Leadership in Transition: Emerging Challenges in Integrated Care System Leadership

Abstract

Aim:

This study investigates the emerging leadership challenges within Integrated Care Systems (ICSs) in England. It focuses on identifying the key obstacles ICS leaders have faced in achieving their main objectives since their formation in 2022. By exploring their lived experiences, the study aims to contribute to the growing but underdeveloped evidence base on ICS leadership and the strategies leaders employ to navigate these challenges.

Design:

A qualitative case study design was utilised to gain in-depth insights into the leadership challenges in ICSs. To gather data on their experiences and perspectives, 28 semi-structured interviews were conducted with 23 ICS leaders. A purposive sampling technique within a case study design was employed, with 23 ICS leaders from one large ICS in England participating. Following Braun and Clarke's six-phase framework, thematic analysis was applied to analyse the interview data.

Results:

The analysis revealed several challenges ICS leaders face, including navigating complex governance structures, managing resource constraints, and addressing health inequalities. The tension between immediate operational demands and long-term strategic goals compounded these challenges. Findings should be understood in the context of a rapidly evolving policy landscape. Interviews were conducted before the 2024 General Election and within the first 18 months of ICSs becoming statutory entities.

Conclusions:

Addressing governance complexity requires enhanced decision-making autonomy. Leaders must be able to implement system-wide improvements while balancing operational and strategic demands. Leadership development frameworks should equip ICS leaders with the skills to navigate multi-tiered governance and financial constraint including strategic negotiation, adaptive leadership, systems thinking, and political astuteness.

Introduction

Integrated Care Systems (ICSs) represent a fundamental restructuring of healthcare delivery in England, designed to improve population health, enhance patient experiences, and ensure financial sustainability. Established as statutory entities in July 2022, ICSs aim to overcome longstanding fragmentation in service delivery by fostering closer collaboration between NHS organisations, local authorities, and

voluntary and community sectors (Charles, 2020; NHS England, 2022). By shifting from a competitive, market-driven approach to a cooperative, system-wide model of care, ICSs are expected to drive more integrated and person-centred services while addressing health inequalities and improving service efficiency (Checkland et al., 2020; Lorne et al., 2019). However, while the policy vision behind ICSs is well established, their implementation has proven complex, particularly in the areas of leadership and governance (Waring et al., 2023; Knight et al., 2025; Darzi, 2024).

Leadership is widely recognised as a critical enabler of integrated care, particularly in complex, multi-agency systems where collaborative working is essential (Bhat et al., 2022). ICS leaders are tasked with navigating highly complex organizational structures, fostering collaboration across diverse professional groups, managing financial and workforce constraints, and aligning strategic goals across multiple stakeholders. Unlike traditional NHS leadership roles, ICS leadership requires system-wide thinking, a high degree of political acumen, and the ability to work across multiple organisations with distinct governance structures, cultures, and priorities (Ham, 2022; Moore et al., 2023; Jones et al., 2023; Knight et al., 2025).

Despite the emphasis on leadership as a key success factor in ICSs, there remains a notable gap in empirical research on the lived experiences of ICS leaders; much of the existing literature focuses on high-level policy analysis or the theoretical benefits of integrated care, with limited insight into the practical realities of leading ICSs at the operational level (Waring et al., 2023; Stein et al., 2023; Knight et al., 2024; Bolden et al., 2023). Moreover, there is insufficient research on the specific leadership competencies required to navigate the complexities of ICS governance, particularly in relation to decision-making authority, accountability structures, and organisational alignment (González-Ortiz et al., 2018; Kaehne, 2022). This complexity can lead to leadership tensions, as ICS leaders balance national policy directives with localised needs within an evolving governance framework (Ham, 2022; Knight et al., 2024).

This case study complements prior realist work by focusing specifically on the lived experiences of ICS leaders during early implementation, offering practical insights rather than theory refinement (Knight et al, 2024; Knight et al., 2025). By exploring the lived experiences of these leaders, this study seeks to contribute to the growing evidence on the emerging leadership challenges within ICSs. While the study is limited to a single ICS site, the findings are consistent with challenges identified elsewhere in the literature (van Elk, 2024), suggesting they may hold wider relevance across other integrated care systems. Findings are presented in summary form in Figure 1.

Methods

This study employed a qualitative case study design to explore the emerging leadership challenges within an Integrated Care System (ICS) in England. The selected ICS was used as a case study to gain in-depth insights into the experiences and perspectives of its leaders. The ICS selected is located in the North West of England and serves a population of approximately 1.5 million, and based on the English Index of Multiple Deprivation, the area is ranked among the most deprived 10% nationally.

The study involved 23 leaders within the ICS from June to September 2023. These participants were purposively selected to provide key informant perspectives, ensuring a comprehensive understanding of the ICS's leadership challenges in its recent formation. Participants included executives, managers, and frontline leaders who had significant experience and involvement in the ICS. Data were collected through semi-structured interviews conducted with each of the 23 participants, with some participants being interviewed in a second wave with follow-up questions, resulting in a total of 28 interviews. The interviews were designed for flexibility and depth, enabling participants to discuss their experiences and perspectives in detail. To ensure comparability across interviews, all participants were asked a core set of prompts, with flexibility to explore emergent themes. The interview guide included open-ended questions on aspects of ICS leadership, including challenges, strategies, and outcomes.

The interviews were conducted over three months, each lasting approximately 60-90 minutes. All interviews were recorded with the participant's consent and transcribed using AI software, followed by manual verification to ensure accuracy in data analysis. Participant references (e.g. 2/1) denote the interview wave and participant number within that wave. Thematic analysis was employed to analyse the interview data to identify, analyse, and report patterns (themes) within the data following a six-phase framework (Braun and Clarke, 2012). To ensure the rigour and trustworthiness of the study, triangulation was used by comparing data from different participants to identify common themes and discrepancies.

The relevant institutional ethical approval was sought and provided for the study. All participants were informed about the purpose of the study, and informed consent was obtained prior to participation.

Results

The primary challenge ICS leaders identified was balancing immediate operational demands with pursuing long-term, strategic goals. Many leaders found themselves overwhelmed by the demands of systemic issues where leaders were consistently pulled into addressing immediate crises, leaving little time and resources for strategic planning and implementation of long-term initiatives.

"The difficulties people have is they get dragged back to the day job, so pursuing the bigger picture is difficult." (Participant 2/1)

A perceived disconnect between national priorities and local ICS objectives compounded this challenge. National performance management metrics were overly focused on immediate, quantifiable outcomes such as financial performance and waiting list reductions. ICS leaders' frustration stemmed from this narrow focus, which failed to capture the broader, more holistic goals of integrated care systems, such as improving overall community health and reducing inequalities.

"We do not get performance management on anything other than the money and waiting lists... social value and tackling inequalities, nobody ever asks us about that. They're only really interested in acute waiting lists." (Participant 2/3)

This lack of focus on prevention and health inequalities in performance management was a significant concern for ICS leaders; a misalignment hampering their ability to address long-term health issues, significantly hindering the achievement of meaningful, long-term health outcomes, and frustrating leaders committed to the comprehensive goals of ICSs.

"I've been a bit frustrated that we never really get the chance at the board to talk about health inequalities and prevention," (Participant 2/7)

Moreover, resource allocation and financial constraints were persistent challenges that impeded the ability to shift focus towards preventative care and address health inequalities. ICS leaders frequently highlighted the disproportionate investment in healthcare compared to social care.

"*The local authority aspect of social care is the poor cousin to the investment into health." (Participant 2/5)*

This disparity reflected the broader issue of funding mechanisms skewed towards immediate, acute care rather than long-term, preventative measures that could reduce the overall burden on the system with leaders highlighting the critical need for a paradigm shift in healthcare funding and priorities to support preventative care.

"If we carry on just trying to deal with ill health as it presents at our doors, we're doing our populations a disservice, we're doing our staff a disservice." (Participant 2/3)

Moreover, the rigidity in funding structures posed a significant barrier to innovation and effective long-term planning. The current financial landscape, characterised by stringent budgets and fixed costs, limited the capacity for innovation and proactive health management. The compounded difficulties faced post-pandemic, where backlogs and resource constraints further limited the ability to invest in preventative care and long-term health strategies, were a significant concern. Furthermore, leaders were acutely aware of the resource limitations that hindered their ability to focus on prevention.

"If we could only have a little, you know, injection of resource to enable us to tackle some of the things that we could do to prevent ill health, then it might be able to reduce the burden in the end… we can't afford to do the prevention stuff, because we've got loads of sick people." (Participant 2/8)

Another significant theme was the structural disconnect between system levels, which created barriers to effective governance and service delivery. Leaders expressed frustration with the top-down approach that often failed to consider local communities' unique needs and characteristics. The gap between Integrated Care Boards (ICBs) and what was happening in the communities they serve further complicated governance and decision-making processes, with leaders emphasising the need for more localised decision-making to address community-specific health needs. The structural issues described by leaders were further exacerbated by the governance frameworks that often did not facilitate seamless integration between different parts of the health and social care systems.

"When you get down to the details of what service delivery models look like, it's from the top. It's not based on any understanding of individual communities. The big problem is the distance between ICBs and what's happening in neighbourhoods." (Participant 2/2)

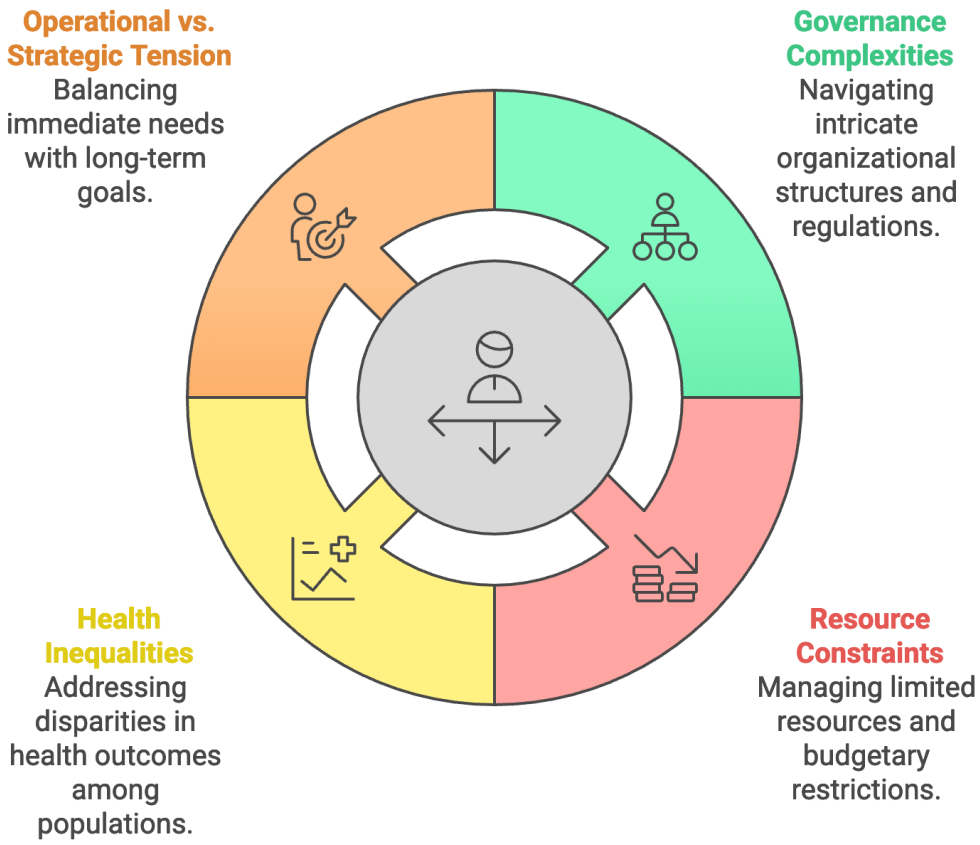

Figure 1: Challenges in Integrated Care System Leadership (Source: Author's own work)

Discussion

The challenges of leadership in ICSs, particularly in balancing short-term operational demands—such as reducing waiting times and managing financial pressures—with long-term strategic objectives, including prevention, population health improvement, and reducing health inequalities have been noted elsewhere (van Elk et al., 2024; Sanderson et al., 2021; Knight et al., 2025). This tension between immediate service delivery pressures and broader transformation goals is a persistent challenge for ICS leaders, requiring them to demonstrate adaptability and resilience in an environment of policy and regulatory constraints. Findings from this study support the assertion that ICS leaders struggle to maintain this balance due to the constant pull of day-to-day responsibilities (Lalani et al., 2023; Knight et al., 2024) and highlight the need for support structures that allow leaders to allocate time and resources to strategic long-term planning.

It is acknowledged that this study took place when the ICS was only 12 months post-formation, and still in the process of establishing statutory governance arrangements, clarifying roles, and developing a coherent organisational identity. Given this, ICS leaders were operating in a context of institutional flux, where role boundaries and authority may have been contested (Waring et al., 2023), with leaders needing to be adaptive and relational in the face of evolving structures and expectations (Lalani et al., 2025). However, the significant disconnect between national performance metrics and local ICS priorities aligns with concerns raised by Checkland et al. (2020), that national metrics often fail to account for regional variations and specific community needs. The findings presented here demonstrate the frustration that ICS leaders experience when working in a system that reinforces a narrow focus on financial performance and access targets, limiting their ability to address broader, systemic health inequalities. This echoes previous critiques that national policies, while attempting to standardise care delivery, often lack flexibility in adapting to local health system needs (Waring et al., 2023). Leaders in this study highlighted how financial constraints further compound these issues, restricting investment in preventative care and long-term health strategies, demonstrating that ICSs remain tied to immediate performance outcomes rather than sustainable, long-term improvements in public health.

Resource allocation and financial constraints emerged as significant barriers for ICS leaders, as the rigidity of funding structures limits their ability to innovate and plan for long-term health improvements, with the experiences of ICS leaders in this study adding depth to existing debates regarding how financial constraints manifest in practice, particularly in the post-pandemic context where backlogs and resource limitations further hinder the ability to invest in preventative care initiatives (Waring et al., 2023). The lack of financial flexibility to prioritise prevention efforts raises concerns over the long-term sustainability of ICS models, echoing the concerns of Darzi (2024) that without strategic funding reform, ICSs risk becoming reactive rather than proactive in addressing public health challenges.

Structural disconnects within ICSs, noted by leaders within this study, have been previously documented as significant governance challenges (Lorne et al., 2019; Waring et al., 2023). The difficulties reported by ICS leaders regarding the misalignment between Integrated Care Boards (ICBs) and localised service needs reinforce arguments that governance frameworks in ICSs often lack the cohesion required for effective decision-making. The top-down nature of ICS structures means that strategic planning often occurs without fully incorporating the lived realities of local service provision, with the findings presented here re-emphasising the need for more place-based decision-making structures that empower local leaders to shape service delivery in line with their specific community needs (Sanderson et al., 2021).

Opportunities for benchmarking across ICSs, particularly those with similar demographics or structural features, could support the diffusion of effective leadership practices. Formal mentoring or peer support schemes may further strengthen leadership capability and resilience, especially for those navigating system-level roles for the first time. Overall, the findings of this study provide further empirical evidence to support calls for governance and funding reforms within ICSs. Without addressing the misalignment between national priorities and local service delivery needs,

alongside ensuring financial structures support long-term investment in prevention, ICSs will continue to face significant leadership challenges.

Conclusion

This study has highlighted the emerging challenges ICS leaders face in England as they navigate a complex and evolving landscape. While ICSs were introduced to foster greater collaboration and system-wide thinking, their leaders continue to struggle with governance complexity, resource limitations, and the structural disconnect between national mandates and local priorities. The rigidity of funding models, which prioritise acute care over preventative measures, exacerbates these challenges, making long-term investment in population health difficult to sustain. Additionally, the centralisation of decision-making authority often limits local flexibility, impeding efforts to tailor solutions to community-specific health needs.

Addressing the leadership challenges within ICSs is central to realising the potential of integrated care. The findings reinforce the need for targeted interventions to strengthen ICS leadership capacity, including developing leadership training programmes tailored to the complexities of system-wide working. Leadership development programmes should equip ICS leaders with the capabilities required to navigate multi-layered governance, manage financial constraints, and drive cross-sector collaboration. These include skills in strategic negotiation, adaptive leadership, systems thinking, and political astuteness.

This study represents a small-scale investigation of ICS leadership in one statutory context. Further longitudinal and multi-site research is needed to explore how leadership challenges and capacities evolve as ICS structures mature, offering a broader comparative perspective on ICS leadership dynamics. Longitudinal studies could also provide deeper insights into how leadership approaches evolve as ICSs mature, particularly in response to ongoing policy reforms and financial pressures. Additionally, exploring the impact of ICS leadership on patient outcomes and service delivery effectiveness would provide valuable evidence to inform policy and practice.

The author declares no conflicts of interest.

Key points

1. ICS leaders struggle to balance immediate operational demands with long-term strategic goals.
2. There is a significant disconnect between national performance metrics and local ICS priorities.
3. Financial constraints and rigid funding structures hinder the implementation of preventative care.

Key words

1. Integrated Care Systems
2. Health Services Administration
3. Leadership

4. Health Resources

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