Scotland

49

Elaine Mead

49.1 Introduction

Scotland is part of the UK, covers the northern third of Great Britain and shares a border with England to the south.[1] At the last census (2011), the population was 5.3 million, the highest ever recorded (Scotland's Census 2014).

Population density is low in comparison with the rest of the UK due to large remote and rural areas, particularly in the Highlands and Islands. While the population has remained stable over the past 50 years, the proportion of people aged 65 and over has grown and is projected to increase by around two-thirds over the next 20 years (Ham et al. 2013).

Health care in Scotland is mainly provided by National Health Service (NHS) Scotland, the country's public healthcare system. The NHS was founded by the National Health Service (Scotland) Act, 1947, and took effect on 5 July 1948 to coincide with the launch of the NHS in England and Wales.

Over the past two decades, there have been some significant changes in how Scotland is governed. Following political devolution that took effect in 1999, the Scottish Parliament was set up with powers to make laws across a wide range of areas including health (Taylor 2015; Mooney and Scott 2012; Keating 2010; Mcfadden and Lazareswich 1999). These new arrangements also saw a move to Scottish parliamentary elections being held every 5 years.

[1]No passport or ID checks are required to cross the border.

E. Mead (✉)
IC&C, Highlands, UK
e-mail: elaine@elainemead.com

© Springer Nature Switzerland AG 2021

V. Amelung et al. (eds.), *Handbook Integrated Care*,
https://doi.org/10.1007/978-3-030-69262-9_49

Since 2001, NHS Scotland has been organised into 14 regional-based health boards, 7 national or special boards and one public health body. Regional boards have overall responsibility for the health of their populations, and they plan and commission secondary care (which is generally provided by medical specialists in acute hospitals) and community health and primary care (which is provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment including GPs, pharmacists, dentists and optometrists). Healthcare funding and policy are the responsibility of the Scottish Government.

This is supported by the executive functions of the Scottish Government's Health and Social Care Directorates. NHS Scotland operates with an annual budget of around 13.4 billion (Audit Scotland 2019)[2] and there is a national formula that deals with the allocation of funding for each regional board.

Adult social care and social work are the responsibility of 32 local authorities (councils). While 85% of their funding comes from central government in the form of a block grant, councils are autonomous bodies, independent of central government and accountable to their electorates for the delivery of services. The remainder of their funding is raised from local taxation ('council tax') and discretionary funds. Integrating health and social care has been on the policy agenda in Scotland for the past 20 years or so (Taylor 2015). Of particular relevance is the Community Care and Health (Scotland) Act, 2002, which enabled health boards and local authorities to delegate some of their functions and resources. The subsequent NHS Reform (Scotland) Act, 2004, required boards to establish one or more community health partnerships (CHPs) with local authorities in their area. These were seen as a focus for integrating health promotion, primary and specialist health services at a local level (Ham et al. 2013; Taylor 2015).

In 2011, the Scottish Government's 2020 Vision articulated a clear aim that 'everyone is able to live longer at home or in a homely setting'. It included a plan for achieving sustainable quality in the delivery of health and social care (Scottish Government 2011). The subsequent Public Bodies (Joint Working) (Scotland) Act, 2014, set out the most recent legislative framework for integrating health and social care.

Under the Act, statutory responsibility for social care functions remains with local authorities but with the provisions that allow for the delegation of some of these functions. This is either through the formation of an integration joint board that is responsible for planning and resourcing service provision for adult health and social care services (Option 1); or alternatively, the health board or the local authority takes the lead responsibility for planning, resourcing and delivering integrated adult health and social care services, known as the 'lead agency' model (Option 2) (Taylor 2015; Bruce and Parry 2015).

[2]£3.9 billion was also spent on social care services (Expenditure on Adult Social Care Services, Scotland, 2013–2014).

Health boards and local authorities were required to put in place their local plans by April 2015 with the full integration of services expected by April 2016. Notably, 31 of the 32 local authorities are implementing Option 1. The Highland Council is the only local authority that is implementing the lead agency model, and in the following sections, we focus on this specific model of integrated care in Scotland.

49.2 Integrated Care in Practice

49.2.1 Problem Definition

NHS Highland Health Board[3] was established in October 2001 and since then has undergone a number of reorganisations, including the establishment of community health partnerships in 2004 (the Highland Council Area) and in 2006 the taking on the responsibility for part of the former NHS Argyll and Clyde region. In doing so, NHS Highland became responsible for the largest health board area in Scotland. It includes some of the most remote and rural parts of the country including 36 populated islands (see Map in Fig. 49.1) (Box 49.1; NHS Highland 2015a).

Box 49.1 NHS Highland at a Glance

- Co-terminus with two local authorities (The Highland Council and Argyll and Bute)
- Covering an area of 32,500 km^2 = 41% of the landmass of Scotland
- 36 populated Islands
- Population of 320,760 (National Records 2014)
- 10,088 employees (8000 whole time equivalent)
- Annual revenue budget 2015/16 c£789 m
- 100 GP practices
- 25 hospitals, made up of the following:
  - 1 district general hospital
  - 2 dedicated mental health units
  - 3 rural general hospitals
  - 19 community hospitals
- 15 care homes (The Highland Council area)
- 39,000 attendances Raigmore Hospital Emergency Department per annum

[3]NHS Highland is managed by a board of directors and is accountable for the performance of NHS Highland. It is underpinned by committees, including: clinical governance, area clinical forum, Highland Health and Social Care Committee.

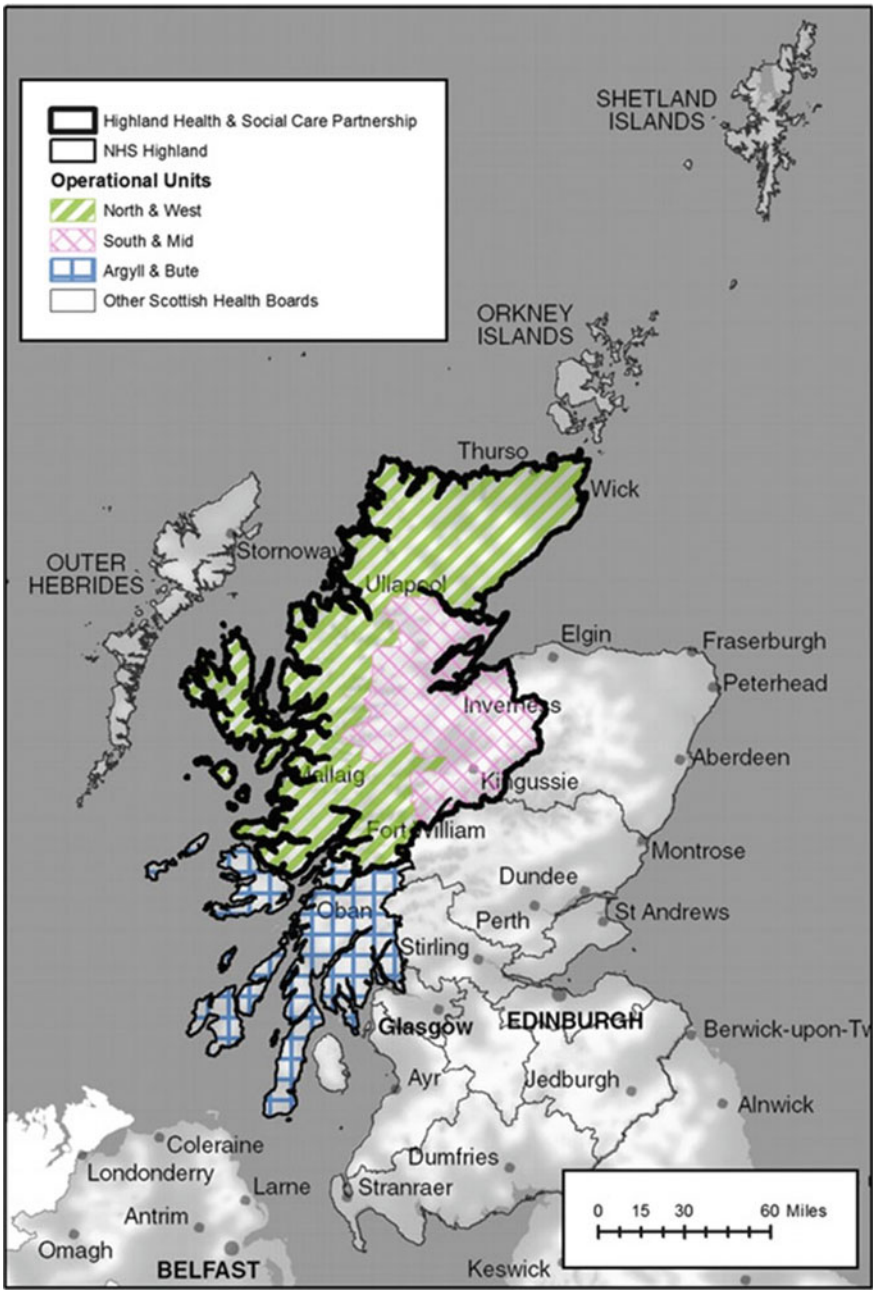

Fig. 49.1 Overview of NHS Highland

Arguably, however, the biggest reorganisation for the health board came in April 2012 with the signing of a partnership agreement between NHS Highland and the Highland Council.

With an ageing population, particularly for those aged over 75 years, and the expectation that public expenditure would fall in real terms, while pressures on health and social spending would increase, the status quo was not seen as a viable option (NHS Highland 2011, 2012a, b).

Furthermore, the Highland Council and NHS Highland recognised that the way some services were organised was not delivering the best outcomes for people. This was despite efforts by frontline staff and managers to overcome day-to-day barriers. Delayed decision-making, conflicts over budgets and accountability, and at times a blame culture, were all considered to be barriers with some significant impacts including:

- Lack of alternatives to emergency hospital admissions
- Limited care at home
- Lack of 'joined-up' responses and delivery of services
- Early (young) admissions to care homes
- Limited collaboration with third and independent sector.

Against this background, there was a perception that more radical reform was needed. A number of fact-finding visits were carried out, and various models were considered, including Torbay in England (Thistlethwaite 2011). Following on from this, a joint meeting of The Council and the Health Board was held in December 2010 and a joint statement of intent was issued:

> We will improve the quality and reduce the cost of services through the creation of new, simpler, organisational arrangements that are designed to maximise outcomes, and through the streamlining of service delivery to ensure it is faster, more efficient and more effective.

A joint board was created to deliver a 15-month programme of work to establish new arrangements to fully integrate services, particularly in relation to adult and children. Some 2 years later, on 21 March 2012, the Highland Council and NHS Highland signed a formal partnership agreement to establish the first lead agency model in Scotland.

49.2.2 Description of the Lead Agency Model

Under the lead agency model, all adult social care services were transferred to NHS Highland from the Highland Council in April 2012, and in a reciprocal arrangement, the Highland Council took on responsibility for the delivery of community children's services (Mead 2015; Mead et al. 2017; Baird et al. 2014; Brown 2013; Highland Partnership 2012).

For NHS Highland, this meant taking on new responsibilities including the management of 15 care homes, the in-house care-at-home service, day care services, telecare services and a wide range of contracts with the third and independent sectors.

It also involved 1400 adult care staff transferring under Transfer of Undertakings (Protection of Employment)[4] from Highland Council to NHS Highland while maintaining their terms and conditions. Alongside this, 200 NHS Highland staff transferred across to the Highland Council. Some of the other practical implications are summarised in Box 49.2 and set out in more detail in Mead (2015) and Highland Partnership (2012).

Box 49.2 Legal, Financial and Management Implications of Lead Agency Model

Legal Arrangements

- Changes to the Adult Support and Protection Act (Scotland), 2007, were necessary and were approved by the Scottish Parliament.
- A legal partnership agreement (detailing legal, professional leadership, governance and performance arrangements) was required.
- Some staff contracts had to be transferred across employers (NHS Highland and Highland Council).
- Change was required to pension's legislation to permit staff that were transferred to remain in their existing pension scheme.

Financial Arrangements

- New single budgets had to be prepared along with requisite resource transfer.
  - £89 million annual budget was transferred from the Council to NHS Highland.
  - £8 million annual budget was transferred from NHS Highland to the Council.
- Different VAT reporting mechanisms for each organisation had to be reconciled.

Management and Governance Structures

- Existing management and governance structures, such as community health partnerships, had to be reorganised.
- Outcomes had to be agreed along with associated performance management frameworks.

[44]Transfer of Undertakings (Protection of Employment) Regulations (TUPE) provides rights to employees when their employment changes when a business is transferred to a new owner.

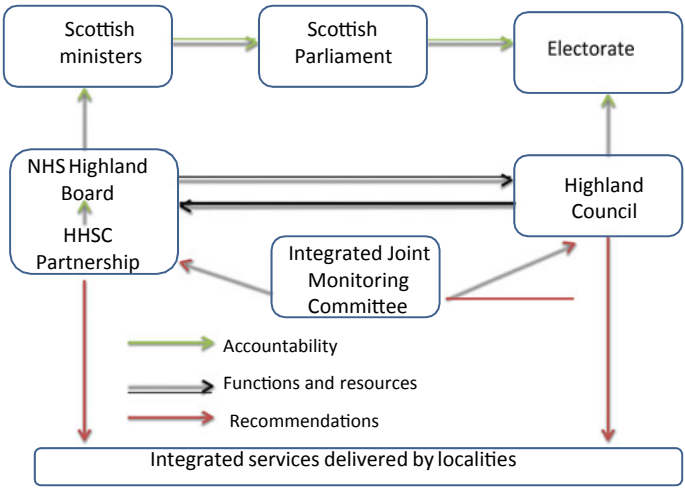

Fig. 49.2 How the lead agency model is structured

49.2.3 Governance

At the point of integration (1 April 2012), new governance and management arrangements were put in place for the lead agency model which followed legislative requirements (Fig. 49.2). These confirm that in terms of adult services the Council remains accountable but NHS Highland is responsible for the delivery of the service. Reciprocal arrangements are in place for children's services.

To make this change, three community health partnerships (north, mid and south-east) were dissolved. These were replaced by a new Highland Health and Social Care (HHSC) Partnership which was established as a committee of the board. The partnership directly oversees the governance but reports into the board via the chair who is a non-executive director of the board (Fig. 49.2). A monitoring framework is also in place.

49.2.4 New Ways of Working

There have been many examples, some small and some bigger, of the positive benefits of integration (Highland Council 2015), and some of these are summarised here.

Co-ordination and Professional Communication More effective integrated district teams have been created. Each of the nine integrated district teams within the Highland Council area has a core team of key health and social care professionals representing, for example, care homes, care at home, occupational therapy, GP practices and community nursing.

By working together in a co-ordinated way, a group of key professionals are now more able to ensure clients' and patients' health and social care needs are met. Each part of the team is linked to a care co-ordinator who ensures that each patient and client get fully co-ordinated care in a timely and efficient manner (NHS Highland 2013).

Commissioning Arrangements and Partnership Working An adult services commissioning group has been established so as to involve as many sectors and representatives as possible, in the making of strategic decisions about investment in adult social care.

In effect, The Highland Council commission services from NHS Highland, while it remains accountable for the delivery of the services. The transaction is delivered through a five-year plan which is monitored in terms of delivery of agreed outcomes and reviewed annually.

Since integration, there has been evidence of much closer working with third and independent sector, with a number of documented benefits.

One example is the introduction of the living wage for the independent care-at-home sector. Contracts are in place between NHS Highland and independent sector care-at-home providers. The Living wage was implemented in April 2014, and since this time, providers have been required to pay their staff the living wage, and provide evidence of having done so, in order to receive an increased fee.

NHS Highland has also been successful in the innovative application of the Social Care Self-Directed Support (SDS) (Scotland) Act which was implemented in April 2014. This supports the vision that care should be based around the citizen, not the service or the service provider. It provides a means through which all clients are given a choice as to how they wish to receive their services and support. This Act places a statutory duty on local authorities and integrated partnerships to offer four choices as to how people are assessed as requiring care and to how they received their care or support.

Self-Directed Support option two is known as an Individual Service Fund (ISF) and enables a service provider of the individual's choice to manage their budget. Given the shortage of care-at-home provision in many remote and rural locations in parts of the Highlands, NHS Highland worked in partnership with independent providers and local communities to put in local solutions to provide care at home. This has proved successful in delivering a care-at-home service where previously traditional models of care at home could not be sustained (NHS Highland 2015c).

Service and Quality Improvement The appointment of a NHS Highland service improvement lead for care homes has brought a more consistent and multidisciplinary approach to training and closer working across all professionals.

A new service was introduced to ensure the safer use of medicines in the care homes managed by NHS Highland. This is because medicines are frequently prescribed for residents of care homes and carry risks, such as adverse drug reactions, which are increased in frail populations. The service involves a pharmacist providing a medication review for every care home resident within 2 weeks of admission and every 6 months thereafter.

In order to ensure adequate staffing, in particular in social care, where recruitment to social worker posts has been challenging in some areas, NHS Highland has taken steps to 'grow our own' by introducing a trainee social work scheme which got underway in 2015 (Highland Council 2015).

Furthermore, additional community geriatricians have been recruited to provide in-reach to community hospitals and care homes, and primary care. This has supported a much more multidisciplinary and joined-up approach to ensure care provision to people outside of acute hospitals.

This has built on work over many years carried out by NHS Highland to improve anticipatory care planning[5] (Baker et al. 2012), polypharmacy reviews (NHS Scotland 2015) and virtual wards[6] all designed to take a proactive approach to reducing hospital admissions (Ham et al. 2013; Somerville 2012; NHS Highland 2011).

Major Service Redesign Under the new integrated arrangements, NHS Highland has been able to plan new service models at district level across all health and social care resources. This has included proposals for developing community and care-at-home capacity which will allow community hospital beds to be reduced (Blackhurst et al. 2015; Thompson et al. 2015).

49.2.5 People Involvement/Service User Perspective (Value)

There was significant public engagement in order to inform the development and shape of the lead agency model. During the early discussions, NHS Highland held meetings with various stakeholder groups and every community care service user or carer group was contacted by letter to invite them to feed back on their experiences. Focus groups were also undertaken by NHS Highland staff with people who used particular services, and public meetings were held across the region (Highland Partnership 2012).

The vast majority of the feedback confirmed the support for change. Those who had direct experience of accessing services expressed frustration about the often disjointed approach. Overall, the feedback provided a strong mandate to continue with integrating services. Qualitative research conducted subsequently pointed to a common theme: generally, public respondents were surprised that NHS Highland and the Highland Council did not already work in a highly co-ordinated way (Beswick 2013).

In Scotland, there is national guidance around how NHS Boards should inform, engage and consult with their local communities, service users, staff and partner agencies about proposed major service change (Scottish Health Council 2010). In the case of major service redesign as described above, this included having a steering group made up of service users, public members, elected members, staff

[5]In 2010, NHS Highland introduced an Anticipatory Care Patient Alert (ACPA) form. This is completed for patients who have one or more pre-existing conditions which may have resulted in them being admitted to hospital as an emergency on several previous occasions.

[6]The virtual wards work just like a hospital ward, using the same staffing, systems and daily routines, except that the people being cared for stay in their own homes throughout.

and partner agencies. This culminated in a formal 3-month consultation with the public (Blackhurst et al. 2015; NHS Highland 2015b; Thompson et al. 2015).

The public consultation is a requirement, and feedback was considered by the board of NHS Highland and ultimately the Cabinet Secretary. The feedback from the public endorsed the proposed new models of care, as well as highlighting areas of concern to be addressed. A tangible example of how consultation shaped redesign proposals was the requirement to develop an integrated transport plan and for it to be in place before closing any hospitals. Another was to develop capacity in care home to provide for flexible use of beds to avoid hospital stays or support end of life care.

Two major service redesigns in Highland were the first to be approved by the Scottish Government since 2007. Arguably working in an integrated way has fostered more collaborative ways of working on moving away from a focus on buildings and beds to investing more in community services (NHS Highland 2015c).

Recently, NHS Highland made a commitment to 'My Home Life'. This is a UK-wide initiative to promote the quality of life for individuals who live, die, visit and work in care homes for older people (Help the Aged 2007). This is achieved by engaging with the community using various approaches to discover what they are prepared to contribute to help develop services.

This approach has led to improvements in community involvement. For example, several homes now hold community events, supported by residents. Other managers of care homes have used the listening tree for residents, relatives and community as a way of facilitating feedback. As an example, one care home now hosts a monthly dementia cafe, and another hosts monthly coffee mornings. Overall, there is increased voluntary input. This builds on work since 2012 to strive to make care homes part of their communities (NHS Highland 2013).

49.2.6 Impacts

Delivering integration and necessary organisational change was a significant challenge, and there was a risk that any effort devoted to integration could have led to deterioration in service delivery. However, during the year following integration (2013), there was no documented evidence of any adverse effects on key performance indicators (Westbrook 2017).

There has been an overall steady improvement in Inspectorate Grades for Care Homes operated by NHS Highland. While there is no reporting mechanism that allows this to be compared across Scotland within Highland, a general improvement was not similarly reflected in care homes run by other providers. Furthermore, the age of people being admitted to any care home has increased by around 2 years since integration.

In addition, NHS Highland continues to perform better than most mainland boards on the performance of the 4-hour emergency target: 98% of patients wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment. This has been sustained 3 years after integration (Scottish Government 2015a, b, c).

A one-year pilot on medicine management in North Highland demonstrated that the new service made medicines safer and more effective for care home residents. This service is now provided permanently to all care homes in North and West Highland, and elements of the service are also being rolled out to care-at-home service users (Claire Morrison, personal communication).

A Medicine Sick Day Rules card was also developed. The card promotes better management of long-term conditions through the safer, more effective use of medicines. Hospital admission data were collected for 9 months and showed a small fall in admissions since the cards were introduced. This was set against a trend of increasing admissions in previous years, indicating that the cards are effective. No increase in admissions for heart failure was observed, highlighting that use of the cards is also safe (Morrison and Wilson 2015).

Considerable challenges remain to further optimise integrated service delivery. Moreover, there is a need to better understand the complex relationships between services and 'flow' and any possible unintended consequences. For example, in 2014/15, only 63% of privately run care home places were available to admissions; five homes were subject to temporary closures, and some were permanently closed due to poor quality. However, this created a shortage of care home places and increased demand on acute and community hospitals increasing the number of people who had delayed discharges—one of the key drivers to integrate health and social care services.

The University of Highlands and Islands has been commissioned to conduct an independent review of performance against the original aims of the Partnership Agreement. Initial (unpublished) results suggest that a majority of indicators show improvements with the exception of delayed discharges.

Since integration, NHS Highland has shifted significant resources from health across to social care. An additional £9 million (recurring) was invested in 2015/16 to develop services to support people to live independently at home including to deliver the living wage. Whether this would have happened prior to integration is debateable but what is clear is that given single budgets, single management and single governance this was a decision that NHS Highland could take more readily and rapidly compared to other NHS boards in Scotland. This has allowed a clear understanding of the direct consequences of one part of the system on another and now with the direct authority and oversight to act.

New ways of integrated working have also been a catalyst for wider reform within NHS Highland. The only District General Hospital in the area (Raigmore in Inverness) has merged with community and primary care services to become one operational unit. Now with single management, single budgets and single governance, the aim is to facilitate greater integration of health services.

49.2.7 Dissemination and Replication of the Case Study

The lead agency model, as established with Highland Council in Scotland, can be seen to constitute a very specific model of integrated care, with its focus on a largely

rural area of Scotland. However, the lessons on joint working that can be learned from this model appear to be entirely transferrable to other health and care partnerships. At the same time, it is important to reiterate that the Highland Council was the only council in Scotland that adopted this model, while all other councils have set up Integrated Joint Boards from April 2016 (Bruce and Parry 2015).

Many of the service interventions that have been introduced since integration have been or are being rolled out across all districts and in some cases across Scotland. For instance, the Medicine Sick Day Rules card developed, tested and evaluated in Highland (Morrison and Wilson 2015) has now been made available nationally. This was to complement the publication of the updated NHS Scotland Polypharmacy Guidance (http://www.sehd.scot.nhs.uk/publications/DC20150415polypharmacy.pdf) (March 2015).

49.2.8 Lessons Learned and Outlook

The lead agency model as established with Highland Council in Scotland has clarified governance and maximised the expertise of individual professionals. Nothing prevented these changes from taking place prior to 2012, but perceived barriers and different cultures and management structures appear to have had the effect of not enabling effective change in Highland and indeed across Scotland. Some of the key lessons learned and outlook may be summarised as follows:

- Leadership and management capacity are required to ensure that changes get embedded, sustained and rolled out across all relevant areas. In some cases, there have been practical challenges to overcome inevitable competing priorities.
- Senior leaders across both organisations demonstrated a 'can-do' attitude and knocked down organisational barriers to change.
- A formal project management approach was not adhered to. Given that integration is a complex, multifaceted process, leaders accepted a degree of uncertainty.
- Support for integration was garnered by avoiding a focus on cost-savings. Respondents were convinced by the argument that, in the long term, integrated services would be more cost-effective because they would involve less duplication and allow greater support for care at home (cf hospital care).
- Practitioners pointed to the importance of leaders recognising professional identities. Professional leadership was put in place outside of line management structures and was significant in allaying some professional mistrust and concerns.
- Partnership working (i.e. mutual trust and decision-making between staff and employers) was also significant in resolving terms and condition issues arising from the staff transfers.
- There are inherent difficulties in trying to measure and interpret the impact of integration both at the macro- and micro-level and in particular at points of time especially over short time scales. Nolte and Pitchforth (2014) found that

evaluative information was scant, and that its scale, complexity and lack of agreed definition made this a very difficult undertaking. They also pointed to a number of reasons why there is a lack of evidence around integration including evaluation not being prioritised.

- There is no doubt this has been a challenging area for this study, but data has been collected pre- and post-integration which will hopefully contribute to the evidence base (Westbrook 2017).
- Some things may get worse before they improve. Fully realising some of the benefits, may take many years (Goodwin et al. 2014). The significance of taking a long-term view is therefore highlighted, along with a recognition that there will inevitably be some ups and downs.
- For what was one of the biggest reforms in Highland, and indeed Scotland for over a decade, integration received remarkably little media attention and minimal interest from communities or groups. This is in stark contrast to how changes to service models or changes in practice have generally been reported in Highland.
- Overall, the one key lesson has to be to focus on the needs of the local population and to reconfigure services around this need rather than the organisational boundaries and limitations of institutions. As this case study has illustrated, however, this is anything but as simple as it sounds.

References

Baird, J., Mead, E., & Stark, C. (2014). Implementing health and social care integration in rural Scotland. *International Journal of Integrated Care.* Annual Conference Supplement. URN: NBN:NL:UI:10-1-116199.

Baker, A., Leak, P., Ritchie, L. D., Lee, A. J., & Fielding, S. (2012). Anticipatory care planning and integration: A primary care pilot study aimed at reducing unplanned hospitalisation. *British Journal of General Practise, 62*(595), e113–e120.

Beswick, E. (2013). *What are the leadership lessons to be learned from the integration of health and social care in North Highland?* M.Sc. dissertation University of Stirling.

Blackhurst, S., Bogle, J., Peters, B., Rodgers, K., Small, N., & Thompson, M. (2015). *We started by sharing the problem: A grass root re-design of health and social care services in Badenoch and Strathspey*. Poster submission to NHS Scotland 2015 event. Retrieved September 27, 2015, from https://nhsscotlandevent.com/sites/default/files/2015%20-%20NHSScotland%20Event%20-%20Posters%20-%20PDF%20-%20VF11%20-%20Maimie%20Thomson.pdf

Brown, C. (2013). A remarkable journey, an historic transition and a new beginning. Scott-Moncrieff. Retrieved September 27, 2015, from https://www.scott-moncrieff.com/news/news-updates/a-remarkable-journey-an-historic-transition-and-a-new-beginning

Bruce, D., & Parry, B. (2015). Integrated care in Scotland. *London Journal of Primary Care (Abingdon), 7*(3), 44–48. Retrieved October 6, 2015, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4494465/

Goodwin, N., Dixon, A., Anderson, G., & Wodchis, W. (2014). *Providing integrated care for older people with complex needs. Lessons from seven international case studies.* London: The King's Fund. Retrieved October 6, 2015, from https://www.kingsfund.org.uk/publications/providing-integrated-care-older-people-complex-needs

Ham, C., Heenan, D., Longley, M., & Steel, D. R. (2013). *Integrated care in Northern Ireland, Scotland and Wales: Lessons for England*. London: King's Fund.

Help the Aged. (2007). *My home life promoting quality of life in care homes. A review of literature*. Prepared for Help the Aged by the National Care Home research and Development Forum (London). Retrieved October 6, 2015, from https://www.scie.org.uk/publications/guides/guide15/files/myhomelife-litreview.pdf?restrue

Highland Council. (2015). *Highland partnership: Chief social work officer report 2014/15*. Retrieved October 6, 2015, from https://www.highland.gov.uk/meetings/meeting/3578/education_children_and_adult_services_committee

Highland Partnership. (2012). *Planning for integration, integrating care in the highlands: Programme report*. Retrieved September 27, 2015, from https://highlandlife.net/content/download/38033/151050/file/P4I%20End%20of%20Programme%20Report%20July12%20pdf.pdf

Keating, M. (2010). *The government of Scotland: Public policy making after devolution* (2nd ed.). Edinburgh: Edinburgh University Press.

Mcfadden, J., & Lazareswich, M. (1999). *The Scottish parliament*. Edinburgh: T & T Clark

Mead, E. (2015). Integration in action in the highlands. *International Journal of Integrated Care*. Annual Conference Supplement. URN:NBN:NL:UI:10-1-116995

Mooney, G., & Scott, G. (2012). Devolution, social justice and social policy: The Scottish context. In G. Mooney & G. Scott (Eds.), *Social justice and social policy in Scotland* (pp. 1–24). Bristol: Policy Press.

Morrison, C., & Wilson, M. (2015). Medicine sick day rules: A safe and effective tool to improve medicines safety in NHS Highland. *International Journal of Pharmacy Practice, 23*(S2), 92–93.

NHS Highland. (2011). *NHS Highland News*. Retrieved October 6, 2015, from https://www.nhshighland.scot.nhs.uk/News/Documents/NHS%20Highland%20News%20-%20Health%20Check.pdf

NHS Highland. (2012a). *Planning for integration—Partnership agreement*. Highland NHS Board special board meeting 21 March 2012. Retrieved September 27, 2015, from https://www.nhshighland.scot.nhs.uk/Meetings/BoardsMeetings/Documents/Special%20Board%20Meeting%2021%20March%202012/3.1%20HC%20NHSH%20Lead%20Agency%20Agreement%20only%20NO%20Schedules.pdf

NHS Highland. (2012b). Leading the way: Integrating care in the highlands, video presentation. Retrieved October 6, 2015, from https://highlandlife.net/integrating_care

NHS Highland. (2013). *NHS Highland News_Autumn*. Retrieved October 6, 2015, from https://edition.pagesuite-professional.co.uk//launch.aspx?eidc4e62b46-c9aa-4fe2-b479-ca03e797257e

NHS Highland. (2015a). *NHS highland 10 year operational*. Assynt House, Inverness: NHS Highland Board.

NHS Highland. (2015b). *Initial agreement for modernisation of community and hospital services in Badenoch and Strathspey*. Retrieved September 27, 2015, from https://www.nhshighland.scot.nhs.uk/Meetings/BoardsMeetings/Documents/Board%20meeting%202%20June%202015/Item%204.3(2)%20Proposed%20Redesign%20Badenoch%20and%20Strathspey.pdf

NHS Highland. (2015c). Care at home Boleskine style video presentation. Retrieved October 6, 2015, from https://www.youtube.com/watch?vLEi6A0xfMXk

NHS Scotland. (2015). *Polypharmacy guidance*. Edinburgh: Scottish government health and social care directorates.

Nolte, E. & Pitchforth, E. (2014). *What is the evidence on the economic impacts of integrated care?* Copenhagen: European Observatory on health systems and policy: A partnership hosted by the World Health Organisation. Available at https://www.euro.who.int/data/assets/pdf_file/0019/251434/What-is-the-evidence-on-the-economic-impacts-of-integrated-care.pdf

Scottish Government. (2011). *Achieving sustainable quality in Scotland's Healthcare: A '20:20' vision*. Edinburgh: Scottish Government. Retrieved October 6, 2015, from https://www.gov.scot/Topics/Health/Policy/2020-Vision/Strategic-Narrative

Scottish Government. (2014). *Scottish budget. Draft Budget 2015–16*. Edinburgh. Retrieved September 27, 2015, from https://doi.org/10.1111/ijpp.2015.23.issue-s2/issuetoc

Scottish Government. (2015a). *Polypharmacy guidance, March 2015*. Retrieved October 6, 2015, from https://www.sign.ac.uk/pdf/polypharmacy_guidance.pdf

Scottish Government. (2015b). *Website*. Retrieved October 6, 2015, from https://www.gov.scot/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/4hrAEStandard

Scottish Government. (2015c). *Scotland's Census 2011*. Retrieved September 29, 2015, from https://www.scotlandscensus.gov.uk/

Scottish Health Council. (2010). *Guidance report: Involving patients, carers and the public in options appraisal for major health service change*. Accessed September 27, 2015.

Somerville, M. (2012). *The annual report of the Director of Public Health Report Health and Wellbeing of Older Adults*. Retrieved October 6, 2015, from https://www.nhshighland.scot.nhs.uk/Meetings/BoardsMeetings/Documents/Board%20Meeting%202%20October%202012/4.4%20DPH%20Annual%20Report-APP.pdf

Taylor, A. (2015). New act new opportunity for integration in Scotland. *Journal of Integrated Care, 23*(1), 3–9.

Thistlethwaite, P. (2011). *Integrating health and social care in Torbay: Improving care for Mrs Smith, The King's Fund*. Retrieved September 29, 2015, from https://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay

Thompson, M., Peters, B., Small, N., & Rodgers, K. (2015). A problem shared. *International Journal of Integrated Care*. Annual Conference Supplement. URN:NBN:NL:UI:10-1-116970.

Westbrook, S. (2017). *A comparison of NHS Highland key performance indicators pre and post integration*. University of the Highlands and Islands.