

Leadership for integrated care: a case study

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Purpose: Integration of health services involves multiple interdependent leaders acting at several levels of their organisation and across organisations. This paper explores the complexities of leadership in an integrated care project and aims to understand what leadership arrangements are needed to enable service transformation.

Design/Methodology/Approach: This case study analysed system and organisational leadership on a project aiming to integrate primary and specialist care. To explore the former, the national policy documents and guidelines were reviewed. To explore the latter, the official documents from the transformation team meetings and interview data from seventeen healthcare professionals and commissioners were analysed using thematic analysis with the coding framework derived from the comprehensive and multilevel framework for change.

Findings: Although integration was supported in the narratives of the system and organisational leaders, there were multiple challenges: 1) insufficient support by the system level leadership for the local leadership, 2) insufficient organisational support for (clinical) leadership within the transformation team, and 3) insufficient leadership within the transformation team due to disruptions caused by personnel changes, roles ambiguity, conflicting priorities, and insufficient resources.

Practical implications: This study provides insights into the interdependencies of leadership across multiple levels and proposes steps to maximise the success of complex transformational projects.

Value: This study's practical findings are useful for those involved in the bottom-up integrated projects, especially the transformation teams' members. The case study highlights the need for a toolkit enabling local leaders to operate effectively within the system and organisational leadership contexts.

Key words: health service transformation, healthcare integration, leadership for integration, case study

Introduction

Changes in the health systems and the need for closer working together

Many health systems look towards intensifying joint working between health services to solve the deepening divisions in the provision of healthcare. These divisions are linked to the growing number of care pathways spanning multiple organisations that patients with complex long-term conditions and multimorbidity struggle to navigate. As a result, care is fragmented and episodic resulting in delays, duplications and gaps (WHO, 2016). This leads to reduced safety, quality, experience, and affordability of healthcare (Stange, 2009). These challenges highlight a growing need for health services to work across organisational and professional boundaries.

To achieve better coordination of care, many health services pursue integration to a varying extent ranging from linkage, through collaboration to full integration with the latter being recommended for organising care for people with severe, complex and long-term needs (Leutz, 1999). Full integration is characterised by multidisciplinary teams managing all care in all key settings using one health record as part of a daily joint practice, pooling funds to purchase all services and sharing benefits (Leutz, 1999, 86-87), and owning the health outcomes of patients (Diabetes UK, 2013). The ambition is for the join between different parts of the health system to be invisible for patients as if they were in contact with a single organisation (Irani, 2008, p.11).

Integration is a complex transformational project; those involved are faced with an adaptive challenge (as opposed to a technical problem) (Heifetz, Linsky & Groshov, 2009) and dynamic complexity (as opposed to detail complexity) (Senge, 1990). While a technical problem is a problem that can be solved with knowledge and procedures already in hand, an adaptive challenge requires new learning, innovation, and new patterns of behaviour (Parks, 2005). While detail complexity refers to problems with many variables, a dynamic complexity refers to situations where cause and effect are subtle and uncertain with the same solutions having dramatically different effects in short vs long term and locally vs other locations (Senge, 1990). The process of integration may experience a variety of barriers since it asks different service providers to give up their independence to some degree, change the established ways of working, and balance conflicting expectations of their own organisations and the new integrated service (Kozłowska et al., 2018).

The leadership for integrated care has to recognise that the task it is facing cannot be approached as a technical problem limited to detail complexity, but rather an adaptive challenge within a dynamic complexity; indeed, it needs to develop new solutions while working in unpredictable environment. Pursuing such challenge requires a particular form of leadership. 'Leadership' described as a process whereby a person influences others to achieve a common goal (Northouse, 2007, p.3) seems to be focused on 'a person' only while the efforts of an individual or a few individuals leading on integration have to be placed in the context of the whole system (Baker, 2011). 'Leadership' becomes an effort on all levels of the healthcare system where action is required to support change and therefore a leadership structure is a complex one spanning from the government (with their position on integration expressed in policies, regulations and recommendations) to the individuals at the forefront of healthcare delivery.

This case study explores the leadership arrangements in developing an integrated diabetes service across primary, community and specialist care. It looks at leadership for integration at the system and organisational levels of change and the factors enabling and hindering effective leadership. In particular the leadership of the transformation team is analysed, the transformation team being a group of individuals representing the stakeholders in the meetings to work out the details of integration. While there is a recognition of how important leadership is to health integration, with a number of effective leadership models and skills (such as the King's

Fund, 2015; Timmins, 2015; West et al., 2015a; West et al., 2014b; Ferlie and Shortell, 2001), there is very little literature providing insight into the practicalities of setting up and supporting an effective leadership system.

Theoretical background

Leadership in the health systems undergoing integration

Delivering integration of services needs to include change at a system, organisational, team and individual level with leadership fully embedded at every level (Ferlie and Shortell, 2001). Regarding the leadership to be embedded, it has been proposed for the framework for leadership to shift its focus from three entities 'leaders, followers and shared goals' to three leadership outcomes 'direction, alignment and commitment' with the latter framework being seen as more adequately supporting understanding of leadership in the context where collaboration is expected or required (Drath et al., 2008). The three leadership outcomes have been described as:

- 'direction' - the agreement on the overall goals, aims and mission
- 'alignment' - the coordination of actions towards achieving the goals
- 'commitment' - the willingness to subsume own efforts and benefits within the shared ones (Drath et al., 2008).

For transformation to succeed, leadership has to have 'direction, alignment, and commitment' embedded throughout the system (Aarons et al., 2014; Lejeune & Vas, 2011), with support for change and coordinated action to implement the new ways of working at all levels:

- System level: political leaders and the government must provide an environment that is conducive to change in relation to payment and regulatory policies.
- Organisational level: organisational leaders must establish a vision for change, provide a supportive environment with the necessary resources, and insist on accountability for results.
- Team level: groups and teams must assume leadership to implement the characteristics of effective teams.
- Individual level: the individual clinicians, managers, and policy makers need to change practice (adapted from Ferlie and Shortell, 2001).

The framework for whole system change (Ferlie and Shortell, 2001) felt to recognise a change agent. This could be a transformation team consisting of individuals representing the stakeholders and tasked with negotiating the vision for change, service specifications and implementation process. It is in this setting that the change leaders are likely to emerge and flourish or struggle depending on their leadership qualities, leadership arrangements within the team, the support of middle and upper organisational management and the enabling of system leadership at a local level. Since clinical leadership has been given a key role with unprecedented responsibility in the NHS (Health and Social Care Act, 2012; NHS Improving Quality, 2013; NHS Leadership Academy, 2011) it is very likely that clinicians will be a key part of the transformation teams and play a vital role in the process.

Clinically driven leadership needs to be fit for integration, bringing together stakeholders from different organisations. It has been proposed that change leaders should work within a distributed leadership model, building a coalition of like-minded people dispersed across the different organisations who could influence change using their legitimacy, authority, and resources (Chreim et al., 2010; The King's Fund, 2011, p.22). There is some literature recognising the importance of adapting an adequate leadership style for integration (West et al., 2015; Fillingham and Weir, 2014; NHS Leadership Academy, 2011; Chreim et al., 2010). However, those working on the integration projects are faced with a difficult task with little or no guidance. Advice on how to organise transformation teams to enable clinically driven leadership, develop effective multi-organisational leadership, and secure support for the project at the organisational and system levels, are a rarity within the field of service transformation (e.g. Lejeune & Vas, 2011). More practical guidance is needed to support those driving change including clinicians. This case study

of integrating diabetes primary and specialist care highlights the need for such guidance and toolkit.

Method

Using the case study method to explore the process of service integration

Case study methodology is well suited to the exploration of the process of service transformation as it allows in-depth, multi-faceted explorations of complex issues in their real-life settings (Yin, 2009). Case study approach lends itself well to exploring integrated care projects in that they are complex, entangled, multi-faceted affairs, initiated in response to different needs and delivered to varying specifications, timeframes, and resources (Crowe, 2011; Sanfey, 2017). It can offer insights into the pre-implementation stages of service transformation when the options are discussed and decisions made and more exploratory approach is needed to answer the 'what, how and why' questions enhancing understanding of the factors responsible for successes and failures of the service transformation projects.

Contextually bound intrinsic/instrumental case study

The current study covers a single integrated diabetes care project. It was analysed in the third year of intense work on the project and with the new integrated diabetes service not yet commissioned. The primary focus of the study was to explore the factors enabling and hindering the process of integration and this paper focuses on the role of leadership in the process. Initially the study was an intrinsic case study to investigate the processes within the ongoing integrating diabetes care project, however it developed into an instrumental case study seeking to gain a broader appreciation of leadership for integration and generate a number of findings potentially transferable to other projects with similar characteristics. Other projects may be assessed as comparable if pursuing 1) full integration, 2) between primary and specialist care, and 3) bottom-up driven (other criteria for comparison available in Calciorali et al., 2011).

Diabetes care is a good example to study integration as diabetes care is provided across healthcare professions and organisations with some patients coming in contact with up to nine healthcare professionals¹ and more if they develop complications from diabetes. The integrated diabetes care project analysed in this study begun in 2014 with an aim of developing a fully integrated diabetes service within Oxfordshire. Its aim was to address the growing demand for diabetes care, provide more person-centred care, improve the overall outcomes of care, and address variation in quality of care across the region while improving use of resources. Multiple organisations were involved in providing primary and specialist (secondary and community) diabetes care commissioned, funded and managed in different ways and using separate electronic patient record systems.

The drive for integration came from the patients and the clinical team and the transformation team was established to determine the specifications of the new service and secure buy-in from all stakeholders including commissioners and service providers from primary care (70 general practices), community care and secondary care. The responsibility for hosting and organising the meetings was taken by Oxfordshire Clinical Commissioning Group (an organisation that plans, buys and oversees health services) working for 700,000 residents of the county with estimated 5% living with diabetes. The transformation team consisted of nearly twenty members representing patients, commissioners, and all service providers of diabetes care with this number fluctuating throughout the project. After three years of work and full integration not quite implemented, the transformation team decided to pilot elements of the new service in one primary care locality following its clinical lead's proactive engagement with the transformation team and declaring the locality's readiness to proceed; **this project required input from the clinical commissioning group,**

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¹ <https://www.diabetes.org.uk/guide-to-diabetes/managing-your-diabetes/interactions-with-healthcare-professionals>

seven primary care practices in the pilot locality and a GP Federation providing legal and organisational support for them, a specialist diabetes team based in a Hospital Trust and a diabetes specialist nurses team based in a Community Trust.

Collecting and analysing the data

Thirty three policy and regulation documents published between 2006 and 2016 were identified and analysed by the researcher (OK) to understand the extent of the system level leadership for integration of health care. In addition, a wider set of official recommendations and proposals by patient organisations and medical associations providing leadership to healthcare professionals involved in service redesign was investigated. Further six documents on local policy on integration were identified and analysed.

Further data came from two sources, 1) the official minutes and documents of the project's transformation team, and 2) the interviews with those participating in transformation of the diabetes service in the county. A group of seventeen respondents involved in planning, implementing and delivering the new service were interviewed including the patient representative, three senior management-leaders (representing the clinical commissioning group, the hospital trust, and the community trust), the clinicians on the transformation team (including front-line health professionals: three consultants in diabetes, one specialty diabetes nurse, one mental health specialist, and two clinical leads for long-term conditions) and the pilot locality team (including the locality clinical lead and three general practitioners and two practice nurses from seven general practices). Semi-structured interviews were used to capture their perception of the process of change and the role of and qualities of leadership in this process. The interview schedule consisted of ten questions aiming to identify if leadership was seen by the interviewees as one of the key factors in transformation and to grasp the interviewees' understanding of what leadership was through analysis of their experiences of leadership, what role leadership played in their service, and what leadership skills they saw as necessary to deliver integrated service. The interviews were collected by researchers (GS and OK).

The study applied the comprehensive and multilevel framework for change (Ferlie and Shortell, 2001) to describe the leadership system and to examine if, and to what extent, leadership was secured with 'direction, alignment, and commitment' achieved throughout the system. Although the need for change to happen at all four levels is recognised, with leadership at system, organisational, team and individual levels, this case study focused on the system and organisational levels with the addition of the transformation team level which previously has not been well explored in the literature. Leadership at the team (healthcare professionals providing care to the same patient) and individual (individual healthcare professionals) levels were not within the remit of this study with the project being in the initiation stage of service transformation prior to implementation.

RESULTS

The results are presented by the healthcare level: system, organisation and transformation team. For each level, a goal (the role of leadership at a specific level in achieving diabetes integrated care in Oxfordshire), a current status (what is being delivered to support integrated care), a source of data, and findings are presented. In the findings, the extent of embedding leadership and securing 'direction, alignment, and commitment' is assessed and its impact on the integrated diabetes care project.

Leadership at the system level - the gap between the narrative and reality of supporting healthcare integration

At the time of developing the integrated diabetes care project, multiple national policies were promoting integrated care. The approach to designing and implementing the new models of care adopted by the leaders for integration at the system level was flexible meaning that the regulatory, financial and incentive solutions were not readily available with local organisations encouraged to develop their own solutions.

Table 1.

Goal	Current status	Source of data	Findings
leadership at the system level to provide support to local integrated care initiatives	expressing imperative to provide integrated care	public policy documents	The system leadership empowered the local leaders (calling for integration) but did not provide sufficient regulatory, financial and incentive solutions for the studied integrated care programme. The flexible approach was challenging for some at the organisational level not ready to take a risk attached to the new solutions. The identified funding enabled support of only some elements of the new integrated diabetes service.
	promoting a flexible national approach to regulatory, financial, and incentive solutions to enable development of local solutions	transformation team's documents: business cases	
	awarding transformation funding to some but not all local integrated care initiatives		

The public policy statements on healthcare integration

The search for the public policy statements on healthcare integration resulted in identifying thirty three documents (appendix 1). These included Acts of the Parliament, guidance from the Government to NHS England, NHS strategy and planning documents, provider licence obligations established by Monitor (regulating NHS foundation trusts), recommendations from the NHS Future Forum (an independent group reporting to the government) and the National Voices (the patients' perspective), and reports published by the healthcare professional organisations. There was a national imperative to provide integrated care across the health services. New models of care, requiring organisational changes to break down existing barriers between services, were expected to provide more person-centred, proactive and cost-effective care, and to reduce emergency hospital admissions (NHS England, 2014). In order to achieve this, the policy documents pledged strengthening system leadership for new care models and supporting local leadership and local solutions (NHS England, 2014). It advocated that the local initiatives could succeed only if operating in a regulatory, financial and incentive system that is conducive of collaboration. Local leaders pushing for change, would be empowered with a set of enablers to develop governance structures promoting care coordination.

Implementing the national policies - the integrated care projects

NHS England initiated a number of national programmes to support integration of care. These included sites nominated to implement the new care models specified in the Five Year Forward View (50 vanguard sites, 20 integrated care pioneers (ICPs), and primary care home model) and the sites applying for the transformation funds to develop new models of care under the NHS England Sustainability and Transformation Plans. The vanguard sites and ICPs had additional resources to develop and test the new models while other sites in need of integration were left to deliver change with their own resources. In addition, the Sustainability and Transformation Plans (STPs) were developed covering the whole of England. These were five year plans covering all aspects of NHS spending, developed between commissioners and service providers. The plans had

1 to promote collaboration and the awarded organisations in order to receive funds for
2 transformation. It is difficult to evaluate the benefits of these programmes with early evaluations
3 indicating a mix of expected and unexpected outcomes (Morse, 2018; Erens, 2017 and NHS
4 England, 2014a; RAND Europe, 2012). Other sites interested in integrating care were supported
5 by individual healthcare professional bodies (e.g. the Future Hospital development sites, RCP,
6 2017), while some sites pursued integration independently.

7
8
9 In the case of the studies project, the system leadership empowered the local leaders (calling for
10 integration) but did not provide sufficient support for the programme. It was not one of the NHS
11 England supported sites and therefore did not initially have additional funding. The local STP plan
12 was developed with engagement from the same organisations as those involved in the provision
13 of diabetes services which resulted in the integrated diabetes care transformation team re-thinking
14 the diabetes service and aligning it with the local STP. However no additional resources were
15 provided. The project benefited from the NHS *Diabetes transformation fund* (awarded mid 2017)
16 which increased collaboration through multidisciplinary team meetings across primary, secondary
17 and community care but was insufficient to fund full integration.

18
19
20 The country-wide push to integrate care with the national leadership supporting the integration
21 projects was expressed by providing a narrative making integration a requirement when considered
22 to be key to provision of good quality care and by funding the new care models development and
23 testing sites. With new solutions under development, there remained significant gaps regarding
24 regulatory and payment advice.

25 26 27 *Gaps at the system level*

28
29 *Split regulatory system* It was planned that the regulatory bodies (the Monitor, NHS England Trust
30 Development Authority and NHS England) would work together to create greater alignment
31 between their respective local assessment, reporting and intervention regimes for healthcare
32 providers and commissioners, complementing the work of the Care Quality Commission and the
33 Health Education England (the *Five Year Forward View*, 2014). During this study, the services
34 providing diabetes care were still measured against different outcomes with Care Quality
35 Commission looking at each service separately.

36
37
38 *Inadequate payment system* In terms of integrating payment systems, the funding of the NHS
39 remained split between primary and secondary healthcare services. This was of special importance
40 to the project since it covered primary and specialist diabetes care. Practice based commissioning,
41 payment by results, plurality of providers, and the opposite priorities for demand management, led
42 to a deterioration in relationships and a growing mistrust between GPs and consultants, managers
43 and clinicians, primary care trusts and hospitals, hindering seamless care along patient pathway
44 (Irani, 2018). In the second decade of the 21st century, the need for transforming services for those
45 with a long term condition(s) and ensuring that payment systems and other incentives reward
46 improve quality and support integrated services were reinforced (DH, 2009, 1.42). The system
47 level leadership was lagging behind, it was proposed to link payment systems with whole pathways
48 of patient care so that providers have incentives to keep patients with long-term conditions healthy
49 and prevent unplanned and unnecessary admissions (DH, 2009, 4.7). Still, the same document
50 linking payment systems with the whole care pathways made 10% of hospitals' income dependent
51 on patients' experience and satisfaction with hospitals' service without linking it with the rest of
52 the pathway sending a message of separate incentives driving the individual services. More
53 integrated-friendly solutions were published later in 2015² to be further tested (NHS England,
54 2016 a,b) with some concerns raised at the national level by the healthcare professional
55 organisations regarding the new contractual arrangements (BMA, 2017a,b).

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60 <http://mc.manuscriptcentral.com/lihs>

² Different payment approaches to support new care models. Collection.

<https://www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models>

Leadership at the organisational level - navigating complex leadership and management arrangements

The local policies relevant to integration of diabetes care were an indication of the organisational level leadership for the project. Together with the reassurance of support for the project, secured by the transformation team members from the chief executives and some of the executive directors across the organisations, the leadership for the project seemed to be secured at this level. However, it transpired that the support was less explicit at upper and middle management levels responsible for operational and day-to-day management of the services.

Table 2.

Goal	Current status	Source of data	Findings
leadership at the organisational level to provide support to the transformation team leading on integrated care project	all participating organisations had integration of healthcare in their strategic objectives	local policies	
	the reassurance of support for the project from the chief executives and some of the executive directors	transformation's team documents	unclear leadership structure and no clear decision making pathway to enforce decisions made by the transformation team
	support less explicit at senior and middle management levels		although there was a positive climate for change, the transformation team was not supported sufficiently by all organisations to effectively progress to implementation of full integration
	senior/middle management leadership vs clinical leadership		the clinical/management leadership split left the clinical leads in an unequal position with some having more support than others and therefore the project not being pursued in a similar way across three organisations

Upper level leadership

Locally, there was a drive to coordinate services better. There was leadership for change coming from the chief executives of all three organisations as the prospect of integrated diabetes service was aligned with the vision for the local health economy. All organisations had integration of healthcare and bringing care closer to home in their strategic objectives published in 2013 and were contributing to the *Sustainability and Transformation Plan* since 2013 and the *Oxfordshire Transformation Programme* since early 2015. The latter was focused on improving healthcare across acute hospital services and community. Encouraging was a success of another initiative, integrated mental health service and the community trust signing an alliance contract with primary care in the county, indicating real commitment of the stakeholders to integration. There was leadership for integration secured at the highest organisational level of all organisations involved (as expressed in the strategic documents, appendix 2) and for the integrated diabetes project (as expressed informally by all chief executives to the members of the transformation team) but no aligned leadership at other levels of change within and across the organisations.

Without the senior management's continuous involvement and full support across all organisations, the progress was hindered. The lack of senior management leadership was a significant risk to the project as the senior level managers had responsibility for assessing the value of the project against the national and local priorities and resources, and therefore, as the decision makers, they were key to the project. The project lacked resources to develop the case for change (collect and analyse evidence from all organisations equally), the project support for members of the transformation team in all organisations, and the resources for implementation of the new service putting the project's future at risk.

Unclear leadership structure

Initially, it was unclear what the structure of leadership across organisations was. It seemed that the structure was complex with different leaders taking different formal or less formal roles across the organisations with clinical and managerial leadership not clearly defined or aligned. On one hand there was a hierarchical leadership system in each organisation linked to a managerial and a decision making structure. And on the other hand there was an unclear leadership configuration within the transformation team without a clear internal and external (with the team members' respective organisations) communication.

Senior/middle management leadership vs transformation team leadership

This was complicated further by lack of clear communication pathways between the senior/middle management and transformation team and therefore, there was no clear decision making pathway to enforce decisions made by the transformation team:

What we don't have in the group [the transformation team] is someone from the xxx management, because it is not only us selling it clinically but also xxx selling it back to its management.

The area we are probably lacking is driving the importance of diabetes at the clinical commissioning group [...]

Senior/middle management leadership vs clinical leadership

An additional challenge was lack of clarity how clinical leadership was aligned with management leadership. Not all clinical leads, members of the transformation team, were supported with the visible presence of their corresponding management leads. Additionally, not all of them were empowered with project management and resources. The clinical/management leadership split left the clinical leads in unequal position with some having more support than others and therefore the project not being pursued in a similar way across three organisations.

In overall, although there was a positive climate for change, the transformation team was not supported enough by all organisations to effectively progress to implementation of full integration.

Leadership at the transformation team level - unclear leadership arrangements within the team

The drive to improve the way diabetes care is organised came from those providing and those receiving diabetes care. Together, they formed a transformation team, a group working on the specifications of the integrated service, with input from all organisations providing diabetes care.

Table 3.

Goal	Current status	Source of data	Findings
leadership at the transformation team level supporting development and implementation of the	limited decision power, going in motions	interviews	unclear role of the transformation team
	confusion among the team members	http://mc.manuscriptcentral.com/lihs	unclear leadership within the team

integrated care service	tensions within the team		competing agendas
	frustrations and disengagement within the team		functioning in an unstable environment

Unclear role of the transformation team

The role of the team and its members during the team meetings (representing their individual organisations) and outside of the meetings (representing the views of the transformation team) were vague making it difficult for the team leadership to develop and effectively drive the change influencing the organisational level leadership. It was not clarified what the decision-making power of the team was - who was the ultimate decision maker on what issues related to the specifications of the new integrated service, its implementation and evaluation. The actions within the team might have given an impression that the team or its members had the right to make the decisions while it was not necessarily the case with the senior management not involved.

One of the indicators of lack of clarity on the team's role was a changing name given to the team by a sequence of newly appointed commissioners hosting the meetings throughout the project: *Clinical Advisory Group Diabetes Commissioning Pilot, Integrated Diabetes Transformation Team, Diabetes Project Board* (accompanied by Diabetes Task and Finish Group).

Unclear leadership within the team

The leadership arrangements within the team were initially not well defined. After three years of working together, the team members hold assumptions about who the leader on the team was (whether it was them or someone else) and whether there was a need for a single leader or a group of leaders, and what their roles would be:

Who is the leader? It is a good question. There is a little bit of a void I think. I think that the leader is meant to be me, who is driving it forward, and I think that I am happy to take it on. I think that the challenge is that if there is a single leader, there is only so much I can achieve. So actually I can be the clinical lead, but what I can't be is the management lead, so I have a corresponding management lead and then I think we probably need leaders in each organisation and each setting as well. So I don't think it is like a unitary person that need to be a leader.

Is there leadership? In the beginning, I did see one person a leader, the emphasis seems to switch a little bit to someone else, I was hoping that the strong leadership would come from that source. At the moment I don't feel that the leadership is strong and there have been too many personnel changes for me to feel that there is a strong leadership. [We need leadership that is] inspirational, focused, determined, ambitious, collaborative, and not just going through the motions.

It is vague, the structure and accountability of the group; people change, it was a bit unclear what the leadership structure was, even on practical level - who would chair a meeting, slightly awkward and not explicit enough.

Tensions within the team - managing competing agendas

Establishing a shared vision for the new service and working together towards making this vision a reality meant working with commissioners, clinicians of different clinical and managerial responsibilities, clinicians embedded in different cultures and driven by respective organisational priorities. This created tensions and managing them without clear leadership was challenging. The team members were aware of the tensions and of the importance of involving everybody, listening to all stakeholders, and balancing different agendas (priorities and timescales):

1 *I think there will always be tensions between the people who are in commissioning and*
 2 *managing roles who want to manage the process to get the results delivered as quickly as*
 3 *you can and the people who are clinicians who are delivering it trying to get the balance*
 4 *realistic time scale and not letting the thing wallow and not deliver. But I think it is a*
 5 *constructive tension.*

6
 7 *We have the right people around the table. It is hard to know how truly invested every*
 8 *single person is. And we have to make sure that we work to keep everyone feeling that they*
 9 *are fully involved. And it is a difficult task of managing this type of transformation. And we*
 10 *need to balance different agendas.*

11
 12 *You need some sort of vision to be able to say look, this is the vision that we have and to*
 13 *be able to sell that and motivate people in order to buy that. Listen to competing demands,*
 14 *there are different stakeholders, and each of the stakeholders has their own personal*
 15 *interests. And obviously everyone cares about the patient but then care about their role.*

16
 17 *Predictably doctors do all the talking. [One of the doctors] manages people who talk too*
 18 *much and he actively involves people who are not contributing. Being actively asked your*
 19 *view about something makes you feel more valued, everybody makes a contribution and it*
 20 *is a particular skill.*

21 *Vulnerability in face of challenges - managing an unstable environment*

22
 23 A lack of clear leadership, and a clear vision shared by everybody, made the programme vulnerable
 24 in face of problems that came along, namely the personnel changes on the transformation team,
 25 the changes in priorities across organisations, the changes in the proposed model of integrated
 26 diabetes service, and prolonging life of the project beyond initially proposed framework. The
 27 project survived and the team kept meeting but there was a growing confusion and frustration.

28 *Frustrations within the team - managing disengagement*

29 Full integration, being a complex transformation, carries a risk of being delayed, causing
 30 frustration and disengagement among the stakeholders. Leaders, focused on the final monumental
 31 goal may overlook opportunities of bringing stakeholders together by delivering small-scale
 32 changes (e.g. 'connected mini-transformations, Kelley-Patterson, 2012). On the studies project,
 33 there was a shared feeling that the transformation "was going slowly" and a concern that it might
 34 come to a halt. It took some time for the leaders to recognise and communicate within the team
 35 that delivering sustainable improvement may be a long process and what is needed to maintain
 36 engagement are:
 37
 38
 39
 40
 41

42 *Smaller tasks, shorter timeframe, something positive coming out of it.*

43
 44 This realisation encouraged the team to apply for smaller funding, to introduce elements of
 45 integrated care to pilot solutions and highlight the positive aspects of working together, and finally
 46 - proceed to a bigger pilot and continue working towards the full integration.
 47
 48

49 **DISCUSSION**

50
 51 The case study provided insights into the complexities of and challenges to leadership during an
 52 integrated care project being an adaptive challenge (Heifetz, Linsky & Groshow, 2009) within a
 53 context of dynamic complexity (Senge, 1990). The study revealed how a service transformation
 54 project aiming to integrate primary and specialist care can be hindered if leadership is not fully
 55 embedded at its multiple levels and the higher level leadership does not enable effective leadership
 56 at the lower levels. While 'the direction,' the narrative supportive of integrated healthcare was
 57 present across all leadership levels, the leadership arrangements and regulation/payment/financial
 58 tools for integration did not necessarily followed. The alignment was lacking at the system and
 59 organisational levels with inefficient resources being provided for leaders at the lower levels, and
 60 the commitment was not secured at the organisational level (especially senior and middle

management) and was not consistent among the members of the transformation team. The commitment at the system level was difficult to conceptualise unless the flexible approach to the payment and regulatory solutions was a sign of readiness to surrender own powers to enable local innovation in a more independent climate.

Rhetoric and reality of healthcare integration

Analysis of leadership at the system level revealed that the rhetoric of integration existing at the system level was not always reflected in regulatory, financial and incentive solutions available. Some of the policy barriers identified by other integrated care programmes across England in the first decade of the 21st century, including perverse incentives, inadequate commissioning, and the negative impact of regulation (Ham and Smith, 2010) were still relevant to the integrated diabetes care project years after. Regarding perverse incentives, the incentives rewarded individual services (payment by result) without rewarding collaboration. In terms of commissioning, clinically led approaches to planning and designing health services introduced in 2013 were seen as more likely to be both innovative and effective, however, the effective commissioning by the clinical commissioning groups have been hindered by three system barriers: lack of autonomy to make decisions that meet local needs, budget and resource constraints, and lack of support for tough prioritisation decisions (Robertson et al., 2016). In terms of regulation, the diabetes services were measured separately against different outcomes.

Also at the system level, the funding programmes rewarding development of innovative coordinated care services, including the Sustainability and Transformation Plans and the New Care Models Programme did not always meet with enthusiasm and support of the service providers what might impact on integration and leadership at organisational and transformation team levels. In the first case, the STP was seen as an opportunity by the integrated diabetes care transformation team but as the diabetes programme was advanced in its development, it had to be rethought to fit the priorities that occurred at the organisational level. Some may see it as disruptive to the work of the transformation team working within the bottom-up approach. Regarding the new care models, the status was awarded to some trusts across the country but not all, excluding the studied case, what meant that the resources have been allocated inconsistently across the country.

Overall, the system level leadership promoted integration and local leadership for integration, however, the environment with limited resources, not fully developed regulation, payment and incentive regimes, and the local services and individual service providers not being motivated enough to take risks and commit resources to integration, brought challenges to execute the recommendations. Additionally, the national programmes with valuable aims and objectives did not always match what was needed locally and what was already achieved. One could argue that this type of environment provides flexibility to develop programmes suitable to the local needs of services and leaders. However, it seems that leadership for integrated care is supported by vision but not necessarily solutions that the local leaders having a task of addressing and convincing the otherwise separate and independent organisations could utilise.

At the organisational level, leadership on the project did not have a clear structure throughout the organisation and was not explained to those who were expected to be led and be leaders (with often two functions joint). Without clear leadership it was difficult for a clear vision of a new service and stakeholders' role in it. If leadership for integration is coming from other source than upper level management, it needs to be supported at this level to be supported with a decision-making structure and provided with appropriate resources including project management (Ham and Walsh, 2013). In the studied project, this gap has made it difficult for leadership at the transformation team level to flourish.

At the transformation team level, 'shared/collective/collaborative' leadership for integrated care was a postulate rather than a reality. The participants still expected someone, one person, to 'fill in a void,' 'chair a meeting,' and provide 'strong leadership.' And while there was understanding that the team needs more than 'a single leader' and 'a unitary person' for the project to succeed,

there was not much clarity on how to proceed. In the end, after three years of working together, the idea of 'leaders in each organisation and each setting' was still only a demand. Since the study took place, this was negotiated and modified with healthcare practitioners cooperating in new ways (e.g., through the multidisciplinary team meetings) and taking up leadership roles centred around improving diabetes service. It is less and less about 'me in my organisation' with more focus on 'me in the system,' hopefully moving towards 'us for the patient.'

The challenges to aligning leadership at all levels

The studied case identified factors responsible for making leadership not fully aligned at the system, organisational and transformation team levels. Healthcare integration was promoted by the system level leaders, reflected in the national level policies, and followed by selected, nominated and funded projects to develop and test new models of care and contractual arrangements. It seems that the system level leadership for integration, although directed at all providers of healthcare considered to benefit from increased coordination of care, was not inclusive of all projects but only of the chosen ones. In the system created with the top-down approach there was little support for projects initiated locally in response to the local needs and searching for the local solutions; on one hand the health services were expected to integrate (as per the national policies) but on the other hand they were expected to wait till the piloted and improved models of care are rolled out across the country.

The studied local project who responded to the national policy call, and local policy calls aligned with the national policies as would be expected, found itself in a difficult position of balancing conflicting messages from the top with the aspirations of the local healthcare providers and receivers. The tensions at the organisational and transformation team levels were a response to this inconsistent system level leadership. In this context, the organisational level leadership was constrained by:

- operating in the times of uncertainty
- operating in the times of scarce resources for transformation
- operating in the times of prioritising savings over investment

The transformation team, taking responsibility for driving the change, was in a vulnerable position of developing a new service without the necessary support. Leadership alignment for full integration of primary and specialist care was challenged by:

- lack of evidence-based guidelines and resources to develop and implement the new service
- lack of evidence-based guidelines and resources to develop and maintain leadership within the team and establish its role against the organisational and system level leadership
- lack of clear communication pathways with the organisational level leadership
- lack of decision making pathways
- the tension between clinical leadership and middle and upper level managers
- the assumed leadership by the team members, the arrangements not being clear, maybe the problem of not being trained or reflective on what leadership is needed, not evaluating as the project was progressing
- personnel changes

Reasons for lack of full system and organisational level leadership for transformation team leadership

The first explanation of the leadership not being aligned is the clash between the system level plan developed by NHS England, and the local aspirations. The national plan was to be selective in developing and testing the new models of care and to be non-prescriptive with solutions to enable local adjustments (NHS England, 2014b). The second explanation is more extreme in thinking, suggesting that the system level policies of integrated care work as a discourse to manage tensions associated with healthcare funding and not as an intervention that can achieve most desired outcomes (e.g. a reduction in hospital admissions) (Hughes, 2017). The third explanation suggests that the alignment is never really possible because of the different value sets present at different

1 levels of leadership with the policy domain being responsible to the electorate, management
2 addressing corporate accountability, and the healthcare professionals seeking the best service for
3 patients (De Burca, 2008). The fourth explanation is related to leadership within the transformation
4 teams and a gap in the literature and practical advice on how to arrange and maintain effective
5 functioning of the teams to be able to drive the change within the constraints imposed by the system
6 and organisational level leadership; the insights into the practicalities of functioning of the
7 transformation teams are rare (e.g. Lejeune & Vas, 2011) with the literature on mergers and
8 acquisitions in the private sector bringing some suggestions around a need for a strategy on
9 managing change and people involved (Steigenberger, 2017) with a call for more research into
10 integration project management, integration team composition, and temporal dynamics within
11 integration projects (Nguyen & Kleiner, 2003).

13 *Practical implications*

14 This case study highlights the importance of clarifying the leadership model when developing an
15 integrated service and aligning leadership at the system and organisational levels of change. It also
16 emphasises the significance of establishing leadership at the transformation team level and
17 working out practicalities of collaborating when deciding on the specifications of the new service.
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21 Although the system level leadership for integration may not be easy to influence, the following
22 steps may help to build leadership at the organisational level to determine what and how can be
23 achieved:

- 24 ● know the decision making structure in all organisations involved and identify the
25 managerial leaders: clarify who will make the final decisions about the implementation of
26 the service and align decision making process across all organisations with indication who
27 on the transformation team needs to communicate what to whom
- 28 ● check if all leaders have project management support so that the message from all
29 organisations is well informed
- 30 ● held regular meetings (as the transformation team) with feedback from action points
- 31 ● divide the project into smaller tasks requiring cooperation and celebrate successes
- 32 ● establish if all leaders share the vision and accept their new roles
- 33 ● strong clinical leadership voiced at the meetings but also clinical practice in everyday
34 interaction across organisations
- 35 ● face-to-face engagement with providers of care to collect their views and address their
36 concerns
- 37 ● engagement with providers of care focused on supporting them, working together to
38 improve quality of care, sharing good practice and avoiding shaming those who do not
39 achieve
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43 **Key points:**

- 44 ● the importance of aligned leadership for integration at the system and organisational levels
45 with leadership at the transformation team level driving change locally
- 46 ● the gap between the rhetoric and reality of the system level leadership for integration of
47 healthcare may hinder full integration of projects functioning independently of the
48 nationally funded programmes
- 49 ● the principles of leadership for integration, for example a system leadership considered fit
50 for the purpose of working across professions and organisations, need to be followed with
51 practical solutions to organise and manage the transformation teams
- 52 ● there is a need for practical guidelines and step-by-step toolkits to support the local leaders
53 in integrating care
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43 Appendix 1. National policies - policy documents relevant to health services integration 2006-2016

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