Culture, Leadership, and Integration (CLI) in the Development of the National Care Service; A Journey to ‘We Are the NCS’?

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Report 1
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# Table of Contents

**Plain Language Summary** ............................................................................................................. 3

**Report Summary** ............................................................................................................................ 4

**Introduction** ...................................................................................................................................... 5

**Context: CLI for the NCS** .................................................................................................................. 8

**The Workforce** .................................................................................................................................. 9

**Literature Review Method** .............................................................................................................. 11

**Literature Review Outcomes** .......................................................................................................... 13

- Perspective 1 Culture-Leadership-Integration .................................................................................. 13
- Perspective 2 Culture-Leadership-Integration .................................................................................. 17
- Perspective 3 Culture-Leadership-Integration .................................................................................. 21

**CLI Perspectives; A Synthesis** ......................................................................................................... 24

**Conclusions; How to Get To ‘We are the NCS’** .............................................................................. 27

- Vision: What can we learn about a clear vision/destination for CLI in the NCS to better value the workforce? .................................................................................................................. 27
- Pathways: Are the ways to attain that vision well-articulated and understood? ......................... 29
- Stakeholders: What are the challenges for all stakeholders to have the motivation to join in the journey to further change? .................................................................................. 30

**Further Questions about Future Research for CLI in the NCS context** .................................... 31

**Recommendations** ........................................................................................................................... 32

**Glossary** ........................................................................................................................................... 35

**References** ........................................................................................................................................ 36

**Appendix 1; Co-design Consultation on Valuing The Workforce** .................................................. 45

**Appendix 2; Context** ....................................................................................................................... 46

**Appendix 3 Employment Value Propositions (EVPs)** .................................................................... 48

**Appendix 4 Literature Review Summary** ....................................................................................... 49

**Appendix 5; Perspectives on Culture and Leadership** .................................................................. 56

**Appendix 6; Potential Data Collection Items** ................................................................................ 58
Plain Language Summary

What did we do?

We searched the literature for evidence about how culture and leadership are managed to enable integration in Health and Social Care (HSC), a journey to thinking and feeling ‘We are the NCS’. The aim was to learn how this might inform better valuing the workforce in the emerging Scottish National Care Service (NCS). The context for this is that integration has not yet been delivered in the way and at the scale desired (Audit Scotland, Stakeholders Perceptions, Workforce, Users experience). Key messages were extracted from this. These can help people have further conversations around the NCS workforce development. To get a place where people think and feel ‘we are the NCS’.

What did we find?

The literature is somewhat conceptual, and case based, ranging from comprehensive system reviews to single organisation studies. This does not provide a clear and coherent exemplar for the evolving NCS context and valuing the workforce. There are some prominent themes commonly highlighted in models and cases. These include inter-professional collaboration and ‘whole systems’ thinking. There are also some gaps in the literature. We highlight the most relevant in the NCS context as potentially being around creating clear messages to attract and retain staff.

What does this mean?

How culture and leadership are managed to enable integration in the NCS context for valuing the workforce is not well evidenced. Knowledge about this needs to emerge in action, which cannot wait. There can be three phases for an NCS CLI conversation about that, however the NCS comes to be constituted. The first phase is about conversations to clarify who can be involved and how change might happen. We suggest clarifying this for the three constituent and combined parts of the NCS. The second phase is about possible interventions based on those conversations. The third phase is about delivering those interventions, and learning from them. For progress towards ‘we are the NCS’ Symbols are not solutions, but solutions can become important symbols. Sources of practice into knowledge and knowledge into practice funding need to be identified for CLI.
Report Summary

Workforce development for the NCS, however it is ultimately constituted, depends on the interaction of three levers of change: culture, leadership, and integration. This area of interest can be defined as the Culture-Leadership-Integration (CLI) domain. The literature in CLI in the context of Health and Social Care (HSC) workforces can be studied to evidence and inform, in Scotland, the development of a National Care Service (NCS). This is the latest phase of integration of Health and Social Care Integration and the way in which health and social care services are planned and delivered across Scotland since the Public Bodies (Joint Working) (Scotland) Act 2014. Integration has not yet been delivered in the way and at the scale desired (Audit Scotland, Stakeholders Perceptions, Workforce, Users experience).

The CLI literature potentially relevant to the NCS contains mostly conceptual and case sources. A set of themes and prescriptions on CLI for HSCI have been established for some time, without much evidence of practice or progress. This literature provides very limited evidence of exemplars to learn from. There seems to be a framing of CLI in HSC concerned with inter-professional collaboration and/or whole systems thinking for quality improvement. While these are pertinent, evidently relevant to CLI in the NCS context, they are not the sole or primary possible concerns for CLI. Thinking beyond these, considering some new themes for CLI can be of value in moving on from the recycling of old themes to potentially innovative and impactful CLI for HSC in the NCS context.

Among these new themes, are having a clear theory of change around CLI and developing clearer Employment Value Propositions (EVPs) in the NCS workforce context. This is relevant for working on CLI in and across community health (NHS), social care (multiple organisations) and social work (LAs). Three phases of change for exploration and enactment of CLI in the NCS context are suggested, with areas in which evidence from practice can be sought and used to inform change. To get to a place where the workforce think and feel 'We are the NCS'.
Introduction

The aim is to help create a body of knowledge that provides a foundation to test out policy responses at the national level with the workforce to create insights and learning on how culture and leadership\(^1\) can contribute to the development of integration in the National Care Service (NCS) workforce\(^2\). Co-design conversations with the workforce have already highlighted several themes (see Appendix1). Hereafter this will be termed knowledge about the Culture-Leadership-Integration (CLI) domain for the NCS. Desk research on understanding what is known about, and cases of, CLI was commissioned to identify the foundations for defining the issues, developing potential solutions, and testing these ideas.

The NCS Bill is presently being developed, with Stage 1 completed Feb 29\(^{th}\) 2024 and now in Stage 2, and so the shape of the NCS in practice is yet to be finalised. Developments emerging from design and system decisions among all stakeholders will ultimately frame what CLI means in detail. Integration has not yet been delivered in the way and at the scale desired in care (Audit Scotland, 2018a; Audit Scotland

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\(^{1}\) We were asked to exclude in this study matters relating to leadership development, so the extensive resources around ‘Leading to Change’ and in the NHS NES which we are aware of were not in the scope of this review. We would simply note that from informed sources it seems these programmes are more in use in the NHS workforce than in Social Work or Social care, which is itself interesting information.

\(^{2}\) A new national framework for social care and social work has been initially agreed by Scottish Ministers and COSLA Leaders as part of ongoing discussions on the National Care Service (Scotland) Bill. Discussions are ongoing based on a proposed model of shared accountability, where Scottish Ministers, Local Authorities and NHS Boards will each have their own responsibilities to fulfil within a new national framework. Under this proposal, local authorities would retain service delivery functions, staff, and assets.
Meantime it is possible to set out what is currently known about CLI and the broad agendas of change that are likely to be encountered emerging from that. A critical point is well made about integration in the context of looking at a range of options for reducing compound pressures on health and social care which have become endemic (Cantrell et al., 2023) that integration has a scale of change, involving multiple stakeholders and organisations, which challenge the capacity of organisations to be able to invest time and effort in organisational change at a time of systemic overload. More easily achieved small-scale adaptation of existing systems may be privileged over more radical system-wide transformation.

CLI is desired and being striven for as a concept, an approach and in practice in several ways associated with workforce development in the UK (Reed et al. 2021). How CLI looks at present is acknowledged to be some way from the ideal (Jeffries et al., 2024) in each part (culture, leadership, integration) so when studies of these are combined it’s not surprising to find more challenges than solutions. Yet solutions are very much what the NCS development aims to find for the workforce of over 200,000 people in a variety of organisations, professions, and roles. For this report and CLI we were asked to exclude justice and child services, so the workforce scope is approximately 155,000 people⁴. The CLI themes explored are shared with children’s and justice services in the system as a whole, though the literature about those and the workforces involved have not been directly considered in this report which is primarily CLI in the context of adult social care integration with community health and social work in that

We have in this context explored the following questions in a literature search:

- What can we learn about a clear vision/destination for CLI for workforces in the NCS to feel they are with an attractive employer?
- Are the ways to attain that vision well-articulated and understood?
- What are the challenges for all stakeholders to have the motivation to join in the journey to further change?

CLI can be part of realising the vision for the NCS. That vision is for everyone to have access to consistently high-quality social care support across Scotland, whenever they might need it, and for the social care workforce to flourish. The goal is to future-proof the social care sector for generations to come - and for people coming into the profession⁵.

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³ British Social Attitudes Jeffries et al., 2024) showed further declines in satisfaction to new lows, with only 13% satisfied with social care, NHS red flags too, with only 24% satisfied. In Scotland, HSCP cuts and compounding crisis around pay as social care falling further behind NHS specifically.

⁴ This workforce given current CLI daily provide critical services to meet the needs of the many who require their care and support. In any one night, around 34,600 people will sleep in a care home (Public Health Scotland 2024a) and 89,620 will be supported at home by formal services, excluding unpaid carers (Public Health Scotland 2024b). These numbers are significant enough for those directly impacted by CLI.

There is a long history of concern with CLI (NHS Confederation 2005), which will not be covered in detail here. What we can briefly note is that since 2016 health and social care is organised as a single, integrated system. 31 integration authorities are now responsible for £9.5 billion of funding for local services (Scottish Government, 2015). CLI is part of the broader culture and leadership needed to improve care and support for people who use services, their carers, and their families. It does this by putting a greater emphasis on joining up services and focusing on anticipatory and preventative care. There are 9 National Health and Wellbeing Outcomes, high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

Integration can improve the experience of people accessing services. The new structure of national oversight to drive consistency of outcomes, whilst maximising the benefits of a reformed local service delivery is in development. There is a common purpose about respecting people across the workforce, and providing equity, consistency, and transparency. But what CLI means to deliver that is evidently a different challenge to different stakeholders. Miller (2024) highlights that if mechanisms were the answer to transcending these challenges, then the desired system and outcomes like equity, consistency and transparency would exist now. But solutions need to pay attention to both structure and culture in social care. Miller emphasise that good conversations are needed to build culture, values and norms through dialogue, conversations with the public, conversations within organisations, and conversations between organisations about values and thresholds. This includes co-design and co-production, though the extent to which those engage significant numbers in the way required for sustained CLI is an issue. Solutions require fresh thinking and greater adaptability and willingness to revise previous policy decisions more than ever before. Even then there are substantial questions about how much CLI can realistically achieve (Reed et al. 2021). CLI cannot be expected to redress insufficient resources, mismatch between objectives, limited data and evidence on targets and integrated finances, not enough regard for existing relationships and structures already in place or for how long changes take to come into effect. Yet there is potential for better focussed conversations about CLI.

At present there are no clear and strong answers to CLI questions in the National Care Service (NCS) context, where national/systems level consideration is ongoing across several workstreams. This literature review aims to supply some evidence and ideas that can help structure and guide the formation of clearer and stronger answers, for further national/systems level consideration. The bottom line is health and social care professionals need to work together effectively to plan and deliver services, to improve outcomes, to improve the quality of services. Ultimately to improve services for users. That needs a workforce culture to attract and retain more people now and, in the future. These challenges are not for Scotland alone, they are shared globally (Sutton, et al., 2023).

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6 Social care has 47% vacancies reported in care, 11% being the national average. Figures for the constituent parts of the NCS (community health, social care, social work) are not known. Various initiatives are underway with recruitment processes both in the sector through HSCP in the media and through international recruitment facilitated by an NES unit.

7 These challenges are not for Scotland alone, they are shared globally (Sutton, et al., 2023).
Context: CLI for the NCS

CLI matters at the policy level, the organisation level and among a wide range of initiatives being implemented around the NCS. Many people are working toward CLI to implement change now, and this is generating innovation and good practice now. But the need for longer term, and scaling up of, widespread transformation to fix some of the ingrained CLI issues within the system is key to ensure change and sustainability for the future. The Audit Scotland (2018b) brief guide to integration is a helpful reference point in a complex landscape.

The guidance on strategic planning and commissioning for integration (Scottish Government 2023) does not mention culture at all, and leadership is mentioned only a few times. This is an area known to be integral to culture (Dickinson et al., 2013). There are elements of the context which explicitly highlight CLI (see Appendix 2). These include the Framework for Community Health and Social Care Integrated Services (2019), the Feeley Review (2021), and more broadly whole systems change in ways of working and employment relations (NIHR 2023). This is also seen in recent guidance on potentially changing care eligibility criteria (Miller, 2024). CLI is featuring at the heart of conversations and developments around the NCS. They have also featured for more than 20 years (Glendenning, 2003) with common characteristics of integrated organisations including shared goals, high trust, close networks, and shared processes. These characteristics are needed across clinical teams, primary and acute care organisations and in many cases across the organizational and cultural divides of health, housing, and social care. Twenty years later this is still the agenda. Hendry et al. (2021) recently captured the contemporary agenda in Scotland:

1. Collaborate and coordinate, for successful transformation through coordinated efforts across the whole of government, the whole of the health and care system at every level, and with citizens.
2. Engage and involve with a compelling vision about improving lives and creating a better, more sustainable future, with equal partners.
3. Empower and enable at the local level, with due regard for local culture, history and buy in.
4. Innovate and improve by adopting technology and new ways of working.
5. Reflect and learn, as new ways will only make sense if anticipated improvements can be evidenced and unintended consequences minimized.

One recent social care grounded review of HSCP strategic plans by the Health and Social Care Alliance Scotland (2024) has a section on transforming leadership and cultures. This shows that efforts to transform ways of working and leadership cultures are evidenced throughout HSCP strategic plans and annual reports, confronting structural barriers and reluctance to change ways of working. Job Descriptions for IJB Chief Officers highlight culture within two organisations and working to create a positive culture and environment for leading change. (Argyll & Bute/NHS Highland, 2021). The case of Fife is cited as showing good CLI practice. Several strategic plans chose to highlight how they are transforming, or intend to transform, their organisational cultures and leadership.
From a contemporary source on leadership in social work (Martin 2024) a clear conclusion was that an organisational culture that allows positive leaders and leadership to flourish, should sit alongside robust training. Indeed, organisational cultures in and of themselves might be more powerful in supporting leaders and leadership, than formal training. In the Social Work context what that means is a stronger national social work voice and wider evidence and innovation support system, as at present it is fragmented and locality dependent. We are aware, for example, that even the opportunities for Chef Officers of HSCP to come together and explore issues is a challenge.

The context now is still that the agenda for CLI needs fresh inputs and fresh thinking grounded in what can be found in the literature. To structure that some questions were explored in a literature review. Before outlining that it is helpful to set out the workforce context.

The Workforce

Social care support is the heart of CLI for the NCS, with community health and social care. This is about supporting people to live independently, be active citizens, participate and contribute to our society, maintain their dignity and their human rights. This means supporting people to stay at home or in a homely setting, with maximum independence, for as long as possible. To deliver this it is essential to attract and retain the right people to work in social care support and social work and raise the status of social care as a profession.

The ongoing development of policy for the NCS to help provide integrated care will involve many strands of analysis including change in CLI. There are five pillars to the workforce strategy for health and social care (see Figure 1, Scottish Government 2022), with multiple associated policies and actions.

![Five Pillars](image)

**Figure 1. Five Pillars**

Three themes from the policy vision were highlighted as relevant in the CLI context:

1. Support and value the workforce.
2. Health, social work, and social care support are integrated with other services.
3. Emphasis on continuous improvement at the center of everything.

There are recognised challenges among all stakeholders around the development of the workforce within the scope of integration (Skills for Care 2021), and in Scotland within the scope of the NCS. These include relations between our Health and Social Care systems, Local and National Government (the Verity House Agreement) and the
Integration authorities and national/systems level including all the workforce within the scope of the NCS and the broader sector of care providers in Independent and third sector organisations. The extent of communication, consideration, and negotiation among these on a range of matters from governance to finance and fair work continues to be strained, problematic and open to change. Meanwhile the front-line services seek to engage and sustain care to the best of their capacities, and those needing care or concerned with those people, can often find their experiences difficult and frustrating (See Figure 2 below from Jeffries et al., 2024).

Figure, 2. Reasons for dissatisfaction with social care, 2021-23. 

Whatever the eventual shape and detail for the NCS\(^8\), with multiple work streams and national/systems level looking at multiple aspects of this, there will be general culture/leadership issues and challenges. This report identifies what CLI aspects of those will be, and ways to engage with them as a part of the overall development of the NCS.

\(^8\)At the national board level, the revised IA/IJB system and the front-line workforce arrangements for those working directly within the NCS in community health/social care/social work as they are constituted under those
When considering culture, the scope and nature of change for those who are in the NCS workforce needs to be clear. At present there are around 211,000 people employed in the various public, voluntary, and private sector organisations who together make up the integrated care system which the National Care Service will encompass. Our remit excludes children and criminal justice. The CLI themes explored are shared with children’s and justice services in the system as a whole, though the literature about those and the workforces involved have not been directly considered in this report which is primarily CLI in the context of adult social care integration with community health and social work in that.

There are frequent mentions of the value of a whole system perspective, in essence incorporating areas beyond the scope of the NCS including education, housing, and employment. For this review we are addressing only the workforce and the CLI in the NCS workforce context as set out below.

A large part of this workforce is in care at home/housing support, across the public, private and voluntary sectors. The next largest workforce is in care homes, predominantly private sector. There are around 1,600 private organisations, 36 public (essentially Local authorities) and 846 voluntary sector organisations. The organisation and employment status of people in the workforce is not going to change. In the wider context primary care, housing and other voluntary/third sector partners also contribute hugely to integrated care and have their own cultures, and leadership strengths and challenges.

What CLI means in contexts is different where there is significant employer, professional and trade union forces (NHS and Local Authorities) compared to contexts where there are many organisations employing Small and Medium Sized (SME) workforces lacking those (Social Care). The purpose and destination may be shared, interventions will need to be contingent.

**Literature Review Method**

We undertook a literature review of key material from three main sources. First was a general database search using keywords. There was a targeted publications search. And relevant sources on CLI from the authors prior research were identified.

The aim was to identify the most relevant literature which dealt in some way with all the key themes of CLI. We were focussed on those most relevant to and aligned with our core questions on attractive cultures, challenges, and solutions.

This is a rapid literature review, and synthesis. It is rapid in being completed over a period of a few weeks, constraining what could be done. It is a synthesis, combining what was found in the search for this project along with team members pre-existing knowledge. It is not a systematic or meta literature review of empirical studies which could enable conclusions about the effectiveness of CLI interventions to be determined. It can provide insights for and grounding for a further national/systems level conversations on the development of the NCS with respect to CLI as a part of that.
We searched electronic databases\(^9\) EBSCOHOST, including MEDLINE, EMBASE, the Cochrane Library, PsycINFO, SCI and SSCI, and CINAHL. We also searched some specific journals. These included BMC journals, The International Journal of Integrated Care; the Journal of Integrated Care; Health and Social Care in the Community; Journal of Care Services Management; Journal of Social Work; Journal of Social Policy. We restricted our database search to those with content related to developed countries, published since 2014. We excluded those that reported only clinical, rather than service delivery integration, or if integrated services did not include social care. We also included ‘grey’ literature from the UK in the form of reports. We looked for Scottish context SSSC and Care Inspectorate sources, as well as national UK material from bodies funding research around CLI. This generated over 900 results.

We filtered these first through title reviews, excluding any not clearly and substantively about health and social care including in a significant way two or more of the key search terms (culture, integration, leadership). These were added to some initial sources provided by the team doing this report. This produced a set of 101. The abstracts of these 101 were then reviewed to filter a final list for inclusion from the database search and journals. These range from comprehensive system reviews to single organisation studies.

These were provisionally categorised as being primarily concerned with a perspective that was either culture, integration, or leadership, or an ‘other’ category. We took each of these categories and identified for each source:

- Type of study (conceptual, literature review, case, qualitative/mixed methods, other)
- Level: if it was national, local, team; and sometimes other aspects are noted too.
- Main findings
- Implication for CLI in the Scottish NCS context

We then allocated the 69 sources identified as core to at least one reviewer. Reviewers met and discussed these. These core 69 (see Table 1) were those which we have relied on most for developing this report narrative and themes. Given the fast-changing context, we then considered most closely the more recent sources, post 2002 sources with primary data (15) and those post 2020 without primary data (21). As we included these as a team in a draft, we identified some potential themes and gaps which led us to seek additional references, if possible, on aspects of context, for example EVPs (see Appendix 3).

\(^9\) The SCIE database Social Care Online closed and is now replaced by a subscription service ‘Social Policy and Practice’ http://www.spandp.net/
Appendix 4 provides the full list of sources by category. This shows three sections; those sources from the search which are post 2020 with primary data; those from the search which are post 2020 without primary data; and all the others from the search pre-2020, with those for context used also.

Literature Review Outcomes

Studies in CLI in HSC provide mostly conceptual and case knowledge, with limited evidence of experience of CLI change and the interventions involved. There are few CLI exemplars found to learn from or copy, and none in any detail or depth. The CLI literature often affirms that change needs to be incremental, and that various interventions are possible, the issue being aligning these. However, even in this there may be a bias towards framing themes in CLI around inter-professional collaboration and whole systems change, which reflects a limited and partial coverage of CLI. These while evidently relevant, are not the sole or primary possible concerns.

The findings set out from the literature review are given according to which of the three core concepts was primary in the study. Culture is first, leadership second, and integration third. In each section some review of the primary concept and the studies associated with it is included. Some synthesis of these on CLI is provided in conclusion.

**Perspective 1 Culture-Leadership-Integration**

The simplest definition of culture in the organisation context is ‘how we do things around here’ (Bradley-Silverio Donato, 2023). Such a definition serves a purpose but begs the question of what that actually means. For the ‘way we do things around here’ is always a combination of the mandated, regulated, and prescribed for the routine and reflective practice for situations that cannot be handled in routine ways. Culture as only one influence on ‘how things are done’ in HSC, alongside influences from strategy, financial control, information systems, and HR (Reynolds & Sutherland 2013).
The set of perspectives on what culture in an organisation can mean is broad (see Appendix 5). Some key points which even more developed definitions can fail to highlight from the outset are (Avruch 2006):

- No population can be adequately characterised by a single culture descriptor, there are always subcultures.
- Culture is socially distributed, which means it varies according to characteristics including life-stage, gender, class, and many other variables may be relevant.
- Culture is psychologically distributed, which means that values and norms are internalised more or less in cognition and affect among individuals; for those in whom a value/norm is more deeply internalised it is significantly motivational, for others it is not.

In short organisation cultures can be ‘how things are done here’ operationalised in various ways, emphasising a range of things or a specific focus, but will be situational, flexible, and responsive to exigencies, locally variable and diverse. Studies treating culture carefully in terms of a research design do exist (Schorderet et al., 2022), but do not yet have any findings to report.

In the CLI for HSCI these points can be seen and appreciated by some (Haring et al., 2023) but in the general CLI literature the operationalisation and meaning of culture is frequently generic and vague (Tietschert et al., 2019; Scobie et al., 2022), as if it's an assumed feature of common language that does not need explaining (Fehsenfeld, 2022). Examples of the use of the term in the Scottish context are present, (Pearson et al., 2018, Pearson & Watson, 2018). Culture may be operationalised somewhat, as a set of values or factors that are believed to enable normative and functional relations among groups (Valentjin et al., 2015, Connolly et al., 2022). And a few references to specific models of culture do exist, such as the Competing Values Framework (Tietschert et al., 2019) but this is rare. We were aware that the ‘culture web’ model (Johnson & Scholes 1999) was previously referenced in Scottish Government in-house analysis. There is not any reference to this model in the CLI for HSCI literature.

In general, though and more often than not the meaning of culture is presumed as either a shorthand for ‘everything’, all the hard and soft aspects of ‘how things are done here’ or focussed on specific theme; a culture for equality (Alonso & Gutierrrez Lopez 2023), a positive culture (Skills for Care 2018), or a culture for productivity (Skills for Care 2021a).

Two illustrative examples of the absence of a coherent perspective on culture is seen with the Feeley review of the Scottish context (2022) the Hewitt Review of the English context (Hewitt 2023).

In Scotland the review of adult social care highlighted some culture of integration change themes (Feeley 2021). These included shifting the paradigm from old to new thinking; bring together everyone with a role to play to achieve a common purpose; strategic integration with the National Health Service; national standards are needed to bring national oversight and accountability.

Specifically, the Feeley review mentioned culture several times, in a general and specific sense. For culture in general the references were about:
• Need for a culture shift to those values’ human rights, lived experience, co-production, mutuality and the common good.
• Do not underestimate the immense culture change implied by what we have set out.
• The purpose needs to provide a direction for the securing of long-term results….it needs to influence culture, behaviours, and values.
• That needs an environment and culture that enable everyone in the system to contribute every day to the achievement of the purpose.
• The key elements of that supportive culture are a focus on long term outcomes, an environment of co-operation and trust, valuing lived experience, replacing judgement with learning, and backing that up with a proper stewardship of our resources.

On culture specifically the references were:

• Creating the conditions for improvement – infrastructure and culture.
• Instil a real learning culture in social care support in Scotland.
• A national approach to improvement and innovation in social care is needed, to maximise learning opportunities and create a culture of developing,
• Testing, discussing, and sharing methods that improve outcomes.
• Big Ideas –a pause button to be pressed on the current procurement system to support the move from a competitive process and culture to a collaborative approach.
• Specific attention should be paid to developing professional support and supervision for people who often work in isolation from their peers, providing care and support in people’s own homes and communities

Hewitt in the review of the English context includes a clear headline view that ‘effective change will require the combination of new structures with changed cultures’ and that ‘while structures matter, culture, leadership and behaviours matter far more’. On the one hand this is seen in culture being mentioned 18 times in the report, also like Feeley in a general sense and a specific sense. But there is no coherence or focus to this. The mentions range from needing a ‘can do’ culture, a culture of collaboration, and a learning culture; that leaders needing to change culture, a common culture, the different cultures of statutory bodies; a need to deepen culture change, an improvement culture, addressing ‘poor’ cultures, culture in the context of IT programmes, a culture of importing and exporting what works. There is not much coherence here.

What we found is a culture led perspective in the literature that replicates this lack of coherence, and often assumes culture in the CLI context as having generic cognitive, emotional, and relational elements, what makes sense, what feels right and interpersonal norms (Millar et al., 2023) or a more specific focus. There is a frequent concern with collaboration as an element of a good culture in this sense, though often limited or undermined by challenges with non-cultural and leadership aspects of systems including financial, information and workforce development (Fournier et al., 2022). In short, that change in desired cultures and leadership for integration
(Freeman et al. 2013) need to be manifest in and reinforced by these parts of the system, but they are not (Baxter et al., 2018; Kelly et al., 2020; Rowland 2019; Tiiriki et al., 2022). The vision of an integrated CLI is not realised if there is a persistence of patterns of differentiation and indeed domination within the system around where resources get allocated, multiple information systems, and workforce employment relations which are fragmented (Looman et al., 2021; Donaldson et al., 2024).

Culture in CLI within healthcare is extensively and intensively researched (Mannion and Davies 2018; SCIE, 2021; Leslie et al., 2023), in a way that is not found in social care and social work. In fact, ‘Integration’ in this context is not just a focus for leadership, it is potentially the essence of the system. This is because three possible characterisations of current and desired cultures in the healthcare context can be identified that include ‘integration’ itself:

- **Integrated cultures**: occur when there is wide consensus on the basic beliefs and appropriateness of behaviours within the organisation. Even where claimed, integration may exist only in broad aggregate or may be more wishful thinking than practically realised.
- **Differentiated cultures**: occur when multiple groups within an organisation possess diverse and often incompatible views and norms. The development of subcultures, misunderstandings, and conflicts is then to be expected.
- **Fragmented cultures**: differentiated cultures may diverge and fragment to such an extent that cross-organisational consensus and norms are absent. The organisation is characterised by shifting alliances and allegiances, considerable uncertainty and ambiguity, and unpredictability.

In healthcare, more specifically in the NHS, the current state of CLI can be argued to be diagnosed as any of these. Some see integration being attained, some see differentiation being perpetuated, some see greater fragmentation occurring.

The current state of CLI for the NCS as it is being constituted could perhaps be equally diagnosed in respect of each of these states. There is an apparent consensus about the direction of change in CLI that the NCS as at present can be integrated. However, in these terms being differentiated might also be a desired state to aim for in the NCS. Or developing the NCS may risk making what is currently fragmented even more fragmented. Acknowledging that uncertainty about the state of both the current and the desired CLI, there are dynamics around the following scenarios:

- **Synergy**: represents a policy of cultural integration based on melding both partners’ cultures.
- **Domination**: melding if impossible, the right of dominance of a given group
- **Segregation**: is based on seeking an acceptable balance between cultures by virtue of maintaining separation rather than seeking integration.
- **Breakdown**: occurs when one partner seeks domination, integration, or mutually acceptable segregation but fails to secure the acquiescence of the other parties.

Greater CLI synergy is the desired direction of travel, though at the same time managing the risks of persisting segregation, breakdown or domination need to be appreciated as part of the current landscape. Boggia & Daly (2021) show how even
simple reviews of definitions of care service, change in the language in use to describe care, can get caught up in concerns with broader transformational change in services.

Mannion and Davies, in the context of the NHS, outline constraints on synergy and the potential of culture change; and that managing the cultural diversity exhibited in integrated care to achieve fit and synergy\textsuperscript{10} between diverse groups will be a challenge. Attempts to enact a cultural transformation within integrated care can expect to meet with resistance, passive or active. Attempts at cultural transformation may induce deleterious and unwelcome changes as well as the sought for cultural shifts. If culture draws attention to a need to communicate across boundaries and venture between them that is helpful. The caveat is that that culture may be too general a construct to be helpful (Sandall, 2001). It can’t explain much if things are packed together beliefs, rituals, values, assumptions. That inhibits the analysis of relationships among these, where they need to be separated out and considered independently.

**Perspective 2 Culture-Leadership-Integration**

The general context here is of new leadership for social action (New Economics Foundation 2017). Audit Scotland (2018b) set out the main players and relationships for most Integration Authorities (see Figure 3) with Integrated Joint boards (IJBs).

![Figure 3; Integration Joint Boards. Source Audit Scotland 2018b.](image-url)
One contemporary review (Knight et al., 2024) based on a literature review of leadership in integrated care highlighted that leadership is most effective when leaders hold themselves and others to account for improving population health, have a sense of purpose fostered through a clear vision, and partners across the system are engaged in problem ownership, with relationships are built at all levels of the system. These are the same points that have repeatedly been made for decades in the domain of integrating care (Kjellström et al., 2024).

Notwithstanding much change towards integration, research into the leadership of integrated care teams and systems is still limited, with ideas often reverting to existing framings of leadership, where teams and organisations are less complex (Sims et al., 2021). Seven potentially important components of leadership in integrated care teams and systems were found by Sims et al.; 'inspiring intent to work together'; 'creating the conditions'; 'balancing multiple perspectives'; 'working with power'; 'taking a wider view'; 'a commitment to learning and development' and 'clarifying complexity'.

In one of the rare examples of substantive rather than literature-based research Elliot et al. (2020) found that in integration new leadership positions were both overwhelming in the scope of tasks required and lack clarity in how these tasks should be undertaken. They concluded that more support should be provided; a joint training programme was needed; and policies and procedures should be compiled into one reference resource for managers of integrated services. Within the Integration Joint Boards (IJBs), local councillors are an integral part of the broader 'integration network' responsible for overseeing H&SCI. Mashkoor (2024) explored how local political leaders play a key role in the strategic decision making of H&SCI, through relationship between political representatives within health and social care areas and senior bureaucratic actors, including chief officers and planners. They adopt different leadership styles that vary along the dimensions of cooperation, vision, teamwork, inclusivity, result orientation, direction, and initiative, depending on the political context and their personal preference. Councillors face various challenges and opportunities in exercising their leadership roles within the IJBs, such as managing the conflicting interests and expectations of different stakeholders, coping with the financial and operational pressures of H&SCI, and navigating the complexity and uncertainty of the reform process.

These studies highlight the limitations of traditional, hierarchical leadership models in the dynamic context of H&SCI (Moore et al., 2023; Leask & Macleod, 2023). A shift towards more adaptive, collaborative, and servant-oriented leadership styles is seen as crucial (Moore et al., 2023). This aligns with transformational leadership, where leaders create a shared vision, motivate teams, and promote continuous learning.

Collaboration across healthcare and social care sectors is essential for successful H&SCI (Nystrom et al., 2014). Leaders play a key role in fostering a culture of trust, respect, and shared decision-making within organizations and Multidisciplinary Teams (MDTs) (Moore et al., 2023; Douglas et al., 2022). Studies suggest that distributed leadership models, where leadership is shared among team members, can promote autonomy, creativity, and staff satisfaction within MDTs (Leask & Macleod, 2023). However, they add that successful implementation requires careful attention to cultural shifts, conflict management, and building trust among team members.
Several studies identify cultural challenges that can hinder effective leadership in H&SCI (Nystrom et al., 2014; Moore et al., 2023). These include silo mentalities, lack of trust, resistance to change, and hierarchical structures (Moore et al., 2023). For Moore et al. leaders need to address these challenges by promoting open communication, continuous learning, and interdisciplinary collaboration. And building trust and social capital within teams is essential for fostering a positive work culture that supports collaboration.

These emphasize that patient-centred care is a core value in H&SC (Crocker et al., 2020). Effective leadership requires prioritizing the needs and well-being of patients and involving them in decision-making processes. This aligns with the principles of servant leadership and transformational leadership, where leaders focus on serving others and creating a shared vision that prioritizes positive patient outcomes.

Crocker et al. found that successful leadership in ICSs (Integrated Care Systems) in ownership and oneself and others accountable for improving population health, fostering a clear sense of purpose through a shared vision, engaging partners across the system in problem ownership, and building relationships at all levels of the system (Figueroa et al., 2019). These findings emphasize the critical role of accountability, vision, engagement, and relationship-building in driving effective leadership within Integrated Care Systems (Knight, et al., 2024).

The contemporary themes are clear, and as is highlighted elsewhere in CLI, they are not new, they are repeated over the years and decades:

- Shifting Leadership Paradigms
- Fostering a Collaborative Culture
- Building Trust and Overcoming Cultural Challenges
- Focus on Patient-Centred Care
- The Importance of Accountability, Vision, and Engagement

This repetition reflects a lack of progress over time. Being stuck with the stasis of inter-professional collaboration is one possibility (Parker et al., 2023). It is hard to break this down. The health and medical professions and models (White-Chu 2009) and values have been and remain most powerful (Huda 2021), in which CLI for safety, uniformity, and health contexts are foremost. This is reflected in the prominence of concerns with the state and costs of NHS/hospital services, free at the point of use, at the heart of policy and strategic thinking. Those with power and ownership around these concerns are dominant in how CLI for HSC is thought about and discussed.

Social care professions are less powerful, indeed large parts of the social care workforce are not deemed to be ‘professional’ at all. Where there are social professional views and values those consider the whole person, family, community, and their wellbeing at the heart of care (White-Chu et al., 2009)\textsuperscript{11}. The persons care network and its integrity, resilience, and dynamism matter most. Those with the power and ownership of concerns here can be seen as subsidiary. In unpaid and paid care

\textsuperscript{11} This is not denying that many in the health domain, in NHS workforce and payment structures, are personally committed to the whole person and community, etc; but that is not the substance of their role, their training and their practice in the way it is for social professionals and non-professionals.
work, historically women have been the prime providers and co-ordinators. The cultural aspects of care obligations and work embodying the unequal status accorded to those providing that (Hauskeller, 2020).

Management and system approaches and values (Zonnenfeld, 2018) attempt to combine and marshal inter-professional collaboration among these. Ostensibly with all sharing 'soft' commitments to a ‘person-centred’ or ‘human rights’ perspective and the same key outcomes that should be straightforward. But in ‘hard’ terms, around who in the system has control, status higher pay, then the hegemony of the health/medical professionals is perpetuated. In part this may be enabled by social professionals’ antipathy to managerial views of integration (Fincham & Forbes, 2015). Managerial meanings of integration could eclipse both the medical and the social meanings, so each has some reason to resist that. And the risk would still be that even the success of a managerial logic in breaking the inter-professional stasis, in favour strategies and plans that might fulfil integration under the scrutiny of auditors, could yet fail to deliver meaningful integration in practice.

Whoever is seen to be dominant at present, and how that creates an environment for promoting or resisting change, what seems to be the main lesson from system change experiences seeking greater integration is that big transformational change does not work, slower more incremental change does (Exley et al., 2024a).

Some contexts here can be given by Table 2, highlighting the Care Inspectorate (CI) evaluation of leadership in the domain where the largest part of the workforce actually work, in care delivery, care homes and care at home.

### Table 2. How good is our leadership? - % of services with each grade

<table>
<thead>
<tr>
<th>Care Service</th>
<th>Subtype</th>
<th>Unsatisfactory</th>
<th>Weak</th>
<th>Adequate</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Placement Service</td>
<td>Alcohol &amp; Drug Abuse</td>
<td>0.0%</td>
<td>7.9%</td>
<td>30.5%</td>
<td>33.6%</td>
<td>44.7%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Child Health &amp; Wellbeing</td>
<td>Blood Pressure</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Care Home Service</td>
<td>Children &amp; Young People</td>
<td>0.9%</td>
<td>4.1%</td>
<td>11.9%</td>
<td>39.1%</td>
<td>38.5%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Elderly Care</td>
<td>Learning Disabilities</td>
<td>0.9%</td>
<td>2.1%</td>
<td>14.3%</td>
<td>40.7%</td>
<td>42.1%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Mental Health Problems</td>
<td>Mental Health Problems</td>
<td>0.0%</td>
<td>0.0%</td>
<td>24.0%</td>
<td>62.0%</td>
<td>34.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Older People</td>
<td>Physical and Sensory Impairment</td>
<td>0.1%</td>
<td>1.9%</td>
<td>20.6%</td>
<td>45.0%</td>
<td>26.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Physical and Sensory Impairment</td>
<td>Physical and Sensory Impairment</td>
<td>0.0%</td>
<td>0.0%</td>
<td>20.3%</td>
<td>45.7%</td>
<td>30.9%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Child Care Agency</td>
<td>Respite Care and Short Breaks</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>21.0%</td>
<td>20.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Child Mindset</td>
<td>Respite Care and Short Breaks</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>11.8%</td>
<td>30.6%</td>
<td>44.7%</td>
</tr>
<tr>
<td>Day Care of Children</td>
<td>Children &amp; Young People</td>
<td>0.2%</td>
<td>1.6%</td>
<td>6.7%</td>
<td>45.5%</td>
<td>41.8%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Fostering Service</td>
<td>Fostering Service</td>
<td>0.0%</td>
<td>4.2%</td>
<td>13.8%</td>
<td>48.3%</td>
<td>32.3%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Housing Support Service</td>
<td>Housing Support Service</td>
<td>0.0%</td>
<td>2.0%</td>
<td>11.0%</td>
<td>36.0%</td>
<td>46.9%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Nurse Agency</td>
<td>Other than Care at Home</td>
<td>0.0%</td>
<td>0.0%</td>
<td>21.7%</td>
<td>45.0%</td>
<td>31.7%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Offender Accommodation Service</td>
<td>Mainstream Residential School</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>18.0%</td>
<td>37.9%</td>
<td>21.1%</td>
</tr>
<tr>
<td>School Care Accommodation Service</td>
<td>Residential Special School</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>9.3%</td>
<td>25.8%</td>
<td>58.1%</td>
</tr>
<tr>
<td>Secure Accommodation Service</td>
<td>School Hostel</td>
<td>0.0%</td>
<td>14.3%</td>
<td>14.3%</td>
<td>28.6%</td>
<td>42.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Support Service</td>
<td>Home at Home</td>
<td>0.0%</td>
<td>1.6%</td>
<td>21.7%</td>
<td>41.2%</td>
<td>42.7%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Support Service</td>
<td>Other than Care at Home</td>
<td>0.0%</td>
<td>0.0%</td>
<td>4.8%</td>
<td>33.3%</td>
<td>50.7%</td>
<td>9.7%</td>
</tr>
</tbody>
</table>

| All types of care services | | 0.1% | 1.4% | 9.0% | 44.8% | 41.0% | 3.1% |

Table 2. How good is our leadership? - % of services with each grade.
Source: Care Inspectorate 2024. Quarterly Statistical Summary Reports

Are these levels of leadership in this major part of the CLI system a baseline from which to envisage improvement? It would be expected that more effective CLI would show through, ultimately, at this level of leadership as well as others. Is the attainment of more ‘Excellent’ leadership to be a focus for CLI? Can more ‘good’ be converted to very good? The use of this data in the context of CLI needs to be considered. This
kind of data on leadership, which is regularly collected and publicly available, ought to be of relevance in the CLI context. This data is reported on fortnightly with all reports and quarterly in summary for at present. Can more be made of using data like this in the CLI context?

**Perspective 3 Culture-Leadership-Integration**

There are multiple meanings of and contexts for integration. Consistently this addresses inter-professional themes in CLI (Sheppard et al., 2022), across medical, social and management meanings (Connolly et al., 2022; Cheng & Catallo 2010) and including values (Zonneveld et al., 2018), from patient experience to systems (Davies et al., 2011). There are also multiple measures in use here (Kelly et al. 2020) though the very large number of available measures and infrequent use of any common set make comparisons between schemes difficult. The promotion of core measurement sets, and stakeholder consultation could advance CLI.

Integration has been described and prescribed in the forms of systemic integration, organisational integration, functional integration, service integration, clinical integration, and normative integration (NHS Confederation 2005). Since then, it seems that not a lot has changed in CLI, except the volume of attention given to conceptual reviews of CLI. Interest in CLI remains within the ‘integration’ discourse as both an organisational (Tiiriki et al., 2022, Millar et al., 2023) and a system concern (Hendry et al., 2021, Valaitis et al., 2017). There are different types, meanings and levels of integration that can be distinguished in the NCS context:

- **Level 1 NCS**: integration *within* the component parts of the NCS workforce and system, each of which have their own internal ‘silos’ (community health, social care, social work)
- **Level 2 NCS**: integration *between* these as constituent parts of the NCS workforce and system (community health, social care, social work)
- **Level 3 NCS**: integration of the NCS with the *wider system* (for example with the National Performance Framework and agencies in, for example, community development, housing, employment, economic development).  

Studies of integration often look at Level 2 most prominently as a focus for CLI. Some prominent examples are the ‘Rainbow’ model of integrated care (Valentijn et al., 2015) and the IFIC model of 9 pillars of integrated care (IFIC 2024). These include culture as a variable for an effectively integrated and person-focussed care system. Normative integration in the Rainbow model is operationalised with respect to the following factors:
- Collective attitude
- Sense of urgency
- Reliable behaviour
- Conflict management
- Visionary leadership
- Shared vision

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12 Noting, for example, that integrated care does feature in discussions about communities but did not feature in plans for Scotland economic strategy.
• Quality features of the informal collaboration
• Linking cultures
• Reputation
• Transcending domain perceptions
• Trust

IFIC have focussed more recently (Alvarez-Rosete, 2023) on how integrated care organisations delivered collaboration for continuity and coordination of care, adopting a WHO (2018) model for that. Continuity is a temporal dimension (care across time) while coordination is linked to spatial dimension (care across providers, professionals, and geographies). Figure 4 shows the kinds of options for CLI being explored in continuity and co-ordination.

A critical point is well made about integration in the context of looking at a range of options for reducing compound pressures which have become endemic (Cantrell et al., 2023) that integration has a scale of change, involving multiple stakeholders and organisations, which challenge the capacity of organisations to be able to invest time and effort in organisational change at a time of systemic overload. More easily achieved small-scale adaptation of existing systems may be privileged over more radical system-wide transformation.

![Figure 4. Continuity and Cooperation Options](image)

The IFIC findings on continuity and coordination were concerns with:

• Seeing small and moderate advances in these, visible through experiments and local initiatives, but “changes are still embryonic”, local and not consistent.
• Service users can feel “I am the person who co-ordinates my care. Appointments, blood tests, chasing referrals, PT, OT. It's up to me to decide and schedule everything”.
• People have more positive views about achievements with care continuity over time than with coordination of care across multiple providers and settings.
• Service users have a more negative perception than providers of the degree to which care services are done with continuity and in a coordinated manner.
• Health and care providers see improvements happening at the organisational level rather than at the system level.

These might help shape a vision of CLI in the NCS context could be, given community health, social care and social work different boundaries aroundcontinuity and coordination. These concerns will reflect the hierarchies and networks of those different contexts with their blends of professions and ethics. Medical contexts can be patient-centred with strong hierarchies, Social Work contexts can be person-centred with a lot of reflection and team discussions, and Social Care contexts are shaped by the SME and larger enterprise management cultures of the private and third sector. These are all under strain in their own ways, and more integrated ways of working around care pathways, facilities and cases create contextual challenges and tensions:

• **Inter-professional Rivalry and Power Dynamics:** Existing professional cultures, jurisdictional disputes, and power imbalances can create friction and hinder collaboration (Fincham & Forbes, 2015; Haring et al., 2023; Millar et al., 2023).

• **Fragmented Social Care Sector:** The limited resources and training opportunities in social care compared to healthcare can impede progress towards integrated care (Stein et al., 2023; Davidson et al., 2021).

• **Disconnect Between Rhetoric and Reality:** A gap may exist between the stated goals of reform and the actual outcomes achieved on the ground. More realistic approaches and potentially more radical reforms might be necessary (Donaldson et al., 2024).

• **National-Local Disconnect:** A lack of communication and coordination between national policy and local implementation can create challenges (Donaldson et al., 2024).

• **Contradictions Within Organizations:** Clashing professional values and organizational structures within healthcare and social care can create internal tensions that need to be addressed (Haring et al., 2023).

One critical study concerned with better integration through commissioning (Smith et al., 2019) found that changes to that may help ensure appropriate monitoring and review of current services, the design and planning of necessary changes, and setting of priorities for funding, but even this powerful lever has its limits and these need to be acknowledged, especially in change at the ‘scale and pace’ so often exhorted by national leaders. This was because many of the elements of the culture promoted were not present. Things that were missing were:

• Successful engagement of front-line health and social care staff, their managers and union representatives in detailed planning for new ways of providing and staffing services.
• Involvement of local politicians in WSIC planning and governance.
• Setting graduated and realistic outcome measures.
• Learning sufficiently from prior local experience of pilots.
Engaging most clinicians employed in community and hospital settings in the implementation. Involving the public, patients, and carers in actual implementation of service change, as opposed to having intensive but narrow engagement in programme planning and governance.

Kelly et al. (2020) found that there are too many kinds of measures around integration for assessing the structures, processes, and outcomes of integrated care. The very large number of available measures and infrequent use of any common set make comparisons between schemes more difficult. They concluded that the promotion of core measurement sets, and stakeholder consultation would advance measurement in this area. One challenge for culture change is to not add to this complexity but become part of the solution. Exley et al. (2024b) attribute this to the continued imbalance between health and social care, with the acute health care sector holding most of the power and financial resources, may mean that integration efforts continue to only occur ‘at the edges’ rather than leading to whole system change.

CLI Perspectives; A Synthesis

Whether sources were comprehensive system reviews (Knight et al., 2024) or single organisation studies studies (Sheppard et al., 2022) or about tools for measuring culture (Rafferty et al., 2015; Simpson et al., 2019) centered on culture or leadership or integration primarily, most shared a common set of conceptual concerns, but little knowledge of interventions and change in practice. There are no exemplars to learn from or copy. Where there seemed some promising examples, these did not ultimately lead to a useful source of evidence. One example of this is the ‘three conversations’ approach offered by Partners for Change (2024)13 which has been used in Edinburgh HSCP. The Care Inspectorate evaluation of that HSCP (Care Inspectorate 2023) did not have evidence to endorse this approach, though some current research on this model is being funded by NIHR (Stevens, 2024). Another example is the SCIROCCO project (Grooten et al., 20019: SCIROCCO 2024). This was a major funded European project with Scottish engagement over several years recently. It provided a model of integration and a tool for assessing the maturity of integration (Grooten et al., 2019). However, on the website there are only a few assessments, including one from East Ayrshire, but the site seems dormant. Discovering ‘hidden’ examples of innovation present but not widely known was a feature of our search (NHS GGC, 2024).

This reinforces the point long and frequently made (Parmelli et al., 2011) about studies of culture in care contexts; they don’t meet robust methodological criteria or show clear evidence of strategies for change. And that there is an absence of scholarly agreement on the validity of existing profiles or comprehensive instruments for measuring cultures (Yeun Joon Kim et al., 2022).

13 Conversation 1: How can I connect you to things that will help you get on with your life – based on your assets and strengths, and those of your family and neighbourhood? Conversation 2; Applicable to people who are at risk. What needs to change to make you safe? How do I help to make that happen? How can I pull them together in an ‘emergency plan’ and stay with you to make sure it works? Conversation 3; What is a fair personal budget and where do the sources of funding come from?
However, from the conceptual frameworks and cases it is possible to highlight key themes, essentially that CLI change needs to be incremental (Exley et al., 2024a; Lennox-Chhugani, 2024), and that various interventions are possible (Scobie et al., 2022; Bos et al., 2021), the issue being aligning those around visions for better integration (Drumm, 2012; SSSC, 2016; Cheng & Catello, 2010).

Integration in this organisational context is a keyword that can be problematic (Evans et al. 2016). Integration in HSC is about the relationship between elements which are discrete and different parts of a system. Often in HSC the context as one of three constituent parts (health, social care, social work) and their inter-relationships. Integration needs to be defined in policy, legislation, professional and management contexts. However, it is also a metaphor, and thinking about integration may either mean, consciously or otherwise, that ‘mechanical’ or ecosystem assumptions are shaping thinking. Organisations may be like machines that can be designed, assembled and if needed reconstructed; ecosystems are living, and have relations of inter-dependence which evolve through complex feedback loops that need to be appreciated. In HSC both are relevant, though they can also be in tension. What co-design means, and what it can achieve, is quite different in each of these senses of integration.

Culture is shaped and can be changed in combination by environment and leadership at several levels (Yeun Joon Kim et al., 2022; Connolly et al., 2022; Myles et al., 2018). Interventions should be considered across these. A range of leadership styles are significant, including transformational, transactional, distributed.

Stein et al. (2023) concludes there is a need to be addressing fragmentation, increasing research on social care, and bridging training gaps are crucial for promoting integrated care and enhancing the capabilities of social care professionals.

There is a lack of concern in the literature with some known drivers of culture change and possible resistance. These include most centrally the clarification of an EVP (see Appendix 3) which addresses fundamentals as well as ‘fashions’ (Furnham, 2015); different ways of working and changing career expectations; inter-generational dynamics in workforces affecting values and behaviors; what features of cultural competence matter as present comfort zones are challenged, and trends of the future come into play.

The absence of any direct treatment of integrated care as a market with businesses which shape CLI is surprising. The most comprehensive dataset on this in the UK is from LaingBuisson (2024), which was not available to researchers. Frank Knight (2023) data can be accessed and is summarized in Figure 5. The most recent government data from the Competition and Markets Authority (2017) provides some dated data and context. More recent studies from the CMA in childcare services have been produced (CMA 202). Social care has a presence and impact of several very large businesses in the UK, including Scotland is a feature of the CLI landscape (See Table 3). The top 10 These represent around 10% of all care home capacity, and around 13% of the market.

The presence and role of these large business in CLI (see Table 3), with UK context data is something which has not been given much attention to date in the literature.
Scenarios for the future in which CLI may contain more large businesses, or fewer businesses (Mudd 2023) and more social enterprises, are both possible. The details on the Scottish context are to be determined. Splits in provision differ from service to service as shown in Figure 6 (O’Toole & Craig, 2020).

### Figure 6 Service Providers. Source IRASC.

Across all adult social care services, according to IRASC:

- No organisation features in the top 10 spend in more than one service type category.
- The private sector is dominant in outsourced care homes and care at home services, which represents 84% of all (18/19) spend on adult social care (£1.12 billion)
- Charities are dominant in all other service types, including mental health, learning disabilities and housing / homelessness services
This is also an increasingly a potential force on CLI with the development of Integrated Care Data Systems, in which large businesses with interests across pharma and software are increasingly engaged with medicine management and other domains. These will both contribute to the workforce in the system themselves, albeit not directly employed in any constituent workforce directly, and shape CLI.

<table>
<thead>
<tr>
<th>UK Care Home Businesses</th>
<th>Homes</th>
<th>Workforce</th>
<th>Revenue (£ Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barchester Healthcare.</td>
<td>200</td>
<td>15,000</td>
<td>£675</td>
</tr>
<tr>
<td>Care UK</td>
<td>130</td>
<td>10,000</td>
<td>£410</td>
</tr>
<tr>
<td>HC-One</td>
<td>170</td>
<td>11,375</td>
<td>£382</td>
</tr>
<tr>
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<td>Four Seasons Health Care</td>
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<tr>
<td>Anchor Hanover Group</td>
<td>120</td>
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<td>£213</td>
</tr>
<tr>
<td>Methodist Homes (MHA)-charity</td>
<td>89</td>
<td>6,509, 3,200 volunteers</td>
<td>£251</td>
</tr>
<tr>
<td>Maria Mallaband Care Group</td>
<td>78</td>
<td>5,738</td>
<td>£209</td>
</tr>
<tr>
<td>Sanctuary Care</td>
<td>98 (5000 beds)</td>
<td>7,300</td>
<td>£193</td>
</tr>
<tr>
<td>Avery Healthcare (England)</td>
<td>98</td>
<td>3,052</td>
<td>£170</td>
</tr>
<tr>
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<td>1221</td>
<td>56916</td>
<td>£3257</td>
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</table>

Table 3; Selected Top 19 Large Providers in Care Homes. Source

Conclusions; How to Get to ‘We are the NCS’.

Our questions were about visions, pathways to change and stakeholders. We set out some conclusions here.

**Vision: What can we learn about a clear vision/destination for CLI in the NCS to better value the workforce?**

CLI in HSC change must be approached through a more explicit theory of change, and a potential focus for that is EVP development. The branding of a company, formally and deliberately or informally and unconsciously, as an attractive employer (Mascarahenas, 2019) commonly uses the construct of Employment Value Propositions (EVP). The term EVP has been used for some time (Ambler and Barrow, 1996). Employment brands, just like product brands, need to have a distinct personality, elements of fads, fashion, and fundamentals (Furnham 2015). Traditional marketing techniques for brand positioning have long been applied to employment branding. The contemporary idea of an EVP (Reddy, 2017) is used for profile building and communicating the promise to potential recruits of the attractions which differentiate the employer. Explicit EVP analysis is rare but has been applied to the social care sector (Gibb 2024).
A current example of new thinking which may be a fashion or a fundamental is ‘belonging’. Culture is also about belonging (Allen et al., 2021). Belonging includes sharing the mindset, feeling a good fit with others, and having the confidence to act competently in situations outside the routine and familiar. In the context of CLI in HSC belonging opportunities can be an integral part of NSC from strategy development to team working. It can be a distinct process which may be managed in its own right as a focus for bringing together a common set of familiar concerns (Arrunda 2023).

The absence of EVP type analyses in the HSCI CLI literature is potentially significant at each level of integration. That is within each of community health, social care, and social work; and between the community health, social care and social work directly withing scope of the NCS; and beyond these parts of the NCS in wider domains of social and economic policy and the institutions in, for example, education, housing and employment.

There is it seems no pressing need for an EVP for the NCS as an employer as such, there is neither a current nor future prospect of workforce integration in Scotland. Even with information, finance and operational systems being better integrated in Scotland the persistence of different employment and employment relations contexts for the NHS, Local Authorities and the diverse network of social care providers preclude the kind of CLI that can emerge around a single EVP.

But EVPs can be helpful for CLI as they have a 'soft' and 'hard' and relational meaning, which allow for multiple aspects of valuing the workforce to be taken into account. There may be a connection here to the project of developing a Workforce Charter for the NCS. The soft is associated with symbols, stories and rituals, and an emotional motivational affect. The hard is associated with control systems, structures, power, and a rational-cognitive affect the hard aspects are cognitive-rational questioning of elements about how a cultural situation and change is to be explicitly characterised and discussed in the context, the kind of change being managed). The soft can be more emotional-appreciative and about generating empathetic engagement and enthusiasm for (or resistance to) the kind of change being proposed. Finally, there will be social-collaborative-engaging elements are the sources of and distribution of ‘frustration’ and ‘fulfilment’ with respect to culture change (Kaplan et al., 2016), different ways of working and changing career expectations; scaling up innovation in the continuity and coordination of care itself more than top down ‘systems’ change and quality improvement; inter-generational dynamics in workforces of the present and the future; and what inter-cultural competence looks like in the future workforce.

It could be that a concern with EVPs at the constituent levels of the NCS, and in HSCPs, as part of their local strategic plans and initiatives, might allow for exemplars and role models to emerge over time. There are at least three inter-related CLI contexts here (See Figure 5) with boundaries between them all; one is community health; one is social work, and one is social care. In the outline of the literature that follows the key themes of Inter-Professional Collaboration, Whole Systems, EVPs and Subcultures will come to be highlighted. It is often recognised that within community health there are different sub-cultures within the dominant professions in health (Mannion & Davies 2018), including medicine, nursing, and allied professions. But similar differentiations exist in social care (Boggia et al. 2021) and social work (Miller 2024). It’s not surprising that features of differentiation and fragmentation may be
present in the overall CLI for the NCS, incorporating as it does such a complex environment of subcultures.

<table>
<thead>
<tr>
<th>Overall CLI Themes for ‘We are the NCS’</th>
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<tbody>
<tr>
<td>Inter-Professional Collaboration</td>
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<td>Whole Systems</td>
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<td>Employment Value Propositions</td>
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<th>Community Health CLI</th>
<th>Social Care CLI</th>
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<tr>
<td>Plan</td>
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<td>Nurture</td>
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**Figure 5. CLI Themes and Workforce Pillars Mapping Across Three Domains. Source, Authors.**

Pathways: Are the ways to attain that vision well-articulated and understood?

Despite there being no explicit and coherent vision for CLI the search for ways to attain culture change has been ongoing. In the absence of a clear destination people still travel hopefully, trying in their own areas to find ways to build their EVPs and attract and retain a workforce as integration is implemented in policy, in systems and service delivery.

To articulate and understand the ways to attain change the further questions below are relevant. One observation prompted by perhaps a groupthink feature is that the prominence of systems thinking, and the consequent engagement with complexity to re-configure systems, can mean that thinking about CLI is oriented on institutions and institutional change. However, the most significant site of change should be with the practical co-ordination of care with individuals, and CLI which improves that. That is where a spirit of understanding, partnership, best fit, and preferred outcomes is most important. Some of the common elements discussed are:

- **Innovative Payment Models:** Implementing innovative payment models that incentivize collaboration across sectors could be a potential solution to address cultural barriers (Looman et al., 2021). Pooled budgets, shared-savings agreements, professional empowerment, and quality measurement and rewards are mechanisms that can stimulate integration.

- **Reallocation of resources:** Community empowerment approaches (Donaldson et al., 2024).
• **Leadership and Political Commitment**: Strong leadership and political commitment at national and regional levels are essential for driving systemic cultural changes and creating a supportive policy environment for integrated care (Looman et al., 2021).

• **Quality-Driven Contracting**: Shifting the focus towards quality-driven contracts that prioritize sustainable care delivery can promote a culture that values quality over economic competition (Looman et al., 2021).

• **Continuous Cultural Learning**: Fostering a culture of open communication, collaboration, and continuous learning within organizations can help address internal contradictions and promote positive change (Haring et al., 2023).

• **Addressing National-Local Disconnect**: Improved communication and coordination between national and local levels can bridge the gap between policy and practice (Donaldson et al., 2024)

**Stakeholders: What are the challenges for all stakeholders to have the motivation to join in the journey to further change?**

No-one is in principle going to be against this and creating change towards CLI. But the motivation to sustain contact across boundaries and progress an actual journey to further change based on that can be mixed. Even if a clear vision of CLI is set out, there will be different response to that among the stakeholders that are presently engaged. CLI can progress with clearly shared aspirations and commitments to improving the quality of care and outcomes. That is acknowledged in stakeholders concerned with policy thinking, the system management, and the actual delivery of services. Motivations for CLI with respect to the following are also potentially significant shared ground:

• **Importance of Continuous Learning and Development**: A skilled workforce is essential. Investment in training and education programs that promote continuous learning and collaboration among healthcare professionals is crucial (Walker & Ghillies, 2014; Baxter et al., 2018). Their involvement and support through education, training, and professional development are critical in acknowledging existing professional cultures and designing digital health applications (Stein et al., 2023). This aligns with the NCS reform agenda, which aims to address the fragmented nature of the social care sector and the disparities in training opportunities.

• **Person-Centred Care**: A core value in a successful H&SCI culture is prioritising patient well-being, involving patients in decision-making, and ensuring effective communication and continuity of care (Walker & Ghillies, 2014; Davidson et al., 2021). A culture that prioritizes patient-centred care, effective teamwork, and commitment to continuous improvement is crucial for fostering transparency, empathy, and respect (Davidson et al., 2021).
• **Collaboration and Partnership Working:** Effective collaboration across healthcare and social care sectors is essential for overcoming fragmentation and driving positive change (Walker & Ghillies., 2014; Stein et al., 2023).

**Further Questions about Future Research for CLI in the NCS context**

In the context of national/systems concerns we would highlight three emergent questions about a theory of change for CLI in the NCS context:

- How can the national/systems level help in defining and managing CLI?
- What theory of change is to be articulated and applied?
- What interventions are possible and practical?

**How can national/systems level help in defining and managing CLI?**

This is an open question. The literature shows that there is a combined role for the environment and for leadership. The points about having conversations at the national/systems level within, among and beyond the various parts and levels of the NCS are relevant here too. Perhaps if the language of CLI is used that can create and enable the spirit of understanding, partnership, best fit, and preferred outcomes all share.

**What theory of change is to be articulated and applied?**

Theories of change can help set out steps along the way, working back from the intended destination. In the absence of an intended destination now (the NCS as legislated for), a clear vision of CLI, there is a lack of clarity about the theory of change which is helpful in this context. This is not just about a refreshed curriculum for leadership development for a few. It is about the CLI involving over 155,000 people. The CLI in HSC literature contains little explicit on theories of change at this scale and needs some attention.

**What interventions are possible and practical?**

The answer to this in part can be set out with respect to a set of standard types of intervention, which need to be initiated by and managed by designated people. There needs to be greater mindfulness of the issues for CLI mapped in Figure 5 (replicated here) domain- community health, social care, social work- can benefit from better articulating their own CLI. The high-level task of achieving that in a combined way should be part of the CLI provided by the NCS, however it comes to be ultimately constituted. This includes the key CLI themes found in the literature which are Inter-Professional Collaboration and Whole Systems thinking. It extends the scope to some of the most significant absences found in the HSC CLI literature.
Recommendations

This report aims to assist understanding of the broad environment of integration and the challenges which will build the foundations for defining the issues, developing potential solutions, and testing these ideas in CLI for the NCS at a national/systems level. EVPs can be a major focus for this, and CLI at the three levels set out above: within, among and beyond the core parts of community health, social care, and social work.

That body of knowledge is at present limited and partial. It is not a strong foundation to test out responses with the workforce to create insights and learnings to shape a CLI strategy for the NCS. Rather more knowledge needs to be created as change for CLI in the NCS is developed. As the 2024 data (Jeffries et al., 2024) show public satisfaction with the NHS and social care, at their lowest ever, set a context in which CLI must be a part of stopping and reversing that decline. Many people have been and are exploring changes and trying to have impact.

If a clearer vision is articulated there is scope for national/systems interventions. There is also scope for actions that do not require authority, resourcing or legislation grounded support. Actions on these also in part need to be set out over time. There is also a need for a focus on wider term issues, like population health and tackling health inequalities. CLI will need to balance this with the often intense short-term, operational challenges.

We revisit the three core questions set and recommend (see Figure 1 below) that through dialogue, at the national/systems level, the following phases and elements are addressed. These can be part of the journey towards ‘We are the NCS’.

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Figure 5. CLI Themes and Workforce Pillars Mapping Across Three Domains. Source, Authors.
Phase 1 has implications for those in the NCS Workforce Policy unit and links with SSSC, Care Inspectorate, Improvement bodies, NES, Scottish Care, Health and Social Care Alliance, Audit Scotland and HEIs. Indeed, strategic partnerships with HEIs may be a fruitful development for the NCS. Inter-professional collaboration, whole systems, different ways of working and changing career expectations, and cultural competence. Benefits of change in CLI at the national/system can be articulated for current and future Leaders, Professionals, Workforce Teams; how to get a place where people think and feel ‘We are the NCS’. There are potential interfaces with other projects and research, including co-design development of a Workforce Charter. Data to inform this phase could be collected on the items set out below and listed in more detail at Appendix 6:

1. **Inter-professional collaboration** refers to working with others both within your own organisation and other organisations when providing care.
2. **The whole system** refers to how finance, information, and partnerships with other organisations are working together.
3. **An EVP** is a strong and valid set of messages about the quality of working life to attract and retain people as employees in a sector with multiple employers.
4. **Leadership** refers both to those in formal roles with authority and power and also to how people in general can take responsibility for co-ordinating actions with others.
5. **Culture** can be defined with respect to values and norms that are presumed or prescribed to shape behaviour, though these values and norms are usually socially and psychologically distributed.
6. **Key themes** (derived from Feeley) ranked from most important to least important for the workforce in the NCS to be more valued.
7. **Continuity and coordination** were concerns with, experiments and local initiatives beyond the organisational level and at the system level.
Phase 2 would need to follow on from and take forward what emerges from Phase 1, so the detail on that is open. Having a coherent view of CLI and a shared theory of change in the NCS context would be part of this phase. Identifying pilot organisations with discrete projects which could be worked on the CLI development context. Interventions to support thinking and feeling in the workforce that ‘We are the NCS’.

Phase 3 is essentially, and directly, going to require multiple stakeholders to not only work on interventions together to deliver CLI in the NCS, but also to give time and resource to capturing and sharing learning. A team to support this, inclusive of research projects which accompany interventions, can be another new feature of a different landscape for CLI which helps Scotland get beyond the known problems and challenges and secure sustainable solutions. Solutions which enable a culture in the NCS context that is attractive to the current and future workforce, with leadership feeling they have got past the challenges of the current situation, and the achievement of integration to deliver the outcomes which matter to those requiring care, their families, and communities.

Possibilities for funding further research in and across these phases may be found in the Scottish context for NCS development, and/or other funding bodies. The journey to a workforce thinking and feeling in practice that ‘We are the NCS’ will not be a quick transformation, it will take multiple projects over time.

- Scottish Government
- NIHCR ‘Research Programme for Social Care (RPSC)’
- Knowledge Transfer Partnerships (KTPs) funded by UKRI with Innovative HSCPs
## Glossary

| **Culture** | Culture is used as shorthand for a complex of the ‘hard’ and ‘soft’ aspects of organisation and often managing a focal and specific theme, such as ‘integration’ |
| **Leadership** | Most commonly leadership is represented as a set of roles which can be enacted in a range of styles, and is a function which exists at various levels, from the highest peak of a hierarchy to front line teams. |
| **Culture-Leadership-Integration (CLI)** | A proposed domain of research and practice which spans the constituent constructs |
| **Integration** | The relationship between elements which are discrete and different parts of a system. Often in HSC the context as one of three constituent parts (health, social care, social work) and their inter-relationships. Integration needs to be defined in policy, legislation, and management contexts. |
| **Employment Value Proposition** | The branding of an employer as an attractive place to work, communicating the value and benefits to attract and retain people. Can also be applied to sectors, with all employers, for good or ill, sharing some elements of an EVP. |
| **HSCP** | All Partnerships are responsible for adult social care, adult primary health care and unscheduled adult hospital care. Some are also responsible for children’s services, homelessness, and criminal justice social work |
| **National Care Service** | That vision for the NCS in Scotland is for everyone to have access to consistently high-quality social care support across Scotland, whenever they might need it, and for the social care workforce to flourish. The goal is to future-proof the social care sector for generations to come - and for people coming into the profession. This involves the workforces in community health, social care, and social work. |
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Skills for Care (2021b) 'The Principles of Workforce Integration’, Skills for Care.


Appendix 1; Co-design Consultation on Valuing The Workforce

- The difference between workforce models causes tension between the health, social care and the voluntary sector workforces – which impacts team morale and how valued staff feel.

- There is a need for consistent and collaborative approaches to determining eligibility, conducting assessment, and making referrals for social care support.

- Effective multi-disciplinary and multi-agency team working is key for delivering quality services that meet people's needs.

- It is vital the social care workforce experience is improved to attract and retain staff.

- The workforce feel inclusive leadership and shared values within the social care sector support the workforce experience.

- There is a need for more consistent and appropriate training to develop the essential skills for a variety of roles, and ensuring the time for development is also crucial.

- Sharing data and information is important to create more effective service delivery across health, social and voluntary sectors.

Appendix 2; Context

The Framework for Community Health and Social Care Integrated services

The Framework for Community Health and Social Care Integrated services (Rowland 2019, P 10) includes an acknowledgement of the role in enabling integration of the value of strong, positive, and consistent culture and values shared across Integration Authority, Local Authority, and NHS Board, as well as the Third and Independent Sectors. (See Figure 5 below)

The framework has a section on ‘Creating an Environment for Effective, Sustainable Integrated Care’. This includes identifying the following CLI related enablers.

- Collaborative, collective, and visible leadership across all the partners and at all levels of the organisation, recognising the importance of nurturing and developing front line leaders to deliver change.
- Shared accountability across all the partners for delivery of change.
- Well, developed, positive relationships across all the partners.
- Clarity and consistency of vision, direction, and purpose.
- Strong, positive, and consistent culture and values shared across Integration Authority, Local Authority, and NHS Board, as well as the Third and Independent Sectors.
- Autonomous team working underpinned by equality, trust, and respect.
- Capacity and commitment, including that required from the third and independent sectors, to participate in the planning of integrated care and support, as well as in the resulting integrated team meetings.
- Positive behaviours that encourage innovation and constructive challenge.
- Organisational Development support made available to partners from statutory, third and independent sectors to build all the above.
Robust clinical and care governance arrangements to enable issue identification, escalation, and resolution; shared learning to improve practice; peer review and support; and the development of and adherence to policies, guidelines, and protocols to support fully integrated working.

The NIHR Research Plan (2023)

The NIHR research Plan (2023) for reducing compound pressures on health and social care has three objectives, one of which is about the health and social care workforce of the future. Research into new and more efficient models of care with a focus on prevention, combined with understanding how the health and social care workforce can be trained and supported to deliver them, are required to deliver high quality care more efficiently.

Research to optimise a public health, NHS, social care, and wider health workforce that is effectively structured, trained, deployed, and supported to deliver future effective and efficient models of healthcare which meet the needs of the UK’s ageing population. Priority research topics are.

- understanding the barriers to recruiting and retaining staff in the NHS and social care and care work
- identifying solutions including supporting wellbeing
- identifying how to structure the workforce to meet future health needs and how to drive cultural and behavioural change within organisations
- developing and evaluating interventions to increase the efficiency and effectiveness of staff (for example, skills-mix, task-shifting and service integration)
- developing and evaluating technology-assisted workforce solutions to reduce burden on staff while maintaining patient outcomes (for example, diagnoses assisted by artificial intelligence, robotics to support surgery and care, remote
Appendix 3 Employment Value Propositions (EVPs)

The Employment Value Proposition (EVP) can both focus on and combine across the various parts of the system from the NHS and LAs to SMEs providing care services can be more prominent. It can incorporate and address fundamentals, including themes like equality, and contemporary trends such as belonging. The importance of CLI is either implicit or explicit as a significant element of this context. However, what this means in the NCS context, and what might need to change, is not well articulated. Health and Social Care integration is not unique in this. But it is a big gap at present.

The system contains at least 3 cultures, each of which encounters its own challenges in an EVP to attract, retain and nurture staff, communicating about the Learning, Equity, Reward, Flexibility, and Talent development commitments for the workforce. The big public sector employers and workforce faces competition with other parts of the public sector to be an attractive employer; the smaller and more agile voluntary/third sector employers and workforce likewise compete with others for funding and recruits. And not least the largest part of the workforce, the independent employers and private sector workforce face competition from other private sector employment.

Culture in an EVP has both a ‘soft’ and ‘hard’ and relational meaning. The soft is associated with symbols, stories and rituals, and an emotional motivational affect. The hard is associated with control systems, structures, power, and a rational-cognitive affect the hard aspects are cognitive-rational questioning of elements about how a cultural situation and change is to be explicitly characterised and discussed in the context, the kind of change being managed. The soft can be more emotional-appreciative and about generating empathetic engagement and enthusiasm for (or resistance to) the kind of change being proposed. Finally, there will be social-collaborative-engaging elements are the sources of and distribution of ‘frustration’ and ‘fulfilment’ with respect to culture change (Kaplan et al., 2016), different ways of working and changing career expectations; scaling up innovation in the continuity and coordination of care itself more than top down ‘systems’ change and quality improvement; inter-generational dynamics in workforces of the present and the future; and what inter-cultural competence looks like in the future workforce.
## Appendix 4 Literature Review Summary

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<td>Connolly et al.</td>
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<td>The Leadership of Co-Production in Health and Social Care Integration in Scotland: A Qualitative Study</td>
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<td>Culture</td>
<td>Qualitative case study, Alberta</td>
<td>Leslie et al.</td>
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<td>Doing primary care integration: a qualitative study of meso-level collaborative practices</td>
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<td>IFIC ANNUAL SURVEY EXECUTIVE SUMMARY. Are we there yet? continuous and coordinated care</td>
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styles, with in depth reflection on issues with these

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Appendix 5; Perspectives on Culture and Leadership

In organisations and management culture and leadership can be understood and examined from various perspectives.

One is the classic anthropological sense, covering the elements of the culture wheel (Figure 6), usually seen in both national cultures and generational subcultures.

Another is the organisational ethnographic (Garsten & Nyqvist, 2013, describing the group cultures of workplace, the soft (stories, rituals, symbols) and the hard (power and control systems and relations) (Alvesson 2016, Ashkanasy et al. 2010). The Johnson & Schole (1999) Culture Web is a version of this (see Figure 8).

Culture and leadership as having cognitive, emotional, and relational elements, what makes sense, what feels right and interpersonal norms, which can be managed. These may have generational and inter-generational aspects to them. For example, ‘baby boomer’ generation cohorts in positions of power and authority at present, with Generation Alpha cohorts about to enter the workforce. Longer waves and trends of generational change are important (Inglehart, 2018). Figure 9 shows one global mapping in this context.
Figure 10 gives an overview of a typical framing of the overview of culture and leadership for developing compassionate, inclusive, and collective leadership and deliver culture change (NHS England 2024). https://www.england.nhs.uk/culture/culture-leadership-programme/

There are models of different types of organisational culture; for example, cultures and leadership to deliver competitiveness, control, creativity, collaboration. See Figure 11. The CVF model

Good or positive cultures and leadership versus problematic/toxic cultures and leadership (for attracting and retaining talent, health, and wellbeing, etc) with respect often to a specific domain (for example, collaboration, safety, diversity, blame, compassion, and so on). (Skills for Care, 2018).

In multi-cultural contexts 'cultural competence' can feature in two forms. One is the culture competence among the workforce teams. One is in relations between carer and cared for if there are cultural differences, with for example, internationally recruited care workers from Asia or Africa working with Scottish clients.

A potential framework that incorporates all of these is Employment Value Propositions, (EVPs) of a sector with multiple employers in it. EVPs have levels of that can eb analysed and described from the superficial to the deeper which articulated as culture. What is observable (fashions, facilities, norms, etc), and what are the fundamentals (Furnham 2015) like values and belief/assumptions.

14 Our brief excludes leadership development; however, this graphic represents well the key themes of culture change in the system. There is no equivalent we are aware of in Scotland, where leadership development involves various stakeholders, mapped overall by the NES.
Appendix 6; Potential Data Collection Items

Items on which data could be collected to inform conversations on CLI change- first draft thoughts only.

Inter-professional collaboration refers to working with others both within your own organisation and other organisations when providing care.

1. Is inter-professional collaboration a significant element of your work?
2. Are your inter-professional collaborations working well?
3. What would help to improve inter-professional collaboration for you?

The whole system refers to how finance, information, and partnerships with other organisations are working together

1. Is the ‘whole system’ a significant feature of your work?
2. Is the ‘whole system’ working well for you?
3. What would help to improve ‘whole systems’ working for you?

An EVP is a strong and valid set of messages about the quality of working life to attract and retain people as employees

1. Do you know what the EVP is in your employment context?
2. What about an EVP do you think might matter most to those who could come to work in HSC

Leadership refers both to those in formal roles with authority and power and also to how people in general can take responsibility for co-ordinating actions with others.

1. How would you define your leadership position; (a) formal role, (b) autonomy with responsibility, (c) no scope for leadership in my role
2. If a what about the current culture present a challenge for you?
3. If b what about the current culture constrain your autonomy?
4. If c what about the current culture could change to engage you as a leader?

Culture can be defined with respect to values and norms that are presumed or prescribed to shape behaviour, though these values and norms are usually socially and psychologically distributed.

1. I tend to take the values and norms of my roles and responsibilities more seriously than my colleagues
2. I think we have the right values and norms to fulfil our roles and responsibilities
3. Values and norms do not much impact how we fulfil our roles and responsibilities, regulations and instructions are far mor important
Please rank the following (derived from Feeley) from most important to least important for the workforce in the NCS to be more valued

1. Creating the conditions for improvement.
2. Instil a real learning culture.
3. A national approach to improvement
4. Testing, discussing, and sharing methods that improve outcomes.
5. Change the current procurement system to support the move from a competitive process and culture to a collaborative approach.
6. Developing professional support and supervision for people who often work in isolation from their peers,

Continuity and coordination were concerns with, experiments and local initiatives beyond the organisational level and at the system level, with respect to.

1. Same professional over time
2. Shared decision-making
3. Teamwork and meetings
4. Co-location
5. Technology supporting this
6. Roles
7. Records
8. Involve those cared for and others