Three Horizons of Integrating Health and Social Care in Scotland

50

Maimie Thompson, Anne Hendry, and Elaine Mead

50.1 Three Horizons of Integrating Health and Social Care in Scotland

The introduction of landmark legislation to integrate health and social care in 2015 was one of the most radical reforms of public services in Scotland arguably since the inception of the NHS in 1948.

Highland was the first area in Scotland to have such a legal agreement in place as described in Chap. 49. This chapter now describes the experience of integrating health and social care across the whole of Scotland since 2015. The story is framed around the three horizons of transformational change as described by the International Futures Forum (three horizons), and considers the design principles and supporting factors at each stage (European Commission 2017).

The opening section outlines the first horizon—the political and policy landscape, financial and demographic context, stakeholder engagement and introduction of new organisational arrangements.

The second section covers important enablers for implementing integrated care. It signposts to local examples of change and considers the challenge of measuring impacts and outcomes. The journey to improve population health and reduce inequalities is the subject of the third section. The chapter concludes with some lessons learned and briefly touches on the implications of the global COVID-19 pandemic, describing one case study which is overcoming what previously seemed unsurmountable barriers to implement new ways of working. It is illustrative of other examples of rapid change throughout the UK linked to COVID-19.

M. Thompson · E. Mead
International Foundation for Integrated Care (Scotland Hub), Glasgow, Scotland

A. Hendry (✉)
University of the West of Scotland, Paisley, Scotland
e-mail: anne.hendry@lanarkshire.scot.nhs.uk

V. Amelung et al. (eds.), *Handbook Integrated Care*,
https://doi.org/10.1007/978-3-030-69262-9_50

50.1.1 The First Horizon, the Political and Policy Landscape in Scotland

Scotland is part of the UK but had its own Parliament established in 1999. The Scottish Parliament has devolved legislative powers across a wide range of policy areas including health and social care (Taylor 2015). Local government is organised through 32 councils.[1] Councils are autonomous bodies, independent of central government, accountable to their electorates for a wide range of services including social care and social work. They directly provide or commission services from the NHS, independent or third sector. Around 80–85% of local authority funding comes from central government in the form of a block grant. The remainder of their funding is raised from local taxation, discretionary funds and 'reserves'. The Convention of Scottish Local Authorities (COSLA) provides political leadership on behalf of the 32 local councils.

50.1.2 Health and Social Care Arrangements

Health care is free at the point of delivery for all in Scotland. Funding and policy are the responsibility of the Scottish Government but are resourced through a block grant from the UK Treasury. Since 2001, 14 regional-based health boards have had overall responsibility to plan, deliver and commission health care for the population in their area. Each NHS Board is accountable to Scottish Ministers through reporting to the Cabinet Secretary for Health and Sport, the Scottish Parliament and ultimately the electorate (Robson 2016).

The Community Care and Health (Scotland) Act, 2002, introduced free personal social care for older people, regardless of income or whether they live at home or in residential care. Personal social care includes support for personal hygiene, at mealtimes, help with medication and assistance with immobility or general well-being. Domestic services such as help with housework, laundry, shopping, attending day care centres or the accommodation element of care home costs may be chargeable. Nursing care that involves the knowledge or skills of a qualified nurse such as administering injections or wound care is provided at no cost to the individual. Legislation to extend free personal care to people aged 16 and over with degenerative neurological conditions came into force on 1 April 2019.

50.1.3 Making the Case for Change

Like most developed countries, the population in Scotland is increasing and ageing. At the 2011 census, the population of 5.3 million was the highest ever recorded (National Records of Scotland 2014). By 2038, one in four people are expected to be over 65 years compared with 14% in 1983 (National Records of Scotland 2019).

[1]Throughout this chapter, the terms council and local authority are used interchangeably.

The prevalence of long-term conditions increases with age, ranging from 25% of adults aged 16–24 to 77% of those aged 75 and over (Scottish Government 2015a). In the 2013 Scottish Household Survey, 34% of households reported at least one adult or child with a long-standing illness, health problem or disability. This figure rises to 45% in households with an income of £20,000 or less as reported in (Hendry et al. 2016). This has significant workforce implications and will increase demand for health and care services.

50.1.4 Building Cross-Party Political Support and Commitment

Integrating health and social care has been on the policy agenda in Scotland for the past 20 years or so (Taylor 2015). A timeline of the related policy and legislation (1999–2016) is summarised by Audit Scotland (2018a).

The initial priority was an integrated approach to chronic disease as described in Improving the Health and Wellbeing of People with Long-Term Conditions in Scotland: A National Action Plan (Scottish Government 2009). This was followed by Reshaping Care for Older People (RCOP) (Scottish Government, 2010a) brokering closer collaboration between health, social care, housing, third and independent sector partners through a £300-million Change Fund to drive local transformation 2011–2015 (Hendry et al 2016).

The Christie Commission on the Future Delivery of Public Services argued the need for reform across all public sector (Scottish Government 2011). Four priorities were service integration at a local level, a greater shift towards prevention, addressing health inequalities and improving outcomes for people. This high-profile report had strong cross-party support such that all major political parties included a commitment to integrate health care and social care in their manifestos for the 2011 Scottish Parliament Election (Taylor 2015).

50.1.5 Engagement

Highland was the first area to press for more radical structural reform. A partnership agreement between Highland Council and NHS Highland was established in 2012 under existing legislation NHS Reform (Scotland) Act, 2004 (HM Gov 2004). Building on the experience of Highland's Lead Agency Model (Mead 2017), the Scottish Government began to engage widely on proposals to integrate health care and social care across the country (Scottish Government 2012). The vision was ambitious but simple: to ensure better health and well-being outcomes for people at home and in local communities through care and support designed around the individual. This care and support would be commissioned through effective cross-sectoral planning for the needs of the local population (Scottish Government 2013).

The positive relationships fostered by the Reshaping Care for Older People Programme (Joint Improvement Team 2015) had generated growing support for health and social care services to be jointly planned, financed and delivered across the continuum of care, drawing on the assets of voluntary and community resources to improve outcomes for individuals and communities.

Engagement on integration was both national and local (Hendry 2016). This process involved a series of national workshops for senior leaders from health care, local government, housing partners, voluntary organisations and independent care providers. These were followed by working groups for dialogue with local health and social care organisations, professional bodies, care regulators and trade union representatives over many months. Engagement also involved an accessible programme of community listening events and 'town hall' conversations with local citizens and workforce across the country. Building on the engagement work in Highland, qualitative research noted strong public support as separation of services did not make sense from a user's point of view (Beswick 2013).

50.1.6 Legislation

The legislation—Public Bodies (Joint Working) (Scotland) Act, 2014—required the creation of integration authorities (Scottish Government 2014) with shadow arrangements from April 2015 and governance to fully integrate services in place by April 2016. This could be delivered through one of two models (Audit Scotland 2018a):

1. Integration Joint Board (Body Corporate) Model

The health board and local authority delegate the responsibility for planning and resourcing service provision for adult health and social care services to an Integration Joint Board (which is a separate legal entity).

2. Lead Agency Model

The health board or the local authority take the lead responsibility for planning, resourcing and delivering integrated health and social care services. In this model, staff are required to transfer to either the council or the NHS Board.

50.1.7 New Organisational Arrangements

Across Scotland, 31 integration authorities have been established.[2] Their size and scope vary markedly, but each is underpinned by an integration scheme which sets out how they will operate. All opted for the Body Corporate Model except for

[2]While there are 32 local authorities, Clackmannanshire and Stirling Councils created a single authority with NHS Forth Valley.

Highland who continued with their Lead Agency Model established in 2012. Appointment of a chief officer and a finance officer is required under both models. Chief officers have two sets of accountabilities: (i) to the Integration Joint Board for strategic leadership and (ii) to the NHS Board and local authority for operational leadership (Audit Scotland 2018a). They are responsible for building effective relationships, trust and collaboration to deliver the same high-level objectives (Box 50.1).

Box 50.1 Objectives—Adapted from Public Bodies (Joint Working) (Scotland) Act, 2014

- Improve the quality and consistency of services for patients, carers and other users and their families.
- Provide seamless, joined-up quality health and social care services to care for people at home or a homely setting.
- Ensured resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with longer term and often complex needs.

50.1.7.1 Financial Context

Attempts to work through the financial complexity facing both the NHS and local authorities predate integration. The Integrated Resource Framework (IRF) was developed by the Scottish Government, NHS Scotland and COSLA. It provides historical patterns of service use and enables a better understanding of costs, activity and variation for different population groups (Public Health Scotland 2019a). The dialogue around the IRF helped to build readiness for strategic planning and commissioning using integrated budgets. Each integration authority includes their financial position as part of their Annual Reports available for public scrutiny. The Scottish budget published on 6 February 2020 reported more than £9.4 billion in health and social care resources directed by integration authorities with 70% of this funding delegated by NHS and 30% by local authorities. However, budget allocation and decisions on where to make savings remain highly political issues. Most integration authorities recorded deficits or had to request additional funding from their NHS Board, local government partners or through brokerage from the Scottish Government (Audit Scotland 2019a).

50.1.7.2 Summing Up the First Horizon

Integrating health and social care has been on the policy agenda in Scotland for over two decades. The case for change was framed around improving outcomes for people by creating more effective and sustainable public services in the face of population changes, workforce challenges and increasingly financial constraints.

Widespread engagement grew the movement for change across sectors and fostered strong cross-party political support. The learning from Highland, as an early implementer in 2012, and the readiness for partnership working fostered by the Reshaping Care for Older People Programme paved the way to progressive legislation to integrate services across Scotland. The legislation was neither the start nor the end point. The process was constantly evolving, reflecting and adapting, and was supported by many other enablers of change. These are explored in the next section.

50.2 The Second Horizon: Supporting Implementation—2015–2019

While few disagree with the vision for integration, progress has often seemed slow and piecemeal. The reasons are inevitably complex. From concept to design and delivery, implementation calls upon many elements to align in order to create the right conditions for change. As different support mechanisms have variable lead times and interdependencies, there has been an inevitable ebb and flow of the pace and scale of reform. In this section, we describe some of the support for implementation across Scotland.

50.2.1 Leadership, Collaboration, Culture and Trust

The Ministerial Strategic Group for Health and Community Care was established to provide high-level and cross-sector national leadership for integration. The group predated the introduction of the legislation and brings together representatives from the Scottish Government, NHS Scotland, local government and integration authorities. The group noted that 'shared and collaborative leadership must underpin and drive forward integration' (COSLA & Scottish Government 2019). A detailed analysis of the leadership role of chief officers can be found in the independent report by Baylis and Trimble (2018). One of their recommendations was to ensure that the chief officers have space to reflect and make sense of the learning that emerges from their work.

The chief officers established Health and Social Care Scotland, a national network through which all those who lead change within health and social care can learn from each other, supported by online resources and networking events to share good practice.[3] One of the concerns of this network has been the degree of organisational churn associated with turnover in chief officers, board chairs and senior executives, a point also highlighted by Audit Scotland (2018b) and Public Audit and Post Legislative Scrutiny Committee (Scottish Parliament 2020). This has prompted a stronger focus on career development opportunities in collaboration

[3] https://hscscotland.scot/.

with Scottish Leaders Forum and with Project Lift—a national programme for talent management and leadership development in NHS Scotland.

Where there is visible leadership and the associated positive behaviours (proactive communication, effective engagement, high levels of trust, collaboration and openness to challenge), integration works well at both grass-roots and governance levels. But achieving this is far from easy (Scottish Parliament 2020; Mead et al. 2017).

Some staff groups expressed concerns about the potential loss of professional identity, often based on misunderstanding of each other's roles. Over time this concern has faded and most staff groups now value leadership and management capability more than a professional label. This shift has been helped by integrated workforce development. For example, You as a Collaborative Leader Development Programme was designed to build operational leadership capability in primary and social care professionals and managers in statutory, third or independent social care organisations (NHS Education Scotland 2020a). This initiative is complemented by action learning opportunities for team leaders, managers and practitioners (NHS Education Scotland 2020b) and by a 'Leading People-Centred Integrated Care' Masters Programme delivered by the University of the West of Scotland for aspiring professionals from different disciplines.

50.2.2 Empowerment and Co-production

A key concern is how to give 'voice' to people who use health and care services and unpaid carers. Scotland has a long history of work on embedding personal outcomes in practice. Early efforts focused on reorienting the conversation at the point of care to achieve personal outcomes identified through shared decision-making. Focusing on what matters to people is now understood as fundamental to transforming and sustaining public services in Scotland. Enabling people to make informed choices about their care and support is promoted by the Health and Social Care Alliance Scotland—the national third sector intermediary for a range of health and social care organisations. With over 2900 members, one of their core aims is: '*to ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services'*.

More recently, this agenda has been promoted through Realistic Medicine, a series of reports on the importance of personalised care and shared decision-making first published in 2016 (Chief Medical Officer 2016). The work on personalisation is supported by a wide range of policy, education and practice development resources (Box 50.2).

Box 50.2 Resources to Support Personalisation of Care

- A suite explains the principles and practice of co-production at https://www.coproductionscotland.org.uk/
- A personal outcome collaborative provides tools for practice at https://personaloutcomescollaboration.org/
- My Condition My Life is a national campaign to promote support for self-management at https://www.alliance-scotland.org.uk/
- Supports for Health Literacy are available at https://www.healthliteracyplace.org.uk/

Empowerment and co-production are themes in other related policy and legislation. The Social Care Self-Directed Support (SDS) (Scotland) Act, 2013, promotes the vision that care should be based around the citizen and provides a means through which all people who are eligible for social care are given choices. This Act places a statutory duty to offer four choices as to how people are assessed and receive their care or support (Scottish Government 2019b).

The Community Empowerment (Scotland) Act, 2015, covers public participation in policy and planning and imposes legal duties to involve community bodies to produce 'locality plans' to improve local outcomes (Audit Scotland 2019b).

Scotland's' Caring Together Strategy (Scottish Government 2010b) was supported by education for professionals on carers as equal partners in care and by the development of a human rights-based Carers Charter and legislation (Scottish Government 2018c).

50.2.3 Digital Health and Care

Scotland's Digital Health and Care Strategy published in 2018 shows a commitment to using technology to reshape and improve services and outcomes (Scottish Government 2018d). It is one important enabler of service transformation supporting a vision for the future where all citizens can say:

> *I have access to the digital information, tools and services I need to help maintain and improve my health and wellbeing.*

The strategy is based on strong partnership working, including with the housing sector, to support people to stay at home for longer and have care closer to home, with improved access and reduced travel. Implementation is through national actions to ensure the required direction and infrastructure supported by local service transformation using Technology Enabled Care solutions such as Home and Mobile Health Monitoring, Near Me, video-enabled consultations, other digital platforms and telecare initiatives (Box 50.3).

Box 50.3 Digital Health and Care Priorities https://www.digihealthcare.scot/

National direction—a joint decision-making board from national and local government and the NHS, supported and advised by industry, academia and the third sector to make national decisions for investment, priorities and policy, and achieve greater consistency, clarity and accountability.

Information governance, assurance and cyber security ensuring appropriate safeguards are in place for the management of data and consistency in decision-making about sharing data and understanding about data protection requirements.

Workforce capability through a joint approach between NHS, Local Government Digital Office, Health and Social Care Partnerships, and the Scottish Social Services Council.

National digital platform for real-time data and information from health and care records to be available to those who need it, when they need it, wherever they are, in a secure and safe way.

Transition process improves and upgrades existing systems in a joint approach between NHS National Services Scotland and the Local Government Digital Office to ensure existing systems continue to work effectively.

Service transformation—a clear, national approach to service redesign and the scaled-up adoption of successful Technology Enabled Care models. https://tec.scot/ and https://www.nearme.scot/.

50.2.4 Integrated Information and Analysis to Inform Commissioning

Since 2017, the Care Inspectorate and Healthcare Improvement Scotland have had a joint legal responsibility to report on the effectiveness of strategic planning by integration authorities. This includes how integration authorities plan, commission and deliver services in a co-ordinated and sustainable way. Historically, many of the barriers relate to limited interoperability between different information systems. This was as much about information governance and a lack of data sharing agreements than the capability of the technical systems.

Scotland has a long-established data record linkage process at the national Information Services Division (ISD) now part of Public Health Scotland. This has allowed summary records from one type of healthcare service to be linked with records from other services at an individual person level. Recently, the linkable

information has been expanded to include records from social care services. This gives, for the first time, an information resource linking individual-level records across the health and social care landscape—a resource for both local and national levels. Tools that provide interactive visualisation of the analysed data have been designed for use locally. Alongside, the development of the Source Tableau Platform (Public Health Scotland—ISD 2020b) has been national investment in localised analytical expertise (*Local Intelligence Support Team—LIST*) to ensure that the increasingly sophisticated resources can be used well to support local decision-makers in planning, commissioning and delivery of services (Public Health Scotland 2020a). A Data Sharing Agreement specifies who will use the data, who can get access and for what purpose, and sets out the process for authorisation and any restrictions. More information can be found at the ISD website (Public Health Scotland 2020c).

Analysis of healthcare cost data in Scotland shows that approximately 2% of the population account for 50% of the resource spent by health and social care partnerships (Healthcare Improvement Scotland 2017). These 'High Resource Individuals' (HRI) generally have complex needs. A novel 'High Health Gain' (HHG) prediction tool calculates the risk of a person becoming, or continuing to be, an HRI in the next 12 months. The tool builds on the experience from the Scottish Patients at Risk of Readmission and Admission (SPARRA) risk prediction tool (Public Health Scotland—ISD Scotland, n.d.). These tools are used to identify patients who may benefit from earlier interventions and preventative care.

50.2.5 Workforce Development and Contracts

Workforce capacity is perhaps the biggest challenge facing health and social care in Scotland. The National Workforce Plan sets out commitments and planned investment over the next five years to develop multidisciplinary capacity in the face of an ageing workforce and anticipated staff turnover (Scottish Government 2019c). Even prior to COVID-19, it was evident that workforce plans must address multiple considerations: incorporate innovations (technology, medicines, medical advances), the impact of Brexit, access to affordable housing, financial realities, perhaps most acutely experienced by social care and the third sector.

The Health and Care (Staffing) (Scotland) Act gained Royal Assent on 6 June 2019. The Act is the first legislation in the UK to set out requirements for safe staffing across both health and care services and most clinical professions. This includes placing a duty on the NHS and social care providers to make sure that there are suitably qualified and competent staff working in the right numbers. What this means in terms of service provision and ultimate accountability remains to be tested.

An important example of contractual change is the new General Medical Services contract for general practitioners in Scotland (Scottish Government 2017a). Introduced as the '*most significant reform of primary care in more than a decade*', it aims to transform elements of Primary Care Services through greater

multidisciplinary working and creation of new roles and arrangements to improve access for individuals and communities (Burgess 2019). New primary care roles include community mental health professionals, community link workers, advanced practitioners and physiotherapists to see patients as a first point of contact (Audit Scotland 2018b). Notably, as we will touch on in the final section this 'reform' made no provision for making greater use of technology to improve access for patients (Thompson, Melting Pot 2020b).

50.2.6 Regulation and Standards

There has been no change to the regulatory framework for professional practice, or in the established professional accountabilities. Guidance on clinical and care governance for integrated working was published (Scottish Government 2015b). Integrated National Health and Social Care Standards *My Support My Life* were introduced in April 2018 to replace the previous sector-specific National Care Standards. The new standards endorse the personalisation agenda and seek to provide better outcomes across all care provision in Scotland (Scottish Government 2017b).

50.2.7 Service Transformation

Integration authorities are approaching service transformation through quality improvement and by engaging the public, service users, politicians and professionals in redesign of services, with varying degrees of success (Stewartet al. 2019; Mead et al. 2017). Proposals which are '*major*' require a period of formal public consultation lasting for a minimum of three months (Scottish Government 2010c). Scottish Ministers are responsible for deciding which proposed service changes will be approved, something Stewart et al. (2019) argued make it even more political and challenging to deliver major change in Scotland. Between 2010 and 2019, only 11 consultations on major service change were undertaken (Thompson 2020a). This makes it more important to share challenges and co-produce solutions. The Scottish Parliament's Health and Sport Committee, however, found a lack of consistency in stakeholder engagement across integration authorities. While some areas of good practice were cited, concerns were raised over engagement being '*tokenistic*', '*overly top down*' and '*just communicating decisions that had already been made*' (Scottish Parliament 2017).

Scotland has long had a strong record in quality improvement as set out in the Healthcare Quality Strategy (Scottish Government 2010d) and delivered through the Patient Safety Programme and a series of National Collaboratives that ran between 2005 and 2011 (Mead et al. 2017). From 2006 to 2016, cross-sector improvement was mainly facilitated by the Joint Improvement Team which had a focus on personal outcomes, co-production, Technology Enabled Care and the Reshaping Care for Older People Programme (Hendry 2016). From 2016, the lead

responsibility for improvement support for integration passed to Healthcare Improvement Scotland, through their Improvement Hub.

50.2.8 Sharing Good Practice

Learning together and sharing good practice has been iterative over many years through local, regional and national improvement networks and collaboratives. Some are care group specific, for example, Focus on Dementia, while others focus on specific interventions such as Technology Enabled Care, strategic commissioning or specific parts of the care continuum such as primary care. Two examples are illustrated below:

Living Well in Communities is a portfolio of improvement programmes which aim to support people to spend more time at home. The portfolio spans people living with frailty or experiencing falls in the community; anticipatory care planning; intermediate care and reablement; hospital at home; and neighbourhood care. Results and case studies are available on the ihub portal and reports.

Improving together: A National Framework for Quality and GP Clusters in Scotland (Scottish Government 2017c) sets out the role of GP clusters introduced from 2016/17, and the national support to enables them to drive improved outcomes. Case studies are available in the national evaluation report (Mercer et al. 2019).

Several publications including Audit Scotland (2018b) (Baylis and Trimble 2018), Healthcare Improvement Scotland (https://www.healthcareimprovementscotland.org/) and the ALLIANCE Scotland (https://www.alliance-scotland.org.uk/) highlight local examples of practice. Many more examples support the refreshed guidance on the key elements required to integrate community services and improve outcomes (https://hscscotland.scot/resources/) along with presentations from annual conferences. Recordings, presentations and topic resources are also shared through the International Centre for Integrated Care—the home of the International Foundation for Integrated Care in Scotland—in their Integrated Care Matters webinars (https://integratedcarefoundation.org/ific_hub/ific-scotland-webinars).

50.2.9 Monitoring Experience, Outcomes and Impacts

The limitations of quantitative data alone for monitoring have become better understood in recent years, and the potential contribution of qualitative information in assessing outcomes for people, families and communities is now widely recognised. (Kumpunen et al. 2019). This is reflected in Scotland's National Performance Framework (https://nationalperformance.gov.scot/) which describes the outcomes and indicators that track progress in achieving the Scottish Government's purpose and values. First launched in 2007 and refreshed in 2016 and again in 2018, the framework reflects the values and aspirations of people in Scotland and is aligned with the UN Sustainable Development Goals (Scottish Government 2019a).

It sets out nine broad measures of national well-being which are underpinned by indicators for integration. These draw on a range of data sources, including local and national surveys of care experience. Each integration authority publishes an annual report of their progress against nine health and well-being outcomes and the national care standards. These local reports are available for public scrutiny on Health and Care Scotland (https://hscscotland.scot).

In their report on 'Health and social care integration; update on progress', Audit Scotland commented: 'Although some initiatives to integrate services pre-date the Act, there is evidence that integration is enabling joined up and collaborative working. This is leading to improvements in performance, such as a reduction in unplanned hospital activity and delays in hospital discharges'. They also highlighted significant local variation in performance against national indicators and state there is much more to be done (Audit Scotland 2018b). A summary of performance across six national indicators taken from Audit Scotland Report is shown (Box 50.4).

Box 50.4 Summary of Findings as Presented in Exhibit 5 Pages 18/19, Audit Scotland

National indicator	National performance 2014/15 to 2017/18
• Acute unplanned bed days	The number of acute unplanned bed days has reduced since 2014/15
• Emergency admissions	The number of emergency admissions has risen each year since 2014/15
• A&E performance	The number of A&E attendances has marginally increased since 2014/15, but achievement of the four-hour waiting time target has declined since 2014/15
• Delayed discharge bed days	Delayed discharge rates have fallen since 2016/17[a]
• End of life spent at home or in the community	A gradual increase in the percentage of people's time spent at home or in a homely setting at the end of their life since 2014/15
• Proportion of over 75 s who are living in a community setting	There has been a slight increase in the percentage of individuals aged over 75 who are living in a community setting

[a]Due to changes in data collection, comparable data is only available for two years

Benefits since introducing Highland's lead agency model in 2012 were not covered in the Audit Scotland Report but are reported in a number of publications (NHS Highland 2019; Mead et al. 2017; Westbrook 2017).

50.2.9.1 Key Trends and Analysis

Admissions to hospital have gradually increased over the last 20 years (Fig. 50.1). On elective activity, the shift towards day case and away from inpatient treatment has continued year on year since 1999/00 with day case numbers rising by 23% across the period. Emergency admissions to inpatient care have risen by 28% over the same period (Public Health Scotland—ISD, Scotland 2019b). Notably, this is similar to the 29% rise in the population aged 65 and over though it should not be assumed that population change alone explains the rise.

For many patients admitted to hospital, their stay is relatively short—in 2018/2019, around one in five inpatients was admitted and discharged on the same day and just under half (46%) of the total were in hospital for one night or less after admission (Public Health Scotland–ISD, Scotland 2019b).

The chart below highlights how length of stay for emergency admissions of older persons, in particular (in this case, age 75 and over), has changed in recent years. Using an index year of 2008/09, it shows a rise of over 30% in the latest year shown in the numbers staying one day or less—and a fall in the number who are staying 15 days or more (Fig. 50.2).

The Reshaping Care Programme tracked trends in hospital and care home utilisation by older people. The work delivered some impressive results: 10% reduction in hospital bed day rate following an emergency admission for people aged 75+, 2009/10–2014/15 despite increasing number of older people (Hendry et al. 2016). These trends have continued and, for example, by 2017/18, each day there were around 1866 fewer beds occupied by older people following emergency admission

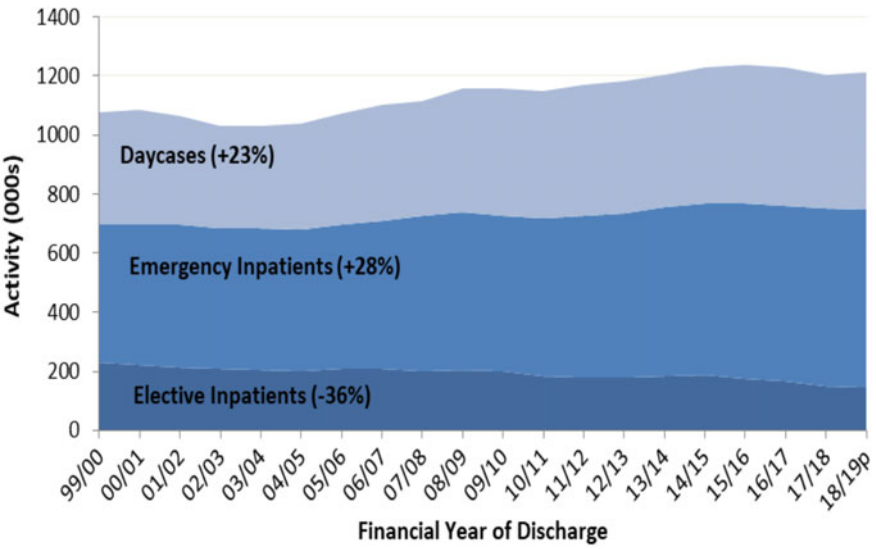

Fig. 50.1 Trends in day cases, emergency and elective inpatients 1999/2000 to 2018/19

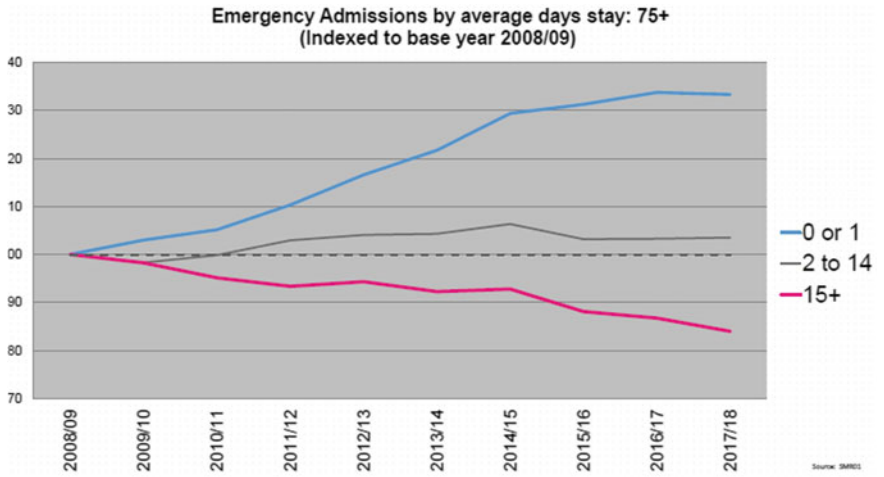

Fig. 50.2 Emergency admissions by average days stay 2008/09 to 2017/18. *Source* SMR01: personal communication P Knight

to hospital than would have been 'expected' had the 2008/09 rate continued in line with population ageing. And, in 2017, there were 7213 fewer older people in care homes each day than would have been 'expected' based on the 2009 rate and demographic trends (Knight 2019). This represents significant institutional care costs avoided, releasing resource for investment in community alternatives.

In line with changing practice, a reduction in length of hospital stay and an increased focus on community services and intermediate care, the average number of available staffed beds for acute specialties has reduced by 6% in the last five years. Despite this reduction in bed capacity, the percentage occupancy has remained relatively stable and was 87% in 2018/19 (https://www.isdscotland.org/Products-and-Services/Transforming-Publishing-Programme/).

As demands continue to rise, there has been a sharper focus on reducing delays in discharge from hospital. A more challenging target was introduced and saw the bed days associated with delayed discharge in 2018/19 reduced by 2% from 2016/17 when the new recording system was introduced. The estimated cost of delayed discharges reduced by £10 million from £132 million in 2015/16 to £122 million in 2017/18, adjusting for changes in daily bed day costs (https://www.isdscotland.org/Products-and-Services/Transforming-Publishing-Programme/). However, the data for 2018/19 shows around one in 12 hospital beds was still occupied by people whose discharge has been delayed, albeit with significant variation across the country. As part of the response to COVID-19, there was a system-wide approach to quickly reducing delayed discharges with various actions undertaken by health boards. These actions have not yet been fully described, and it remains to be seen what implications they had on outcome and whether they can be sustained post-COVID-19.

50.2.10 Summing up the Second Horizon

The implementation of the Public Bodies (Joint Working) (Scotland) Act, 2014, is still at a relatively early stage. By nature, implementation is multifaceted, incorporating a range of local experience and interventions in varying contexts. There are many positive examples of change and some emerging evidence of impacts. Clearly, however, analysis of system trends needs to acknowledge the increasing complexity over time associated with ageing and multimorbidity. In that context, even just 'standing still' may be a significant system achievement.

The Scottish Government's former Director for Health and Social Care Integration commented that easily measured factors, such as hospital activity data, are a '*very thin way of understanding healthcare with the quality of that care not necessarily captured'* (Fooks et al. 2018). There is also a continuing challenge to track changes in community interventions such as intermediate care for which there is currently no systematic national data collected. A further challenge in assessing progress is that the scale, complexity and lack of agreed definition of integrated care make evaluation including around any economic impact very difficult (Nolte and Pitchforth 2014). This is particularly the case when considering population health and addressing inequalities, not least because they need to be considered in both a national and local context and over a long period. Progress towards this, the third horizon, is explored in the next section.

50.3 The Third Horizon

The policy context on inequalities is complex, and in common with many countries, progress has been elusive and hindered by a decade of austerity (Marmot et al. 2020). In 2018, the gap in premature mortality rates between the most and least deprived areas in Scotland increased to its highest point since 2008. Relative inequalities have widened over the long term (Scottish Government 2020b). In the most affluent areas of Scotland, men experience 23.8 more years of good health and women 22.6 years compared to the most deprived areas. The life expectancy of people with learning disabilities is substantially shorter than the Scottish average. Gender-based violence is unequal, with 17% of women and 7% of men having experienced the use of force from a partner or an ex-partner at some point in their lives. Inequalities extend to literacy and numeracy skills in young people where the education attainment gap is also widening.

While health and care services make an important contribution to population health, the impact of the wider determinants of health and well-being is even more powerful (Marmot et al. 2020). Integration authorities must work more closely with their community planning partners from education, housing, employment, criminal justice, business, leisure, digital through to the environment if progress is to be made. The Scottish Index of Multiple Deprivation 2020 is a tool for identifying the places where people are experiencing disadvantage across different aspects of their

lives. It focuses on data zones of around 800 people in neighbourhoods to allow consideration of local conditions such as poor housing, a lack of skills, poor public transport infrastructure and access to connectivity. This data can help target resources to areas with greatest need to improve the lives of all local people.

Place-based approaches are emerging as a way of encouraging a clearer focus on prevention and early intervention to improve population health (Naylor and Wellings 2019). The science of population health is still evolving but will be supported by Scotland's new national public health body—Public Health Scotland—charged with improving and protecting the health and well-being of all of Scotland's people to achieve the vision of a Scotland where everybody thrives. Launched in April 2020, it was immediately confronted with the challenge of how to mitigate both short- and longer-term impacts of the COVID-19 pandemic on individuals, families and communities.

This section describes some examples of place-based and citizen-led health initiatives that represent our most ambitious third horizon. Clearly, all this will need to be closely reflected upon as we move through recovery from COVID-19 and beyond.

50.3.1 Self-management and Social Prescribing Partnerships

The ALLIANCE leads My Condition My Life (https://www.myconditionmylife.org/) a national campaign and fund to promote support for self-management. Many self management initiatives and networks have been established across Scotland. For example, in Highland, Let's Get on With It Together (LGOWIT) hosted by the Highland Third Sector Interface has been active for almost ten years. The partnership of public, private and third sector (voluntary) organisations supports people living with long-term conditions through local officers, a dedicated website with a range of resources and a self-management guide co-written by local people living with long-term conditions and professionals.

Social prescribing is increasingly being used across Scotland with a wide range of community-based partners and activities (ALLIANCE 2017). An example, thought to be the first of its kind in the UK, is a partnership with RSPB Scotland where GP Surgeries across Shetland prescribe nature as part of the care plan. Scotland's House of Care Programme also embraces local assets and opportunities for social prescribing (https://www.alliance-scotland.org.uk/blog/resources/house-of-care-learning-report/. The Links Worker Programme introduced a new role into GP practices. Links workers support patients living in challenging circumstances to cope with issues like loneliness, mental health problems, addictions or debt.[4] The approach evaluated well and is being extended across Scotland to enhance relationships between the multidisciplinary team and community partners (Smith and Skivington 2016).

[4]The GP at the Deep End is a collaboration serving the 100 most deprived practice populations in Scotland, with 86 of these practices in NHS Greater Glasgow and Clyde.

50.3.2 Anticipatory Care Planning

This is a person-centred, proactive, '*thinking ahead*' approach, in which professionals have collaborative conversations with individuals and their carers to identify personal goals in the context of their situation and health conditions. It builds on a decade of work in one GP practice in Highland who reported that the cohort with an anticipatory care plan had significantly fewer hospital admissions, days in hospital and associated costs than a matched control group (Baker et al. 2012). The approach has spread across Scotland levered through improvement support and an enhanced service in primary care aligned with polypharmacy reviews (https://www.polypharmacy.scot.nhs.uk/polypharmacy-guidance-medicines-review/). More individuals and carers can now make more informed choices and express their preferences for future care and place of care. Working with national IT providers enabled a summary of the ACP—Key Information Summary (KIS)—to be shared with emergency services so the right decisions can be made at a time of crisis and reduce avoidable emergency hospital treatment.

In Tapsfield's study, 65% of deaths in patients with anticipatory care plans were at home or in the community, compared to only 27% of deaths in those without anticipatory care (Tapsfield et al. 2015). In their larger study, they found 79% of those who had an advanced progressive illness had a KIS and started a median of 45 weeks before death (Finucane et al. 2020). For people with frailty and/or dementia, the anticipatory care plan discussions took place a median of 32 weeks before death, compared to 25 weeks for people with organ failure, and only six weeks for people with cancer. The odds of dying in the community compared to hospital were 3.7 times higher with a KIS than without one. Across Scotland, in 2017/18 there was a further 12% increase in the number of people with a KIS in place. This achievement contributes to progress in the national indicator that tracks time spent at home or in a community setting in the last six months of life. Over the nine years, 2010/11 to 2018/19 the indicator has increased from 85.3 to 88.1% (Public Health Scotland-ISD 2019c).

50.3.3 Compassionate Communities

Work by the Carnegie UK Trust identifies how kindness and everyday relationships can effect change and support the well-being of individuals and communities (Ferguson 2016). Connected Scotland is the Scottish Governments' strategy for tackling social isolation and loneliness. Published in December 2018, it highlights the power of kindness and the collective responsibility to build stronger connections to ensure communities are more cohesive (Scottish Government 2018b). Across Scotland, many community initiatives are beginning to tackle loneliness and social isolation. Two examples include work in Highland and Inverclyde: The Reach Out Initiative highlighted that 67% of people aged 65 years and over in Highland feel lonely (NHS Highland 2016). *Highland Compassionate Communities* is a partnership between NHS Highland Public Health, Age Scotland and the Life Changes

Trust that evolved from the Dementia-Friendly Communities Collaboratives. Information on this and other examples of Dementia-Friendly Communities in Scotland can be found on Life Changes Trust website (https://www.lifechangestrust.org.uk/).

Compassionate Inverclyde, an award-winning social movement, started with conversations about what matters most to local people: kindness, helpfulness and being neighbourly. The evaluation offers rich insights and describes examples of improved personal, relational and community outcomes experienced by many thousands of people (Barrie et al. 2018).

50.3.4 Housing

The importance of thinking about where, and how, citizens live as they grow older is seen as increasingly important. Security, connectedness, activities and purpose are critical elements of a good place and a good life (Scottish Government 2018a). The housing strategy cuts across many areas of policy and practice such as fuel poverty, dementia, social isolation and connectivity—all essential to enable Scotland's growing population of older people to age safely in place and independently at home for longer. Fit Homes is an innovative partnership between NHS Highland, Albyn Housing and a housing manufacturer to create modular housing. These homes incorporate high levels of technology which can be rapidly constructed and transported to new locations to meet changing need. The technology is used to closely monitor residents who have high levels of care needs and trigger appropriate action when a problem is identified. Although currently being undertaken as a research project, work is ongoing to consider how it can be replicated (https://attoday.co.uk/fit-homes-key-independent-living/).

50.3.5 Neighbourhood Care

From March 2016 to March 2019, 12 teams in five areas tested the Buurtzorg model of neighbourhood nursing, adapted for the context of integrated teams. The teams applied five core principles:

- Putting the person in the centre of holistic care
- Building relationships with people to make informed decisions about their own care, which promotes well-being and independence with active involvement of family, neighbours and the wider community, where appropriate
- Everyone, including support functions, enabling person-centred care at the point of delivery
- Small self-organising, geographical-based teams and
- Professional autonomy.

In rural and island areas, workforce challenges are particularly pressing and are driving the development of new roles and integrated working. One example is the creation of a health and social care support worker role to sustain access in remote areas in Highland. An evaluation revealed that a multidisciplinary team approach and more 'dispersed' models of provision could be delivered in ways that both communities and healthcare professionals found acceptable (Munoz et al. 2018). Further examples relating to remote, rural and island settings are highlighted in Dayan and Edwards (2017) and through the Scottish Rural Medicine Collaborative (SRMC)—https://www.srmc.scot.nhs.uk/.

50.3.6 Summing Up the Third Horizon

While Scotland's health is improving, the gap in health outcomes between the most and least advantaged groups in society is widening. Integration authorities and their community partners must go further and faster on local prevention and early intervention to transform lives and communities. Almost a decade ago, the Christie Commission called for significant changes in the way public services are delivered including a move towards preventative and assets-based approaches. Since then, there has been almost year-on-year publications of policies, strategies and plans all geared towards integrating care, improving health and reducing inequalities. Intuitively, there should be a virtue in multiple policies which are mutually supportive. However, addressing population health and inequalities against a backdrop of rising demand and financial pressures is complex and remains largely elusive.

Now all these complex challenges will need to be viewed through the prism of COVID-19. For instance, the use of technology for homeworking, shopping, online banking, social-connectedness and remote consultations has been critical to Scotland's response to the pandemic. However, it has exposed further inequalities with some 800,000 people across Scotland who lack access to digital solutions. This might be through lack of IT equipment, connectivity, capability, affordability or motivation to learn or be taught. The Scottish Government's Framework for Decision-Making in COVID-19 includes a commitment to renew the country and build a fairer and more sustainable economy and society (Scottish Government 2020a). There are other related initiatives such as 'No one left behind' actively looking to address digital inequalities (https://www.scotlandis.com/blog/no-one-left-behind-digital-scotland-covid-19-emergency/).

In the final section, we explore some of the lessons learned in Scotland's journey to integrate care and close with a case study which illustrates the transformative power of disruptive innovation.

50.4 Lessons Learned and Reflections on Scaling up

50.4.1 Lessons Learned

There have been various reports on lessons learned and insights around integration in Scotland. These mostly point to issues of leadership, culture, workforce challenges, sharing practice, difficulties with evaluation and the challenging financial context (Audit Scotland 2018a, b; Fooks et al. 2018; Baylis and Trimble 2018; The Scottish Parliament's Health and Sport Committee 2017; Dayan and Edwards 2017; Mead 2017; Mead et al. 2017).

We have distilled some key learning from these reports and from our own experiences:

1. There are no magic bullets for achieving ambitious, sustainable system change.
2. Successful transformation requires co-ordinated efforts across the whole of government, the whole of the health and care system, and at every level, and with citizens.
3. No single change framework can capture all the key elements to be addressed.
4. Nurture creative, flexible and resilient leaders at all levels to inspire and empower people to change policy, practice and behaviours.
5. Every community is different. Understanding the local context and readiness for change is important.
6. Invest time in building trusting relationships and strive to understand different cultures and what underpins varying behaviours and levels of co-operation.
7. Start with realistic conversations on the values and outcomes that matter to individuals and communities as the main drivers and agents of change.
8. Use information and stories on the quality and experience of care to influence hearts and minds and be open to being influenced.
9. Understanding data on relative inequalities can help target resources to areas with greatest need.
10. Co-produce a compelling vision and narrative about improving lives and a better, more sustainable, future.
11. Involve citizens and people who use services in co-designing future models of care.
12. Be prepared to cede power and control to other organisations, communities and individuals.
13. Investment needs to align with new models and approaches.
14. Stay curious, keep learning together, and look beyond boundaries for insights and solutions. Be prepared to fail fast, flex and adapt.
15. Embrace disruption and external challenges as opportunities for innovation to change pace.
16. Adopting technology and new ways of working is complex. Change needs to be co-produced, using quality improvement, and supported by the right leadership and peer support.

17. In ordinary circumstances, changes will take longer than initially expected but in crisis situations the pace and scale of change may be transformational. It remains to be seen whether such transformation goes from strength to strength or return to previous ways.
18. If hard-won gains are to be sustained, they need to be carefully planned and supported by well-timed communication, training and ongoing engagement.
19. Accepting new ways will only make sense if anticipated improvements can be evidenced and any unintended consequences managed.
20. Stick with it—this is a marathon not a sprint. Some things may appear to get worse before they get better. Be ready when opportunities present themselves.

50.4.2 Scaling Up the Gains—A Case Study

The global COVID-19 pandemic triggered unprecedented rapid scale-up of remote video consultations, across primary and secondary care, known as Near Me in Scotland (Greenhalgh et al. 2020a, b), and started to overcome some unsurmountable problems (Gray 2020, and Box 50.5).

Commenting on the wider use of remote consultations, Professor Trish Greenhalgh, Nuffield Department of Primary Care Health Sciences, Oxford University, said:

> *Until a few weeks ago, unless you lived somewhere remote, it was easy to pop to the hospital or the GP. With COVID-19, if you are a patient and you go to a GP surgery or you are a doctor and you see patients face-to-face, there is a high risk of infection. Suddenly the relative advantage of virtual consultations has changed dramatically. I cannot think of any comparative situation in the history of the NHS. This is such a complex innovation, changing the way we relate to patients and the workflows of the NHS. This is not just about video and telephone consultations, but also what is known as the total triage system, where a patient can't just phone up and book to see a doctor, they can't walk into the surgery to ask for a prescription. This is a radical and complex innovation, but the relative advantage is huge*. (Health Foundation 2020).

The use of remote consultations will be critical as we move through the phases of the pandemic and beyond but there will no doubt be further work to capture the learning and continue to win hearts and minds regarding changing the way we access services (Thompson, Melting Pot 2020b).

Box 50.5 Use of Video Consultations in Response to COVID-19

- Background

Attend Anywhere, a well-established video consulting platform developed in Australia, was procured by the Scottish Government's Technology Enabled Care (TEC) Programme in 2017 to improve access to services. Pharmacists in Highland were early adopters and led to *Pharmacy Anywhere* being

developed in partnership with the Health Foundation's Innovating for Improvement Programme (Morrison 2018). This proof of concept led to the creation of NHS Near Me supported by the national TEC Programme, initially for hospital outpatient appointments in NHS Highland.

An initial focus was in response to public protest in 2017 in the far north of Scotland around discussions around changes to services (Thompson 2020a). Through these discussions, it emerged some people were having round trips of over eight hours for short 5–10-min appointments. The board of NHS Highland and the public were united in tackling this and work began in earnest with communities and clinicians to co-produce changes (Thompson 2020a, b, c).

- Co-design

Through the co-design process with patients and the public, the name was changed to Near Me to reflect its use at home and recognising the potential use across wider health, social care and public sector settings (Morrison 2019).

- Use of Near Me pre-COVID-19

Although Near Me was made available across Scotland, until the end of 2019 the most significant uptake remained in the north of Scotland—Highland c60 consultations per week and Grampian c30 per week—still a mere drop in the ocean www.tec.scot.

- Evaluation

Nevertheless, interim evaluation was positive, in terms of both the functionality of the video consulting platform and the experience of patients and clinicians. The report commended the quality improvement approach adopted in Highland and recommended this as a way forward to support wider roll-out (Greenhalgh et al. 2020a, b).

From early 2020, the plan was to scale up Near Me across Scotland focused initially on hospital outpatient appointments. In April 2019, a target had been set that by March 2020 there would be >1000 consultations per month on the Attend Anywhere platform. That work was just two weeks underway when the outbreak of COVID-19 hit Scotland in early March.

- Use of video consultations during COVID-19

The priorities for the roll-out of Near Me quickly changed to scale up video consultations including for primary care to allow as many people as possible to have remote consultations from their own home. In a matter of weeks, all

GP practices were equipped and use across secondary and primary care expanded.

Interest from all professionals continued to grow. Across a 10-day period in April 2020, over 2680 allied health professionals joined webinars in the drive to hear from front line practitioners around how they were using video consultations. Feedback was positive with plans to expand to nursing, midwifery, other professionals, and multi-disciplinary teams. In June it was made available to all community pharmacies across Scotland. It is also being used in the third sector and being adopted for use in ITU settings to enable virtual 'visiting'.

In terms of the numbers, prior in March 2020, there were around 300 video consultations per week using the Near Me system; by June, there were almost 17,000 every week, with around 150,000 in total https://tec.scot/. *Although much has been achieved in a short space of time, much more is still to be done*. Recognising the rapid increase in use, the Scottish Government prepared a vision (see here: www.nearme.scot/views) that 'all health and care consultations in Scotland are provided by Near Me whenever it is appropriate'. To seek views, a public engagement exercise got underway on 29 June which included an online public survey, views sought from professional bodies including a survey and wide range of stakeholders contacted and invited to feed back.

Finding ways to engage with service users who are not online during the pandemic has been challenging, and options to address this are being considered. Resources, reports and plans are available at https://tec.scot/digital-health-and-care-in-scotland/video-enabled-health-and-care/.

50.5 Reflections

This overview describes the three horizons in Scotland's journey to integrate health and social care over the past two decades. Only time will tell if we fully realise the potential from the legislation and manage to build on and sustain the gains. Few would argue that the pace and scale of integrated care need to increase now. Now more than ever we need all partners to work together towards a common goal. In the fullness of time, there will be so much more to reflect on and to share. Our journey of discovery continues. We hope this case study provides some useful insights on our experience and is a source of inspiration to others embarking on a similar journey.

Acknowledgements The authors are grateful to Peter Knight, National Lead for Information on Integration and Primary Care, Public Health Scotland, for advice on the information and monitoring sections of the manuscript. Thanks also to the Scirocco Exchange Project for enabling the International Centre for Integrated Care to undertake a grey literature search to identify key documents and web resources on integrated care in Scotland.

References

ALLIANCE. (2017). *ALLIANCE report developing a culture of health. The role of signposting and social prescribing in improving health and wellbeing*. Glasgow: ALLIANCE. Retrieved from https://www.bing.com/search?q=Developing+a+Culture+of+Health.++The+role+of+signposting+and+social+prescribing+in+improving+health+and+wellbeing+The+ALLIANCE+&form=EDGSPH&mkt=en-gb&httpsmsn=1&msnews=1&plvar=0&refig=44cc2f4e9e304bab84f444eb96ebd58a&PC=HCTS&

Audit Scotland. (2018a). *What is integration? A short guide to the integration of health and social care services in Scotland*. Edinburgh: Audit Scotland.

Audit Scotland. (2018b). *Health and social care integration: Update on Progress*. Edinburgh: Audit Scotland

Audit Scotland. (2019a). *NHS in Scotland 2019*. Edinburgh: Audit Scotland.

Audit Scotland. (2019b). *Principles for community empowerment*. Edinburgh: Audit Scotland.

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

Barrie, K., Miller, E., O'Brien, M., & Hendry, A. (2018). *Compassionate Inverclyde Evaluation Summary Report*. Retrieved from https://ardgowanhospice.org.uk/wp-content/uploads/2018/12/CI-evaluation_-summary.pdf

Baylis, A., & Trimble, A. (2018). *Leading across health and social care in Scotland: Learning from chief officers' experiences, planning and nest steps*. London: The Kings's Fund.

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

Burgess, L. (2019). *SPICe Briefing primary care in Scotland*. Edinburgh: Scottish Parliament.

Chief Medical Officer. (2016). *Chief Medical Officers's Annual Report, 2014–2015, Realistic Medicine*. Edinburgh: Scottish Government.

COSLA & Scottish Government. (2019). Ministerial strategic group for health and community care: Health and social care integration: progress review (Final Report). *Health and Social Care*. Retrieved from https://www.gov.scot/publications/ministerial-strategic-group-health-community-care-review-progress-integration-health-social-care-final-report/

Dayan, M., & Edwards, N. (2017). *Learning from Scotland's NHS*. London: Nuffield Trust.

European Commission. (2017). *Blocks. Tools and methodologies to assess integrated care in Europe*. Report by the Expert Group on Health Systems Performance Assessment. Brussels: European Commission.

Ferguson, Z. (2016). *Kinder communities: The power of everyday relationships*. Carneigie UK Trust. Retrieved from https://www.carnegieuktrust.org.uk/publications/kinder-communities-power-everyday-relationships/

Finucane, A., Davydaitis, D., Horseman, Z., Carduff, E., Baughan, P., Tapsfield, J., et al. (2020). Electronic care coordination systems for people with advanced progressive illness: A mixed-methods evaluation in Scottish primary care. *British Journal of General Practice 2019*, *70*(690): e20–e28. https://doi.org/10.3399/bjgp19X707117

Fooks, C., Goldhar, J., Wodchis, W., Baker, R., & Coutts, J. (2018). Integrating care in Scotland. *Healthcare Quarterly, 21*(3), 37–41.

Gray, P. (2020, March 26). *Melting pot*. Retrieved from Reform Scotland: https://reformscotland.com/2020/03/we-cant-go-back-to-the-way-we-were-professor-paul-gray/

Greenhalgh, T., Wherton, J., & Shaws, S. (2020). *Interim summary of key literature and our evaluation of attend anywhere in Scotland*. Oxford: Oxford University.

Greenhalgh, T., Wherton, J., Shaw, S., & Morrison, C. (2020). Video consultations for covid-19 An opportunity in a crisis? *BMJ*, 2.

Health Foundation. (2020, March 30). *Using virtual consultations in the fight against COVID-19*. Retrieved from Health Foundation: https://www.health.org.uk/news-and-comment/newsletter-features/using-virtual-consultations-in-the-fight-against-covid-19

Health Foundation. (n.d.). *Pharmacy anywhere*. Retrieved from Health Foundation: https://www.health.org.uk/improvement-projects/pharmacy-anywhere

Healthcare Improvement Scotland. (2017). *An approach to understanding resource usage data to inform strategic commissioning*. Edinburgh: Health Improvement Scotland.

Hendry, A. (2016). Creating an enabling political environment for health and social care integration. *International Journal of Integrated Care, 16*(4), 7, 1–3. https://doi.org/10.5334/ijic.2531

Hendry, A., Taylor, A., Mercer, A., & Knight, P. (2016). Improving outcomes through transformational health and social care integration—The Scottish experience. *Healthcare Quarterly, 19,* 73–79.

HM Gov. (2004). Retrieved from legislation.gov.uk. https://www.legislation.gov.uk/asp/2004/7/pdfs/asp_20040007_en.pdf

Joint Improvement Team. (2015). *Reshaping care for older people change fund: building on progress report*. Edinburgh: Joint Improvement Team.

Knight, P. (2019, November 27). *Advantage managing fraility*. Retrieved April 26, 2020, from Advantage Joint Action: https://advantageja.eu/images/ADVANTAGE-JA_BrusselsScotland.pdf.

Kumpunen, S., Trigg, L., & Holder, J. (2019). Helping older people to use quality information to choose residential care. *Journal of Long-Term Care*, 87–98.

Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J. (2020). *Health equity in England: The Marmot review 10 years on.* London: Health Foundation. Retrieved from https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Mead, E. (2017). In V. S. Amelung (Ed.), *Handbook of integrated care* (pp. 525–539). Berlin: Springer.

Mead, E., Stark, S., & Thompson, M. (2017). Creating and leading a quality improvement culture at scale. *Management in Healthcare, 2*(2), 115–124.

Mercer, S., Gillies, J., Noble-Jones, R., & Fitzpatrick, B. (2019). *National evaluation of new models of primary care in Scotland.* Glasgow: University of Glasgow. Retrieved from https://www.sspc.ac.uk/media/Media_645962_smxx.pdf

Morrison, C. (2018). *Innovating for improvement: pharmacy anywhere, NHS Highland*. London: Health Foundation.

Morrison, C. (2019, January 23). *NHS near me: Getting our Q Exchange project started*. Retrieved from Health Foundation: https://q.health.org.uk/blog-post/nhs-near-me-getting-our-q-exchange-project-started/

Munoz, S., Bradley, S., & Hines, F. (2018). *Final evaluation report of the being here programme: Stakeholder experiences of changes to remote and rural healthcare services.* Inverness: University of the Highlands and Islands. Retrieved from https://www.uhi.ac.uk/en/t4-media/one-web/university/research/srhp/BEING-HERE-EVALUATION-FINAL-REPORT-24052019.pdf

National Records of Scotland. (2014). *Scotland's Census*. Retrieved from National Records of Scotland: https://www.scotlandscensus.gov.uk/census-results

National Records of Scotland. (2019). *Registrar General Annual Review 2018.* Retrieved from National Records of Scotland: https://www.nrscotland.gov.uk/files//statistics/rgar/2018/rgar18.pdf

Naylor, C., & Wellings, D. (2019). *A citizen-led approach to health and care. Lessons from the Wigan Deal*. London: King's Fund.

NHS Education Scotland. (2020a). *Management and Leadership*. Retrieved from Turas Learn: https://learn.nes.nhs.scot/641/leadership-and-management-programmes/you-as-a-collaborative-leader

NHS Education Scotland. (2020b). *Leadership and management programmes*. Retrieved from NHS Education Scotland Turas Learn: https://learn.nes.nhs.scot/641/leadership-and-management-programmes/you-as-a-collaborative-leader

NHS Highland. (2016). *The Annual Report of the Director of Public Health:Loneliness and Health.* 2016: NHS Highland. Retrieved from https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH%20Annual%20Report%202016%20(web%20version).pdf

Highland, N. H. S. (2019). *The annual report of the director of public health: Past, present and future trends in health and wellbeing*. Inverness: NHS Highland.

Nolte, E., & Pitchforth, E. (2014). *What is the evidence on the economic impacts of integrated care?Technical report.* Copenhagen: World Health Organization. Retrieved from https://www.kingsfund.org.uk/sites/default/files/media/Ellen%20Nolte%20-%20What%20is%20the%20evidence%20on%20the%20economic%20impacts%20of%20integrated%20care.pdf

Public Health Scotland. (2019a, November 26). *Health and social care integrated resource framework NHS Scotland and local authority social care expenditure years ending March 2015–March 2018 A management information publication for Scotland*. Retrieved from https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2019-11-26/2019-11-26-IRF-Health-and-Social-Care-Resource-Summary.pdf

Public Health Scotland—ISD, Scotland. (2019b). *Acute Hospital Activity and NHS Beds information for Scotland. Annual—Year ending 31 March 2019.* Edinburgh: ISD.

Public Health Scotland—, & ISD. (2019). *Percentage of end of life spent at home or in a community setting*. Edinburgh: ISD.

Public Health Scotland. (2020a). *Local Intelligence Support Team*. Retrieved from Public Health Scotland: https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Local-Intelligence-Support-Team/Information-governance/

Public Health Scotland—ISD. (2020). *Source Tableau platform.* Retrieved from https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Health-and-Social-Care-Integration/Introduction/.

Public Health Scotland. (2020c). *Data and Intelligence*. Retrieved from Public Health Scotland: https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Health-and-Social-Care-Integration/Introduction/

Public Health Scotland—ISD Scotland. (n.d.). *SPARRA risk prediction tool*. Retrieved from ISD: https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/

Robson, K. (2016, December 9). *Reserach briefings.* Retrieved from Scottish Parliament: https://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_16-100_The_National_Health_Service_in_Scotland.pdf

Scottish Government. (2009). *Improving the health and wellbeing of people with long term conditions in Scotland: A National Action Plan*. Edinburgh: Scottish Government.

Scottish Government. (2010a). *Reshaping care: A programme for change 2011–2021*. Edinburgh: Scottish Government.

Scottish Government. (2010b). *Caring together: The carers strategy for Scotland 2010–2015*. Edinburgh: Scottish Government.

Scottish Government. (2010c). *CEL4 (2010) Informing, engaging and consulting people in developing health and community care services*. Edinburgh: Scottish Government.

Scottish Government. (2010d). *NHS Scotland quality strategy—Putting people at the heart of our NHS*. Edinburgh: Scottish Government.

Scottish Government. (2011). *Report of the Commission on Future Delivery of Public Services*. Edinburgh: Scottish Government.

Scottish Government. (2012). *Integration of adult health and social care in Scotland: Consultation on proposals*. Edinburgh: Scottish Government.

Scottish Government. (2013). *Integration of adult health and social care in Scotland consultation: Scottish Government Response*. Edinburgh: Scottish Government.
Scottish Government. (2014). *Public Bodies (Joint Working) (Scotland) Act 2014*. Edinburgh: Scottish Government.
Scottish Government. (2015a). *The Scottish Health Survey*. Edinburgh: Scottish Government.
Scottish Government. (2015b). *Clinical and care governance framework: Guidance.* Retrieved from https://www.gov.scot/publications/clinical-care-governance-framework/
Scottish Government. (2017a). *GMS contract: 2018*. Edinburgh: Scottish Government.
Scottish Government. (2017b). *Health and social care standards my support, my life.* Edinburgh: Scottish Government. Retrieved from https://hub.careinspectorate.com/media/2544/sg-health-and-social-care-standards.pdf
Scottish Government. (2017c). *Improving together: A national framework for quality and GP clusters in Scotland*. Edinburgh: Scottish Government.
Scottish Government. (2018a). *Age home and community—The next phase.* Scottish Government. Retrieved April 27, 2020, from https://www.gov.scot/publications/age-home-community-next-phase/
Scottish Government. (2018b). *A connected Scotland: Our strategy for tackling social isolation and loneliness and building stronger social connections.* Edinburgh: Scottish Government. Retrieved from https://www.gov.scot/publications/connected-scotland-strategy-tackling-social-isolation-loneliness-building-stronger-social-connections/
Scottish Government. (2018c). *Carers' charter your rights as an adult carer or young carer in Scotland*. Edinburgh: Scottish Government.
Scottish Government. (2018d). *Scotland's digital health and care strategy: Enabling, connecting and empowering*. Edinburgh: Scottsih Government. Retrieved from https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/
Scottish Government. (2019a). *Scotland's Wellbeing—Delivering the national outcomes.* Edinburgh: Scottish Government. Retrieved from https://nationalperformance.gov.scot/sites/default/files/documents/NPF_Scotland%27s_Wellbeing_May2019.pdf
Scottish Government. (2019b). *Self-directed support strategy 2010–2020: Implementation plan 2019–2021*. Edinburgh: Scottish Government.
Scottish Government. (2019c). *The health and social care: Integrated workforce plan.* Edinburgh: Scottish Government. Retrieved from https://www.gov.scot/publications/national-health-social-care-integrated-workforce-plan/
Scottish Government. (2020a). *COVID-19—A framework for decision making.* Edinburgh: Scottish Government. Retrieved from https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2020/04/coronavirus-covid-19-framework-decision-making/documents/coronavirus-covid-19-framework-decision-making/coronavirus-covid-19-framework-decision-making/govscot%3Adoc
Scottish Government. (2020b). *Long-term monitoring of health inequalities: January 2020 report.* Edinburgh: Scottish Government. Retrieved from https://www.gov.scot/publications/long-term-monitoring-health-inequalities-january-2020-report/
Scottish Parliament. (2017). *Are they involving us? Integration Authorities' engagement with stakeholders.* Edinburgh: Scottish Parliament.
Scottish Parliament. (2020, March 5). *Public Audit and Post Legislative Scrutiny Committee*. Retrieved from Scottish Parliament: https://www.parliament.scot/parliamentarybusiness/CurrentCommittees/101363.aspx
Smith, M., & Skivington, K. (2016). *Community links: Perspectives of community organisations on the Links Worker Programme pilot and on collaborative working with primary health care —A sub-project of the Evaluation of the Links Worker Programme in 'Deep End' general practices in Glasgow Fi.* University of Glasgow, Institute of Health and Wellbeing. Retrieved from https://www.healthscotland.scot/media/1253/27362-community-links-evaluation-report-april-2016-cr.pdf

Stewart, E., Greer, S., Erica, A., & Donnelly, P. (2019, April 12). Transforming health care:the policy and politics of service reconfiguration in the UKs four health systems. *Health Economics, Policy and Law*, 1–19. Retrieved from https://www.cambridge.org/core/journals/health-economics-policy-and-law/article/transforming-health-care-the-policy-and-politics-of-service-reconfiguration-in-the-uks-four-health-systems/6BC5FD0A0FA269EB74B7047F48CAD5C6

Tapsfield, J., Hall, C., Lunan, C., McCutcheon, H., McLoughlin, P., Rhee, J., et al. (2015). Many people in Scotland now benefit from anticipatory care before they die: an after death analysis and interviews with general practitioners. *BMJ Published Online*. https://doi.org/10.1136/bmjspcare-2015-001014

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

Technology Enabled Care in Scotland. (2020). *Retrieved from technology enabled care in Scotland*. https://tec.scot/new-home/about/

Thompson, M. (2020a, April 3). *COVID-19: Insights from Highland*. Retrieved from Health Foundation: https://q.health.org.uk/blog-post/covid-19-insights-from-highland/

Thompson, M. (2020b, May 5) *If we want things to stay as they are, things will have to change.* Retrieved from Reform Scotland: https://reformscotland.com/2020/05/if-we-want-things-to-stay-as-they-are-things-will-have-to-change-maimie-thompson/

Thompson, M. (2020c, June 1). *COVID-19: Insights from Highland, part two*. Retrieved from Health Foundation: https://q.health.org.uk/blog-post/insights-from-highland-part-two/

Three Horizons. (n.d.). *Retrieved from International Futures Forum*. https://www.internationalfuturesforum.com/three-horizons

Westbrook, S. (2017). *A comparison of NHs highland key performance indicators pre and post integration*. Inverness: University of Highlands and Islands.