NOTTINGHAM & NOTTINGHAMSHIRE ICS OD COLLABORATIVE

Review of Literature and Evidence

Richard Bolden, Rob Sheffield, Selen Kars-Unluoglu, Margaret Roberts & Carol Jarvis
Bristol Business School
University of the West of England

August 2021

Contents

1. INTRODUCTION

This document presents outcomes of the review of theory, research, policy and practice (nationally and internationally) completed as part of the scoping work for the Nottingham and Nottinghamshire Integrated Care System (ICS) Organisation Development (OD) Collaborative.

The review explores five key areas which underpin effective organisation development:

1. Leadership
2. Organisational Culture
3. Improvement
4. Equality, diversity and inclusion (EDI)
5. Talent management

A multi-disciplinary team at UWE, Bristol compiled materials informed by the project brief to capture:

- Key insights from theory, research, policy and practice
- Frameworks, methods and approaches commonly considered to be good practice
- Evidence of impact from use in practice
- Systems insights from Health and Care cases
- Systems Insights from other sectors
- Implications for Organisation Development.

The choice of themes and questions was framed by the client, with a request to include system-level examples, where possible.

This report is structured according to the five topic areas, with sub-headings as required. Each section concludes with a set of implications for organisation development. The final chapter collates themes from across all five areas to guide the work of the OD Collaborative for Nottingham and Nottinghamshire ICS going forward.

2. LEADERSHIP

2.1 KEY INSIGHTS FROM THEORY, RESEARCH, POLICY AND PRACTICE

Systems leadership

There is a large and growing body of literature on leadership in health and social care. Whilst the focus was traditionally on the skills and behaviours of people holding formal clinical and/or managerial responsibilities, over the past decade the attention has shifted towards **systems leadership**[1]. Systems leadership is widely recognised as essential in facilitating the transition to integration and collaboration across health and social care, as illustrated in the following quotes.

> *"System leadership is vital to delivering integrated care, transforming services to address the financial and demographic challenges facing health and social care, and tackling health inequalities." (NHS Confederation, 2014)*

> *"National bodies and NHS organisations should prioritise the development of system leadership both for the NHS as a whole and in local health economies. This should include learning from other sectors and moving beyond the pace-setting styles that have been dominant in the recent past." (Ham and Murray, 2015)*

The Social Care Institute for Excellence (SCIE, 2018) outlines the features of effective systems leadership for integrated care, as follows:

System leadership for integrated care

What is it and how does it work?

- System leadership is about building relationships and connectivity across organisations and sectors to drive the improvement, innovation and transformation of services.

Effective system leadership is:

- shared, participatory, diffused and co-productive
- relationship building, personal and person-centred
- place-based and community-oriented
- adaptive and solution-focused
- capable of surfacing conflicts and consensus seeking
- primarily accountable to people and communities.

Source: https://www.scie.org.uk/integrated-care/research-practice/enablers/system-leadership

An influential review of systems leadership, published by the Virtual Staff College in 2013, highlights the public service context as one characterised by increasing demand, decreasing resources, wicked[2] issues, regulation and inspection, opportunity, paradox, interdependency and interconnectedness, risk and VUCA (volatility, uncertainty, complexity and ambiguity). These, in turn, shape the nature and

[1] The terms 'system' and 'systems' leadership are used fairly interchangeably in the literature. Within this report we use the plural form to highlight that the work of health and social care does not fall within a single, neatly bounded system but rather across multiple, interconnected systems – the boundaries, content and purpose of which may be redrawn depending on who is involved and what they are trying to achieve.

[2] A wicked problem is one that is challenging to find a solution to because of complex, contradictory, and changing requirements that are often difficult to recognise and/or achieve agreement about (Grint, 2008).

purpose of systems leadership and the need for systems leaders to develop their ways of feeling, perceiving, thinking, relating, doing and being (see Figure 1).

Figure 1 – An integrated model of systems leadership

(Ghate et al., 2013, as reproduced in Bolden et al., 2019, p.21)

The notion of systems leadership is informed by principles of **systems thinking** (see, for example, Senge et al., 2015) - which highlights the interconnected, relational and boundary-spanning nature of leadership practice and the need for a shift in mindset from hierarchy to system. Despite the emphasis on taking a 'systems perspective', however, the majority of health and social care policy, practice and development continues to focus on the characteristics of 'system leaders' and their ability to exert influence (agency) within the system (see, for example, the King's Fund work on system leadership). Whilst this may be helpful in recruiting and developing people for senior leadership roles in health and social care (such as Clinical Directors, Directors of Public Health, Adult Social Care, Commissioners, etc.) it downplays a significant body of theory and research on the dynamic and emergent nature of leadership and management practice in complex systems.

The work of authors such as Professor Ralph Stacey, and colleagues at the Complexity & Management Centre at the University of Hertfordshire, is particularly helpful in shifting attention from 'leaders' (as people) to 'leadership' (as a process) by highlighting the ongoing patterns of social interaction that create and recreate social structures and norms. His theory of **complex responsive processes of relating** provides a rich conceptual framework for rethinking management and leadership practice, as summarised in Table 1 below.

Orthodox management	Analogy from complexity sciences
Stability – change – stability	Continual change – 'one damned thing after another'
Leadership and managers can predict	Predictable unpredictability
Leaders and managers are in control	No single locus of control – whatever happens occurs because of what everyone is doing
Focus on the 'big picture' – separation of thinking from action, means from ends, task from process	Focus on local interaction and the general patterns it produces at the same time – linking means and ends
Alignment – leaving politics at the door, sharing values	Exploration of difference – enabling constraints, politics and power

Table 1 – Rethinking leadership and management practice

(Adapted from Stacey, 2018)

Through revealing the lack of predictability and control in complex systems, Stacey highlights the significance of power and politics in determining the perceived nature, purpose and outcomes of effective leadership in complex environments.

> *"From the dominant perspective, organizational continuity and change is the realization of the choices of powerful people. From a complex responsive processes perspective organizational continuity and change emerge in many, many local interactions as patterns across population which no one planned or intended. Outcomes emerge in the interplay of everyone's plans and intentions and no one can control the interplay." (Stacey, 2009)*

In a thought piece for the National Leadership Centre[3], Bolden (2020) highlights four main rationales for adopting a systems leadership approach in public services - *effectiveness*, *efficiency*, *engagement* and *equity* - noting the potential contradictions between these agendas and the differing assumptions on which they are based. In a related journal article, based on an evaluation of the Systems Leadership: Local Vision programme Bolden and colleagues note the tensions between a market-based approach (which emphasises principles of efficiency and effectiveness) and a democratic and inclusive approach (which emphasises principles of engagement and equity). Drawing on the principle of **public value** (Moore, 1995) - a key concept within the public administration literature - it is argued that:

> *"The promise of systems leadership… risks becoming empty rhetoric if it does not look beyond the neoliberal drive for a market-based approach, which construes public services in functional rather than relational terms […] Instead, a focus on 'the full range of democratic and constitutional values'… implied in more recent conceptions of public value must be maintained, along with open and honest dialogue that engenders a genuine sense of trust and relationship." Bolden, Gulati and Edwards, 2020*

For more on leadership for public value and the significance of **political astuteness** in navigating complex public sector contexts please see Hartley et al., 2019.

[3] The National Leadership Centre was established to support leadership development for senior leaders across the UK public sector. A useful series of short 'thought pieces' on systems leadership, impact, engagement and effectiveness can be found at https://www.gov.uk/government/publications/national-leadership-centre-research-publications

Compassionate leadership

Alongside system leadership, another concept that has been widely embraced within health and social care is **compassionate leadership**. Whilst this is perhaps most clearly aimed at people in frontline clinical roles, it is associated with an emphasis on staff wellbeing that would apply to managerial leaders as well.

In 2017 the King's Fund published a report *Caring to Change*, which identified four main components of compassion - *attending*, *understanding*, *empathy* and *helping*. These factors demonstrate the need for NHS staff to engage with others at a deep emotional level – acknowledging suffering, attempting to understand the cause(s) of distress, demonstrating a genuine empathic response, and taking thoughtful and appropriate action. The research identifies a strong link between compassionate leadership, innovation and performance and highlights how genuine compassion at individual and team level is dependent on an enabling environment at organisational and systems level, including (1) inspiring vision and strategy, (2) positive inclusion and participation, (3) enthusiastic team and cross-boundary working, and (4) support and autonomy. For NHS employees to demonstrate compassion in their interactions with patients and staff they need to feel valued and supported. As the authors argue:

> *"In order to nurture a culture of compassion, organisations require their leaders – as the carriers of culture – to embody compassion in their leadership." (West et al., 2017:4)*

In the largest study of culture in the English NHS, Dixon-Woods et al. (2014) concluded that six key elements were necessary for sustaining cultures that ensure high quality compassionate care for patients, as summarised below.

Sustaining cultures of high-quality compassionate care

- inspiring visions operationalised at every level by leaders;
- leaders ensuring clear aligned objectives for all teams, departments and individual staff;
- supportive and enabling people management;
- high levels of staff engagement;
- leaders focused on ensuring learning, innovation and quality improvement in the practice of all staff; and
- effective team working.

Source: Dixon-Woods et al., 2014, cited in West and West, 2015

Whilst compassionate and caring leadership is undoubtedly desirable within health and social care it places challenging expectations upon those in leadership roles. In an analysis of the philosophical underpinning of the concept of 'caring leadership' Tomkins and Simpson, 2015 note:

> *"It involves tolerance of complexity and ambivalence; a rich sense of temporal trajectory; concern for one's presence in the world; and crucially, the ability to resist the soothing normativity of 'best practice'. From this position, we argue that the problem with the growing scholarly interest in an ethic of care is that it provides too tempting a recipe to follow. In a Heideggerian view, caring leadership has little to do with compassion, kindness or niceness; it involves and requires a fundamental organization and leadership of self."*

Such observations are largely absent within practitioner-orientated literature but have important implications for how leaders are supported, developed and rewarded. In a related article, reflecting on their own experiences of 'caring' the following implications for leadership practice were identified.

An Ethic of Care: Reconnecting the Private and the Public

- Reconnecting our experiences across the so-called work-life boundary.
- Challenging the notion that care is purely a domestic issue, or something "pink and fluffy".
- Acknowledging the emotional undercurrents of both workplace and private relationships.
- Acknowledging the complexities of decision-making, especially in relation to the question of intervention.
- Learning to value the evidence of our own experience, rather than always reaching for evidence in the shape of facts and figures.

Source: Tomkins and Simpson, 2015 - https://uwe-repository.worktribe.com/output/878407

Inclusive leadership

The relationship between leadership and culture are also evident in the growing literature on **inclusive leadership** (see Bolden et al., 2019 for a review). Inclusive leadership is seen as essential to enhancing recruitment and retention and ensuring that the NHS and partner organisations are able to meet the needs of a diverse population. Despite a commitment to inclusive leadership, however there is considerable evidence of systemic inequalities, as highlighted in the Independent SAGE Committee report into the disproportionate impact of Covid-19 on Black, Asian and minority ethnic (BAME) communities:

> *"A reoccurring theme throughout the evidence on the impact of COVID-19 on ethnic minority communities is the issue of racism and discrimination within the health and social care system, including within the NHS. We therefore recommend that the NHS reiterates its commitment for increasing diverse leadership at all levels in health and care systems, reflecting the communities which it serves. It is also critical for NHS Trusts to review processes by which BAME staff are able to raise concerns about occupational risk and safety." Independent SAGE, 2020*

Removing barriers to progression for BAME staff and those with other protected characteristics remains a key challenge that the NHS is yet to resolve. Roger Kline, who wrote the Snowy White Peaks of the NHS report which paved the way for the introduction of the Workforce Race Equality Standard (WRES) within the NHS, recently argued:

> *"In healthcare, leadership is decisive in influencing the quality of care and the performance of hospitals. How staff are treated significantly influences care provision and organisational performance so understanding how leaders can help ensure staff are cared for, valued, supported and respected is important. Research suggests 'inclusion' is a critical part of the answer." Kline, 2019*

> *"Inclusion may be regarded as the extent to which staff believe they are a valued member of the work group, in which they receive fair and equitable treatment, and believe they are encouraged to contribute to the effectiveness of that group. Inclusive workplaces and teams value the difference and uniqueness that staff bring and seek to create a sense of belonging, with equitable access to resources, opportunities and outcomes for all, regardless of demographic differences. Inclusive organisations are more likely to be 'psychologically safe' workplaces where staff feel confident in expressing their true selves, raising concerns and admitting mistakes without fear of being unfairly judged." Kline, 2019*

A systemic approach to developing inclusive leadership in the NHS was taken by Building Leadership for Inclusion, which emphasised the social justice argument for enhancing diversity and inclusion. This initiative drew on **social movement** principles to raise ambition on ED&I and tackling discrimination and inequality (see the section on ***Equality, Diversity and Inclusion*** for further details).

Collective leadership

Research by Professor Mike West and colleagues for the King's Fund (in collaboration with the Center for Creative Leadership) emphasises the need for a collective leadership approach in health and social care. Key messages from this work are summarised below.

Developing collective leadership for health care

- The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the emerging culture of an organisation.
- Boards are responsible for ensuring their organisation develops a coherent, effective and forward-looking collective leadership strategy for their organisation and assuring themselves that it is implemented. This strategy comes from purposefully describing the leadership culture desired for that organisation.
- Collective leadership means everyone taking responsibility for the success of the organisation as a whole – not just for their own jobs or work area. This contrasts with traditional approaches to leadership, which have focused on developing individual capability while neglecting the need for developing collective capability or embedding the development of leaders within the context of the organisation they are working in.
- Collective leadership cultures are characterised by all staff focusing on continual learning and, through this, on the improvement of patient care. It requires high levels of dialogue, debate and discussion to achieve shared understanding about quality problems and solutions.
- Leaders need to ensure that all staff adopt leadership roles in their work and take individual and collective responsibility for delivering safe, effective, high- quality and compassionate care for patients and service users. Achieving this requires careful planning, persistent commitment and a constant focus on nurturing leadership and culture.

Source: West et al., 2014 - https://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care

In a recent review article (part of a special issue of the journal *Human Relations*) Ospina and colleagues distinguish theory and research on **collective leadership** in terms of the 'locus of leadership' (within the group or system) and the 'view of collectivity' (as a type or a lens). Whilst systems leadership is not mentioned, arguably most work would situate it within Cell 2, alongside distributed, network and complexity leadership (see Table 2 below).

Locus of leadership	**View of collectivity** Type	 Lens
Group	***1. 'Collective' refers to plural forms of leadership and leadership resides in interpersonal relationships*** E.g. dual/co-leadership, shared leadership, social network leadership, team leadership	***3. 'Collective' refers to a theoretical lens and leadership resides in interpersonal relationships*** E.g. leadership-as-practice, relational leadership
System	***2. 'Collective' refers to plural forms of leadership and leadership resides in systemic dynamics*** E.g. distributed leadership, network leadership, collective leadership, complexity leadership, systems leadership	***4. Collective' refers to a theoretical lens and leadership resides in systemic dynamics*** E.g. Collective constructionist leadership, discursive/ communicative leadership, (some) critical leadership studies

Table 2 – Mapping collective approaches to leadership

(Adapted from Ospina et al., 2020: 443)

Whilst existing work in health and social care draws extensively on insights from cells 1 and 2 of this table there is little evidence of engagement with theories/concepts from cells 3 and 4. The practice-based focus of concepts such as **leadership-as-practice** (cell 3), however, has good potential for informing the work of the OD Collaborative, as summarised below.

> *"The foundation of the leadership-as-practice approach is its underlying belief that leadership occurs as a practice rather than reside in the traits or behaviors of individuals. A practice is a coordinative effort among participants who choose through their own rules to achieve a distinctive outcome. Accordingly, leadership-as-practice is less about what one person thinks or does and more about what people may accomplish together. It is thus concerned with how leadership emerges and unfolds through day-to-day experience. The social and discursive- material contingencies impacting the leadership constellation – the people who are effecting leadership at any given time – do not reside outside of leadership but are very much embedded within it. To find leadership, then, we must look to the practice within which it is occurring."* *Raelin, 2016*

By revealing the assumptions underpinning leadership practice, particularly in terms of how power is enacted, **critical, constructionist and communicative** approaches (cell 4) have the potential to shift deeply embedded cultural norms and foster a more inclusive approach, as argued below (see Bolden et al., 2019 for further details of how these concepts could be applied within healthcare).

> *'Rather than leadership being a straitjacket, it should seek to improve interactions between managers, clinicians, knowledge workers and all employees... [Leadership] learning should encourage participants to challenge the taken for granted, normative and hegemonic assumptions of leadership and introduce other ways of seeing, interpreting and understanding themselves, their colleagues and their work contexts. Embracing more critical approaches to leadership learning should encourage scholars, students and practitioners alike to be more eclectic, creative and heterogeneous in their approaches to thinking about, researching and practising leadership.' (Ford, 2015: 263)*

Place-based leadership

A final concept to be reviewed is **place-based leadership**. Integrated Care Systems require close collaboration between partners in a specific locality to identify the needs of their local population and allocate resources accordingly. A recent report published by the NHS Confederation, 2020 in collaboration with SCIE, based on interviews with leaders from across the sector highlights the need for a 'place-led' approach, as summarised below.

From place-based to place-led: a whole-area approach to integrating care systems

- A key enabler for place-based working is having a clear framework and set of guiding principles for the scope of work and decision making at each level of the wider system.
- Place-based partnerships often start with a 'coalition of the willing', with local government playing an important leadership role.
- To help local partnerships withstand the pressures and pace of change, many local places are investing in development programmes to strengthen relationships and expand leadership capacity.
- Effective place-based leaders are moving their thinking beyond the integration of health and social care to develop a shared understanding of their combined resources and assets, and then are using this as the basis for joint action.
- As they implement their long-term plans, local leaders are managing simultaneously to balance the needs of the whole population with the aim of delivering better care to individuals.
- Good governance is undoubtedly fundamental to place-based working. Places that are more rapidly progressing their plans are avoiding becoming distracted by rigid, bureaucratic and topdown governance structures.
- Although early days, local partners are learning to accept responsibility for the overall financial position of the place. Different approaches to contracting are being used to move away from the perverse incentives of a tariff-based payment system.
- Local places are involving local citizens and communities in different ways in the governance and decision making, but all consider this involvement integral to the delivery of local plans.
- Having a core group of highly skilled and experienced staff to support the local partnership enables place-based working and the delivery of the local ambition.

Source: NHS Confederation, 2020 - https://www.nhsconfed.org/resources/2020/03/from-place-based-the-place-led

An important focus here is on the development and provision of patient-centred leadership through closer collaboration and partnership working across boundaries. Attention is also brought to the need for appropriate **governance**, although this remains highly variable – especially in situations where the partnership is not a legal entity in its own right.

For local authority partners there may be a focus on **citizens, communities** and **residents** rather than 'patients' and the ability to align and coordinate services across a wide range of partners beyond health (including police, housing, education, vol sector, etc.). The focus here would be on the broader social determinants of health rather than just clinical interventions for patients.

A recent book by Prof Robin Hambleton, 2020 looks at the role of local leadership post covid, using his '**new civic leadership**' framework to highlight five key domains of leadership at a place-based level: political leadership, community leadership, business leadership, trade union leadership and public

managerial/professional leadership. At an ICS level many of the partners will be from the first and fifth domains and actions may be required to deepen engagement and interaction with the other domains in order to create innovation and change. Three key themes from Hambleton's work in relation to post-Covid recovery include: progressive values, public innovation, and collaboration and partnership.

2.2 FRAMEWORKS, METHODS AND APPROACHES COMMONLY CONSIDERED AS GOOD PRACTICE

Key policies and reviews

There have been a number of major policies and reviews in recent years that have highlighted significant weaknesses in NHS leadership practice, and which have laid the basis for the policies driving a transition towards integrated care. Together these documents and policies set out the policy and practice landscape for leadership and management in health and care over the coming years. A brief summary is given below.

- The Health and Social Care Act 2012 brought in 'the most wide-ranging reforms of the NHS since it was founded in 1948' (Kings Fund - The NHS after the Health and Social Care Act). The changes were introduced in response to 'Rising demand and treatment costs', 'Need for improvement' and 'State of public finances' and paved the way for 'Clinically led commissioning', 'Provider regulation to support innovative services', 'Greater voice for patients', 'New focus for public health', 'Greater accountability locally and nationally' and 'Streamlined arms-length bodies' (DHSC, 2012 - Overview of the Health and Social Care Act)
- The NHS Five Year Forward View (2014) set out a five-year strategy to deliver the transformation and changes required to address three areas where there is a "significant and widening gap between current NHS resources and the demands on the service. These are health and wellbeing; care and quality; and funding and efficiency." (NHS Confederation – The five year vision explained). Within the plan a commitment was made to "back diverse solutions and local leadership" and "create aligned national NHS leadership" (FYFV, 2014)
- In 2015 the Rose Review of NHS leadership identified three main areas of concern:
    - **Vision**: There is a lack of One NHS Vision and of a common ethos.
    - **People**: The NHS has committed to a vast range of changes however there is insufficient management and leadership capability to deal effectively with the scale of challenges associated with these.
    - **Performance**: There is a need for proper overall direction of careers in management across the medical, administrative and nursing cadres.
- Also in 2015 the Review of centrally funded improvement and leadership development functions, led by Ed Smith, concluded that
    - The current architecture for improvement is remote, fragmented and unclear […]
    - The system's current leadership and management capability and capacity is insufficient to meet the current and future needs of the system. In particular it is insufficiently system (as opposed to organisationally) orientated; and
    - There is wide variation in the extent to which leadership development is connected to and aligned with local priorities and deliverables and the focus of local organisations and systems;
    - There is broad support for many of the current national leadership development programmes, although it is too early to determine to their systemic impact.
- The NHS Long Term Plan, published in January 2019, outlined a future strategy for the NHS, including a commitment to
    - **Doing things differently**… including developing 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.
    - **Preventing illness and tackling health inequalities**… including greater focus on wellbeing and prevention.

- **Backing our workforce**… including increased training and recruitment and '[making] the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.
- **Making better use of data and digital technology**… including improvements to the planning and delivery of services based on analysis of patient and population data.
- **Getting the most out of taxpayers' investment in the NHS**… working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly- used products for cheaper, and reduce spend on administration.

- The NHS People plan, published in July 2020, set out a strategy for building and sustaining a workforce to deliver the Long Term Plan and the move towards integrated care. It includes specific comments about:
  - **Looking after our people** - with quality health and wellbeing support for everyone
  - **Belonging in the NHS** - with a focus on tackling the discrimination that some staff face
  - **New ways of working and delivering care** - making effective use of the full range of our people's skills and **experience**
  - **Growing for the future** - how we recruit and keep our people, and welcome back colleagues who want to return
- In February 2021, the government published its White paper on Health and Social Care, which set out further plans on the integration of services and the development of ICS as statutory bodies to address issues around governance and accountability.

Leadership models and frameworks in NHS and social care

Alongside the growing set of policies on leadership and management in health and social care are a variety of frameworks that underpin recruitment, appraisal and development of staff across the sector.

The Healthcare leadership model, for example, was developed for the NHS Leadership Academy in 2013 and sets out a nine key areas competence for NHS leaders:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results

Skills for Care published their own Leadership Qualities Framework for Adult Social Care in 2014, which includes 7 key areas, of which the first five apply to all staff and the last two (in italics) are most relevant for senior staff:

- Demonstrating personal qualities
- Working with others
- Managing services
- Improving services
- Setting direction
- *Creating the vision*
- *Delivering the strategy*

It is unclear the extent to which either of these frameworks are still being used in practice and, in 2018 the Civil Service transitioned from their own competency framework to a success profile approach, focussed on ability, technical, behaviours, strengths and experience.

In 2016 key organisations[4] with NHS responsibilities co-developed *Developing People, Improving Care* (National Improvement and Leadership Development Board, 2016), an ambitious framework to tackle the challenges of health and wellbeing, care and quality, and funding and efficiency identified in the NHS England *Five Year Forward View* (NHS England, 2014b). This document highlights the relationship between staff development and service delivery and identifies five conditions for quality health and care systems and three pledges, endorsed by partners, which underpin the development and implementation of these principles across the NHS in England (see Table 3).

Five conditions	**Three pledges**
1. Leaders equipped to develop high quality local health and care systems in partnership. 2. Compassionate, inclusive and effective leaders at all levels. 3. Knowledge of improvement methods and how to use them at all levels. 4. Support systems for learning at local, regional and national levels. 5. Enabling, supportive and aligned regulation and oversight.	1. We will model in all our dealings with the service and in our own organisations the inclusive, compassionate leadership and attention to people development that establish continuous improvement cultures. 2. We will support local decision-makers through collectively reshaping the regulatory and oversight environment. In particular we owe local organisations and systems time and space to establish continuous improvement cultures. 3. We will use the framework as a guide when we do anything at national level concerning leadership, improvement and talent management so we engage across the service with one voice.

Table 3 – Developing People, Improving Care: Five conditions and three pledges
(Source: National Improvement and Leadership Development Board, 2016: 10-12)

A guide to *Leading Large Scale Change* compiled by the NHS Sustainable Improvement Team and the Horizon's Team, 2017 highlights 10 key principles to inform practice (see below).

Principles of large-scale change

1. Movement towards a new vision that is better & fundamentally different from the status quo.
2. Identification and communication of key themes that people can relate to and that will make a big difference.
3. Multiples of things ('lots of lots').
4. Framing the issues in ways that engage and mobilise the imagination, energy and will of a large number of diverse stakeholders in order to create a shift in the balance of power and distribute leadership.
5. Mutually reinforcing change across multiple processes/subsystems.
6. Continually refreshing the story and attracting new, active supporters.
7. Emergent planning and design, based on monitoring progress and adapting as you go.
8. Many people contribute to the leadership of change, beyond organisational boundaries.
9. Transforming mind-sets, leading to inherently sustainable change.
10. Maintaining and refreshing the leaders' energy over the long haul.

Source: NHS Sustainable Improvement Team and the Horizon's Team, 2017

[4] Including Department of Health, NHS England, NHS Improvement, Health Education England, NHS Leadership Academy, Public Health England, National Institute for Health and Care Excellence, Care Quality Commission, Skills for Care, Local Government Association, NHS Providers, NHS Clinical Commissioners and NHS Confederation.

2.3 EVIDENCE OF IMPACT FROM USE IN PRACTICE

Throughout the documents outlined in this section there has been a strong focus on policy although evidence of impact on practice is less evident.

A key intervention in relation to place-based integration of health and social care, for example, is the Health and Wellbeing Boards, established following the 2012 Health and Social Care Act. According to the Kings Fund, 2016:

> *"Health and wellbeing boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. They have a statutory duty, with clinical commissioning groups (CCGs), to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population."*

In a review of the impact of Health and Wellbeing Boards (HWBs), Hunter et al., 2018 concluded.

The policy intention is that HWBs will fulfil a system leadership function to drive change for improved health and wellbeing of the population. System leadership is collective and shared, involving leaders from across a system working collaboratively around a shared purpose (Timmins, 2015, West et al., 2014). HWBs create the necessary structural conditions through which this can happen, creating the space for leaders from across the newly-reconfigured public health system to come together in a way that transcends organisations. However, effective system leadership relies on agency as well as structures; relationships of trust between members based on a coalition of shared versus siloed interests, a capacity to create the conditions for others to work collectively across a system and distribution of leadership for others to have autonomy to drive and enact change are key (Senge et al., 2015), in addition to individuals having the appropriate skill-sets to deliver this (Hulks et al. 2017). For HWBs, not least in the absence of any statutory powers, this 'soft' role of influencing, engaging and relationship building across the system is integral (Miller et al., 2010), if they are to 'turn their health and wellbeing strategies into reality' (Communities and Local Government Committee, 2013).

However, HWBs are likely to face a number of challenges in enacting such a role. Systems leadership requires having the capacity to overcome well-recognised challenges of the wider institutional environment to move away from competition to collaboration, focus on integration versus fragmentation and collectivism versus siloed hierarchical working (Hulks et al. 2017). Furthermore, as will be discussed later in the report, systems leadership was viewed by respondents in the study as a multi-faceted concept with different emphases on various aspects, including the elements of system leadership that were most important to ensure its success. A study of system leadership undertaken by the King's Fund (Timmins, 2015: 8, 9) also identified a number of common themes on system leadership echoed in our work including:

- It requires a conflicting combination of constancy of purpose and flexibility.
- It takes time - often a lot of time - to achieve results.
- It starts with a coalition of the willing.
- It is important to have stability of at least a core of the leadership team across those involved.
- System leadership is an act of persuasion that needs to have an evidence base for change - not least because that is the key tool for persuading the unconvinced.
- In most people's eyes, financial stringency is yet to lead to a fundamental acceptance that system working is key to the future of health and social care.

The pressures of regulation, financial balance and organisational targets are still leading people and organisations to draw in their horns and 'hunker down' to survive, rather than seeing the way forward in terms of changes that will alter and, in some cases, downsize what their organisation

does. Regulation, in particular, needs to be reformed. All too often, the current system gets in the way of system change, and thus system leadership.

For HWBs, there are likely challenges associated with working collectively across the boundaries of local authority, NHS, third sector and public stakeholders against a backdrop of wider institutional uncertainty, power hierarchies, diverse and fragmented directives and accountabilities and resource constraints in a climate of austerity, all of which carry the potential to undermine collaboration around a systems perspective and shared interest in population health and wellbeing. There are, therefore, questions to be addressed through the evaluation, regarding the extent to which HWBs are able to effectively fulfil their system leadership function, how and under what conditions.

Source: Hunter et al., 2018, p20 -https://eprints.whiterose.ac.uk/151457/1/Evaluating%20HWBs%20FINAL%20REPORT%20-%20April%202018%20Final.pdf

This work highlights the collaborative, boundary-spanning nature of systems leadership, as well as the tensions and challenges this poses within a sector that continues to be shaped by competition, regulation and fragmented accountabilities. Similar opportunities and challenges illustrated in this report will be faced by Integrated Care Systems (ICS) and have implications for the provision of leadership and organisation development (OD) interventions and support.

Kline, 2019 makes a similar point, arguing:

> *"However, command and control are deeply embedded in senior NHS leadership behaviours. Status and funding are used to either support or, in effect, beat up local leaders, confusing bullying with accountability. The behaviours of national bodies largely shape what local leaderships do or don't do. Where NHS trusts are highlighted as being particularly innovative, effective and safe employers, it is unclear how many of them became so because of top-down support."*

Similar conclusions were reached in the research by Deeds and Words, 2020, who worked with a group of 80 staff from across the NHS, who in turn worked with a further 240 individuals to explore inclusive leadership in the NHS. Their report concluded:

> *"What counts as success in relation to existing leadership interventions does not currently encourage a focus on inclusive, transformative and collective leadership. Measures of success tend to focus on individual career success only, rather than measuring impact on health and well- being outcomes for staff, volunteers and patients, and how individual successes further these outcomes. Those who succeed in the NHS are particularly adept at navigating the systems that value individual success. They go on to lead and maintain the status quo. There are no leadership standards relating to inclusion or creating inclusive cultures. One leader said that 'current leaders do not take responsibility for a lack of inclusivity'." Deeds and Words, 2020*

The ability to assess the impact of leadership and organisation development interventions in health and care is challenging due to the complexity of the system, frequent changes in policy, organisational restructuring and the absence of rigorous and reliable outcome indicators. To increase consistency across programmes and interventions, in 2017 the NHS Leadership Academy developed a Leadership Development Evaluation Framework, to guide the design and implementation of evaluation activities, and the identification of *before*, *during* and *after* (BDA) indicators, as outlined below.

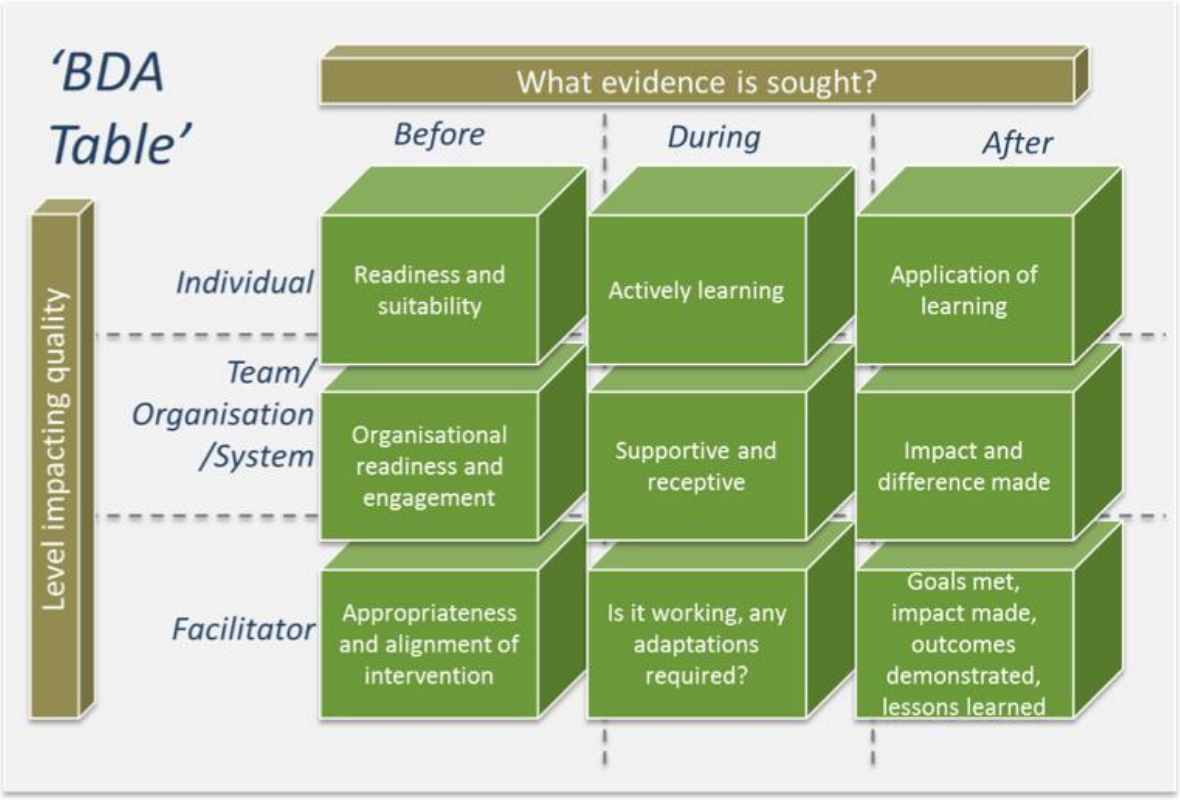

Figure 2 – The 'BDA' Table
(Source: NHS Leadership Academy, 2017: 15)

2.4 EXAMPLES OF GOOD PRACTICE

Systems insights from the health and care system

Systems leadership in A&E

"For the past two years the Leadership Centre, in collaboration with NHS England, has been providing Systems Leadership support to places across the country as part of the National A&E Improvement Programme. The support has involved working with NHS representatives and other stakeholders from local government and the voluntary care sector on local A&E Delivery Boards across England, developing more collaborative leadership to support improvements in Emergency Care performance.

Our focus has been on mobilising whole health systems to re-imagine the way they collectively work in service of their populations. …has enabled local leaders to obtain a clearer, common understanding of what the complexities might be across A&E departments in England; to reveal more of the inter-connected system to itself, thereby deepening local understanding and relationships; and to create enough clarity to proceed to action whilst working on ever evolving issues…our approach is to collaboratively develop new ways of thinking, behaving, learning and working together, in the context of their locality, so local leaders build shared trust, meaning and action to nurture the transformational change they desire.

Throughout the two years there has been clear evidence of progress, including the development of common purpose across sector and professional boundaries, different behaviours, improved relationships and new working methods."

Source: Vize (2018) https://www.leadershipcentre.org.uk/wp-content/uploads/2018/10/Leadership-AE-4pp-publication-v1.pdf

The **Frimley 2020 and LiGM programmes** had positive impacts on participants, enhancing participants' skills, confidence and capabilities and encouraging a more outward-looking, place-based approach to leadership. It was less clear what the longer-term impacts of the programmes were on organisations and systems.

The two programmes, with their focus on collaborative systems leadership and place-based action, strongly align to the plans in the NHS Long Term Plan to develop integrated care systems. Both programmes offer examples, tools and approaches that could be rolled out successfully to other ICSs and areas seeking to develop place-based, collaborative forms of leadership.

Involving professionals from different organisations was seen as a strength of both programmes, although participants felt that more could have been done to ensure the right mix of people took part.

It is important that future programmes continue to, or develop further the opportunity to, offer places to a wide range of stakeholders, and importantly, make funding available for people who are not employed by the NHS, but who are working to improve health across the wider community.

Whilst both programmes had a strong focus on local communities, participants felt that greater levels of co-production and citizen involvement were needed in future programmes.

Participants welcomed the opportunity the programmes gave to provide people with a network of peers to connect with. Future place-based leadership programmes should set out plans for how they will encourage the development of peer networks, and how they will be sustained beyond the life of the programmes.

Source: https://www.scie.org.uk/integrated-care/leadership/learned/place-based-leadership

Systems insights from other sectors

Systems leadership in agriculture

"…the World Economic Forum established a Transformation Leaders Network to exchange experiences, lessons and best practices among 150 local leaders and global partners in its New Vision for Agriculture initiative. The program ran for five years, resulting in dozens of new collaborations, replication of innovative approaches, and the development of new tools to share best practices. It also provided a peer-to-peer support network for Systems Leaders in the agriculture sector. Systems Leaders in all sectors often encounter similar dynamics or realizations in the course of their journeys. These often crystallize in an "Aha! Moment" – a new insight that describes what a group of stakeholders is experiencing at any given stage of the journey. While not every initiative or individual experiences every one of these moments, they appear frequently across many Systems Leadership stories. As a result, they may serve as useful reference points for stakeholders trying to navigate an ambiguous systems change initiative. These recurring insights and "Aha! Moments" are [summarised] below."

1. **No one is in control** – no single entity has authority over the entire system
2. **It's up to us** – stakeholders recognize a collective responsibility to address the challenge
3. **Everything is connected** – collective mapping and learning about the system generates new insights
4. **That's our North Star** – the group agrees on a shared goal or vision to guide and align their efforts
5. **To go far, go together** – engaging and securing buy-in from a wide array of stakeholders is essential
6. **We'll find a way** – challenges and setbacks can spur innovation and collaboration

7. **I can make a difference** – one person, organisation or small group can have a significant impact
8. **We need coordination** – as the initiative grows, a coordinating team or Secretariat is often needed
9. **Wow! Change is happening** – demonstrating and celebrating progress helps maintain momentum
10. **We're in it together, for the long haul** – reaffirming commitment and evolving to meet changing needs enables long-term success

Source: Dreier, Nabarro and Nelson, 2019
https://www.hks.harvard.edu/sites/default/files/centers/mrcbg/files/Systems%20Leadership.pdf

Different cases, common attributes

"In 2015, the landmark Paris Agreement committed 195 countries to a framework for action on climate change – including specific targets for reducing greenhouse gas emissions, support for climate mitigation and adaptation, and a monitoring and reporting framework. Advocacy and negotiations leading up to the agreement engaged thousands of organizations including governments, industry, civil society, international organizations, academia and research, faith organizations and indigenous communities. A number of individual leaders within these stakeholder networks played crucial roles in building alignment, mobilizing action and securing commitment. The most visible was Christiana Figueres, who led this historic process as Executive Secretary of the UN Framework on Climate Change (UNFCC), establishing what many characterized as a new model of collaborative diplomacy – engaging a broad diversity of stakeholders in jointly developing solutions and commitments

Across the world in the city of Richmond, California, a grassroots organization called Rich City Rides set out to address the inter-locking challenges of poverty, chronic disease and environmental degradation which disproportionately affect the city's communities of color. They conceived a vision for developing Richmond as a bicycle-friendly community, using cycling to improve health, provide sustainable transportation, generate job opportunities, and strengthen the community's social fabric. They established a bike shop, working with local youth to reclaim and repair over 1,000 bicycles, building job skills and economic assets as well as sustainable, low-cost transport. They organized bicycle outings, camping trips and park cleanups to engage families in healthy exercise and nature appreciation. In the process the founder of Rich City Rides, Najari Smith, engaged local community organizations, city and regional government, philanthropists and industry to help support and implement these innovative programs."

(The report contrasts the contexts, but goes on to outline common approaches from both leaders.) "Both set out to address a complex problem which involved multiple dimensions and required multi-faceted solutions. Both worked with diverse stakeholders to develop an ambitious and holistic vision for change and leveraged the power of networks to mobilize action and commitment toward that goal. Both took a collaborative approach, engaging and empowering relevant stakeholders rather than trying to control or direct them."

Source: Dreier, Nabarro and Nelson, 2019
https://www.hks.harvard.edu/sites/default/files/centers/mrcbg/files/Systems%20Leadership.pdf

The report from the Harvard Kennedy School that gives these examples concludes:

> *Systems leadership "involves building and mobilizing alliances of diverse stakeholders around a shared vision for systemic change, empowering widespread collaboration, innovation and action; and enabling mutual accountability for progress to shift systems towards sustainability." Dreier, Nabarro and Nelson, 2019*

2.5 Implications for Organisation Development

A number of key themes/issues arise from this review that have important implications for the Nottingham and Nottinghamshire ICS and the OD Collaborative.

1. Ensure that there is a robust conceptual and empirical basis for how leadership is recognised, rewarded and developed

Despite surface-level similarities there are important differences between the principles and assumptions informing different models of leadership and leadership development in health and care. Systems leadership is a particular case in point, which is often operationalised in rather mechanistic and individualistic ways. The extensive literature on complexity and process thinking shifts attention towards the relational and interdependent nature of leadership practice. Such principles have the ability to shift/reframe dominant perspectives and paradigms to facilitate more inclusive, compassionate and collective leadership cultures. The persistence of command and control, however, poses a real challenge and threat to progress. There are also likely to be different frameworks and processes in place within different partner organisations and support may be required to help increase alignment with the aims/strategy/approach of the ICS.

> *'From the perspective of complex responsive processes of relating, leading leadership development involves encouraging radical doubt, enquiry and reflexivity as a way of developing the capacity of leaders to manage in circumstances of high uncertainty and ideological and political contestation. However, radical doubt does not mean throwing everything up in the air at once. It means learning how to navigate between the poles of absolute certainty and absolute doubt, while persisting in seeing the world as more complex than it is portrayed in the dominant discourse.' (Flinn and Mowles, 2014: 19)*

2. Facilitate opportunities for creating shared understanding, language and values

Linked to the previous point, there are significant differences between levels of understanding and the ways in which concepts and ideas are communicated, which requires the creation of opportunities for collective learning and engagement. The coordination of cross-sector partnerships, where people from different sectors come together around a shared agenda, is an important place where this can happen (such as during the Covid pandemic) but requires skilled facilitation in order to create a common sense of direction, alignment and commitment[5] across partners. The theory and practice reviewed in this document highlights the significance of building trusting relationships across areas of difference and the OD Collaborative could play a role in supporting this through hosting cross-sector training/events as well as coordinating opportunities for secondments/placements. Whilst this takes time, it can be accelerated through 'crucible'[6] experiences, such as the visits to deprived neighbourhoods within one of the *Systems Leadership: Local Vision* projects (described in section 3.2) and/or the many opportunities for collaborative working that have arisen during the Covid pandemic.

> *"The response to Covid-19 underlined the power of system-working in many areas. Whether this was mutual aid between NHS providers, work with voluntary, community and social enterprise organisations or closer engagement with local government. This system-working has been the goal of successive policy makers but often proved difficult to progress at pace. Covid-19 changed that (although not everywhere). At its best this should mean that system*

[5] The principles of direction, alignment and commitment underpin the boundary spanning leadership approach advocated by the Center for Creative Leadership - https://www.ccl.org/articles/leading-effectively-article/make-leadership-happen-with-dac-framework/

[6] Warren Bennis introduced the notion of 'crucibles of leadership' to describe processes of transformative learning that can arise when leaders undergo a particularly challenging experience - https://hbr.org/2002/09/crucibles-of-leadership

partners can come together to understand the challenges and opportunities facing their populations, drawing on expertise from across health and care." Murray, 2021

3. Create protected spaces in which people can share/learn from stories of lived experience

Despite an espoused commitment to collaboration, there remains a significant culture of competition and command and control across many parts of the health and social care system. This is partly a result of the issues outlined above, where people are acculturated into different ways of thinking and working, but is also an inherent feature of complex systems. Whilst point 2 calls for greater consistency and commonality around how concepts and ideas are used, this point acknowledges that where people with different personal and professional experiences come together there will always be differences of perspective and opinion. The point here is about developing a genuine appreciation and respect for the views of others and developing inclusive cultures that enable diversity to thrive. The *Building Leadership for Inclusion* initiative, for example, created spaces where people from similar identity groups (BAME, female, LGBT+, disabled, etc.) could come together to share their experiences as well as mixed-identity spaces where people were actively encouraged to engage with different perspectives from their own. Addressing discrimination and inequality requires deep work on emotions, identity and intersectionality – from those in majority rather than just minority groups - in order to bring about lasting personal transformation.

'Creating change is about changing the conversations that shape everyday thinking and actions. It is about bringing new, different and diverse voices into the change conversation and creating new perspectives, stories, texts, narratives and other socially constructed realities that impact on how people think and make sense of things.' (Fairman and Bevan, 2016:10)

4. Prioritise learning and development, and allocate sufficient time and resource for the difficult work of individual and cultural change

Following on from the last point, the evidence suggests that there is no 'quick fix' to embedding a culture of collective, compassionate, inclusive, place-based systems leadership. Leading large-scale change is demanding and time consuming that cannot be done in isolation from other areas of organisation development, including culture, EDI, innovation and improvement, and talent management. Whilst leadership training and development are often treated as discrete, standalone activities for particular cohorts of individuals, the shift towards an ICS requires a systemic approach. The Sustainable Improvement Team and the Horizon's Team, 2017 report on *Leading Large Scale Change* cites the work of Hamel and Zanini, 2014, calling for a shift from 'change programmes' to 'change platforms', that embrace the benefits of diversity and divergent thinking. The focus here is creating a culture of learning and reflection, that involves everyone, rather than simply prioritising the development of middle/senior leaders. This is not to say that individual development is not important but it should be linked to a larger strategic purpose and embedded within day-to-day working practices.

'To be fully effective, a development system must be integrated with the organization's other processes: management planning, performance management, job selection, reward and recognition systems, and even mistake systems. The confluence of these processes determines the relative effectiveness of any one development activity.' (McCauley et al., 1998:228-9)

5. Recognise the contested and politicised nature of leadership in cross-sector partnerships, and design interventions accordingly

Bryson et al. (2017) suggest that the "new world [of public service leadership is a] polycentric, multi-nodal, multi-sector, multi-level, multi-actor, multi-logic, multi-media, multi-practice place characterized by complexity, dynamism, uncertainty and ambiguity in which a wide range of actors

are engaged in public value creation and do so in shifting configurations." Within such contexts, power and politics have a strong impact on what is/can be achieved - as the Kings Fund report on Leading for Integrated Care stated: "If you think competition is hard, you should try collaboration" (Timmins, 2019). Based on extensive research on public sector leadership, Prof Jean Hartley highlights the importance of political astuteness in navigating the diverse and ambiguous contexts experienced. From the perspective of the OD Collaborative, buy-in and engagement from key stakeholders will be essential - not just from a senior level but also within key target communities (e.g. BAME, etc.). There is no shortage of excellent initiatives that fail to progress due to resistance and/or inertia within the system. Attention will need to be given to key leverage points and mobilising energy and social change within the system. The use of role modelling, placements and shared system change projects will be key ways through which people can develop their political astuteness and ability to navigate complex power dynamics.

> *'Politics' has sometimes been a dirty word – within organisations and the process of democratic governance. But our research reflected a more positive view. Managers realise that, through politics, they can learn what is required of them – politics is a means of getting things done. Hartley et al., 2013*

6. Acknowledge the pressure and trauma within the system and prioritise interventions that enhance staff wellbeing and community resilience

The effects of many years of structural, financial and policy reforms, combined with the impact of the Covid pandemic, has put staff within health and social care under immense pressure. The work required to deliver changes that will be necessary for Integrated Care Systems to thrive is highly demanding – both physically and emotionally. There is significant concern about the mental health and wellbeing of the NHS workforce and the wider health and care system. Any OD interventions must be aware of this and delivered in a way that feels restorative and/or cathartic rather than as just another demand on finite time and energy. An appreciation of system psychodynamics and responses to trauma would help ensure that staff are not burdened with additional/unwanted expectations and/or responsibilities. Building a sense of citizenship and belonging within networks and communities of practice could be an important part of the work of the OD Collaborative. This is not about avoiding the difficult work of system change – but ensuring that individuals and teams are sufficiently resilient and supported to make the transition.

> *'Honoring the reality that adaptive processes will be accompanied by distress means having compassion for the pain that comes with deep change. Distress may come with the territory of change, but from a strategic perspective, disturbing people is not the point or the purpose, but a consequence. The purpose is to make progress on a tough collective challenge.' (Heifetz et al., 2009: 29)*

7. Put in place meaningful targets and metrics around leadership and organisation development

This report has emphasised the elusive nature of leadership in complex environments and the need to facilitate and enable processes of emergence. Whilst the NHS (and other public services) rightly focuses on 'evidence-based practice' this is more challenging to assess and evaluate for the kinds of change sought through greater integration. Yes, of course there should be demonstrable impacts on patient/citizen outcomes and more efficient use of resources but these alone are not sufficient to determine the extent to which the necessary individual, collective and systemic capacity has been built to enable adaptation and change to meet the needs of a changing demographic, social, political, economic and environmental context. Finding meaningful targets and metrics for leadership and organisation development will be key in developing and refining impactful interventions. The OD Collaborative would be advised to facilitate discussion and enquiry around the impacts and metrics for leadership and organisation development

'Because outcomes are unpredictable in a complex context, leaders need to focus on creating an environment from which good things can emerge, rather than trying to bring about predetermined results and possibly missing opportunities that arise unexpectedly.' (Snowden and Boone, 2007:75)

'…many career development interventions are geared to traditional, and arguably male, conceptions of career as a linear and agentic climb up a hierarchy. This may work against people who have different definitions of career success, especially subjective experiential ones, which for many people take precedence.' (Barnard et al., 2016:71)

Principles for inclusive leadership development

A research project on inclusive leadership commissioned by the NHS Leadership and Lifelong Learning Academy identified that successful interventions enable leaders to:

1. make a direct, specific and personal connection between a diverse and inclusive internal workplace culture and NHS effectiveness
2. have more inclusive conversations across differences to critically challenge mindsets
3. better understand their own power, influence and agency
4. explore how hierarchy, status and role affects workplace systems and organisational effectiveness
5. reflect on how biases and discrimination have an ongoing negative impact on individuals (including through talent management), teams, organisations and society
6. make specific commitments to making changes within their own workplace systems, alongside working with others to evaluate and share the learning on the impact of these changes
7. build enduring and collaborative peer support networks
8. build inclusive leadership capabilities, knowledge and relationships across differences that transform

Source: Deeds and Words, 2020 – Inclusive leadership and culture in the NHS

3. ORGANISATIONAL CULTURE

3.1 KEY INSIGHTS FROM THEORY, RESEARCH, POLICY AND PRACTICE

Since the seminal work of Peters and Waterman (1982) the need to build effective workplace cultures is recognised as essential if the main purpose of the organisation is to be actualised and sustained. Ann Cunliffe (2008) states that organisational culture is important because it:

- shapes the image that the public has of an organisation
- influences organisational effectiveness
- provides direction for the company
- helps to attract, retain and motivate staff.

Culture is widely defined as a set of shared, take-for-granted, implicit assumptions that organisational members hold (Schein, 1992). It exerts profound influence on how organisational members perceive, think about and react to things and on their behaviour and everyone who interacts with the organisation. As such, every interaction and transaction in an organisation both reveals and shapes its culture – for instance, how a social care worker talks to the people they are working with, and how they talk to each other. In these interactions, organisational members unconsciously reflect what an organisation values: quality, safety, productivity, power, justice, compassion and so on. These values are also "transmitted by socialisation processes that newcomers have, the decisions made by management, and the stories and myths people tell and retell about their organizations" (Schneider and Barbera, 2014, p. 10).

The emphasis on interaction also suggests that cultures are co-created by all members of an organisation and, in that sense, they are emergent and dynamic. As members communicate and collaborate up, down and across the organisation they will be influencing the culture. If these interactions signal strong values of compassion, new staff will learn the importance of an ethics of care. If they observe established staff members or senior staff behaving aggressively to hit performance targets, they will emulate that behaviour in their workplace interactions and actions. It is, therefore, important to understand and specify the core cultural characteristics needed to actualise and sustain the purpose of the organisation. Writers agree that organisational culture possesses four key attributes (Groysberg et al, 2018):

- **Shared**: resides in the shared behaviours, values and assumptions of groups and is experienced through their norms and expectations.
- **Pervasive**: permeates the organisation and is manifested in surface manifestations such as artefacts, physical layout, group rituals, mottoes and slogans, symbols, and stories and jokes.
- **Enduring**: directs the thoughts and actions of employees over time. Culture becomes self-reinforcing as individuals are attracted to characteristics similar to their own, and companies select applicants who will 'fit in'.
- **Implicit**: despite its subliminal nature, individuals are hardwired to recognise and respond to culture instinctively.

Drawing from two major programs of study in the English NHS (Dixon-Woods et al., 2013; Dawson et al., 2011), West and colleagues (2014) propose that six key elements are necessary for sustaining high performance cultures in health and social care:

1. **An inspirational vision:** In the best performing organisations, all leaders (from the top to the front line) made it clear that high-quality compassionate care was the core purpose and priority of the organisation (Dixon-Woods et al., 2013). And there is evidence that such alignment has an important influence on reducing the effects of "faultlines", defined as group

and status differences that interfere with effective collaboration which are a common problem in healthcare organisations (Bezrukova et al., 2012).

2. **Clear aligned objectives**: Clear objectives begin with the top management team having clear purpose and five or six clear objectives (Wageman et al., 2008). This clarity of objectives must then be cascaded down to every department, every team, and every individual to communicate the priorities of the organisation clearly and consistently. When people have clear, challenging objectives at work, they are generally motivated to work harder and to innovate (Locke and Latham, 2013) and they feel more engaged to know that their everyday work is aligned with and contributes to the purpose, vision, mission and values of the organisation (Willis et al., 2016).

3. **Supportive people management:** The UK NHS national staff survey data offers a valuable source of data that reveals significant insights into the relationships between people management and performance. Coercive managers inhibit an organisation's flexibility by diluting the ability of their staff to make good decisions and to generate new ideas. "People's sense of responsibility evaporates: unable to act on their own initiative, they lose their sense of ownership and feel little accountability for their performance" (Goleman, 2000, p. 82). In the long run this leaves people alienated from their own jobs as they cannot see how their jobs fits into the shared purpose. Such a loss can be measured in terms of diminished clarity and commitment, dampening motivation and depleting emotional resources (Goleman, 2000). In contrast, authoritative or coaching managers can successfully mobilise people toward a vision when a clear direction is needed and can develop people to improve their performance and develop their strengths for the future (Goleman, 2000).

4. **High levels of staff engagement:** When people feel involved and connected, and see their job as meaningful and energising their levels of engagement increases as well. In the literature, engagement is typically described as having three components: vigour, dedication and absorption (Schaufeli and Bakker, 2004) and we can see how a clear narrative on purpose and a supportive leadership style giving staff skills, resources, freedom and responsibility in their jobs can contribute to the emerge of these components in the experience of work.

5. **Continuous learning and improvement:** Collective learning leverages the many forms of reflection on process and progress that need to be cultivated to gauge systems aliveness and make adjustments accordingly (Kuenkel et al., 2021). A key to learning is structured reflection. Reflection can be a challenge, because most highly engaged actors will be overworked and not used to taking time for reflection. However, success hinges on regular joint reviews of roles, purpose, and procedures. When team members collectively reflect on the team's purpose, practices and performance and make changes accordingly ('team reflexivity'), teams are more productive, effective and innovative (Widmer et al 2009, Konradt et al 2015). In contrast, non-reflexive teams show little awareness of team objectives, strategies and the environment in which they operate. Instead, they tend to rely on habitual routines that ultimately lead to poor performance, lack of innovation and inability to adapt to a changing environment. Continuous learning and improvement start by seeing tasks as learning spaces, supported by learning mechanisms officially established as part of review meetings, as an essential element of governance structures, and as a way of keeping the system of actors in a continuous reflective conversation.

6. **Enthusiastic team-working, cooperation and integration:** In an era in which 'everyone will have a part to play as the creator and implementer of new ideas' (West & Rickards, 1999: 55), improvement is no longer delegated to a special group of people, such as the creative genius of top management, or the R&D departments (Schmid, 2006). The need to source novel ideas has spread to all areas of the workforce. The democratisation of innovation in organisations calls for a shift in focus to innovation in teams. There is much evidence that teamwork is an important contributor to health and social care quality. And the imperative for effective teamwork is also consistently emphasised by policymakers (Department of Health, 2010).

However, the reality of producing innovations in teams is not straightforward. Teamwork involves social and psychological processes that can influence improvement. For example, team members are unlikely to generate and communicate novel ideas if they expect these to be dismissed or criticised (Mumford & Gustafson, 1988; West & Anderson, 1996). They require a psychological atmosphere that allows novel ideas to be openly communicated, fairly evaluated, and properly implemented (Amabile & Gryskiewicz, 1987).

Shaping Organisational Culture

Mainstream literature identifies the role that an organisation's leaders have in conceiving the desired culture and shaping organisational culture in a particular way consistent with managerial intentions and visions. The literature which extols the virtues of transformational leadership demonstrates widespread support for this view (Ogbonna and Harris, 2000). Such work argues that leaders have a vision of what the organisation should be and what its members should value and prioritise. This vision affects the selection process. People whose values, thoughts and feelings are aligned with that vision are hired. The socialisation processes – onboarding, training, appraisal – further indoctrinate staff by signalling desired attitudes and values. While people who 'fit' the culture are retained and promoted, those who do not, over time, choose to leave or are removed by the organisation. This process is visualised in Figure 3, below.

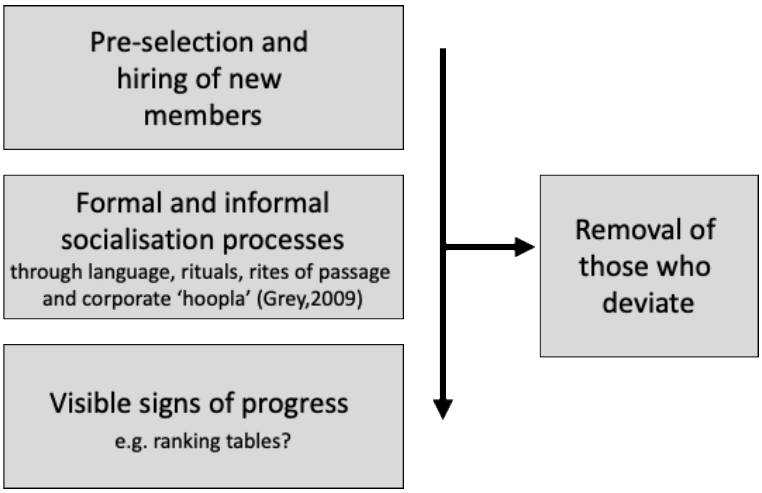

Figure 3 – Mainstream perspectives on managing culture

This model highlights the crucial role of human resource (HR) departments in:

- employee resourcing – getting the 'right' people into the organisation,
- performance management – ensuring that these people perform in a particular way,
- employee development – training staff in 'appropriate' ways,
- employee relations – encouraging 'suitable' forms of communication between management and staff

Senior staff are also seen to act as role models, encouraging employees to identify with and internalise the cultural values they reflect. As such, they are "culture carriers" who set the general climate of what behaviour is acceptable and what is not. Through what they say and how they behave they establish norms that filter through the organisation as to whether risk taking is desirable, how much initiative employees are allowed, what actions will pay off in terms of pay rises, promotions and other rewards. They involve, quite literally, 'walking the talk', acting out the organisation's cultural vision because, in the old adage, actions speak louder than words. Indeed, managers should 'be seen as spending a lot of time on matters visibly related to the values they preach' (Deal and Kennedy, 1982).

According to Jackson & Carter (2000) if an organisation 'successfully' creates their organisational culture their employees will often show signs of:

- Using corporate language e.g. ‘we’ not ‘me’
- Going the ‘extra mile’ – greater commitment and flexibility
- Singing the organisation’s praises
- Being unable to be critical of the organisation and their practices.

Whilst such a perspective on leadership and culture remains widespread within healthcare and many other sectors it has been extensively critiqued due to the embedded assumptions around power and authority and the tendency to perpetuate inequalities. Willmott (1993), for example, compares the practices of these strong cultures to totalitarian regimes where alternative perspectives are not tolerated. ‘Those who kick against the monoculture [single standardised culture] are “moved sideways” or they are expelled’ (p. 531). As Peters and Waterman (1982) put it bluntly: ‘The excellent companies are marked by very strong cultures, so strong that you either buy into their norms or get out. There’s no halfway house for most people in the excellent companies’ (p. 72).

Despite attempts by managers and organisational consultants to manage, mould and change culture to improve performance, this approach can be highly problematic (e.g. Meek, 1988; Willmott, 1993). Chris Grey, for example, criticises culture management programmes arguing that they are an aggressive approach, focused primarily on employees rather than upon the quality of their work. He stated that:

> *“Culture management aspires to intervene in and regulate [employee] being, so that there is no distance between individuals’ purposes and those of the organisation for which they work.” (Grey, 2009: 69)*

Others argue that this ambitious desire to shape individuals’ beliefs is unrealistic since organisational culture is far more complex and richer than simply a tool for management. Linda Smircich (1983), for example, suggests the underlying assumption of these functional, managerialist approaches is that culture is something the organisation ***has***, a possession that can be changed and controlled. Culture in this in view is seen as something owned and designed by the top management and available for manipulation to achieve unity and consensus.

The alternative view sees culture as something the organisation ***is*** (Smircich, 1983), integral to the fabric of the organisation. Culture, therefore, is not owned by the management. On the contrary, everyone is involved in creating it through interaction and negotiation in an emergent way. From this point of view, employees do things and work together in certain ways. Through these social (inter)actions employees produce and reproduce a culture which evolves spontaneously, and is therefore unamenable to managerial control. Actually, the emerging culture may not even conform to what the management wants, resulting in subcultures (distinguishing themselves by occupation, profession, geographical location, organisational function or age). This pluralistic view on culture, despite being in sharp contrast with the unitarist perspective conceptualising the culture as monolithic, characterised by consistency, organisation-wide consensus and clarity, captures the complexity, diversity and richness of organisational life far better.

3.2 Frameworks, methods and approaches commonly considered to be good practice, and evidence of impact from practice

The role of Communities of Practice in Sustaining Organisational Culture

Transformational change in health and care systems often involves an organic approach, with the strategic direction emerging over time rather than being specified in advance, albeit guided by a core purpose that remains constant throughout (Naylor & Wellings, 2019). This requires us to consider alternative conceptualisations of culture to account for emergence.

As mentioned in the previous section, in the traditional functional perspective, organisational culture is treated as an "tool" that can and should be manipulated by leaders. In the symbolic-interpretive perspective, organisational culture is viewed as a "social phenomenon". Consequently, the roles and challenges of leaders become significantly different from the traditional perspective, transformed from a "creator" to a "curator".

When newcomers join an organisation, they join a micro-cosmos full of knowledge, a world that makes sense to other people – their managers, colleagues, stakeholders, customers. They enter a territory already occupied by others and they learn by participating in this world and come to embody its ideas, perspectives, prejudices and practices. They learn a way of thinking, perceiving and behaving. They join a "community of practice" who have a common stock of knowledge and a shared sense of identity and common values.

The literature defines a community of practice as a self-organised group of individuals concerned with a specific practice, who are learning how to improve this practice through regular interaction. In this report, we adopt Wenger's (1998) definition of community of practice – a group that coheres through mutual engagement on an indigenous enterprise and creating a common repertoire (Wenger, 1998). In the community of practice, individuals are practising together using specific tools, representations, and other artefacts (Wenger, 1998) and as such mastery is a collectively achieved property of the community, not merely an individual achievement (Lave and Wenger, 1991). Such communities can be used as the main pillar of developing and sustaining the desired culture in the organisation as they share many commonalities with the six elements of high-performance cultures described above, given their sense of purpose, their commitment to continuous learning, improvement, cooperation and integration. Wenger (1998, pp. 72–84) identifies three dimensions of the relation by which practice is the source of coherence of a community.

1. members interact with one another, establishing norms and relationships through mutual engagement;
2. members are bound together by an understanding of a sense of joint enterprise;
3. members produce over time a shared repertoire of communal resources, including, for example, language, routines, artifacts and stories.

The existence of these elements is likely to produce and sustain trust-based relations, creating social conditions that are conducive to further learning, improvement and cooperation.

Lave and Wenger (1991) used the term 'legitimate peripheral participation' to characterise the process by which people learn and become socialised into being a member of a community through gradually increasing levels of participation in community activities, during which time they simultaneously move from being peripheral members of the community to become more central and legitimate members of it. Informal learning from other group members is a key element of this process, or as Trowler and Turner (2002: 242) suggest, 'learning to become an organisational member is far more a question of socialisation than of formal learning'. The informality of these communities stems from the fact that they emerge from the social interactions between organisational members as they undertake their work activities.

Historically, communities of practice have been treated with hostility by senior management, who may be concerned about how these groups may undermine formal structures and systems (Brown and Duguid 1991). However, due to the increasing acknowledgement of the role they can play in facilitating learning and improvement, organisations have been attempting more and more often to deliberately support and develop communities of practice (see examples later, such as Borzillo et al. 2011). The sustained mutual relationship between members of the CoP characterised by shared language, local lore and shortcuts to communication offer possibilities for the propagation of innovation. The perspective of social construction of innovation shows how innovation results from a process of meaning making (Woolgar, 1981). The implication is that innovations depend on and are shaped by interaction with others. Sometimes innovations fail to take root when they fail to connect to critical actors (Hoholm and Araujo, 2011). From an actor-network theory perspective emergence

and institutionalisation of innovation happens after a process of successful *interessment* and enrolment (Callon, 1986). This process requires the focal actor to mobilise instruments and conceptualisations of the world and to build alliances. During this process the focal actor tries to translate the interests of other actors in an effort to enrol them and to achieve some level of acceptance of innovation by other actors in the network (Latour, 1999). The process relies on the focal actor expressing "in one's own language what others say and want, why they act in the way they do and how they associate with each other… At the end of the process, if it is successful, only voices speaking in unison will be heard" (Callon, 1986: 223).

In this model of i*nteressment* "the fate of the innovation depends on the active participation of all those who have decided to develop it" (Akrich et al., 2002: 208) making the process of translation of greater importance than the intrinsic qualities of the innovation itself. Arguably, this process of translation and mobilisation is easier to achieve in communities of practice where the shared practices and language give an advantage to the focal actor. Support for innovation can be mobilised using the community by aligning a range of actors and facilitating the flow of knowledge about the innovation and interests across the community of practice (Swan et al., 2002). The process of translation requires the focal actor to recognise the interests of related actors' that are often multi-dimensional (Sarker et al., 2006). Community membership equips actors with the ability to read the local context and to participate in the complex web of people and interactions in ways that are recognised and valued by other actors who are members of the community (Contu and Willmott, 2003: 285). We argue, this makes it easier to build mobilisation and *interessment* strategies dynamically around actors' interests and emerging alliances.

However, by their very nature, communities of practice are not easily amenable to deliberate management and control. Despite the challenges involved, more and more organisations are attempting to develop and support communities of practice as part of their learning and improvement initiatives. First, it is argued that their management should be done with a 'light touch', as managerial initiatives that are too directive or controlling of workers may inhibit communities (Thompson, 2005). Ward (2000), utilising a garden metaphor, argues that communities of practice require to be 'tended and nurtured rather than commanded and controlled' (p. 4). Some more specifics include:

- Emphasise practice-based, peer-supported learning methods rather than formalised, classroom-based methods as this reinforces the existing ways that communities learn and share knowledge.
- Have specific people within a community undertaking organising roles which have the objective of sustaining and developing the community.
- Develop continuity. Due to the significant length of time required for communities of practice to develop, discontinuous social relations are likely to hamper their functioning.
- Find, nurture, and support existing communities (Borzillo et al. 2011). McDermott (1999) suggests strengthening their existing mechanisms for social interaction and providing them with adequate autonomy to allow them to decide and control both what knowledge is important, as well as how it should be organised and shared.

Influencing Organisational Culture through Climate Interventions

The 'light touch' approach suggested by community of practice scholars to 'manage' communities can be applied to manipulate the organisational culture through climate interventions. Climate is a concept that was developed by the social scientists Lewin, Lippitt and White seven decades ago (1939). The term was used to describe the subjective feeling and the atmosphere Lewin and colleagues encountered in their studies of organisations. There is consensus in the theoretical and empirical literature that organisational climate is a multi-dimensional phenomenon describing the general psychological atmosphere (Ekvall, 1987). Ekvall (1987) describes organisational climate as the observable attitudes and recurring behaviour patterns which characterise life within the organisation (as experienced, understood, and interpreted by organisational members). These are the visible and

observable results or effects created by the organisation's culture, which is made up of the beliefs, traditions and values of organisational members (Ekvall, 1987). In this way, culture is an antecedent to climate (Ehrhart et al.,2014). Different organisations had distinctively different climates. Daily exposure to a particular organisational climate generates lasting influence on employee behaviour (Ekvall, 1987) by influencing the mental and physical efforts of both the mind and body (Pace, 2003). Expectedly, this suggests a link between climate and organisational success.

Climate has been found to be more amenable to deliberate change efforts and direct control by leaders compared to culture. Culture reflects the deeper ideological foundations of the organisation and hence is harder to shift and change (Denison, 1996; McNabb & Sepic, 1995). Climate, on the other hand, is the aggregate individual appraisals of specific factors within their work environments that help or hinder their innovation efforts (Isaksen et al., 1995) and leadership behaviour has a major influence on these appraisals through their direct decision-making, how their behaviour is perceived and observed by others, and their intervention on the elements of the work environment (Isaksen, 2017). Growing evidence suggests that interventions to organisational climate are useful in enhancing innovation and to better respond to uncertainty in the external environment, changes in the competitive environment and demands for variation and transformation in the internal environment (Patterson et al., 2005). A leader can indirectly affect the ideas generated in the organisation by establishing a climate perceived by employees as supportive of their innovative endeavours (Mumford & Gustafson, 1988; Amabile et al., 2004). For managers, understanding climate helps to determine the appropriateness of current climate for innovative success and it may allow the organisation to better structure itself towards a more innovation-conducing climate by building upon structures, processes and practices that seem to be working well and modifying those that are not.

It is because of the overall and lasting effect and the amenability of organisational climate, that this concept is of interest and important to our understanding of innovation in organisations. If climate is so important, then how do we describe and define it? One of the main attempts to conceptualise climate for creativity and innovation came from Ekvall (1983; 1987; 1991) which was further developed by Isaksen et al. (1995) eventually resulting in The Situational Outlook Questionnaire® (SOQ). The SOQ® assesses climate on nine dimensions: challenge/involvement, freedom, trust/openness, idea-time, playfulness/humour, conflict, idea-support and risk-taking (outlined in Table 1 below). These dimensions are found to predict higher levels of organisational support for creativity and innovation and effectively discern climates that either encourage or discourage innovation (Isaksen et al 2001). The benchmarks in Table 4 show the average score associated with the most innovative and least innovative (described as 'stagnant') organisations (Ekvall, 1996.)

Dimension	Description	Benchmark (range = 0-300)	
		Innovative organisations	Stagnant organisations
Challenge/ Involvement	The degree to which people are involved in daily operations, long-term goals, & visions	238	163
Freedom	The independence in behaviour exerted by the people in the organisation	210	153
Trust/Openness	The emotional safety in relationships	178	112
Idea-Time	The amount of time people can (and do) use for elaborating new ideas	148	97
Playfulness/ Humour	The spontaneity and ease displayed within the workplace	230	140
Conflict	The presence of personal and emotional tensions in the organisation	78	140
Idea-Support	The ways in which new ideas are treated	183	108
Debate	The occurrence of encounters and disagreements between viewpoints, ideas, differing experiences and knowledge	158	105
Risk-Taking	The tolerance of uncertainty and ambiguity exposed in the workplace	195	53

Table 4 - The nine dimensions of climate for creativity and innovation

Based on their research in the NHS, Sheffield et al. (in press) identified some practical steps leaders can take to shift their climate for innovation. These are summarised in Table 5 below:

Dimension	Leadership practices that encouraged …
Challenge and involvement	• Increased collaboration/earlier involvement of others • Seek perspectives beyond own team/ organisation • Greater, earlier patient involvement • Use of peer networks to test and challenge new ideas
Freedom	• Increased delegation of power and authority • Active discouragement of permission-seeking culture • Avoid 'over-planning' • Expect the unexpected
Trust/ openness	• Appreciative Inquiry – take energy from what we do well • Seek and provide opportunities for constructive feedback • Promote coaching and active listening
Idea-time	• Allocate and protect time in team meetings, away days/off-sites • Make time and space to reflect on and in action
Playfulness/ humour	• Take time out as team for informal conversation • Use creative methods; e.g. drawing, storytelling, Lego Serious Play™
Conflict (reduction)	• Value diversity and difference • Surface and deal with issues in timely and transparent fashion
Idea-support	• Storytelling targeted to audience • Delegation increases time to promote projects and seek support • Foster "innovation champions"
Debate	• Value diversity of views and all the different expertise available to you • Allow time to get beneath surface issues
Risk-taking	• Accept failure as inevitable side effect of innovation – and learn from it • Awareness (of self, impact, organisational priorities, costs, etc) mitigates risk

Table 5 - Leadership practices to promote a climate of innovation in health

All nine dimensions above call for attention to the way staff (and other actors in the system) communicate with each other. This is important because the largest ever multi-method study of cultures of health care in England concluded that dark spots of poor quality were widespread, partly because of very low levels of dialogue about quality problems and solutions (Dixon-Woods et al., 2013). However, in system-wide initiatives it is important to stay mindful of the fact that any attempt to initiate, implement, or facilitate multi-actor collaborations is an intervention into sometimes fragile, often controversial systems of actors. So, careful attention is needed to the quality of process, the quality of relationships and interaction among system of actors, as well as to the functionality of collaboration structures. In the next section, we focus on the role of dialogic communication in cultivating cultures of learning and improvement.

Catalysing Culture and Climate through Dialogic Communication

The lesson from many multi-actor collaborations is that progress cannot be built on convincing others to follow a predefined vision or objectives, goal, strategy, or action plan, but rather must be built on the broad willingness to co-create new pathways into the future (Kuenkel, 2019). Quality communication is necessary for creating cohesion among the otherwise diverse, and at times conflicting or mutually distrustful, actors in a community. It can overcome difficult situations and contribute to a sense of belonging and building trust in an otherwise complex endeavour. Quality communication can be enhanced by three supporting practices (Kuenkel et al., 2021).

1. **Structured dialogue**, built upon agreed and transparent rules of communication within and beyond the participating actors (and wider stakeholders), is important for understanding differences as well as consensus building, vision development, and planning action. Skilled dialogic process facilitation, by participating actors or external professional facilitators most often eases the road to success. In order to enhance structured dialogue, the core members of the community can:
    - Ensure that community events are organised for joint purpose formation.
    - Build learning and communication between levels of actors to regularly update the understanding of the purpose and the context.
    - Cultivate listening and integrating different perspectives.
    - Make sure that dialogue is the core approach to agreements, reviews, action planning and conflict resolution.
    - Agree on rules for external communication among all relevant stakeholders.

2. **Governance mechanisms**, which introduced formal structures such as steering committees, ensure different perspectives and expertise are acknowledged and integrated. In order to strengthen governance mechanisms, the core members of the community can:
    - Establish transparent decision-making structures
    - Create collaborative and representative governance structures
    - Ensure the utilisation of complementary knowledge, competences and resources
    - Transparently inform stakeholders about plan, decisions and progress.

3. **Collective learning** leverages the many forms of reflection on process and progress that need to be cultivated to gauge systems aliveness and adjust roles, processes and practices accordingly. These become the bases for empowering monitoring systems that are fully owned by the community but can also include external evaluations that are agreed to by and then discussed by all stakeholders. In order to improve collective learning, the core members of the community can:
    - Create dedicated spaces that include joint review of roles, purpose, progress and practices
    - Regularly review strategies, actions and impact with system actors to enhance mindfulness, iterative learning and agility

- Ensure events and tools are in place for mutual learning and exchange to keep the system of actors in a continuous reflective conversation.

In the day-to-day management of implementation, with delivery pressure and time-consuming consensus building, the actual aspiration of working collaboratively and in dialogue might at times move into the background. Having the supporting practices in place is important in that respect. They help actors to stay in touch with their specific context and the larger picture. They allow taking note of what other actors are doing, connecting the learning and developing wider impact strategies together. They ensure all actors have current knowledge about how others are approaching the issues or challenges and who else is active in the field of activities. Anchoring understanding about local activities invigorates willingness to support each other.

3.3 Enhancing Culture, Climate, Communities and Communication through Organisational Levers

Values-based Recruitment

Values-based recruitment is a method of recruiting staff whose values are a good fit with your organisation's values while making sure the recruitment process communicates the organisational values to potential recruits at an early stage. Research has revealed the importance of ensuring a fit between the values of the organisation and of new staff – so-called 'person-organisation fit.' The better the fit, the more committed a new employee is to their organisation and the longer they stay. Employees who do not fit in with the organisational culture negatively affect those around them. They can stifle the enthusiasm, motivation and dynamics of their team. And poor employee motivation diminishes the productivity and profitability of the organisation.

Organisations within and outside the health and social care sector have successfully implemented values-based recruitment and report benefits such as:

- reduced recruitment costs
- increased employee engagement
- positive impact on staff turnover
- increased staff morale
- a more positive work environment characterised by productive energy
- reduced sickness absence
- increased job satisfaction

Pukka Herbs, for example, has a step in their recruitment process called Wisdom Seeds. Candidates will be given statements that broadly represent Pukka's four wisdom seeds - effort, respect, purity and compassion. – and they will be asked to pick one that describes them best.

Values-based Induction

An onboarding programme built around organisational values enables staff to perform more effectively and helps them understand the values underpinning the organisation's culture. Considerable evidence demonstrates the importance of well-managed inductions and transitions in:

- reducing subsequent turnover (Bauer et al, 2007)
- reinforcing the sense of 'value fit' between new staff members and their organisations (Meyer et al., 2010, De Cooman et al 2009)

The transition cycle approach (developed by Nicholson 1987) is a helpful way of identifying four key stages of transitions and understanding the challenges that each stage presents. The summary diagram below draws on a framework detailed in Nicholson (1990).

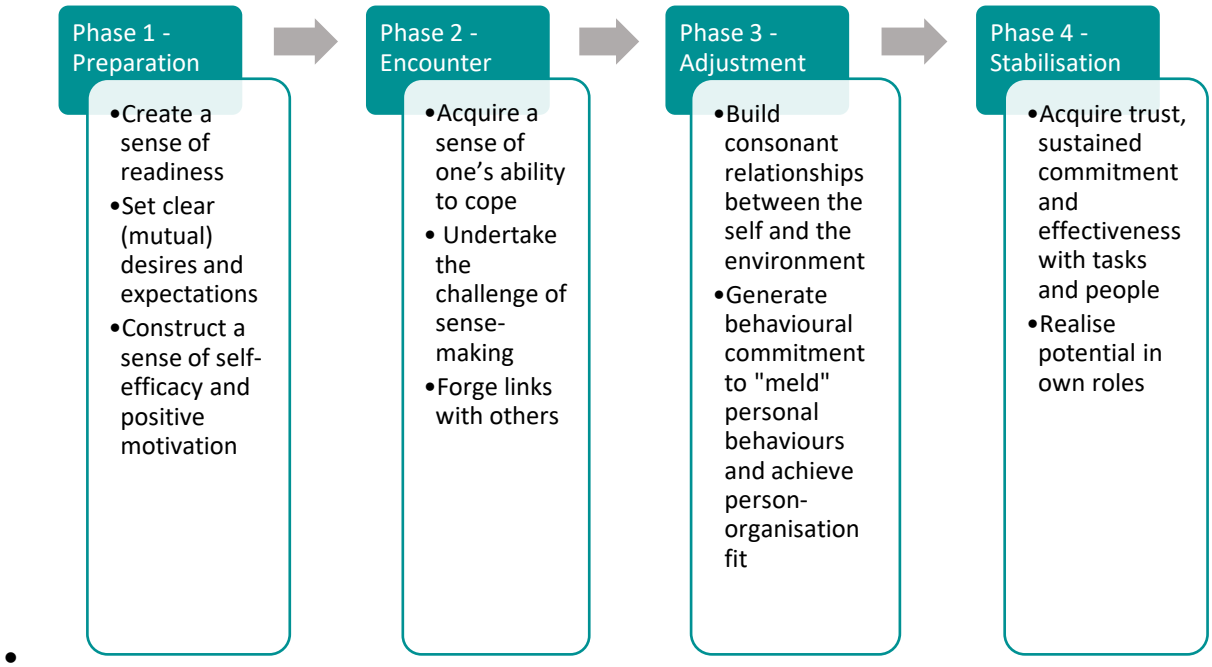

Figure 4 – The transition cycle

(Source: adapted from Nicholson, 1990)

The diagram suggests that transition is an ongoing and ever-unfolding process which implies the importance of ***values-focused learning*** and training curricula underpinned by the core values that staff are expected to demonstrate, along with mentoring relationships to equip employees with the direction, alignment and commitment to the values to support the organisation's purpose.

Values-based Appraisal

The values-based approach to appraisal is designed to ensure that the appraisal process reinforces the organisation's values. It does this by evaluating performance based on the extent to which employees model the organisation's values. In practice it involves:

- agreeing objectives aligned with core organisational values
- helping the staff member align their job performance with core organisational aims
- making sure they feel their efforts to implement the values in their work are recognised, valued and appreciated.

Given the widespread discrimination against minority groups in health and social care (West et al., 2015), appraisals need to be scrutinised to ensure they are high quality, fair and do not embed systemic bias or inequality.

An important part of the cultural change in Wigan Council which paved the way to the new approach to delivering services (known as the 'Wigan Deal'), has involved specifying very clearly the values, attitudes and behaviours that are compatible with the ethos of the Wigan Deal and that are needed to build the new relationships that underpin it. The three core values are described as being positive, accountable and courageous. These values have been incorporated into all human resources materials and processes, including those used for recruitment, induction and appraisal. A strong emphasis is placed on induction when people join the council. In addition to the Deal training, all new and existing staff take part in a half-day immersive experience called the 'Be Wigan Experience'. This aims to reinforce the council's values and explain the behaviours that the council expects of staff, including how the council aims to work with local people and external partners. Line management and appraisal processes have also been redesigned. Staff have 'My Time' and 'My Time Extra' meetings with their line manager, in which line managers are encouraged to develop a more rounded view of the member of staff and have the same kind of different conversations that frontline staff have with clients.

Appraisals and performance reviews are used as an opportunity to assess people's performance against the expected attitudes and behaviours as well as technical skills and competencies.

Leadership Development and Succession Planning

The most important influence on the development and maintenance of cultures is current and future leadership (Schneider and Barbera, 2014), which includes leadership from the strategic apex through to the front line, informal as well as formal leadership, and which reflects leadership processes as well as the qualities of the individuals who occupy leadership positions. Every interaction by every leader at every level shapes the emerging culture of an organisation as the staff will learn and adopt the values to win leaders' approval. Nurturing cultures advancing the organisation's purpose, therefore, requires having leaders and leadership behaviours aligned with values that are core to the desired culture (Brown and Trevino, 2009). If leaders focus more on targets, cost efficiencies and productivity (vital though these are) than patient experience and quality of care, it undermines trust in the organisational vision and shapes the culture accordingly.

As such, making sure organisational values and purpose are maintained and strengthened over time relies on effective leadership development and succession planning. Identifying potential successors as far as possible, and preparing them for future roles, ensures continuity and sustained performance. By ensuring consistency of leadership values over time, organisations can sustain the desired culture. Developing leaders with the skills, values and attitudes central to the culture. Research into succession planning suggests that the best organisations integrate succession planning systems by:

- developing the organisation's mentor network
- providing potential leaders developmental experiences that reinforce values and develop knowledge & skills, such as job experiences, projects, secondments and lateral job moves
- exposing potential leaders to a wide range of colleagues across the organisation

As with appraisals, and given the widespread discrimination against minority groups in health and social care (West et al., 2015), succession planning must reinforce the core values of inclusion, equality and diversity. This helps secure leaders who represent the communities they serve, as well as their staff.

Secondments

Secondments take employees outside of the boundaries of their roles, teams, or even organisation and offer them the opportunity to work in a different organisational culture, to broaden their experience and skills and share their learning. It is particularly useful for an employee to widen their perspectives by experiencing how a different organisation, with a different culture, systems and processes, may nevertheless achieve similar outcomes to their own. Typical secondments can include:

- a healthcare employee seconded to a private sector company (such as an assignment that enables the employee to move up or down a step along the value chain)
- a professional firm seconding employees to work in-house with a client
- headquarters or corporate functions assigning staff to local, more patient-focused organisations
- job swaps between employees in equivalent organisations in healthcare or across health and social care.

Job Crafting

Job crafting theory (Wrzesniewski et al., 2013) elaborates on classic job design theory that focuses on the top-down process of managers designing jobs for their employees. Job crafting is a means of describing the ways in which employees utilise opportunities to customise their jobs by actively changing their tasks and interactions with others at work, to make their jobs more purposeful and

meaningful. Recrafting jobs allows employees to deploy their strengths and passion not only to make work more enjoyable but also to transform a routine job or a stalled career into a calling. Three different forms of job crafting can be offered to employees to allow them to contribute to the purpose of the organisation and to make a difference:

(1) alter the boundaries of their jobs by taking on more or fewer tasks, expanding or diminishing the scope of tasks, or changing how they perform tasks (e.g., an accountant creating a new method for filing taxes to make her job less repetitive).
(2) change their relationships at work by altering the nature or extent of their interactions with other people (e.g. A computer technician offering help to co-workers as a way to have more social connection).
(3) cognitively change their jobs by altering how they perceive tasks (e.g. a hospital cleaner seeing his work as a means to help ill people rather than simply cleaning; or an insurance agent seeing her job as 'working to get people back on track after a car accident' rather than 'processing car insurance claims'). Storytelling (see below) can help employees with changing cognitive frames.

Storytelling

It has been said that organisations are made up of many stories and competing story interpretations (Boje, 1995). The stories that are told in an organisation can facilitate tuning into and trying to bring about a change in an organisation's culture. Specific applications of organisational storytelling include, among others, confirming shared experiences, generating commitment, renewing a sense of purpose, co-creating a vision, engaging emotions, driving strategic change, and facilitating sense-making. As Forster et al. (1999, p. 14) point out, stories ''...act as both mirrors and windows on the human experience, showing people either how to look at reality in a different way or suggesting alternative realities''. They help us to define who we are, why we are here, and what we should value.

Leaders at all levels can help staff reconnect with the organisation's purpose and values by telling stories of success that encapsulate these. Forster et al. (1999, p. 19) emphasise that ''[t]o be truly effective, leaders should not only communicate stories, but also embody them. Inspirational leaders can make their messages even more powerful by leading by example''.

> *'Social movement leaders tell new public stories: a story of self, a story of us, and a story of now. "A story of self" communicates the values that call one to action. "A story of us" communicates the values shared by those in action. "A story of now" communicates an urgent challenge to those values that demands action now. Participating in a social movement not only often involves a rearticulation of one's story of self, us, and now, but marks an entry into a world of uncertainty so daunting that access to sources of hope is essential.' (Ganz, 2010: 14-15)*

Since stories are value-laden, storytelling can also be seen from a leader controlling perspective or from a participatory, freeing, co-creating perspective. As Boyce (1996) suggests, storytelling can be used in an attempt to control and manipulate employees, or to develop the self-potential and sense of well-being of employees.

Team reflexivity

Team reflexivity involves team members collectively reflecting on the team's objectives, strategies and processes, as well as their wider organisation and environment, and adapting accordingly. There is increasing interest in this approach because it is an effective way of developing teamwork generally (Schippers et al 2008, West 2000, Konrad et al 2015). Team reflexivity has three stages or components (West 2000):

- **reflection**: a team's joint review of work related and social functioning (this is what a good sports team does at half time and at the end of the game)
- **planning**: detailed planning for change
- **action or adaptation**: implementation.

Vashdi et al. (2013) highlighted the importance of structure, frequency and regularity of what they called 'reflection sessions' for optimum value. One approach to achieve this is the process of after-action reviews. These are debriefs of specific team performance events or episodes to encourage reflection and self-discovery, target potential opportunities for improvement, and thus improve the quality and rate of learning. A meta-analysis of 46 studies by Tannenbaum and Cerasoli (2012) explored the use of debriefs or after-action reviews to improve learning and performance. The review found that compared to controls, the use of debriefs improved effectiveness for teams and individuals alike, by an average of 25%.

Growing evidence over the past 25 years shows that teams are much more effective and innovative if they regularly take time out to review what they are trying to achieve, consider how they are going about it, and adapt their objectives and processes accordingly (e.g. Widmer et al 2009, Konradt et al 2015). In contrast, non-reflexive teams show little awareness of team objectives, strategies and the environment in which they operate. Instead, they tend to rely on habitual routines that ultimately lead to poor performance, lack of innovation and inability to adapt to a changing environment. Unfortunately, in a study of 250 healthcare team members by Wiles and Robison (1994) three-quarters reported not having regular team meetings: most met each other only if there was a specific problem to be resolved. Similar findings were reported by Borrill et al (2000). This means many teams continue to pursue goals and targets that are not appropriate for their context.

Edmondson et al. (2007) found that learning only takes place in teams whose members trust each other and believe that well-intentioned action will not lead the team to punish or reject them. Konradt et al. (2015) conducted an experimental study of 98 teams investigating a reflexivity intervention. They found that the teams that had the reflexivity training demonstrated a greater capacity to reflect and share feedback and improved significantly compared with teams that had not had the intervention.

Teams can reflect on their task. But they can also reflect on their social functioning – the ways in which they provide support to members, how they resolve conflicts and the overall climate of the team. They can build self-awareness and monitor how members co-ordinate with one another. As a result, they are more likely to recognise areas that need attention and development and implement improvement plans accordingly (Tjosvold et al., 2004). There is evidence that such social interventions improve people's wellbeing and can improve performance (Daniels et al., 2017).

3.4 Examples of Good Practice

Systems insights from the health and care system

Example 1: Southern Health NHS Foundation Trust has implemented assessment processes to ensure the right people get appointed, especially to leadership positions; behaviourally based appraisal to align all objectives to the business plan and all behaviours to values; talent management to identify, nurture and retain staff on the basis of their current performance and future potential; and succession planning to identify those with the potential to move into leadership positions. The organisation has used a variety of methods to develop internal leadership capability including:

- a programme to develop the leadership characteristics required for the business
- a coaching programme for leaders
- a tailored development intervention for the senior management team
- team development for newly formed teams or those facing challenges

- a value-based programme of induction for new medical consultants to support them in adjusting to a leadership role.

All of Southern Health's development programmes are specially designed to help nurture the culture, rather than being 'off the shelf' programmes.

Example 2: Similar to after-action reviews, **Schwartz Center Rounds®** can be used to provide a forum for staff from a range of disciplines to meet once a month (or every other month) to explore together some of the challenging psychosocial and emotional issues that arise. With help from a skilled facilitator, discussion focuses on a particular case that is introduced by a mixed panel of staff, led by a doctor, who were involved in the patient's care. The panel gives a brief summary of the patient's case story and panellists take it in turns to describe their involvement in the case and, in particular, how it made them feel and what sort of challenges it may have raised for them. An independent evaluation of the Rounds ® in the United States showed that they have benefited both individuals and teams and have influenced hospital culture. The Point of Care piloted the Rounds ® between October 2009 and October 2010 in two hospitals (the Royal Free Hospital and Cheltenham Hospital) and found that the participants benefitted from the Rounds® for themselves, for their day-to-day care of the patients, and for their teamwork. Similarly, they have reported small but significant changes in hospital culture.

Further details at: https://www.kingsfund.org.uk/projects/schwartz-center-rounds

Example 3: Wrightington, Wigan and Leigh (WWL) NHS Foundation Trust introduced a joint initiative initially aiming to increase mutual understanding and bridge hierarchical divides between senior managers and staff. Directors' walkabouts' were initiated as an opportunity to listen to staff at the front line, and give staff regular opportunities to talk directly to the senior team. This engagement was greatly strengthened by the implementation of the Listening into Action (LiA) programme, which involved large-scale staff listening events led by the chief executive and other directors. In these events staffs are asked three questions: what works well, what needs to improve, and what are the barriers to improvement? Getting these events ingrained in the trust's culture has produced quick wins and bigger system changes. They exemplified the opportunity for all staff to lead in the organisation.

Example 4: As elaborated extensively in a recent King's Fund report authored by Naylor and Wellings (2019), a distinctive feature of Wigan Council's efforts as part of the '**Wigan Deal**' is the constancy of purpose evident both in the senior leadership team and at other levels in the council. A common vision was forged early on between executive and political leaders, and a clear narrative developed about the changes the council wanted to bring about and why they were needed. However, while the overall approach and the values underpinning it have been non-negotiable, an enabling style of leadership has meant that staff have had considerable freedom to develop their own ideas about how the principles of the Deal can be put into practice in their work. This exemplifies job crafting. Social care workers are encouraged to have different conversations with people they work with, the services are encouraged to bring local voluntary sector organisations and community groups on-board to deliver employment and welfare services to citizens. And the impact of job crafting is seen clearly. One of the themes repeatedly emphasised in King's Fund report by Naylor and Wellings (2019) on the Wigan Deal is the renewed sense of purpose that staff felt in their work. Staff felt reconnected with why they had wanted to work in public service. This sense of purpose was not limited to staff who have direct contact with residents but is felt across

the whole council, with over 80% of staff saying that they understand the connection that their work has to making a difference to people's lives.

Source: https://www.kingsfund.org.uk/publications/wigan-deal

Systems Insights from other sectors

Example 1: After-action reviews, which originated from the US Army, mostly feature in high-reliability organisations. However, they have been adopted by a variety of organisations including NGOs. For example, in 2005, CARE, World Vision International, OXFAM and Catholic Relief Services organised an after-action review following the crisis caused by the tsunami of 26 December 2004. The after-action review focused mainly on the four most affected countries: Indonesia, India, Sri Lanka and Thailand. The primary purpose was to explore ways in which participant organisations could jointly improve their performance and quality of work by reflecting back on their activities and actions. It presented an opportunity for participants from various organisations to discover for themselves what happened and why, and how to build on strengths and improve on areas of weakness, as well as exploring ways in which they might collaborate more effectively together. Participants discussed best practices and lessons learned in country groups and then action planned how to work collaboratively on the lessons learned. More information on the approach and tools utilised in these after-action reviews and their findings are summarised In this report:

https://www.betterevaluation.org/sites/default/files/joint-after-action.pdf

Example 2: In Tunisia, the agricultural region of Kairouan experienced a severe reduction in their water resources brought about by climate change, mismanagement, and overexploitation. Integrated water resource management was urgently needed, but difficult to achieve because of severe challenges in aligning stakeholders' interests. A collaboration ecosystem was needed between the local administration and farmers to avert a severe economic crisis and social conflict. However, before any strategy could be co-designed, core collaborative groups first needed to be built among administration and farmers separately. A highly inclusive facilitated process support for the 400 farmers resulted in them building a representative structure. High quality dialogues led them to propose a clear vision of the change needed. This bottom-up vision development provided the turning point for engaging the administration in a co-creative definition of goal clarity, which led to joint planning of activities and role distribution among farmers and administration alike. The result was an increased sense of ownership and accountability for a jointly agreed water charter and strategies on reducing water consumption. A joint committee made up of farmers and administration began to monitor and support the implementation process. More information about the project and the approach is available at: http://www.iwrm-dialogue.com/en/cases/25/

3.5 Implications for Organisation Development

1. **Communicate an inspiring vision of what system working can achieve**:
   A key aspect of the culture literature focuses on crafting a shared, meaningful vision of a desired future state. What are the health outcomes you desire for your population that require collaboration? What can only be possible through collaboration across the Nottinghamshire system, as opposed to organisation-level work? And convey these messages to staff through communication events, allowing for two-way discussion, feedback and joint crafting of the aims. This will cultivate a sense of shared pride and reinforce superordinate goals, over and above, (while not dismissing), organisational belonging.

2. **Dialogue and shared understanding**:
   Much of the culture literature around systems emphasises the criticality of understanding the needs and worlds of people from different parts of the system. How will you construct a process of dialogue so that people feel understood by others?

3. **Cultivate communities of practice**:
   It is through participation in a community that individuals develop their practices and identities. A community of practice is a forum for the exchange and interpretation of information amongst members who have a shared understanding. It can reframe knowledge in "living" ways unlike a database, capturing its tacit aspects. It can steward competencies as members discuss novel ideas and disseminate new developments. And it can provide a home for identities making the communication and dialogue easier to achieve by aligning individual values and beliefs with those of the community. Building institutional and technological infrastructures to recognise, support and leverage communities of practice will contribute to nurturing a more collaborative and knowledge / practice-sharing culture.

4. **Climate as a manageable step to culture change**:
   Taking the first steps to culture change can be a daunting prospect. Consider the concept and measure of climate as a step to doing so. Climate is more amenable to change, more within the scope of the everyday actions of actors in your system, and is directly influenced by local and senior leadership. It is also measurable.

5. **Senior leadership and power**:
   Part of the role of senior leadership must be to identify priority areas for system-wide work and collaboration. Having done that, they must agree the people needed to do the work, and allocate the resources, support and authority to act, within agreed boundaries. Agile implementation, and freedom to act will be needed across the system, if changes are to take place and embed. This will be the case for clinical operational workgroups - as has happened out of necessity through COVID – and for functional and project collaborative groups throughout the ICS. Clarify their work, and grant them decision-making authority, so they can act within agreed parameters. The challenge here for senior leadership is in letting go of appropriate power.

6. **Role of Human Resources**:
   In organisations with strong cultures, Human Resources professionals build desired cultural values systematically into their 'everyday' processes of recruitment, selection, development, performance management and retention. And then find creative, everyday ways of embedding these through both formal and informal practices.

7. **Reflexivity, learning and sharing**:
   Without the process of reviewing action, learning lessons and communicating wider, daily action can become a short-term palliative, with no felt-sense of purpose, and making no progress. Encourage system-teams to reflect on their task, social processes, and their achievements. And to spread key highlights across relevant organisational units. This can aid the process of deeper meaning-making, and can also spread news of progress and of learnable lessons to others. This can help avoid duplication, boost morale and spread practices.

8. **Leadership development:**
   Many insights from research and practice on culture point to the criticality of the role of leaders, from the most senior levels, to local, unit level. How might you support the development of leaders at all levels, so that they understand the cultural values to reinforce, have access to other leaders to build their system networks, are clear on their leadership responsibilities, and embed processes of team reflexivity into regular work routines?

4. IMPROVEMENT

4.1 KEY INSIGHTS FROM THEORY, RESEARCH, POLICY AND PRACTICE

The meaning and boundaries of what constitutes Quality Improvement (QI) need some defining. In their 2013 quick guide, the Health Foundation tell us:

> *"There is no single definition of quality improvement. However, a number of definitions describe it as a systematic approach that uses specific techniques to improve quality."*

The report goes on to use the definition provided by Øvretveit (2009):

> *"The conception of improvement finally reached as a result of the review was to define improvement as better patient experience and outcomes achieved through changing provider behaviour and organisation through using a systematic change method and strategies."*

The meaning of quality in a health context also needs agreement. The institute of medicine (1990) has listed the following areas as targets of quality efforts:

- **Safe**: helping patients avoid harm.
- **Effective**: service provision based on evidence, producing a clear benefit.
- **Patient-centred**: partnership working between practitioners and patients to ensure care respects patients' needs and preferences.
- **Timely**: reducing waits and, sometimes, harmful delays.
- **Efficient**: avoiding waste.
- **Equitable**: care provision that does not vary because of a person's characteristics.

There are many frameworks, methods and tools for Quality Improvement (QI). However, regardless of the approach, there are common elements of an improvement initiative:

- A change that people agree to make.
- A QI method to follow.
- Data methods to demonstrate that improvement has taken place.
- People working in a particular context.

While pointing to the potential benefits, Alderwick et al (2017) point out that QI initiatives are not being applied consistently and systematically across organisations and systems. And that, in order to "deliver the changes that are needed to sustain and improve care, the NHS needs to move from pockets of innovation and isolated examples of good practice to system-wide improvement." They recommend 10 guidelines, as outlined below:

1. *Make quality improvement a leadership priority for boards*, since senior leaders, and boards in particular, play a vital role in setting the strategic direction of NHS organisations and creating a supportive culture and environment for quality improvement.
2. *Share responsibility for quality improvement with leaders at all levels.* While board support is essential, it is not enough. There should be a clear vision for the role of improvement, aligned with leaders across levels and service areas, with integrating mechanisms to ensure co-ordination. The criticality of staff engagement in QI is confirmed by Taitz *et al (*2011).
3. *Don't look for magic bullets or quick fixes.* Evidencing quality of improvement takes time, and must be done in complex local contexts. And this is especially so across systems.
4. *Develop the skills and capabilities for improvement.* NHS leaders should invest time and resource in building the QI capabilities of their staff.

5. *Have a consistent and coherent approach to quality improvement.* In summarising the evidence, the authors suggest that no single QI method works best. What matters is agreeing a consistent approach and applying it rigorously.
6. *Use data effectively:* "…to identify quality problems, define indicators for improvement and track the impact of different interventions on quality of care."
7. *Focus on relationships and culture.* This may be more important than the selection of tools and methods. Without the support of leaders, within and across organisational boundaries, change efforts are likely to be unsustainable. Healthy work relationships are needed, supported by a purposeful change focus, with time for reflection, resources and permission to engage in improvement. This is consistent with Jabbal's (2017) point about providing a clear rationale for QI, especially in a context where health systems are under huge pressure, and QI can unlock productivity gains, as well as safer, better care.
8. *Enable and support frontline staff to engage in quality improvement.* Many successful QI efforts have been carried out by frontline teams, often 'under the radar', and without any formal support. Frontline workers should be freed up with time and resource for training and implementation. This is likely to be fuelled by their intrinsic motivation for providing quality of care for their patients. Jabbal (2017) points out that this might mean senior leaders letting go of control, as frontline staff, service users and carers are often better placed to develop solutions through iterative discovery. (Note that this sounds much like an agile methodology approach to implementation.)
9. *Involve patients, service users and their carers.* This can ensure that patients identify relevant quality problems, help co-develop solutions to address them, and ensure that changes bring the outcomes that matter to them.
10. *Work as a system,* pooling resources and working together across local systems of care. To do this, NHS leaders must develop new forms of 'system leadership' based on distributed power, alliances and collaborations.

Source: Alderwick et al., 2017

Many of these points are reiterated by Jabbal's (2017) review of the enablers of effective QI approaches. The author adds that a further enabler is to engage staff:

> *"in a continued commitment to quality improvement by celebrating successes and ensuring that staff are able to take ownership and feel proud of their achievements." (p. 11)*

It should be noted that notions of 'improvement' are based upon assumptions around what constitutes high quality care and will be influenced by which performance measures are in place. Over the last two decades, since the Blair/Brown Labour government introduced nationally defined targets around waiting times etc, they have been a key feature of the NHS landscape. Whilst targets have had a positive impact on some aspects of clinical care, they have also produced a number of unintended consequences including distortion of clinical priorities and the allocation of funding and resources (Kings Fund, 2010, Kings Fund, 2019). A review of NHS performance targets was announced by the Prime Minister in June 2018 and led by the NHS England National Medical Director, Professor Steve Powis, who published an interim report in March 2019. Following consultation with a range of stakeholders, including patient representatives, clinicians, and healthcare leaders, and trialling of measures in 14 pilots sites, the full 'Clinically led review of urgent and emergency care standards' was published by NHS England and NHS Improvement on 26th May 2021. It is yet to be seen what effect this will have on clinical outcomes, or the experiences of patients and staff within the NHS, but indicates an ongoing commitment to the monitoring and assessment of NHS services against a series of nationally defined criteria.

4.2 FRAMEWORKS, METHODS AND APPROACHES COMMONLY CONSIDERED AS GOOD PRACTICE

Improvement covers a wide range of methods, frameworks and tools, applied both in broader industry and in healthcare. Boaden et al (2008) provide a useful summary of the origin of improvement philosophies, including influential figures in the development and spread of theory and practice. Some of the approaches which have found advocates widely include:

- *Business process re-engineering*, with its emphasis on process mapping of current/future states.
- *Experience based co-design*, involving patients and staff working in partnership
- *Lean,* with its roots in Toyota's car manufacturing process, and emphasis on five principles: customer value; managing the value stream; regulating flow of production; reducing waste; and using 'pull' mechanisms to support flow.
- *Model for Improvement,* with its emphasis on small testing iterations through the plan, do, study, act cycle.
- *Statistical process control*: focuses on five principles: customer value; managing the value stream; regulating flow of production (to avoid quiet patches and bottlenecks); reducing waste; and using 'pull' mechanisms to support flow.
- *Theory of constraints*: recognising that movement along a process, or chain of tasks, will only flow at the rate of the task that has the least capacity
- *Total Quality management* or continuous quality management, with attention on quality and the role of the people within an organisation to develop changes in culture, processes and practice

It should be noted, however, that given the origins of most of these approaches within corporate settings there has been, and continues to be, active debate around their suitability within public sector organisations such as the NHS. As we'll see later, the evidence suggests that using tools and methodologies is not the biggest challenge in healthcare. The bigger hurdle is in gaining a consensus of stakeholder agreement to define the problem, and to agree a way forward. Contextual factors, pertaining to leadership and peer support seem to be more important considerations in determining later success.

The Institute for Healthcare Improvement (IHI) in the United States has developed a 'Triple Aim' framework – a framework to optimise health system performance that focuses on improving the health of the population and patients' experience of health care, while reducing the cost of health care per person (Jabbal and Lewis, 2018).

The Quality, Service Improvement and Redesign (QSIR) approach is an influential approach in UK healthcare synthesising a wide range of tools for leading improvement, project management, creative thinking, stakeholder engagement, process mapping, improvement measurement and supporting people through change.

There is an issue of the nature of work challenges suited to QI:

> *"We need to realise that improvement usually comes through small changes that make a measurable difference. Quality is rarely the result of learning brand new knowledge, exciting innovations or one-off changes. Instead, we need to focus on the regular and often painstaking work of providing a reliable service and continuously trying to improve what we do." (Berwick et al, 1992a and 1992b, cited in 1000 Lives Improvement, 2014)*

This sounds much like what Bessant calls '*do what we do better*' (Allen and Kokshagina, 2020). In other words, more incremental change. It's a matter of degree of change. Bessant contrasts this with '*do different*' approaches to change, where we may be doing something radically new. He describes radical as usually involving totally new performance features; performance or feature improvement a

least 5 times greater than present; significant reduction in cost, at least by 30%. These are changes we're unlikely to make by improving existing approaches.

Kirton (2003) developed this distinction by arguing that people have a fixed preference for more incremental or more radical change. This has implications for bringing in cognitive diversity into collaboration. And this expression of thinking style manifests in our attraction to problems that suit our style.

In an early design meeting with organisation development (OD) and Human Resource (HR) professionals in the Nottingham and Nottinghamshire ICS, we asked people to what extent your future work would evolve or transform your current approaches. They responded as follows:

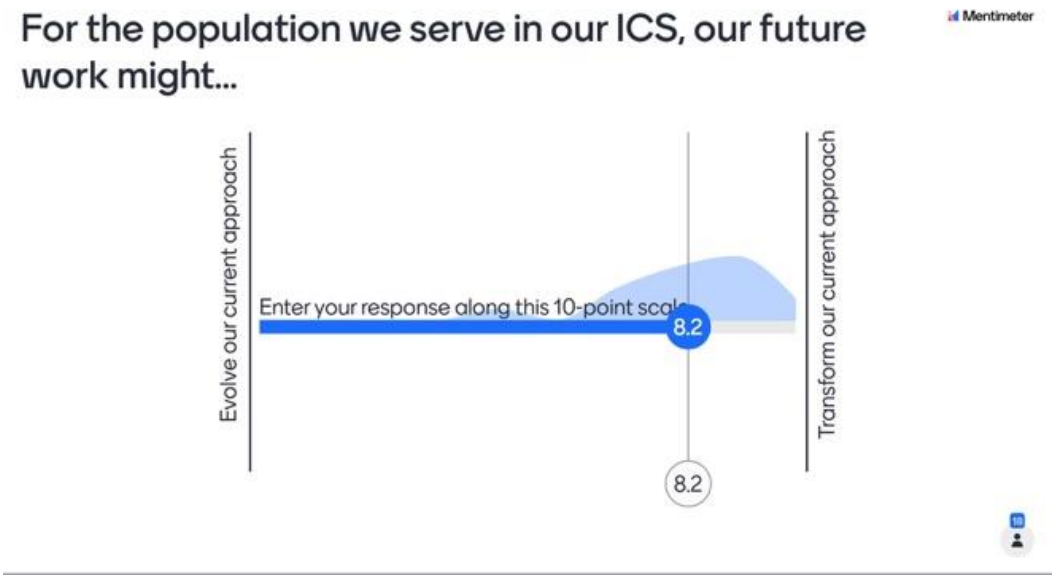

Figure 5 – ICS work: Evolution vs Transformation

The group was clearly suggesting that they anticipate more radical change. Connected to this, Bevan et al. (2011) describe the following 3 dimensions of large scale change: pervasiveness, depth and size. What's clear is that the Integrated Care System (ICS) concept is highly pervasive – it affects all of the system; it is also strong on 'size', being able to affect around 1.1 million people in Nottinghamshire; and has the potential to be a depth change, because of shifts in paradigm like the opportunity to move from healthcare treatment to prevention. This is large-scale work where social, relational and political contexts will inevitably shape problem-defining and solution-acceptability.

While it's arguable that QI approaches developed, largely to provide more incremental, continuous improvement of current approaches, James notes (2012) that a *mature quality system* uses both breakthrough and incremental improvement at the same time:

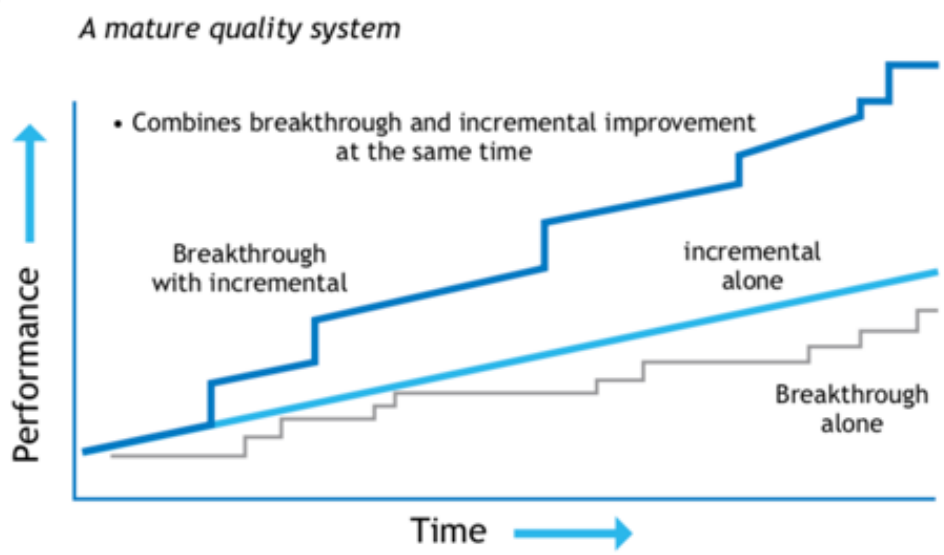

Figure 6 – Incremental and breakthrough change
(Source: James, 2012)

The Nottingham and Nottinghamshire ICS is still at an early stage of development, with pockets of excellence. But it is some way from maturity. You will need a range of improvement and innovation approaches to suit the nature of the challenges you face. And these will cover the continuum of incremental to more radical.

Sometimes the language of *Improvement, Change and Innovation* can be an obstruction to becoming equipped with the full range of tools needed to do the work. Labels can lead to membership in-groups and out-groups. When people get attached to tools and methodologies, the risk might be of core competences becoming core rigidities (Leonard-Barton, 1992), and of not selecting the right tools for the challenge.

Kokshagina and Allen (2020) describe the balance of an organisations' portfolio as, ideally, involving 60% of focus on core work that incrementally improves what we do now; 30% on stretch projects, extending the edges of our current approaches; and 10% on highly exploratory, much more uncertain projects. Their approach, and Van Wulfen's (2013) FORTH methodology are direct attempts to navigate the greater uncertainties inherent when more radical change is required.

Looking wider, it is worth noting that an international standard has been published for innovation since 2019. This is a manifestation of a growing global interest in understanding the ecosystem of innovation, and how to develop a more sustainable approach to this discipline.

An important point here is that innovation skills are increasingly viewed as part of employees' future skill-set. Organisations want people to turn ideas into value, in the form of new products, services, processes, business models, markets, strategies, etc. The demand for these skills is rising. And they are not easily substituted by artificial intelligence and machine learning. They are likely to remain essential human skills for the foreseeable future, and a good bet for investment for future employability. The World Economic Forum considers them to be a key area for skills investment, as summarised in their Future of Jobs report (2020), which identifies 10 top skills of 2025, grouped into four categories:

1. **Problem solving**: analytical thinking and innovation; complex problem-solving; critical thinking and analysis; creativity, originality and initiative; reasoning, problem-solving and ideation;

2. **Self management**: active learning and learning strategies; resilience, stress tolerance and flexibility;
3. **Working with people**: leadership and social influence;
4. **Technology use and development**: technology use, monitoring and control; technology design and programming.

Another important consideration here is the contrast between the front-end of innovation, and that of wider adoption of innovation. Practice experience of working in this space has led us to conclude that it is far easier to generate ideas in the health system than to implement, and, certainly, to spread successful ones. Generation can be more of a personal and psychological process, whereas implementation and spread are more social and political processes. Many factors contribute to this, one of which being that the health sector devotes much more resource to initial research and development, than to wider adoption (Collins, 2018):

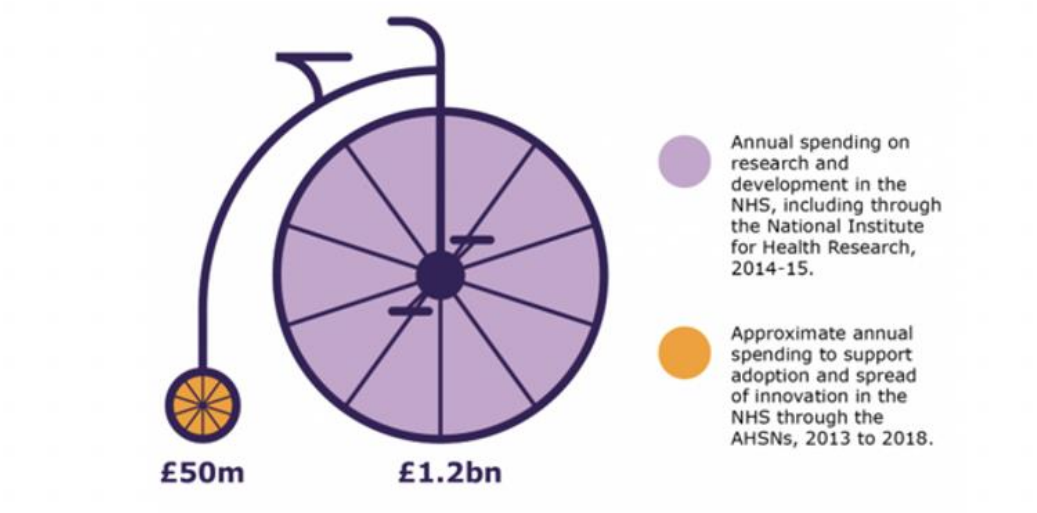

Figure 7 – Annual spend on R&D and spread of innovation in the NHS

Failure to capitalise on the benefits of wider adoption can lead to inefficient duplication of efforts, as similar, and different, ideas are developed across the system in response to the same challenges. Also, there is the missed opportunity of the proper celebration of 'good news' stories which give a sense of progress and can boost morale.

Finally, as ideas develop and become socialised, there is typically a continuum describing when people get involved. This can be influenced by personal interest, and contextual opportunity. Rogers (1983) described the diffusion of innovation as being essentially a social process. Moore (1991) argued that an important juncture occurs between early adopters and the early majority. And while every innovation is different in nature, the concept of gaining a critical mass for embedding sustainable change seems a key one for the radical organisational innovation that is the integrated care system (ICS).

4.3 EVIDENCE OF IMPACT FROM USE IN PRACTICE

Most evidence of improvement approaches in practice is from within organisations, because that's where most healthcare work has been done. Systems working is relatively new and less widely studied, and this is a considerable drawback of the current literature.

Bate et al. (2008) also argued that there had been little research into implementation of quality improvement. The main conclusions of the study were that:

"There are many different paths to successful, sustained quality improvement. However the unifying features ... are an ability to address multiple challenges simultaneously and to adapt solutions and strategies to the organisation's own context" (Bate et al. 2008, cited in Boaden et al, 2008, p. 126).

Jabbal (2017) reviewed some of the strategic considerations for organisations embarking on an Improvement journey:

- **Evaluating the impact of improvement activities:** "…Improving the quality of health care is complex and takes time to achieve …Individual quality improvement initiatives often take considerable time to demonstrate impact, and even the most successful efforts will face obstacles and setbacks along the way. Several of our participants noted the importance of being patient… 'keeping the faith' with the approach taken and the improvement work despite operational pressures." (p. 23)
- **Spreading quality improvement methodologies:** "Most of the participants in the study had started on a quality improvement journey within the previous two years. Although their focus remained on improvement approaches within their own organisation, they did note that, in the future, it would be increasingly important to have a coherent strategy for spreading improvement approaches throughout the NHS." (p. 24).
- **Aligning quality improvement with the wider priorities of the health care system:** "…areas of care not covered by targets may not receive sufficient attention, and that performance management creates a culture of compliance and risk aversion within NHS organisations that can inhibit innovation. At its worst, performance management has the effect of disempowering those working in the NHS and creating an over-reliance on central guidance, in effect the exact opposite of what is needed for quality improvement."

Boaden et al (2008) reviewed the critical success factors from those studies which gave generally favourable results in relation to the impact of continuous QI on clinical processes and outcomes:

- the participation of a nucleus of physicians,
- feedback to individual practitioners,
- a supportive organisational culture,
- a conducive external environment (for example, alignment of policy, regulatory and incentive related factors),
- a *"phased coordinated spreading"* approach where top management monitored progress, coordinated efforts and allocated resource.
- bottom-up activities, supported by *"top-down policies that are consistent with the improvement objectives"* as well as the relinquishing of some control by senior managers.

4.4 Examples of Good Practice

Systems insights from health and care

There are cases of systems working in healthcare. And while these are not usually written through the lens of improvement, or innovation, and they are not targeted at an OD audience, we can still extract lessons that are very relevant.

Example 1: Community care in Frome

Challenge: how to overcome the fragmentation of approaches to providing community care support for residents in Frome?

Approach: From April 2013 onwards Frome medical practice collaborated with a group of other practices, and other health organisations, to create a community support hub. Over time this would evolve to provide holistic, human-centred care to more than 43,000 people in the region. This care model included patient identification; goal setting and care planning; enhancement of naturally occurring supportive networks; and linkage to community resource

Results: A 14% reduction in unplanned admissions to hospital, in the pilot area, compared with a 28.5% increase in the remainder of the county through the same time period. Cost savings of 20.8% were reported for a single year of the study, from £5,755,487 in 2013-14, to £4,560,421 in 2016-17.)

Learning: The origin of the idea was nurtured when a member of the GP practice team was attending a leadership programme. The climate for innovation for the practice team improved significantly over a 9-month period. This early nurturing was important. Also, significant time was spent gaining agreement among stakeholders, crossing organisational boundaries, in the early stages of planning. This was intentional, and with a view to securing sustainable change in the future.

Source: Abel et al (2018)

Example 2: Lessons from integrated care

From the following source of NHS England cases, we can infer some common and core lessons:

- ***A clear clinical work focus***. For example, supporting the frail and/or elderly to receive care at home.
- ***Intrinsic motivation to act*** was often driven by staff wishing for clinical improvement for patients.
- ***Urgent need***, (sometimes from COVID), accelerated collaboration.
- ***Target populations were defined***. For example, in providing mental health services across greater Manchester for more than 2000 students to help them move through college, work and university.
- ***Data was captured on impact***. For example, in Dorset, where teams also use a 'virtual ward' approach for frail, elderly people, with GPs, social care, consultants and physios monitoring and intervening quickly to keep people well and independent. In 18 months, unplanned hospital admissions for the area have been the lowest in the three county's hospitals.

Source: https://www.england.nhs.uk/integratedcare/resources/case-studies/

Example 3: Broader reflections from ICS senior leaders

A more explicit reflection on learning is captured from a panel discussion at the NHS Confederation conference in 2019, where 4 system leaders reflected on learning from system working in Surrey Heartlands, South West Yorkshire Partnership NHS Foundation Trust and West Yorkshire and Harrogate ICS, Bristol, North Somerset and South Gloucestershire STP and Sussex and East Surrey STP. Extracts of the discussion are provided below:

The importance of relationships

"We've invested in the chief execs and clinical leaders across all the organisations, making sure we all get to know each other and understand the problems each organisation is facing", explained Claire. "We've also worked on organisational development with our delivery teams, starting to enable that blurring of skill sets and helping people feel comfortable to take on roles that have traditionally been held by others."

"The ICS has also launched Surrey 500, a collective leadership programme for 500 managers from across the partnership and colleagues, as "the more time we can spend together, the better".

"There's also been a focus on the relationship with local people. Claire added: "Our citizens' panel is now up to 3,000 strong, and it is demographically recruited to by postcode, so we know that it is representative of the people, not just those who are shouting the loudest."

Getting the right systems in Place

In 2016, the STP was rated the second worst in the country, and since then, he says success has been measured by finances. "I didn't come to work to look at life through a financial lens, but when you are a deficit system to the level that we were, you have to," he said. "This year, we are the most improved STP area in our financial framework, which has given us the ability to start to write a population health check.

"Why did the money get better? Because of the relationship that we managed to build with every single one of our counterpart provider chief executives."

Adam added that consolidating governance processes such as the commissioning system across the eight CCGs also helped improve the STP's position, with organisations bearing risk together – which he said, "you can only do with someone that you trust."

Organisational Development matters

"Organisational development clearly matters," she said. "It's about getting people to a place where you understand where each other is coming from; where you stop pointing fingers or thinking 'if you just gave me all the responsibility I could sort it out'.

"We've worked really hard on saying 'can we have a shared view about what our challenges are, and then a shared sense of ownership about needing to resolve them?'"

Focusing on a shared destination

An important first step they took as an ICS was to change the mindset – "You're not stuck in traffic; you are traffic". They realised that thinking about the issues they had wasn't going to drive things forward; they needed to come together as a system with a burning ambition for everyone to get behind. Theirs includes their whole patch being healthy and giving everyone the best start in life, support throughout life, and the ability to die in their chosen place at the end of life.

Aligning strategy and governance

Rob adds that for good governance and relationships the local authority must be an equal partner on the ICS board and everything should be fair, open and transparent. For example, they have a joint committee of CCGs that meets in public and can make decisions, as well as joint committees for their acute hospitals and mental health providers, all of which are decision-making.

Source: https://www.england.nhs.uk/integratedcare/resources/case-studies/the-keys-to-achieving-integrated-care/

Systems Insights from other sectors

As with the above cases, we can infer lessons for improvement and organisation development with some translating from the contexts below.

Example 1: Education in Houston - Early Matters

***The challenge**:* In 2013, the majority of children living in Houston were not ready for kindergarten. The 38 percent of children living in poverty were significantly less likely to graduate from high school than their peers. Early Matters, an education-focused collective impact initiative of more than 100 community leaders, formed in response to this data.

***The approach**:* Launched in 2014 by the business and community leaders at the Greater Houston Partnership, *Early Matters* was initially focused on policy change in pre-K issues at the state level. Beyond policy, the coalition was interested in a holistic approach to early childhood education, focusing on the roles of poverty, health, and family stress in supporting child brain development and ultimately school readiness and success.

In 2015, the Houston Endowment engaged FSG consultancy to help expand its work beyond policy into other forms of systems change, clarify goals and indicators for the initiative, create processes and formalize its working group structures, and ensure that a diverse group of stakeholders was actively involved.

The results: Early Matters continues to make progress toward its 10-year goal: by 2025, ensuring all children in the Greater Houston area are reading at grade level in 3rd grade.

***The learning**:*

- *Connected data analysis to coalition decision-making*. FSG analysed data from 50 school districts and 45 charter schools in the Greater Houston area and broke it down by district, race, ethnicity, and economic background. Thirty-five percent of economically disadvantaged children were reading below grade level in 3rd grade, while 29 percent of economically advantaged children were reading above grade level by 3rd grade. Knowing that students are 4 times more likely to drop out of school if they are not reading at grade level by 3rd grade, and after seeing the data this way, the coalition's next move became clear. Early Matters decided to focus on closing this gap and determined that its objective would be to ensure that all students in the Greater Houston area can read at or above grade level by the end of 3rd grade.
- *Engaged members of the community in the 4th largest metro area in the U.S.* The next task was to work with people who interact with young children, such as parents, school officials, social service providers, paediatricians, faith-based entities, and other community members. Early Matters sought out voices from different economic, racial, and cultural groups to better understand the experiences of families across the region. These voices continued to be heard in strategy development, including testing phone apps with parents and using their feedback to select one for promotion.
- *Created structures and facilitating processes across a large and diverse coalition*. FSG helped form 5 working groups focused on different aspects of the early childhood experience, including family support, healthcare, early education settings, K-3rd grade, and policy and regulatory change. FSG and Early Matters also established the administrative home of the backbone function at the United Way of Greater Houston, hiring and coaching new staff to support the growing, multi-faceted work of the coalition. Early Matters also secured grants from 3 local funders to support the backbone, a sign of the broad-based commitment to a new, collaborative approach around Houston to early childhood outcomes.

Source: https://www.fsg.org/projects/improving-early-childhood-education-houston-texas

Example 2: Copenhagen's plans to be carbon neutral by 2025:

The challenge: Copenhagen's plan to be net carbon-neutral by 2025.

The approach: "A green, smart, carbon-neutral city," declared the cover of the climate action plan, before detailing the scale of the challenge: 100 new wind turbines; a 20% reduction in both heat and commercial electricity consumption; 75% of all journeys to be by bike, on foot, or by public transport; the biogas-ification of all organic waste; 60,000 sq metres of new solar panels; and 100% of the city's heating requirements to be met by renewables.

The results: CO2 emissions have been reduced by 42% since 2005, and while challenges around mobility and energy consumption remain, the city says it is on track to achieve its ultimate goal. Also, the Danish capital's carbon transformation has happened alongside a 25% growth in its economy over two decades.

The learning:

- *It took time.* The idea was first floated in the late 1990s.
- *Proper planning and allocation of resources*: "So we made detailed, concrete plans for every area, set the carbon target, and demanded the money and the manpower to make it a reality."
- *Stakeholder involvement*: The mayor in 2010 brought on board more than 200 stakeholders, from businesses to academia to citizen representatives, and helped them develop 22 specific business plans and 65 separate projects.
- *Citizen involvement*: "Moreover, there is a general awareness that climate change now calls for immediate, ambitious and collective action." A 2018 survey by Concito, a thinktank, found that such action was a top priority for voters. Current mayor, Frank Jensen, is keen to stress the cooperative nature of the plan and says "our visions have to be grounded in the everyday lives of people to be politically feasible". Indeed, involving so many stakeholders, and allowing them to actively help shape both the ends and the means, has been key to the plan's success so far and the continued goodwill it enjoys.

Source: https://www.theguardian.com/cities/2019/oct/11/inside-copenhagens-race-to-be-the-first-carbon-neutral-city

4.5 Implications for Organisation Development

1. **Organisation Development professionals**, and others, need improvement and innovation tools to fit the range of challenges they face. Some of these will be incremental; others will be more radical in nature. Across your OD collaborative, you should be equipped with tools and frameworks for the whole continuum of challenges.

2. **Spreading learning about improvement methods and tools** is important. As is being faithful to the methodology, and patient to see results and impact emerge. However, learning about tools and frameworks is the (relatively) easy part. The contextual factors of gaining social, political processes of agreement take more time, and are critical for success. Allocate time and resources to staff to equip them properly to do the full range of work of improvement.

3. **Lessons of sustainable change from system-work** examples tell us that sustainability works best when it's planned early. Change-makers should plan for the wider adoption of their change as an integral part of the change process. This will, inevitably, involve wide stakeholder engagement from early stages, and will also include communicating the results and impact of change to interested audiences.

4. **When improvement work has been successful in systems**, whether in healthcare or elsewhere, several success factors have been common: a clear work scope focusing on a desired future direction; staff selected with the drive and motivation to improve lives for people; the team is given the authority to act; adequate time is spent on stakeholder engagement; there is proper planning and allocation of resources; and data is captured on impact. Systems change takes time and requires discipline, perseverance, and a clear work focus.

5. **The organisational formation of the ICS is an example of innovation**. Its creation will be partly conceived through senior-level plans and concepts. However, innovation is primarily a social process of meaning making, involving different groups joining the conversation at different stages, and re-creating the meaning of the ICS according to their own identities and agendas. These conversations will shape the extent to which the ICS is socially institutionalised.

6. The Surrey 500 leadership programme devoted resources to **bringing together leaders and building relationships based on trust and psychological safety**. This kind of social capital creation will be the foundation of a willingness to collaborate. How might you connect people from different organisations across the system, to build the social capital you need for the work to be done? And how will you secure the social capital gains that have already emerged as a result of collaboration through Covid?

7. A different type of leadership approach is needed, where **senior leaders have to think system first**, and tap into the intrinsic motivation of frontline workers to channel their efforts where they can demonstrably improve the lives of patients. Implementation teams will need to take (moderated) risks; decide how to proceed, with delegated authority to act; and build trusting and safe relationships in order to explore ways not tried before. All of this will involve senior leaders thinking of themselves as powerful connectors and enablers of others, rather than having all the answers.

5. EQUALITY, DIVERSITY & INCLUSION

5.1 KEY INSIGHTS FROM THEORY, RESEARCH, POLICY AND PRACTICE

Critical Race Theory

Critical Race Theory (CRT) in its broadest sense refers to the need to critically examine social issues through a current and historical understanding of race. As Delgado and Stefancic (2013) highlight, CRT refers to a collection of work by scholars and activists interested in transforming the relationship between race, racism and power. This body of work originated in the 1960s in study of law, by authors such as Derrick Bell and Kimberly Crenshaw, it has been utilised across various disciplines and subject areas.

One of the basic tenants of CRT argues that whilst there are some biological differences between individuals who are typically perceived as Black or white, race is fundamentally a socially constructed and historically informed concept. Thus, to understand race and racialised issues, it is imperative to understand context and complexity of this socially constructed idea.

Critical Race Theorist, Kimberly Crenshaw, is particularly well known for coining the phrase "intersectionality". Crenshaw (1989) utilised this word to discuss how race, gender, class and other identities intersect. By examining the legal context in the US, she argued that the experience and challenges encountered by those with intersecting identities, is inherently different from the experiences of those who have experience of just one part of that identity (e.g. the experience of Black women is not the same as a simply adding the together the experience of Black men and white women). This understanding of complexity shifts us away from colour-blind or one-size-fits-all approaches, acknowledging the need for adaptivity and on-going reflexiveness in order to create impactful change.

When it comes to organisation development, this approach informs us of the complex, historic, social and dynamic nature of identity. As such, it is important to understand how racialised identities emerged in a given context and how this is connected to the experiences of individuals today. Critical Race Theory also encourages a critically aware understanding of the intersection of identity in all its complexity; gender, sexuality, and disability must be considered in relation to race.

Post-colonial and Decolonial Theories

Post-colonial theories aim to critically examine history and the impact of colonisation. It is an approach which aims to connect the past with the present by exploring historic events and considering what impact these events might have on our organisations, systems, processes and ways of thinking. Decolonial approaches build on this concept but seek to go further in undoing the process of colonialisation.

Strangely, decolonial theory, which consists of a wide ranging and expansive body of work that broadly seeks to verify and deepen our historic understanding, has been widely misrepresented as an attempt to erase or make invisible British /colonial history. It is in fact the opposite of this, as many decolonial theorists assert that the initial stage of decolonisation and repair is to truthfully and holistically understand the past in all its complexity. When it comes to organisation development it is asserted, historic blank-slate thinking is discouraged as it is asserted that change cannot be meaningful or inclusive unless it is grounded in an understanding of the past.

In the present day it is argued that postcolonial and decolonial theories can help us to understand the current structure of the NHS, the stereotypes and assumptions encountered by marginalised individuals, health inequalities and issues such as vaccine hesitancy.

Another important dimension of decolonial theory is to recognise how assumptions and stereotypes (pertaining to race, gender, disability and sexuality) that emerged from the colonial period remain deeply embedded in our psyches and societies today. Work such as Fanon's (1952) seminal decolonial text entitled 'Black skin, White masks' highlights how even Black, Asian or Minority Ethnic individuals may need time to deconstruct and understand the beliefs which they might not normally question. In regard, to organisation development this theoretical insight, highlights the need for sustained and ongoing deep work with all individuals involved. Lived experience, whilst extremely important, should not be conflated with or seen as a short cut to understanding complex and historically informed racialised issues.

The Social Model of Disability & Crip Theory

As highlighted by Oliver and Barnes, **the social model of disability** attempts to break the causal link between impairment and disability. The 'reality' of impairment is not denied, but physical impairments are not viewed as the cause of disabled people's economic and social disadvantage. (Oliver and Barnes, 2010). Furthermore, rather than focusing upon physical difference, it is argued that that there is a need "to embrace disability as an asset and as a different way of working" (Brown, 2020).

Crip theory is a term initially defined by McRuer in the 1990s. In order to challenge perceived bias in disability studies, various theories were developed to explore disability where it intersected with other identities. Schalk (2013) asserts that crip theory thus allows the margins of disability studies to engage with other minority/identity discourses, in substantive and lasting ways. The term and theoretical genre has caused some controversary, as crip theory intentionally attempts to reclaim the term cripple, in order to disrupt normative narratives.

> *"Crip is shorthand for the word "cripple" which has been (and is) used as an insult toward people with disabilities, but which has been re-appropriated as an intra-group term of empowerment and solidarity." (Schalk, 2021)*

Identity Politics & Queer Theory

Identity politics refers to organising politically around the experiences and needs of people who share a particular identity. Arguably, the term is closely connected to the 1970s Black feminist movement and to the Stonewall riots which laid the foundations for the LGBTQ+ civil rights movement which spread across the globe. In 1974 a group of Black women known as the Combahee River Collective published "A Black Feminist Statement" which defined this term. Black womanist and queer author, Audrey Lorde, was one of the founding members. They state

> *'Above all else, Our politics initially sprang from the shared belief that Black women are inherently valuable, that our liberation is a necessity not as an adjunct to somebody else's but because of our need as human persons for autonomy' (The Combahee River Collective, 1974)*

Drawing from the feminist principle 'the political is personal, and the personal is political', the Combahee River Collective asserted that solidarity could only be found through the recognition of difference. That their experiences are different to white women or Black men and that too often the issues that they face are not addressed when issues of race or gender are examined separately.

The Combahee River Collective statement on identity politics emerged after the 1969 Stonewall uprising which was led by Black trans women, Ms. Rivera and Ms. Johnson, after police raided the Stonewall Inn. The concept of identity politics asserts that for social change to happen, activism must not shy away from the specific issues faced by specific identity based groups whilst building solidarity with groups facing different challenges.

Queer theory challenges the normative social ordering of identities along the heterosexual/homosexual binary and the way that heterosexuality is viewed as 'natural' and homosexuality as its deviant (Browne and Nash, 2016). Like crip theory, queer theory emphasises the importance of recognising the intersection of identities and of reclaiming terms that were once viewed as derogatory.

Arguably, Queer approaches became visible in the HIV/AIDS activism in North America in the 1970s and early 1980s. It remains a term more widely adopted in North America than in the United Kingdom. In preference to defining oneself by a specific identity many queer scholars choose this term in order to often resist the binaries of identity - heterosexual/homosexual, man/woman etc. Queer theory is particularly helpful in understanding the ways in which complex identities can be explored without forcing individuals into boxes.

5.2 FRAMEWORKS, METHODS, APPROACHES AND EVIDENCE OF IMPACT IN PRACTICE

Data highlights that staff members in the NHS experience disproportionate harm as a result of their work. For example, in January 2021 the BMA reported that 63% of healthcare workers and 95% of doctors who died from COVID-19 were BAME (BMA, 2021).

The causality of the harm is contested, whilst the BMA has proposed that discrimination and disproportionate access to PPE may be a factor, the UK Government has disputed this. What we do know is that year-on-year, staff with protected characteristics in the NHS report higher levels of workplace discrimination. The 2020 staff survey suggested 10.2% of BME staff in CCGs personally experienced discrimination at work from a manager, team leader or other colleagues, this was compared to just 4.4% of white staff (NHS, 2020).

Furthermore, authors such as Williams note the weathering effect of discrimination and assert that experiences of discrimination are directly related to an individual's physical and mental well-being. Regardless of debates of causality, it is argued that approaches to organisation development should consider the need to adequately support staff members should they encounter discrimination or work-based harm. The likelihood of encountering harm appears connected to identity, with those who identify as having protected characteristics being more likely to encounter these experiences.

It would undoubtedly be better to eliminate any potential for harm and discrimination. However, if one accepts that the potential for harm and discrimination cannot be immediately eliminated, then support should be incorporated into considerations of organisational change. Furthermore, any support intervention should be designed with due consideration to accessibility and appropriateness.

Identity-focused Networks

Network approaches to change are increasingly being adopted across the NHS (Ferlie et al, 2013) and offer the potential to span the divide between a focus upon the individual and a focus upon the system. In relation to inclusion, however, network approaches may be tokenistic where groups act in isolation, devoid of ability to influence wider systemic change. Particularly where networks are not supported by financial and time resources it has been argued that the expectation for marginalised individuals to participate within networks can be exploitative as membership is often unpaid and not considered as part of everyday work.

A 2018 study on LGBT+ networks in the NHS found that they were lacking in both gender and sexual diversity, with the largest group being gay men (41.8%), then lesbians (22.4%), trans individuals (9.1%) and bisexuals (3.6%). (Einarsdóttir et al., 2020).

Networks also are usually not good at supporting those who don't publicly identify. Only 2% of network members are not open about their sexuality, compared to 37% of those who have never been involved in a network (Einarsdóttir *et al.*, 2020)

Counselling and support

An organisation must look after its staff especially when there is risk of harm, or harm has been caused as a result of work. This is a major issue for the NHS and initial feedback is that BAME staff members are most affected but not being offered culturally appropriate services.

Nilaari is a Black, Asian and Minority Ethnic (BAME) led community-based charity in Bristol that provides culturally appropriate free counselling. As an organisation critically aware of culturally appropriate therapy and a lack of BAME therapists, their diverse staff team delivers culturally appropriate and responsive social care support and talking therapies. Nilaari leads a partnership with Bristol Black Carers and Bristol Somali Resource Centre, working to support anyone from a BAME background who experiences mental health difficulties or emotional distress. This helps prevent mental health deterioration.

Janette Francois is a scholar who explores how time could be utilised as a form of reparation. The emotional labour of racial abuse takes time, crawling up the career ladder takes time, unpaid labour in explaining lived experience and racism takes time, working more because you earn less takes time. Time could be one of the most significant and unexplored mechanism for creating change.

In response to the unequal negative health impacts of Covid-19 on the BAME community and the collective trauma of the anti-Black violence brought to light by the international Black Lives Matter movement, Loughborough University granted two weeks of pre-approved optional compassionate leave for BAME staff. This policy falls under the legal heading of 'positive action' in relation to the Equality Act 2010.

Communication & Advocacy

Data recently published by MBRACE-UK (MBRACE-UK, 2018, 2020) highlights that Black pregnant women are four times more likely to die in pregnancy or childbirth in the UK and eight times more likely to be admitted to hospital with Covid-19 than white women.

Deaths at work would typically be reported and would lead to a public inquiry. Under new COVID regulations this hasn't happened. 95% of healthcare workers who have died are BAME and many have asserted that discrimination was a contributory factor. The families are now campaigning for an inquiry. But the lack of inquiry is harming staff trust across identity and the organisational culture particularly in regard to safeguarding. If safe and inclusive organisations are to be developed we need an open and transparent process to assess what happened.

Organisation Development can provide an important forum for the sharing of lived experience and mobilising groups and organisations in response to significant issues. An example of a professional group supporting this work in the NHS is the Association of South Asian Midwives (ASAM), which offers a platform for the South Asian Midwifery Workforce and birthing community to share their stories.

OD can also support the development of advocacy and public speaking skills. The LGBT rights organisation Stonewall cites the example of the Sussex Partnership NHS Foundation Trust 'Expect Respect' campaign which led to the number of staff saying that they had experienced harassment or abuse because of their sexual orientation falling by half.

Trade unions and professional bodies have proven to be powerful advocates for staff during COVID, who could also collaborate more closely with professional groups and organisations to bring about change. During the Covid pandemic, for example, the British Medical Association (BMA) conducted a series of surveys that have consistently found concerning disparities in doctor's experiences by ethnicity. Which has led to concerns that occupational factors, such as more staff from BAME backgrounds working in patient-facing roles, workplace culture and the supply of PPE may also contribute to the disproportionate impact on BAME healthcare workers.

Champions

There are two distinct schools of thought on the idea of champions. First, it is a way of individuals leveraging their positional power and personal privilege as a mechanism for leveraging organisational change. It also is a way of practically facilitating change without burdening those who are most affected and potentially least responsible. It has its benefits. However the second school of thought sees championing as a form of saviourism that typically centres the voice of those who are least effected whilst marginalising those who are. It can be used as a form of careerism and be driven by ego and tokenism. Where those with lived experience are utilised as champions it can put marginalised individuals further at risk. This can be powerful, but the skill involved in doing this properly is often underestimated. The process has to be negotiated with those who do have lived experience so action is taken in an appropriate and ethical manner.

5.3 Inclusive Environments, Systems and Processes

Data and Accountability

Accountability broadly refers to how you ensure and demonstrate responsible action. In regard to organisation development, it is evident that equality data can be used to assist on-going identification of inequality and barriers to inclusion. Furthermore, accountability mechanisms, such as the Workforce Race Equality Standard (WRES) or the Workforce Disability Equality Standard (WDES), can be utilised to set inclusion standards and to monitor change against those standards in organisations. However, when it comes to equality, diversity and inclusion, there is no universal agreement about what constitutes responsible action or how to measure it. Data collation and terminology pertaining to identity is notoriously inconsistent, and many individuals have noted a struggle to achieve practical change against defined standards.

The NHS **Equality Delivery System (EDS2)** and **NHS Staff Survey**, which have been in operation since October 2010 and April 2012, rely upon rigorous engagement with staff on key issues, such as discrimination, harassment and having fair and transparent processes by providing supportive and family friendly flexible working arrangements, improving diversity at all levels, tackling harassment and discrimination and developing the skills and talents of all staff to improve service delivery and have better outcomes for staff and patients.

In 2020, for the first time the NHS survey included data on staff member's experience of work during the COVID pandemic, demonstrating a differential of 47% to 31.1% of BME vs white staff working on a Covid-19 specific ward or area during the pandemic.

The **Workforce Race Equality Standard (WRES)** highlighted that whilst the proportion of BME staff members had increased to 21%, just 10% of board members and 9.2% of staff at AfC pay bands 8c and above are from a BME background.

Inclusive Recruitment & Promotion

White applicants were 1.61 times more likely to be appointed from shortlisting compared to BME applicants (NHS, 2020). Inclusive recruitment and promotion can contribute, but typically the impact is not significant unless embedded within a more holistic approach. And it is typically only utilised for lower level jobs, not helping with leadership, which is where change can best be effected.

Just 40.7% of BME staff believed that their organisation provides equal opportunities for career progression or promotion compared to 88.3% for white staff (NHS, 2020) As above, research shows that a lone initiative typically has little impact, but can be beneficial if part of wider systemic change.

Research on the impact of **positive action initiatives** highlights that interventions primarily benefit white women. Quotas and positive action approaches are widely misunderstood and often believed to be a process whereby unqualified individuals are recruited instead of majority candidates. Whilst

data highlights that initiatives are typically successful in increasing representation, the effect typically is not sustained as staff will quickly leave or be removed from organisations that fail to address wider systemic issues. They can have impact but must be carefully designed, well communicated and embedded within a wider systemic process to have any chance of success.

Accountability: Organisation Development and Legal Duties

The **Public Sector Equality Duty (PSED)** is made up of a general equality duty supported by specific duties. The general equality duty is set out in section 149 of the Equality Act 2010. This is the same for England, Scotland and for Wales and it came into force on 5 April 2011. The specific duties are created via secondary legislation. These are different for England, Scotland and Wales. The full text of the general equality duty and the specific duties for England can be found at the end of this guide.

The public sector equality duty is the title of the duty, and how it is referred to in the Equality Act. It consists of the general equality duty which is the overarching requirement or substance of the duty, and the specific duties which are intended to help performance of the general equality duty. (*The Essential Guide to the Public Sector Equality Duty | Equality and Human Rights Commission*, 2014)

The **Care Quality Commission (CQC)** is legally required to set equality objectives under the Equality Act 2010. The CQC equality objectives were: 1. Person-centred care and equality; 2. Accessible information and communication; 3. Equality and the well-led provider; 4. Equal access to pathways of care; 5. Continue to improve equality of opportunity for our staff and those seeking to join CQC. The well-led dimension of the CQC's work questions whether the leadership, management and governance of the organisation make sure it's providing high-quality care that's based upon individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture. From April 2017, the CQC stated that they would support inspectors to look more closely at the equality aspects of the well-led key questions which inform the CQC inspection.

Pay Gap Reporting

Whilst unequal pay between women and men for doing work of equivalent value would be a direct violation of the Equality Act (2010) the NHS's mean gender pay gap is calculated utilising the current UK government guidelines, whereby the difference is taken from the mid-point hourly salary for men and for women.

Introduced in 2017 Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between their male and female employees.

Unlike the gender analysis there is no legal obligation for employees to report their ethnicity pay gap. However in 2018 the office for National statistics undertook an ethnicity pay gap analysis and found notable differences between ethnic groups. For example, it was noted that employees from the Bangladeshi ethnic group, on average, earned 20.2% less than White British employees (*Ethnicity pay gaps in Great Britain - Office for National Statistics*, no date)

Due to the impact of Coronavirus (COVID-19), the Equality and Human Rights Commission (EHRC) have announced that enforcement of gender pay gap reporting for the 20/21 reporting year will not begin until 5 October 2021.

Accessibility & the Physical Environment

The **Built Environment** touches on co-creation in accessible design. For example, making toilets accessible for everyone and discussing the topic of gender neutral toilets.

Recent data on **homeworking** from the 2020 NHS Staff Survey has noted that BME staff members are less likely to be able to work from home than white staff members (29.0% vs 37.7%). A factor which has led inevitably to differential exposure to the Covid virus and which may have led to the disproportionate impact upon staff fatalities.

Addressing Technological, Bureaucratic & Administrative Barriers to Inclusion

Digital Inclusion

The UK Government has expressed a national commitment to digitally transform the NHS and improve interoperability across the health and care system. There are local pockets of high digital maturity in the NHS but there is still a long way to go, to fully realise the tech vision and the benefits case outputs for patients. As highlighted by Health affairs 'the COVID-19 pandemic has spurred a dramatic acceleration in digital health including telemedicine, remote monitoring for chronic conditions, and mobile apps for contact tracing, as well as school and small-business safety monitoring' (Health Affairs, 2021).

However, this rapid expansion of technology raises serious concern regarding whether accessibility and inclusion have been factored into considerations of organisational change. Crawford and Serhal (2020) highlight that we do not yet have sufficient data to understand the multiple ways in which digital determinants of health may impact digital health equity. Whilst their inquiry is at an early stage they propose the following framework to explore digital health equity.

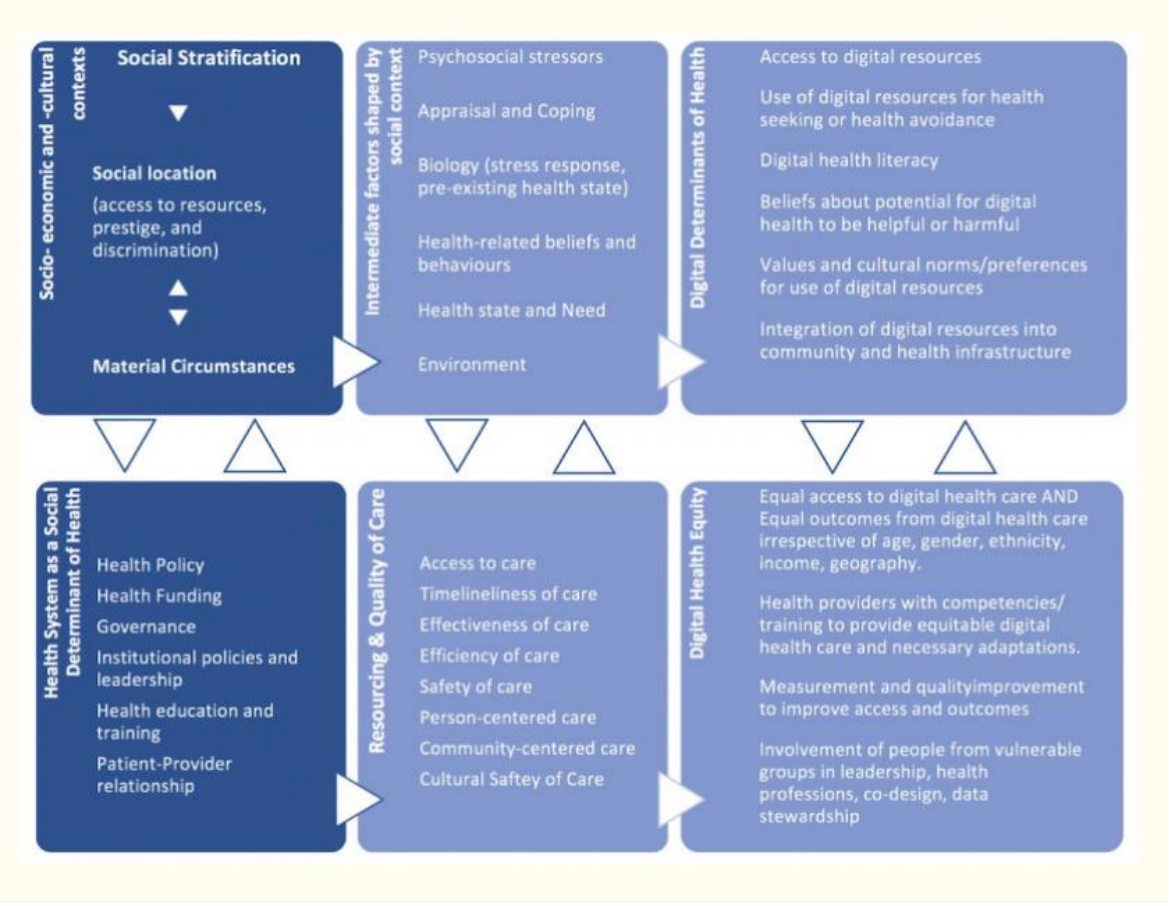

Figure 8 - Digital Health Equity Framework
(Crawford and Serhal, 2020)

Mainstreaming

The concept of **gender mainstreaming (GM)** emerged out of the World Conference on Women in 1995. Whilst this approach was championed by the United Nations and embraced by numerous organisations internationally it did not appear to garner the same interest in the United Kingdom. Broadly, gender mainstreaming, can be considered as a means for 'infusing mainstream policy agendas with a gender perspective and transforming the institutions associated with them' (Eyben, 2010: 159). Gender mainstreaming does not just consider the issues and challenges affecting women in organisations. It is an approach that considers the relationships, power and processes that are

affected by gender-based issues. Thus, it holistically considers issues affecting men, women and non-binary individuals.

Gender mainstreaming is the responsibility of all actors. Gender mainstreaming ensures that the perspectives of women and men, girls and boys, and the relationship between and among them, are considered and acted upon throughout the cooperation process. It is not only a women's issue. A single standard mainstreaming requirement for all interventions will not suffice. The shape and form of mainstreaming has to be adjusted to the context and the surrounding society. Sida's model for gender mainstreaming includes three steps.

1. **Gender analysis:** Sida asserts that the mainstreaming process should always begin by analysing the gender equality situation in the given context and identify the expected results in terms of strengthened gender equality.
2. **Identify how:** Based on the gender analysis, Sida must identify relevant areas for collaboration, the approach to use and how to reach the expected results.
3. **Three main approaches:** These may be implemented separately or in combination:
   - Integration of gender equality in interventions in general
   - Targeting specific groups or issues through special interventions
   - Dialogue with partners on gender sensitive issues and aspects

https://publikationer.sida.se/contentassets/9d450477fa6b49be81a77ded3c2e474a/gender-tool-mainstreaming.pdf

Feminist Bureaucracy & Subversive Leadership

We might see bureaucracies as instruments of discipline that work to maintain the status quo, sometimes despite the best intentions of those within working for change. As Eyben notes, much of the debate on gender mainstreaming concluded that it failed as an instrument of transformation, because it has had to work within existing paradigms and organisational forms (Eyben, 2010).

The strategic solution is to use what Clegg (1989) describes as 'outflanking manoeuvres' to reinforce discursive change and to further unsettle the status quo. The strength of this concept is its focus on political activity rather than, as in 'gender mainstreaming', on organisational change. It sees networks and alliances across and between organisations as the instruments for changing power, while formal organisations (perhaps with their own conservative networks) tend to be preservers of the status quo.

> *"Feminists working inside international organisations can mobilise human and financial resources through alliance-building, being aware of and making use of networks within and beyond their own organisation to support their agenda. Alliances with civil society networks help the latter gain access to financial resources. Facilitating an alliance of lobbyists' access to policy spaces is strategic, provided the transformative agenda is a clear shared goal and that both the insider activist and the alliance leaders do not let the logic of the bureaucracy co-opt the alliance to its own agenda of conserving the status quo." (Eyben, 2010).*

5.4 Leadership Approach, Individual Change and Inclusive Practice

Utilising Leadership as a lever for Change

In 2018 Health Education England defined **inclusive leadership** as "leading by example, demonstrating a commitment to progressing equality, valuing diversity, and providing challenge where needed if staff are experiencing bullying, harassment or any other form of negative experience" (2018). Broadly, inclusive leadership can be regarded as a holistic approach that engages leaders, regardless of identity, to enhances their inclusive practice and which builds the capacity of individuals to leads organisational change on inclusion.

In discussion of '**feminist leadership**' Batliwala (2011) talks explicitly of power and how leadership approaches should be value-driven to create equity of power. In her model of feminist leadership, Batliwala distinguishes between leadership values and leadership principles. She states values are the ethical norms that guide behaviour; principles are norms that guide action'. For instance, 'equality and equity are values as well as principles; but functioning in democratic, transparent and accountable ways are principles derived from the value of equality'.

Inclusive Practice, Behaviour Change & Organisational Culture

Disabled staff are 10.7 percentage points less likely to say that they feel their organisation valued their work when compared to non-disabled staff (37.2% vs. 47.9%) (NHS England, 2020).

Cultural Competency, Unconscious Bias & Implicit Bias Training

Research has repeatedly demonstrated the existence of unconscious bias. For example, in the United Kingdom we are aware that 5 times more Black women will die in child birth than white women. One reason proposed for this disparity is that studies have shown that doctors will act differently to distress and reports of pain expressed by Black women. Studies have also highlighted that Black men are more likely to be perceived as dangerous when experiencing a mental health crisis. This in turn seems to be connected to the number of Black men arrested when in crisis. However, whilst evidence highlights the existence of unconscious bias, research has shown that unconscious bias training typically has a neutral or even detrimental impact. Particularly when the training is not embedded within a broader holistic approach it is not viable to expect immediate behaviour change. What emerges instead is resentment and a cheat sheet for avoiding accountability on problematic behaviour. The inference that the behaviour is unconscious negates the possibility that actions are conscious.

Allyship Training

As interest and enthusiasm for unconscious bias and cultural competency training has grown, interest has gathered in allyship and anti-racist training. Many individuals seek to take action on issues that do not directly affect them.

Whether action is taken on issues relating to gender, race, sexuality or disability, the process of being a good ally is usually more complex than people first assume. Good intentions are not enough. Allyship training helps individuals to understand how to act ethically and safely in order to help others.

Allies are members of dominant social groups (e.g., men, Whites, heterosexuals) working to end the system of oppression that gives them greater privilege and power based upon their social group membership (Endres and Weibler, 2017). Whilst good intentions are easy, individuals need to learn how to become allies. The process requires trust between those involved and a critical reflection upon your own actions.

Stonewall's Workplace Trans Allies programme is designed to "empower[s] attendees to be active and positive allies who work to create more inclusive workplaces for all trans people".

> *"I am determined to support my trans colleagues and customers on a journey where the destination is hopefully true equality for all. As an ally, I take responsibility to consistently influence our working culture and practice to be inclusive and take a zero-tolerance approach to bullying, harassment and discrimination" (John Glenton, Executive Director of Care and Support, Riverside Housing)*

5.5 EXAMPLES OF GOOD PRACTICE

Systems insights from health and care

Case Study: Building Leadership for Inclusion

In April 2017 a team from Bristol Leadership and Change Centre at the University of the West of England (UWE) was appointed by the NHS Leadership Academy to facilitate action research to support the process, capture learning and evaluate the impact of Building Leadership For Inclusion (BLFI) – an ambitious new initiative that aimed to:

1. Raise the level of ambition on inclusion
2. Quicken the pace of change towards inclusion
3. Ensure that NHS leadership is equipped to achieve and leave an ever increasing and sustainable legacy of inclusion

At the procurement stage the tender document highlighted that BLFI sought to identify a partner that could 'travel the journey' and act as a 'critical friend' for the team leading the work. Responding to these aspirations a multi-disciplinary research team was put together, comprising a range of methodological expertise, subject knowledge and lived experience.

Through the proposal document and subsequent consultation with the programme leads and facilitators a participative, action-informed approach referred to as 'Collaborative Inquiry' was developed and implemented. Whilst designed specifically to meet the needs of this commission, this approach is informed by a range of concepts and approaches which have been utilised globally in practice-based settings (such as in schools, hospitals, charities and businesses) in order to engage critical thought and to address real-world problems. This approach can be considered as a particular type of action research, which is aligned to the ontological and epistemological assertions that are common within this methodological genre.

Further details: https://www.leadershipacademy.nhs.uk/resources/inclusion-equality-and-diversity/blfi-2/

Case Study: The DIPP Programme

The NHS leadership Academy requires all facilitators to take part in a one day course module 'Diversity, Inclusion, Power and Politics' (DIPP). The course covers a wide-range of areas including anti-racist practice and decolonisation. Feedback from delivery of DIPP has been highly, with many racial majority individuals commenting how this was the first time they had considered inclusion and inequality in depth.

Case Study: NHS Reciprocal Mentoring for Inclusion programme

Reciprocal mentoring provides opportunities for individuals from under-represented groups (such as BAME, LGBTQ+, disability) to work as equal 'partners in progress' with senior executive leaders in a relationship where knowledge and understanding of both sides of lived experiences creates awareness, insights and action that directly contributes towards the creation of a more equitable and inclusive organisation where the factors that generate inequity are positively and proactively addressed.

https://www.leadershipacademy.nhs.uk/programmes/reciprocal-mentoring-for-inclusion-programme/

Systems insights from other sectors

Case Study: A2i Dyslexia Support

A2i dyslexia support was established after it was recognised that Black individuals were less likely to be assessed for dyslexia and that neuroatypical Black individuals are less likely to receive practical supported in school or workplace. A2i's approach is informed by Critical Race Theory, which recognises the difference of experience of Black and white neuroatypical individuals. The organisation seeks to counter historically informed stereotypes of intellect and the high exclusion rates of Black children, by working with teachers, Black parents and Black students to discuss neurodiversity and their rights of individuals to access assessment and support. In the workplace, the organisation recognises the existence of systemic and institutional discrimination as it carefully advocates on behalf of adults who may have been denied reasonable adjustments. As an explicitly Black-led organisation, it utilises its positionality to build trust with those who may already fear discrimination and stereotyping in regard to their perceived intellect and capacity.

Source: https://a2idyslexia.org.uk/

Case Study: Ladders4Action, Knowledge is Power Campaign

Following the NHS inquiry into the disproportionate impact of COVID upon BAME communities in the UK, the Government announced supplementary funding to support further inquiry on this subject area. This funding partially arose as Black, Asian and Minority Ethnic Communities and NHS staff members had felt that the NHS inquiry had not sufficiently addressed their primary concerns. When the allocation of funding was announced, it became apparent that from the £4.3 million allocated, no Black principal researchers were funded. Furthermore, it was noted that one of the assessment panel participants was a co-investigator on 3 of the 6 successful awards and had written/worked with at least 6 of the 7 recipients previously.

Following this event, 10 Black women working in research wrote an open letter to the United Kingdom Research Institute to highlight their concern regarding research funding inequality. The letter garnered the support of nearly 3,000 individuals and led to widespread critical reflection about the nature of research and how it is funded.

As a result of this action various organisations in healthcare and higher education have reassessed how they generate knowledge and how potential bias in the research process might impact upon research/evidence informed action.

https://knowledgeispower.live/

Case Study: Voluntary Ethnicity Pay Gap Reporting, Network Rail

For the past two years, Network Rail has voluntarily collated and published its ethnicity pay gap data. Calculated in accordance with Government regulations for calculating gender pay gaps, Network Rail noted a 2.3 per cent decrease over the past year. The gender pay gap data forms part of a broader initiative, the Race Matters project, which is designed to foster and support systemic organisational change.

> *"Our Race Matters project is helping us to better understand the barriers BAME employees and candidates face and what we need to do to level the playing field. To do this, we must first understand the root cause of the issue, so that we are better able to fix any systemic problems at the source. A tremendous amount of work has gone into trying to understand*

more about how our internal processes and procedures could be negatively impacting our BAME colleagues" (Andrew Haines, chief executive, 2021)

https://www.networkrail.co.uk/who-we-are/diversity-and-inclusion/ethnicity-pay-gap-report/

5.6 Implications for Organisation Development

1. **Embrace Complexity:** The theories in this section highlight the complexity of identity and the need to understand individuals in their entirety. It is unlikely that individuals without lived experience of marginalisation, discrimination and/or exclusion would ever be able to fully understand the experiences and complexity of views and perspectives of their workforce and marginalised staff members. Rather than majority individuals trying to speak on behalf of others it is more ethical to ensure that genuine and meaningful inclusion is integrated into the OD process and that any knowledge created for OD purposes incorporates the perspective of marginalised individuals from the outset.

2. **Do not seek out simple solutions and blueprints for change**: Many individuals seek clear and consistent answers and guidance for change. However, because people and contexts are so complex OD professionals must resist the urge to locate fixed blueprints and instead they must work collaboratively with staff members to identify, explore, act and reflect upon the change process. OD initiatives must be inclusive from start to finish.

3. **Inclusion in the OD process and in knowledge creation:** Part of the decolonising process is about recognising complexity and different ways of knowing. It is important to allow space for this within the OD process.

4. **Critically examine normative assumptions and understand the history of context**: Discrimination typically emerges despite good intentions. Particularly where a process has been guided by majority individuals, it is vital to critically examine majority views and common sense to ensure that decisions have not been influenced unduly. Understanding the history of the NHS and how identity-based stereotypes emerge will help individuals to remain alert to flawed assumptions.

5. **Staff and harm**: Human Resources (HR) and organisation development (OD) professionals should adequately support staff members that encounter discrimination or work-based harm. The likelihood of encountering harm appears connected to identity, with those who identify as having protected characteristics being more likely to encounter these experiences. You will need to do collaborative, co-produced research to understand this, and a lot of work is needed. The most significant issue is about reversing the power dynamics of accountability when it comes to staff, so that those exposed to harm have true influence over process and desired outcomes.

6. **Data and accountability:** When it comes to equality, diversity and inclusion, there is no universal agreement about what constitutes responsible action or how to measure it. Data collation and terminology pertaining to identity is notoriously inconsistent, and many individuals have noted a struggle to achieve practical change against defined standards. It is exceptionally important to co-construct data and accountability mechanisms with a diverse group of stakeholders. To critically assess proposals for agendas and bias and to ensure any proposed tools and frameworks are appropriate and practical. When using data to make decisions in the OD process, those involved must understand how the data was constructed and differentials in identity assumptions in construction of the data.

6. TALENT MANAGEMENT

6.1 KEY INSIGHTS FROM THEORY, RESEARCH, POLICY AND PRACTICE

Talent Management has many definitions depending on industry sector and company. In general, the term can be broken down into two parts. First, 'Talent' which refers to individuals who are seen as being able to make an extraordinary contribution to the organisational performance. Second, 'talent management' which is the systematic identification, attraction and retention of individuals who are of particular interest to the organisation either because of their ability to achieve high productivity or those that have a crucial skill needed by the organisation.

Talent management has moved away from purely recruitment activities into the auspices of a management activity. Therefore, line managers become particularly important in recognising internal skills development and protecting learning by current employees.

There is also more importance on identifying skills gaps in order to predict where investments will benefit both employees and the organisation. Talent no longer just refers to the 'top talent' or heroes or the organisation, but is seen as part of performance management and employee retention. Today talent management strives to be 'something you look for in employees' as described by Eugenio Pirri, VP of OD at the Dorchester collection. If an organisation embeds talent searching in this way, it must also be cognisant of the language around talent in order to ensure that diversity and inclusion are a part of talent spotting.

The features of talent management typically focus on certain areas depending on the organisation's needs but could include: talent acquisition, succession planning, life-long learning, leadership development, career management, employee engagement and retention. However, it is important to first identify the individuals that you want to cultivate as your talent pool. This section focuses mainly on the attraction of talent and the opportunities to retain such individuals.

Typically, the NHS has focused on its value as a good employer; as a good place to build a career and a great place to work. However, this is not a universal experience for staff. Whilst many individuals would report that the NHS is a great place to work, people do leave the service for reasons including: perceived lack of opportunity, little work-life balance, no clear career path, too much reliance on goodwill of staff, and harassment and bullying.

There are different needs depending on where employees are in their career path. Staff at the beginning of their career do not always have the required level of management support, in particular during transitions to roles with increased levels of responsibility. This can result in reduced levels of engagement and poor mental wellbeing, and in turn may make them more likely to leave the NHS.

There is a need for a greater understanding of the generational shift that is occurring in the workforce and the implications this may have for meeting the needs of staff. More needs to be done to support new staff, including continuing professional development and ensuring that staffing levels do not lead to an over-reliance on newly qualified staff. A key part of this will be giving less-senior staff clearer progression pathways.

Retention is largely a result of other aspects of people's experience in work. It is directly related to the leadership and culture of the organisation. People leave because they feel overworked, underpaid, poorly treated, unable to deliver good care, unable to progress, or some combination of all these things. It is important to understand how all these factors influence people's desire to stay in the NHS.

The NHS needs to understand its role as part of a wider labour market and how it can work better in partnership with social care rather than competing with social care for staff. Given the ambitions in the long-term plan for greater integration between health and care, this should be embraced.

In summary:

1. Retention is a key issue in general for the NHS. Consider flexibility in work rotations to meet the needs of the Trust but also the individual. (See NHSBT-VBR- case study)
2. Recruit and develop staff to optimise skill mix and productivity. Using methods to motivate employees such as job crafting.
3. Represent the Diverse Community it covers and have more BAME staff especially in Senior leader roles. Proactively reaching out to potential candidates through networks. Mentorship and secondment for candidates to gain experience in leadership and other roles.
4. Address an ageing workforce through better recruitment and flexible working practices to retain knowledge whilst still provided flexibility in work patterns. Creating opportunities for returners and methods for transitioning to retirement workers.

6.2 FRAMEWORKS, METHODS AND APPROACHES CONSIDERED TO BE GOOD PRACTICE

The NHS already has a robust recruitment model through value-based recruitment (VBR). The VBR uses pre-screening assessment; value based interviewing and assessment centre approaches. These can elicit illuminating responses from candidates but it is a long process and can be daunting to those new to career recruitment. The candidate process is lengthy, time consuming, and can be confusing with HR jargon.

There seems to be a strong push for VBR in the literature and examples from Foundation Trusts around the country (e.g. ELFT, Moorfields, St. George's London, Cardiff and Vale, Oxford University Hospitals), Source: ELFT. (2020)

NHS Health Education England has published a values tool to help Trusts link their values to the NHS Constitution. There is also a tool to help prospective candidates assess themselves against the values in order to gauge whether the NHS is a good fit for them.

The VBR is closely aligned to the literature of Person-Organisation fit. It has long been recognised that individuals whose ideas, interests and beliefs that align with the organisation's will have a higher rate of job satisfaction and performance productivity. However, there is a downside to Person-Organisation fit with employees feeling pressure and stress to 'fit in' with prima facie values. A balance should be struck between promoting organisational values and allowing employees to be unique.

More recently, health care research has turned its focus to recruitment of health professionals who are also aligned to the communities they serve ensuring that professionals can work with specific target populations. With concerns over the continuity of care and the impact of high staff turnover, some health organisations are turning to incentives of additional training, providing educational time off or other related perks that would enrich an environment and retain well trained practitioners.

6.3 THE EVIDENCE OF IMPACT FROM USE IN PRACTICE

The National Blood Service has been successful in increasing its pool of recruitment candidates and in their retention through using the VBR model. The NHSBT re-designed their recruitment materials to reflect desired values and behaviours and to focus on the person specification rather than the traditional job description. The NHSBT saw an increase in higher quality candidates but had fewer overall applicants. Applicants self -selected based on the new standards put forward by the NHSBT (NHSBT, 2021).

The results were encouraging: a 79 percent increase in views of the job adverts and with 95 percent of candidates rating the recruitment documentation as excellent – a 22 percent increase from previous non VBR campaigns.

VBR highlights the vital role of high quality, safe and compassionate healthcare, particularly the values and behaviours of staff caring for patients. For example, Kaiser Permanente in the US has used

mentorship and secondments to help increase awareness of the issues facing their service user population. This has helped to understand how to improve alignment with the organisation's values and improved the service overall.

Lessons from merger integration

Most of the literature around talent retention focuses at the organisational level, rather than at systems level. This is not surprising, since organisations are the 'host', employing organisation. However, it can be instructive to look at lessons from organisational mergers, when integration of two or more organisations have occurred, and a new pattern of collaboration is expected.

Mergers can bring to the surface uncertainties about workloads, future opportunities and new networks of relationships. And protracted implementation can be tiring. All of which may cause employees to consider leaving for other organisations.

Several lessons seem key:

- While, for senior people, a financial incentive was common, it did not rebuild long-term trust, Rather, it bought time to build trust (Erickson and Roloff, 2007).
- Perceived organisational support is important. Employees want to believe that organisations respect and support them to remain committed and loyal, satisfied with their jobs and willing to work hard. In times of change, organisations can take specific steps to support employees (Erickson and Roloff, 2007):
    - Reducing uncertainty through credible leadership.
    - Providing access to information about organisational changes.
    - Offering personal and professional development.
- Managerial support also counts for a great deal. Eisenberger et al (2002) report that their immediate manager affects employees' intentions to remain in the organisation through carefully assessing employees' potential; linking organisational goals to employees' everyday work, encouraging employee development; and helping them access technology, information and resources. Because of the criticality of their role, Managers should be accountable for employee retention, and have three key contributions regarding retention:
    - Monitoring workloads and ensuring that skills are commensurate with requirements.
    - Meeting regularly with employees, and conveying care and concern about employee well-being.
    - Providing performance management, including skills assessment, development and feedback.

Talent and the 'new-normal'

As organisations differ in their response to a post-Covid 'new-normal', people are likely to be even more watchful of how organisations treat their staff with regard to flexibility of place and time of work. This is likely to become an important component of talent engagement.

For example:

- In investment banking, the CEO of Goldman Sachs has described working from home (WFH) as an aberration, stating: "...young employees at the investment bank needed direct contact and mentorship that you could only get in the office."
- Nationwide has told its 13,000 staff they can choose from where to work.
- British Petroleum (BP) has told office staff they can spend two days a week WFH.
- Similarly, PwC has told its accounting and consulting staff they can work at home for two days a week, and start as early or late as they want.

Source: https://www.bbc.co.uk/news/business-56591189

A recent survey of 5,000 full-time workers in the UK indicates a significant and lasting impact of the Covid pandemic on attitudes towards working from home, with 68% of respondents indicating a preference for working two or more days a week from home in 2022 and beyond (Taneja et al., 2021). The authors, however, note a wide variation in both preferences and opportunities for people to work from home and the potential unintended consequences on diversity and inclusion that will pose challenges for employers.

> *"So, post COVID, British employees want to retain WFH for about two days a week, but there is a huge variation in preferences. This is going to cause headaches for employers – do they let employees choose how many days to WFH but have meeting and events with mixed-mode, which is known to be hard. Worse still those WFH may end up suffering long-run in terms of promotions, which would be a major issue for diversity if certain demographics, like women with young kids, opt to WFH more and miss out on promotions. Or instead do firms force all employees to choose to WFH for 2 days a week, which is about the middle point in preferences, overriding individual preferences? Managers are going to face these tricky issues as we return to offices."*

The report identifies some marginal impacts on productivity and notes that working from home has played a large role in reducing virus transmission while keeping the economy running. The report frames the potential for WFH as a perk, with the average employee reporting that 2 days a week from home is the equivalent of a 6.47% pay raise. The authors, though, raise the risk of WFH increasing existing inequalities because higher-paid staff may have more potential to WFH – something that is likely to be exacerbated in the health and care sector given the prevalence of low paid workers in frontline clinical and admin roles.

At this key moment for the ICS, where the talent retention of key system-influencers is key, it is worth noting the findings from a recent cross-continental survey by McKinsey. 49% of employees report some symptoms of burnout, which is likely to be an under-estimate, say the authors, since employees experiencing burnout are less likely to complete surveys. And this is especially pronounced for employees who feel anxious because of a lack of organisational communication. They are nearly three times as likely to report moderate to high levels of burnout.

With the coming ICS restructuring, decisions about the shape of post-pandemic work, all on top of a moment, in which the workforce, which is evidently tired, the implication is clear:

> *"The obvious recommendation for organizational leaders: share more with employees, even if you're uncertain about the future, to help improve employee well-being now." (Alexander et al, 2021)*

6.4 Good Practice Examples

Systems insights from health and care

Example 1: Boots UK refocused its recruitment criteria to reflect its changing business model, which has seen pharmacists move to more "front of shop" healthcare consultancy roles. Instead of identifying people with highly technical knowledge, it now focuses on people who have communication, consultation and relationship development skills.

Source: Boots UK, Human Resource International Digest, 2007

Example 2: Kaiser Permanente, one of the largest healthcare providers in the United States with tightly integrated care delivery networks uses this approach with their recruitment and talent management. Consistent with this care model, new hires and students are matched with practitioners with various specialities for mentorship and exposure to different clinical areas. Training focuses on practical elements but with a heavy focus on outcomes-based care. New practitioners and trainees develop social and knowledge networks across specialities that create a captive talent audience in a 'build vs buy' talent model.

Source:
https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_case_study_2009_jun_1278_mccarthy_kaiser_case_study_624_update.pdf

Systems Insights from other sectors

Recruiting in modern times can be challenging but also exciting in terms of choice of method especially with the myriad of online platforms to promote an organisation in a variety of ways. The four main models of recruitment in the corporate sector are:

- *Fully outsourced model*: less internal labour costs; fewer technology costs; better results at lower costs. However, there is very little day-to-day management of this system from the organisation.
- *Light internal recruiting as a hybrid strategy*; Often this model is a small team within an HR department that serves as a task force for vetting prospects.
- *Heavy internal recruiting*: This model works best with an organisation that already has an established brand name. Prospective candidates will actively seek out the organisation. In this case, social media and applicant tracking software is paramount.
- *Innovative recruitment strategies:* Benefiting from the gig economy and allowing for more IMAS or Bank candidates to take on roles; Employee referrals through an in-house referral easy to use and access referral programme; Social media through FB Group Membership e.g. professional groups, or special interest groups, Instagram, Twitter and Linkedin; the social media campaigns also help to engage with passive candidates who were not necessarily thinking of a move.

Example: Talent and Big Causes

There is the potential in healthcare to attract talent to support you in working on society-changing challenges. These may be longer-term goals, such as illness prevention, and large-scale population health management – the sort of challenges that can only be dealt with effectively by systems. Examples of cause-driven drives to target, recruit and highlight the impact of segments of people include:

- The Tech Talent Charter (TTC), which has recruited over 600 signatory organisations to support the system-level goal of "Bringing together industries and organisations to drive greater inclusion and diversity in technology roles." (See https://www.techtalentcharter.co.uk/home)
- The WISE campaign which has helped double the number of women in engineering over the last decade, and to increase the number of women in broader science, technology, engineering and maths' roles.

These causes are clearly framed as goals for bringing about a fairer, more equitable society. They are also increasingly cited as being key for innovation, which requires diversity and inclusion for longer-term sustainability. They both connect topics of talent, equality, diversity, inclusion and innovation to a meaningful longer-term purpose.

6.5 Implications for Organisation Development

1. Part of your attention should be in **attracting new and different talent into the organisation**. When you focus on high-impact, paradigm-shifting system goals, such as illness prevention instead of treatment, these can be attractors for many people, including young people seeking to build a record of demonstrating impact through their work. This will require you to align purpose directly with your talent recruitment, engagement and retention strategies. In turn, this will require you to lift your attention from short-term urgencies and to create compelling, hopeful future visions.

2. **Immediate and senior managerial support** will be key to the recruitment, engagement and retention of staff. Managers should be supported and equipped in their role, as well as having a clear accountability for the retention of staff. This would be even more pronounced for the retention of those considered critical to the success of the ICS.

3. Although the NHS has a robust process for recruitment, it may be necessary to **train line managers on how to get the best from the information that they receive**. Though there are guidance notes to help candidates through the process, a 'helpline' team for candidates new to job hunting or returners to work may prove helpful. This may require training of HR staff as well have a bank of practitioners to answer informal questions from candidates. Once a candidate has made it through the VBR online application process, the line manager may still need additional support and training to provide a positive interview experience for prospective staff.

4. **Training for HR staff in writing the person specifications.** At present, the online 'trac jobs' application process is extremely detailed and lengthy. Following the VBR model, the candidate is asked to produce examples that correspond to the person specification. This is very helpful for the short-listing process and to determine if the candidate has the requisite value driven approach. However, there is a caveat. This approach requires an understanding of the HR language to be able to match one's experience to the description which means that the recruiting organisation could be missing out on valuable candidates.

5. There is a potential tension between adherence to the values of healthcare and the wish for diversity in all its manifestations. How can you marry the wish for values-alignment with an approach to diversity that is equitable, morally-right and built into your policies and procedures?

6. Finally, with the current confluence of statutory ICS restructuring, the potential for a reconfiguration of post-pandemic work patterns, and the broad acknowledgment that staff are tired and need recovery, it is key that broad, effective communication takes place to assure staff about their work. This should include the principles and plans for the ICS, as well as staff's role and importance in making the change a success.

7. SYNTHESIS OF IMPLICATIONS

The previous sections summarise an extensive body of literature and evidence. As will be clear, there are a number of significant areas of overlap between the topic areas and commonalities within the implications for organisation development, as summarised at the end of each section. In this final section of the report we synthesise insights from across the five topic areas to provide some broader recommendations for organisation development practice to inform the work of Nottingham and Nottinghamshire ICS.

1. Understanding the ICS as an example of an organisational innovation

The structural and cultural formation of the ICS is an example of an organisational innovation. And, as each new phase of the workforce joins the conversation, they will inevitably be re-shaping and re-constructing the nature of the innovation, through the lenses of their own identities and agendas. This is because innovation is a social process of meaning-making, which requires new groups to be included in the conversational process, in order that a critical mass of people help institutionalise the change. The meaning of the ICS will become embedded partly through senior-level conceptual plans, but much more through this iterative process of including new groups of people in the ICS conversation. The role of organisation development is to include people in the conversation, as well as hold a facilitative role which allows for meaning to emerge, while understanding that control of the conversation is neither desirable nor possible.

2. Having a clear, shared understanding of effective systems-leadership capabilities and capacities

As we mention in our leadership summary, the persistence of command and control notions of leadership pose a considerable threat to systems leadership progress. However, the "…extensive literature on complexity and process thinking shifts attention towards the relational and interdependent nature of leadership practice. Such principles have the ability to shift/reframe dominant perspectives and paradigms to facilitate more inclusive, compassionate and collective leadership cultures." Systems leadership inevitably means leading across boundaries, beyond the limits of one's authority. No leader has all the answers, nor the power, hence collaboration is needed. While this way of thinking emphasises the importance of relationship quality, organisation development leadership competency frameworks still focus largely on individuals. Practitioners would do well to consider what inter-dependent and collective leadership means, and to consider relationship quality as a systems asset worth developing.

3. Creating and communicating a shared and meaningful purpose

Collaboration is hard work, and people will not do it without a compelling vision of a desired future state. That means crafting a succinct, meaningful and realistic purpose which can only be achieved by system working, and which also appeals emotionally to your staff and the populations you serve. The conception of the purpose should involve as many people as practicable, from across the different parts of your systems. And should then be communicated widely, and reinforced. The purpose can act as an attractor, supporting your long-term system causes, and attracting outside talent to join your work. Organisation Development can play a role in facilitating this process of purpose definition and sharing.

4. Building relationships and a shared understanding

In a system of multiple sectors, concepts, ideas and language will reflect underlying differences in identity and association. Allow time and opportunities for this, so that people can come together, and start the processes of relationship-building, and of understanding each other's worlds. Without this shared asset of mutual understanding, your individuals' talents will be latent but not applied across the system. In systems, it is a smart investment to work at the speed of relationship building, and

invest in those relationships that are likely to endure over time, and be the basis for collaborative system work. From an organisation development perspective, it requires skilled facilitation to create this common sense of direction, alignment and commitment across partners.

5. Power, politics and getting things done

As we note above, the "new world [of public service leadership is a] polycentric, multi-nodal, multi-sector, multi-level, multi-actor, multi-logic, multi-media, multi-practice place characterized by complexity, dynamism, uncertainty and ambiguity in which a wide range of actors are engaged in public value creation and do so in shifting configurations." (Bryson et al, 2017). Power and politics are an inevitable aspect of this, yet these are still tentative topics and felt by many to be risky to raise. From our various examples of systems leadership, it is clear that efforts spent on stakeholder engagement are essential and that acting beyond the limits of one's personal authority is one of the defining aspects of effective systems leadership – something that may require the development of 'political astuteness' and commitment to a common set of ethics and values.

6. Actively fostering inclusive cultures and working practices

There is strong evidence of systemic inequalities and barriers to the progression of BAME and other marginalised groups within the NHS workforce. Fostering inclusive cultures requires active engagement from majority individuals to learn from the lived experience of those who are marginalised and to actively engage diverse stakeholders in meaningful decision-making about matters that affect them. Without this, attempts to improve working practices may simply widen existing differences. Organisation development professionals have a key role to play in this process by engaging disparate stakeholder groups, challenging embedded power dynamics, building influence and capacity across the system and holding senior leaders to account.

7. Understanding and advocating characteristics of successful systems-working

The lessons from successful examples of systems work are not always easy to access. They are held in disparate cases, in different sectors, and different media platforms. But there are some shared lessons, including:

- Having a clear focus on a desired long-term goal that matters to the people living and working in the system.
- Extensive stakeholder engagement, including with diverse, local communities, to establish a broad mandate for change, reflects the felt-needs of those communities.
- Clear and adequate allocation of resources to support the work.
- Building social capital bonds between people who are invested in the system for the long-term.
- Evidencing change over time and space with appropriate data to demonstrate a shift.
- You are among the pioneers of systems change and should learn and spread the emerging lessons of success.

8. Planning, resourcing and goodwill

Many years of restructurings, financial pressures, policy reforms and Covid have put the healthcare system under huge pressure. Add to this that the sector inevitably attracts people who want to help others. This can create the emergent phenomenon whereby discretionary effort, or goodwill, is granted by willing workers, improves work outcomes, gradually becomes expected, informally-institutionalised, and, eventually, taken for granted. If it continues, it absolves senior managers from the task of properly resourcing work. But it typically relies on a small cadre of "usual suspects", which puts organisations at risk from key people leaving, making it difficult to develop truly sustainable

practices. In the successful systems examples above, organisations allocate money, time and senior support to suit the needs of the work.

9. Equipping organisation development professionals

Build up the collective capabilities of your OD collaborative. This can include being able to facilitate challenges, even hackathons; enabling conversations across the system; being able to diagnose the system climate health; and being able to use a range of improvement and innovation methodologies. It should also cover how you use digital platforms to help groups co-create, making the best of synchronous and asynchronous learning. And you'll need to be able to measure and assess the impact of system interventions. Consider creating a joint funding pot for skills-building across the OD collaborative.

10. Put in place meaningful and helpful metrics of OD enablers

The ICS White Paper emphasises the 'triple aim' of improved health population outcomes, better care and efficient use of public money. And while these three broad aims will be visible and essential, as we mention above, they are not sufficient to determine the extent to which the necessary individual, collective and systemic capacity has been built to enable adaptation and change to meet the needs of a changing demographic, social, political, economic and environmental context. We suggest that you search and decide upon core metrics for organisation development, that will support the employee experience and system performance.

11. Facilitating change in complex systems

A lesson from complexity, is that most of organisational life occurs in a constant tumult of local, spontaneous interactions. These are not designed and are not controllable. And this exists at the same time as senior leaders design plans, programmes and interventions. Complexity thinking tells us that our experience of work is both predictable and unpredictable, with some things controllable, but most not. However, intentional and spontaneous influence are possible and are regular features of organisations and systems. It will help your facilitation work if you discern the interplay between top-down plans and the patterns of ground-up interactions. You will need to notice that interactions are happening, and to see patterns of movement occurring across populations, as they coalesce around 'attractors' - themes that bring people together. And, in your work as conversation-facilitators, pay attention to repetitive patterns of conversation that are likely to reproduce existing behaviours, and to novel thoughts emerging spontaneously, that might lead to new approaches.

8. REFERENCES

8.1 LEADERSHIP

Barnard, S., Arnold, J., Bosley, S. & Munir, F. (2016). *Onwards and Upwards? Tracking Women's Work Experiences in Higher Education: Year 1 Report*. London: Leadership Foundation for Higher Education.

Bennis, W. and Thomas, R.J. (2002) Crucibles of leadership, *Harvard Business Review*. September.

Bevan, H. and Fairman, S. (2016) The new era of thinking and practice in change and transformation: A CALL TO ACTION FOR LEADERS OF HEALTH AND CARE. NHS Improving Quality.

Bolden, R. (2020) *Systems Leadership: Pitfalls and possibilities*. London: National Leadership Centre.

Bolden, R., Adelaine, A., Warren, S., Gulati, A., Conley, H. and Jarvis, C. (2019) *Inclusion: The DNA of leadership and change*. UWE, Bristol on behalf of NHS Leadership Academy, Leeds.

Bolden, R., Gulati, A. and Edwards, G. (2020) Mobilizing Change in Public Services: Insights from a systems leadership development intervention, *International Journal of Public Administration*, 43(1), 26-36.

Bryson, J., Sancino, A., Benington, J. and Sørensen, E. (2017) Towards a multi-actor theory of public value co-creation, *Public Management Review*, 17(5), 640-654.

Deeds and Words (2020) Inclusive Leadership and Culture in the NHS.

Dixon-Woods, M. et al. (2014) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study, *BMJ Quality and Safety*, 23:106–115.

Dreier, L., Nabarro, D. and Nelson, J. (2019) *Systems Leadership for Sustainable Development: Strategies for Achieving Systemic Change*. Corporate Responsibility Initiative, Harvard Kennedy School

Flinn, K. and Mowles, C. (2014). *A complexity approach to leadership development: Developing practical judgement*. London: Leadership Foundation for Higher Education.

Ford, J. (2015). Going beyond the Hero in Leadership Development: The Place of Healthcare Context, Complexity and Relationships; Comment on "Leadership and Leadership Development in Healthcare Settings – A Simplistic Solution to Complex Problems?". *International Journal of Health Policy and Management,* 4**,** 261-263.

Ghate, D., Lewis, L. and Welbourn, D. (2013) *Systems Leadership: Exceptional leadership for exceptional times - synthesis report*. Nottingham, UK: Virtual Staff College.

Grint, K. (2008). Wicked problems and clumsy solutions: the role of leadership, *Clinical Leader*, 1(2).

Ham, C. and Murray, R. (2015) *Implementing the NHS five year forward view: aligning policies with the plan*. London: The Kings Fund.

Hambleton, R. (2020) *Cities and Communities Beyond COVID-19: How Local Leadership Can Change Our Future for the Better*. Bristol: Bristol University Press.

Hartley, J., Alford, J., Hughes, O. and Yates, S. (2013). *Leading with political astuteness - a white paper. A study of public managers in Australia, New Zealand and the United Kingdom*. Australia and

New Zealand School of Government, Chartered Institute of Management & The Open University Business School.

Hartley, J., Sancino, A., Bennister, M. and Resodihardjo, S.L. (2019) Leadership for public value: Political astuteness as a conceptual link, *Public Administration*, 97(2), 239-249.

Heifetz, R. A., Grashow, A. and Linsky, M. (2009). *The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World*, Boston, Harvard Business Press.

Hunter, D.J., Perkins, N., Visram, S. et al. (2018) Evaluating the leadership role of health and wellbeing boards as drivers of health improvement and integrated care across England. University of Sheffield.

Independent SAGE (2020) Disparities in the impact of COVID-19 in Black and Minority Ethnic populations: review of the evidence and recommendations for action.

Kline, R. (2014). *The snowy white peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England*. London: Middlesex University.

Kline, R. (2019) Leadership in the NHS, *BMJ Leader*, 3:129-132

McCauley, C. D., Moxley, R. S. and Van Velsor, E. (1998). *The Center for Creative Leadership handbook of leadership development*, San Francisco, Jossey-Bass.

Moore, M.H. (1995) *Creating Public Value*. Cambridge, MA: Harvard University Press.

Murray, R. (2021) Covid-19 one year on: how can the health and care system recover? London: The Kings Fund.

National Improvement and Leadership Development Board (2016) *Developing People Improving Care*.

NHS Confederation (2020) *From Place-Based to Place-Led*. London: NHS Confederation.

NHS Confederation (2014). *The future of systems leadership*.

NHS Leadership Academy (2017) The Leadership Development Evaluation Framework.

NHS Sustainable Improvement Team and The Horizons Team. (2018). *Leading Large Scale Change: A guide to leading large scale change through complex health and social care environments A practical guide*. NHS England.

Ospina, S.M., Foldy, E.G., Fairhurst, G.T. and Jackson, B. (2020) Collective dimensions of leadership: Connecting theory and method, *Human Relations*, 73(4), 441-463.

Raelin, J. (2016) Introduction to leadership-as-practice, in J. Raelin (ed.) *Leadership-as-Practice: Theory and Application*. London: Routledge.

SCIE (2018) System leadership for integrated care. Social Care Institute for Excellence.

Senge, P., Hamilton, H. and Kania, J. (2015) The dawn of systems leadership, *Stanford Social Innovation Review*, 13(1), 26-33.

Snowden, D. J. and Boone, M. E. (2007). A leader's framework for decision making. *Harvard Business Review,* 85(11):68-76.

Stacey, R.D. (2009) *Complexity and Organizational Reality: Uncertainty and the Need to Rethink Management after the Collapse of Investment Capitalism*. London: Routledge.

Stacey, R.D. (2018) Complex responsive processes – 4 pillars of thought, 5 key insights. Complexity & Management Centre, University of Hertfordshire.

Timmins, N. (2019) *Leading for integrated care: 'If you think competition is hard, you should try collaboration'.* London: The Kings Fund.

Tomkins, L., and Simpson, P. (2015). Caring Leadership: A Heideggerian Perspective, *Organization Studies*, 36(8), 1013-1031.

Vize, R. (2018) *Messages for national leaders from the A&E frontline*. London: Leadership Centre.

West, M. A., Eckert, R., Steward, K. and Pasmore, W. A. (2014). *Developing collective leadership for health care*, London: King's Fund.

West, M. and West, T. (2015) Leadership in Healthcare: A Review of the Evidence, *Health Management*, 15(2).

West, M., Eckert, R., Collins, B. and Chowla, R. (2017). *Caring to change*. London: The Kings Fund.

8.2 CULTURE

Akrich, M., Callon, M., Latour, B., & Monaghan, A. (2002). The key to success in innovation part I: The art of interessement. *International Journal of Innovation Management*, 6(02), 187-206.

Amabile, T., & Gryskiewicz, S. S. (1987). *Creativity in the R&D laboratory*. Center for Creative Leadership. Amabile et al., 2004

Bauer, T. N., Bodner, T., Erdogan, B., Truxillo, D. M., & Tucker, J. S. (2007). Newcomer adjustment during organizational socialization: A meta-analytic review of antecedents, outcomes, and methods. Journal of Applied Psychology, 92(3), 707.

Baumard, P. (1999). *Tacit knowledge in organizations*. Sage.

Bezrukova, K., Thatcher, S., Jehn, K. A., & Spell, C. S. (2012). The effects of alignments: Examining group faultlines, organizational cultures, and performance. *Journal of Applied Psychology*, 97(1), 77.

Boje, D. M. (1995) Stories of the storytelling organization: a postmodern analysis of Disney as ''TamaraLand'', *Academy of Management Journal*, 38(4), 997-1035.

Borrill, C., West, M., Shapiro, D., & Rees, A. (2000). Team working and effectiveness in health care. *British Journal of Healthcare Management*, 6(8), 364-371.

Borzillo, S., & Kaminska-Labbé, R. (2011). Unravelling the dynamics of knowledge creation in communities of practice though complexity theory lenses. *Knowledge Management Research & Practice*, 9(4), 353-366.

Boyce M. E. (1996). Organizational story and storytelling: a critical review. *Journal of Organizational Change Management*, 9(5), 5-26.

Brown, J. S., & Duguid, P. (1991). Organizational learning and communities-of-practice: Toward a unified view of working, learning, and innovation. *Organization Science*, 2(1), 40-57.

Brown, M. E., & Trevino, L. K. (2009). Leader–follower values congruence: Are socialized charismatic leaders better able to achieve it?. *Journal of Applied Psychology*, 94(2), 478.Callon, 1986

Contu, A., & Willmott, H. (2003). Re-embedding situatedness: The importance of power relations in learning theory. *Organization Science*, 14(3), 283-296.

Cunliffe, A., L. (2008). *Organization Theory*. Sage.

Daniels, K., Watson, D., & Gedikli, C. (2017). Well-being and the social environment of work: A systematic review of intervention studies. *International Journal of Environmental Research and Public Health*, 14(8), 918.

Dawson, J.F., West, M.A., Admasachew, L. and Topakas, A. (2011), NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data, Department of Health, London, available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/.

De Cooman, R., De Gieter, S., Pepermans, R., Hermans, S., Du Bois, C., Caers, R., & Jegers, M. (2009). Person–organization fit: Testing socialization and attraction–selection–attrition hypotheses. *Journal of Vocational Behavior*, 74(1), 102-107.

Deal, T.E. & Kennedy, A. A. (1982). *Corporate Cultures*. Addison-Wesley.

Denison, D. R. (1996). What is the difference between organizational culture and organizational climate? A native's point of view on a decade of paradigm wars. Academy of management review, 21(3), 619-654.

Department of Health. (2010). The NHS Constitution. The NHS belongs to us all. Retrieved from:www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., ... & West, M. (2014). Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ Quality & Safety*, 23(2), 106-115.

Edmondson, A. C., Dillon, J. R., & Roloff, K. S. (2007). Three perspectives on team learning: outcome improvement, task mastery, and group process. *Academy of Management Annals*, 1(1), 269-314.

Ehrhart, M. G., Schneider, B., & Macey, W. H. (2013). *Organizational climate and culture: An introduction to theory, research, and practice*. New York: Routledge.

Ekvall, G., Arvonen, J., & Waldenström-Lindblad, I. (1983). *Creative organizational climate: Construction and validation of a measuring instrument (Report 2)*. Stockholm: Swedish Council for Management and Organizational Behaviour.

Ekvall, G. (1987). The climate metaphor in organization theory. In *Advances in organizational psychology*, by B. and Drenth, P. Bass. Beverley Hills, CA: Sage.

Ekvall, G. (1991). The organizational culture of idea management: a creative climate for the management of ideas. *In Managing Innovation*, by J. and Walker, D. (Eds.) Henry, 73-79. London: Sage.

Ekvall, G. (1996). Organizational climate for creativity and innovation. *Journal of Work and Organizational Psychology, 5* (1), 105-123.

Fagerberg, J. (2005). Innovation: A guide to the literature. In J. Fagerberg, D. C. Mowery, & R. R. Nelson (Eds.), *The Oxford Handbook of Innovation*. Oxford University Press.

Forster N., Cebis M., Majteles S., Mathur A., Morgan R., Preuss J., Tiwari, V. & Wilkinson, D. (1999). The role of story-telling in organizational leadership. *Leadership & Organization Development Journal*, 20(1), 11-17.

Goleman, D. (2000). Leadership that gets results. *Harvard Business Review*, 78(2), 4-17.

Groysberg, B., Lee, J., Price, J. & Cheng, J.Y-D.(2018). The leader's guide to corporate culture. *Harvard Business Review*, 96(1), 44–52.

Grey, C. (2009). *A Very Short, Fairly Interesting and Reasonably Cheap Book About Studying Organizations*. Sage.

Hoholm, T., & Araujo, L. (2011). Studying innovation processes in real-time: The promises and challenges of ethnography. *Industrial Marketing Management*, 40(6), 933-939.

Isaksen, S. G., Lauer, K. J., Murdock, M. C., Dorval, K. B., & Puccio, G. J. (1995). *Situational outlook questionnaire: Understanding the climate for creativity and change (SOQ™)—A technical manual*. Buffalo, NY: Creative Problem Solving Group.

Isaksen, S. G. (2017). Leadership's role in creative climate creation. In Handbook of research on leadership and creativity. Edward Elgar Publishing.

Jackson, N. and Carter, P. (2000) *Rethinking Organisational Behaviour: A post-structuralist framework*. London: Financial Times/Prentice Hall.

Konradt, U., Schippers, M. C., Garbers, Y., & Steenfatt, C. (2015). Effects of guided reflexivity and team feedback on team performance improvement: The role of team regulatory processes and cognitive emergent states. European Journal of Work and Organizational Psychology, 24(5), 777-795.

Kuenkel, P. (2019). *Stewarding Sustainability Transformations.* Springer

Lave, J., & Wenger, E. (1991). Situated Learning: Legitimate peripheral participation. Cambridge University Press.

Lewin, K., Lippitt, R., & White, R. K. (1939). Patterns of aggressive behavior in experimentally created "social climates*". The Journal of Social Psychology*, 10(2), 269-299.

Locke, E. A., & Latham, G. P. (Eds.). (2013). New developments in goal setting and task performance. Routledge.

McDermott, R. (1999). Nurturing three-dimensional communities of practice. *Knowledge Management Review*, 26-29. Available at: https://www.nickols.us/Dimensions.pdf

McNabb, D. E., & Sepic, F. T. (1995). Culture, climate, and total quality management: Measuring readiness for change. *Public Productivity & Management Review*, 369-385.

Meek, V. L. (1988). Organizational culture: Origins and weaknesses. *Organization Studies*, 9(4), 453-473.

Meyer, J. P., Hecht, T. D., Gill, H., & Toplonytsky, L. (2010). Person–organization (culture) fit and employee commitment under conditions of organizational change: A longitudinal study. *Journal of Vocational Behavior*, 76(3), 458-473.

Mumford, M. D., & Gustafson, S. B. (1988). Creativity syndrome: Integration, application, and innovation. *Psychological Bulletin*, 103(1), 27.

Nicholson, N. (1987). The transition cycle: A conceptual framework for the analysis of change and human resources management. *Research in Personnel and Human Resources Management*, 5, 167-222.

Nicholson N, West M (1988) *Managerial job change: men and women in transition*. Cambridge University Press.

Ogbonna, E., & Harris, L. C. (2000). Leadership style, organizational culture and performance: empirical evidence from UK companies. *International Journal of Human Resource Management*, 11(4), 766-788.

Pace, R. W. (2003*). Organizational dynamism: Unleashing power in the workforce*. London: Quorum.

Patterson, M. G., West, M. A., Shackleton, V. J., Dawson, J. F., Lawthom, R., Maitlis, S., Robinson, D. L. & Wallace, A. M. (2005). Validating the organizational climate measure: links to managerial practices, productivity and innovation. Journal of organizational behavior, 26(4), 379-408.

Waterman, R. H., & Peters, T. J. (1982). *In search of excellence: Lessons from America's best-run companies*. New York: Harper & Row.

Sarker, S., Sarker, S. & Sidorova, A. (2006). Understanding Business Process Change Failure: An Actor-Network Perspective, *Journal of Management Information Systems, 23*(1), 51-86.

Schaufeli, W. B., & Bakker, A. B. (2004). Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study. Journal of Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior, 25(3), 293-315.

Sheffield, R., Kars-Unluoglu, S. & Jarvis, C. (in press). Climate for innovation: A critical lever in the leadership of innovation. In R. Agarwal, R. Green, E. Patterson & S. Pugalia (Eds.) *Contemporary Issues in Innovation*. Routledge.

Schein, E. (1992). *Organisational Culture and Leadership* (2nd ed.), Jossey-Bass, San Francisco.

Schippers, M. C., Den Hartog, D. N., Koopman, P. L., & Van Knippenberg, D. (2008). The role of transformational leadership in enhancing team reflexivity. Human Relations, 61(11), 1593-1616.

Schmid, T. (2006). *Promoting health through creativity: for professionals in health, arts and education*. London: John Wiley & Sons.

Schneider, B., & Barbera, K. M. (2014). Introduction: The Oxford handbook of organizational climate and culture. In B. Schneider & K. M. Barbera (Eds.), Oxford library of psychology. *The Oxford Handbook of Organizational Climate and Culture* (p. 3–20). Oxford University Press.

Smircich, L. (1983). Concepts of culture and organizational analysis. *Administrative Science Quarterly*, 28(3), 339–58.

Swan, J., Scarbrough, H., & Robertson M. (2002). The Construction of Communities of Practice in the Management of Innovation, *Management Learning*, 33(4), 477–96.

Tannenbaum, S. I., & Cerasoli, C. P. (2013). Do team and individual debriefs enhance performance? A meta-analysis. Human factors, 55(1), 231-245.

Naylor, C. & Wellings, D. (2019). A citizen-led approach to health and care: Lessons from the Wigan Deal. The King's Fund. Available at: https://www.kingsfund.org.uk/publications/wigan-deal

Thompson, M. (2005). Structural and epistemic parameters in communities of practice. Organization Science, 16(2), 151-164.

Tjosvold, D., Yu, Z. Y., & Hui, C. (2004). Team learning from mistakes: the contribution of cooperative goals and problem-solving. *Journal of Management Studies*, 41(7), 1223-1245.

Trowler, P. R., & Turner, G. H. (2002). Exploring the hermeneutic foundations of university life: Deaf academics in a hybridcommunity of practice'. Higher Education, 43(2), 227-256.

Vashdi, D. R., Bamberger, P. A., & Erez, M. (2013). Can surgical teams ever learn? The role of coordination, complexity, and transitivity in action team learning. *Academy of Management Journal*, 56(4), 945-971.

Wageman, R., Nunes, D. A., Burruss, J. A., & Hackman, J. R. (2008). *Senior leadership teams: What it takes to make them great*. Harvard Business Review Press.

Ward, A. (2000). Getting strategic value from constellations of communities. *Strategic Leadership*. Available at: https://www.emerald.com/insight/content/doi/10.1108/10878570010341537/full/pdf?title=getting-strategic-value-from-constellations-of-communities

Wenger, E. (1998). Communities of practice: Learning as a social system. Systems Thinker, 9(5), 2-3.

West, M., & Rickards, T. (1999). Innovation. Vol. 2, in Encyclopaedia of Creativity, by Pritzker, S., Runco, M. (Eds) 45-55. San Diego: Academic Press.

West, M.A., & Anderson, N.R. (1996). Innovation in top management teams. *Journal of Applied Psychology, 81*(6), 680–693.

West, M. A. (2000). Reflexivity, revolution and innovation in work teams. In M. Beyerlein, D. Johnson, Beyerlein, S. (Eds.) *Advances in Interdisciplinary Studies of Work Teams*. JAI Press.

West, M. A., Lyubovnikova, J., Eckert, R., & Denis, J. L. (2014). Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance,* 1(3), 240-260.

West, M., Dawson, J. & Kaur, M. (2015). *Making the Difference: Diversity and inclusion in the NHS.* The King's Fund. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf

Widmer, P. S., Schippers, M. C., & West, M. A. (2009). Recent developments in reflexivity research: A review. *Psychology of Everyday Activity*, 2(2), 2-11.

Wiles, R., & Robison, J. (1994). Teamwork in primary care: the views and experiences of nurses, midwives and health visitors. *Journal of Advanced Nursing*, 20(2), 324-330.

Willis, C.D., Saul, J., Bevan, H., Scheirer, M.A., Best, A., Greenhalgh, T., Mannion, R., Cornelissen, E., Howland, D., Jenkins, E. & Bitz, J. (2016). Sustaining organizational culture change in health systems. *Journal of Health Organization and Management*, 30(1), 2-30

Willmott, H. (1993). Strength is ignorance; slavery is freedom: Managing culture in modern organizations. *Journal of Management Studies*, 30(4), 515-552.

Woolgar, S. (1981). Interests and explanation in the social studies of science. *Social Studies of Science*, 11, 365–394.

Wrzesniewski, A., LoBuglio, N., Dutton, J. E., & Berg, J. M. (2013). Job crafting and cultivating positive meaning and identity in work. *Advances in Positive Organizational Psychology*. Emerald Group Publishing Limited.

8.3 IMPROVEMENT

1000 Lives Improvement (2014), *The Quality Improvement Guide: The Improving Quality Together Edition*

Abel et al. (2018). Reducing emergency hospital admissions: a population health complex intervention of an enhanced model of primary care and compassionate communities. British Journal of medical practice. November 2018.

Alderwick et al (20017). Making the case for quality improvement: lessons for NHS boards and leaders. The Kings Fund and Health Foundation joint report. Available at: https://www.kingsfund.org.uk/publications/making-case-quality-improvement#what-should-nhs-leaders-do- (Accessed on 30/3/21)

Bate, P, Mendel, P, Robert, G. (2008). *Organizing for quality*. Oxford: Radcliffe.

Berwick DM, Enthoven A, and Barker JP (1992a), *'Quality Management in the NHS: The doctor's role – I'*, British Medical Journal issue 304, pp 235 - 239

Berwick DM, Enthoven A, & Barker JP (1992b), *'Quality Management in the NHS: The doctor's role – II'*, British Medical Journal issue 304, pp 304 - 308

Bevan, B. Plsek, P. and Winstanley, L. (2011). Leading large Scale change: A practical guide. www.institute.nhs.uk/catalogue (Now available at: https://www.basw.co.uk/system/files/resources/basw_54010-9_0.pdf)

Boaden et al (2008). Quality Improvement: theory and practice in healthcare. NHS Institute for Innovation and Improvement.

Collins, B. (2015). Adoption and spread of innovation in the NHS. https://www.kingsfund.org.uk/publications/innovation-nhs. (Accessed: 7th May 2021.)

Health Foundation. (2013). Quality improvement made simple: what everyone should know about healthcare quality improvement. Quick guide.

Jabbal, J. (2017) Embedding a culture of quality improvement. The Kings Fund

Jabbal, J. and Lewis, M. (2018) Approaches to better value in the NHS, improving quality and cost. The Kings Fund.

James, B (2012) *A Mature Quality System.* Presentation at the IHI Forum.

Kirton, M. J. (2003). Adaption-Innovation In the context of Diversity and change. Routledge.

Kokshagina, O. and Alexander, A. (2020)the radical Innovation playbook: a practical guide for harnessing new, Novel or game-changing breakthroughs. De Gruyter.

Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington DC: National Academy Press, 1990

Leonard-Barton, D. (1992). Core capabilities and core rigidities: A paradox in managing new product development. Strategic Management Journal, 111-125

Moore G.A. (1991). Crossing the chasm - Marketing and selling technology products to mainstream customers. HarperCollins, New York

Øvretveit J. (2009). Does improving quality save money? A review of the evidence of which improvements to quality reduce costs to health service providers. London: Health Foundation, 2009.

Rogers, E. M. (1983). Diffusion of innovations (3rd ed.). New York: Free Press of Glencoe

Sheffield, R, Schols, G. and Hameister, F. (Sep 2020). Real-time learning from the virtual world: international insights on innovation learning online. BMJ leader. (Accessed 20/4/21:

https://blogs.bmj.com/bmjleader/2020/09/17/real-time-learning-from-the-virtual-world-international-insights-on-online-innovation-learning-by-rob-sheffield-geert-schols-florian-hameister/)

Taitz JM, Lee TH, Sequist TD (2011). 'A framework for engaging physicians in quality and safety'. BMJ Quality & Safety, vol 21, no 9, pp 722–8. Available at: http://qualitysafety.bmj.com/content/21/9/722

Van Wulfen, G. (2013). The Innovation Expedition: A visual toolkit to start innovation. BIS. Amsterdam

8.4 Equality, Diversity and Inclusion

Adelaine, A. *et al.* (2019) *Beyond the White Wall: New Horizons for leadership and inclusion in the NHS*. Bristol: Bristol Leadership and Change Centre.

Batliwala, S. (2011) *Feminist leadership for social transformation: Clearing the conceptual cloud*. CREA India.

Bell, D. (2018) *Faces at the bottom of the well: The permanence of racism*. Hachette UK.

BMA (2021) *COVID-19: the risk to BAME doctors*, *The British Medical Association is the trade union and professional body for doctors in the UK.* Available at: https://www.bma.org.uk/advice-and-support/covid-19/your-health/covid-19-the-risk-to-bame-doctors (Accessed: 28 March 2021).

Bolden, R. *et al.* (2019) *Inclusion: The DNA of leadership and change*. Bristol: Bristol Leadership and Change Centre. Available at: https://uwe-repository.worktribe.com/output/852067/inclusion-the-dna-of-leadership-and-change.

Brown, N. (2020) 'Introduction: Theorising ableism in academia'.

Browne, K. and Nash, C. J. (2016) 'Queer methods and methodologies: An introduction', in *Queer Methods and Methodologies*. Routledge, pp. 1–24.

Clegg, S. R. (1989) *Frameworks of power*. London: Sage.

Crawford, A. and Serhal, E. (2020) 'Digital Health Equity and COVID-19: The Innovation Curve Cannot Reinforce the Social Gradient of Health', *Journal of Medical Internet Research*, 22(6). doi: 10.2196/19361.

Crenshaw, K. (1989) 'Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics', *U. Chi. Legal F.*, p. 139.

Crenshaw, K. (1991) 'Mapping the margins: Intersectionality, identity politics, and violence against women of color', *Stanford law review*, pp. 1241–1299.

Delgado, R. and Stefancic, J. (2013) *Critical race theory: The cutting edge*. Temple University Press.

Einarsdóttir, D. A. *et al.* (2020) 'Understanding LGBT+ employee networks and how to support them', p. 56.

Endres, S. and Weibler, J. (2017) 'Towards a Three-Component Model of Relational Social Constructionist Leadership: A Systematic Review and Critical Interpretive Synthesis', *International Journal of Management Reviews*, 19(2), pp. 214–236.

Ethnicity pay gaps in Great Britain - Office for National Statistics (no date). Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/ethnicitypaygapsingreatbritain/2018 (Accessed: 5 April 2021).

Eyben, R. (2010) 'Subversively accommodating: feminist bureaucrats and gender mainstreaming', *IDS Bulletin*, 41(2), pp. 56–61.

Fanon, F. (1952) 'Black skin, white masks [1952]', *New York*.

Fanon, F., Sartre, J.-P. and Farrington, C. (1963) *The wretched of the earth*. 36th edn. Grove Press New York.

Health Affairs (2021) *Accelerating Digital Health To Achieve Equitable Delivery Of The COVID-19 Vaccine | Health Affairs Blog*. Available at: https://www.healthaffairs.org/do/10.1377/hblog20210127.478657/full/ (Accessed: 5 April 2021).

Health Education England (2018) *Diversity and Inclusion: Our Strategic Framework 2018-2022*. Available at: https://www.hee.nhs.uk/our-work/diversity-inclusion/diversity-inclusion-our-strategic-framework-2018-2022.

Hooks, B. (2014) *Teaching to transgress*. Routledge.

Johnson, A. *et al.* (2018) *The Fire Now: Anti-Racist Scholarship in Times of Explicit Racial Violence*. Zed Books. Available at: https://books.google.co.uk/books?id=Ib2rDwAAQBAJ.

MBRACE-UK (2018) *Perinatal Mortality Surveillance Report Summary*. Available at: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-surveillance-report-2018/MBRRACE-UK_Perinatal_Surveillance_Report_2018_-_summary.pdf (Accessed: 28 March 2021).

MBRACE-UK (2020) *Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18*. Available at: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-

UK_Maternal_Report_Dec_2020_v10.pdf (Accessed: 28 March 2021).

NHS, (2020) *Workforce Race Equality Standard 2020 Report*. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf (Accessed: 27 March 2021).

NHS England (2020) *NHS England » Workforce Disability Equality Standard (WDES) annual report 2019*. Available at: https://www.england.nhs.uk/publication/wdes-annual-report-2019/ (Accessed: 5 April 2021).

Oliver, M. and Barnes, C. (2010) 'Disability studies, disabled people and the struggle for inclusion', *British Journal of Sociology of Education*, 31(5), pp. 547–560. doi: 10.1080/01425692.2010.500088.

Schalk, S. (2021) 'Black Disability Gone Viral: A Critical Race Approach to Inspiration Porn', *CLA Journal*, 64(1), pp. 100–120. doi: 10.1353/caj.2021.0007.

The Essential Guide to the Public Sector Equality Duty | Equality and Human Rights Commission (2014). Available at: https://www.equalityhumanrights.com/en/publication-download/essential-guide-public-sector-equality-duty (Accessed: 21 May 2021).

8.5 TALENT MANAGEMENT

Alexander, A. et al (April 2021). What employees are saying about the future of work. https://www.mckinsey.com/business-functions/organization/our-insights/what-employees-are-saying-about-the-future-of-remote-work?cid=other-eml-alt-mip-mck&hdpid=c094b8a1-2f8c-4883-adaa-6ea6a7aaf1b8&hctky=10357528&hlkid=e4f2e265f24644f2be59961eb8021f71 (Accessed on 9th May 2021)

Beech, J., Bottery, S., Charlesworth, A., Evans, H., Gershlick, B., Hemmings, N., Imison, C., Kahtan, P., McKenna, H., Murray, R. and Palmer, B., 2019. Closing the gap. *Key areas for action on the health and care workforce. London: The Health Foundation/Nuffield Trust/The King's Fund*.

Cable, D.M. and Judge, T.A., 1996. Person–organization fit, job choice decisions, and organizational entry. *Organizational behavior and human decision processes*, *67*(3), pp.294-311.

Deniz, N., Noyan, A. and Ertosun, Ö.G., 2015. Linking person-job fit to job stress: The mediating effect of perceived person-organization fit. *Procedia-Social and Behavioral Sciences*, *207*, pp.369-376.

Eisenberger, R., Stinglhamber, F., Vandenberghe, C., Sucharski, I. L., & Rhoades, L. (2002). Perceived supervisor support: Contributions to perceived organizational support and employee retention. Journal of Applied Psychology, Vol. 87 No. 3, pp. 565-573.

Erickson, R. A. & Roloff, M. E. (2007). Reducing attrition after downsizing: Analyzing the effects of organizational support, supervisor support, and gender on organizational commitment. International Journal of Organizational Analysis, Vol. 15 No. 1, pp. 35-55.

HRMID (2007), "Boots has the prescription for simpler staff recruitment: Online system copes easily with large number of applications", *Human Resource Management International Digest*, Vol. 15 No. 2, pp. 27-29. https://doi.org/10.1108/09670730710735735

https://rhythmagency.com/case-studies/kaiser

https://www.catalyst.org/research/kaiser-permanente-achieving-our-mission-and-growing-the-business-through-the-national-diversity-agenda/

https://www.cipd.co.uk/knowledge/strategy/resourcing/talent-factsheet#gref

https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_case_study_2009_jun_1278_mccarthy_kaiser_case_study_624_update.pdf

https://www.elft.nhs.uk/About-Us/Trust-Board-Meetings/Trust-Board-Papers-2020

https://www.nhsemployers.org/-/media/Employers/Publications/Workforce-Supply/NHS-People-Plan--Inclusive-Recruitment-final.pdf

Lester, H., Schmittdiel, J., Selby, J., Fireman, B., Campbell, S., Lee, J., Whippy, A. and Madvig, P., 2010. The impact of removing financial incentives from clinical quality indicators: longitudinal analysis of four Kaiser Permanente indicators. *Bmj*, *340*.

Lewis, R.E. and Heckman, R.J., 2006. Talent management: A critical review. *Human resource management review*, *16*(2), pp.139-154.

Light, D. and Dixon, M., 2004. Making the NHS more like Kaiser Permanente. *Bmj*, *328*(7442), pp.763-765.

McHugh, M.D., Aiken, L.H., Eckenhoff, M.E. and Burns, L.R., 2016. Achieving kaiser permanente quality. *Health care management review*, *41*(3), p.178.

Ngune, I., Jiwa, M., Dadich, A., Lotriet, J. and Sriram, D., 2012. Effective recruitment strategies in primary care research: a systematic review. *Quality in primary care*, *20*(2), pp.115-123.

NHSBT (2021) Using VBR to expand the talent pool and improve candidate experience; NHS Bland transplant: https://www.nhsemployers.org/-/media/Employers/Publications/Workforce-Supply/NHSBT-VBR-case-study-Fin.pdf

Pilbeam, S. and Corbridge, M., 2010. *People resourcing and talent planning: HRM in practice*. Prentice Hall.

Roper, J., 2015. What do we mean when we talk about talent. *HR Magazine*.

Rubin, M. and Kilgore, R.C., 2020. Integrated care workforce development: University-community collaboration. *Social Work Education*, *39*(4), pp.534-551.

Taneja, S., Mizen, P. and Bloom, N. (2021). Working from home is revolutionising the UK labour market. https://voxeu.org/article/working-home-revolutionising-uk-labour-market. (Accessed 9th May 2021.)

Whysall, Z., Owtram, M. and Brittain, S., 2019. The new talent management challenges of Industry 4.0. *Journal of management development*.

Wolf, E.J., 2001. Four strategies for recruitment and retention. *Healthcare executive*, *16*(4), pp.14-18.