

Leadership in integrated care systems:

Report prepared for the NHS Leadership Academy

Introduction

The NHS Leadership Academy commissioned SCIE to undertake this research to further expand the understanding of systems leadership and leadership of integrated care systems. This research will inform the Leadership Academy's long-term plans for supporting leaders in integrated care systems. This paper, aimed at chief executives, directors and senior managers from the NHS, local authorities, housing organisations and voluntary and community sector, is based on findings from interviews with systems leaders and a review of the literature. Quotes from these leaders are presented throughout the report.

Key messages

- Integrated care systems (ICSs) are a critical part of 'the biggest national move to integrating care of any major western country'.³
- With no basis in law, ICSs are entirely dependent on a collaborative approach to leadership and a willingness on the part of the organisations involved to work together.
- Leadership in ICSs is very much a form of systems leadership, but with new and unique challenges, such as the need to exert influence across an even larger range of organisations and co-produce services with people who use them.
- Effective systems leadership relies on a composite set of capabilities and behaviours, which can be grouped under the following four domains (NHS Leadership Academy Systems Leadership Framework):
 - ✓ innovation and improvement
 - ✓ relationships and connectivity
 - ✓ individual effectiveness
 - ✓ learning and capacity-building.

- Leaders in ICSs need to be skilled at:
 - ✓ identifying and scaling innovation (e.g. from pilots)
 - ✓ having a strong focus on outcomes and population health
 - ✓ building strong relationships with other leaders, and often working with them informally to develop joint priorities and plans
 - ✓ establishing governance structures which drive faster change, often going where the commitment and energy is strongest
 - ✓ setting the overall outcomes and expectations on behaviours, but handing day-to-day decision-making to others
 - ✓ supporting the development of multidisciplinary teams (MDTs)
 - ✓ designing and facilitating whole-systems events and workshops to build consensus and deliver change
 - ✓ understanding and leading cultural change
 - ✓ building system-wide learning and evaluation frameworks
 - ✓ fostering a learning culture across the whole system.
- Leaders told us that they would welcome support in the following areas:
 - ✓ skilled external facilitation, to help deliver complex programmes
 - ✓ the creation of 'safe spaces' for leaders to meet with peers and share problems and solutions
 - ✓ more opportunities to learn from other professions and sectors

- ✓ systems leadership development for middle managers across the system
- ✓ masterclasses on:
 - co-production theory and practice
 - finance and risk-sharing
 - scaling innovation
 - understanding local government and social care
 - large-scale and large-group facilitation
 - working and influencing across multiple layers of governance.

Context

Our health and care system is experiencing unprecedented pressures. The population is rising and ageing, and more people are living with complex and long-term conditions. Funding is hugely constrained and there are vacancies and skills gaps across the workforce. For decades, it has been widely agreed that breaking down organisational barriers through better integration has the potential to deliver higher quality care that achieves better outcomes and uses resources more efficiently. Yet this goal remains elusive in practice.

The drive towards integrated care gained new form and impetus with the publication of the NHS 'Five year forward view' (2014),¹ and 'Next steps on the NHS five year forward view' (2017).² These required NHS commissioners and providers to work together to develop sustainability and transformation partnerships (STPs) to improve services, taking a population-based approach to their geographical 'footprints'.

Where such strategic partnerships and collaboration are most advanced, STPs have now developed further to create integrated care systems (ICSs) – where NHS commissioners, providers and local councils work collaboratively, taking collective responsibility for resources and population health. ICSs have no statutory basis, but depend on voluntary collaboration between NHS and local authority leaders to develop a shared, system-wide approach to strategy, planning and commissioning, financial and performance management, and driving integration of care and services.

The first 10 ICSs started in 2017, and four more were announced in 2018. NHS England intends that other areas will become ICSs over time. Effective systems leadership will clearly be crucial to the success and impact of ICSs. Integrated systems require distinctive leadership skills and a unique strategic perspective that may differ significantly from traditional ways of leading health and care organisations.

This paper looks at the components of effective systems leadership in the context of ICSs and STPs. Drawing on an evidence review and interviews with ICS leaders, we explore how they are working in a system-wide way across organisational boundaries, and the leadership skills and qualities they require. The paper also looks at the challenges and barriers to effective systems leadership in ICSs, and what enables people to overcome them. Finally, it sets out ways in which the support and development needs of systems leaders can be addressed.



Policy and operational context

The 2014 NHS 'Five year forward view'¹ represented a major policy shift away from a competition-based model of health care, towards collaboration and integration. It recognised that organisations working together, sharing know-how and resources, were more likely to meet the significant challenges of rising demand, limited funding and the need to improve outcomes and patient experience. Simon Stevens, Chief Executive of NHS England, recently called it 'the biggest national move to integrating care of any major western country'.³

The first 10 ICSs vary considerably in geography, demography, population size, drivers for change and number of partners involved. But they also have many characteristics in common:

- They are collaborative, involving NHS commissioners, providers, GPs and local authorities.
- They are place-based.
- They adopt a population-based approach.
- They focus on outcomes.
- They focus on preventing ill health.
- They promote a shift towards more care in the community and people's homes, rather than hospital.
- They have a shared responsibility for delivering strategy and outcomes.
- They share resources and financial risk (financial 'system control totals').
- They are given more autonomy from the centre, including financial autonomy.

ICSs are an example of integration at **organisational, strategic** and **planning** levels. They are intended to underpin, and result in, integrated care at **service** and **patient** levels. The governance and delivery structure can be complex, and is not underpinned by a statutory framework. Professor Chris Ham of The King's Fund described the approach as follows:

"It is important to recognise that ICSs have no basis in law and are entirely dependent on the willingness of the organisations involved to work together. NHS trusts and CCGs (clinical commissioning groups) have their own statutory duties and members of their boards may need reassurance that these duties are not being compromised by ICSs... Different accountabilities in the NHS and local government may also cause tension."⁴



ICSs are part of a larger drive towards collaboration and integration that affects the whole of the English NHS. At the very least, all NHS commissioners, providers and local authorities in England are now expected to be involved in STPs, which necessarily means working together and focusing on place and local population. Many are testing new models of care and some are developing integrated care partnerships (ICPs) – these adopt a looser approach to collaboration than ICSs, focusing on delivery without formalised collective responsibility and shared risk.

By their nature all these approaches are experimental, but expectations are high. NHS England hopes that the early ICSs will generate learning for the whole of the health and care system, while also producing meaningful benefits in terms of outcomes, patient experience and efficiencies.

ICSs are set to become a permanent feature of the health and social care landscape. Michael MacDonnell, National Director, Transforming Health Systems at NHS England, recently made it clear that collaboration and integration will remain central to the forthcoming 10-year NHS plan:

“The long-term plan for the NHS, which will be published in the autumn, will set out how we intend to catalyse [ICSs] across the country, supercharging their spread. These systems are the opportunity and the vehicle for providers to be at the forefront of evolving a health service fit for the next 70 years.⁴”



Features of effective systems leadership

The leadership model for health and care continues to shift from one that is hierarchical and focused on a single organisation, to one that involves leading change across a whole range of organisations using influence rather than management direction.

This shift is described in Figure 1.

Figure 1 Leadership model for health and care

1. Hierarchical
2. Fixed, prescriptive
3. Power-centred
4. Focused on individual organisations
5. Territorial, proprietary, centralised
6. Professional-driven
7. Transactional
8. Primarily accountable to regulators and policy-makers
9. Self-centred
10. Short-term, task-focused
11. Avoids conflicts
12. Competitive, conflict-prone

1. Horizontal, multidirectional
2. Adaptive, comfortable with chaos
3. Seeks to influence
4. Place-based, whole system
5. Complementary, diffused, distributed, participatory
6. Person-centred, inclusive, co-productive
7. Relationship-based, personal
8. Primarily accountable to people and communities
9. Altruistic
10. Long-term, focused on transformation of whole system
11. Surface conflicts, solution-focused
12. Consensus seeking, builds a shared vision and narratives

Leadership in ICSs is very much a form of systems leadership, but those in leadership roles told us they face a different and more complex set of challenges. It was described by one leader as 'turbocharged' systems leadership. The role of systems leaders is emergent and evolving, and the support they need is also likely to evolve further.

Leaders told us that they were expected to manage the following new demands.

- **Span of influence** – leaders in ICSs need to influence change across an even broader group of organisations and stakeholders, such as public health, housing, children's social care, mental health and the voluntary community sector.
- **Co-creation and co-production** – leaders told us that to ensure that change on this scale 'sticks', you need to co-design and co-produce solutions with those who receive health, care and support, and work effectively with elected politicians

- **Place-shaping** – leaders told us that there is an even stronger emphasis than before on focusing on people and place, and understanding how strategic plans relate to very locally-based neighbourhood teams. Understanding how to commission and deliver population improved health is another important skill.
- **Leading large-scale change** – leaders in ICSs increasingly need to be skilled at leading complex, large-scale change, through excellent facilitation and influencing skills.
- **Tackling 'wicked' issues** – systems leaders have always dealt with complex, multifaceted problems, but some believe challenges are becoming even more complex, evading traditional solutions. Examples of 'wicked' issues include: regional estates strategies; cross-system workforce planning; shifting care out of hospitals and into communities; and planning for the winter.

- **Building commitment within organisations** – leaders need to focus on how they can build systems leadership skills deeper within organisations, engaging middle managers, and leaders of MDTs in their thinking.

“There is an important role for us as senior leaders to build the vision and make the strategic connections. But, increasingly, systems leadership will operate within neighbourhood teams (MDTs).”

(Local government leader, ICS)

The findings of this study are structured around the four domains of the NHS Leadership Academy’s Systems Leadership Development Framework:

- Innovation and improvement
- Relationships and connectivity
- Individual effectiveness
- Learning and capacity-building.

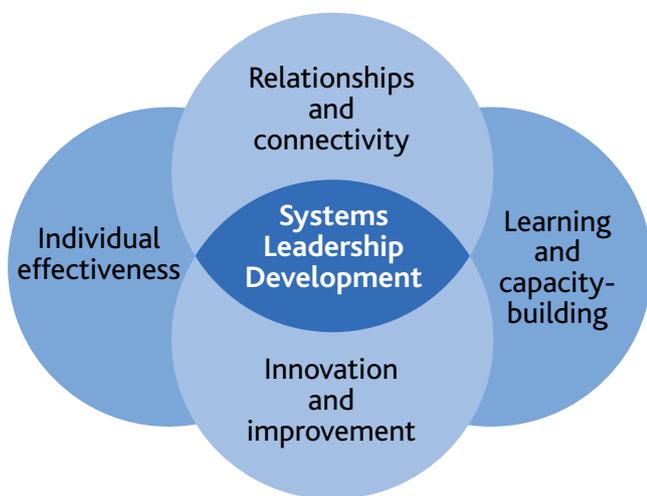


Figure 2 Systems Leadership Development Framework

Innovation and improvement

The leaders of ICSs told us that they are increasingly expected to understand how to develop the right conditions locally to foster innovation. They are also expected to understand how to scale innovation (e.g. from a pilot or new model of care developed elsewhere, to other parts of the local system). This means that leaders must encourage colleagues to test new approaches and learn from innovations (e.g. in areas such as technology and self-care), and they must be ready to offer additional support to staff if and when an innovation does not succeed.

“I am thinking more and more about how we support thriving communities, building on people’s assets. Yes I have to track whether we are bringing down unnecessary referrals, but in the long run we need to be all focusing on these longer-term outcomes for communities.”

(Senior clinician, ICS)

Leaders in ICSs told us that they need to have a strong focus on outcomes. They must be able to steer conversations and decisions away from organisational-specific objectives, towards broader outcomes for communities, such as reducing social isolation and promoting self-care. This is likely to mean that over time there will be less focus on traditional hospital-based metrics, and greater attention to the wider determinants of health, such as people feeling socially connected and able to support their own care.

As well as workshops involving staff and the public, mechanisms for senior leaders from across the system to come together and have honest face-to-face discussions are crucial. Leaders told us that using skilled external facilitators had been vital in enabling them to build trust, bring tensions to the surface and discuss difficult issues. In this context, NHS Leadership Academy interventions around whole-group leadership development were welcome.

Relationships and connectivity

Leaders of ICSs need to be able to build productive relationships. They told us that they spend more time than ever before developing good relationships with colleagues and, as part of this, trying to listen to and empathise with their concerns and issues. Often these relationships are fostered outside formal meetings, with lots of 'pre-work' on the phone or over coffee to prepare for more formal partnership meetings.

Leaders must also be able to establish governance structures which drive faster change, rather than being beholden to complex arrangements no longer fit for purpose. People spoke about the need to sometimes break up existing structures when they are not performing, and go where the energy is strongest or where there are governance structures that work well already.

"I don't have a team like a traditional leader. I am building one, but I don't have a team to make things happen. That means core to my role is the ability to influence others to do things for you. You need to be good at convincing people of the need to deliver an outcome and why we need to work together on something.

For accountable care to work effectively, key partners in the system need to build credible and resilient relationships and be very clear and honest with each other about what their collective focus and priorities should be for the health and care system."

(Chief executive of NHS organisation and leader in ICS)

To make change happen on this scale, leaders need to be increasingly effective at working collaboratively – not only with staff from across the system but also with patients, people who use services, elected politicians and citizens. Changes cannot be imposed but must be supported by the wider community. In Frimley Health and Care ICS, for instance, they have recruited and developed 'community champions' to reach out to communities, and in Surrey Heartlands they have established a resident panel to get involved in service co-design.

"Systems leaders probably spent 10 to 20 per cent of their time on partnership activity 10 years ago. Now it needs to be 50 per cent to focus effectively on collective aims."

(Local government leader, ICS)

Leaders told us, however, that good stable leadership relationships take time to build. Some of the most successful ICSs have long-standing and trusting relationships across the senior level in the system.

Leaders spoke to us about how their roles were often highly challenging and isolating. Those new to a leadership role, in particular, need greater support and encouragement and a recognition that it takes time to develop the capabilities and behaviours required to lead challenging systems.

Individual effectiveness

Leaders of systems are unlikely to succeed in such a complex and diffuse operating environment if they seek to control or direct change. Leadership in ICSs is more about setting an ambition and the direction of travel, the goals and the behaviours expected. The onus is on leaders to build a distributed leadership model, and foster a culture of leadership at all levels within the system.

“It can be described as tight and loose leadership – being clear that we expect certain outcomes and behaviours and being tight around this – but trusting your managers to get on with delivery and at times letting them fail – being loose.

This is absolutely key to it and big learning for some of our more traditional leaders – it is about influence, collaborative working, facilitation, trying to learn and share understanding, and work across different perspectives. What it is not about is leading from the front, being directive, taking a command and control approach – it is the opposite of that.”

(Chief executive of NHS organisation and leader in ICS)

ICS leaders are increasingly expected to support the development of MDTs, a process which is being accelerated under ICSs. In practice, this means you need to be good at building the right conditions in which MDTs can thrive (e.g. working with leaders from other agencies to remove barriers to data-sharing and budget-pooling, devolving more decision-making to MDT leaders and encouraging joint staff development).





Case study: A new vision of care for people with frailty or complex conditions

Frimley ICS set up a review of the way care was provided for people with frailty or complex needs.

“The starting point for this work was the question, how can we pool our expertise so that services we develop are built on the best of what is happening locally and nationally?”

(Senior clinician, ICS)

The review involved CCGs, the local authorities, NHS foundation trusts, the ambulance service, patient groups, the voluntary sector and the local community.

The design group involved around 40 clinicians, social care staff, and people from local patient and community groups. A steering group was also established.

A key theme throughout was an emphasis on treating frailty more like other long-term conditions. Thus, rather than waiting for a crisis to happen and then responding to it, the aim was to start systematically and consistently identifying those at risk of frailty.

The design group produced a new vision of care:

- Promote health, wellbeing and the quality of our lives.
- Respect our choices and capabilities and encourage us to influence the care and support we receive.
- Help us maintain independence for as long as possible.
- Be driven by our goals and ambitions and those of our family and carers.
- Be easy to navigate day or night.
- Make the right thing to do the easy thing to do.
- Be holistic and integrated, making best use of the strengths of the local system including the voluntary sector.
- Be high quality.
- Require us to tell our story only once by sharing our information securely with those who need to know.
- Be adaptive, flexible, sustainable and affordable.
- Be well governed.
- Feature excellent safeguarding.

The new vision of care created a new model and a set of guiding principles which have shaped the collaborative work of health and care organisations in East Berkshire and Frimley, and have become part of Frimley ICS.

Those we interviewed also talked about the importance of systems leaders having an entrepreneurial mindset, and being open to alternative ways of doing things. At times this means that leaders are expected to be disrupters, introducing different ideas and innovations into decision-making. In Buckinghamshire ICS, for example, there is a strategic commitment to 'access external support and rapid learning with other like-minded systems, maximising efficiencies of collaborating and enabling us to move at a faster pace through our organisational development programme'.

Leaders told us that another core skill was translating complexity – such as a set of complex policies and initiatives – into something that is easy to communicate and use to build commitment for change. This could include, for example, creating logic models or plans on a page to explain why change is needed and how different activities are intended to bring about that change. The SCIE Logic Model for Integrated Care, which we developed for the Department of Health and Social Care (DHSC), seeks to capture a complex system into a single page, as shown below.

“Locally, good systems leaders are ‘translators’, making sense of disparate policy drivers, legislation, performance requirements, regulatory systems and funding mechanisms.”

(Local government leader, ICS)

Leaders told us that they needed to be increasingly skilled at designing and facilitating whole-systems events and workshops to build consensus and deliver change, and manage often difficult conversations through good listening

and negotiation skills. Leaders told us that they needed to be very good at ‘deliberative’ engagement techniques, which involve providing people with information and time to consider options, before arriving at decisions.

“For me, it is no longer about giving a presentation on a plan and hoping it will happen. You have to educate people and take them on the journey and enable them to see that not everyone will win.”

(Chief executive of NHS organisation and leader in ICS)



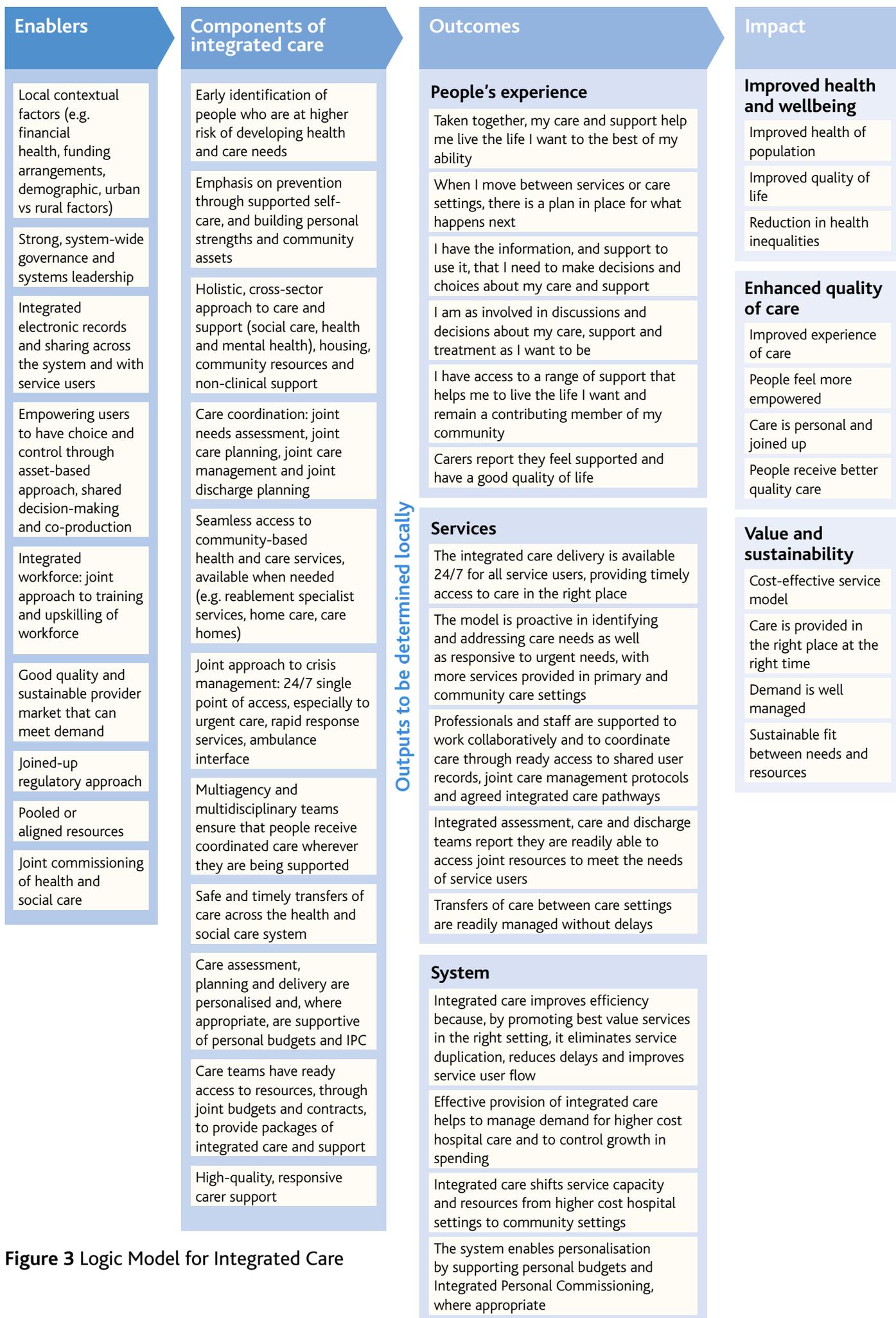


Figure 3 Logic Model for Integrated Care

Learning and capacity-building

Leaders recognise that huge cultural change is needed, given that until recently the NHS approach to improvement was based on competition between organisations, not collaboration. This shift can be harder for many middle managers and those in 'back office' positions than for people in patient-facing roles. And yet, unless staff at all levels really start to think and work differently, integrated care will not become embedded. Possessing a strong understanding of how to lead cultural change and a familiarity with the tools and techniques, such as coaching and action learning, may help make this happen.

In many ICSs, systems leaders are increasingly expected to build system-wide learning and evaluation frameworks which enable them to capture and act on the lessons from innovation.

Pilot programmes are also commonplace in ICSs – it is important that arrangements are in place from the start to support formative learning. In Surrey Heartlands, for instance, which is developing a new single care record, an evaluation framework has been established which enables people to learn – in real time – from the implementation process.

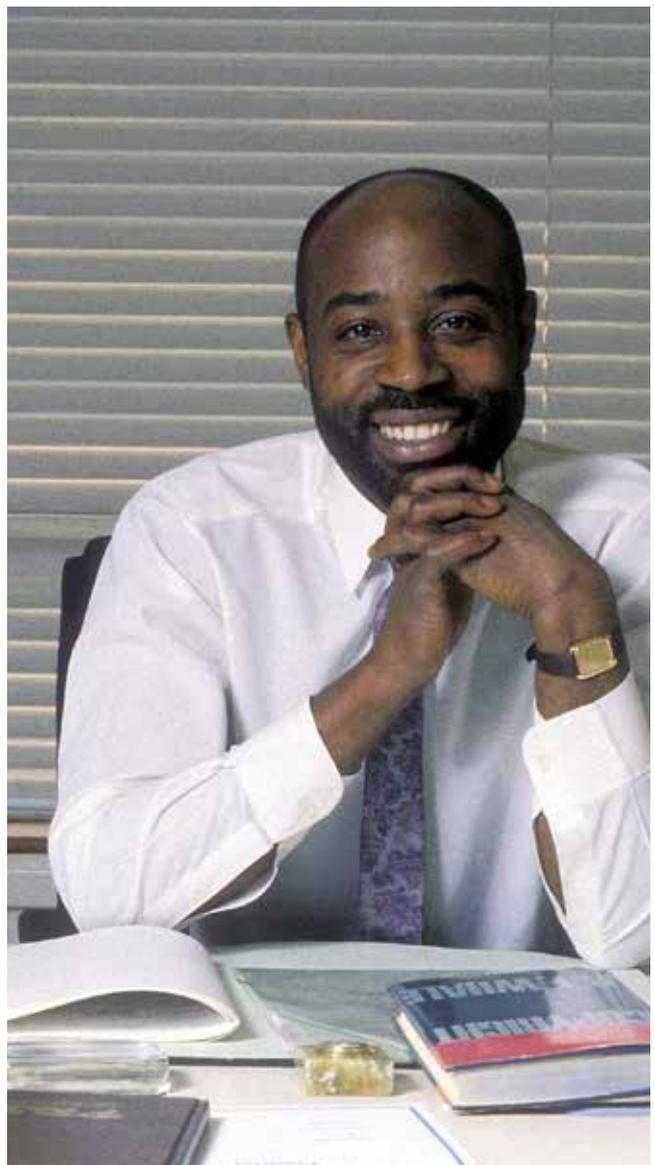
Building a learning culture across the system is also important. This involves leaders bringing together and aligning skills development programmes (e.g. health and social care leadership), developing groups of champions who will disseminate learning and good practice, and finding ways for people to learn together more informally (e.g. through peer networks).

Figure 4 summarises the key features of systems leadership identified by the literature.

Case study: Surrey Heartlands Health and Care Partnership Clinical Academy

Surrey Heartland's ICS has established a Clinical Academy to help support systems leadership across the local area, spread best practice and test and evaluate new innovations. Its specific aims are to:

- empower citizens: we will use information to help citizens be better informed to make decisions about their care and take personal responsibility for their health
- enable current, and future, pockets of innovation developed by Surrey Heartlands' clinicians to grow and have a positive impact on the lives of the Surrey Heartlands population
- spread best practice, test and evaluate current and new innovations (with a particular focus on digital) and support systems leadership
- help create and establish a culture and environment for generating ideas and making them happen for the benefit of the Surrey Heartlands population
- support our clinical workstreams in designing financially sustainable pathways of care.



Case study: Millom: an integrated health and care system

The Cumbrian town of Millom and its partners came together to form the Millom Alliance: to develop and understand the skills needed for collective leadership and to develop local health, public sector and community leaders. The Alliance is a formal integrated health and social care collaboration between organisations with responsibility for the care of the population of the town. The NHS NWLA awarded the Alliance a system leadership grant to create a diagnostic tool to build on existing knowledge, and develop a core leadership programme.

The Millom Alliance achieved much in the way of results early on and continues to develop. Results were prioritised and driven by the population of Millom rather than by the NHS and social care organisations such as:

- GP practice moved in to the community hospital
- a community-led GP recruitment campaign
- dual trained nurse practitioner (physical and mental health)
- community mobilisation for health and wellbeing
- a new multi-specialist, multidisciplinary model of primary care
- telehealth

Cumbria is building a new paradigm for healthcare, based on the Millom project.

Figure 4 Key features of systems leadership

Core components of successful leadership	
Innovation and improvement	Understanding how to scale innovation
	Clear idea about what to prioritise and what 'good' looks like
	Constancy of purpose but degree of flexibility – keep the momentum but adjust your approach/methodology
	A whole population approach, starting from a focus on specific segments of the population (e.g. cohorts of patients)
Relationships and connectivity	Strong relationships and frequent personal contacts
	Involve primary care from the start
	Involve patients, service users and carers – co-design and co-creation
	Involve local authorities, with a focus on population health and service integration
	Shared responsibilities and decision-making
Individual effectiveness	A positive working relationship between providers and commissioners
	Starting with individuals and teams that have already shown commitment and willingness to lead the change locally
	Stability in senior leadership positions across organisations
	Distributing decision-making roles – responsibility for making change happen cannot be held centrally
Learning and capacity-building	Continuous learning – 'test, evaluate and adapt for continuous improvement'
	Having a tolerance for things not working – learn to 'fail well'
	Learning from elsewhere, through formal and informal networks, establishing communities of practice
	Using performance measures and data to inform design and planning

Enablers and barriers to effective systems leadership in integrated care

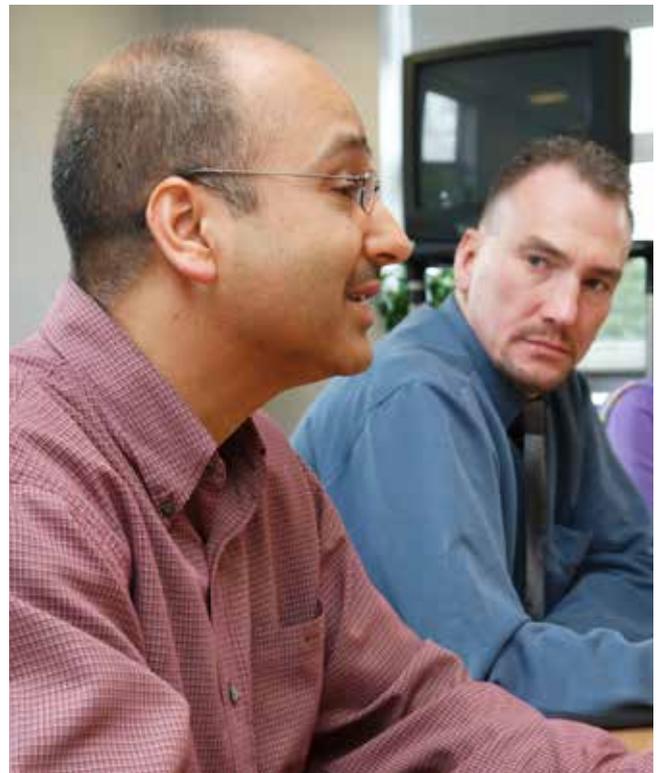
This research has identified a number of factors which can facilitate or hinder effective systems leaders, across the four features of effective leadership discussed in the previous section.

Innovation and improvement

A key theme from our research was the importance of working together to create a shared vision. Leaders told us about workshops involving people from many organisations and professional disciplines aimed at identifying priorities, outcomes and goals together, without a pre-set agenda. Such an approach builds relationships and trust, and enables people to better understand each other's perspectives and identify what each can contribute. It helps generate a shared commitment to collaborative ways of working, and to the priorities and outcomes that are agreed as a result.

Although all ICSs are taking steps to involve local communities, patient representatives and the voluntary sector, there is a long way to go to ensure widespread co-production with patients and the public. For these approaches to become the norm, more must be done to develop professionals' understanding of both the theory and practice of co-production, participatory approaches and community engagement.

Systems leaders are concerned about the fragility of a system that has no statutory basis – ICSs are dependent on the voluntary participation of all organisations involved, and a partner organisation could, in theory, walk away in response to an irreconcilable disagreement. However, many leaders suggested the multiple differing requirements made of partner organisations is a greater challenge on a day-to-day level. They cited a lack of alignment between national bodies, especially NHS England and NHS Improvement, resulting in inconsistencies in policy, priorities, expectations and requirements. Systems leaders want national bodies that are more enabling and permissive, less prescriptive and better coordinated with each other.



Innovation and improvement

Enablers

- Using facilitators to help develop a shared understanding of challenges and allowing issues and tensions to surface.
- Involving staff and service users.
- Developing logic models collaboratively to agree desirable outcomes and interventions. Process is also an opportunity to build relationships – but requires time and bringing partnerships together to get it right.
- Having the security to make long-term plans.
- Trust and delegation of autonomy from the centre – a permissive, not prescriptive, approach and national guidance that provides a broad, enabling framework.
- Having the time and space to innovate.
- Having a tolerance for things not working – learning to 'fail well'.
- Clarity about how performance will be judged.
- Clarity about how accountability will work, and responsibilities of individual organisations.

Barriers

- Strategies and agendas that are imposed by NHS England on local areas rather than being clinically-led and driven by local need.
- Lack of coordination and alignment at national level between NHS England and NHS Improvement.
- Legislative framework not conducive to place-based solutions – STPs and ICSs have no statutory powers to deliver their reform agendas.
- Complex accountability structures and configurations.
- Different performance regimes and cultures, including between the NHS and local authorities.
- Multiple legal and technical barriers including VAT treatment, pensions, contracts, information governance and procurement laws.
- Coping with austerity and a system under stress – funding pressures dwarfing attempts to introduce innovation.
- Lack of a coherent view of whole population needs.
- Sheer volume of bureaucracy involved in getting service changes through.





Case study: **Citizen leadership project**

The **Citizen Leadership Project** is an **innovative** programme developed in the north west to activate community citizenship, **empowering** and **enabling** communities to mobilise their assets. **Over 100 participants** from black, Asian and minority ethnic (BAME) backgrounds took part in the project which had four overarching aims:

- Increase confidence in leadership skills, knowledge and behaviours
- Develop communication skills to enable effective engagement with decision-makers
- Encourage participants to become more formal leaders and to actively engage in **networks**
- Empower citizens to become a powerful conduit for shared learning from their own **lived experience**

Interactive question and answer sessions enabled participants to engage with **local decision-makers** and key leaders to share their **stories and experiences**. Many of these leaders were from BAME backgrounds taking part in round-table discussions and conversations about their **individual leadership journeys** and topics such as overcoming barriers, maximising opportunities and engaging with networks and services.

Outcomes

- Creating a **Women's Leadership Network** in Oldham to extend the citizen leadership programme in a locality
- Self-nomination of participants to **chair local groups** when they previously would not have considered this
- Contacting public organisations about Greater Manchester devolution priorities to **influence decision-making**
- Exploring **involvement** in the local GP patients' group to impact on how services are delivered
- **Engaging** with the Chair of a clinical commissioning group to look at how local people could be better engaged
- Applications to become **volunteers** as part of a local HealthWatch organisation
- **Returning to work** in the NHS or in other local services which they would not have considered before
- Challenging themselves to seek employment and utilise what they already have i.e. **identifying their own assets**
- Exploring with councillors and council leaders possible routes into becoming **elected members** themselves

Relationships and connectivity

The importance of honest and high-trust relationships was the strongest and most consistent theme from our research. Leaders stressed the investment of time and effort required to build trust and mutual understanding – there are no short cuts. Being able to appreciate issues from the perspective of people in other roles and organisations is key.

The involvement of local councillors was identified as highly important. There is a tendency for NHS senior staff to focus on relationships with local authority executives, but not always acknowledge the role of elected councillors. This requires careful relationship-building, as each ICS involves several local authorities of differing political complexions.

NHS board non-executives and elected councillors may not have experience of whole-systems and integrated working, and there is a need to invest in developing their understanding.

Leaders face particular challenges in striving for greater integration of strategy and operational plans across NHS and local authority organisations, with their differing cultures, expectations and regulatory requirements. There is pragmatism and understanding of these differences, but also frustration at the effects.

“In system working, relationships are critical, they make or break success. As more ICSs develop, we have to get the message over that this took time. We have been working on productive relationships for well over three years. We have been building trust and supporting a new generation of leaders to come through locally. It takes time.”

(Chief executive of NHS organisation and leader in ICS)

These barriers go beyond cultural differences and represent complex legal and technical dissimilarities in the requirements made of local authorities and NHS bodies – issues which cannot be resolved without national guidance, decisions or legislation. In the meantime, ICS systems leaders frequently need to resort to complicated ‘work-arounds’.



Relationships and connectivity

Enablers

- Stability in senior leadership positions across organisations.
- Previous involvement with national initiatives that focused on integration or primary care.
- Relationships before structures – drawing on established working relationships built over the years.
- Having the support and involvement of elected local authority councillors, providing leadership and liaising with local communities.
- Formal links with national bodies and programme-central teams (e.g. NHS England designated account managers; named Care Quality Commission [CQC] contacts).

Barriers

- As ICSs and programmes mature, gaps emerge between the system described in current legislation and what happens on the ground – resulting in confusion about who is accountable and where decisions are made.
- Insufficient local authority and local councillor involvement; in 2017, just four of the 44 STPs were led by local government chief executives rather than NHS leaders.
- Lack of transparency, public engagement and consultation, especially at national level, leading to public opposition to plans in local communities.
- Regulatory frameworks and quality assurance processes that focus on individual organisations, and less on the outcomes people want for themselves and their actual needs.
- Insufficient level of autonomy and control, but also a tendency at times to seek independence/autonomy for its own sake.
- Lack of clarity on the relative importance of competition or collaboration at the local level.



Individual effectiveness

Unsurprisingly, individuals differed in the kinds of support and development they had found most useful. Many spoke favourably about structured leadership development programmes (some focused on systems leadership), and formal or informal networks and action learning sets providing peer support. Opportunities to learn from others who had been involved in systems leadership were greatly valued.

Many leaders told us that a one-on-one coach provided invaluable support and space for reflection. One had previously used her coach at times of change (e.g. a new job or major project) but with the ever-increasing complexity of her role, she now speaks to her coach regularly, and expects all her senior team to have a coach.

As well as formal development, leaders stressed that constantly engaging with others in all parts of the system was important for their effectiveness. Getting 'out and about' to see services at first hand, and talk with staff at all levels, across all parts of the system, is not merely a 'nice to do' but an essential.

Looking to the requirements of emerging and future systems leaders, there is a need for more 'entry-level' development for those who take on such roles. It is increasingly important for health and care professionals from different disciplines and backgrounds to undertake development together. The leaders we spoke to recognised that system leadership skills need to become much more widespread, going far beyond those in the most senior roles. The more that people at all levels are able to initiate, drive and champion transformative changes, the more likely those changes are to be successful.



Individual effectiveness

Enablers

- Leadership programmes and professional development opportunities.
- Peer support including mechanisms for 'buddying up'.
- Staff 'ownership' of clinical and social care models.
- Local champions who will push and progress the work, and 'win hearts and minds'.
- Distributing decision-making roles; recognising that responsibility for making change happen cannot be held centrally.
- Having a dedicated central project team with a mix of skills and expertise (an 'engine room').

Barriers

- Insufficient development, support and peer support for leaders.
- Capacity and capability of local leaders, pressure and stress in these roles, uncertainty about the future.
- People in leadership roles finding the job lonely and feeling isolated.
- A culture of blame towards leaders.
- High turnover of the leadership workforce, resulting in loss of experience and skills.
- Confusion about where the decision-making power lies.
- Clinical leadership especially challenged by bureaucratic constraints.
- STP leads that are currently voluntary and part-time – some said they should be appointed into formal paid positions and adequately resourced.

Learning and capacity-building

For system-wide and integrated ways of working to become the norm, it is important to invest in staff skills at all levels, not just the top echelon of leaders. A starting point is helping people see beyond loyalty to their own organisation, enabling them to understand in straightforward terms the ambitions of the whole system.

The valuable role of skilled independent facilitators was highlighted. As integrated approaches spread through health and care systems, it will be important for facilitators and organisational development (OD) practitioners to ensure their knowledge and skills keep pace. Many do not yet have experience of working collaboratively with multiple organisations to achieve change in support of a shared vision.

Local leaders need time, space and a consistent national approach if they are to build capacity across their organisations and systems. Such large-scale changes take time and sustained effort, over many years. Some fear that, while NHS England has allowed the first ICSs some degree of flexibility in developing governance arrangements and structures, the 'centre' may

soon want to impose specific structures and reduce local autonomy. Leaders urged NHS England and other national bodies to 'be brave' and resist the desire to centralise – it is only through allowing systems leadership to grow and local ownership of change to flourish that we, collectively, will be able to achieve transformation at the scale required.

“The people who struggle the most with this are the middle managers, especially those in traditional roles like contracting and assurance, who feel their job is either quite a combative role or about servicing demands, holding to account... anything that is helping those groups would be enormously beneficial. Otherwise, there will be a big swathe of people that you're not touching.”
(Chief executive of NHS organisation and leader in ICS)

Learning and capacity-building

Enablers

- Establishing communities of practice, through formal and informal networks.
- Peer support, buddying up.
- Staff 'ownership' of clinical and social care models.
- Leadership programmes, professional development.
- Having joint approaches to training and career development, so that staff can more easily move between health and social care.

Barriers

- Performance management and assurance processes that are not aligned to learning and self-reflection.
- Excessive emphasis on performance management with increased levels of bureaucracy and reduced local autonomy.
- Requests for information and data collection from NHS England that are burdensome, with significant geographic variation.
- Assurance processes that are vague and lacking in transparency.
- A sense that the goalposts keep moving with priorities, funding and expectations changing.

Supporting systems leaders

The systems leader within an ICS faces a daunting range of challenges. Their role, as we described earlier, is evolving and emergent and their support needs will most likely change over time.

It is clear from this research that there are some areas where additional support would be welcomed. Leaders told us that their role was often isolated, and that while they could draw upon good managers to help them in most cases, additional help with facilitating complex change programmes would be invaluable. This could take the form of help to plan and deliver a large-scale event with the public, or help to facilitate a difficult conversation which may have become 'stuck'.

Creating safe spaces

Systems leaders told us that they can often feel quite isolated, and may not even have a team which reports to them. They welcomed having access to 'safe spaces' to share their views and concerns with others who have a similar role, either through informal networking or something more structured, such as a peer network. Help would be welcomed from organisations like the Leadership Academy, to match leaders to peers with similar backgrounds or interests. Several leaders told us that they welcomed having access to alumni who have rolled out leadership programmes they previously took part in, such as the NHS Leadership Academy Bevan Programme.

Learning together

Leaders increasingly need to lead change with people from different professional disciplines and sectors. Leadership programmes that successfully brought leaders from different organisations together were welcome, because they helped to break down barriers and build mutual understanding. There was a desire for the Leadership Academy to do more to ensure that its programmes bring together leaders from across the whole system, including social care, housing and the voluntary sector.

Supporting middle managers

Middle managers and people leading MDTs can often find it difficult to represent both the system and their own organisations and teams. Leadership programmes that help this group manage this tension and execute system-wide change would be welcome in many local areas.

Masterclasses

Leaders often told us that while they usually had several specialist areas of knowledge, (e.g. social work or general practice), they were increasingly required to have a good understanding of an even broader range of topics. This knowledge was essential if you were to be successful in leading often difficult conversations with colleagues and professionals from across settings and specialisms with sufficient confidence and a sound grasp of the context and nuances.

Many of them would welcome opportunities to learn more about:

- co-production – understanding the theory and practice of co-production and community engagement
- local government and social care
- scaling innovation
- risk- and benefit-sharing
- large-scale and large-group facilitation
- working and influencing across multiple layers of governance.





Case study: [Frimley Health and Care ICS 2020 Leadership Programme](#)

The 2020 Leadership Programme was commissioned by Frimley Health and Care in 2017, with the aim of breaking down organisational barriers and allowing the participants to engage with their communities. The idea was to give them a real and specific connection with and understanding of their local population's health. The first cohort was made up of 24 leaders from health and social care including GPs, social care workers, voluntary and community sector and acute sector managers. The Programme is a partnership initiative which Frimley Health and Care co-designed and co-funded with NHS Leadership Academy – Thames Valley and Wessex.

The specific aims of the Programme are to:

- create a new movement of leaders who will move the focus from reactive problem-solving to co-creating solutions
- explore and test out ideas in a safe space to innovate and spread innovation without organisational boundaries
- work with communities to support improvements for people and populations.

The ICS has pioneered a number of innovative ways to deliver better integrated care, including a single point of access into integrated MDTs. Frimley Health and Care ICS leads the country in terms of improving system outcomes. For instance, it has reduced care home admissions by 12 per cent and GP referrals into hospital by 13 per cent.

["I had a kind of 'eureka' moment \(being part of the 2020 Leadership Programme\). I realised this wasn't just about the NHS. We can be very blinkered; it's about a sense of place and the impact we have on the community around us."](#)

[\(Programme participant\)](#)

The next step on the journey is focused on building stronger strategic links to the voluntary and community sectors. Frimley is also reviewing its board membership to ensure there is representation across the whole sector.

NHS Leadership Academy's support for systems leaders

The NHS Leadership Academy seeks to equip leaders of integrated care systems, and other whole-systems approaches to integrated health and social care, with the skills and capabilities to transform health and care.

The outcomes being sought through this work include:

- change mindsets – shift people’s mindsets from competition to collaboration
- change behaviours – from a focus on speeding up the pace to relational leadership approaches
- build relationships – facilitate connections and collaborations in real time and in real work
- support and develop leaders to support systems – now and in the future
- unleash transformation, creativity and the potential of our workforce
- build a pipeline of system-ready health and care leaders.

The Academy’s focus is on developing people, innovation and collaboration (see below).

The NHS Leadership Academy offers a menu of support for ICS’ and STPs ranging from our award winning core programmes to a more localised menu of ‘in place’ interventions and funding.

For more information, please go to the NHS Leadership Academy (www.leadershipacademy.nhs.uk) for our core programme offer and contact your local NHS Leadership Academy team to have a conversation about your needs and more localised support.

Figure 5 Developing people, innovation and collaboration

Developing People	Developing Innovation	Developing Collaboration
<p>Skills for system leadership Equipping individuals and groups with the skills to transform</p> <p>For individuals Diagnostics, tools, coaching, mentoring, buddying, inclusive programmes</p> <p>For groups Building OD capability, team development, handling conflict, organisational design</p>	<p>A leadership mindset Promoting a culture of thought leadership and quality improvement</p> <p>Thought leadership Evidence-based, publications, keynote speakers, 2020 and other innovation programmes</p> <p>Quality improvement Sharing evaluation and best practice</p>	<p>Leaders working together Connecting people across systems and communities</p> <p>For systems Talent management and development, experience sharing, bursaries, localised support</p> <p>For communities Action learning, networking events, stakeholder perspectives and engagement</p>

Case study: System leadership behaviours

The NHS North West Leadership Academy (NHS NWLA) aimed to identify the kinds of behaviours that are needed to improve system leadership across the public sector in the north west. It looked to harness the wisdom of people working across the system to support population health.

Representatives from the NHS, local authorities, police, fire, higher education, third sector and beyond worked together to share experiences, learn from each other and identify the key behaviours needed for effective system leadership across the north west.

Thirteen key themes were identified as being especially pertinent to system leadership including 'building trust', 'collaboration and co-creation', 'relationships', 'bravery' and 'doing things together'.

The NHS NWLA took the behavioural themes identified at the stakeholder event to a much wider group of participants using an online 'crowdsourcing' platform. They analysed and refined the ideas and explored them in more depth with senior system leaders.

The NHS NWLA is exploring how these findings can best inform and shape current and future development.



“The information and recommendations contained in this report guide us within the NHS Leadership Academy, both nationally and locally, to develop the most appropriate leadership development interventions needed for our stakeholders in practice. Working within and across the Academy, it is crucial that we too address the development areas outlined here ensuring our own capability to deliver – as developers our challenges echo those of our service colleagues. In order for us to be understanding and knowledgeable of what is required in this new world, we need to work differently, exploring and experimenting with new interventions, operating in a collaborative space with our systems to enable us to develop leaders fit to lead in this evolving landscape. We too must shift our mindsets and change our behaviours to build relationships that facilitate connections and collaborations. We must practise what we preach if we are to have the crucial impact in supporting the delivery of high-quality, safe, inclusive, compassionate services and improving population health.”

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Leadership in integrated care systems: Report prepared for the NHS Leadership Academy

About SCIE

The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works. We are a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK. We also work closely with related services such as health care and housing.

www.scie.org.uk

About the NHS Leadership Academy

As part of Health Education England (HEE), the NHS Leadership Academy's philosophy is simple – great leadership development improves leadership behaviours and skills. Better leadership leads to better patient care, experience and outcomes. Our purpose is to work with our partners to deliver excellent leadership across the NHS to have a direct impact on patient care. We offer a range of **tools, models, programmes and expertise** to support individuals, organisations and local partners to develop leaders, celebrating and sharing where outstanding leadership makes a real difference.

www.leadershipacademy.nhs.uk

Future of care

The SCIE Future of care series aims to stimulate discussion amongst policy-makers and planners about the future of care and support, based on analysis of developing evidence and projections for the future. Thanks to the NHS Leadership Academy for its support in developing this paper.

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