

# System leadership

Lessons and learning from  
AQuA's Integrated Care  
Discovery Communities

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# Contents

|          |   |           |
|----------|---|-----------|
| <b>1</b> | <b>Introduction</b>   | <b>3</b>  |
| <b>2</b> | <b>The AQuA Integrated Care Discovery Communities</b>                     | <b>5</b>  |
| <b>3</b> | <b>The characteristics of effective system leaders</b>                    | <b>11</b> |
| <b>4</b> | <b>The current state of leadership in health and social care</b>          | <b>14</b> |
| <b>5</b> | <b>Developing the system leaders of the future</b>                        | <b>16</b> |
|          | 'Micro level' – team and locality   | 18        |
|          | 'Meso level' – services and patient pathways                              | 19        |
|          | 'Macro level' – whole system  | 19        |
|          | What does the AQuA Leading Integrated System-Level Change Programme do?   | 20        |
| <b>6</b> | <b>A case study: Manchester's 'Living Longer Living Better' programme</b> | <b>24</b> |
|          | Context   | 24        |
|          | Progress to date  | 26        |
|          | The evolution of new leadership roles                                     | 27        |
|          | Supported learning and development  | 28        |
|          | Reframed governance arrangements  | 29        |
|          | Reflections   | 30        |



|          |                   |           |
|----------|-------------------|-----------|
| <b>7</b> | <b>Lessons</b>    | <b>33</b> |
| <b>8</b> | <b>Conclusion</b> | <b>37</b> |
|          | Bibliography      | 38        |
|          | References        | 40        |
|          | About the authors | 43        |
|          | Acknowledgements  | 44        |



# 1 Introduction

Across the world health care systems are under pressure. Policy-makers and health and social care leaders are individually and collectively searching for approaches that can deliver better-quality, safer care and improved health at a reduced cost – the holy grail of health strategy. We have to rethink the way care is delivered, and improved co-ordination around the needs of the individual will almost certainly be part of the solution.

In England a cross-party consensus is forming around the concept of ‘integrated care’ approaches as the best hope for a sustainable NHS in the future ([Goodwin et al 2013](#)). There is general agreement that the goal involves more joining-up of services around the needs of individual patients and citizens. However, there is less agreement, and scant real evidence, about the best means of achieving this. The challenge to leaders in the health care system presented by this aspiration is immense as there are unlikely to be any ready-made formulae that can be easily applied. Leading across complex interdependent systems of care is a new and different role that needs to be undertaken alongside the already difficult task of leading successful institutions.

We believe that enough has been written to make the case for the need for a new style of leadership across health and social care systems ([Ham and Walsh 2013](#); [Goldsmith no date](#)). The task now is to identify the skills, knowledge and behaviours that this new breed of system leaders will need if they are to be successful and to consider how such an approach to developing leadership – which is likely to be different to that found inside many of our institutions – can best be fostered.

This paper:

- describes the work carried out by AQuA (the Advancing Quality Alliance) and The King’s Fund in the north-west of England between 2011 and 2014, which has taken a ‘discovery’ approach to developing integrated care and the leadership capabilities to support it



- considers why the style of leadership currently dominant in much of health and social care does not lend itself well to leading across complex integrated networks and the implications for developing system leaders
- sets out in general what we have learned about the skills, knowledge and behaviours displayed by the most effective 'system leaders' and system leadership teams
- explores in more detail the learning from an in-depth case study in relation to one particular community – the City of Manchester
- concludes with reflections on this work for those interested in the development of the system leaders of the future.



## 2 The AQuA Integrated Care Discovery Communities

If it is true that ‘the system is perfectly designed to get the results it gets’ we will need to redesign the system that produces and develops health care leaders if we want them to think and act differently (Batalden 2008).

This section of our paper describes the learning emerging from work over the past three years in the north-west of England with this assumption as its guiding principle. Since 2011 AQuA and The King’s Fund have worked in partnership to support a new form of learning and development – an Integrated Care Discovery Community. The aim has been to accelerate the development of effective integrated care systems, while at the same time helping to grow a new cadre of system-level leaders ([OPM 2014](#)). Nineteen health and social care economies have come together to share insights and learning.

AQuA is unusual in the NHS in that it is a membership-funded improvement agency working at regional level hosted by a foundation trust. AQuA has 72 NHS organisations in membership drawn equally from commissioners and every sector of providers. One of the organisation’s core aims is to support members to join up services around patients in order to achieve improved health, better quality of care and better value for taxpayers’ money.

From the outset of this work, both AQuA and The King’s Fund believed that a traditional leadership development approach would not be best suited to this particularly complex challenge. We recognised that the members of the Discovery Communities were at different stages in their progress towards integrated services, operating in different geographical, organisational and relational contexts. Their learning needs were not fully understood, although we observed a preference for technical tasks and skills-based training. This is not surprising: it fits with a



common preconception of training and development and often feels safer. One of our challenges was rapidly to build trust and safety in the communities so that they could also work on leadership behaviours and group development.

It was clear that a standard one-size-fits-all development programme would not deliver the outcomes the Discovery Communities aspired towards. Instead our strategy was to develop and support learning communities founded on the principles of learning in complex adaptive systems.

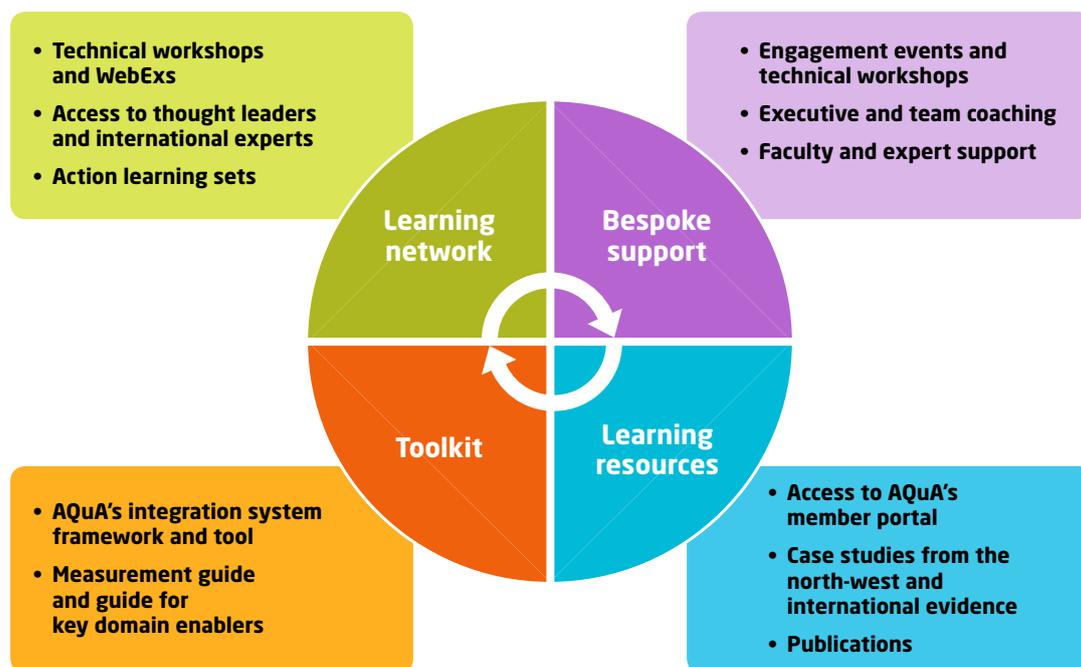
### Learning in a complex adaptive system

- Learning needs emerge and change
- Inter-organisational and inter-professional teams are critical to successful change
- What works is context specific... so local organisation and health economies will need to adapt not just adopt
- A successful change will require attention to technical aspects ('the anatomy') and cultural aspects ('the physiology').

(Zimmerman *et al* 1998)

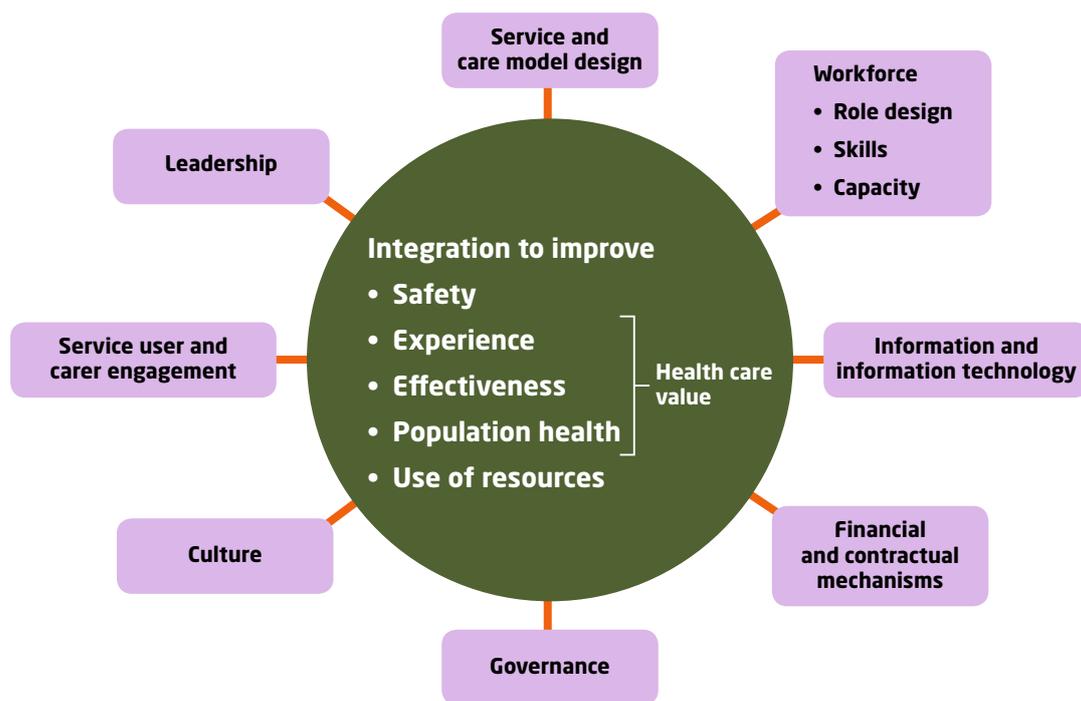
Over the three years since the Integrated Care Discovery Community was created members have worked together in a variety of ways to test out ideas and to develop new knowledge, skills and behaviours. While there has been input from recognised national and international experts on integrated care, there has also been a continued and strong emphasis on the rapid testing and implementation of learning in local communities. Figure 1 opposite sets out the key aspects of how the Integrated Care Discovery Communities have operated.

**Figure 1** How the Integrated Care Discovery Communities operate



Feedback from community members endorsed the AQuA Integration System Framework (see Figure 2 overleaf) and Assessment Tool (see Figure 3, p 9) as being particularly helpful interventions. The framework was developed from observations that many organisations and communities found themselves struggling to know where to begin. The Discovery Community therefore created an eight-domain framework to provide some structure and starting points to tackle the barriers to integrated care at system level. The framework has been developed, tested, adapted, refined, implemented and evaluated over the past three years, and that process continues as new knowledge emerges, and as communities adapt the framework to suit local needs. Currently it serves as a way of focusing the community teams on all the elements that we understand impact on the delivery of integrated care services.

**Figure 2** AQuA's Integration System Framework



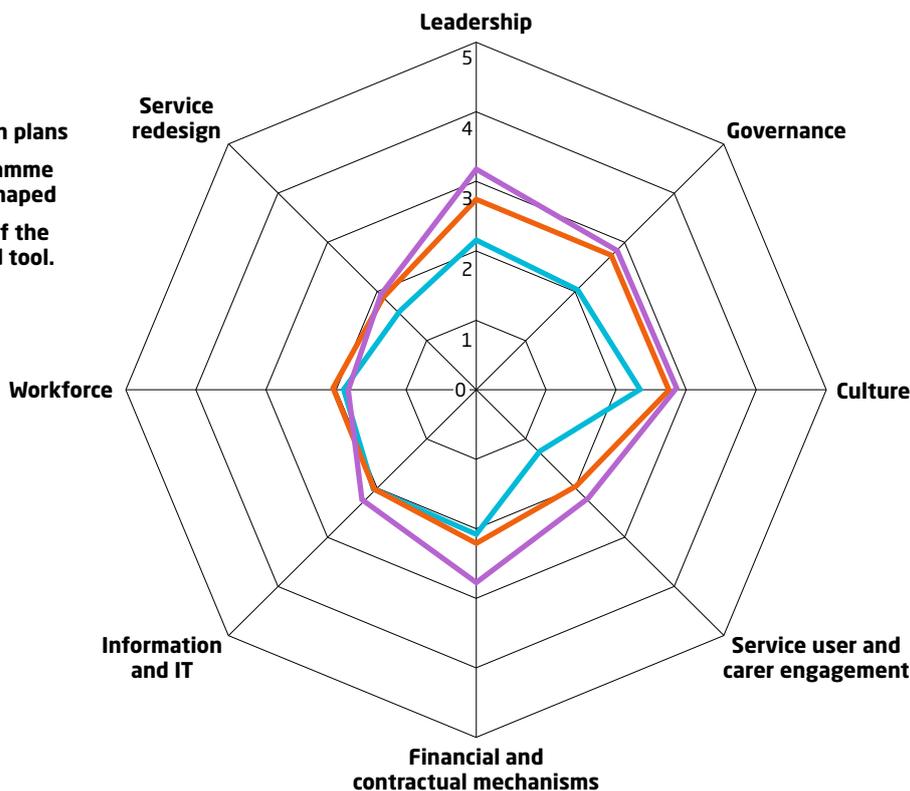
There is much valuable learning in relation to each of these domains. Some of them are harder-edged – representing what Zimmerman describes as the anatomy of integrated services. These include work on service and workforce redesign, infrastructure and IT, and finance and contractual mechanisms. Others are softer (though not easier!) and represent the physiology of the integrated system: they include work on leadership, patient and carer engagement, governance and culture.

The Integrated Care Framework Assessment Tool has enabled health economies to assess their current level of readiness in relation to the introduction of integrated care approaches. It has also given them focus as they have planned actions for improvement and measured progress over time across the key enablers.



**Figure 3** AQuA's Integrated Care Framework Assessment Tool

- This informs:**
- economy action plans
  - how the programme of support is shaped
  - development of the framework and tool.



|   | April 2012 | October 2012 | May 2013 |
|---|------------|--------------|----------|
| <b>Leadership</b>                           | 2.13       | 2.71         | 3.15     |
| <b>Governance</b>                           | 2.00       | 2.71         | 2.79     |
| <b>Culture</b>                              | 2.33       | 2.74         | 2.83     |
| <b>Service user and carer engagement</b>    | 1.25       | 2.00         | 2.21     |
| <b>Financial and contractual mechanisms</b> | 2.08       | 2.21         | 2.79     |
| <b>Information and IT</b>                   | 2.08       | 2.03         | 2.27     |
| <b>Workforce</b>                            | 1.88       | 2.03         | 1.83     |
| <b>Service redesign</b>                     | 1.54       | 1.84         | 1.88     |

**Note:** The Integrated Care Framework Assessment Tool asks participants to score themselves on a range from a 0 (low) to 5 (high) on their self-assessed capability level across each of the eight domains. They are guided in this by a series of definition statements for each level for each domain. The scoring shown was carried out in Salford during a period of just over a year but it is typical of the patterns generated by teams within communities. The value of the tool lies in generating debate among partners, creating a shared awareness of strengths and weaknesses, and helping to develop jointly owned action plans.



An excellent example of this is to be found in the community of Salford. Here Salford clinical commissioning group (CCG), Salford Royal NHS Foundation Trust and Salford City Council have been working together to develop an integrated care programme to meet the needs of a fictional but typical resident – Sally Ford – and her family. Similar approaches have of course been adopted earlier and successfully in Torbay (Mrs Smith), Jonkoping (Esther) and elsewhere. While these all use the device of a person as a means of engaging communities and stakeholders around individual needs, it is worth noting that Sally Ford is from Salford. She speaks with a Salford accent, lives in a Salford street, travels on Salford trams. This then is an example of adaptation as much as of adopting good practice from elsewhere, and it reflects Zimmerman’s notion that improvement approaches must be context-specific.

Leaders in the Salford community used the AQuA framework at six-month intervals to self-diagnose progress and areas in need of attention. They encouraged teams at different levels in each of the partner organisations to use the framework and through this process gained insights by comparing the results. This activity has in itself been an important leadership development intervention: exchanging information, testing assumptions and coming together to develop a shared understanding of need and strength across the community partners has helped leaders to break down barriers and forge new relationships.



## 3 The characteristics of effective system leaders

The NHS and local government have many highly experienced, capable and skilled leaders. They have risen to leadership positions in complex, politically charged environments and are battle-hardened from their experiences of seeking to improve quality in ever-more challenging economic times. So why is it so difficult for these leaders to shift their focus to deliver more co-ordinated approaches? The Discovery Community has attempted to answer this question by drawing on lessons from outside the health and social care system.

There is a fascinating literature on the differences in nature between markets, hierarchies and networks, illustrated by Walter Powell's summary shown in Table 1.

**Table 1** Learning from other sectors: markets, hierarchies, networks

| Key features                        | Market              | Hierarchy               | Network                     |
|-------------------------------------|---------------------|-------------------------|-----------------------------|
| <b>Normative basis</b>              | Contracts           | Employment relationship | Complementary strengths     |
| <b>Means of communication</b>       | Prices              | Routines and rules      | Relationships               |
| <b>Conflict resolution</b>          | Haggling/litigation | Administrative edict    | Reciprocity seeking win/win |
| <b>Commitment among the parties</b> | Low                 | Medium to high          | High                        |
| <b>Tone or climate</b>              | Suspicion           | Formal bureaucratic     | Open-ended mutual benefit   |
| <b>Actions</b>                      | Independent         | Dependent               | Interdependent              |

Source: Adapted from Powell (1990)



Using Powell's model we would suggest that the NHS in England maintains all the characteristics of a hierarchy. Although arguably versions of an internal market have existed since 1989, the predominant culture is still one of direction or regulation from above. Foundation trusts are ostensibly independent but are heavily regulated and many senior leaders feel themselves to be in a hierarchical relationship with Monitor. For NHS trusts this is even more clearly the case in terms of their relationship with the NHS Trust Development Authority. Sir David Nicholson's exhortation for leaders to look 'outwards not upwards!' is not in reality the dominant leadership strategy within the NHS (Thompson *et al* 1991).

Why is that a problem? After all, routines and rules that support regulation, monitoring and compliance with safety and performance targets are undeniably important. But if hierarchies are useful for many things, they are not the most effective structures for co-ordinating products and services across complex interdependent networks. In other sectors there has been a growing trend towards different forms of social and economic organisation. This is apparent in fields as diverse as textiles, finance, telecommunications and the media and film industries (Tam 1994). These new organisational forms lie part-way between traditional corporate hierarchies and free markets. They have been characterised in a variety of different ways – as strategic alliances (Jarillo 1988), dynamic networks (Miles and Snow 1986), or value-adding partnerships (Johnston and Lawrence 1988).

In the commercial world new forms of leadership have emerged to support these dynamic networks. These leaders display a new set of attributes that are different from the ones that helped them successfully climb the corporate ladder (Moss Kanter 1985). They must:

- learn to operate without the might of the hierarchy behind them and use their individual skills rather than their formal position to achieve results
- be able to compete in a way that enhances rather than undercuts the competition – to do this these leaders must become successful collaborators
- conduct their business to the highest ethical standards; trust is crucial to successful alliance-building
- develop a process focus – concentrating not only on what is to be achieved but how.



Such networks are consciously managed by entrepreneurs who use collaborative approaches to pursue their institutional objectives. What lessons are there in this for the NHS? Even the guru of private sector competitiveness, Michael Porter, has recognised that to deliver improved value (increased quality at lower cost) there is a need for health care organisations to co-operate together across the whole value cycle of care delivery. Porter's argument is that 'accountability for value should be shared amongst the providers involved' rather than 'focussed factories concentrating on narrow groups of interventions, we need integrated practice units accountable for total care' (Porter and Teisberg 2006).

In its next stage of evolution, health care needs to operate much more effectively through dispersed networks rather than through top-heavy hierarchies.

In the next section we consider how far the NHS exhibits the type of collaborative leadership now seen in some commercial settings.



## 4 The current state of leadership in health and social care

A seminal King's Fund report on health care leadership in 2011 observed that a leadership model holds sway within the NHS based on the idea of the single heroic individual ([The King's Fund 2011](#)). Such a model has been fostered in part by the dominant political and clinical role models within the service. The heroic leadership style suited the goals of capacity-building and target delivery within institutional silos as the NHS sought to reduce long wait times during the 2000s.

It comes as little surprise that a deeper analysis of almost 1,000 top health care leaders found that 80 per cent had 'pacesetting' as a favoured style. Pacesetters are good at driving up performance on a narrow range of goals within a single organisation ([The King's Fund 2012](#)), but the characteristics of pacesetting are a long way removed from those displayed by effective leaders of dynamic networks in the commercial world.

As Ham and Hopson make clear, 'the skills required to lead different organisational models are often different from those required to run a successful single institution' ([The King's Fund and Foundation Trust Network 2014](#), pp 3–6).

Indeed, the pacesetting style identified as predominant among top NHS leaders is in many ways antithetical to the leadership requirements for effective integrated care services. Pacesetting leaders 'know' what is required, and waste little time asking questions, since uncertainty may be perceived as a weakness and shared understanding takes time to achieve. But in complex adaptive systems there is much that is unknown: uncertainty and ambiguity are the modus operandi for leaders. While decision-making across organisational boundaries and traditional governance structures is a lengthy and often frustrating process, the lack of shared goals, of



collective understanding of the issues and of the opportunity to hear from many voices means that system-level plans fail, too often, to deliver system-level change.

Based on our experience of working in-depth with such leaders over the past three years, curiosity, connectivity and coaching capability seem to be far more significant traits of effective leadership in the current health and social care environment. This is explored in more detail in Chapter 6 in relation to the specific example of the City of Manchester.

This analysis is not exclusive to the health sector. Archie Brown, in *The myth of the strong leader* (2014), describes the sub-optimal perception of the role of the head of an organisation as ‘the leader as boss’, described in earlier work by Peter Senge (2006). Brown is talking about political leaders but the same holds true for the NHS. He goes on to argue that more successful leadership is collegiate in form. Collegiate leaders are only as effective as the people they delegate to and work with, which suggests that the real job of a leader may be to build and support leadership capability within her or his organisation or system.

Brown also points out that for collegiate leadership to succeed there must be a substantial shift in our understanding, culturally, of what makes a good leader. ‘The strong leader may be a myth,’ he contends, ‘but it is a powerful one.’



## 5 Developing the system leaders of the future

Developing leadership capability requires a dual focus: both on developing individual leaders and on developing a leadership system. We should ‘...be wary of great leaders... (and) hope that there are many small leaders’ (Seeger 2011). Effective leadership in complex systems is not solely an attribute of top bosses, but is better understood as a shared process of many ‘small’ (and great) leaders working together with empowered followers to get things done in the context of a shared understanding of local needs.

If the problem exists at the level of the system then logically the solutions will not be exclusively at the level of the individual. We cannot hope to address a need for effective system leadership simply by working to develop individual leaders. Just seeking to replace the power-hungry pacesetters of today with the collegiate and collaborative coaches of tomorrow will not be enough – unless we also change the incentive structures and organisational relationships that impact upon them. And, as we go on to explore in this report, the system needs both pacesetting leaders and collaborative coaches if it is to deliver integrated services rapidly and sustainably.

As West *et al* note, ‘traditional approaches to leadership have focused on developing individual capacity while neglecting the need for developing collective capability or embedding the development of leaders within the context of the organisation they are working in’ (2014).

Our work with the Discovery Community has focused on developing individual system leaders and at the same time on developing relationships between these individuals and also between their organisations.

The requirements for system leadership do not negate the requirements for effective organisational leadership. As we have said, both types of leadership are necessary and important. Rather than seek to develop super-leaders, who have the leadership



attributes required both to lead effective organisations *and* to lead across systems, might it be possible to develop leadership capability within systems that collectively encompasses all of these qualities?

The Discovery Community has developed a framework for the knowledge and skills needed for successful leadership across integrated systems.

**Table 2 Knowledge and skills framework**

**What skills and knowledge do you need to do this?**

|                               |   |
|-------------------------------|---|
| <b>Technical know-how</b>     | <ul style="list-style-type: none"> <li>• Service design</li> <li>• Governance arrangements</li> <li>• Innovative contracting and financial mechanisms</li> <li>• Technological ‘savvy’</li> </ul> |
| <b>Improvement know-how</b>   | <ul style="list-style-type: none"> <li>• Systems thinking</li> <li>• Improvement science</li> <li>• Large-scale change</li> </ul>   |
| <b>Personal effectiveness</b> | <ul style="list-style-type: none"> <li>• Interpersonal skills and behaviours</li> <li>• Coaching ability</li> <li>• A visionary and participative style</li> </ul>                                |

A number of issues become clear when we analyse leadership capability in this way. First, systems with a serious aspiration to become more genuinely integrated would do well to pay attention to all three dimensions. Second, we have observed that leaders are often more naturally drawn to one or other of the dimensions – rarely to all three. Our experience is that leaders’ first response has often been to request more technical knowledge in their drive to deliver integrated services. This observation aligns with the notion of leaders as predominantly pacesetters – a ‘give me the tools and I’ll get the job done’ approach. This assumes that ‘the job’ is known and agreed on by all, and that the leaders have the interpersonal skills to bring diverse and disparate views along with them in pursuit of ‘getting the job done’. We know that neither of these assumptions necessarily holds true in complex adaptive systems. Third, the conceptual frameworks and practical tools offered by improvement science are just as valuable when working across systems of care as



they are when tackling issues within institutions. Ham has recently argued that a mastery of improvement methods is one of the core attributes of enduring high-quality health care organisations (Ham 2014). In addition, Timmins has shown how in Canterbury, New Zealand, such methods were used to develop more integrated approaches to care delivery (Timmins and Ham 2013). Improvement methods can create a common language and approach that help connect leaders across professional and organisational boundaries. Our experience with the Discovery Community bears out these opinions.

The AQuA/King's Fund Discovery Community is adopting a range of approaches to develop system leadership at the micro, meso and macro levels with this aim in mind.

### 'Micro level' – team and locality

The Advanced Team Training programme has been adapted from a leadership development approach used by Intermountain in the United States. It brings together teams of staff on a multi-professional and multi-agency basis. They work together over a period of several months to learn about improvement methods, develop the technical skills to deliver change projects and build effective interpersonal relationships across diverse teams. Teams select and implement an improvement project that spans professional and organisational boundaries. The projects act as a vehicle for learning and a means of delivering improvements in a short time frame.

The Trafford health community was an early pioneer of this work. An evaluation of the impact within Trafford concluded that it helped to build a culture conducive to integrated approaches, even at a time when organisational restructuring has hampered the development of co-ordinated care (Shaw and Levenson 2011). This feedback supports our observation that the process of the team coming together to discover, learn and plan collectively has been as important as the technical and content knowledge that the teams have acquired on the programme.

A second example at the micro level is work to develop Integrated Neighbourhood Teams. This was one of a triumvirate of recommendations from the Department of Health Long-Term Conditions QIPP Programme, alongside developing risk stratification and self-management support for patients and their families. The



Integrated Neighbourhood Team is an important feature in the Torbay approach and has also been adopted by North West London. Some communities in the north-west of England, most notably Wigan and the City of Liverpool, are taking a developmental approach to this. They are setting out to become a learning community. They aim to ensure that Integrated Neighbourhood Teams not only have the technical infrastructure that they need to operate effectively, but also have leaders who understand the complexities of working in a multi-agency system.

### 'Meso level' – services and patient pathways

At the meso level AQuA has worked with the North West Leadership Academy in the delivery of the Leadership for Integration (L4I) Programme. L4I engages groups of commissioner and secondary care clinical leads, together with a manager and their social care partners, in a 12-month programme. Interventions include leadership development, improvement support for an integrated care project and a study tour to an international integrated health care system (NHS Leadership Academy 2013). Again, this example exemplifies the 'adapt...and adopt' approach cited by Zimmerman and others.

### 'Macro level' – whole system

At the macro level there has traditionally been less opportunity for senior leaders to work and learn together. Partly this is a function of time – senior leaders generally have little time to devote to non-business critical activity and have equally often perceived creating time to learn, explore and co-create with peers as non-business critical. Our analysis suggests, however, that if delivering integration is the core business, then investment in discovery and leadership learning across systems is essential. This is supported by the experience of Warrington. Its Health Summit for Senior Leaders in January 2013 concluded that:

*...there is a shared recognition across the partners in Warrington and Halton that a radical transformation of services is needed. Critical to delivering the vision are: the active engagement of staff across all partners organisations; strong leadership at every level [our emphasis], [and] investment in relationships so that the partners develop joint solutions to problems.*

**(Warrington Clinical Commissioning Group 2013)**



At the same time, recent messages from the highest levels in both the NHS and social care spheres endorse the notion that integrated services must be developed and led in the context of local needs: there is no one-size-fits-all model. For example, Simon Stevens in his speech to the NHS Confederation in June 2014 called for ‘different answers for diverse communities’ and ‘far greater local flexibility to meet the health and social care needs of the people we serve’ (Stevens 2014).

It is in this context that AQuA and The King’s Fund have designed and developed a new approach to support Discovery Communities – the Leading Integrated System-Level Change Programme.

### What does the AQuA Leading Integrated System-Level Change Programme do?

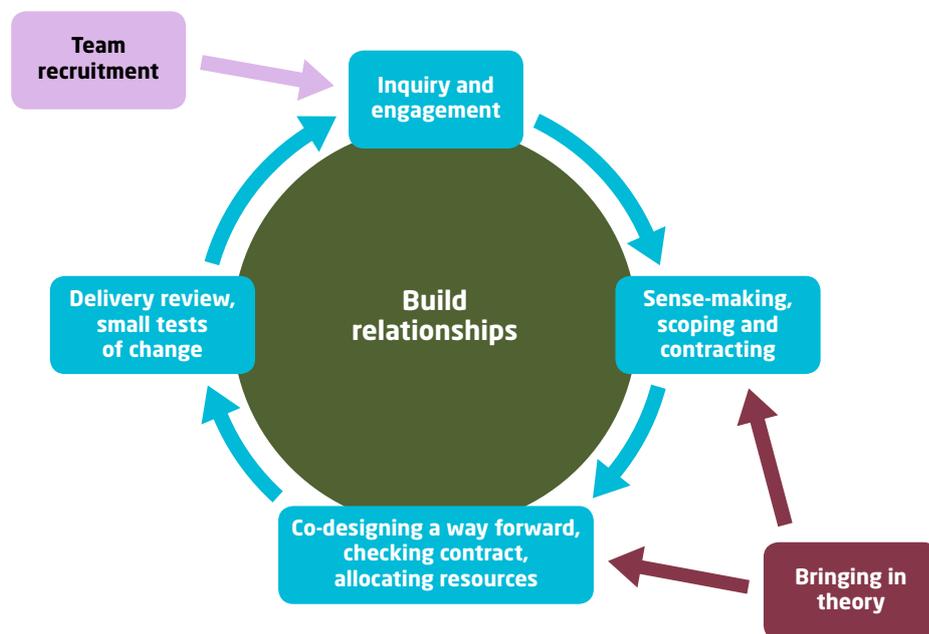
There are development programmes aimed at individual system leaders – Intersect, run by the National Leadership Academy, for example, and The King’s Fund’s own Collaborative Leadership programme, which seeks to develop very senior leaders in learning communities. There are also offers, such as the NHSiQ programme for pioneer sites, which provide development and support at local systems level. What sets the Leading Integrated System-Level Change Programme apart is that it aims to do both – that is, provide support to local senior leadership teams in the context of the wider, regional or national, health and social care system and at the same time to work to develop individual senior system leadership capability and skills. The benefit of this model for teams is that they work together to refine and extend their integration ambitions, and at the same time share their learning with peers. This fosters the development of a collective leadership culture ‘forging an interdependent network of organisations that work together to deliver high-quality care’ (West et al 2014).

This process – bringing together the senior leaders in a health and social care economy, together with other leadership teams engaged in the same endeavour; spending time reflecting on both the technical requirements for integration and the softer skills needed; and sharing that learning across and within systems – is beginning to develop the capacity for change leadership to support integration within local systems.



The Leading Integrated System-Level Change Programme has been developed around a number of theories and models that help to explain what good looks like, in relation to systems leadership.

**Figure 4** Integrated Discovery Community support



The programme has been co-designed with the Discovery Community to help the teams of leaders from north-west health and social care economies reflect and build on their work to date in leading system-level integration of care services.

The programme includes four masterclasses designed and delivered by Paul Plsek, the international expert on managing change in complex systems, and four



leadership development workshops designed and led by The King's Fund. The workshops incorporate contributions from national and international experts in aspects of delivering successful system-level integrated change, from both within and outside the health sector. All sessions focus on developing the skills and capability of senior teams to deliver integration at scale and pace, and provide the opportunity for teams to benchmark, share best practice, challenge and learn from peers.

The programme is designed to meet a number of leadership learning needs simultaneously:

- the development of technical skills and know-how: each masterclass and workshop looks at models, frameworks, theory and concepts that underpin approaches to leading large-scale change in complex systems
- the application of programme-learning to real system-level challenges: teams are encouraged to consider the learning in the context of their own local systems and to explore 'what this means for Trafford/Wigan/Manchester'
- the opportunity to learn from others, to benchmark and test ideas: speakers bring stories of their own journeys to integration, not as exemplars but as material to be explored, dissected and used where it is helpful
- the discovery of the behaviours and relational aspects of leading across systems that help or hinder: experiential activities have provided opportunity both to act on the learning and to learn in action. The programme space has represented a model of 'the system' in which participants can explore how to be effective system leaders and what gets in the way of this.

Teams have been offered additional coaching from senior programme faculty and some have found this helpful in focusing their team conversations onto specific and immediate local system challenges.

This is a new programme in a three-year journey of discovery and the Discovery Communities are still learning as this unfolds. Nevertheless there are already



some key themes emerging about the most effective ways to support system-level leadership for integrated care.

For example:

- Space to learn. AQUA and The King's Fund's partnership has essentially brokered a space for system learning: a forum in which ideas can be shared and tested, information is exchanged and in which, crucially, leaders are not expected to know all the answers. This is not dissimilar to the Qulturum concept in Sweden, and it recognises that in complex adaptive systems leaders must privilege time for learning, reflecting and connecting. We have observed that this has been liberating for some – but challenging for others.
- Focus on place. Leadership teams have discovered many differences in their approaches to integration: language, professional training, appetite for risk and sense of urgency, but one very strong unifying element has been the importance of place. Clearly such a focus potentially brings in a much wider range of system leaders than have been involved in the Discovery Community – patients and citizens, police and faith leaders, housing and local commerce – and many of the teams are using the Discovery Communities learning to explore how to engage more effectively across this much broader system.
- Insatiable curiosity is a key leadership trait for effective systems leadership. The desire to understand (rather than know), to learn (rather than teach), to share (rather than compete), to experiment (rather than stick to how things are always done), are all capabilities we have seen develop in the teams that are taking embracing the learning from the Discovery Communities and using it to drive their integrated care ambitions.
- Following on from all this, there is a requirement for almost all leaders to engage in considerable unlearning. That takes courage.



## 6 A case study: Manchester's 'Living Longer Living Better' programme

These themes are illustrated in the following case study into the work carried out across the City of Manchester. We should note that neither the authors nor the Manchester team would claim this as a model for others to follow – not least because, as we have noted previously, approaches must be context-specific. What works well in Manchester may not be relevant in Margate. At the same time, the Manchester example offers some insights into how a Discovery Community has used the learning in practice.

### Context

Manchester is a vibrant, dynamic city with a growing population. However, the city has the second-worst life expectancy for men and the worst for women in England. There is a higher than average prevalence of long-term conditions and deaths from circulatory disease are almost double the England average. What is more, across the city there is great variation in the levels of disease and in the way individuals receive their care ([Manchester City Council 2013a](#)).

The health and social care landscape across Manchester is a complex one. Within the area covered by Manchester City Council, with a population of more than 500,000 residents, there are seven NHS organisations – three CCGs, three acute/community services providers and a mental health trust. In addition of course there are also social services, general practices, an ambulance trust and many providers of care within the independent and voluntary sectors, as well as informal carers looking after friends and relatives.



Together the eight statutory organisations – the City Council and the seven NHS bodies – have committed to work in partnership. Their vision is to bring about ‘a radical change in the way health and social care services are offered in the city’. Furthermore, they recognise that this will require ‘a new culture amongst our professionals, our managers and leaders, and our citizens’ together with ‘new ways of using our financial resources so we can collectively achieve the best for our population’ (**Manchester City Council 2013b**).

The partners have been working informally together on the goal of integrated care since 2010. There are three CCGs (North, South and Central) covering the city and they had been progressing the development of integrated teams engaging GPs, social services, and their local acute and community service providers. This work had some success but there was a growing sense that it needed to move at greater scale and pace. Furthermore, there was an ambition to share learning across the city and to ensure that all residents can experience a similarly high standard of patient-centred care regardless of their place of residence.

Consequently early in 2013 a multi-agency group of eight senior leaders was created (one from each of the partners) to create a ‘blueprint’ for the way forward. This group captured the vision for Manchester as being Living Longer Living Better (**Manchester City Council 2013a**). The way in which this group has gone about its business has been a catalyst for an emerging new approach to public sector leadership in the city.

The need for a new style of leadership was explicitly recognised in the Strategic Outline Case, approved by the city’s health and wellbeing board in July 2013. This stated:

*If we are to build a new system of health and wellbeing...a whole system that works holistically for citizens and families at a neighbourhood or place level, we will need a new leadership approach.*

*The leaders of the new world in the context of public sector reform need to be able to work upwards, outwards, horizontally and vertically in their own and other organisations.*

**(Manchester City Council 2013b, p 94)**



## Progress to date

Over the past 18 months, the eight partners have begun to learn how to work together in a different way. Progress has varied in different parts of the city. At times there have been frustrating delays and obstacles. Yet there has also been a notable resilience and a determination among senior leaders to hold fast to their principles of partnership working.

An added complication has been that the drive towards greater health and social care integration has been taking place at the same time as two other significant developments that relate not only to the City of Manchester but also to the wider conurbation of Greater Manchester made up of 10 local authorities. The two other developments are the Healthier Together programme, which is a CCG-led reconfiguration of hospital services, and a primary care development programme led by NHS England as the commissioners for primary care. The leadership team in the City of Manchester has had to work hard to demonstrate the inter-linkages between these different programmes of work. They have striven to create a compelling narrative that makes sense to frontline staff and local citizens and which shows how these three inter-related programmes will affect the care delivered for Manchester residents.

Over the past 18 months there have been a number of notable steps forward:

- The programme has refocused its attention from the sickest 2 per cent to the whole 100 per cent of the population.
- It has agreed an approach to developing commissioning-led care models, which set out the standards of service delivery expected for particular groups in the population.
- Three city-wide care models have been prioritised and developed for adults at the end of life, adults with long-term conditions and frail older adults/ adults with dementia. These three are recognised as a start towards care models that will cover the whole of the population, and together they now cover 20 per cent of Manchester residents.
- Integrated multidisciplinary teams have been developed in each of the three locality systems (based on the CCG geographies). These have successfully



engaged the vast majority of GPs practising in the city alongside community services and social care professionals to deliver co-ordinated health and social care services.

- The work on Living Longer Living Better has been closely linked to the development of the Better Care Fund, which has been supplemented by local resources to create a local development fund. The aim of this is to provide the start-up capital and transitional funding needed to move towards new models of service delivery.
- Providers have been working in collaboration either informally or in some cases through formal alliances to create new service delivery models in response to the commissioning-led care specifications. Twenty such business cases have now been developed and approved.
- A framework for measurement and evaluation of the programme has been developed with metrics demonstrating impact on services such as reduced hospital admissions, improved experience of care with feedback from citizens and patients, and improved value for money recognising the significant financial challenge faced by the NHS and particularly the local authority.

Underpinning these achievements have been three important developments: the evolution of new leadership roles; supported learning and development for those leaders; and the establishment of a governance framework to underpin this, which seeks to highlight and address potential inter-locality and inter-organisational tensions and conflicts.

### The evolution of new leadership roles

As Living Longer Living Better has developed, the partners have recognised the need for clear and cohesive system leadership. The overarching body responsible for this is the health and wellbeing board. Crucially in Manchester, this consists not only of commissioners and elected local authority members but also representatives of the key statutory providers in the city. While the health and wellbeing board has a much broader remit than Living Longer Living Better, the programme is seen as one of the most important vehicles by which the health and wellbeing board will implement its vision for transformed public services in the city.



Supporting the health and wellbeing board is an executive health and wellbeing group, chaired by the City Council chief executive. This has chief officer (and in the case of CCGs, clinical chair) representation from all of the partners. Again it has a wider remit than Living Longer Living Better but the programme has dominated the executive health and wellbeing group's agenda over the past year. The CEOs on this group have continually emphasised their commitment to a partnership approach. They have also made it clear that while changes to services need to be implemented at locality and neighbourhood level, they are seeking city-wide consistency in terms of the standards of care delivered. The CEOs' group has played an important role in generating an ambitious vision while at the same time remaining rooted in the day-to-day challenges that the system faces.

Supporting these two groups has been a new leadership construct which emerged from the team that developed the blueprint document in 2013. This has been dubbed the City Wide Leadership Group and in many ways it has been the 'engine room' driving Living Longer Living Better forward. The group has representatives from all eight partner organisations together with other important players including the director of public health. The group has been constructed in such a way that its members have a system-wide role working on behalf of the city overall while also retaining their own organisational responsibilities. In this way they create a bridge between the statutory role of each individual partner and the determination of those partners to work in close collaboration on behalf of Manchester.

The development of the City Wide Leadership Group has not been without its challenges. In particular, these have included some of the inherent conflicts in the roles of these individuals as well as potential over-burden due to the pressures of leading a city-wide programme while at the same time maintaining significant responsibilities back within their own institutions. The key to the group's success has been its commitment to reflect on and learn from its experiences and to make constructive changes as a result.

### Supported learning and development

Members of the City Wide Leadership Group have taken part in a range of development events during the 18 months of the Living Longer Living Better programme. The partners are all AQuA members and have participated in a variety of development interventions linked to the AQuA Discovery programme. Most



recently they have found the Leading Integrated System-Level Change seminars led by Paul Plsek using the principles of complex adaptive systems to be of particular value. In addition AQuA has provided support as coach and critical friend to the group. This has included a number of development sessions that have helped the group's members think through their own individual styles and approaches and the resources that they can draw on to handle conflict constructively. The concept of 'disruptive governance' has been important here, namely recognising that conflict is healthy and desirable and that the absence of it might suggest that important differences are being accommodated or 'swept under the carpet'. The group has learned together the best ways of bringing such issues to the surface and working through them to achieve mutually beneficial solutions.

### Reframed governance arrangements

Early in 2014 a governance review was conducted by AQuA in relation to the Living Longer Living Better programme structure. As a result a number of changes have been made to further strengthen the work. These include:

- clarification of the role and responsibilities of the City Wide Leadership Group in relation to the executive health and wellbeing group
- a stronger input from professional leads in relation to the various enabling domains such as HR, estates and IT (this proved to be particularly effective in relation to finance, with the engagement of finance directors as the proposal for the Better Care Fund was shaped)
- a strengthened programme office as the 'glue' that holds the programme together
- a recognition that implementation will take place at locality and neighbourhood level and that the same spirit of partnership working and skills of system leadership need to be distributed across a much wider cohort of leaders.

Development work has now begun in each of the localities to facilitate the emergence of these new relationships and a new leadership style.



## Reflections

Living Longer Living Better is one of the most complex and ambitious integration initiatives anywhere in England. Impressive progress has been made over an 18-month period, including on:

- a spirit of co-operation and collective working among the eight partners
- the development of the City Wide Leadership Group as an engine room to drive change
- top-level commitment from chief executives and from health and wellbeing board members
- the development of care model specifications identifying the standards that commissioners want to see delivered for priority population groups
- alignment of the Better Care Fund and Local Development Fund to create transitional resources
- a conscious effort to develop a new leadership style and culture.

Despite this progress, considerable challenges remain:

- Some of the enabling work streams have progressed more quickly than others. There is a particular need to accelerate progress in the areas of work force, IT and technology.
- Some of the City Wide Leadership Group members have become overstretched as they have been carrying this work out on top of busy day jobs.
- The management and leadership resources to support the programme will need continued attention and support as the work progresses.
- The development of successful integrated care models at scale is not merely a technical challenge but also a cultural one. The capacity and capability of leaders at every level in the system is a vital component.



Delivering on our vision for Manchester is not an easy task as it is such a complex system with eight organisations, general practitioners, and of course thousands of informal carers. The progress that we have made over the last year is reflected in the fact that people are increasingly thinking in terms of place – the City of Manchester – rather than just their own institutions. At the same time we need to be realistic and recognise that the goal has to be to deliver both the system’s aims and also those of individual organisations. To do this we need a leadership style that is both visionary and participative and at the same time challenging in a respectful way so that we can produce real progress and real results at a scale and pace.

The role of the health and wellbeing board, which in Manchester has provider members on it, has been critical over the last year in setting direction and providing top-level support for this work. In my own role I work hard to understand the challenges that colleagues in other organisations face so I can best help them to tackle the barriers that will inevitably exist. I think that this is the best way for us to make progress towards what is a very exciting common vision.

**Mike Houghton-Evans, Strategic Director, Families, Health and Wellbeing, Manchester City Council**

I do believe we’ve made good progress in developing our partnership over the past couple of years. But it is a slow process and you need patience and tenacity to build the right types of relationships. We still have a tendency to agree things in principle in partnership forums but when we get back to our organisations other pressures can overwhelm our good intentions.

Many of our partner organisations are in themselves large and complex, so freeing up time to work with others isn’t easy. I’ve personally learned a huge amount over the past year about the different culture and perspectives in primary care, social care and particularly in the voluntary sector. We are a partnership of equals so can’t get things done through the kind of hierarchical governance arrangements you have at a foundation trust. You need instead to build understanding, trust and confidence.

Of course there are big challenges ahead – such as finding adequate transitional funding and reskilling our community-based workforce. But by working together we have a much better chance of improving care for our patients, which at the end of the day is what we all want.

**Gill Heaton, Chief Nurse/Deputy Chief Executive, Central Manchester University Hospitals NHS Foundation Trust**



The work that we are doing together in Manchester is built on a legacy of effective joint working over a number of years. Nevertheless, getting such a large number of partners signed up to a common vision has been no easy task. An even bigger challenge is that of implementation, though we are just beginning to see measurable results on the ground. A number of things have helped in this process. The clear direction set by the health and wellbeing board and executive health and wellbeing group is very important. The city-wide leadership group has been an invaluable 'engine room' for change and helped make sure we are striving for equity across the city as a whole. The City Council has played a particularly important role. Its emphasis on demonstrating delivery at pace isn't always easy but is a useful challenge. Finally, the way in which the finance teams have worked collaboratively to set measurable goals and thinking about incentives has really helped.

I've worked in a variety of leadership role in Manchester for almost 20 years and this long history of good working relationships is definitely a plus point. As Chair of the CCG, which is a membership organisation, I know that I have to draw people together and work towards a consensus. That fits well with my preferred personal style and I aim to carry that approach forward into our wider partnership work. We know that we can achieve far more for our patients and the people of Manchester by working collaboratively with others than we possibly can on our own.

**Dr Mike Eeckelaers, Chair, Central Manchester Clinical Commissioning Group**



## 7 Lessons

In our final section we reflect on lessons for developing system leaders. These draw on our review of the literature and experience in other sectors; but they have been particularly strongly shaped by three years' 'hands-on' experience working with the members of the AQuA Integrated Care Discovery Community.

- 1. Build the will to develop a new cadre of system leaders.** In our experience a new style of system leadership begins to develop only when there is a widespread readiness for change across any particular community. Curiosity, a willingness to learn and a recognition that a new approach is needed are essential.
- 2. Adapt and apply the principles of complexity science and of leading large-scale change.** Health and social care organisations are complex adaptive systems. Successful approaches to developing system leaders recognise this. This entails an acceptance that there is no single right way of moving forward; it has to be context-specific. It helps to adopt a systems-thinking perspective and to recognise that learning needs will emerge and change over time. Leaders must be comfortable working across often blurred boundaries and are far more likely to become engaged if there is a process for seeking their personal commitment through a compelling narrative that speaks to the heart as well as the head.
- 3. Adapt and apply the principles of improvement science.** Recent studies have concluded that the world's most successful health care systems share a number of common characteristics (Baker 2011). The foremost of these is the widespread and systematic use of improvement methods. An improvement science approach will encourage learning by doing, using small tests of change to identify what works best for a particular community, while being forever mindful of the cultural aspects of change, not just the technical. In this way leaders will develop an ability to lead across systems through an iterative series of plan, do, study, act cycles. As Fuller (no date) pointed out, it is easier to 'act yourself into a new way of thinking than think yourself into a new way of acting'. Approaches to developing system leaders that are overly theoretical or academic are likely to lack this important perspective.



- 4. Support the development of many system leaders at multiple levels within the system.** Our examples suggest that key to this is a distributed approach to leadership, where clinicians and managers at every level in the system have the knowledge and skills to work effectively across boundaries, influencing and persuading others to deliver common goals (West *et al* 2014). But we also recognise the need for strong and effective organisational leadership. The two leadership strategies must co-exist, within the system if not within individuals. This point is echoed in lessons for success from the Local Vision programme, which argues for the need for ‘...leaders to see themselves as part of the collective leadership of the system, *as well as* [our italics] a leader of their own organisation. Organisational success must not come at the expense of the system as a whole...’ (Vize 2014).
- 5. Have a place-based focus.** Successful system leaders are more likely to emerge where there is a common vision and a set of ideals focused on the needs and ambitions of a particular community. A dialogue with local people encourages leaders to work together across boundaries and can add energy and urgency to the need to improve. Tapping into the connection people have with place can help system leaders to transcend more temporary attachments to organisational form and to develop a set of common goals anchored in what is good for a community.
- 6. Develop effective mechanisms for handling conflict.** As new forms of leadership emerge across systems conflict is inevitable. Indeed the absence of conflict would be both worrying and potentially damaging as it might suggest that important issues are being ignored and that opportunities for imaginative win–win solutions are being missed. Any approach to developing system leaders needs to tackle this head-on. New-style leaders need effective means of airing conflicts whether they be individual, professional or inter-organisational, and of handling them in a constructive and system-minded fashion.
- 7. Build a virtuous triangle of new leadership roles, supported learning and effective governance.** There is an interdependency between new roles that will often include both institutional and system responsibilities, supported learning and development to allow leaders to gain the new knowledge, skills and behaviours they need and effective governance mechanisms. The latter serve as an important holding framework that can help minimise potentially



challenging conflicts, while at the same time fostering ‘creative difference’ and generating wide-ranging debates about future possibilities and the means for achieving these.

- 8. Simultaneously develop system leaders and the system for developing system leaders.** Too many leadership development programmes concentrate only on meeting the learning needs of individual leaders themselves. They can fail to recognise the wider opportunity to share the way in which these leaders think, act and work. Successful approaches will simultaneously support the personal growth of individuals and pay attention to the many wide-ranging factors that are impacting on their leadership style and behaviours. This is likely to include the selection, reward and recognition systems and the behaviours modelled by the most senior leaders in the system. Chief executives who exhort their teams to adopt collaborative behaviours but who then consistently and only act in competitive ways will seriously undermine the message.
- 9. Be patient, persistent and resilient.** The evidence suggests that securing system-wide bottom line improvements takes time. Anthony Staines described the concept of the investment threshold, arguing that organisations can take five to seven years from the start of an improvement initiative such as the development of an integrated care system to the delivery of system-wide bottom line results (Ovretveit and Staines 2007). During this period it is helpful to think of these organisations as making an investment in the balance sheet rather than seeking improved operating results. Only when an investment threshold is reached do improved outcomes begin to be seen. It takes time to build the will, skills and relationships needed to make integrated care systems a success. During this period leaders need to hold their nerve and generate a series of ‘small wins’ to build momentum behind the change. The peer support generated by programmes such as Leading Integrated System-Level Change helps leaders to benchmark and support each other during what may seem to some a lengthy transition.
- 10. Measure impact.** In our experience the lack of impact measures in most of the current attempts to develop system-wide leadership is startling. Even though population-wide improvements do take time to deliver, a formative evaluation framework that captures learning as the work progresses is invaluable. It assists in building the momentum described above and also gives those leading the work important signals about what is proving to be effective and what isn’t.



Any such evaluation framework needs to work at three levels – identifying the growth and development of key leaders in the system; assessing the progress in effective team-working across organisational boundaries; and most critically of all assessing the progress towards improved outcomes for patients, citizens and tax payers.



## 8 Conclusion

Much of the literature on integrated care systems emphasises the technical infrastructure that needs to be put in place to deliver integrated care successfully. Nevertheless there is a growing recognition that effective system leadership is a necessary prerequisite to achieving truly effective care co-ordination. Indeed, where leadership is disrupted, even systems that have had considerable success in integrated approaches can take a backward step. This has recently been argued to be the case in the NHS's best-known and often cited example of integration, Torbay (Farnsworth 2012).

This paper has argued that system leadership needs different knowledge, skills and behaviours to those of effective leaders within an institutional hierarchy, and that both are essential in delivering system-level integration. In this we concur with Ibarra, who suggests a need for leaders who can 'command and collaborate' (Ibarra 2012). However, we would also suggest that the experience of the Integrated Discovery Community is that, while different leadership approaches can be adopted and nurtured within the system, it is challenging for individuals to incorporate both approaches. Therefore, we need approaches that work simultaneously with leaders and with systems. We currently under-invest in developing system leaders, though there are some emerging examples of how to do this well. Those who are genuine about wishing to develop integrated approaches need to increase the scale and pace at which leaders are developed at every level of the system. The ability to work across boundaries and to put the needs of the system ahead of, or at least alongside, those of their own institution will be one of the hallmarks of the leaders who will thrive in the new world.



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## About the authors

**David Fillingham** was appointed as the first Chief Executive of AQuA in April 2010. AQuA is a membership-funded improvement organisation based in the north-west of England. Its mission is to support its members to improve health and the quality of health care.

David joined the NHS in 1989 from a career in manufacturing. He went on to take a number of chief executive posts including Wirral FHSA, St Helens and Knowsley Health Authority, North Staffordshire Hospitals NHS Trust, and Royal Bolton Hospital NHS Foundation Trust.

From 2001 to 2004 David was Director of the NHS Modernisation Agency developing new ways of working and promoting leadership development across the NHS as a whole. He was awarded the CBE for this work. David is also a visiting senior fellow at The King's Fund and a non-executive director at Aintree Hospital NHS Foundation Trust.

**Belinda Weir** is an Associate of The King's Fund, which she joined in 2010, and has more than 30 years' experience in health and social care.

Belinda began her career in the non-profit sector, becoming the first Chief Executive of Community Options, a housing and care organisation for people with mental health problems. She has worked in the commercial sector, as a management consultant on several major NHS transformation projects, and in the pharmaceutical industry, developing innovative partnership approaches.

Belinda was a Non-Executive Director and latterly vice-chair of Lancashire Care NHS Foundation Trust from 2006 to 2011. She is a senior lecturer at the Health Services Management Centre, University of Birmingham and an Associate with the Centre for Education, Training and Development at Lancaster University. She has an MA from Edinburgh University in Sociology, and an MBA from Manchester Business School. Belinda is a qualified MBTI and Firo-B practitioner, and qualified in Prince 2 in 2009. She is also a visiting fellow at the Department of Business and Enterprise at the University of Suffolk.



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Health care systems are under pressure across the world. Policy-makers and health care leaders are searching for approaches that deliver the holy grail of health strategy – better quality care at reduced cost. In England, a consensus is emerging around the concept of integrated care as the best hope for a sustainable NHS. But integrating health and social care will require radical new approaches to leadership. What are these new approaches? How will they fit with current hierarchical leadership styles? And is there any evidence that they are succeeding?

*System leadership: lessons and learning from AQuA's Integrated Care Discovery Communities* describes the skills, knowledge and behaviours required of new system leaders and debates how best to nurture their development. It draws on three years' work by The King's Fund in partnership with the Advancing Quality Alliance (AQuA) to support a new form of learning and development – the Integrated Care Discovery Communities. As well as sharing the learning emerging from this work, the paper explores in detail the experience of one particular community – the City of Manchester.

The experience of this community, along with a review of literature from other sectors, informs the lessons for developing system leaders of the future.

- Widespread readiness for change is needed for a new style of leadership to emerge.
- Much can be learned and adapted from the principles of complex adaptive systems and of improvement methods.
- Leaders are needed at different levels of the system but this distributed approach must co-exist with effective organisational leadership.
- It takes time to build the will, skills and relationships needed to make integrated care systems a success – so patience, persistence and resilience are essential.

Those with a genuine desire to develop integrated approaches must increase the scale and pace at which leaders are developed at every level of the system.

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