many types of 'systems' within healthcare and leadership contexts, in this paper the term system is used to refer to Integrated Care Systems.

### NHS NWLA Doing Things Differently System Leadership Behaviours Framework

The framework identifies key behaviours for effective system leadership, developed through collaborative projects with various sector leaders (NHS North West Leadership Academy, 2018). Four overarching themes of 'Being', 'Relating and Communicating', 'Leading & Visioning', and 'Delivering' structure the findings, exploring what works in different contexts to support effective ICS leadership.

### **Initial Rough Programme Theories**

An IRPT is foundational for a realist review, providing structure for analysis (Shearn *et al.*, 2017). Developed using the 'Doing Things Differently' framework, IRPTs in this study offer a narrative on leadership effectiveness in ICSs integrating programme strategies, NHS guidance, and key informant interviews. IRPTs for this study are provided in *Supplementary File 2* and summarise the interplay of context, mechanism, and outcomes, exemplified through quotations supporting the programme theories (Rycroft-Malone *et al.*, 2012).

### **Phase 1b: Empirical testing of CMOCs**

The original nine CMOCs supporting programme theories, **with two each for Being, Leading & Visioning, Relating, and communicating, and three for Delivering**, were validated against 18 empirical papers, synthesising contexts, mechanisms, and outcomes. **Evidence for contexts, mechanisms, and outcomes were gleaned from these papers and compared to the original nine CMOCs**. Four CMOCs (1, 6, 7, 8) had empirical support with refinements, one (3) lacked evidence, and four (2, 9, 4, 5) were merged due to insufficient distinct evidence, resulting in the following six CMOCs.

#### *IPT: Being*

*CMOC 1: In the context of ICS formation and development (C) leaders with a clear and sustained vision communicate clarity of intent (M – Res), which fosters a sense of purpose in stakeholders (M- Rea) and helps to focus on the achievement of ICSs' objectives (O).*

Empirical studies emphasise the need for ICS leaders to consistently commit to a clear vision, facilitating supportive actions aligned with ICS goals by partners collaboratively and independently, while minimizing miscommunications. The lack of this clear vision contributes to management challenges (Aufegger *et al.*, 2020; Aunger, Millar, Rafferty, Mannion, *et al.*, 2022; Harlock *et al.*, 2020; Kozłowska *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).

#### *IPT: Leading & Visioning*

*CMOC 2: In the context of determining and measuring ICS priorities (C), the transparent and democratic engagement of clinical and care professionals, non-health partners and local communities (M-Res) promotes a sense of mutual accountability (M-Rea), and a focus on population health and wellbeing reducing the impact of health and social inequalities (O)*

CMOC 1 emphasises a clear, sustained vision for ICS objectives, mandating partner action, while CMOC 2 focuses on mutual accountability through partner engagement in developing

1  
2  
3 and measuring ICS priorities (Sims *et al.*, 2021). Empirical literature underscores involving all  
4 stakeholders, including the public, in setting local ICS priorities, especially in early integration  
5 stages (Bell *et al.*, 2022; Gordon *et al.*, 2020; Harlock *et al.*, 2020; MacLeod *et al.*, 2019;  
6 Martin, 2021; Miller and Stein, 2020; Mitchell *et al.*, 2020; Nicholson *et al.*, 2018; Round *et*  
7 *al.*, 2018; Urtaran-Laresgoiti *et al.*, 2018). This involvement aims to address broader ICS goals  
8 like population health, illness prevention, and reducing health inequalities.

### 9 10 IPT: Relating & Communicating

11  
12 *CMOC 3: In the context of bringing together health and social care organisations with*  
13 *different histories, funding mechanisms, and governance (C) developing strong relationships*  
14 *through shared goals and frequent face to face interactions (M-Res) nurtures trust and*  
15 *understanding (M-Rea), which supports collaborative decision-making and the resolution of*  
16 *tensions (O)*

17  
18 The literature underscores recognising historical power and resource imbalances between  
19 health, social care, and the voluntary sector as crucial for developing collaborative relationships  
20 (Chang, 2021; Gordon *et al.*, 2020; Martin, 2021; Sims *et al.*, 2021). Trust, fostered through  
21 frequent interactions and face-to-face meetings, is vital, as is resolving tensions to maintain  
22 trust and collaboration (Auger, Millar, Rafferty, Mannion, *et al.*, 2022; Bell *et al.*, 2022;  
23 Embuldeniya *et al.*, 2018; Harlock *et al.*, 2020; MacLeod *et al.*, 2019; Miller and Stein, 2020;  
24 Nicholson *et al.*, 2018; Shand and Turner, 2019).

### 25 26 IPT: Delivering

27  
28 *CMOC 4: In the context of a shared culture of learning (C) system partners facilitating and*  
29 *supporting each other to innovate and identify learning from successes and failures (M-Res)*  
30 *supports psychological safety and encourages creativity and innovative thinking (M-Rea),*  
31 *leading to effective service redesign and continuous improvement (O)*

32  
33 ICSs require a novel approach to health and social care, fostering learning and innovation (Sims  
34 *et al.*, 2021). Empirical studies emphasise developing processes that support innovation  
35 (Gordon *et al.*, 2020) and encourage experimentation while managing risks (MacLeod *et al.*,  
36 2019). Leaders should create conditions for innovation by mobilising resources and allowing  
37 for risk-taking and learning from mistakes, crucial for inventive service delivery (Martin, 2021;  
38 Miller and Stein, 2020; Mitchell *et al.*, 2020; Round *et al.*, 2018; Urtaran-Laresgoiti *et al.*,  
39 2018).

40  
41 *CMOC 5: In the context of population health management and digitalisation (C) the use of*  
42 *shared digital intelligence (M-Res) supports leaders to better understand local population*  
43 *needs (M-Rea) which leads to improved targeting or prioritisation of local communities, so*  
44 *they access services (O)*

45  
46 There was empirical evidence of the need for real-time data sharing across partners and an  
47 acknowledgement that this was limited by a lack of shared systems or information governance  
48 requirements (Embuldeniya *et al.*, 2018; Pearson and Watson, 2018). The development of  
49 shared data systems, or intelligence dashboards, which can be used at all levels to support  
50 delivery to local communities (Bell *et al.*, 2022; Gordon *et al.*, 2020; Mitchell *et al.*, 2020;  
51 Nicholson *et al.*, 2018), was therefore seen of importance to support leaders in utilising  
52 intelligence to target interventions. (Bell *et al.*, 2022; Gordon *et al.*, 2020; Mitchell *et al.*, 2020;  
53 Nicholson *et al.*, 2018).

54  
55 *CMOC 6: In the context of developing a culture of accountability (C), clear governance*  
56 *structures and transparent decision-making, with a robust process for monitoring and*  
57  
58  
59  
60

1  
2  
3 *evaluation (M-Res) ensures partners accountability for quality, value for money, effective*  
4 *service provision (M-Rea) which leads to the achievement of system outcomes (O)*  
5

6 Empirical evidence indicates that clear, collaborative governance and engagement processes,  
7 like regular action-focused meetings, enhance system accountability and progress monitoring  
8 (Bell *et al.*, 2022; Gordon *et al.*, 2020; Sims *et al.*, 2021). However, historical health and social  
9 care sector differences can impede this approach (Pearson and Watson, 2018). Leaders who  
10 challenge the status quo in a transparent environment facilitate goal achievement (MacLeod *et*  
11 *al.*, 2019; Miller and Stein, 2020; Nicholson *et al.*, 2018), with progress monitoring against  
12 meaningful measures bolstering accountability and outcome achievement (Aunger, Millar,  
13 Rafferty, Mannion, *et al.*, 2022; Mitchell *et al.*, 2020; Urtaran-Laresgoiti *et al.*, 2018).  
14  
15

## 16 **Discussion**

17  
18 Our findings build on previous studies by suggesting key mechanisms for effective leadership  
19 and identifying that leadership in ICSs work when: i) ICS leaders hold themselves and others  
20 to account for improving population health, ii) a sense of purpose is fostered through a clear  
21 vision, iii) partners across the system are engaged in problem ownership, and iv) relationships  
22 are built at all levels of the system. Whilst these findings were derived from, and therefore  
23 relate to, executive level leaders within an ICS the findings may be of relevance differing  
24 leadership levels within an ICS context.  
25

26 Many of the CMOC elements identified in this review are similar to those identified by other,  
27 non-realist studies, such as the challenges arising from health and social care organisations  
28 with different histories, funding mechanisms, and governance functions collaborating in  
29 partnership (Barker, 2014; Exworthy *et al.*, 2017; Miller *et al.*, 2021; Miller and Glasby, 2016;  
30 Parkin, 2019), increasing the validity of our findings. However, we build on these elements by  
31 making connections between the resources (mechanism) offered in contexts and the reasoning  
32 of those involved in leadership of ICSs; for example, the development of trust and  
33 understanding. The refined theories corroborate existing ICS leadership guidance, emphasising  
34 relationship development and maintenance across health and social care systems for sustained  
35 partnership and collaboration.  
36  
37

38 This aligns with previous realist reviews on integrated care leadership (Aunger, Millar,  
39 Rafferty, Mannion, *et al.*, 2022; Harris *et al.*, 2022), explaining how relationships bolster  
40 effective ICS leadership. Aunger *et al* (2021) has previously noted the complexity involved in  
41 health and social care partnerships, like ICSs, due to the large number of organisations coming  
42 together across sectors; impacting not only effective communication but hindering the  
43 development of trust due to previously established competitive approaches. This resonates with  
44 our findings; we argue that historical imbalances in cross sector organisational partnerships  
45 impacts on collaborative working, and the development of trust. Aunger *et al* (2021) suggest  
46 a clear patient focus from all parties across the system as a means to overcome these pre-  
47 existing differences and conflicts, this was linked to our notion of a ‘shared sense of purpose’.  
48  
49

50 Our research builds on existing realist-informed studies of healthcare partnerships or  
51 collaboration (Aunger, Millar and Greenhalgh, 2021; Aunger, Millar, Greenhalgh, *et al.*, 2021a,  
52 2021b; Aunger, Millar, Rafferty and Mannion, 2022; Aunger, Millar, Rafferty, Mannion, *et al.*,  
53 2022), and in particular recent realist reviews focused on leading in integrated care (Harris *et*  
54 *al.*, 2022; Sims *et al.*, 2021) by providing a specific focus on ICS leadership and offering  
55 Programme Theories as guidelines for ICS leadership development.  
56  
57

58 This rapid realist review was based on leadership within ICSs and informed, in part, by key  
59 informant interviews with leaders from a regional ICS. However, the results can be applied to  
60

ICSs across England with potential to inform learning within other nations that implement integrated health and social systems. Key learning identified from the review, could support the development of effective leadership within an ICS but given the inherent complexity within such systems, composed of leaders as individuals with relationships this will influence the context and mechanisms, and hence outcomes each ICS demonstrates. Moreover, whilst the CMOCs are presented here positively, in most cases the opposite is likely to apply; for example, a lack of clear governance structures and transparent decision making, within a context of developing a culture of accountability, can reduce partner accountability for quality, value for money, and effective services provision, limiting the achievement of system outcomes. Table 2 offers Programme Theories as guidelines for ICS leadership development.

Table 2: Theories of effective ICS leadership utilising *Doing Things Differently: Rethinking Leadership Behaviours as an organising framework* (NHS North West Leadership Academy, 2021).

<b>Delivering</b>	Effective ICS leaders hold themselves and others to account for improving outcomes for the local population. They utilise available intelligence to take actions that support targeting and prioritisation of local communities. Effective ICS leaders support and encourage learning, curiosity, and calculated risk-taking enabling innovative approaches that lead to service improvements.
<b>Being</b>	Effective ICS Leaders communicate a clear vision, fostering a sense of purpose across the system regarding the achievement of agreed ICS outcomes.
<b>Leading &amp; Visioning</b>	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
<b>Relating &amp; Communicating</b>	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

Further research is required to further build, test, and refine these theories. We suggest this can be achieved through a case study of ICS leadership to test these Programme Theories and CMOCs in a larger real-world case study. Therefore, the next stage of this research will entail further testing and refining these theories through a realist evaluation.

### Strengths and limitations

This rapid realist review, adhering to RAMESES guidelines, offers a detailed and transparent process report. Key stakeholder engagement, a recommended aspect in realist reviews (Wong, Greenhalgh, *et al.*, 2013; Wong, Westhorp, *et al.*, 2013), informed the development and refinement of findings. Despite being a rigorous and comprehensive investigation, stakeholder input was limited to one ICS, potentially restricting insights from varied geographical contexts. Additionally, the recent establishment of ICSs meant limited literature availability, with few empirical studies conducted. Although this emphasises the importance and originality of the research, this scarcity posed challenges in extracting and applying certain programme theory elements, particularly context. Finally, whilst the focus of this review was ICSs within the English NHS, findings may be relevant to integrated health and care systems within other geographical contexts.

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*Contribution of included papers to final CMOCs*

Source	CMOC 1:	CMOC 2:	CMOC 3:	CMOC 4:	CMOC: 5	CMOC: 6
(Aufegger et al., 2020)	x					
(Aunger et al., 2022)	x		x			x
(Bell et al., 2022)		x	x		x	x
(Embuldeniya et al., 2018)			x		x	
(Harlock et al., 2020)	x	x	x			
(Gordon et al., 2020)		x	x	x	x	x
(Kozłowska et al., 2020)	x					
(MacLeod et al., 2019)	x	x	x	x		x
(Martin, 2022)	x	x	x	x		
(Miller and Stein, 2020)	x	x	x	x		x
(Ming-Fang Chang, 2021)			x			
(Mitchell et al., 2020)		x		x	x	x
(Nicholson et al., 2018)		x	x		x	x
(Pearson and Watson, 2018)					x	x
(Round et al., 2018)	x	x		x		
(Shand and Turner, 2019)			x			
(Sims et al., 2021)	x	x	x	x		x
(Urtaran-Laresgoiti et al., 2018)	x	x	x			x

IRPT: Being

Effective ICS Leaders communicate a clear sense of purpose, encourage learning, curiosity, and calculated risk-taking. They are aware of how their behaviour influences an organisation and others, and support both reflection and learning from success and failures.

<b>CMOC 1:</b>	<i>In the context of ICS leaders having a clear sense of purpose (C) they communicate clarity of intent and purpose (M - Res) which is motivating for others (M- Rea) and helps them to see how their work contributes to the achievement of the ICSs strategic objectives (O).</i>
<b>Linked Quotations:</b>	<p>“knowing what's right is one thing but being able to communicate what is right and therefore bringing people with you as a leader, I think is the other really important bit” [1]</p> <p>“we need to be consistent with the messages...we've got to be really clear about what we are doing and what we're not doing” [3]</p>

<b>CMOC 2:</b>	<i>In the context of a shared learning culture (C) leaders acting in an open and honest manner (M-Res) supports others to feel safe and supported to reflect on both success and failure (M-Rea), and are therefore better able to identify learning that leads to continuous improvement (O)</i>
<b>Linked Quotations:</b>	<p>“as leaders we've got to be able to say ‘these are the parameters, but you've got flexibility to do and be creative’” [3]“it doesn't matter what the strategy looks like if we haven't got people motivated and doing the right things and feeling empowered to do it then it won't work” [3]</p>

IRPT: Leading & Visioning

Effective ICS leaders prioritize community needs and system outcomes, breaking down barriers and empowering others in decision-making and problem-solving. This aligns with literature themes on culture alignment and a shared vision for improved population health.

<b>CMOC 3:</b>	<i>In the context of a shared and clear shared sense of purpose (C), clarity regarding accountability across the system (M-Res) supports partners to understand who is responsible for delivering what, with which levers and what budgets (M-Rea) and leads to partners working successfully across the system to plan, design, and deliver services (O)</i>
<b>Linked Quotations:</b>	<p>“so, there's no point [one place] striving forward with integration if somewhere else [in the system] is struggling and cannot get where they need to be. So, I see my role...making sure that we all succeed together and that's really important” [3]</p>

<b>CMOC 4:</b>	<i>In the context of a focus on population health (C) when partners are given an opportunity to contribute to discussion and decision making (M-Res) they feel that their perspective is understood (M-Rea) and leads to decisions taken closer to, and in consultation with, communities (O)</i>
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<b>Linked Quotations:</b>	“my leadership role in all of that is really important in terms of bringing together our key partners and getting them involved in some of the solutions” [3]
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### IRPT: Relating & Communicating

Effective ICS leaders build relationships at all levels of the system, they promote empathy, care, and collaboration. Leaders encourage a collective agreement about what needs to be achieved and communicate openly about how and why decisions are made.

<b>CMOC 5:</b>	<i>In the context of attempting to reduce the impact of health inequalities (C) providing citizens with choices about where and how they can access care (M-Res) empowers them to make decisions about their care (M-Rea) and access appropriate, timely support within their communities (O)</i>
<b>Linked Quotations:</b>	“where we show that these health inequalities are being tackled, where we are improving the outcomes of that core 20 Plus five, then I will see that our job as a system is being done.” [1]

<b>CMOC 6:</b>	<i>In the context of developing relationships that support partnership working (C) regular and open communications about how decisions are made (M-Res) fosters trust and mutual accountability (M-Rea) which supports system partners to focus on tackling the wider socio-economic causes of poor health and inequality (O)</i>
<b>Linked Quotations:</b>	“Communication is absolutely essential on this. But not just a ‘here’s the facts’, but us actually taking time to think about, what is the implication of this for individual organisations” [2]  “if you look at the kind of deprivation levels that we’ve got in [place], we’re not going to deal with this without having all our partners around the table” [3]

### IRPT: Delivering

Effective ICS leaders are accountable for enhancing local outcomes, optimally utilizing resources, and encouraging innovative methods. This encompasses clear governance, problem-solving, and progress measurement.

<b>CMOC 7:</b>	<i>In the context of a culture of accountability (C) transparent decision-making, with people and communities involved in governance, meetings held in public, published minutes and regular updates on progress (M-Res) ensures partners feel held to account for quality, effective service provision (M-Rea) and secure value for money service provision (O)</i>
<b>Linked Quotations:</b>	“and it’s a bit about, how do you hold each other to account?” [2]  “There needs to be, and particularly because of financial challenges in the NHS as well as local government, a real sort of hold to account” [3]

<b>CMOC 8:</b>	<i>In the context of population health management and digitalisation (C) the use of shared digital intelligence (M-Res) supports leaders to better understand local population needs (M-Rea) which leads to improved targeting of those with chronic diseases, so they access services (O)</i>
<b>Linked Quotations:</b>	“digital is such an important one, not just that the population and people are accessing that, but that we are getting that basic level absolutely right.” [1]

<b>CMOC 9:</b>	<i>In the context ICSs doing things differently (C) system partners facilitating and supporting each other to innovate (M-Res) encourages curiosity and innovative thinking (M-Rea) leading to effective service redesign (O)</i>
<b>Linked Quotations:</b>	“we are not here simply to take over a commissioning role, it has to be about what does this allow us to do differently” [1] “as a big organisation as the ICSs is, there is a risk that you try command and control . . ., and it stifles innovation and it creates inertia and you just don’t get stuff done” [3]

## Search Strategy

**Search Dates:** 15<sup>th</sup> September to 1<sup>st</sup> October 2022

**Search Terms:** Integrat\* AND health OR care OR “health care” OR “health servic\*” OR healthcare OR social-care OR “social care” OR NHS AND system\* AND leader\*

**Limiters:** English language only; Abstract;

**Date range:** 2017-2022 (In June 2017, NHS England selected ten pilot areas to develop the first ICSs)

### Databases

- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- MEDLINE
- PubMed
- ABI Inform
- ProQuest Central
- Business Source Complete
- Wiley
- Emerald

### Grey Literature

Grey literature relating to policy and organisational-based material searches on Google Scholar, government and other specialist websites [e.g., NHS Leadership Academy, National Institute for Health Research, Skills for Care, Social Care Institute for Excellence, The King’s Fund, Nuffield Trust, The Institute of Healthcare Management, Social Care Online, NHS England and NHS Improvement]. Keywords adapted from the main search strategy will be used including ‘leader’, ‘leadership’, ‘integrated care’ and ‘integrated system’.

### Hand-searching of Key Journals

Journal of Interprofessional Care, Journal of Integrated Care and International Journal of Integrated Care were searched for the term ‘leadership and systems’ in the online versions.