Understanding key mechanisms of successfully leading integrated team-based services in health and social care: A realist synthesis

Ruth Harris,[1]* Simon Fletcher,[2] Sarah Sims,[1] Fiona Ross,[2] Sally Brearley,[2] Jill Manthorpe.[3]

[1] Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London, London, UK.
[2]Faculty of Health, Social Care and Education, Kingston University and St George's University London, London, UK.
[3]NIHR Policy Research Unit in Health and Social Care Workforce, King's Policy Institute, King's College London, London, UK.

*Corresponding author Ruth.Harris@kcl.ac.uk Tel. No.[redacted]

Keywords

Integrated care, leadership, integration, multiteam systems.

Acknowledgement

This project was originally conceived and developed with the late Professor Scott Reeves, who died unexpectedly on May 3rd 2018. Scott, a global research leader, was first and foremost a sociologist and ethnographer. He brought his sociological lens to the study of wicked problems of health and social care professional relationships, in their learning and their work. His original ideas and considerable expertise in interprofessional healthcare research were instrumental in the formation of this study and the research team dedicate this project to his memory.

Potential conflict of interest

- Ruth Harris is a member of the National Institute for Health Research (NIHR) Trainees Coordinating Centre Doctoral Research Fellowship Panel (TCCDRF).
- Fiona Ross is Chair of Trustees of Princess Alice Hospice, Independent Governor at Westminster University and a member REF England Equality and Diversity Advisory Panel.

- Jill Manthorpe is Panel Chair of the NIHR Policy Research Programme (PRP) (ended Jan 2021), reviewer for NIHR PRP, panel member and reviewer for NIHR Research for Social Care, NIHR Academy - reviewer, panel member Senior Fellowships, NIHR PRP Covid Response (Renew, Reset and Recover) Co-Chair of 3 Panels, Health & Social Care Research & Development Division of the Public Health Agency (Northern Ireland), Leverhulme Trust 2021, Norwegian Research Council panel member, May 2021, Guy's and St Thomas Charitable Trust, Long Term Conditions panel, and Chair, May 2021, Long Covid panel member, NIHR June 2021, NIHR Research for Patient Benefit, Mental Health North, Panel member June 2021, Member NIHR Strategy Board, Member: Chief Social Worker for Adult Research Reference Group DHSC, Member: Adult Social Care Strategy Forum, DHSC, NIHR Multiple Long-term Conditions Oversight Group, NIHR Policy Research Unit Older People and Frailty Advisory Group, Member Advisory Group Growing Older, Planning Ahead, University of Oxford /Open University NIHR HSDR, NIHR Dementia Strategy Advisory Group, Chair UKRI OSCAR study advisory group, Cardiff University, Member Steering Group, appointed by NIHR, Experts 11, London School of Hygiene and Tropical Medicine, Member Advisory Group, Advanced Care Research Centre, University of Edinburgh, Member D-PACT, Advisory group, appointed NIHR, University of Plymouth, 2020-21, Member advisory group ExChange Wales, University of Cardiff, Board member NIHR Applied Research Collaboration (ARC) South London, NIHR National Priority Area Social Care and Social Work Applied Research Collaboration (ARC)

Important

A 'first look' scientific summary is created from the original author-supplied summary once the normal NIHR Journals Library peer and editorial review processes are complete. The summary has undergone full peer and editorial review as documented at NIHR Journals Library website and may undergo rewrite during the publication process. The order of authors was correct at editorial sign-off stage.

A final version (which has undergone a rigorous copy-edit and proofreading) will publish as part of a fuller account of the research in a forthcoming issue of the Health Services and Delivery Research journal.

Any queries about this 'first look' version of the scientific summary should be addressed to the NIHR Journals Library Editorial Office – journals.library@nihr.ac.uk

The research reported in this 'first look' scientific summary was funded by the HS&DR programme as project number 18/01/06. For more information visit https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/180106/#/

The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors have tried to ensure the accuracy of the authors' work and would like to thank the reviewers for their constructive comments however; they do not accept liability for damages or losses arising from material published in this scientific summary.

This 'first look' scientific summary presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR Programme or the Department of Health and Social Care. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR Programme or the Department of Health and Social Care.

Scientific Summary

Background: As the organisation of health and social care in England moves rapidly towards greater integration, the resulting systems and teams will require distinctive leadership. However, little is known about how the effective leadership of these teams and systems can be supported and improved. In particular, there is little understanding of how effective leadership across integrated teams and systems may be enacted, the contexts in which this might take place and the subsequent implications this has upon integrated care.

Objectives: This review developed and refined programme theories of leadership of integrated teams and systems in health and social care, exploring what works, for whom and in what circumstances, to produce recommendations for policy makers, health and social care leaders, managers and clinicians. The objectives of the review were:

1. To investigate who are the leaders of integrated care teams and systems and what activities contribute to their leadership roles and responsibilities.

2. To explore how leaders lead integrated care teams and systems that span multiple organisations, agencies, and sectors.

3. To develop realist programme theories that explain successful leadership of integrated care teams and systems iteratively through stakeholder consultation and evidence review.

4. To identify the development needs of the leaders of integrated care teams and systems.

5. To provide recommendations about optimal organisational and interorganisational structures and processes that support effective leadership of integrated care teams and systems.

Methods: Following realist synthesis methodology and informed by the RAMESES publication standards for realist syntheses, the literature searching was split into two distinct phases; Stage 1 and Stage 2. This literature searching was also informed by consistent stakeholder engagement, who offered critical insight as the findings were refined.

Stage 1: A detailed search strategy designed in collaboration with Information Services Specialists was run in the following databases: Embase, HMIC, Social Policy and Practice, CINAHL, Medline, International Bibliography of Social Sciences, PsychInfo and Education Research Complete. A total of 1,446 empirical research papers were identified, of which 532 duplicate papers were removed, leaving a total of 914 papers for review. These papers were divided between two reviewers, who read the abstract only to determine whether it was relevant to the focus of the review. The inclusion criteria were broad, although inclusion was kept within health and social care contexts at this stage. We deemed 848 research papers not relevant and therefore these were excluded from the review, leaving a total of 66 research papers. These papers were divided between two reviewers and read in full. Forty-three papers were deemed not relevant and excluded from the review, leaving a total of 23 research papers. Forty-one pieces of grey literature were also identified and read in full by one reviewer. After reading in full, 27 pieces of grey literature were excluded from the review leaving a total of 14. Thirty-seven papers (23 empirical research, 14 grey literature) were therefore included in the first phase of the stage 1 search. These papers were divided between three reviewers who each independently compiled a list of preliminary mechanisms. Following stakeholder consultation, it was agreed that to develop these preliminary mechanisms further, the search would need to be expanded beyond health and social care. This led to the further inclusion of 12 studies. The above process was repeated and led to the identification of 10 preliminary mechanisms.

Stage 2: A second stage search was undertaken to look specifically for any empirical evidence of the 10 preliminary mechanisms. A second search of the following databases was undertaken: Social Policy and Practice, Education Research Complete, Social Care Online, Scopus, CINAHL, MEDLINE, International Bibliography of the Social Sciences, EMBASE, Health Management Consortium, PSYCHINFO and PubMed. Handsearching of the Journal of Interprofessional Care, Journal of Integrated Care and International Journal of Integrated Care was also undertaken. Five thousand, six hundred and seventy-three papers were identified at this stage and all abstracts were read by two reviewers. We excluded 5,253 papers, due to either being duplicates or being deemed not relevant, leaving a total of 420 remaining papers. A further 22 papers were suggested by the study stakeholder group and added into the documents for review, along with: two further papers that were picked up in the Stage 1 searches but not Stage 2; 11 papers identified through searching reference lists of relevant papers and 3 papers recommended by the study team. This initially resulted in 458 possible papers, although 16 of these were inaccessible through library resources. A total of 442 papers were therefore divided between two reviewers and read in full. At this stage, the researchers were only seeking empirical research based in health and/or social care settings and a data extraction form was created and completed for each paper read. In line with realist synthesis methodology, conventional approaches to quality appraisal were not used. Rather, each study's

'fitness for purpose' was assessed by considering its relevance and rigour. Of the 442 papers read in full, 36 papers were included. The evidence collected from these 36 papers was synthesised by drawing together all information on contexts, mechanisms and outcomes and comparing similarities and differences to build a comprehensive description of each mechanism and its role in the leadership of integrated care teams and systems.

Results: From the 36 research papers included in this synthesis, there was empirical evidence for seven of the originally identified mechanisms. These were:

- 'Inspiring intent to work together'
- 'Creating the conditions to work together'
- 'Balancing multiple perspectives'
- 'Working with power'
- 'Taking a wider view'
- 'Commitment to learning and development'; and
- 'Clarifying complexity'.

There was insufficient evidence to identify two of the original mechanisms ('Adaptability of leadership style' and 'Planning and coordinating') as mechanisms in themselves, therefore they were incorporated into the remaining seven mechanisms. There was no evidence for the mechanism, 'Fostering resilience'. Findings for each mechanism were divided into two sections – those components of the mechanism that were identified at a systems leadership level and those that were identified at a team level. In some cases, the same components were identified as important for leaders at both levels. The key characteristics of these mechanisms were then described and interpreted through Context, Mechanism, Outcome (CMO) configurations with a view to identifying the central components of effective leadership and the optimum conditions under which it is activated. These mechanisms, their description and subsequent realist interpretation were presented to the stakeholder consultation group and refined through further interrogation, reflection, and discussion. Key findings and questions from these analyses were as follows:

- **There is a paucity of empirical evidence.** There was little evidence that specifically addressed leadership of integrated care teams and systems despite the widespread policy rhetoric and partial implementation of this model of organising services.
- **There is an emphasis on the individual/personal qualities of the leader.** The strongest evidence found in the review was around how leaders inspired people's intent to work together within integrated care. This evidence focused on who the leader *is* rather than what the leader *does.*
- **There is an absence of evidence of the patient/service user perspective.** It was a stark finding that we found no evidence of the patient/service user perspective of leadership or involvement in leadership of integrated care teams and systems.

- **The importance of power is underestimated.** The nature of power was deemed to be far more complex and nuanced than the evidence suggested, and questions remained about how leaders of integrated care teams and systems saw their power and reasoned how to use it.
- **The benefits and barriers of pre-existing networks require further investigation.** Drawing upon pre-existing networks resulted in a tendency to drift towards organisational, cultural, and professional familiarities, which was likely to narrow the focus of innovation. This may also inadvertently be a barrier to diversity within leadership.
- **There is little practical guidance about how to lead within integrated care teams and systems.** Throughout the evidence, only general statements of the important activities that leaders do in leading integrated care teams and systems were provided. These offered very little explanation about how leaders undertook these activities, their reasoning of what the best approach would be, the trade-offs they may have made, and the challenges they encountered.

Conclusions: To our knowledge, this is the first theory-informed realist review of leadership of integrated care teams and systems. It makes a significant contribution to the understanding of what is known and, perhaps more importantly, to the gaps in the empirical evidence. However, making explicit some of the assumptions about how leaders lead integrated care teams and systems has provided new perspectives, offering fresh theoretical grounding that can be built on, developed, and tested further.

Strengths and limitations: A key strength of the study was the use of a realist review approach. This has enabled the complexity of leadership in integrated care to be explored in depth, even with the lack of empirical evidence. Another strength was evident in the consistent collaboration with the stakeholder consultation group, as their insights supplemented and went beyond what was found in the literature. Challenges included defining the terms 'integrated care team' and 'integrated care system', as existing definitions described what they did rather than what they were. There was also a lack of terminological distinction between 'leader' and 'manager', which were often used interchangeably.

Implications: The prominence of the policy imperative to expand implementation of integrated care systems throughout England and the importance of leadership to achieve this, highlight the contribution of this review. Key implications are as follows:

- **Implications for governance structures.** There are implications for governance structures, as new legislation to create a 'legal form' of integrated care systems is expected in 2021. The findings of this review suggest that it would be very important to ensure that legislation provides clear power sharing requirements to protect social care and non-NHS organisations from being disadvantaged.
- **Implications for education preparation of leaders of integrated care teams and systems.** Important considerations for leadership education were also highlighted. These include the

importance of understanding the whole system, which suggests that leaders need a wider understanding of organisations. In addition, the highly complex, dynamic nature of leading integrated care teams and systems and the imperative to adapt to varied circumstances demonstrates that leaders need to develop a viable sense of self-as-a-leader and be comfortable with uncertainty and ambiguity, rather than the command and control approach that is common in the NHS. Leadership training needs to encompass bespoke, individualised mentoring/coaching programmes. Approaches that increase exposure and understanding of other sectors may also be useful, such as work placements, coaching, and secondments.

- **Implications for individual leaders and integrated care teams and systems.** To our knowledge this is the first realist review in this area and offers leaders insights about their actions that potentially affect care delivery and outcomes, and team and system working. We hope this understanding supports leaders to reflect on their practice and factors that may support them in their work.

Future research: In initial theory development, we identified political astuteness as being necessary for leading integrated care teams and systems, but we found no mention of it in the research evidence. The expert stakeholders advised that leaders cannot operate without a sense of political leadership and therefore this area warrants research. Research is also required to understand the reasons why the individual characteristics of leaders and 'hero leadership' are so prominent and how leaders can be supported to be able to take a processual approach to leading that is more comfortable with complexity and uncertainty in the system. There is also scope to more fully investigate the notion of 'fostering resilience' in leaders, what this means and how it develops. While there was no research evidence about this, our expert stakeholders were concerned that this may mask anxiety and avoid adequate management. They suggested it would be useful to explore the cultures that leaders set around this.

Study Registration: This study is registered as Prospero 2018 CRD42018119291. Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42018119291

Funding: Funding for this study was provided by the National Institute for Health Research Health Services and Delivery Research programme number: 18/01/06.