Developing programme theories of leadership for integrated health and social care teams and systems: a realist synthesis

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

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Scientific summary

Programme theories of leadership

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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 on 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 to:

- investigate who are the leaders of integrated care teams and systems and what activities contribute to their leadership roles and responsibilities
- explore how leaders lead integrated care teams and systems that span multiple organisations, agencies and sectors
- develop realist programme theories that explain successful leadership of integrated care teams and systems iteratively through stakeholder consultation and evidence review
- identify the development needs of the leaders of integrated care teams and systems
- 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 Realist And Meta-narrative Evidence Syntheses: Evolving Standards (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 the consistent engagement of stakeholders, 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, Health Management Information Consortium (HMIC), Social Policy and Practice, Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, International Bibliography of Social Sciences, PsycINFO and Education Research Complete. A total of 1446 empirical research papers were identified, of which 532 were duplicates and 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 or not 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 that 848 research papers were 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. In total, 37 papers (empirical research, $n = 23$; grey literature, $n = 14$) 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. The second search comprised a search of the following databases: Social Policy and Practice, Education Research Complete, Social Care Online, Scopus, CINAHL, MEDLINE, International Bibliography of the Social Sciences, EMBASE, HMIC, PsycINFO and PubMed. Hand-searching of the *Journal of Interprofessional Care*, *Journal of Integrated Care* and *International Journal of Integrated Care* was also undertaken. In total, 5673 papers were identified at this stage, and all abstracts were read by two reviewers. We excluded 5253 papers because they were either duplicates or deemed not to be relevant, leaving a total of 420 papers. A further 22 papers were suggested by the study stakeholder group and added into the documents for review, along with two 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 three papers recommended by the study team. This initially resulted in 458 possible papers; however, 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 seeking only 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. Instead, 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:

1. inspiring intent to work together
2. creating the conditions to work together
3. balancing multiple perspectives
4. working with power
5. taking a wider view
6. commitment to learning and development
7. clarifying complexity.

There was insufficient evidence to identify two of the original mechanisms ('adaptability of leadership style' and 'planning and co-ordinating') 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 of and barriers to pre-existing networks require further investigation. Drawing on 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 in 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 that they may have made and the challenges that 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, it highlights 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 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 its 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, highlights 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 2022. 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 and 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 to 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 that 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 fully investigate the notion of 'fostering resilience' in leaders, what this means and how it develops. Although there was no research evidence about this, our expert stakeholders were concerned that this may mask anxiety and avoid adequate management. They suggested that it would be useful to explore the cultures that leaders set around resilience.

Study registration

This study is registered as PROSPERO2018 CRD42018119291.

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