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Integrated care system leadership: a rapid realist review

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Abstract

Purpose – Given the complex nature of integrated care systems (ICSs), the geographical spread and the large number of organisations involved in partnership delivery, the importance of leadership cannot be overstated. This paper aims to present novel findings from a rapid realist review of 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 a review of ICS strategies and guidance documents, a scoping review of the literature and 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, six 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 *et al.*, 2013).

Findings – The review informed four programme theories explaining that leadership in ICSs works when ICS leaders hold themselves and others to account for improving population health, a sense of purpose is fostered through a clear vision, partners across the system are engaged in problem ownership and relationships are built at all levels of the system.

Research limitations/implications – Despite being a rigorous and comprehensive investigation, stakeholder input was limited to one ICS, potentially restricting insights from varied geographical contexts. In addition, 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.

Originality/value – This review will be of relevance to academics and health-care 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 health-care systems.

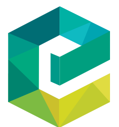
Keywords ICSs, Leadership, Realist review, Health and social care integration

Paper type Literature review

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) and 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



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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) emphasised 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. In addition, 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, although 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 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 used 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:

- 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; and
- to develop the IRPT into a refined programme theory based on empirical data published in the academic literature.

Methods

This study uses realist approaches to formulate theories for effective leadership in ICSs, focusing on desired outcomes (Pawson and Tilley, 1997; Wong *et al.*, 2017). Theories, termed

IRPTs, 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 used the context + mechanism = outcome 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.

This study built IRPTs 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 (CMOCs).

Search

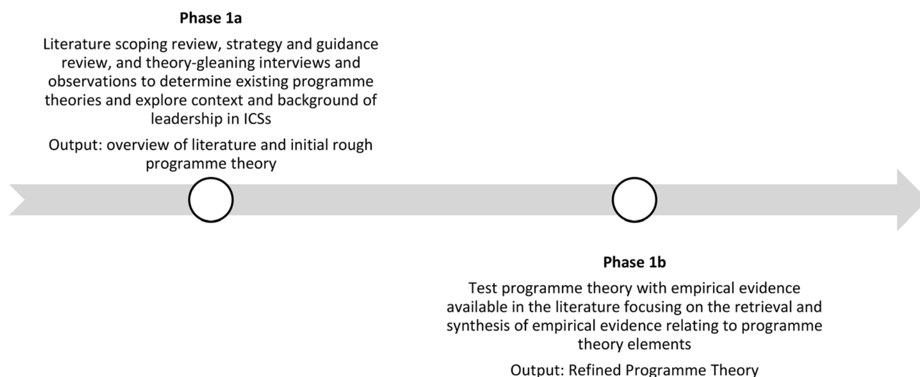
Adhering to RAMESES standards for transparency, this review targets literature post-2017, coinciding with the inception of England's ICSs. This timeframe aligns with the historical evolution of ICSs and the pilot phase resulting in a rapid realist review, that uses realist processes within a limited literature set (Wong, Westhorp, *et al.*, 2013, p. 18). Search strategy is available as *Supplementary File 3*.

Selection and appraisal

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

Data extraction

Each paper's characteristics, including objectives, study location, design and participants, were extracted. Focus was on identifying CMOCs and refining programme theory. Dalkin *et al.*'s (2015)



Source: Authors' own work

Figure 1. Phases in the development of initial programme theory

formula: M (resource) + C → M (reasoning) = O, and operational definitions of context, mechanism and outcome, as shown in Table 1, guided mechanism-context delineation.

Data synthesis

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

Programme theory development

Search results

After screening the initial 5,716 records by title and abstract, 99 records were screened by full text. In total, 22 records were evaluated for relevance (Alonso and Andrews, 2022; Aufegger *et al.*, 2020; Aunger *et al.*, 2022b; Bell *et al.*, 2022; Chang, 2021; Elliott *et al.*, 2020; Embuldeniya *et al.*, 2018; Gordon *et al.*, 2020; Harlock *et al.*, 2020; Kozlowska *et al.*, 2020; MacLeod *et al.*, 2019; Martin, 2021; Martin and Knowles, 2019; Miller and Stein, 2020; Mitchell *et al.*, 2020; Nicholson *et al.*, 2018; Pearson and Watson, 2018; Robert *et al.*, 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. Three 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.

Integrated care systems 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 and Social Care, 2021; Department of Health and Social Care, 2022a, 2022b; National Audit Office, 2022;

Table 1. Operational definitions of context, mechanisms and outcomes

	Operational description
Context	A situation or condition that existed before the formation of ICS, or a situation or condition outside of the control of ICS that is relevant to the leadership of ICS and may change over time
Mechanism	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)
Outcome	Result or consequence of ICS leadership (intended or unintended)

Source: Authors' own work

NHS Employers, 2022; NHS England and NHS Improvement, 2021a, 2021b, 2021c, 2022, 2021d, 2021e).

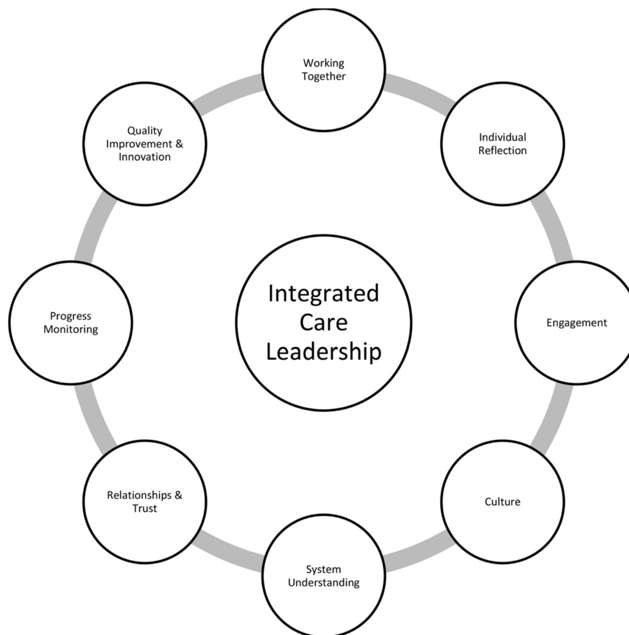
The scoping exercise highlighted essential elements for effective leadership in integrated health and social care, encompassing individual leader traits and structural considerations, detailed in Figure 2.

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

Working together. Integrated care leadership involves tackling complex “wicked” problems and managing conflicts (Hulks *et al.*, 2017; Social Care Institute for Excellence, 2018). Leaders must collaborate, share powe, and use distributed leadership approaches (Aunger *et al.*, 2022b; Baylis and Trimble, 2018; Harris *et al.*, 2022; Miller and Stein, 2020). Clear governance structures and data sharing are crucial for managing risk and decision-making (Booth-Smith, 2017; Cheng and Catallo, 2019; Harris *et al.*, 2022).

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

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



Source: Authors’ own work

Figure 2. Literature scoping key themes

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

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

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

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

Substantive theory

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

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). While there are many types of "systems" within health-care and leadership contexts, in this paper the term "system" is used to refer to ICSs.

NHS North West Leadership Academy Doing Things Differently system leadership behaviour 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 and 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 context–mechanism–outcome configurations

The original nine CMOCs supporting programme theories, with two each for Being, Leading and 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 with the original nine CMOCs. Four CMOCs (1, 6, 7 and 8) had empirical support with refinements, one (3) lacked evidence and four (2, 9, 4 and 5) were merged because of insufficient distinct evidence, resulting in the following six CMOCs.

Initial programme theory (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 minimising miscommunications. The lack of this clear vision contributes to management challenges (Aufegger *et al.*, 2020; Aunger *et al.*, 2022b; 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).

IPT: Leading and 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 well-being, reducing the impact of health and social inequalities (O).*

CMOC 1 emphasises a clear, sustained vision for ICS objectives, mandating partner action, whereas CMOC 2 focuses on mutual accountability through partner engagement in developing and measuring ICS priorities (Sims *et al.*, 2021). Empirical literature underscores involving all stakeholders, including the public, in setting local ICS priorities, especially in early integration stages (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). This involvement aims to address broader ICS goals like population health, illness prevention and reducing health inequalities.

IPT: Relating and communicating.

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

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

IPT: Delivering.

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

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

CMOC 5: 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 or prioritisation of local communities so they can access services (O).

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

CMOC 6: In the context of developing a culture of accountability (C), clear governance structures and transparent decision-making, with a robust process for monitoring and evaluation (M-Res), ensure partners accountability for quality, value for money and effective service provision (M-Rea), which leads to the achievement of system outcomes (O).

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

Discussion

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

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

This aligns with previous realist reviews on integrated care leadership (Aunger *et al.*, 2022b; Harris *et al.*, 2022), explaining how relationships bolster effective ICS leadership. Aunger *et al.* (2021a) have previously noted the complexity involved in health and social care partnerships, like ICSs, due to the large number of organisations coming together across sectors; impacting not only effective communication but hindering the development of trust due to previously established competitive approaches. This resonates with our

findings; we argue that historical imbalances in cross-sector organisational partnerships impact collaborative working and the development of trust. Aunger *et al.* (2021a) suggest a clear patient focus from all parties across the system as a means to overcome these pre-existing differences and conflicts; this is linked to our notion of a "shared sense of purpose".

Our research builds on existing realist-informed studies of health-care partnerships or collaboration (Aunger *et al.*, 2021a; Aunger *et al.*, 2021b, 2021c; Aunger *et al.*, 2022a, 2022b), and in particular recent realist reviews focused on leading in integrated care (Harris *et al.*, 2022; Sims *et al.*, 2021) by providing a specific focus on ICS leadership and offering Programme Theories as guidelines for ICS leadership development.

This rapid realist review was based on leadership within ICSs and informed, in part, by key informant interviews with leaders from a regional ICS. However, the results can be applied to ICSs across England, with the 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 the 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 the context of developing a culture of accountability can reduce partner accountability for quality, value for money, and effective service provision, limiting the achievement of system outcomes. Table 2 offers Programme Theories as guidelines for ICS leadership development.

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

Table 2. Theories of effective ICS leadership using doing things differently: rethinking leadership behaviours as an organising framework (NHS North West Leadership Academy, 2021)

Delivering	Effective ICS leaders hold themselves and others to account for improving outcomes for the local population. They use 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
Being	Effective ICS leaders communicate a clear vision, fostering a sense of purpose across the system regarding the achievement of agreed ICS outcomes
Leading and 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 and 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

Source: Authors' own work

investigation, stakeholder input was limited to one ICS, potentially restricting insights from varied geographical contexts. Additionally, the recent establishment of ICSs has 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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Further reading

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Supplementary material

The supplementary material for this article can be found online.

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