A research agenda for integrated care: supporting collaboration in turbulent times

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INTRODUCTION

Integrated Care Systems (ICSs) were created across the English National Health Service (NHS) to foster collaboration between health and care organisations within 42 geographical footprints. They were established, in part, to address significant financial and operational challenges, which had only intensified by the time ICSs became statutory bodies in 2022 [1–3]. Thus, ICSs find themselves attempting to foster collaboration amidst intense system turbulence, which is liable to undermine such efforts. Deemed 'the makings of a sensible management structure' by Lord Darzi's recent review of the English NHS, ICSs show no signs of going away [4]. Accordingly, this commentary outlines a research agenda to explore whether and how ICSs can effectively collaborate in this turbulent context, and to support them in these efforts. This problem-driven research agenda does address leadership issues, but not exclusively, also calling for research on how ICSs can navigate competing goals and manage power within their systems.

INTEGRATED CARE SYSTEMS AND THEIR CHALLENGES

The permissive legislation codifying ICSs enables widespread variation in their structures [5]. Yet at their core sits an Integrated Care Board (ICB), a commissioning body which plans a region's NHS care in collaboration with other local healthcare bodies. This plan should contribute to the wider health and care strategy agreed by the Integrated Care Partnership (ICP), which brings those NHS bodies together with local authorities, voluntary sector partners, and others. Yet these structures are supposed to be the beginning, not the extent, of collaboration. ICBs are expected to work across their geographies to foster what the wider public management literature terms 'collaborative governance': formal, consensus-oriented decision-making about public programmes involving multiple actors [6,7].

While the NHS has previously tasked a range of bodies with regional 'system management', ICSs' responsibilities go further [8]. Unlike prior bodies, ICSs are intended to foster collaboration not only within the NHS, but also with other agencies that promote community health, including social care and public health functions housed in local government [9]. Achieving this collaboration is likey to be challenging. In the wake of the Health and Social Care Act (2012), ICSs are overlaid onto remuneration, accountability and regulatory structures oriented around individual organisations, not systems [10]. These pressures are liable to pull participants away from collaborative approaches. Substantial financial and cultural barriers also remain between NHS and local government, often deepened by years of mounting distrust [6,11]. Nor, given the NHS's history of tokenistic collaboration and of using ICSs to enforce national priorities, will local stakeholders easily be persuaded that this latest attempt to collaborate is genuine [7].

Amidst these challenges, ICSs are tasked with improving population health outcomes, tackling inequalities, enhancing productivity, and supporting the NHS's contribution to broader socioeconomic development [1,5]. These goals were always going to be pursued under difficult circumstances. ICSs were created partly to address the 'wicked' quality, financial and operational problems posed by increasingly complex population needs [11]; and to enable joint responses to serious emergent system challenges like today's workforce crisis [1]. The Sustainability and Transformation Partnerships (STPs) from which ICSs developed were widely seen as a response to the system's deepening financial woes [2]. Thus, ICSs are asked to a develop collaborative governance in a highly turbulent system.

By the time ICSs were established as statutory bodies, this turbulence had only intensified. When ICSs came together to coordinate local responses to COVID-19 [12], some hoped the pandemic could become a sustained 'force for change and collaborative working' [13]. Instead, post-COVID-19

waiting lists threaten to distract system actors from collaborative endeavours. The pandemic exacerbated the NHS's already critical operational pressures; financial woes deepened; and a growing workforce crisis left organisations severely understaffed, placing quality under critical pressure [4,11]. Local governments face still harsher financial challenges while care needs go unmet [3]. Today, amidst the uncertainty that follows a general election, this turbulence is again increased [4].

Such turbulence makes sustaining change difficult [14] and inhibits the early successes that can foster collaboration [6]. Combined with regulatory and performance management regimes based around individual organisations [10], it encourages ICSs' members to turn inwards towards their own waiting lists, bottom lines and vacancy rates. This threatens to stymie collaboration by prompting leaders to protect their own organisational turf, and starves collaborative endeavours of senior time and attention [6,11]. ICSs must not only facilitate collaboration, but must do so amidst significant systemic turbulence.

Research supporting ICSs in navigating this turbulence must be a priority for healthcare scholars [15]. Yet empirical research on ICSs remains in its infancy [10,16,17]. Thus, four authors convened a workshop of sixty academics and practitioners working in the sector to consider research priorities for ICSs. Inspired by those discussions, this paper outlines a research agenda, noting opportunities, methodological strategies and theoretical approaches to understand and support ICSs' endeavours.

A RESEARCH AGENDA FOR INTEGRATED CARE SYSTEMS

Early research on ICSs illuminates the importance of the shared goals that the COVID-19 pandemic gave emerging systems [12,13]. Simultaneously, it underscores challenges in managing competing objectives [18], developing effective quality management systems [10], and embedding research and primary care within collaborations [16,19]. Research on the STPs from which ICSs developed complements this evidence, highlighting politicised systems wherein trust-building is difficult [17,20] and which demand significant political skill of system leaders [21]. However, the non-statutory nature of STPs and early ICSs created distinctive challenges [22]. Empirical studies of statutory ICSs are scarce [23], with many conducted in the very different circumstances of COVID-19 [10,21,24].

Thus, research is needed to support ICSs in achieving their vital goals amidst today's financial, operational, policy and wider system turbulence. Rising system pressures risk encouraging organisations to focus on their own goals and metrics [10], which may directly conflict with, or else divert time from, collaborative work [6,11]. Moreover, systemic turbulence threatens shocks that can disrupt once stable collaborations [14]. It is vital that ICS research recognises these challenges and supports ICSs to navigate them. With international health and social care systems under widespread strain and collaboration a growing focus, such a research agenda promises insights focused on ICSs that nevertheless bear far wider relevance [11,13].

We suggest three areas for new ICS research. First, with intensifying financial and operational challenges casting ICS members' often-divergent goals into stark relief [8], research should investigate how ICSs can **collaborate amidst competing goals**, whether by navigating disagreement or forging shared objectives [12,13,21]. Second, as systemic pressures encourage potent actors to resist the 'give-and-take' collaboration relies upon [6,25,26], research must investigate **power and its management** within ICSs. Finally, with significant responsibility for navigating this turbulence delegated to local ICS leadership [1], research must support ICSs in identifying, enacting and developing appropriate forms of **system leadership** [27].

Collaboration and competing goals

Evidence from the COVID-19 pandemic demonstrates how effectively organisations can collaborate when working towards a clear shared goal [12,13]. We might hope that such collaboration would continue, as health and care organisations share a fundamental commitment to 'the patient' (or service-user). Yet this masks key fault lines between actors' goals: *which* patients do we focus on?; how should we best satisfy their needs?; and how do clinical aims translate into organisational goals? In today's 'under-funded and over-stretched public services', these dividing lines grow stronger, undermining unifying goals of the sort COVID-19 provided [16,24,28,29]. Today, understanding how ICSs can best collaborate despite initially divergent goals is vital.

Early writing on ICSs [30] and collaborative governance [6] suggests the importance of forming shared goals. Yet we still lack understanding of how ICSs can develop shared goals where these are initially lacking. Accordingly, some research points to the need for robust, trusting relationships to mitigate divergent goals [17,19,30], while others stress the need to work with divergence and disagreement [21,24,31]. This may entail exercising 'strategic ambiguity' [32], 'cycling back and forth' between polar goals [18], or facilitating give-and-take arrangements [7,21,24]. However, employing strategic ambiguity can undermine collaborations over time, as different perspectives and interests resurface [2,27], particularly as today's pressures encourage organisations to turn inwards [10,13].

Research should thus interrogate whether and how ICSs can form shared goals or navigate divergent ones. Collaborative governance theory provides a valuable framework to interrogate the former, pointing to the importance of shared problem definitions founded on process commitment and face-to-face dialogue [6,28]. To investigate how competing goals are navigated, researchers might usefully turn to the Economies of Worth [33], a framework designed to examine value conflicts and compromises in challenging contexts like resource-constrained healthcare organisations [34]. Such investigations should go beyond the initial 'formation' of shared goals, or compromises over divergent ones. Greater challenges may arise when sustaining and mobilising these agreements for public benefit [24]. Thus, we should also ask how the shared goals or accommodated tensions underpinning ICSs shape the public outcomes they can achieve [7,13,23].

Power and its management

ICSs are designed to unite the NHS and social care in equal partnerships [35]. Research on integrated care [31] and collaborative governance [6,7] suggests a sense of equality between partner organisations is central to fostering collaboration. However, significant and longstanding power disparities exist between health and social care, and among different NHS actors. Efforts to integrate care can risk disrupting delicate power equilibria within systems [24]. Circumventing these challenges to facilitate equal collaboration would be a real achievement at the best of times. With powerful organisations incentivised to protect their own financial and operational interests, doing so today is more difficult still [6,26].

Early evidence suggests that power imbalances persist within ICSs [19,21], reflecting research on integrated care [31] and collaborative governance [28]. For instance, hospitals often hold more influence than primary care providers [19]. ICSs also face challenges balancing national, system, place, and neighbourhood-level power [18]. However, power imbalances need not be problematic, depending on how that power is deployed [36]. For instance, power can be used to convene collaborations or even to enfranchise marginalised partners [31].

This underscores the importance of research on the evolving use and distribution of power within ICSs as they mature. Purdy's framework for analysing power in collaborative governance may be relevant [36]. It illuminates the interaction of different forms of power among the participants,

processes, and content of collaborative governance arrangements. Research should prioritise investigating the extent to which places, neighbourhoods, citizens and communities are empowered within ICSs, and how. This could draw on the literature on co-creation: a form of collaborative governance that foregrounds citizens' roles in defining and resolving public problems [25,28]. Recognising that actors can lead organisations from various formal positions, studies might also explore how politically astute actors wield influence irrespective of their organisational roles [24].

System leadership

This points to the wider importance of leadership in today's ICSs. Both ICSs' power structures and their members' competing aims raise significant leadership challenges [18,36,37]. Research points to how hard navigating these dynamics and their associated micro-politics can be [10,21,29]. With national structures designed around local flexibility, responsibility for resolving these challenges is largely delegated to ICS leaders' local ingenuity [1]. These difficulties are redoubled by today's turbulent financial, operational and policy contexts. For instance, as financial and operational challenges grow, national priorities and performance management systems risk 'crowding out' ICSs' collaborative remit [10,38]. So, how can ICS leaders buffer emergent local relationships and collaborations [14] from these national pressures [8] and thus enable ICSs to improve local outcomes, inequalities, productivity, and broader socio-economic development?

ICS scholarship emphasises the importance of leadership [10,12,13,21] and early evidence suggests it is beginning to influence change [38]. However, research also points to significant challenges enacting leadership, including managing tensions to hold systems together [18], while navigating financial and other risks [37]. Wider integrated care scholarship highlights the potential importance of leaders' capacities to span boundaries, deploy diplomatic skills, inspire collaboration and adopt wider, more strategic perspectives [7,23,31]. Yet evidence about how leadership can enable ICSs to achieve their goals in today's turbulent context remains limited.

Accordingly, research must investigate how ICSs enact leadership amidst such challenges. As the policy literature argues, ICSs will need not (only) organisational leaders, but a wider 'system leadership' that transcends organisational boundaries and professional disciplines [39]. With ICSs inherently pluralistic, and lacking top-down authority over participants, this system leadership must be conceptualised as collective, distributed and relational [15,27]. This entails a constellation of leaders across organisations and occupational groups, collectively influencing change. Not only does this theorisation better capture ICSs' dynamics, it also recognises how system leadership is enabled and constrained by national policy and local contexts [27]. This will be vital if we are to explain how system leadership emerges, functions, and can be developed to deliver ICSs' aims amidst today's turbulent landscape.

DESIGNS FOR ICS RESEARCH

Engaging with these diverse questions will demand significantly more research conducted with ICSs. The theoretical framings highlighted previously, such as collaborative governance [6,28], the role of power therein [36], and collective leadership [27], hold the potential for powerful insights. Methodologically, this task demands detailed research that not only spans ICSs synoptically but gets 'under the skin' of individual systems. It is crucial to understand, in practice, how divergent goals are navigated, how power is distributed, and how leadership is enacted, all of which necessitate detailed longitudinal qualitative case studies.

Given the crucial role research plays in supporting ICSs, some of this should be applied work that draws on action research to co-produce rapid learning with practitioners and communities. Such

research typically engages locally with questions around how ICSs are achieving outcomes, and generates rapid, contextually grounded advice on potential improvements.

In addition, longer-term explanatory work is vital for elucidating the underlying drivers of ICSs' success in fostering collaboration. This work should span time and/or multiple sites to facilitate comparison. Configurational research can effectively identify the clusters of characteristics typifying ICSs that achieve desired outcomes. Meanwhile, longer-term processual work deeply exploring the development of a smaller number of ICSs could reveal the evolving dynamics among organisations, thus enhancing understanding of how ICS collaboration is sustained. These approaches would engage with all three of the research areas identified above. With negotiating shared goals, power and leadership key issues in collaboration more widely, such approaches could also develop knowledge generalisable to other modes of healthcare organisation [6,28,31,36].

Simultaneously, there is a need for critical research that problematises change and can thus unpick issues of politics, power and leadership. To place ICSs within their broader policy context [2,8], such research should transcend a detailed study of an individual ICS, through sector-wide synoptic work, or by attending to national policy. This will enable research to engage with the broader policy trajectories in which ICSs are situated and how both individual and collective leaders navigate them. Critical research can also produce conclusions that assist ICSs' operations by critiquing and problematising structural limitations constraining them from achieving their established goals. Together, critical, explanatory, and applied research involving detailed, longitudinal, qualitative work can address the questions to which ICS leaders urgently need answers.

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