

# From Policy to Practice

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Explaining Successes and  
Barriers in Scotland's Health  
and Social Care Integration  
(2014-2025)

Mücahit Bektaş  
Paul Cairney

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PRESS

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## From Policy to Practice: Explaining Successes and Barriers in Scotland's Health and Social Care Integration (2014-2025)

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Bektaş: Conceptualization, Data curation, Funding acquisition, Investigation, Methodology, Project administration, Validation, Writing – original draft, Writing – review & editing

Cairney: Conceptualization, Methodology, Supervision

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# Executive Summary

Scotland's 2014 integration settlement sought to shift the system from fragmented delivery to person-centred, outcomes-focused care by delegating key health and social care functions to Integration Authorities (Integration Joint Boards-IJBs) and by requiring local partners to plan and deliver jointly. A decade on, integration is widely supported in principle across participant groups in this study, yet experienced as uneven in practice: the “idea” of integration is often described as self-evident, while its operationalisation is reported as constrained by accountability ambiguity, misaligned incentives, workforce instability, and limited data interoperability.

This report explains why some integration efforts are perceived as successful (often locally and relationally) while barriers persist system-wide. It is based on 44 semi-structured elite interviews (G1-G3) conducted in 2025, supplemented by a structured documentary review of statutory, policy, and evaluative materials covering the 2014-2025 period. Rather than score each area, the report identifies recurring mechanisms and ‘boundary conditions’ that help explain divergent delivery realities.

Three headline findings stand out. First, participants repeatedly differentiate strategic intent from decision capacity: where decision rights are fragmented across Health Boards, Local Authorities, and IJB governance, integration becomes a negotiation rather than an operating model. Second, “integration” is still frequently experienced as a set of organisational interfaces rather than a redesigned service user journey, particularly where financial rules and performance governance reward organisational protection rather than shared outcomes. Third, where integration is seen to work, it is typically enabled by relational infrastructure: Stable leadership, trusted boundary-spanning roles, and practical joint working at locality level; these conditions are vulnerable to turnover, fiscal tightening, and inconsistent data systems.

Recommendations are therefore structured at two levels. At strategic level, the report prioritises clarifying accountability and decision rights; strengthening commissioning and incentive alignment (including transparent reserves and set-aside practices); and investing in workforce capacity and data interoperability as core integration enablers. At operational level, the report

proposes implementable actions for the next 0-24 months: Joint planning cycles, shared performance conversations, practical information-sharing protocols, and structured engagement with third sector and service users that goes beyond consultation. This report does not argue for a wholesale replacement of Scotland’s current integration settlement. Its main recommendations are oriented towards improving delivery within the existing institutional architecture, while also identifying a smaller set of more ambitious structural options for longer-term consideration

Finally, the report situates these recommendations within the 2026 implementation landscape, including the Care Reform (Scotland) Act 2025 and the planned national rollout of MyCare.scot (Digital Front Door). These developments create both opportunities and risks: They can provide a clearer national “operating environment” and digital access pathway, but only if they are coupled with local capacity, governance clarity, and inclusion safeguards.

### **Key Messages**

- Integration is widely supported as a principle (seamless, person-centred care), but implementation is experienced as uneven and often constrained by structural and fiscal realities.
- It is important to note that ambiguity in accountability and decision rights is a recurring mechanism. IJBs are expected to lead strategic change, yet control over key levers frequently remains dispersed.
- It is evident that financial alignment remains partial. In practice, ‘pooled budgets’ can retain organisational identity, which limits reallocation toward prevention and community support.
- The workforce is characterised by fragility, with issues including vacancies, turnover, differential terms and conditions, and professional boundary disputes. This functions as an “integration tax” on local delivery.
- Research indicates that successful integration is commonly attributed to leadership stability, trust-based relationships, and boundary-spanning roles that translate policy into practice.
- The limitations on data and information governance, including interoperability, access, and GDPR-related risk aversion, can impede the coordination of care and perpetuate siloed working practices.

- Meaningful voice and participation requires moving from consultation to shared problem-definition and co-design; participants warn against “tick-box” engagement.
- COVID-19 is treated here as a stress test rather than the analytical centre: it exposed fragilities but did not create the underlying structural issues.
- Recommendations should be sequenced: Governance clarity and incentive alignment are prerequisites for sustainable service redesign.
- The 2025-2026 policy landscape (Care Reform Act 2025; Digital Front Door/MyCare.scot) should be leveraged to strengthen (not substitute for) local integration capability.

### Clarifying the institutional distinction

	<i>Primary role</i>	<i>Practical implication</i>
<i>IJB</i>	Strategic planning, commissioning, governance, and direction-setting for delegated functions	Expected to lead strategic change, but does not usually operate as the direct employing body
<i>HSCP</i>	Joint delivery arrangement bringing together health board and local authority services in practice	Functions as the main partnership vehicle through which integrated delivery is organised locally
<i>NHS Board &amp; Local Authority</i>	Statutory bodies retaining major employment, corporate, financial, and legal responsibilities	Many key operational levers remain located in partner organisations rather than in the IJB itself

## Policy Options at a Glance

The table below presents three “bundles” of policy and delivery actions. They are not mutually exclusive; rather, they provide different sequencing emphases.

	<i>Core idea</i>	<i>What changes in practice</i>	<i>Key risks to manage</i>
<i>Governance</i>	Clarify accountability and decision rights to reduce negotiated implementation.	Strengthen IJB authority over delegated functions; align national-local performance governance; formalise escalation routes.	Risk of reform fatigue; may be perceived as structural change without service redesign unless coupled with delivery support.
<i>Incentives</i>	Realign financial rules so prevention and community investment are viable and protected.	Transparent reserves; consistent set-aside practices; commissioning cycles anchored to outcomes and locality needs; reduce cost-shifting behaviours.	Risk of short-term destabilisation during reallocation; requires robust data and political cover.
<i>Delivery</i>	Invest in the practical enablers of joint working (workforce + data) and scale what works locally.	Boundary-spanner roles; shared training; interoperability roadmap; standardised information-sharing protocols; inclusion supports for digital pathways.	Risk of local ‘islands of success’ without system-level alignment; benefits can be slow to surface.

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## Acronyms

COSLA	Convention of Scottish Local Authorities
DFD	Digital Front Door
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
GDPR	General Data Protection Regulation
HSCP	Health and Social Care Partnership
IG	Information Governance
IJB	Integration Joint Board (Integration Authority)
IT	Information Technology
KMI	Key Mention Indicator
LA	Local Authority
NES	NHS Education for Scotland
NHS	National Health Service
RCOP	Reshaping Care for Older People
SG	Scottish Government
SPICe	Scottish Parliament Information Centre
CHP	Community Health Partnership
CHCP	Community Health and Care Partnership
CHaSCP	Community Health and Social Care Partnership
IRF	Integrated Resource Framework
SSA	Single Shared Assessment



# Section 1



## Introduction

### *Purpose and audience*

This report explains how Scotland’s policy ambition for health and social care integration translated into practice (what has worked, what has worked only partially, and where barriers have constrained delivery). It is written primarily for public-sector decision-makers and senior leaders in Health and Social Care Partnerships (HSCPs), Integration Joint Boards (IJBs), local governments, and NHS Scotland as well as those in the third and voluntary sectors. It is also intended for any decision-makers and senior leaders engaged in national policy design, scrutiny, and improvement support.

The analysis is designed to be usable in two ways:

- As a policy narrative; tracing the logic of reform from legislation and national strategy through governance arrangements and local delivery
- As an implementation diagnosis; identifying the mechanisms (enablers and constraints) that help explain variation between places, priorities, and periods

### *What “integration” means in this report*

In this report, integration refers to the statutory and operational arrangements established under the Public Bodies (Joint Working) (Scotland) Act 2014 and its implementation architecture, particularly the establishment of Integration

Authorities and IJBs to oversee planning, resourcing, and delivery across health and social care functions.

Audit Scotland (2015) characterised the 2014 Act as a “significant programme of reform”, intended to break down organisational barriers between councils and NHS boards, with an overarching aim to improve support for people using health and social care services. These new partnerships were designed to direct and coordinate a very substantial share of Scotland’s health and care resource base.

A key practical clarification (also important for governance and accountability) is the organisational reality that IJBs were not initially expected to directly employ staff; the Chief Officer and Finance Officer functions support the IJB but are typically employed by either the council or NHS board and seconded into the IJB. This matters because it shapes “who can instruct whom”, how authority is exercised, and how accountability is understood in day-to-day system management.

### *Background and reform rationale*

While the statutory focus of integration begins in the mid-2010s, the policy rationale has deeper roots in Scotland’s long-running reform agenda; shifting from fragmented, reactive services towards coordinated, person-centred support, delivered closer to home, and oriented to outcomes and prevention.

This direction of travel was already visible in the reshaping-care agenda for older people. Audit Scotland (2014) highlighted that Scotland faced “significant challenges” in reshaping care for older people while still meeting current demand, in the context of demographic change and rising complexity of need. It also framed the reshaping agenda as a major transformational change programme that required strong leadership at both national and local level. These pressures and reform intentions formed part of the wider conditions into which integration was introduced.

Integration, therefore, should be read as both:

- A governance reform (new bodies, new schemes, new planning duties)
- A service reform (a deliberate attempt to change how resources, decisions, and professional practices combine to improve outcomes)

### *Aims and analytical orientation: “from policy to practice”*

The central aim is to explain the relationship between:

- The policy intent (what integration was expected to achieve)

- The implementation reality (what the system delivered, where, and why)

The report is anchored in the premise (explicit in national scrutiny) that integration is complex and requires sustained engagement and clarity of purpose. Audit Scotland (2015) noted that integration authorities need ongoing public engagement so that people understand the purpose of integration and can influence service change, and that service users may not see immediate differences even when reforms are underway. This report therefore treats integration as an implementation problem as much as a policy-design problem.

A second analytical anchor is that integration sought to move performance thinking away from internal process metrics toward outcomes. Audit Scotland (2015) observed that the national outcomes framework signalled an important shift from measuring internal processes to assessing impact on people using services. The report uses this outcome-oriented framing as a lens while also examining how performance systems, governance dynamics, and resource constraints affect what can be achieved.

### *Evidence base at a glance*

The report draws on two complementary forms of evidence:

- Primary documentary evidence; legislation, statutory guidance, national strategies, parliamentary and governmental materials, and scrutiny/audit outputs treated as the baseline for describing “what the system is” and “what it was expected to do”
- Elite qualitative interviews; semi-structured interviews with senior actors involved in strategic commissioning, governance, and delivery. In total, 46 interviews were conducted; two participants later withdrew their transcripts, leaving 44 transcripts used for analysis (project fieldwork record)

The documentary evidence sets the formal context; participant evidence is used to interpret how the system operated in practice, how decisions were made, and why barriers emerged or were overcome.

### *Period covered: what “2014–2025” includes*

The report’s core policy focus is the integration settlement introduced in the mid-2010s, but it explicitly incorporates:

- Background conditions and pre-2014 reform trajectories that shaped why integration was pursued (e.g., demographic pressures and the reshaping-care agenda)

- Developments up to and including 2025, with attention to how the integration system evolved over time

Because this report is being finalised in 2026, it also flags major post-interview and late-period developments where they materially affect interpretation and recommendations. Audit Scotland's 2018 national update is used as an important mid-point benchmark, noting that several significant barriers needed to be overcome to speed up change, including governance disagreement, leadership capacity issues, turnover, and difficulties in safely sharing data. Later sections then connect these recognised barriers to the interview evidence and to more recent reform moves.

### *How to read this report*

Section 2 sets out the policy and system context, and Section 3 details the research design and evidence base. Sections 4 and 5 present the thematic findings and cross-theme synthesis supported by participant evidence. Sections 6 and 7 translate the findings into policy options and practical recommendations, before drawing out concluding implications for delivery and oversight.

Throughout, the report maintains a strict anonymity approach: organisational areas may be named at the HSCP/IJB level, but participant roles are not paired with specific areas, and direct quotations are attributed only to participant codes.

# Section 2



## Policy and System Context

This section summarises the key policy drivers, statutory design, governance arrangements and major system developments that have shaped Scotland's health and social care integration. It highlights what the reform set out to achieve, as well as the most significant implementation pressures identified by oversight bodies. It also notes the most significant developments since the interviews were conducted that are important for understanding the current situation.

### **2.1. Policy background before the 2014 statutory model**

The integration of health and social care in Scotland did not begin with the Public Bodies (Joint Working) (Scotland) Act 2014. Instead, the statutory model should be seen as the culmination of a longer reform process, during which successive governments sought to move care away from organisational fragmentation towards more coordinated, community-based and person-centred arrangements. Audit Scotland's timeline prior to 2014 places this trajectory within a broader sequence of reforms, including the Joint Future agenda (2000), community planning reforms (2003), the Community Health Partnerships regulations (2004), and subsequent policy instruments focused on service redesign, prevention, and shifting the balance of care.

A key institutional precursor was the establishment of Community Health Partnerships (CHPs). According to Audit Scotland (2011), the NHS Reform

(Scotland) Act 2004 required NHS boards to establish one or more CHPs to bridge the gap between primary and secondary care, as well as between health and social care. By 2011, there were 36 CHPs across Scotland, comprising both health-only structures and integrated health and social care variants. Notably, some areas had transitioned from conventional CHP structures to more integrated partnership models, such as Community Health and Care Partnerships (CHCPs) and Community Health and Social Care Partnerships (CHaSCPs). These new models were accountable to both the NHS board and the relevant council. Audit Scotland also emphasised that these arrangements had evolved incrementally, resulting in a “cluttered partnership landscape” in which new structures were often layered onto existing ones rather than replacing them outright.

This pre-statutory landscape is especially important in parts of the NHS Greater Glasgow and Clyde area, where local partners had already adopted integrated arrangements prior to 2014. In East Renfrewshire, an integrated CHCP had been in place since 2006, and official commentary in 2015 described this as a relatively mature partnership with established trust and integrated management arrangements (White, 2015). In West Dunbartonshire, the CHCP formally came into being on 1 October 2010 as a single integrated structure bringing together NHS Greater Glasgow and Clyde and council responsibilities for community-based health and social care services, while retaining separate statutory accountability and employment lines (W. Dunbartonshire CHCP, 2011). In Inverclyde, a CHCP was also developed in 2010 as an “enhanced partnership arrangement” between the council and NHS Greater Glasgow and Clyde, explicitly intended to strengthen joint working, align governance, and improve outcomes (Inverclyde Council, 2012). These examples matter because they show that, in some areas, the 2014 settlement built on earlier local integration experiments rather than starting from an institutional blank slate.

Alongside these organisational developments, Scotland also introduced preparatory tools intended to make joint planning more practical. The Integrated Resource Framework (IRF), introduced in 2008, was designed to show how money was being spent across health boards, councils, and CHP areas, thereby giving local partners a better basis for strategic commissioning and service redesign (Audit Scotland, 2014). At the service level, the Single Shared Assessment (SSA) was intended to reduce duplication and coordinate access by enabling different professionals to work from a more shared understanding of need (Scottish Executive, 2004). These instruments did not in themselves create integrated governance, but they formed part of the policy architecture that attempted to make cross-boundary planning and delivery more operationally feasible.

Therefore, the Reshaping Care for Older People (RCOP) programme should be considered within the broader context of pre-2014 reforms, rather than being treated as the sole precursor. Audit Scotland's overview of care for older people shows that RCOP was part of a much longer series of policies focusing on prevention, care closer to home, delayed discharge and integrated support. In this context, the 2014 Act was less a wholly new direction and more an attempt to give statutory status to a reform agenda that had already been pursued through initiatives such as Joint Futures, CHPs/CHCPs, resource-mapping tools and local partnership experiments. In short, the emergence of integration as a policy idea was not what changed in 2014, but rather the attempt to give it a more uniform legal, governance and accountability framework across Scotland (Audit Scotland, 2014; 2015).

## **2.2. The 2014 reform model: What it was designed to do**

The 2014 reform model is best understood as both a statutory settlement and a reorganisation of how authority, planning, and responsibility were expected to operate across health and social care. This section therefore examines the reform in two connected ways. It first outlines the statutory architecture and the intended system shift created by the Public Bodies (Joint Working) (Scotland) Act 2014, before then clarifying how governance, delegation, and accountability were structured within the new integration arrangements.

### **2.2.1. Statutory architecture and intended system shift**

The Public Bodies (Joint Working) (Scotland) Act 2014 should not simply be understood as a statement of support for closer partnership; it marked the point at which integration was converted into a statutory operating framework. While earlier policy had encouraged joint working, the 2014 Act was designed to go further than discretionary collaboration by requiring local authorities and NHS boards to establish formal integration arrangements and set them out in an integration scheme for approval. In this respect, the reform aimed to transform the status of integration from a desirable policy direction into a mandatory institutional settlement.

At the centre of that settlement was a requirement to define, in a more formal and durable way, which functions and resources would be brought within integrated planning and resourcing. The Act did not treat integration as a vague aspiration. It required partners to specify the scope of integrated functions and to establish an agreed statutory basis for joint working. Audit Scotland (2015) described this as a “significant programme of reform” affecting most health and care services and over £8 billion of public money, with the aim of ensuring that people receive the care they need at the right time and in the

right setting, with a stronger emphasis on community-based and preventative care. At a minimum, the reform was intended to integrate the governance, planning, and resourcing of adult social care, adult primary and community health care, and unscheduled hospital care for adults, while allowing some areas to include additional services according to local decisions and context (Audit Scotland, 2015; 2018).

The Act was designed to achieve more than just the creation of new structures. Its purpose was to embed a different set of planning assumptions into the system, emphasising improving wellbeing, anticipating needs, supporting people to live independently, respecting dignity, encouraging participation, reducing inequalities and making the best use of available resources. From a design perspective, this is important because the reform model was not just intended to connect organisations administratively. Rather, it was intended to reorient service planning around the experience and outcomes of service users, rather than around inherited institutional boundaries.

This outcome-oriented design was reinforced by the Act's provision for national health and wellbeing outcomes. Rather than allowing each partnership to define success independently, the legislation established a shared national outcomes framework against which integrated arrangements would be planned and evaluated. The Scottish Government's (2015a) outcomes framework explicitly stated that integration was intended to transform both the organisation of services and their expected outcomes for individuals and communities. In this sense, the reform model linked structural integration to a broader performance logic of improving personal outcomes, supporting independence and shifting the system away from focusing solely on narrow process measures (Audit Scotland, 2015).

Another key feature of the 2014 model was its focus on strategic planning as the primary means of system change. The Act required integration authorities to prepare strategic plans for each local authority area and to incorporate localities and structured participation from relevant stakeholders in the process. This demonstrates that the reform was designed as an ongoing planning process rather than a one-off structural reorganization. The intention was for integration to operate through recurring cycles of needs assessment, priority setting, resource alignment and service redesign rather than through isolated partnership projects or short-term coordination efforts. The Scottish Government's strategic planning guidance (2015c) also positioned the strategic plan as the mechanism through which delegated functions, resource use and intended outcomes would be brought together in a coherent local framework.

The locality dimension is equally important to the design logic of the Act. The reform model did not assume that integration could be achieved solely through top-level institutional agreement. By requiring attention to localities, the legislation aimed to connect strategic intent with the realities of place, population need, and service configuration. This reflected an assumption that effective integration would depend not only on national reform and partnership-wide planning, but also on an ability to tailor service redesign to local patterns of demand, provider capacity, and community context. In that sense, locality planning was intended to function as the bridge between national ambition and operationally meaningful redesign.

Taken together, the 2014 reform model was designed to do four closely related things. First, it placed integration on a statutory footing rather than leaving it to voluntary partnership. Second, it required partners to bring defined functions and resources within an integrated planning framework. Third, it established a common outcomes-based logic intended to shift attention towards prevention, community support, and improved user experience. Fourth, it treated strategic and locality planning as the principal means through which these ambitions would be translated into service redesign. Read in these terms, the Act was not only a governance reform. It was also an attempt to reshape the purpose, scale, and planning logic of health and social care delivery in Scotland.

### **2.2.2. Governance, delegation, and accountability structure**

The governance architecture established under the Act 2014 was not designed as a full organisational merger. Rather, it created a statutory framework through which NHS boards and local authorities were required to integrate specified functions and associated resources through an agreed integration scheme. That scheme was intended to define the model of integration, the functions to be delegated, and the institutional basis on which strategic planning and resourcing would operate. In this sense, the reform did not abolish existing organisations or replace them with a single unified provider. Instead, it created a new layer of integrated authority intended to coordinate planning, priorities, and direction across bodies that remained legally and organisationally distinct.

A central distinction within this architecture is between the two statutory integration models. In most of Scotland, integration proceeded through the body corporate model, under which an Integration Joint Board (IJB) was established as a separate legal entity responsible for the strategic planning of delegated functions and budgets. In Highland, by contrast, a lead agency

model was used, under which the NHS board and local authority each led different parts of the integrated system rather than creating an IJB in the usual form. This distinction matters because it shows that the 2014 settlement did not impose a single institutional template. It established a common statutory goal of integration, but allowed different governance routes through which that goal could be operationalised.

Where the body corporate model is used, the IJB occupies a strategic rather than directly managerial position. Scottish Government (2015b) guidance makes clear that the IJB is responsible for the strategic planning of delegated functions and for ensuring that these functions are delivered, but service delivery itself is operationalised through directions issued to the partner NHS board and local authority. This is a critical structural point. The IJB does not typically deliver services through its own organisational apparatus; instead, it seeks to shape delivery through planning authority, budgetary oversight, and formal direction-making powers. The practical effect is that integrated governance depends not on simple command-and-control authority, but on a structured relationship between the integration authority and the partner bodies that continue to employ staff, hold corporate infrastructure, and discharge a range of operational responsibilities.

This is also why the distinction between governance structures and employing bodies is so important. Under the statutory design, IJBs were not generally expected to become large employing organisations in their own right. Explanatory materials to the Act indicate that an IJB would not necessarily be given powers to employ staff directly, and early implementation guidance and oversight reporting similarly emphasised that key roles such as the Chief Officer and Finance Officer would usually be employed by the NHS board or local authority and assigned or seconded to support the IJB. In other words, the governance centre of the integrated system was separated from many of the employment, managerial, and corporate support lines through which day-to-day service capacity actually operated. This arrangement helps explain why formal integration did not eliminate institutional boundaries, but instead reorganised how those boundaries were expected to be managed (Audit Scotland, 2015; Scottish Government, 2015b).

The accountability implications of this design are equally significant. Even when functions are transferred to integrated arrangements, NHS boards and local authorities remain statutory bodies. The Scottish Government's (2015b) guidance makes it clear that partner bodies remain responsible for certain legal duties and corporate accountabilities, including some complaints and statutory service obligations. Later assessments by Audit Scotland (2018)

similarly note that governance under integration became more complex, not less, because responsibility for planning, delivery, scrutiny, professional governance, finance and legal duties no longer sat neatly within a single chain of command. This creates a multi-principal accountability structure in which the IJB is expected to provide strategic leadership across delegated functions, while the partner bodies retain control over the workforce, corporate support, legal responsibility and operational execution. Accountability is therefore distributed rather than unitary.

This matters because the statutory architecture helps explain why integration has always depended on more than formal institutional design alone. The 2014 model created a framework for shared planning, delegated authority, and coordinated decision-making, but it did so across organisations with different professional systems, statutory duties, financial regimes, and internal reporting lines. The significance of governance structure, therefore, lies not only in describing where authority formally sits, but in clarifying the conditions under which integrated action becomes possible. Put differently, the reform model brought organisations into a shared planning and accountability space, but it did not erase the separate institutional foundations on which implementation still depended. That structural feature is essential for understanding the later practical challenges of coordination, decision-making, and delivery explored in the following sections (Audit Scotland, 2015; 2018).

### **2.3. Early implementation pressures highlighted by oversight bodies**

Early oversight reporting presented integration not as a routine administrative transition, but as a compressed reform programme entering operation under considerable pressure. Audit Scotland (2015) framed the new arrangements against longstanding demographic and service pressures, arguing that there was a pressing need for reform to succeed if Scotland was to shift care away from avoidable hospital use and towards more preventative and community-based support. In that sense, the earliest implementation challenge was not simply whether new bodies could be established on time, but whether they could begin to change patterns of service delivery quickly enough to respond to rising demand and entrenched system imbalance.

A central concern in this early phase was the maturity of strategic planning. Audit Scotland (2015) found that, although strategic planning was meant to sit at the core of the new model, many Integration Authorities were still at an early stage of development. At the time of audit, only a small number had published strategic plans, and those in place were often described as

aspirational rather than operationally robust. The problem was not simply delay. Oversight reporting suggested that many plans did not yet set out with sufficient clarity what resources would be required, what success would look like, or how progress would be monitored and reported publicly. This created an early risk that integration might become formally established before it was strategically capable of reshaping services in a substantive way. Audit Scotland also linked this weakness to unresolved budget-setting, noting that uncertainty over agreed budgets was making it harder for partnerships to move from broad reform intent to credible medium-term planning.

Oversight bodies also highlighted a wider readiness problem around the practical enablers of implementation. Integration Authorities were expected not only to produce overarching strategic plans, but also to develop supporting strategies for workforce, risk management, data sharing, and engagement with people using services. Audit Scotland's (2015) assessment showed substantial variation in the timetable for putting these foundations in place. In some areas, such strategies were scheduled well before full operation; in others, they were not due to be agreed until many months after the new arrangements had formally gone live. This mattered because the reform depended on capabilities that could not be assumed into existence by legislation alone. Workforce planning was identified as particularly challenging, given the need to coordinate staff employed across different organisations and to support a shift towards more community-based models of care. In parallel, incomplete data-sharing arrangements limited the ability of some partnerships to plan on the basis of a sufficiently integrated evidence base.

A further early pressure concerned the extent to which locality working had become real rather than nominal. The statutory model placed considerable weight on localities as a mechanism for linking strategic planning to local priorities, service redesign, and community input. Yet Audit Scotland found that locality arrangements were often underdeveloped in practice, partly because partnerships were still preoccupied with budgets and governance, and partly because some key guidance arrived relatively late in the implementation process. In many places, locality work initially centred on networking and needs assessment rather than on taking a strong role in shaping service change. Oversight reporting therefore suggested that one of the reform's most important mechanisms for grounding integration in place-based planning had not yet matured at the point when the wider system was expected to begin delivering change.

Leadership and governance capability were also identified as early implementation pressures. Audit Scotland noted that IJB members required

training and development to fulfil their role effectively, and its recommendations stressed the need for clear and strategic leadership to articulate the purpose of integration, align partners, and carry the reform agenda forward. This point is important because it shows that early implementation pressures were not confined to budgets or structures. They also concerned institutional capability i.e. whether new boards, senior leaders, and partner organisations had the shared understanding, authority, and practical preparedness needed to make the reform operative. Read together, these early oversight findings suggest that the first phase of implementation was defined less by the formal creation of new bodies than by the difficulty of making those bodies strategically coherent, operationally supported, and locally grounded quickly enough to deliver the intended shift in care.

#### **2.4. Progress and barriers by the late 2010s**

By the late 2010s, oversight reporting was presenting a mixed picture: Integration had produced identifiable areas of progress, but these gains remained uneven and fragile. Audit Scotland's 2018 update concluded that Integration Authorities had begun to introduce more collaborative ways of working and had made improvements in several important areas, including reductions in unplanned hospital activity and delays in discharging people from hospital. It also pointed to evidence that more people at the end of life were spending time at home or in a homely setting rather than in hospital. These developments mattered because they suggested that the legislative framework could support practical improvement. At the same time, the report was explicit that such progress did not amount to system-wide transformation and that much more remained to be done if integration was to deliver its intended long-term effects.

Therefore, the central message of oversight in the late 2010s was not that integration had failed, but that progress was being made within an implementation environment that was still unresolved. Audit Scotland (2018) argued that significant barriers continued to impede progress and identified six areas requiring collective action:

- Collaborative leadership
- Effective strategic planning
- Integrated finances
- Agreed governance and accountability arrangements
- The ability and willingness to share information

— Meaningful engagement

This represented an important shift in emphasis. While early implementation reporting had focused heavily on readiness, by 2018 the concern was increasingly whether the system could convert formal integration into sustained service redesign at sufficient scale and pace.

Financial planning was one of the clearest late-2010s constraints. Audit Scotland (2018) stated directly that financial planning was not integrated, long term, or sufficiently focused on achieving the best outcomes for people who need support. It described this as a fundamental issue that would limit Integration Authorities' ability to improve the health and wellbeing of local populations. The report further noted that, while all Integration Authorities had short-term financial plans, only a minority had medium-term plans and none had longer-term plans in place at the time of fieldwork. It also highlighted a lack of evidence that councils and NHS boards were treating Integration Joint Boards' finances as a genuinely shared resource. In practical terms, this meant that the strategic ambition to shift care upstream into prevention and community settings was still constrained by annual budget cycles, service pressures, and unresolved resource-sharing practices.

Governance and accountability also remained unsettled. The 2018 update did not suggest that the legislative framework itself had to be abandoned; rather, it stressed that local partners still needed to agree how responsibilities and accountabilities should operate where there was disagreement over interpretation of the Act and its underpinning principles. This point is especially important because it indicates that, several years into implementation, some of the most significant barriers were no longer about establishing structures but about making those structures work consistently across organisational boundaries. The same report linked this problem to continuing difficulties around "set-aside" budgets for hospital functions delegated to Integration Joint Boards. Audit Scotland described the non-implementation of the set-aside element of the Act as a major source of debate and disagreement and warned that this would hinder Integration Joint Boards' ability to use resources strategically in support of prevention and community-based care.

Late-2010s oversight also showed that information, performance, and engagement remained weaker than the reform model required. Audit Scotland (2018) argued that an inability or unwillingness to share information was slowing the pace of integration and highlighted inconsistent data-sharing practices, variable willingness to share learning, and ongoing difficulties in building the evidence base needed to demonstrate improved outcomes. At the same time, it stressed that meaningful and sustained engagement

was still uneven across partnerships. Its account drew attention to concerns that engagement could become tokenistic, overly top-down, or limited to communicating decisions that had already been made. Taken together, these findings suggested that by the late 2010s the main barriers were no longer best understood as transitional teething problems. They had become recurring system constraints affecting how far integration could move from statutory form into durable changes in planning, delivery, and public legitimacy.

## **2.5. Post-interview developments that materially change the context**

Three developments are especially consequential for interpreting the current landscape and for ensuring that recommendations do not lag behind policy reality.

### **2.5.1. Care Reform (Scotland) Act 2025: Implications for integration**

The Care Reform (Scotland) Act 2025 is now part of Scotland's live statutory landscape for care reform. The Act confirms that it was passed by the Scottish Parliament on 10 June 2025 and received Royal Assent on 22 July 2025 (Care Reform (Scotland) Act 2025).

Crucially, the Act also embeds phased commencement rather than “switch-on” implementation. Under the commencement provision, section 30 and the Act's final provisions came into force the day after Royal Assent, while other provisions require commencement regulations and associated policy/operational preparation. Section 30 is substantively important because it creates a standing requirement for Scottish Ministers to publish a report on projected social care needs over a 10-year period, first due by the end of 2026 and then at five-year intervals thereafter. This matters for integration because projections, demand intelligence, and resource planning are recurring pressure points for strategic commissioning and for IJB-level prioritisation decisions.

For interpreting integration, the Act is best understood as the end point of a highly consequential legislative journey that began as the National Care Service (Scotland) Bill (introduced in 2022). During scrutiny and amendment (especially at Stage 2) the Bill changed shape dramatically. SPICe's Stage 3 briefing foregrounds that the Scottish Government's amendments removed most of the original “structural” architecture (including proposals for new national/local care boards and major shifts in accountability), and that Part 1 of the Bill (the structural reform core) was removed, leaving the remaining package focused more on care records, digital/information matters, and a

range of delivery-related provisions. In that context, the Bill's renaming to the "Care Reform (Scotland) Bill" is not a cosmetic change; it signals that the legislation could no longer credibly be described as establishing a National Care Service (SPICe, 2025).

This transition has two direct implications for this report's reading of integration reform. First, it indicates a move away from wholesale structural reconfiguration of the integration settlement (e.g., replacing or subsuming existing partnership arrangements) toward a more incremental and enabling reform package that sits around current integration governance. Second, it reinforces why the report's long-running "implementation conditions" (clarity of accountability, commissioning capability, workforce capacity, information governance, and local decision rights) remain decisive; the Act creates powers and duties, but delivery and system effects will depend on how those powers are operationalised across multiple partner organisations and localities (SPICe, 2025).

Substantively, the provisions most directly relevant to integration governance and practice sit in Part 1 (Health and Social Care Information). The Act establishes:

- A statutory basis for Ministers to facilitate the creation of a digital care record
- Powers to create information sharing schemes via regulations
- A framework for producing information standards governing the processing of Scottish health and social care information, including defining who standards may apply to and establishing compliance duties

It is worth noting that the Act anticipates the application of information standards to system actors central to integration, explicitly including local authorities, Integration Joint Boards, and NHS boards. In terms of integration, these provisions align with the ongoing challenges reported by participants, including fragmented records, interoperability gaps, inconsistent information governance, and weak cross-boundary information flows. However, the Act's information architecture will only translate into "felt" integration if the technical measures are matched with workflow redesign, agreed accountability for implementation, and shared operational incentives across partners.

The Act also covers governance and commissioning conditions that shape integration delivery. In the integration space, section 15 amends the Public Bodies (Joint Working) (Scotland) Act 2014 by inserting a new ministerial power to modify (via regulations) the statutory integration planning

principles and integration delivery principles. This is significant because the 2014 Act's principles are part of the normative and statutory backbone of integration; a regulation-making power to adjust them creates a mechanism for government to recalibrate the “rules of the game” without reopening primary legislation. Alongside this, the Act introduces duties around ethical commissioning guidance and makes changes that connect commissioning practice to integration realities. For example, procurement-related provisions that explicitly reference functions delegated to an “integration authority” and alignment with the integration authority's strategic plan. These provisions speak directly to recurrent integration challenges around commissioning fragmentation, inconsistent incentives, and tensions between strategic intent and contractual practice.

Finally, the Act is already functioning as an enabling framework for secondary legislation which is analytically important because it demonstrates how integration-relevant change may now arrive through regulations, codes of practice, and impact-assessment guided implementation rather than through structural redesign. The Scottish Government's (2026a) final Business and Regulatory Impact Assessment for the Care Home Services (Visits to and by Care Home Residents) (Scotland) Regulations 2026 states that these regulations are introduced under powers conferred by section 14 of the Care Reform (Scotland) Act 2025, and specifies that they were laid in Parliament on 21 January 2026 and are due to come into force on 31 March 2026.

The accompanying Equality Impact Assessment similarly frames the regulations (commonly referred to as “Anne's Law”) as introduced under section 14 and describes their core duties around identifying at least one Essential Care Supporter and facilitating meaningful contact, subject to tightly framed exceptions (Scottish Government, 2025c). Although these regulations are not “integration architecture” in the narrow governance sense, they intersect with integration in practice because they shape cross-system responsibilities (care home providers, inspection, local authority roles), rights-based practice expectations, and information/record-keeping requirements that sit at the boundaries of health and social care delivery.

Overall, the Care Reform (Scotland) Act 2025 should be read as reinforcing an integration policy direction that is enabling and implementation-heavy; it strengthens the statutory toolkit around information, principles, and commissioning conditions, while leaving the existing integration settlement broadly in place. For this report, the practical implication is that recommendations should stay focused on the “delivery conditions” that determine whether statutory powers become real coordination, especially

data infrastructure and interoperability, decision-rights clarity, commissioning capability, workforce capacity, and accountable implementation pathways across partners (SPICe, 2025).

### **2.5.2. The Integration Joint Boards Amendment Order 2025 (SSI 2025/405)**

A further post-interview development that materially changes the integration context is the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Amendment Order 2025 (SSI 2025/405). Although narrower in scope than the Care Reform (Scotland) Act 2025, the Order is directly relevant to integration governance because it amends the 2014 IJB Order so that representatives of the third sector, service users, and unpaid carers become voting members of Integration Joint Boards. It also makes corresponding changes to provisions on resignation and proxy voting and is scheduled to come into force on 1 September 2026.

The significance of this change lies less in institutional restructuring than in its effect on board-level representation and decision-making authority. The accompanying policy note presents the reform as a response to the existing two-tiered system, under which lived-experience members participated in IJB discussions without equivalent voting status, and argues that extending voting rights should improve parity in decision-making. In that sense, the amendment is important not because it redesigns the integration system as such, but because it alters who may formally influence strategic decisions within that system (Scottish Government, 2025b).

At the same time, the change does not remove the wider structural ambiguities already discussed elsewhere in this report. The policy note is explicit that extending voting rights to lived-experience representatives does not alter the statutory accountability of local authorities or NHS boards. It also records a number of implementation concerns, including questions about democratic accountability, conflicts of interest, the pressure placed on volunteer representatives, and the need for additional training, support, recruitment processes, and updated codes of conduct. The Scottish Government (2025b) states that revised statutory guidance will therefore be needed to support implementation.

For the purposes of this report, the amendment matters because it changes the governance context within which integration must now be understood. It does not replace the earlier architecture of delegated functions, shared planning, and distributed accountability, but it does shift the representational balance within IJB decision-making. As a result, post-interview analysis of

integration can no longer assume that third sector, service user, and unpaid carer members remain confined to a purely advisory position. From September 2026 onwards, they are positioned more directly within the formal voting structure of local integration governance (Scottish Government, 2025b).

### **2.5.3. MyCare.scot and Scotland's Digital Front Door**

Digital access has become a more salient national policy instrument since the interview period, with Scotland's Digital Front Door (DFD) positioning MyCare.scot as a foundational service intended to reshape how citizens navigate health and social care information and interactions. Official programme communications frame MyCare.scot as part of a nationally led programme managed by NHS Education for Scotland (NES) in partnership with the Scottish Government (and, in programme documentation, with COSLA), and emphasise an incremental, user-centred build aligned to the Digital Scotland Service Standard (NHS Education for Scotland, 2025; Digital Health & Care Scotland, 2025).

The first release of MyCare.scot was launched in NHS Lanarkshire on 3 December 2025, targeted initially at a defined cohort of dermatology outpatients, with a clear “start small, evaluate, iterate” logic before scaling (Digital Health & Care Scotland, 2025; Scottish Government, 2025c). In this preliminary version, MyCare.scot (2026a; 2026b) is presented less as a comprehensive application and more as a secure online service that begins to consolidate core citizen-facing functions, including secure sign-in, basic personal information access, appointment visibility, and digital communications (NHS Education for Scotland, 2025; Scottish Government, 2025a). Access is currently managed through an invitation-based model, with verification and protection of personal information facilitated by ScotAccount sign-in.

Across the programme pages, the intended minimum viable functionality is described in broadly consistent terms: Users are expected to be able to log in securely; view upcoming appointments; receive digital letters rather than waiting for postal communications; view selected personal health information (with early communications highlighting medicines, allergies, and vaccinations); and use a service finder/directory to support navigation across services (NHS Education for Scotland, 2025; Scottish Government, 2025a; MyCare.scot, 2026a).

Programme documentation also clarifies the enabling infrastructure: MyCare.scot (2026c) leverages cross-government digital capabilities such as ScotAccount and a digital mailbox, and the initial Lanarkshire release routes digital communications through the ScotAccount mailbox ecosystem

(Scottish Government, 2025a). Importantly, official messaging also stresses that MyCare.scot is intended to complement rather than replace non-digital routes of access, positioning “choice” and inclusion as design principles rather than afterthoughts (Digital Health & Care Scotland, 2025; Scottish Government, 2025a).

The national rollout plan sets out an explicitly multi-year, iterative trajectory. Government publications describe MyCare as a “single, secure front door” developed over time to support the Service Renewal Framework agenda, with rollout continuing through to 2030 and a staged expansion from an initial secondary care (hospital-based) focus toward wider integration with GP practices, pharmacy, social work, and social care as readiness and technical foundations mature (Scottish Government, 2025a). The plan also signals that the approach is “nationally led” but “locally collaborative,” including organisational readiness assessment (covering leadership/ culture, infrastructure, fairness/value, and inclusion) and prioritisation of high-volume services and national priorities as onboarding progresses (Scottish Government, 2025a). Public-facing government communications further state that MyCare.scot will be made available “in some form” across Scotland from April 2026, following evaluation of the Lanarkshire launch (Scottish Government, 2025c).

This development matters for the report’s later analysis and recommendations because interview participants frequently described integration constraints that are structural to information flows and cross-boundary coordination; fragmented records, slow handovers, duplicated administrative work, and citizen difficulty navigating organisational boundaries. MyCare.scot addresses this issue by aiming to establish a unified citizen entry point, standardised identity and messaging infrastructure, and a service-finder function. However, programme materials also implicitly recognise the report’s primary concern that without interoperable data foundations, organisational readiness, and inclusive design, the “front door” might become a superficial digital layer over existing back-office fragmentation (Scottish Government, 2025a; Digital Health & Care Scotland, 2025).

# Section 3



## Methodology

### 3.1. Research design

The present study adopts a qualitative design with the aim of elucidating the translation of Scotland’s health and social care integration policy intent into delivery realities.

The research methodology comprised two complementary approaches:

- Semi-structured interviews were conducted with senior actors occupying governance, strategic oversight, and delivery roles within the integration system
- A documentary analysis of key statutory, policy, and implementation materials (including official publications and organisational documents) was undertaken to contextualize and corroborate interview accounts

The research is of an explanatory and interpretive nature, seeking to understand how actors define “success”, diagnose constraints, and describe mechanisms that shape implementation across places. The study design and utilisation of open-ended interviewing is consistent with established qualitative interviewing principles, emphasising depth, sequencing, and structured flexibility (Seidman, 2006, pp. 30-36).

### 3.2. Sampling strategy and recruitment

The sampling method employed was non-probability and purposeful, consistent with qualitative designs where the objective is to identify information-rich participants rather than to produce statistically representative estimates (Suri, 2011, pp. 63-66). Participants were selected on the basis of their positional involvement and/or reputational knowledge of integration governance and delivery challenges. This approach aligns with established guidelines for conducting elite interviews in process-oriented qualitative research, which underscore the strategic identification of key informants and, when deemed necessary, the utilisation of chain-referral (snowball) techniques to minimise the probability of overlooking pertinent participants (Tansey, 2007, pp. 766-771).

The recruitment process primarily involved the utilisation of direct email outreach, complemented by chain-referral (snowball) methods and sporadic introductions facilitated by intermediary contacts. The inclusion criteria focused on the following domains:

- Formal governance roles within IJBs, including both voting and non-voting membership
- Senior leadership positions within integrated delivery arrangements across IJBs, HSCPs, councils, and NHS boards
- Stakeholder roles with system-facing knowledge of pathways, access challenges, and service-user experience, including third sector, voluntary sector, independent sector, and service user representation

### 3.3. Participants and analytic groupings (G1-G3)

A total of 46 interviews were conducted. Following a review of the transcripts, two participants withdrew their permission for their transcripts to be used, and these interviews were excluded entirely. The analysis is thus based on a total of 44 transcripts.

In order to facilitate structured interpretation, participants were grouped in the following analytical manner:

- G1: HSCP senior leadership (comprising chief officer-level and closely associated senior management perspectives)
- G2: IJB voting members (including chairs, vice-chairs and other voting members)
- G3: IJB non-voting members

The distribution of participants across the 46 interviews was as follows: G1 (n=17), G2 (n=11), and G3 (n=18). Following the withdrawal process, the analytic corpus comprised G1 (n=16), G2 (n=11), and G3 (n=17) participants (n=44), as outlined in Table 1. Across Scotland's 30 IJB areas, the interview sample included at least one participant from 27 areas, while the remaining three were not represented. Group totals are reported only at the aggregate level and are not linked to quotations, locations, or titles.

### 3.4. Data collection procedures

The interviews were conducted between March and August 2025, employing a semi-structured guide that was designed around the following domains:

- Policy intent
- Governance and accountability
- Implementation mechanisms
- Operational constraints
- Perceived change over time

The interview guide (see the Interview Questions Form in the appendices) was designed in line with open-ended questioning principles, with the aim of eliciting narrative accounts, concrete examples, and causal explanations rather than short categorical responses (Husain et al., 2012, pp. 456-458).

*Table 1. Participant profile by group (n=44)*

Group	n	Typical roles represented (illustrative)	Interview modes
G1	16	Chief Officer, Chief Executive, IJB Secretary	In-person: 4; On-line: 12
G2	11	IJB Chair/Vice-Chair, IJB voting member	In-person: 1; On-line: 10
G3	17	Third Sector, Service User, Council Union	In-person: 4; On-line: 13

Most interviews in the analytic corpus (n=44) were conducted via Microsoft Teams (n=35), with a minority conducted in person (n=9) as summarised in Table 1. Interviews were conducted in English; therefore, quotations are presented in English and no translation was required.

With consent, interviews were audio-recorded using a standalone recording device to support accurate transcription.

### 3.5. Transcription, participant review, and data preparation

Audio recordings were transcribed in MS Word. Transcripts were then:

- Checked against recordings for accuracy
- Subject to initial cleaning and anonymisation
- Shared with participants for transcript review (“member review”) where requested/appropriate, with revisions incorporated based on participant feedback

This process was intended to improve accuracy and reduce the risk of misinterpretation or factual error in attributed accounts. Two participants subsequently exercised their right to withdraw their transcripts; as noted, both were removed from the dataset prior to analysis.

### 3.6. Ethics, consent, and confidentiality

Ethical approval was obtained through the University of Stirling ethics process (see ethics documentation in the appendices). Participation was voluntary and informed consent was obtained (electronic consent materials are provided in the appendices). Participants were at liberty to decline answering any question and could withdraw their data, consistent with standard research ethics principles for qualitative interviewing.

Confidentiality and anonymity were treated as critical, given the policy-facing nature of the report and the small-world characteristics of senior governance communities. The report therefore applies the following rules:

- Participants are referenced only via anonymised identifiers (Pxx)
- Roles/titles are not attached to direct quotations
- HSCP/IJB/city/town’s names are anonymised in the transcriptions (e.g. XX)
- HSCP/IJB areas may be named for contextual discussion, but HSCP/IJB areas are not matched with participant titles or identifiers

Specific quotation restrictions were applied where required: two withdrawn transcripts are excluded entirely; one transcript is included for analysis but not quoted directly.

### 3.7. Institutional architecture reflected in the analysis

The analysis applies a consistent institutional framing aligned with Scotland’s statutory integration model. Within this framing, IJBs are treated as strategic governance bodies rather than direct employing organisations. Operational

delivery continues to depend largely on staff employed by NHS boards and local authorities, working within integrated arrangements, while chief officers provide senior partnership leadership across organisational boundaries. This distinction is important because many participant accounts relate directly to distributed authority, multi-employer workforce realities, and the practical consequences of working across organisations that remain legally separate even within an integrated system.

### **3.8. Documents and secondary sources**

Documentary analysis was used for three purposes: to establish the formal policy and governance context of integration; to identify key statutory, strategic, and implementation milestones; and to triangulate interview claims where participants referred to formal requirements, guidance, or system reforms. The documentary corpus included legislation, statutory guidance, national policy documents, audit and oversight reports, organisational briefings, and other relevant publicly available materials used to interpret how the formal integration system was expected to operate.

### **3.9. Analytic approach: Manual coding and AI-assisted synthesis**

The following steps were taken in the research:

- Familiarisation; this involved repeated reading of transcripts and documentary materials
- Initial coding; a combination of manual coding and computer-assisted qualitative data analysis was used to support systematic organisation of extracts
- Theme development; codes were clustered into candidate themes, refined through comparison across transcripts, and checked for internal coherence and distinctiveness
- Cross-theme synthesis; mechanisms and interdependencies across themes were identified to explain why barriers recur and how pressures cascade across domains
- Validation checks; key claims were checked back against transcript evidence, with attention to divergent cases and differences in emphasis across G1-G3

In addition to qualitative interpretation, the report employs a rudimentary descriptive indicator (the KMI-Key Mention Indicator) to communicate the extent to which each theme was disseminated across the analytic corpus (n=44). KMI is calculated by determining the number (and percentage) of

interviews in which a theme is raised at least once, irrespective of the duration of the discussion. The indicator therefore signals breadth of salience rather than intensity, importance, or causal weight. A theme with a higher KMI was mentioned by more participants, but this does not automatically mean it was experienced as “more significant” in any single setting. As indicated in the relevant literature, KMI values are reported consistently at the commencement of each theme chapter (e.g., KMI=42/44; 95.5%) and should be read in conjunction with quotations and the narrative synthesis, which collectively elucidate the significance and implications of the theme, the conditions under which it became most visible, and its intersection with other constraints.

### 3.10. Quality, rigour, and limitations

A number of strategies were employed in order to enhance credibility and interpretive robustness.

These included:

- The use of triangulation between interviews and documentary sources in order to corroborate factual claims and contextualise perceptions
- The review of participant transcripts with a view to improving accuracy and reducing the risk of misattribution
- The implementation of systematic coding and auditability through a structured coding workflow and versioned analytic notes
- The attention to variation and dissent, ensuring that themes reflect not only consensus but also meaningful divergence in emphasis
- The circulation of a draft version of the report to participants and informed stakeholders for comment on clarity, emphasis, and practical resonance, with feedback used to refine presentation while leaving final analytic judgments with the authors

Key limitations include:

- Elite sample characteristics; findings reflect high-level governance and system-facing perspectives; they are not intended to represent public views or frontline experiences exhaustively
- Recall and positionality effects; accounts reflect participants' roles, responsibilities, and institutional locations; these shape both access to information and interpretive frames
- Anonymity constraints; high confidentiality standards limit the degree of contextual detail that can be attached to specific quotations

### **3.11. AI transparency statement**

AI-assisted tools were used to support parts of the analytic workflow (e.g., organising coded material, drafting candidate thematic summaries, and improving clarity of prose). All substantive interpretive decisions, inclusion/exclusion judgments, and final text remain the responsibility of the human author(s). AI outputs were treated as provisional and were checked against the underlying transcripts and documentary record prior to inclusion in the report, consistent with emerging research integrity guidance emphasising transparency, verification, privacy protection, and accountability in AI-supported research.



# Section 4



## Thematic Findings

This section synthesises patterns across the full interview corpus (n=44) to explain how Scotland’s integration reforms are understood in practice, why progress is uneven, and where constraints repeatedly surface. It first sets out an integrated theory of change, then presents seven thematic chapters with supporting quotations and descriptive indicators, and finally draws out cross-theme mechanisms and intersections that link policy intent to delivery reality and explain patterned variation in emphasis.

### **4.1. An integrated “theory of change” emerging from the interviews**

Across the various themes, participants implicitly described a shared “theory of change”. Integration is expected to enhance outcomes by aligning governance, resources, and service pathways with the needs of individuals. This approach facilitates the provision of support at an earlier stage, ensures more effective continuity, and optimises the utilisation of community capacity. In practice, interviewees consistently suggested that the theory is applicable only when three enabling conditions co-exist:

- Firstly, coherent decision rights and accountability are required, i.e. who is authorised to make decisions, who is responsible for them, and how any disputes are resolved

- Secondly, the following deliverable operational levers should be considered: workforce capacity, flexible budgets, commissioning tools and functioning support infrastructure
- Thirdly, the concept of “routinised joint working” can be defined as the establishment of trust, the presence of shared norms, and the facilitation of seamless information flow

These elements contribute to the normalisation of cross-boundary collaboration, thereby rendering it less exceptional and more routine.

In circumstances where any of these conditions is found to be deficient, participants have described a shift in integration towards a more limited mode. This is characterised by the transformation of governance into a domain for negotiation, the delivery of services becoming stabilisation, and the deferral of longer-term reform (including prevention) on multiple occasions.

The pandemic provides a useful stress-test example of this pattern. Several participant accounts suggest that COVID-19 temporarily intensified cross-boundary coordination by making responsibilities more immediate and by reducing some routine procedural constraints. Yet these same accounts also indicate that such gains were often crisis-contingent rather than institutionalised, with collaboration becoming harder to sustain once the emergency context receded.

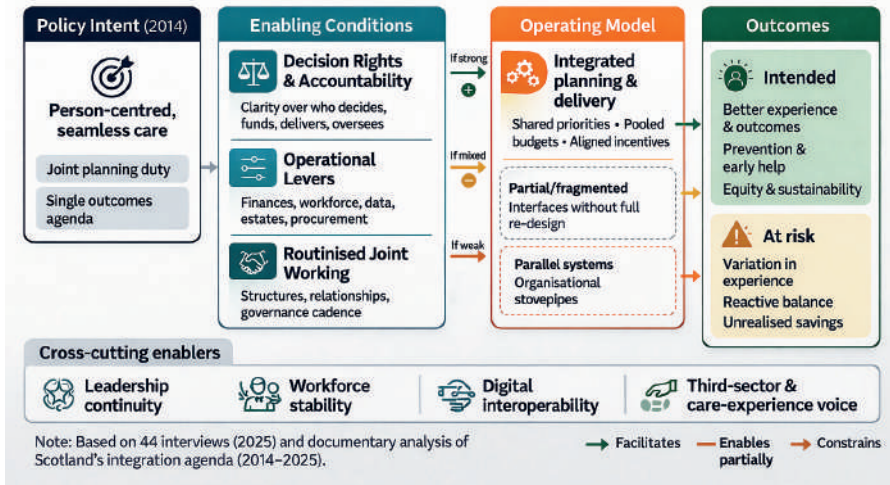


Figure 1. Interview-derived theory of change for integration

Figure 1 summarises the integrated “theory of change” implied across interviews, showing how decision rights, operational levers, and routinised joint working combine to shape whether integration becomes an operating model or a negotiated settlement under pressure.

### *Indicators of “success” in participant accounts*

Across themes, participants described success less as a single endpoint and more as a set of observable conditions:

- Clarity of roles and decision rights, with workable dispute-handling and less defensive governance
- Pragmatic alignment of levers (even partial) so strategy has a realistic delivery pathway
- Stable relationships and routinised pre-work, enabling disagreement to be resolved upstream and reducing reliance on formal votes
- Operational pathways that reduce friction for citizens, including fewer hand-offs and less repeated storytelling
- Information flow that supports continuity, so integrated teams can work with shared situational awareness

In this context, success is characterised as a functional operating model, whereby integration becomes a standard aspect of professional practice rather than exceptional coordination.

### *The continuing barriers that recur across themes*

The participants provided detailed descriptions of barriers that exhibited a persistent nature, with these barriers reciprocally reinforcing each other. The following was identified as a recurrent theme:

- The ambiguity surrounding accountability, in conjunction with constrained levers, resulted in risk aversion and a tendency towards slow decision-making processes
- The phenomenon of workforce scarcity, when considered in conjunction with market fragility, gives rise to a state of reliance on stabilisation and short-term solutions
- It is evident that the annual balancing process, in conjunction with acute protection measures, has been superseded by the prioritisation of prevention, which has been repeatedly postponed
- The combination of data fragmentation and governance caution has been demonstrated to result in a deficiency of continuity and an absence of robust learning loops

One participant noted the varied usage of statutory tools and called for clearer operationalisation of mechanisms such as directions, illustrating how policy intent can be diluted by uneven local practice. As posited by another contributor (P81), the notion of a shared citizen record has been a subject of discourse for many decades. This record continues to be regarded as a significant impediment to the process of integration. The argument was made that this barrier is not solely technical in nature, but rather, it is also influenced by cultural and organisational factors. (P91)

### *Differences in emphasis by participant group (G1-G3)*

This section examines how participants' accounts vary by institutional position, using an analytic grouping into G1 (HSCP/IJB senior management), G2 (IJB voting members), and G3 (IJB non-voting members). The objective is not to "attribute" views to individuals, but rather to identify recurring emphasis patterns associated with role location in the integration system. The utilisation of group labels is exclusively for the purpose of aggregate interpretation, and they are not appended to quotations.

### *Analytical approach and interpretive caution*

The utilisation of group comparison as a structured lens for interpreting variation in problem definition, perceived feasible levers, and credibility tests ("what counts as success") is a key element of the study. Anonymity is of the essence in this context; quotations are presented as standalone extracts, with no correlation to group membership. Group differences are therefore evidenced through patterned interpretation across the corpus, supported by illustrative extracts that remain unattributed beyond the PXX identifier.

### *G1 emphasis: deliverability, levers, and operational risk*

Across the corpus, participants in delivery-centred senior roles were more likely to define problems in terms of implementability: that is, the conditions that must be fulfilled for plans to translate into change at pace. It is evident that their accounts consistently foregrounded the following:

- Constrained levers; workforce supply, HR systems, budgeting flexibility, commissioning capacity, and corporate support
- Operational risk management; what can safely be changed without destabilising services
- Bandwidth constraints; assurance and crisis response displacing transformation
- Cascading effects; how one bottleneck (e.g., homecare capacity) propagates into discharge performance and system pressure

In this emphasis pattern, the concept of “good governance” is prioritised chiefly as a mechanism for effecting change (i.e. the establishment of clear decision rights, the promptness of decisions, and a reduction in procedural loops), as opposed to being regarded as an objective in itself.

*G2 emphasis: stewardship, legitimacy, and defensible decision-making*

Voting members and those holding formal oversight roles more frequently articulated challenges through a stewardship lens, namely how to balance transparency, accountability, and fairness while managing contested trade-offs under fiscal and performance pressure. It is evident that their accounts more frequently emphasised the following:

- Decision rights and legitimacy; i.e. who has authority; how votes, quorum, and representation shape acceptability
- Scrutiny and public accountability; i.e. recorded meetings, public visibility, reputational risk
- Boundary setting; i.e. clarity that statutory partners retain responsibilities, even within integrated arrangements
- Defensibility of trade-offs; i.e. how to justify service change, disinvestment, or resource shifts

In this emphasis pattern, governance is a primary arena for integration, in which the credibility of decisions is as important as the technical merits of plans.

*G3 emphasis: voice, inclusion, and whether the system is usable*

Non-voting members were more likely to evaluate integration through inclusion and usability tests. These tests were designed to ascertain whether people and communities can influence priorities, and whether the system reduces friction for citizens and frontline services. It is evident that their accounts more frequently emphasised the following:

- Voice without power, i.e. the absence of influence in decision-making processes despite active participation
- Citizen-facing navigation, signifying the clarity and accessibility of access routes and pathways, thereby reducing the repetition of narratives
- Third sector visibility and data inclusion, emphasising the treatment of community delivery capacity as an integral part of the system rather than as a peripheral entity

- Meaningful feedback loops, highlighting the connection and reporting back to the communities they represent by representatives

In this emphasis pattern, integration is said to succeed when it becomes manifest in quotidian experience; fewer hand-offs, clearer routes in, and genuine participation rather than procedural presence.

*Convergence and divergence: shared constraints, different “tests of success”*

Despite the differences in emphasis, participants from across the groups concurred strongly on a core set of constraints, namely workforce fragility, fiscal pressure and the mismatch between strategic ambition and operational levers. The primary divergence of opinion occurs in the identification of the decisive integration test:

- In the context of accounts oriented towards deliverability, the attainment of success is evidenced by the presence of operational traction, which can be defined as the functionality of pathways, the progression of discharges, and the stabilisation of community capacity
- The success of stewardship-centred accounts is demonstrated by legitimate and defensible governance, as evidenced by transparent decision-making, clear accountability, and fair representation
- The inclusion-centred paradigm is predicated on the notion that success is demonstrated by usability and voice. This is evidenced by such factors as clear access routes, reduced repeat-story burdens, and meaningful participation

The significance of these varied assessments lies in their capacity to influence the prioritisation of reforms and the credibility of the identified “quick wins”. Furthermore, they facilitate comprehension of the reasons behind the occurrence of circular integration debates. Participants may concur on the diagnosis (pressure, fragmentation) whilst disagreeing on the appropriate remedy (governance reform, workforce investment, citizen-facing redesign, or data infrastructure).

*Illustrative extracts*

The extracts below illustrate the range of emphases described above. They are intentionally presented without mapping to G1-G3.

Deliverability under pressure

*“It was definitely reactive, 100%. 100% reactive. We always react. We try to be proactive.... So every budget meeting we come, we try to be proactive. But sadly, it comes to the crux. We’re firefighting.” (P69)*

## Dual accountability and leadership constraints

*“I would say lacks leadership. Because there are two masters. Because the chief officer of the integration authority reports to both the NHS chief executive and the council chief executive.” (P41)*

## Stewardship and role expectations

*“I’ve been delegated by the XX because I am a member of that organisation and we have 14 members. But my responsibility is to look at budgets, services and things as a member of the IJB, not as a XX.” (P145)*

## Party dynamics in contested decisions

*“What you’ll find is, for example, we had the budget vote. The councillors from the main party voted one way. The opposition councillors voted the other way. And it’s all purely on party lines, and that is becoming a big problem.” (P76)*

## Public scrutiny shaping behaviour

*“I understand why because they’ve got managers that are watching on this and watching and listening and seeing the outputs of what, because not now the IJB the meetings are recorded and broadcast. They’re live streamed. And they’re on YouTube forever.” (P34)*

## Document burden limiting meaningful scrutiny

*“And it’s quite difficult to understand. I don’t fully understand. I have to say finance is not my fault. But so you get a finance report at the IJB meetings in amongst 150 other pages of stuff that you’re expected to be able to read and understand...” (P123)*

## Citizen access to key information (digitally enabled continuity)

*“Through a pathfinder site we are testing shared access to key information such as anticipatory care plans, DNACPR documentation, care plans and medicines, using a QR-code approach that can be accessed at the right time by the ambulance service, the person (or their representative), the NHS, social work and supporting staff.” (P178)*

## Voice without vote

*“But what we have is that people with a lived experience or people representing those of us with a lived experience of health and care services, when it comes to a vote, they don’t have a voice... But actually when it comes to the bit, and there’s a decision, they don’t have a vote.” (P84)*

## 4.2. The seven themes and their subthemes

To help readers navigate the thematic findings, Table 2 summarises the seven themes and orders them by KMI (the proportion of interviews, out of 44, in which each theme was raised at least once).

*Table 2. The themes, KMI (n/44) and their primary analytical function*

Theme	KMI	What this theme primarily explains	Mechanism keywords
Governance	44/44 100%	How decision authority is distributed and enacted in practice, and how this shapes accountability and legitimacy.	Decision rights; Directions; Consensus; Scrutiny; Accountability
Workforce	44/44 100%	How staffing constraints, divergent terms/conditions, and professional hierarchies limit integration delivery on the ground.	Vacancies; Retention; Terms and conditions; Boundary work; Hierarchy
Data	44/44 100%	How interoperability and information-governance conditions enable or block coordination and continuity across organisational boundaries.	Interoperability; IG; Data sharing; Single view; Workflows
Finance	42/44 95.5%	How financial rules, commissioning and incentives shape what is feasible and what becomes prioritised (often under acute pressure).	Overspend; Pooled budget; Commissioning; Incentives; Disinvestment
Leadership	41/44 93.2%	Why similar formal arrangements produce different results across places, depending on trust, continuity, and partnership maturity.	Trust; Continuity; Partnership maturity; Brokered agreement; Variation
Voice	40/44 90.9%	Whether participation translates into influence, and how “voice without vote” affects perceived legitimacy and responsiveness.	Lived experience; Representation; Tokenism; Feedback loops; Legitimacy
Service-user	37/44 84.1%	How integration is experienced by citizens through access, navigation, discharge/flow and continuity, especially at interfaces.	Navigation; Discharge; Home first; Continuity; Access

The remainder of Section 4 unpacks each theme in turn, using quotations to illustrate the core claim, the main subthemes, and the boundary conditions under which the theme becomes most visible.

### 4.2.1. Theme 1: Governance, accountability, and decision rights

Participants most often positioned integration governance as a formally specified but practically negotiated arena. IJBs were described as having

statutory standing, public-facing governance routines, and formal levers (including “directions”), yet participants repeatedly stressed that what the IJB can decide and what the system can deliver are not identical. Governance was narrated as a balancing act between partnership consensus and decision clarity, operating within complex accountability lines that span local government, NHS boards, and partnership leadership.

— KMI: 44/44 (100.0%)

Recurring tensions were:

- Formal structure vs real-world levers; statutory duties exist, but operational control often sits elsewhere
- Consensus vs decisiveness; consensus stabilises relationships yet can prolong the status quo
- Accountability complexity; multiple principals, multiple scrutiny routes, and blurred lines of responsibility

This theme captures participants’ accounts of the decision-making process, including the factors that influence decision-making and the allocation of responsibility when competing priorities arise (e.g., service redesign, resource shifts, disinvestment). The subject encompasses board design, voting and consensus practices, the utilisation (and limitations) of “directions”, and the practical ramifications of IJBs’ institutional position (frequently characterised as strategic rather than operational).

*Subtheme A: Decision rights and operational levers (delegation, directions, employment)*

A significant proportion of the participants described an incongruity between formal governance instruments and delivery capacity. The concept of “directions” was recognised as a method for influencing the behaviour of partner organisations. However, several accounts also highlighted that IJBs frequently depend on factors such as influence, relationships, and negotiated compliance. This is particularly evident given that key operational levers (including employment and line management) are situated within partner organisations.

*“So, the voting members come from the bodies to create this, and then the integration board sends directions back to the Health Board and Council to tell them how to do other service.” (P1)*

*“In my view it would have been much more sensible to take the funding from the health boards and the Councils and give it directly to the Integrated Integration Authority.” (P2)*

*“Basically, the IJBs don’t employ anyone, which is daft. They’re on contract... The money comes from the partner agencies, so they decide how much we’re getting. So if they don’t give us any money, enough money, we can’t do the work. At the same time, we have got to set directions. We’ve got to tell the health board how to spend the money.” (P76)*

*“So the council would have to have a full democratic process within the council to make financial decisions. And they will also make a decision each year about how much they contribute to the partnership. Whereas the NHS, they don’t have the same structures, they will make a decision in a more straightforward way as to how much money they can contribute.” (P177)*

Participants in this study conceptualise decision rights as being distributed rather than centralised. Formal instruments are in existence, yet their impact is contingent on the translation of decisions into operational action by partner organisations. This renders governance effectiveness contingent on both design and inter-organisational power relations.

### *Subtheme B: Board dynamics (consensus, voting, politics)*

Participants frequently described IJB governance as consensus-based, with formal votes being used infrequently. This was occasionally presented as a virtue, insofar as it supports shared ownership and limits adversarial “winner/loser” outcomes. Nevertheless, several accounts also stressed that consensus norms can slow decisions or encourage avoidance of politically difficult trade-offs.

*“The reality is that almost every aspect of this relies on consensual working... We’ve only ever had one vote in the IJB... There’s no casting vote for a chairperson... If it’s four each, then the status quo kind of remains... So it’s very deliberately based on consensus.” (P61)*

*“We often don’t have votes in IJB meetings... generally we get papers from officers... and we sort of agree them by consensus. Sometimes we have votes when it’s controversial things.” (P159)*

*“The IJB members voting and non-voting members of the IJBs and the chief officers, it’s I would say the council and health board chief executives have a big, big sway and how integration works locally its providers and their staff so that could be the NHS board provider or the council or independent third sector providers of services and their staff.” (P17)*

*“For two years, you have a council member who’s the chair of the board and then for two years, then you have an NHS. Now the NHS are just about to take over on September beneficiaries IJB and I just feel there is a lack of accountability, because that person is not elected.” (P49)*

The concept of consensus is multifaceted, serving as both an asset and a constraint. In its role as an asset, consensus fosters relationship preservation and shared ownership, while in its capacity as a constraint, it functions as a status quo default, impeding swift progress in redistributive decisions. In circumstances where the practice of voting is infrequent and tie-break mechanisms are limited, “non-decisions” have the potential to evolve into a fundamental characteristic of governance.

### *Subtheme C: Accountability and scrutiny (multi-principal governance and legitimacy)*

A recurrent theme that emerged from the discourse was the challenge of ensuring accountability within a governance framework characterised by multiple stakeholders and a plethora of scrutiny channels. Participants posed inquiries regarding the determination of ultimate accountability in circumstances where service pressures intensify, financial resources become constrained, or performance is subject to scrutiny. It has been asserted by certain accounts that concerns regarding accountability and legitimacy are exacerbated in circumstances where governance appears to be procedurally correct but practically opaque to the public or wider stakeholders.

*“I’m voting member of the IJB. My responsibilities are non-existent. I don’t have responsibilities in the sense of having a function to fulfil.” (P77)*

*“As individuals with the same level of governance accountability as me on that board, I had a much higher level of public scrutiny than they will ever have.” (P163)*

*“One of my main concerns... the IJBs, maybe a lack of accountability in terms of political control...” (P49)*

Accountability is characterised as being structurally complex and, at times, ambiguous in its practical implementation. This is of significance because accountability is not solely about compliance; it determines whether integration governance is regarded as legitimate and able to manage risk when contested decisions emerge.

### *Theme boundaries*

Include in this theme when...

- The account is about who decides, how decisions are reached, voting/consensus, board membership, directions, statutory duties, scrutiny/audit, accountability lines, or decision-right ambiguity.

Exclude from this theme when...

- The core issue is money flows, commissioning, contracts, market stability → code primarily under Finance, commissioning, and incentives.
- The core issue is staffing, recruitment/retention, pay/terms, professional boundaries → code primarily under Workforce capacity, cultures, and professional boundaries.
- The core issue is data systems, interoperability, IG/GDPR constraints → code primarily under Data, digital enablement, and information governance.

Overlaps and coding rule-of-thumb

- If participants discuss governance because of budget pressure (e.g., “board can’t act because of overspend”), dual-code Governance + Finance, but set the primary code to whichever is framed as the *causal driver* in the account.

#### **4.2.2. Theme 2: Workforce capacity, cultures, and professional boundaries**

It was asserted that workforce issues were a significant impediment to the success of integration initiatives. Participants repeatedly described integration ambitions (service redesign, community shift, pathway improvements) as being limited by staffing shortages, recruitment/retention pressures, and reliance on temporary staffing. In addition to the issue of capacity, a significant number of accounts highlighted the friction engendered by disparate organisational cultures, divergent professional logics, and parallel employment regimes, which collectively contribute to the challenge of maintaining a cohesive “one team” dynamic.

- KMI: 44/44 (100.0%)

Recurring tensions were:

- Capacity gaps vs integration ambition
- Employment/terms differences reinforcing boundaries
- Culture change as ongoing labour, not a one-off reform

This theme captures how workforce capacity and professional cultures shape integration in practice, including recruitment/retention constraints, pay/conditions divergence, role clarity, boundary work, and the interpersonal labour required for cross-sector collaboration.

*Subtheme A: Recruitment, retention, vacancies, and reliance on temporary staff*

Participants highlighted recruitment and retention challenges across roles and settings, often linking staffing gaps to delays, stress on teams, and limits to preventative/community approaches. The phenomenon of workforce instability was characterised as both a practical delivery problem and a strategic impediment.

*“We have had trouble recruiting GP’s, but that has turned a corner. Now that’s much, much better. Community psychiatric nurses have been difficult, but we’re now growing our own in house. But again, there’s a shortage of them nationally and internationally.” (P25)*

*“We can’t compete with the terms and conditions. You’ve got a lot of providers out there that are paying reasonable. Thirteen-fifteen pound an hour, but then the council coming off and pays eighteen.” (P51)*

*“So one in terms of the people that we serve, but also our own aging workforce and the ability to recruit younger folk into, let’s face it, jobs that not an awful lot of people really want to do a lot of the time.” (P163)*

Participants identified workforce instability as a fundamental challenge, asserting that even when governance and strategy are coherent, staffing shortages can render integration appear aspirational rather than achievable.

*Subtheme B: Terms and conditions, pay gaps, and mobility barriers*

A recurrent theme pervasive throughout the discourse was the pernicious persistence of multiple employment systems, which the participants portrayed as reinforcing boundaries and complicating collaborative endeavours. A correlation has been demonstrated between disparities in remuneration structures and conditions, and perceptions of fairness. These disparities have also been linked to heightened levels of competition in recruitment, and constraints in workforce mobility across organisational boundaries.

*“And the pay structure is different. The working conditions are different.” (P36)*

*“And different cultures, different policies, different employment terms and conditions, different expectations, different approaches.” (P7)*

*“So today internally when I was at the organisation and so we brought them back into the Council so that that improves their terms and conditions a bit. It also that’s what they wanted, you know, they wanted to be part of the Council.” (P5)*

*“Because it can get confusing sometimes because you get confused where the people are the council, whether they’re the health board, because they’re on different rates of pay, they’re on different terms and conditions...” (P11)*

Participants describe the divergence of terms and conditions as a structural barrier that “reproduces” separation. Whilst integration may result in the alignment of strategies, employment regimes continue to differentiate identities, incentives, and retention capacity.

### ***Subtheme C: Culture, role clarity, and professional boundary work***

It has been asserted by several accounts that the process of integration necessitates the ongoing implementation of cultural initiatives. These initiatives encompass the acquisition of knowledge pertaining to the roles of individuals within different groups, the negotiation of responsibilities, and the establishment of shared norms across various professional cohorts. The aforementioned process was characterised by its time-consuming nature, its uneven progression, and its vulnerability to turnover.

*“I think it’s difficult for, you know, you’re so used to doing your job in a certain way. So, there’s been a lot of culture change work going on so that we understand each other’s roles.” (P23)*

*“The cultures were going to be different because there are hierarchical structure in the NHS because they’re appointed by the cabinet secretaries because they’re driven by the Scottish Government.” (P70)*

*“And I think often our HSCPs are seen as completely separate from council services and at times from NHS services which isn’t helpful because it’s all about our people and we’re all there to support the same people, the same communities.” (P84)*

*“So one of the big challenges we have is in our interfacing to the acute hospitals and that’s where we get the real tension there and the culture clash between our teams because as you say, there’s a big frustration about sort of voice of social care and social workers there says what medics are saying. Needs to happen for a patient and ultimately as you see, they’re at the very top of the hierarchy.” (P54)*

The concept of culture change is depicted as a process rather than a policy outcome. The professional hierarchies and divergent role expectations that

characterise healthcare settings engender a multitude of day-to-day friction points, particularly at the interfaces between hospitals and communities, where decisions are made under time constraints and with elevated stakes.

### *Theme boundaries*

Include in this theme when...

- The core account is about staffing levels, vacancies, recruitment/retention, agency/locum reliance, pay/conditions, professional hierarchy, role clarity, culture change, or cross-professional boundary tensions.

Exclude from this theme when...

- The primary story is about contracts, commissioning decisions, procurement models → Finance.
- The primary story is about board voting, directions, statutory governance → Governance.
- The primary story is about IT systems, interoperability, IG barriers → Data.

Overlaps and coding rule-of-thumb

- If the issue is “we can’t recruit because commissioning rates are too low”, dual-code Workforce + Finance, but keep Finance as primary if the emphasis is on funding/market constraints.

### **4.2.3. Theme 3: Data, digital enablement, and information governance<sup>1</sup>**

Participants frequently characterised data and digital infrastructure as the “hidden backbone” of integration. This is a highly consequential concept, as it demonstrates the profound impact that effective integration has on various aspects of society. Conversely, the failure of integration to function can be seen as deeply obstructive. A significant number of accounts have described fragmented systems, limited interoperability, and cautious information governance as producing delay, duplication, and avoidable risk. Digital enablement has been described as uneven, with innovation existing but system-wide interoperability and governance clarity remaining constraints.

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<sup>1</sup> Although reforms such as MyCare.scot have now emerged, their current scope remains limited in both service coverage and geographical rollout. More importantly, this theme addresses wider system-level issues of interoperability, information governance, and cross-boundary data sharing across public, private, and third-sector actors. For that reason, the findings presented here remain directly relevant beyond the current reach of MyCare.scot.

— KMI: 44/44 (100.0%)

Recurring tensions were:

- Interoperability vs fragmentation
- Information governance caution vs operational need
- Digital ambition vs legacy systems and uneven capacity

This theme captures how data systems, interoperability, and information governance shape integrated working. It is important to consider whether professionals are able to see a whole-person picture, whether data can support planning and performance management, and whether information sharing is practically feasible and legitimate.

### *Subtheme A: Interoperability gaps and fragmented systems*

Participants described fragmentation as a practical barrier to person-centred delivery. The problem is not merely technical inconvenience; it is characterised as a risk factor, contributing to delays and necessitating the use of workarounds.

*“Information governments that we have around to effectively share better, we made much easier if we had a single health and social care record, for example. But in the absence of that, I have never had major challenges.” (P20)*

*“Yeah, that gets in the way of delivering what the person needs because it doesn't serve the purposes well if things are within five different systems and we can't see all of the information.” (P56)*

*“Until there is integration of the data and the information necessary for individuals to receive the care that they need, until that integration happens and wider healthcare professionals, social work, social care professionals are working with one arm tied behind their back.” (P34)*

*“And then I suppose in terms of the IT systems, so the patient databases council people can't record on the NHS databases, NHS people can't record on the council databases, so you don't have shared records even if you've got a shared team that's got the NHS and the council people in the team. They can't use the same systems.” (P25)*

*“Alongside these developments, the current lack of interoperability remains a significant risk and causes delays to improvement, wellbeing and sometimes life, as well as avoidable resource costs caused by systems not talking to each other and paper-based processes.” (P178)*

Interoperability is described as a core enabling condition for integration. The phenomenon of fragmentation has been shown to result in the adoption of

workaround practices by staff members, thereby compromising both efficiency and the coordination of efforts.

### *Subtheme B: Information governance and information-sharing barriers*

The issue of information sharing was a recurrent theme in the discourse, being characterised as both essential and challenging. Participants articulated a sense of uncertainty, caution, and professional/governance barriers that hindered routine coordination.

*“It’s been an ambition to join up the dots to make that more integrated, but then you’re into a whole load of governance.” (P70)*

*“And Data requirements, everybody is stressed about GDPR and cyber-attacks. So security of the IT systems is an extremely important matter.” (P97)*

*“I have an understanding of the data around children and the child protection system and it’s very difficult to share information between different professionals. You know they’re measured in different ways.” (P14)*

*“I think that the data sharing is a big issue and sharing of resources between particularly between health and social care itself is a massive issue. So they have their own separate processes, and even integration in that respect, they’ve not integrated the back office administration...” (P57)*

Participants in this study have defined information governance as being twofold in nature, being both a practical constraint and a legitimacy issue. The need for clarity and permission structures for the appropriate sharing of information is a necessity for staff, but the caution that is associated with governance can act as a barrier to integrated delivery.

### *Subtheme C: Digital enablement and workarounds*

Participants referenced digital enablement as both an aspiration and a contested reality; some described reductions in investment, while others highlighted the need to maintain focus on digital health and care despite competing pressures.

*“They appear to me to have done absolutely nothing about that, but what they have done is strip back investment in digital services for the purposes of health and social care.” (P61)*

*“I do continue to be frustrated by our ability to talk to each other electronically and use the same systems and share.” (P89)*

*“It’s an issue everywhere and it’s an issue between local authorities because different local authorities use different systems. It’s an issue between the NHS*

*and the HSCP and that kind of, and the local authority all using different systems.” (P182)*

*“How do we develop our consistency for people that those bits haven’t been lost in some of the things around fair work and some of the things around right to break for carers and about sharing of information and digital health and care and things like that. These haven’t been lost, and I think that’s important. But yeah, I think there was a lot of vested interest.” (P29)*

Digital enablement is characterised as being uneven and politically/practically fragile. Investment decisions and system capability shape whether integration becomes routinised or remains dependent on individual workarounds.

### *Theme boundaries*

Include in this theme when...

- The core issue is interoperability, multiple systems, single record, data quality/access, information governance, data sharing, GDPR/permissions (explicitly or implicitly), digital capability, or workarounds (paper-based processes, manual transfer).

Exclude from this theme when...

- The primary story is about staffing capacity or professional culture → Workforce.
- The primary story is about budget, commissioning, procurement → Finance.
- The primary story is about board decision rights, voting, directions → Governance.

Overlaps and coding rule-of-thumb

- If “data sharing” is raised mainly as a legitimacy/participation problem (e.g., public trust, transparency), dual-code Data + Voice, with primary code determined by whether the emphasis is on *systems/governance* (Data) or *representation/legitimacy* (Voice).

#### **4.2.4. Theme 4: Finance, commissioning, and incentives**

It was reported that financial pressure was pervasive and frequently served as the organising logic behind challenging decisions. Participants described budget balancing, overspends, and constrained settlements as factors that shape the possible scope of action, and occasionally displace care priorities. The commissioning and procurement processes were identified as pivotal in this regard, given their capacity to influence workforce terms, the viability

of service providers, and the ability to allocate resources towards community support.

- KMI: 42/44 (95.5%)

Recurring tensions were:

- Budget dominance vs care priorities
- Commissioning as an indirect wage/quality setter
- Incentives that lock spend into acute demand

This theme captures how financial flows, contracting processes, commissioning mechanisms, and incentives influence integration outcomes, including the challenges associated with resource allocation and the governance dynamics that emerge due to overspends and risk.

#### *Subtheme A: Budget pressure, annual balancing, and risk*

It was repeatedly asserted by participants that financial constraints and overspending were the root causes of conflict, and that such circumstances had a significant impact on the strategic options available to the parties concerned. It has been asserted by several accounts that overspends can engender political tension and result in decisions being viewed through a financial lens rather than a service lens.

*“And the challenge at the moment is absolutely financial and I wouldn’t, you know, we’ve got huge savings to make to actually stay within budget and at a time when there is more and more demand in the system.” (P2)*

*“...but at the same time they’ve reduced the budget by so much money that we’ve said that we’ve services have been taken away across the board from everything from old age care to learning disabilities to mental health and the problem with it’s so sustainable.” (P36)*

*“And the way we’ve shifted because of our financial and resources position is like crisis management. So, social workers have really significant caseloads, people are all in crisis that they’re dealing with, so they’re not able to do any of the product, proactive stuff with people that they might have aspired to.” (P39)*

It has been asserted that budgetary constraints represent a prevailing factor that exerts a significant impact on the available strategic scope. In circumstances where financial risk is elevated, boards and partners may prioritise stability and compliance over transformation.

### *Subtheme B: Commissioning, procurement, and contracting as delivery hinge*

The commissioning decisions that were made were described as having a significant impact on the conditions of the workforce, the behaviour of the providers, and the resilience of the services. Participants frequently characterised commissioning as the conduit between strategic intent and the prevailing circumstances on the ground.

*“We’re negotiating at the minute. So, in this area, if you have staff as a private provider, you won’t be able to afford to pay them £14.26, so through the processes of procurement and getting the contracts. They’ll be paying their staff £12.21 and that’s what they’ll build in, but we get £14.26.” (P63)*

*“So I suppose the third sector could if the IJB was the commission and the third sector to deliver, then find the third sector is much more agile, much more effective and much better at delivering services to people. And the statutory services like health and social care, they’re very clunky and quite on that boat down by bureaucracy, where is the third sector, just focuses on people and making sure that people get their help and support they need. So it’s much more agile and I wish that the IJB would commission or provide grants to the sector because it would be much more effective rather than trying to run their own in-house very expensive models operation.” (P57)*

*“And as I say, for those services that we commission externally on the third sector, while we do pay the living wage requirements, which is what we have often the terms and conditions of staff working in the third sector are less they don’t have the same sickness, right, they don’t have the same pensions, they don’t have the same annual leave which is why it is cheaper for us to commission from the third sector.” (P27)*

The concept of commissioning is not described as a technical purchasing activity, but rather as a structural determinant of delivery capacity, particularly in contexts where contracts influence factors such as remuneration, staff retention, and the continuity of services.

Participants’ accounts also suggest that the third sector should not be understood only as an invited stakeholder or participatory voice within integration governance. In many areas, third sector organisations form part of the practical delivery infrastructure of integration, particularly in prevention, early intervention, low-level support, and maintaining community connection. This matters because commissioning choices affect not only service availability, but also the resilience of community-based capacity that can reduce pressure elsewhere in the system.

### *Subtheme C: Incentives and the (non-)shift to prevention/community capacity*

Participants frequently articulated an aspiration to redistribute the balance of care, yet this endeavour was often thwarted by the pervasive presence of acute pressures. The concept of integration was originally intended to facilitate the establishment of more efficient pathways. However, the presence of incentives and capacity constraints has resulted in a reversion towards crisis response.

*“There’s been some baby steps in that direction, but my view would be that if you want to shift the balance of care, you need to shift the balance of funding.” (P5)*

*“We’ve increased our investment in family support services and so early intervention and prevention.” (P91)*

*“We’ll get all everybody on board, all sinking, so that instead of me having to phone fifty-five different people for five different things to get somebody out of hospital, for example, I have to still go out, you know, I could have phoned one person who is in a hub.” (P69)*

*“Because if we think about somebody’s journey, so somebody, whatever, but they’re going to get an acute, they’re going to a hospital, yeah, to allow us to bring that person out of hospital, yeah, they need a care package. Yeah. So that cost has moved from the acute setting to a care package to the social care element. But as in Scotland at the moment, the NHS side, or acute side, is struggling financially.” (P81)*

Participants describe incentive misalignment as a persistent drag on progress. While prevention is valued rhetorically, practical incentives and acute demand pressures constrain the scale and speed of upstream shifts.

Several accounts imply that this problem is especially visible where community and third sector provision is treated as peripheral rather than as part of the system’s preventive capacity. Where such organisations are unstable, under-recognised, or commissioned too narrowly, the practical ability to sustain prevention and early intervention is weakened, even when these goals are widely endorsed in principle.

#### *Theme boundaries*

Include in this theme when...

- The account centres on budgets, overspends, settlements, disinvestment/investment, financial risk, commissioning, procurement, contracting, provider markets, or incentive structures.

Exclude from this theme when...

- The primary issue is staffing/culture/professional boundaries → Workforce.
- The primary issue is board decision rules and accountability → Governance.
- The primary issue is service-user pathway experience (access, continuity, navigation) unless explicitly tied to resource/incentives → Service-user journey.

Overlaps and coding rule-of-thumb

- If the narrative is “financial pressure causes pathway breakdown”, dual-code Finance + Service-user, with Finance primary when funding is framed as causal.

#### **4.2.5. Theme 5: Leadership, relationships, and local variation**

It was repeatedly asserted by participants that the attainment of integration outcomes was contingent upon leadership and relationships, with this contingent relationship being most pronounced at senior levels. Local variation was not regarded as an anomaly, but rather as an expected feature. It was hypothesised that similar statutory structures could produce different trajectories depending on trust, continuity, geography and partnership maturity. The concept of leadership was articulated as both relational, characterised by the establishment of trust, and structural, entailing the establishment of discipline, routines, and clarity.

- KMI: 41/44 (93.2%)

Recurring tensions were:

- Relationship fragility vs partnership stability
- Leadership capacity vs assurance burden
- Local variation vs national expectations

The overarching theme elucidates the manner in which leadership practices, relationship quality, continuity and local context exert a significant influence on the performance and experience of integration.

##### ***Subtheme A: Trust, relationships, and partnership maturity***

Participants frequently described trust as cumulative and easily eroded, particularly “at the top of the tree”. The quality of the relationship was

identified as a key factor in facilitating collaboration and providing a measure of protection against structural friction.

*“It’s about building relationships all over again and building relationships of trust. And it’s a constant piece of work, if I’m honest. It’s tiring.” (P98)*

*“And a real sense of partnership working in that respect and I mean we have a good relationship with partners. They do listen. They want to hear what the real issues and barriers are for people...” (P23)*

*“I think a lot of success of integration is about relationships and personalities. If you had two chief executives with one in the health board, one in the council that just got on like a house on fire, then actually you probably would have good integrated arrangements in those areas. So, but if you have two that don’t get on at all, then you know that this is going to be a real challenge.” (P17)*

*“I don’t know if you’ve seen the press coverage of Scottish Government encouraging us to maintain a partnership, but there is something there about actually it can break down really easily based on relationships at the top of the tree... the people that do sometimes play politics with what they are doing behind the scenes, but they would never publicly admit that.” (P138)*

*“So it for me, it means an opportunity to have greater collaboration across the different organisations who try to meet the needs of people, it is also an opportunity for efficiency in the way that we manage services and the way that we try to deliver services and it’s an opportunity for greater strategic collaboration around the planning of services to respond to local need.” (P56)*

Trust is defined as an enabling infrastructure for governance and delivery. In circumstances where trust is found wanting, formal structures alone are inadequate for sustaining arduous decisions or extended transformation.

### *Subtheme B: Leadership bandwidth, assurance burden, and “keeping the system moving”*

It has been asserted by certain accounts that leadership is a practical undertaking, entailing governance routines, the demands of scrutiny, and the continuous coordination required to ensure the effective functioning of cross-organisational systems in high-pressure environments.

*“I think it’s just about trying to make sure that a very senior level, we’re maximising our use of resources or buildings or you know to best effect. I think that’s probably the bit around how do we integrate, and integration actually should be beyond just health and social care.” (P20)*

*“And we thought and were right that X were not as supportive and they would take longer to come in, but eventually wouldn't want to be left out, so would want to join in. And so that was a huge amount of work that the officers had to do with the direction of the leadership from the political side that we wished them to go ahead and sort out that structure.” (P97)*

*“But the NHS are externally audited by PricewaterhouseCoopers, and they were not happy about a public committee having sight of their audit reports. So the audit committee could see the council side of it, but it couldn't see the NHS side of it. So that took two years to resolve and still we get sight of the papers as of our last meeting, but we have to view them in private and we're not allowed to view them in public and comment on them in public.” (P182)*

The concept of leadership is increasingly being viewed not as an abstract vision, but as sustained coordination work under scrutiny. This involves maintaining governance discipline in the face of capacity and financial constraints.

### *Subtheme C: Local variation (geography, demography, complexity)*

Participants described geography and local context as shaping both need and feasibility. As has been demonstrated by a number of accounts, effective integration planning and delivery necessitates a precise understanding of demography, deprivation, and service landscape factors.

*“It is not dealing with the reality and the remote geography that we have because we're very rare all in a very old population.” (P7)*

*“We need to know demographics of people, we need to know geography, and we need to be able to link that with areas of multiple deprivation.” (P159)*

*“When you've got two local authorities working together, they can both do things better financially, but also in a kind of governance way to ensure that if we're working together, we get the best outcomes in terms of financial outcomes, but also to ensure we're learning lessons from both areas that, one area can learn from another and then that leads to better services...” (P177)*

Local variation is characterised as structural, rather than incidental. The concept of “good integration” is influenced by various factors, including demography, geography, and the structure of partnership networks. The pace at which this integration can be achieved is also subject to these influences.

### *Theme boundaries*

Include in this theme when...

- The account is about leadership behaviours, relationship quality, trust, partnership maturity, continuity/turnover, and differences between places.

Exclude from this theme when...

- The primary issue is formal decision rules, accountability, board voting → Governance.
- The primary issue is workforce shortages/terms/professional boundaries → Workforce.
- The primary issue is budgets/commissioning → Finance.

Overlaps and coding rule-of-thumb

- If “relationships” are discussed mainly as the reason governance works/doesn’t, dual-code Leadership + Governance; set primary based on whether the emphasis is *board mechanics* (Governance) or *trust/people* (Leadership).

#### 4.2.6. Theme 6: Voice, participation, and legitimacy<sup>2</sup>

Participants frequently raised questions regarding the following issues; who is heard, whose contributions shape decisions, and how participation translates into influence. Voice mechanisms (comprising public partners, third sector representatives and individuals with lived experience) were occasionally characterised as meaningful, yet more often than not, portrayed as fragile, inconsistent or tokenistic. Concerns regarding legitimacy were observed to be concentrated in three areas; “voice without vote”, representation, and the question of whether engagement leads to observable change.

- KMI: 40/44 (90.9%)

Recurring tensions were:

- Voice vs power
- Representation dilemmas and tokenism risk
- Trust/legitimacy as outcome of process and feedback loops

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2 Although the 2025 amendment (SSI 2025/405) gives voting rights to third-sector, unpaid carer, and service-user representatives from 1 September 2026, the wider participation and influence issues discussed in this theme extend beyond those three categories. The amendment is therefore significant, but it does not remove broader questions of representation, agenda-setting, tokenism, or whether participation translates into visible influence within IJB governance.

This theme captures the participatory and democratic dimensions of integration, incorporating lived experience, involvement, third sector participation, representation claims, tokenism concerns, and legitimacy judgements.

*Subtheme A: Voice without vote (public partners, non-voting members)*

It has been asserted by several accounts that participation can occur in the absence of formal power. The notion of “being at the table” was not invariably interpreted as implying the capacity to influence decisions, particularly for non-voting members and participants with lived experience.

*“I will say that the chair and vice chair are both very welcoming when I first arrived and they instructed me of like my card and to put it on the mic, how to put it on the microphone of when I wanted to speak. But that was about the end of it, they didn't say. And I know that I am a non-voting member as well, so that I am just there as a service user and patient, a representative.” (P169)*

*“I think it is a significant issue that within the IJBs we have voting and non-voting members. That has stifled the ability of the third sector, service user reps, carer reps to have the same standings. We've written into our legislation that there's a two-tier, so you've got power imbalance written in. That's a significant issue.” (P174)*

Participants have posited that, whilst voice mechanisms are considered necessary, they are frequently deemed to be insufficient for the purpose of achieving legitimacy. The distribution of power, both formal and informal, has been identified as a crucial factor in determining whether voice translates into influence.

*Subtheme B: Representation and (perceived) tokenism*

A number of participants have suggested that participatory contributions should be considered performative; in other words, they are heard and recorded, but not acted upon. Furthermore, questions were raised about the legitimacy of representation and how voices deemed suitable for the system are selected.

*“I think the non-voting members, which includes myself, and the carers' reps and service users' reps and all that have no power whatsoever. They are patronised. Reports will come and they'll be spoken, they'll be explained, and they'll be a tokenistic. They have no influence or power, in my opinion.” (P123)*

*“We have some councillors, some elected local councillors, we have a few patient threats, and we have some representatives of a couple of other third sector*

*organisations, we have the obviously the director of public health is there as well, and it's struggles I think to engage with the public.” (P14)*

*“It's consistent that third sector interfaces like myself feel we are in that room, but really we're not there to make decisions. The decisions really sometimes have already been made by those people in power and are presented to us. It does feel often like a token gesture being there.” (P98)*

The concept of representation is considered a key element in the process of legitimisation. When participation is perceived as tokenistic or organised in a selective manner, concerns about legitimacy increase, even when formal participation structures are in place.

### *Subtheme C: Feedback loops, trust, and legitimacy claims*

Participants repeatedly linked legitimacy to whether engagement has visible consequences and whether trust can be sustained across partners. Trust was described as a quality that takes time to establish and can be easily damaged in circumstances where the sharing of information, collaboration, or the execution of plans is perceived to be uncertain.

*“So it seems to be that it took ages in order to trust because that's a huge thing to trust that partner to say. We will share this information for you and you share with us, but that seemed to take an enormous amount of time.” (P63)*

*“And I think genuinely working in partnership with our partners in health, local authority, third sector, independent sector, but most importantly, our partners in our communities, the people that we serve, and talking to them about what they want and what they need, and really engaging with those kind of service users and their families, I think is really, really important.” (P89)*

*“In terms of thinking about, the vulnerabilities, the trust that you have in that person to look after you and do what's required of such an important role. But there is that perception that it's just a career and we pay the carers, you know, pretty much the minimum wage...” (P39)*

Legitimacy is defined as an outcome of process quality, characterised by elements such as voice, transparency, follow-through, and trust. In instances where feedback loops are found to be ineffective, participation may be interpreted as symbolic rather than substantive.

### *Theme boundaries*

Include in this theme when...

- The account is about voice, participation, lived experience/public partners, representation, tokenism, legitimacy, trust (as public/participatory judgement), and feedback loops from engagement to decisions.

Exclude from this theme when...

- The primary issue is board voting rules, directions, statutory governance → Governance.
- The primary issue is data sharing as a technical/IG constraint → Data (unless framed mainly as legitimacy/trust).
- The primary issue is workforce culture unless explicitly about inclusion/representation.

Overlaps and coding rule-of-thumb

- If “trust” is narrated as *public trust in governance/participation*, keep primary under Voice; if it is narrated as *senior relationship trust enabling delivery*, keep primary under Leadership.

#### 4.2.7. Theme 7: Service-user journey and person-centred integration

Participants described the service-user journey as the ultimate test of integration, but also as an area where structural constraints become most visible. The aspirations of the person-centred approach were frequently reported to be in conflict with budgetary constraints, the fragmentation of systems, and the inconsistency of capacity across different localities. It has been posited that certain accounts allude to innovation (e.g. hubs, “front door” reforms, home-first approaches). However, it is crucial to acknowledge that the efficacy of these initiatives is contingent upon the existence of a conducive environment encompassing the workforce and the system as a whole.

- KMI: 37/44 (84.1%)

Recurring tensions were:

- Seamlessness vs reality under pressure
- Navigation burden and pathway complexity
- Hospital-community interface as a stress point

This theme captures integration as experienced through pathways; access, navigation, continuity, discharge, and whether services feel joined-up for individuals and carers.

### *Subtheme A: Access, navigation, and “front door” complexity*

It has been suggested that access depends on the design of the system and the ability to navigate services. In the case of complex pathways, service users may require “insider knowledge” or support to understand where to go and which language and thresholds apply.

*“People are not served when systems or bureaucracies do not work well together and they have poorer outcomes. So for example, people are not served when they are in hospital for longer than they want to be because a social work referral hasn’t been made.” (P174)*

*“And I could see as a patient or a service user that you have to have something like probably like a health background or a social work background to be able to feel comfortable in it and to be able to express your opinion about it all because there’s language getting used that not everybody understands. And there is language that I now hear that I don’t understand anymore because I’ve been out of health for 12 years.” (P169)*

*“So we’ve got, for example, last year opened a mental health assessment hub at the front door of our XX hospital, so our ability to try and do really innovative and different things and is probably well understood in X. There’s just that’s a lot of our places biggest challenges remain resources and money. There’s just not enough and the governance and the mechanism for that flowing through to IJB is really complex and clunky.” (P54)*

Participants in this study have posited that the issue of access can be conceptualised as a matter of design and capacity. They contend that even in instances where services are available, navigational challenges and the utilisation of professional language can act as barriers, thereby compromising the person-centred intent that underpins these services.

### *Subtheme B: Hospital-community interface, discharge, and “Home First”*

Discharge and flow were identified as the core stress points. Participants emphasised the coordination labour required to ensure the safe mobilisation of individuals, particularly in contexts where community capacity is limited.

*“But we have a home first team that works in hospital as well and we’ll work around things like planned data discharge and to try and get people out as quickly as possible and support them and their family for them to be home as quickly as possible because not everybody will need a care package.” (P29)*

*“Well, I think that’s, I’ve kind of already answered that as best my answer is, which was this delayed discharge and the fact that there was an artificial*

*boundary between health and social care that there was to the detriment of the whole system.” (P77)*

*“So the delayed discharge is as much connected to the resourcing of social care. And it’s reductionist in my view in that it assumes that social work and social care exists as a handmaiden to acute hospitals.” (P91)*

*“We’ve worked really hard on things like delayed discharge from hospital. It’s been an issue, I mean, across the UK and actually across the world, if you look at health care, and that’s been about our home-based social care team and also our social care teams who may run care homes and work in care homes, working with our hospital based team.” (P145)*

The hospital-community interface has been identified as a nexus where the success or failure of integration can be observed. The process of discharge is contingent upon the presence of a skilled community workforce, effective coordination mechanisms, and the establishment of clarity across professional boundaries.

### *Subtheme C: Continuity, repeated storytelling, and person-centredness under constraint*

Participants have occasionally highlighted a discrepancy between the intention to provide person-centred care and the reality of organisational practice. Merging large systems without ensuring they are operationally coherent does not necessarily result in person-centred experiences.

*“They feel that integration, which was meant to be about prioritising the individual, being very person-centred, has actually just brought together two large organisations in my, where I am, three large organisations who have got more power than before.” (P84)*

*“People will only have one main person that they’re dealing with and just get the professionals when they need them so that they’re not going from one service to another to another, telling people the same story a million times.” (P11)*

*“When that individual goes along to meet the next service, they start from scratch, so they’ll take their entire history and start from the beginning every time. So, from the viewpoint of a service user, it can be really frustrating getting handed between loads of different services.” (P1)*

*“So, the official goals are they do say person centred care to address inequalities. However, when you’re in the context of budget cuts and very different sets of protocols and working arrangements in the different agencies, that’s not been my experience of how care has worked out seamless journeys for service users and patients across different organisations and themes.” (P41)*

Participants suggest that person-centred integration cannot be achieved through structural alignment alone. The concepts of continuity and “seamlessness” are contingent upon the implementation of consistent protocols, adequate capacity, and system interoperability. In the absence of these factors, integration may come to be perceived as being more of an organisational nature than an experiential one.

### *Theme boundaries*

Include in this theme when...

- The focus is on pathway experience; access, navigation, continuity, discharge, home-first/flow, repeated storytelling, service-user/carer experience of “joined-up care”.

Exclude from this theme when...

- The primary account is about budgets/commissioning → Finance.
- The primary account is about workforce shortages/culture → Workforce (unless explicitly framed through pathway consequences).
- The primary account is about interoperability/IG → Data (unless framed through service-user experience).

Overlaps and coding rule-of-thumb

- If a pathway problem is explained mainly via staffing, dual-code Service-user + Workforce; keep primary where the participant places causal emphasis.

### **4.3. Themes intersection matrix**

Integration was described by participants as a system of interdependencies, rather than a set of isolated workstreams. In practice, the seven themes function as interconnected components. Alterations in one domain (e.g., workforce supply, budget rules, data-sharing constraints) swiftly engender consequences in other domains (e.g., discharge flow, decision-making confidence, legitimacy of participation). This section therefore maps where themes most strongly intersect in participants’ accounts.

The matrix is conceived as an analytical navigation instrument. The analysis revealed the instances in which participants most frequently established causal connections between issues (e.g., “because budgets... therefore decisions...”), the instances in which they described one theme as a constraint on another (e.g., “we cannot do X without workforce”), and the instances in which they described co-occurring pressures within the same narrative segment. The

designation of an intersection as “high” (H) does not signify the presence of an identical theme; rather, it denotes a recurrent description by participants of these themes as being mutually influential in the context of day-to-day implementation.

*Table 3. Themes intersection matrix*

	G	W	D	F	L	V	S
Governance (G)	—	M	M	H	H	H	M
Workforce (W)	M	—	M	H	M	M	H
Data/Digital (D)	M	M	—	M	M	M	M
Finance (F)	<b>H</b>	<b>H</b>	M	—	M	M	H
Leadership (L)	<b>H</b>	M	M	M	—	M	M
Voice (V)	<b>H</b>	M	M	M	M	—	M
Service-user (S)	M	<b>H</b>	M	<b>H</b>	M	M	—

Legend: H = High intersection, M = Medium, L = Low

As illustrated in Table 3, the letter H is used to denote a strong and recurring coupling, whilst M is used to denote a periodic coupling (often in specific settings or roles). Finally, L is used to denote limited coupling (raised occasionally or treated as secondary). It is important to note that the significance of certain intersections is not necessarily reflected in their frequency, particularly in cases where they are associated with elevated levels of risk (e.g., finance × service-user journey) or legitimacy (e.g., governance × voice).

Finally, the matrix has a practical implication; it helps avoid “single-lever” recommendations. In circumstances where intersections are high, the accounts of participants suggest that interventions must be bundled (for example, governance reforms without fiscal flexibility; pathway redesign without workforce capacity; participation initiatives without decision rights) will struggle to be implemented.

### *Evidence for each High (H) intersection*

#### *H1) Governance × Finance*

Participants repeatedly described financial pressure as governance-defining, shaping board attention, priorities, and what becomes “decidable” in practice.

*“I have to say the biggest the biggest influence on the IJB and local level at the moment is the financial department application council. Everything that we have done the last year and a half fail to be influenced by budgets rather than actually caring for what we do...” (P36)*

*“And the way we’ve shifted because of our financial and resources position is like crisis management. So, social workers have really significant caseloads, people are all in crisis that they’re dealing with, so they’re not able to do any of the product, proactive stuff with people that they might have aspired to.” (P39)*

## *H2) Governance × Leadership, relationships, and local variation*

Governance effectiveness was often narrated as contingent on leadership capacity and relationship quality, especially in a dual-authority arrangement.

*“OK, practically the integration authority, I would say lacks leadership. Because there are two masters. Because the chief officer of the integration authority reports to both the NHS chief executive and the council chief executive. They have very different understandings of integration.” (P41)*

*“I don’t know if you’ve seen the press coverage of Scottish Government encouraging us to maintain a partnership, but there is something there about actually it can break down really easily based on relationships at the top of the tree... the people that do sometimes play politics with what they are doing behind the scenes, but they would never publicly admit that.” (P138)*

## *H3) Governance × Voice, participation, and legitimacy*

Participants linked legitimacy to whether participation is empowered and whether non-voting roles have meaningful influence within governance.

*“They are patronised. Reports will come and they’ll be spoken, they’ll be explained, and they’ll be a tokenistic. They have no influence or power, in my opinion.” (P123)*

*“I will say that the chair and vice chair are both very welcoming when I first arrived and they instructed me of like my card and to put it on the mic, how to put it on the microphone of when I wanted to speak. But that was about the end of it, they didn’t say. And I know that I am a non-voting member as well, so that I am just there as a service user and patient, a representative.” (P169)*

## *H4) Workforce × Finance*

The reality of commissioning and funding, as well as the competitiveness of terms and conditions across different sectors, were repeatedly linked to workforce constraints.

*“And we see I think because we can’t compete with the terms and conditions. You’ve got a lot of providers out there that are paying reasonable. Thirteen-fifteen pound an hour, but then the council coming off and pays eighteen.” (P51)*

*“And as I say, for those services that we commission externally on the third sector, while we do pay the living wage requirements, which is what we have often the terms and conditions of staff working in the third sector are less they don’t have the same sickness, right, they don’t have the same pensions, they don’t have the same annual leave which is why it is cheaper for us to commission from the third sector.” (P27)*

#### *H5) Workforce × Service-user journey and person-centred integration*

Participants often said that pathway performance, especially discharge/flow, was directly affected by workforce capacity and the availability of community support.

*“But we have a home first team that works in hospital as well and we’ll work around things like planned data discharge and to try and get people out as quickly as possible and support them and their family for them to be home as quickly as possible because not everybody will need a care package.” (P29)*

*“We’ve worked really hard on things like delayed discharge from hospital. It’s been an issue, I mean, across the UK and actually across the world, if you look at health care, and that’s been about our home-based social care team and also our social care teams who may run care homes and work in care homes, working with our hospital based team.” (P145)*

#### *H6) Finance × Service-user journey and person-centred integration*

Accounts linked pathway experience to resource constraints: discharge coordination work and the ability to sustain community capacity were narrated as financially conditioned.

*“We’ll get all everybody on board, all synching, so that instead of me having to phone fifty-five different people for five different things to get somebody out of hospital, for example, I have to still go out, you know, I could have phoned one person who is in a hub.” (P69)*

*“Because if we think about somebody’s journey, so somebody, whatever, but they’re going to get an acute, they’re going to a hospital, yeah, to allow us to bring that person out of hospital, yeah, they need a care package. Yeah. So that cost has moved from the acute setting to a care package to the social care element. But as in Scotland at the moment, the NHS side, or acute side, is struggling financially.” (P81)*

### *Practical reading of the intersections*

#### *Governance × Finance (H)*

Decision rights and accountability become most visible when budgets tighten. Participants frequently described overspends, settlements, and financial risk as what turns governance from routine discussion into contested decision-making.

#### *Workforce × Finance (H)*

Contracting conditions and funding shape recruitment/retention and provider stability. In practice, “workforce capacity” is repeatedly narrated as a financial and commissioning outcome, not only an HR issue.

#### *Workforce × Service-user journey (H)*

Pathways (particularly discharge and community support) are experienced as workforce-dependent. When staffing is thin, person-centred integration becomes harder to deliver regardless of governance intent.

#### *Governance × Voice (H)*

Participation affects legitimacy only when it connects to decision rights and visible impact. Participants repeatedly framed non-voting roles as a structural constraint on meaningful influence.

#### *Governance × Leadership (H)*

Leadership and relationships are described as the mechanism that makes a dual-authority governance model workable. Where trust deteriorates at senior levels, governance processes become slower and more brittle.

#### *Finance × Service-user journey (H)*

Resource mobility (or the lack of it) shapes service-user experience. Participants repeatedly linked hospital-community flow and discharge coordination burden to funding pressures and capacity constraints.



# Section 5



## Discussion: Explaining What Changed and What Constrained Delivery

### 5.1. Reconnecting the findings to the policy intent

The integration reforms were introduced with the explicit logic of improving outcomes by aligning governance, resources, and service pathways around people's needs. This enables earlier support, better continuity, and a greater capacity to support independence in the community. Across a series of interviews, participants generally accepted this logic as both coherent and desirable. The divergence was not a result of differing intent, but rather of differing conditions required for delivery, which also varied across different locations.

In practice, participants described integration as operating through a dual (and sometimes multi-partner) system in which statutory structures can establish shared objectives, yet implementation depends on levers that remain distributed across partner organisations and markets. The findings thus support the central interpretive proposition that integration is most likely to progress when decision rights, delivery levers and joint working routines are aligned. When any one of these is weak, the system defaults to stabilisation and negotiation.

## 5.2. What “success” looks like in participant accounts

Participants did not define success as a single endpoint. Instead, they identified a set of observable features that demonstrate whether integration is functioning as an operating model rather than merely an aspiration:

- More coherent cross-boundary working routines, including preparatory work, manager-to-manager problem-solving, and the ability to resolve disagreement upstream of formal board meetings
- Shared strategic direction with credible delivery pathways, where plans are linked to operational capability rather than remaining predominantly rhetorical
- Reduced friction for citizens, including clearer routes into support, fewer avoidable hand-offs, and reduced repeated-story burdens
- Improved continuity and coordination, supported by practical information flow and a shared situational awareness among those delivering care
- A capacity to manage acute pressure without permanently displacing longer-horizon change, particularly prevention and community capacity building

These markers of success are of significance insofar as they anchor interpretation in practical functionality as opposed to formal compliance with integration structures.

## 5.3. Why barriers recur: four system-defining constraints

Across the corpus, four constraints repeatedly appeared as system-defining. The concept of “upstream” in this context refers to the ability to influence and shape the scope of feasibility across a wide range of other issue areas.

The accounts of participants suggest that barriers recur not solely due to local performance differences, but rather because a small set of system-defining constraints repeatedly shape the scope of what is feasible.

The subsections that follow provide a more detailed explanation of each constraint, and demonstrate how these constraints interact (frequently reinforcing one another) through the implementation hinges and stress points described in Sections 5.4–5.5.

### *Governance and accountability*

Participants frequently described blurred accountability, dispersed authority, and the need to lead through negotiation rather than command. This tendency

is characterised by a propensity towards cautious decision-making, a gradual pace, and an emphasis on defensibility, particularly in the context of fiscal constraints.

#### *Workforce capacity and employment fragmentation*

The prevailing narrative consistently identified workforce scarcity as the overarching constraint on delivery. Despite the existence of a harmonious relationship between governance and strategy, the viability of service redesign is contingent upon the presence of a stable workforce supply and effective cross-employer arrangements. Furthermore, participants emphasised that disparities in remuneration, terms and conditions, and mobility across different employers and provider types engender operational friction within the context of integrated delivery.

#### *Financial sustainability*

The discipline of finance was characterised less as a technical sub-issue and more as a driver of system behaviour. As is evidenced by a multitude of sources, the practical ability to allocate resources towards prevention and community capacity is diminished by annual balancing and acute protection pressures, even in circumstances where the policy ambition is widely shared.

#### *Partnership maturity*

In circumstances where formal levers are fragmented, partnership maturity becomes an informal capability that can compensate. The presence of trust, shared norms, and routinised joint working is indicative of the potential for the system to transition from procedural alignment to operational change. Nevertheless, participants were keen to emphasise that reliance on relationships can also engender fragility if progress is contingent on specific individuals or local histories.

When considered as a whole, these constraints provide a rationale for the phenomenon that the same statutory intent can result in divergent delivery realities. They influence whether integration functions as a functioning system or a negotiated settlement under pressure.

COVID-19 offers a useful, but bounded, illustration of this dynamic. In participant accounts, the pandemic did not resolve the underlying structural ambiguities of integration. Rather, it temporarily overrode some of them through emergency coordination, more immediate responsibility-taking, and faster cross-boundary action. Several participants described this period as one in which organisations were compelled to work together more closely,

but also noted that many of these gains were not retained once emergency conditions eased and more familiar organisational silos reasserted themselves.

#### **5.4. The “implementation hinges” linking strategy to delivery**

The accounts of participants in the study suggest that integration commonly stalls at a set of hinge mechanisms. These are points where shared intent must be converted into practice.

##### *Strategy versus operational levers*

Strategic plans have the capacity to align priorities and provide a shared narrative. However, implementation requires control over a number of factors, including budgets, the workforce, commissioning tools, corporate support functions and operational management lines. In circumstances where these levers are partial or contested, there is a risk of a divergence between strategy and delivery reality.

##### *Leadership bandwidth*

The role of leadership was characterised as requiring a high level of effort, with the responsibilities including the negotiation of different perspectives, the maintenance of cohesion, and the management of scrutiny and crisis pressures. In circumstances where assurance and fiscal politics consume capacity, transformation is displaced by stabilisation.

##### *Commissioning and procurement constraints*

As is often the case in such contexts, the commissioning process is expected to engender transformation (community capacity, prevention, alternatives to admission). However, the participants described procurement drag, risk aversion, and thin provider capacity as factors which limit the scope and speed of feasible change.

##### *Performance management and scrutiny*

Participants, when asked about their experiences, described a tension between accountability and improvement capacity. They explained that reporting cycles can become a parallel workload, and that data limitations constrain meaningful “data-led” scrutiny. The pragmatic issue is not whether scrutiny exists, but whether it engenders actionable learning or predominantly engenders compliance work.

The significance of these hinges lies in their capacity to elucidate the phenomenon whereby integration can appear coherent at the level of plans and governance while remaining uneven at the level of service change.

A recent policy development helps clarify this point, but does not overturn it. The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Amendment Order 2025 (SSI 2025/405) is important because it addresses one visible element of the earlier “voice without vote” problem by extending voting rights to three previously non-voting categories; third sector, service user, and unpaid carer representatives. However, this should be read as a targeted improvement rather than a full solution to the wider participation and legitimacy problem. Other stakeholders remain outside this change, and the amendment does not in itself resolve broader questions about agenda-setting power, selective influence, tokenism, or whether participation leads to visible change in decisions and follow-through.

### **5.5. The system “stress tests”: Where constraints become most visible**

A number of issue areas have been identified that incorporate numerous constraints within a single operational chain. These issue areas are considered stress tests of system alignment.

#### *Hospital-community interface (discharge and flow)*

Delayed discharge and flow were described by participants as significant pressures that lead to elevated short-term throughput concerns. The discharge readiness of a community often depends on its capacity to provide home care, respond promptly, facilitate reablement, and ensure the availability of care home places. Consequently, the acute bed pressure experienced by the community becomes a manifestation of its limited capacity.

#### *Prevention and early intervention*

Participants generally supported the concept of prevention, yet described it as being structurally disadvantaged in circumstances where acute pressures predominate and the annual balancing logic prevails. Prevention is repeatedly postponed due to its reliance on a stable workforce supply, investable capacity, and consistent coordination across various settings. However, these conditions are often undermined by crisis-driven operating modes, resulting in an uneven and often ineffective response.

#### *Citizen-facing access and navigation*

Participants frequently used terms commonly understood by citizens when discussing integration, such as the ability to locate the appropriate service, comprehend the available pathways, and circumvent the repetition of narratives. In circumstances where access routes are unclear or constrained, citizens tend to resort to the most visible entry points. This phenomenon

serves to exacerbate acute pressures and hinders the adoption of strategies that encompass a longer timeframe.

### **5.6. Place-based variation as an explanatory layer**

The findings indicate that place-based variation is not incidental. Participants described structural differences in governance complexity, the number of partner bodies, and local capacity as producing materially different operating conditions under the same national frame. The impact of variation is further compounded when statutory mechanisms are implemented inconsistently and when routinised learning-and-spread mechanisms are ineffective.

This approach facilitates the interpretation of divergent local experiences without resorting to simplistic categorisations such as “good areas versus bad areas”. In participant accounts, variation can be attributed to a combination of institutional geography, interpretive space in national guidance, and uneven delivery capacity.

### **5.7. Interpreting differences in emphasis by institutional position**

The participants' views were largely convergent with regard to core constraints, but divergent with regard to the decisive test of integration success. Section 4.1 examines these differences across G1-G3, highlighting the presence of patterned variations in how different institutional positions treat the decisive tests of integration success. In summary, delivery-centred accounts placed significant emphasis on implementability and levers; oversight-centred accounts placed significant emphasis on legitimacy and defensibility; and inclusion-centred accounts placed significant emphasis on voice and usability. These discrepancies are of consequence, as they influence the types of reform that are prioritised and the types of evidence that are regarded as persuasive.

### **5.8. What this means for the next section**

The discussion leads to the practical conclusion that the main challenge lies not in the absence of policy intent, but in aligning governance, levers, capacity and routines. Consequently, Section 6 must concentrate on options that are viable within actual constraints, prioritise the most significant barriers to consensus (workforce, finance, governance clarity, joint-working routines), and regard data/digital enablement as a pragmatic infrastructure concern rather than a distinct technological project.

# Section 6



## Policy Options and Recommendations

This section sets out options and recommendations aimed at public bodies and system leaders responsible for delivering Scotland's health and social care integration agenda. Recommendations are presented in two complementary registers:

- 6A. Practical, delivery-focused options: implementable within current structures, prioritising achievable improvements in decision rights, capacity, and day-to-day delivery
- 6B. Ambitious, structural options: higher-impact reforms that would require stronger national alignment, deeper institutional change, and (where relevant) system redesign

### 6.1. Principles for implementation

Across interviews, the most credible reforms were those that:

- Clarify decision rights and accountability
- Protect delivery capacity
- Reduce avoidable process burden
- Focus on visible system stress points (notably discharge/flow) while sustaining longer-horizon change (including prevention)

Recommendations are therefore framed as sequenced packages, not standalone initiatives.

A consistent organisational premise is used throughout. The IJBs do not employ staff, and their core support is provided by officers who have been seconded from the NHS Board (within NHS Scotland) and the local authority. Similarly, HSCP delivery functions are undertaken by staff employed by the NHS Board and/or the local authority and assigned/seconed into integrated arrangements, with the Chief Officer role providing senior leadership across the partnership.

## **6A. Practical, delivery-focused options**

### *6A.1. Clarify decision rights and escalation routes (governance that enables delivery)*

Recommendation A1: Publish a local “decision rights map” and escalation protocol for each partnership.

Each area should maintain a concise, operational document that specifies:

- Which decisions sit with the IJB, HSCP senior leadership, the NHS Board, and the local authority
- Thresholds for escalation (financial, safety, political, reputational)
- A standard route for dispute resolution
- How statutory tools (including directions) are operationalised in practice

### *6A.2. Protect leadership and improvement bandwidth (reduce “assurance sprawl”)*

Recommendation A2: Introduce a “minimum viable reporting set” and cap routine papers. IJBs, alongside the HSCP Chief Officer(s) and senior officers seconded from the NHS Board and local authority, should move to:

- A smaller number of core performance and finance indicators that are routinely scrutinised
- Short-form dashboards by default, with deep-dives by exception
- Time-limited review cycles (sunset clauses) for standing reporting items that do not generate actionable decisions

Rationale: Scrutiny is essential, but reporting can become a parallel workload that reduces time for redesign and delivery improvement.

### *6A.3. Stabilise workforce capacity where the system is most fragile (community-first delivery constraints)*

Recommendation A3: Prioritise “workforce stabilisation” packages in the community interface. Local systems should identify the roles and service lines that most directly determine flow and safety (e.g., homecare, reablement, rapid response, intermediate care) and implement targeted stabilisation measures across the NHS Board and local authority workforce, and the commissioned provider market:

- Retention measures (pay and non-pay, where feasible)
- streamlined onboarding and rota flexibility across services
- Joint recruitment pipelines and shared induction content across partner organisations
- Provider sustainability interventions where market fragility is acute

Rationale: Many reforms fail because implementation assumes workforce capacity that does not exist in practice.

### *6A.4. Make financial planning more delivery-realistic (medium-term, not annual firefighting)*

Recommendation A4: Adopt a joint 3-year financial narrative tied to delivery levers. Even where funding flows remain complex across the NHS Board and local authority, partnerships can improve credibility by producing:

- A three-year financial narrative (pressures, assumptions, mitigations)
- Explicit identification of “non-discretionary” cost drivers (e.g., demography, pay awards)
- A small number of invest-to-save priorities with protected governance oversight
- Clear articulation of which decisions require NHS Board and/or local authority approval

### *6A.5. Strengthen commissioning as a practical tool (not only a strategic aspiration)*

Recommendation A5: Use commissioning to secure capacity and continuity before pursuing transformation.

In thin or unstable provider markets, commissioning should prioritise:

- Continuity of provision and workforce sustainability
- Simplified contracting where complexity adds little value

- Shared outcome measures that are feasible to collect
- Explicit contingency planning for provider failure or withdrawal
- Recognition of third sector provision as part of the system's preventive and community-support infrastructure, rather than only as a supplementary or consultative partner

Rationale: “Transformational commissioning” is not credible where baseline provision is fragile. This is particularly relevant to third sector and community-based provision. In many areas, these organisations contribute not only to representation and engagement, but also to prevention, early intervention, and the maintenance of local support networks that help people remain connected within their communities.

#### *6A.6. Treat discharge/flow as a system design issue (not a hospital-only problem)*

Recommendation A6: Create a joint “flow compact” aligning the NHS Board, local authority and commissioned providers.

Local systems should implement a single cross-organisational flow agreement covering:

- Criteria and timelines for “clinically ready” pathways
- Rapid access to interim support (reablement/intermediate care)
- Responsibilities for equipment, adaptations, and care package coordination
- Escalation routes when community capacity is the binding constraint

Rationale: Discharge pressure is a recurring stress test because it concentrates workforce, finance, provider capacity, and governance incentives into one operational chain.

#### *6A.7. Implement minimum-viable interoperability (operational milestones, not open-ended aspirations)*

Recommendation A7: Adopt staged interoperability milestones tied to priority pathways. Local systems should move away from open-ended “integration of systems” goals and adopt staged milestones such as:

- Role-based access agreements for priority pathways (e.g., discharge, urgent care)
- A shared identifier matching plan where legacy systems constrain interoperability

- Routine information-sharing for operational coordination (not just ad hoc requests)
- Clarity on information governance roles across the NHS Board, local authority, and (where lawful and appropriate) third sector providers

This is important because, as the interviews revealed, information-sharing is a practical enabler of continuity. Reducing ambiguity and establishing routine access can improve coordination without waiting for a complete replacement of the platform.

*6A.8. Use MyCare.scot / Digital Front Door to reduce citizen friction (inclusion by design)*

Recommendation A8: Treat MyCare.scot as a service redesign programme, not a digital deployment.

As NHS Scotland's Digital Front Door programme expands, local systems should:

- Pair digital access with non-digital navigation support (telephone, in-person, community channels)
- Prioritise features that reduce friction (clear service finder, correspondence/ appointments visibility, accessible information) before expanding scope
- Adopt inclusion metrics (who is excluded, why, and how mitigations work)
- Ensure digital routes reduce repeated-story and avoidable contact burdens, rather than creating parallel complexity

*6A.9. Reduce avoidable place-based variation through targeted learning mechanisms*

Recommendation A9: Create a small set of "learning priorities" and compare like-with-like. Variation is partly structural, but local systems can reduce avoidable variation by:

- Selecting 3-5 learning priorities (e.g., directions practice, discharge pathways, provider sustainability, data-sharing governance)
- Benchmarking comparable areas (similar institutional geography and constraints)
- Translating learning into operational guidance and routinised practice, not only reports

## **6B. Ambitious, structural options**

### *6B.1. Move towards more unified workforce principles across integrated delivery*

Option B1: A staged route to common workforce principles across the NHS Board and local authority interface.

A staged approach could include:

- Common role profiles for key integrated functions
- Portability arrangements for training and competencies
- Shared leadership and professional development pathways
- A roadmap to reduce the most operationally disruptive pay/conditions mismatches

### *6B.2. Re-set the accountability model (reduce “two systems” effects without erasing local flexibility)*

Option B2: Strengthen clarity of delegation and responsibility for delivery levers. A structural option would:

- Standardise minimum expectations on delegation and practical levers
- Clarify which bodies hold delivery responsibility for key constraints (workforce, corporate support, financial risk)
- Provide a national model for dispute resolution and escalation, reducing ad hoc negotiation

### *6B.3. Deliver a genuinely interoperable integrated care record ecosystem (beyond pilots)*

Option B3: A national interoperability “spine” with enforceable information standards and role-based access.

An ambitious approach would:

- Set enforceable interoperability standards
- Require role-based access across relevant care settings
- Ensure citizen access in accessible formats
- Bring third sector delivery into the information ecosystem where lawful and appropriate

Risk to manage: Digital exclusion and trust; mitigation requires parallel non-digital routes and clear governance.

#### *6B.4. Rebalance incentives so prevention is protected (not perpetually deferred)*

Option B4: Create protected prevention capacity that cannot be routinely cannibalised by acute pressure.

Structural options include:

- Multi-year prevention investment envelopes with strong governance oversight
- Minimum community capacity standards for rapid response and reablement
- Policy mechanisms preventing acute performance pressure from absorbing all system capacity

#### *6B.5. Scale MyCare.scot into a mature citizen-facing spine (with safeguards)*

Option B5: Over time, integrate wider pathways into MyCare.scot while preserving inclusion and accountability.

A more ambitious path would:

- Integrate more pathways gradually (while maintaining inclusion safeguards)
- Connect citizen-facing access to practical coordination functions (including discharge support information where appropriate)
- Reduce avoidable contact burdens (letters, updates, pathway clarity) through simpler citizen journeys

## **6.2. Suggested sequencing**

The report presents a range of options, both practical and ambitious, and as such, the order in which these options are pursued is of significance. Pursuing an excessive number of reforms simultaneously can lead to implementation overload. Table 4 provides a simple roadmap that stages priority actions over 0-6, 6-12, and 12-24 months, making explicit the dependencies and the early signals that implementation is moving in the intended direction.

Table 4. Sequencing roadmap; actions, dependencies, and early signals

Months	Action	Dependency Precondition	Owner(s) Decision Locus	Early Signal of Progress	Main Themes Addressed
0-6	Decision-rights map + escalation route	Agreement on “who decides what” for top 10 recurring decisions	IJB + HSCP leadership LA & NHS Board execs	Published decision-rights map Escalation route used at least once	Governance Leadership
	Reset reporting burden (“assurance-lite” pack)	Baseline inventory of duplicative Reporting and committee cycles	IJB Secretariat + partners	Reduced paper volume / fewer duplicative dashboards. Time saved documented	Governance Leadership
	Discharge/flow compact (single interface rules)	Shared definition of “ready to discharge” and minimum info set	HSCP + NHS acute/community leads	Reduced “re-work” in discharge Fewer failed handovers	Service-user journey Workforce
	Minimum viable information-sharing protocol	Legal/IG sign-off Agreed lawful basis and roles	IG leads (LA/NHS) + HSCP	Protocol adopted Staff report fewer “can’t share” blocks	Data/IG Service-user journey
6-12	Workforce stabilisation plan (critical roles)	Identify top 5 pinch-point roles Align recruitment incentives	HSCP workforce leads + commissioning leads	Vacancy/turnover begins to fall in pinch-point roles	Workforce Finance
	Commissioning reset for continuity (contract stability)	Market engagement. Agree minimum standards and payment terms	IJB commissioning + LA/NHS procurement	Fewer spot purchases Improved provider continuity	Finance Workforce
	Interoperability “thin slice” (single view for priority cohort)	Choose priority cohort/pathway Technical feasibility check	Digital/IT leads + HSCP pathway owners	Live pilot: shared summary view for cohort	Data/IG Service-user journey
12-24	Prevention shift package (resource mobility test)	Multi-year financial narrative Agreed disinvestment safeguards	IJB + partner finance directors	Spend shift documented Prevention capacity increased in target pathway	Finance Governance
	Participation to influence (feedback loop guarantee)	Define which decisions require lived experience input. Timeline	IJB + Public Partners / Third sector	“You said–We did” log Participation linked to decisions	Voice Governance
	Digital Front Door alignment (service redesign + inclusion)	Inclusion-by-design assessment Pathway readiness	SG/Programme + HSCP + local delivery	Uptake without exclusion harms Clear service navigation outcomes	Data/IG Service-user journey

This sequencing should be regarded as a decision support tool rather than a fixed programme plan, with local context, baseline capability, and current pressures shaping the sequence of delivery in a manner that avoids creating additional strain elsewhere in the system.



# Section 7



## Conclusion

This report set out to examine the translation of Scotland’s health and social care integration policy intent into delivery reality, drawing on qualitative interview evidence and supporting documentary sources. The findings indicate that the core challenge is not a lack of ambition or clarity of high-level purpose, but the alignment of governance, delivery levers, capacity, and routinised joint working required to make integration function consistently as an operating model.

Across the corpus, participants described a shared understanding of what integration is trying to achieve; more person-centred support, improved continuity, and a stronger capacity to enable independence in the community. However, they also described persistent constraints that repeatedly shape what is feasible in practice, particularly the interaction of workforce fragility, financial pressure, and distributed authority within a system where key levers remain held by constituent organisations. In such conditions, integration can default to stabilisation and negotiation, with longer-horizon change (especially prevention) repeatedly deferred by immediate pressures.

The evidence suggests that progress is most likely when three enabling conditions co-exist:

- Clear decision rights and accountability, with practical escalation routes and consistent operationalisation of statutory tools

- Credible delivery capacity, especially in community services, supported by realistic medium-term financial narratives and commissioning approaches that stabilise provision before pursuing transformation
- Practical joint-working infrastructure, including routines that resolve disagreement upstream, and interoperable information flows that reduce friction for staff and citizens

Recent governance change reinforces this argument, but does not remove it. The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Amendment Order 2025 (SSI 2025/405) is a meaningful step because it gives voting rights to third sector, service user, and unpaid carer representatives and thereby reduces one visible element of the earlier “voice without vote” arrangement. Even so, the reform should not be overstated. It improves formal representation for three important categories of members, but it does not by itself eliminate wider participation deficits, informal power imbalances, or the continuing need to link lived experience and third sector input to agenda-setting, decision-making, and follow-through in practice.

Participants also emphasised that Scotland’s integration agenda is implemented through place-based systems operating under a national frame, with variation shaped by institutional geography, local capacity, and how national guidance is interpreted and enacted. Reducing avoidable variation therefore requires targeted learning mechanisms and clearer norms for the use of core tools, rather than uniformity for its own sake.

The recommendations in Section 6 reflect a sequencing logic derived from the evidence:

- Start by clarifying governance and protecting capacity
- Stabilise the workforce and provider market where the system is most fragile
- Strengthen discharge/flow arrangements as a system design issue
- Pursue interoperability and citizen-facing digital pathways in ways that simplify journeys and preserve inclusion

Taken together, these steps are intended to shift integration from a model sustained primarily by relationships and workarounds towards a more reliable and scalable operating system for joint working.

Importantly, the report does not argue that progress depends on wholesale replacement of Scotland’s current integration settlement. Its central argument is that a great deal of improvement remains possible within the existing

institutional architecture, provided that decision rights, delivery levers, workforce capacity, and joint-working routines are better aligned. The more ambitious structural options set out earlier should therefore be read as longer-term possibilities rather than as preconditions for near-term improvement.

In summary, the integration reforms proposed by the Scottish Government are, in principle, widely supported, but their practical success is dependent on the successful addressing of the upstream constraints that repeatedly shape delivery. The most credible path forward is not a single “silver bullet” reform, but rather an evidence-informed package that aligns decision rights, capacity, and operational infrastructure. This would ensure that integration becomes the default way the system works, rather than an additional layer of complexity operating alongside it.



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# Appendix

## Ethics approval form



University of Stirling  
Cottrell 3B1  
Stirling  
FK9 4LA

20/01/2025

Dear Mucahit Bektas

Ethics Application Form : [The Integration Policy of Health and Social Care in Scotland After the Covid-19 Experience](#)

Ethics Reference Number: [GUEP\\_2025\\_20599\\_15932](#)

Thank you for your submission of the above ethics application.

The ethical approaches of this project have been approved and you can now proceed with your project.

Please note that should any of your proposal change, a further change request submission will be necessary.

If you have any further queries, please do not hesitate to contact the Panel by email to [ethics@stir.ac.uk](mailto:ethics@stir.ac.uk)

Yours sincerely,

General University Ethics Panel

Research Ethics in Practice training is available online:

[Staff & Postgraduate Research Students](#)

[Undergraduate & Postgraduate Taught Students](#)

## Interview questions form

**UNIVERSITY of  
STIRLING**



### Interview Questions Form

#### The Integration Policy of Health and Social Care in Scotland After the Covid-19 Experience

*GUEP Approval Number: GUEP 2025 20599 15932*

This research examines between 2014-2024, the structural, legal, cultural, and financial successes and challenges that the two public services have encountered in creating a common organisational structure, the extent to which they have been able to implement what they had determined prior to the integration policy, and what role, if any, Covid-19 has played in this process. I seek to identify transferable lessons for other countries with this research. You will be asked to respond to the following nine questions (and follow-up questions to your answers). The interview will take approximately 40-60 minutes.

#### **Mucahit Bektas**

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Visiting Associate Professor  
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#### **with Paul Cairney**

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#### **Questions**

- 1- What are your roles and responsibilities?
  - 2- What does integration mean to you?
  - 3- What are the official goals of the integration?
  - 4- What factors have promoted the integration policy?
  - 5- Who are the main actors in the integration process?
  - 6- Has Covid-19 had an impact on the integration process and its goals?
  - 7- What are the main successes and challenges you have faced during the process?
  - 8- What lessons can the Scottish experience offer to other countries?
- Is there anything else you would like to mention?

Electronic consent form



**Electronic Consent Form**

**Research Project Title:**

The Integration Policy of Health and Social Care in Scotland After the Covid-19 Experience

GUEP Approval Number: GUEP 2025 20599 15932

Please tick box	
I confirm that I have read and understood the information sheet explaining the research project and I have had the opportunity to ask questions about the project.	<input type="checkbox"/>
I understand that my participation is voluntary and that I am free to withdraw at any time during the study without giving a reason, and without any penalty. I understand that if I withdraw no more data will be collected from me. However, any data collected up until the point that I withdraw may be kept and used in the data analysis.	<input type="checkbox"/>
I have been given a unique identifying number [        ] and know whom to (Mucahit Bektas – <a href="mailto:mucahit.bektas@stir.ac.uk">mucahit.bektas@stir.ac.uk</a> ) contact should I wish to withdraw my data.	<input type="checkbox"/>
I understand that my responses will be kept anonymous, and I give permission for members of the research team (Mucahit Bektas and Paul Cairney) to have access to my anonymised responses.	<input type="checkbox"/>
I give permission to use direct quotes from my interview (pseudonymised, with reference to role).	<input type="checkbox"/>
I agree to take part in this study	<input type="checkbox"/>



## Quote-Participant-Theme/Subtheme Index

Below is an index showing, for each participant, where they appear (Theme/Subtheme).

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Theme 7 — Subtheme C

### **P2**

Theme 1 — Subtheme A

Theme 4 — Subtheme A

### **P5**

Theme 2 — Subtheme B

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Theme 2 — Subtheme B

Theme 7 — Subtheme C

### **P14**

Theme 3 — Subtheme B

Theme 6 — Subtheme B

### **P17**

Theme 1 — Subtheme B

Theme 5 — Subtheme A

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Theme 3 — Subtheme A

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Theme 5 — Subtheme B

# From Policy to Practice

Explaining Successes and Barriers in Scotland's Health  
and Social Care Integration (2014-2025)

Mücahit Bektaş

Paul Cairney