Health and Social Care Reform in Scotland – What Next?

ANNE HENDRY
MAIMIE THOMPSON
PETER KNIGHT
ELEANOR MCCALLUM
ALISON TAYLOR
HELEN RAINNEY
ANDREW STRONG

*Author affiliations can be found in the back matter of this article

ABSTRACT

Introduction: This paper analyses the important enablers, barriers and impacts of country-wide implementation of integrated health and social care in Scotland. It offers insights for other systems seeking to advance similar policy and practice.

Description: Landmark legislation was based on a shared vision and narrative about improving outcomes for people and communities. Implementation has involved coordination of multiple policies and interventions for different life stages, care groups, care settings and local context within a dynamic and complex system.

Discussion: Relational and citizen led approaches are critical for success, but it takes time to build trusting relationships, influence organisational and professional cultures and cede power. Assessing national impacts is challenging and progress at a national level can seem slower than local experience suggests, due in part to the relative immaturity of national datasets for community interventions. Five years on there are many examples of innovation and positive outcomes despite increasing demographic, workforce, and financial challenges. However, inequalities continue to increase.

Conclusion: Realising the true value from integration will require a stronger focus on place-based prevention and early intervention to achieve a fairer Scotland where everybody thrives. Solidarity, equity, and human rights must guide the next phase of Scotland’s story.

CORRESPONDING AUTHOR:
Anne Hendry
University of the West of Scotland, GB
anne.hendry@lanarkshire.scot.nhs.uk

KEYWORDS:
integrated care; policy; transformation; evaluation; reform

TO CITE THIS ARTICLE:
Hendry A, Thompson M, Knight P, McCallum E, Taylor A, Rainey H, Strong A. Health and Social Care Reform in Scotland – What Next? International Journal of Integrated Care, 2021; 21(4): 7, 1–14. DOI: https://doi.org/10.5334/ijic.5633
INTRODUCTION

Integrated care is advocated as an effective way to improve outcomes for people with chronic disease or complex needs [1, 2]. However, much of the evidence is based on small scale studies or in specific care groups [3–7] and evidence of country wide large scale system change is lacking [8–10]. Recently, several regions have applied realist evaluation [11] and designed mixed methods studies to understand what works in scaling up integrated care [12–16].

This article reflects on progress of large scale, system wide reform of health and social care in Scotland since 2015. It does not purport to be an independent academic evaluation. Rather, it presents the experience of expert stakeholders in developing and implementing national policy for integrated health and social care and a critique of the related enablers, barriers, and impacts. The content draws on a documentary review and analysis of published reports conducted in 2019 by the International Foundation for Integrated Care’s hub in Scotland (IFIC Scotland) for the European Union funded Scirocco Exchange project (https://www.sciroccosexchange.com/). Synthesis was undertaken by experts with different perspectives drawn from IFIC Scotland’s multi-sector Reference Network https://integratedcarefoundation.org/ifc-scotland-3. Thus, it blends both the reference and reflective quality paradigms of integrated care research [17].

Discussion of enablers and barriers is framed around the nine conceptual pillars proposed by the International Foundation for Integrated Care [18]. These pillars map to the building blocks for integrated care developed by the European Commission [19] and operate across the macro, meso and micro levels of integrated care [20]. The impacts of system change are based on publicly available national and local data that relate to the Quadruple Aim of improved population health, enhanced quality of care, better care and provider experience, and more cost–effective care [21].

COUNTRY CONTEXT

As a devolved nation within the United Kingdom (UK), the Scottish Parliament has legislative powers across a wide range of policy areas including health and social care [22]. Policy for the National Health Service (NHS) in Scotland is the responsibility of the Scottish Government and funding is resourced through a block grant from the UK Treasury. Fourteen territorial NHS Boards are responsible for planning and providing healthcare for their local population, accountable to Scottish Ministers, the Scottish Parliament and ultimately the electorate. The Convention of Scottish Local Authorities (COSLA) provides political leadership on behalf of Scotland’s 32 local councils who directly provide or commission a wide range of services including social work and social care. Around 80–85% of local authority funding comes from the Scottish Government in the form of a block grant.

The Scottish population is projected to grow from approximately 5.4 million in 2014 to 5.7 million by 2039 [23]. By then, one in four people (25%) are expected to be over 65 years compared with 14% in 1983 [24]. The prevalence of chronic disease in Scotland increases with age, from 25% of adults aged 16–24 to 77% of those aged 75 and over [25]. Around one in five people (20%) in Scotland have multimorbidity and its prevalence is 38% higher in the most deprived decile compared to the least deprived areas [26]. The onset of multimorbidity occurs 10–15 years earlier in deprived areas compared with more affluent areas, particularly multimorbidity that includes a mental health disorder [27].

Description of the Policy Reform

Integrating health and social care has long been a policy ambition in Scotland [22, 28]. Faced with demographic, workforce, and financial challenges, in 2011 the Christie Commission [29] proposed four priorities for reform of public services:

• A shift towards prevention and early intervention to prevent negative outcomes.
• Greater integration of public services at a local level bringing public, third and independent sector partners together with communities to deliver outcomes that matter to people.
• Greater investment in the people who deliver services through developing the workforce and effective public sector leadership.
• Improved performance through greater transparency, innovation and use of digital technology.

LAYING THE FOUNDATIONS

The Reshaping Care for Older People (RCOP) programme [30], an early policy response to Christie, brokered collaboration between health, social care, housing, third sector and independent providers. Between 2011 and 2015, around 1% of the annual healthcare and social care budget for older people was ring-fenced as a Change Fund to be used for local transformation. The programme helped to generate support for services to be jointly planned, financed, and delivered across the whole system [31]. Highland, in the north of Scotland, was the first area to press for radical reform and a partnership agreement between Highland Council and National Health Service Highland was established in 2012 under existing legislation [32]. Known as the Lead Agency Model, NHS Highland took responsibility for planning, resourcing, and delivering adult health and social care services. In a reciprocal arrangement, the council became the lead for children’s services.
NINE PILLARS TO ENABLE IMPLEMENTATION

Shared values and vision
Faced with the scale of the required reforms, by 2011 there was cross party agreement that ambitious new legislation, strategies, and policies would be required [22]. Widespread engagement, both national and local, fostered strong support for a shared vision and values for integration: better health and well-being outcomes through care and support at home and closer to home designed around what matters to people and communities [22, 32–34]. Macro level engagement with senior leaders from healthcare, local government, housing sector, voluntary organisations, and independent care providers was followed by dialogue with local health and social care organisations, professional bodies, care regulators and trade union representatives. A series of ‘town hall’ conversations across the country heard the voices of local citizens, family carers and the workforce. The extensive dialogue built a movement for change with strong and enduring support for the ‘why’ of integration. However, the details of the ‘what’ and the ‘how’ were less clear.

System wide governance and leadership
New legislation to integrate health and social care was introduced through the Public Bodies (Joint Working) (Scotland) Act 2014 [35]. This required shadow arrangements to be in place by April 2015 and governance to fully integrate services by April 2016 through one of two models: Lead Agency (as described for Highland) or a Body Corporate Model. In the Lead Agency model, the lead agency becomes the “Integration Authority” for specific services and the accountability rests with the relevant Chief Executives and Finance Directors. With the exception of Highland [32], all others areas chose a Body Corporate Model where the NHS Board and corresponding local authority (or local authorities where the NHS Board interfaces with more than one local authority) delegate responsibility for planning and resourcing services to new Integration Authorities (IA) [22, 28, 35]. Thirty IAs were established as distinct legal entities, each operating under the direction of their Integration Joint Board (IJJB) comprising non-executive members of the local NHS Board, elected members from the local authority and clinical, Third sector and community representatives. Two new senior posts of Chief Officer and Chief Finance Officer for each IA provide a single point of management for integrated services and related budget. The absence of an overly prescriptive approach was generally perceived as a virtue, allowing a degree of emergence to agree on the scope and details of the local organisational model.

The Chief Officers have two sets of leadership accountabilities: (i) to the IJB for strategic leadership, and (ii) to the NHS Board and local authority for operational leadership [22, 28, 35]. Chief Officers and IJB Chairs are responsible for building the effective relationships, collaboration, trust, and openness to challenge that are key requirements for successful leadership and management of integrated care [36–39]. Effective system leadership for large scale change must be distributed, operating at all levels, and involve people who both use and provide care and support [40, 41]. At a macro level, the Ministerial Strategic Group [42] which predated the legislation continues to provide valuable high level national strategic direction and leadership for integration. At the meso level, Health and Social Care Scotland (https://hscscotland.scot) was established by Chief Officers as a national learning network to build a social movement for change and to share good practice. However, significant turnover in Chief Officers, IJB Chairs and in senior NHS, local government, and civil servants since 2016 has challenged relational continuity [43, 44].

At the point of care delivery, effective integrated care is heavily influenced by culture, trust and relationships between professionals from different teams, care setting and sectors [45, 46]. A series of coaching and collaborative action learning programmes have attempted to address these human factors [47]. A new Masters programme ‘Leading People-centred integrated care’ was introduced by the University of the West of Scotland in 2018. Both of these initiatives target mid-career community health and care professionals and partners from third sector and strive to build leadership capability and enable succession planning. However, to date there has been limited engagement of professionals from acute hospitals in the national and local integrated care development programmes. This raises concerns about the need to further strengthen relationships between community and acute services.

Aligned payment systems
Recognition of the benefit of understanding the relationships between costs, activity and variation for different population groups to inform joint strategic planning and commissioning led to the development of an Integrated Resource Framework [48]. More than £9.4 billion in health and social care resources are now directed by IAs with approximately 70% of this funding delegated by the NHS and 30% by Local Authorities [49]. However, in 2019, most IAs recorded deficits or requested additional funding from their National Health Service Board, local authority or the Scottish Government [50].

Provision of social care is acknowledged as an important contributor to current overall health and social care cost pressures. Free personal social care for people aged over 65 years, first introduced in 2002 [51] was extended in 2019 to adults with degenerative neurological conditions. For both care groups, domestic services, day care or the accommodation element of care home costs may be chargeable. While Adult Social Care was the focus of a rapid, wide ranging independent
review launched in 2020, the report of the review recommends some changes in the membership of IAs and in processes for commissioning services and care [52].

People as partners in care
A strong focus on what matters to people and communities has been central to policy on integration in Scotland [22, 31, 34, 35]. Efforts to embed personal outcomes in practice have largely focused on re-orienting conversations at the point of care to achieve outcomes identified through shared decision making [53–55]. New integrated Health and Social Care Standards seek to improve personalisation and outcomes across all health and care providers [56]. Empowerment, co-production and personalisation are further supported by legislation that places a statutory duty to offer choice in how people are assessed and receive their social care or support, [57] and by a human rights-based Carers Charter and legislation [58]. IAs are tasked with involving the public, people who use services, politicians, and professionals in local service redesign. There are examples of good practice in engagement and co-design but also concerns over examples of tokenistic consultation and limited public involvement [32, 44, 59, 60].

Resilient communities and new alliances
Scottish policy has a strong commitment to outcomes and asset-based approaches [61, 62]. Health and Social Care Scotland’s Statement of intent signalled a commitment to develop new alliances to create more sustainable compassionate and caring communities [63]. The Long Term Conditions Alliance, established in 2009 as a national intermediary for a range of health voluntary organisations, was reformed as the Health and Social Care Alliance Scotland (the ALLIANCE https://www.alliance-scotland.org.uk/) to amplify the voice of over 3,000 voluntary sector organisations and associates as partners for integration. Their analysis of progress in fostering new alliances cited continuing organisational, cultural, and financial challenges [64] but also many examples of successful asset-based initiatives [65]. Examples include: Community Links Practitioners [66] who work alongside primary care to support people living in challenging circumstances or facing loneliness, mental health problems, addictions or debt to draw on individual and community assets; strength based collaborative care and support planning [67]; national and local support for self-management [68]; and social prescribing initiatives [69].

Workforce capacity and capability
Integration has not changed the regulatory framework or accountabilities for professional practice, but national guidance describes clinical and care governance for integrated working [70]. The National Workforce plan [71] set out commitments to develop the right workforce skills and capacity. Implementation of this plan is largely work in progress, but a critical step was the introduction of a new General Medical Services contract for general practitioners [72], supported by additional investment in primary care of £250 million to 2021/2022 [73]. The new contract introduces new roles in primary care for community mental health professionals, community link workers, pharmacists, and advanced nursing and allied health practitioners to improve access and quality of care for individuals and communities [74]. The independent review of social care is expected to make some recommendations on workforce capacity and capability, the vital role of the third sector, and the ‘wicked’ issue of parity of pay and conditions between social care and healthcare workers [52].

The vital contribution of improvement support for large scale change cannot be overstated. Between 2006 and 2016, improvement support for integrated working was provided by the Joint Improvement Team, a multi-sector improvement partnership overseen by senior representatives of the Scottish Government, NHS Scotland, COSLA, Third Sector, Independent providers and the Housing Sector [31, 34]. From 2016, in an attempt to rationalise improvement support for health and social care, the Scottish Government commissioned the established national healthcare scrutiny and improvement organisation, Healthcare Improvement Scotland, to extend their portfolio to integrated health and social care. With hindsight, changing well established implementation support relationships to IAs may have been an additional challenge at a time when relational continuity, trust and organisational memory were critical. Examples of improvement in primary care and community services are reported in several publications [39, 44, 75] and at https://hscscotland.scot/resources/.

Digital solutions
Scotland’s Digital Health and Care Strategy [76] promotes technology enabled care solutions such as Home and Mobile Health Monitoring, Near Me Video Enabled consultations, Digital Platforms and Telecare initiatives. A Strategic Portfolio Board provides oversight of investment and support and has engaged advice from global experts, industry and academia [77]. The digital health and care delivery programme helped build readiness for rapid innovation and adoption of digital solutions in response to Covid-19. Notably an improvement approach underpinned the unprecedented scale up of Near Me video enabled consultations [78]. The approach has been well received by patients, carers, family and professionals [79].

Population health and local context
The places we live in and the wider determinants of health have a powerful impact on outcomes [80, 81].
The Scottish Index of Multiple Deprivation 2020 [82] provides granular data on these determinants for data zones of around 800 people in 6,976 neighbourhoods. The interactive tool can be used by IAs to identify where people experience disadvantage across different aspects of their lives in order to target health and care resources to local areas with greatest need. However, understanding of population health and prioritisation of targeted investment for specific localities remains relatively underdeveloped. Investment in local analytical expertise and population health management data and tools is supporting leads for strategic planning and commissioning to better meet the needs of local populations [83]. Data Sharing Agreements specify who can get access to data, for what purpose, and set out the process for authorisation and any restrictions [84].

Transparency of progress, results, and impact

Published reports note positive progress in collaborative working and encouraging evidence of impacts, albeit with significant local variation in the pace and scale of progress [39, 42, 44, 64, 65]. Since 2017, national scrutiny bodies have undertaken detailed joint inspections in eight IAs (27%) to review leadership, performance and strategic planning and commissioning processes and outcomes. Scotland’s National Performance Framework [85] describes the outcomes and indicators that track progress in achieving Scotland’s national purpose, values and ambitions. IAs produce annual reports on indicators for nine national health and wellbeing outcomes [86]. These indicators draw on routinely recorded hospital and community data and on regular national surveys of care experience. National health and care data and data linkage systems offer ways to measure the impact of the reform, in particular through analysis of key trends over time. To appreciate these trends in the context of an ageing population, it is possible to consider how trends over the decade might have looked (‘expected’) in the absence of transformational change.

Emergency hospital admissions, a sentinel system level indicator, have risen annually [87]. The trends for people aged 65 and over admitted as an emergency, indexed to 2008/09 (prior to the RCOP programme) and presented by broad length of stay, are shown below (Figure 1). The analysis reveals a 56% increase by 2018/19 in the number of older people admitted for urgent assessment who return home within hours or after one overnight stay. The trend for stays of between 8 and 14 days rose by only 7% over the period with virtually no change since 2012/13. The number of older people staying 15 days or more has been largely static since 2008/09, whilst decreasing slightly in 2018/19.

Further perspective on changes over the decade can be gained by comparing an ‘expected’ trend, adjusted for the changing age profile of the population since 2008/09, alongside actual trends. The first example here shows such a comparison for use of acute hospital beds by older people following emergency admission. The gap between the actual and the expected use of beds (‘emergency beddays’) has increased year by year since 2008/09. The number of emergency beddays used during 2018/19 (2.8 million) is considerably less than ‘expected’ (3.5 million) based on projection of the 2008/09 rate (Figure 2).

The number of people aged 65+ in long stay hospital care has markedly declined since 2008/09 and their beddays used reduced from 472,000 in 2008/09 to 229,000 in 2018/19 (Figure 3).

When days spent in long stay hospital care are combined with acute hospital stays, the actual bed days for people aged 65+ in 2018/19 are 27%
lower than the population adjusted trend would have suggested. Notably, this gap between actual and expected has not been accompanied by an expansion in long term residential care [88]. The same comparative approach reveals the gap between actual and expected numbers of long-term care home residents has also grown – the number of age 65+ long-stay residents at March 2019 (30,418) is 20% lower than would have been expected based on 2009 rates (Figure 4).

The complexity and heterogeneity of integrated care make evaluation and attribution of economic impact difficult [89]. However, Figures 2–4 demonstrate a significant shift to care at home, avoiding institutional care costs and releasing resource for investment in community health and care support and services. One way to appreciate the scale of the shift from the previous balance of care is to present the 2018/19 figures above as ‘daily averages’. This method suggests around 10,000 more people aged 65+ were living at home each day in 2018/19 than ‘expected’ (Figure 5).

Allied with a 6% reduction in emergency bed days for all adults (2014/15 – 2018/19), this shift has enabled a managed and proportionate disinvestment in hospital bed capacity while bed occupancy remains stable [87].

Multiple complex interventions have contributed to achieving this shift [31]. Evidencing the contribution of
specific interventions is not an exact science. Routine national collection of data has been principally focused, to date, on acute healthcare and, more recently, has included linkable data from statutory social care services [90]. The impact of community interventions such as intermediate care, reabilitation and third sector support for wellbeing has been more difficult to assess at a national level. The full potential of linkable information from routinely collected general practice data has yet to be realised in Scotland.

One notable exception is availability of data on Anticipatory Care Planning (ACP), a person-centred approach that encourages practitioners to work with patients, carers and families to express their preferences and goals for future care. From 2008, national support for ACP built on innovation in a single General Practice [91] and has incrementally enabled spread to cover 5% of the population by February 2020. This focus on ACP has contributed to a modest increase in the time people spend at home or in a community setting in the last six months of life [92, 93]. Following further rapid scale up during the Coronavirus pandemic, by October 2020 around 20% of primary care clinical records included an electronic summary of the patient’s anticipatory care plan that is routinely shared with out of hours and acute care providers.

The value of qualitative information on outcomes for people, families and communities is widely recognised but is not easily tracked at a national level. Academic evaluations of specific initiatives, for example of the Links worker programme [66], the House of Care early adopters [67] and of a compassionate community in one IA [94], highlight many examples of improved personal, relational and community outcomes. A standardised national survey of Health and Care Experience is sent every two years to a random sample of citizens [95]. It seeks to capture their experiences of accessing and using local healthcare services and of receiving care, support and help with everyday living and caring responsibilities. Data from the 2017/2018 Primary Care Health and Care Experience survey suggests good levels of communication but a need for greater continuity and coordination of primary care (Figure 6).

In the most affluent areas of Scotland men experience 23.8 more years of good health and women and additional 22.6 years compared to the most deprived areas [96]. Integration of health and social care has had little impact on these systemic inequalities.
DISCUSSION

While few disagree with the vision for integration, national progress has often seemed slow and piecemeal [39, 42–44, 64]. As implementation requires careful alignment of many policies and support mechanisms with significant interdependencies, it is not surprising that there has been an ebb and flow of progress over time and across the country. One factor has been significant turnover in the first cohort of Chief Officers and IJB Chairs and by changes in key personnel in Ministerial, policy and senior NHS management posts [43, 44].

Implementing major reform after a prolonged period of austerity has proven challenging. Now the economic context is even more volatile and uncertain as a result of Coronavirus. However the pandemic has undoubtedly demonstrated what can be achieved by working together across organisational and sectoral boundaries: better local collaboration, greater ability to pivot and enhanced capability to facilitate key infrastructure and practice changes at unprecedented speed. Facing stark health and economic challenges from the pandemic [97], IAs and NHS Boards must further strengthen their alliances with community partners and the third sector to improve lives and opportunities through a stronger focus on prevention, early intervention and targeted action on the wider determinants of health.

Progress on addressing inequalities in Scotland has been elusive, in common with many countries [81]. Relative inequalities have widened over the last 10 years and life expectancy at birth remains relatively poor and has not improved since 2012. Some argue this requires reimagining local governance beyond health and social care [98]. Although there seems little appetite for further structural change in Scotland’s public bodies, there is growing recognition of a need to strike the right balance between centrally directed organisations such as the NHS and flexible arrangements for local delivery through strong horizontal integration with community partners. A Blueprint document from local government [99] affirms the need to accelerate progress on integration and includes proposals for the next phase of reform. Several strategic actions are already underway, including the introduction of legislation to adopt the European Charter for Local Self Government [100] in Scots’ law. This aims to guarantee political, administrative and financial independence for Local Authorities along with new powers to raise and set taxes and make spending decisions based on local priorities and economic realities.

Linked with this is a commitment to reinvigorate the relationship between Public Health and Local Government to improve and protect community wellbeing, particularly for vulnerable populations who have experienced greater disadvantage from the health and economic impacts of Covid-19. Public Health Scotland’s Strategic Plan 2020–2023 sets out four priority areas of action where collaboration with local government on wider determinants of health will be critical [101]. These priorities are: Covid-19 response, recovery and renewal; understanding and influencing the economic, social and emotional factors that create good relationships and mental wellbeing, and eliminate discrimination and stigma; use of data and intelligence to understand the unique needs of Communities and Place to improve health and wellbeing in communities that experience the worst outcomes; and identifying and supporting evidence based actions to address poverty and improve child health.

LESSONS LEARNED

Various published insights on Scotland’s integration story describe critical issues of leadership, culture, workforce, difficulties with demonstrating impact and managing a challenging financial context [22, 31, 39, 44, 64, 65, 102, 103]. From analysis of these reports and reflecting on our accumulated wisdom as expert stakeholders collaborating in developing and implementing this policy reform for over a decade, we offer five key lessons for other systems considering similar reform:
1. **Engage and Involve:** Start with the ‘why’ and co-produce a compelling vision about improving lives and creating a better, more sustainable future. You are more likely to build a successful movement for change if you involve people who use and deliver services in co-designing the future. Bringing people together as equal partners is necessary to understand differing perspectives and challenges and creates an environment where all concerned may be more open to being influenced. Realistic conversations on the values and outcomes that matter to individuals and communities are seen as increasingly important. Touch hearts and minds with judicious use of information and stories about the quality and experience of care.

2. **Empower and Enable:** Every community is different and, perhaps curiously, many are more likely to be open to new ways of working from another country than their neighbouring district. Transferring solutions, no matter how well tested, will fail if implemented without due regard for local culture, history and buy-in. Understanding the local context and readiness for change is important so invest time in building trusting relationships. Strive to understand what underpins different behaviours and levels of co-operation. Be prepared to cede power and control to partners, individuals and communities to empower and enable them to design local and sustainable solutions.

3. **Collaborate and Coordinate:** Successful transformation requires coordinated efforts across the whole of government, the whole of the health and care system at every level, and with citizens. Even with political will, new legislation is not enough to deliver radical reform. The reasons are complex and relate to issues of power and vested interests, and the inherent management and leadership capability for managing complex change. Multiple policy, financial and contractual levers need to be aligned, mutually reinforcing and their deployment well timed and coordinated to create the right conditions for integration to flourish.

4. **Innovate and Improve:** Adapting technology and new ways of working is complex. In ordinary circumstances, changes will take longer than one might reasonably expect but in crisis situations the pace and scale of change may be transformational. Be ready when opportunities present themselves. Embrace disruption and external challenges as opportunities for innovation to overcome barriers and change pace. Invest in improvement capacity and build local capability to test, spread and scale up new ways. Whenever possible look to co-produce solutions with citizens and with the workforce. People, not policies, change lives. Culture change can take a generation so invest from the outset in developing the habits of people centred integrated care within undergraduate training curricula and postgraduate practice.

5. **Reflect and Learn:** New ways will only make sense if anticipated improvements can be evidenced and unintended consequences minimised. Some things may appear to get worse before they get better. Do not stint on analytical support and invest in formative evaluation from the outset. Crucially, be humble and curious and learn from your mistakes and from other systems on a similar journey. It may take some time to fully understand the impact of integration but stick with it – this is a marathon not a sprint.

**CONCLUSIONS**

Published reports note positive progress in collaborative working and high level national data demonstrate encouraging evidence of impacts from this policy reform. Only time will tell if the potential can be fully realised in order to scale up and sustain these early gains. Notably, even ‘standing still’ in performance over the last five years has been a significant achievement given the economic challenges, increasing system demands and complexity of care needs. However, important questions remain unanswered. Could the early progress achieved through the RCOP programme [30] have been sustained and spread to other care groups without introducing new legislation? Is there any difference between the outcomes realised through the two models of integration (Lead Agency vs Body Corporate)? While there has been national scrutiny of progress [28, 43, 44], there has been little in-depth academic research on observed changes in local processes, relationships and cultures over time.

Experience from Covid-19 to date has demonstrated what can be achieved by working together across organisational and sectoral boundaries: better local collaboration, greater ability to pivot and enhanced capability to facilitate key infrastructure and practice changes at unprecedented speed. Careful reflection and analysis of this experience will be required to understand why this was the case and what were the respective contributions of people, communities, processes, structures and technologies in creating the conditions to enable rapid change. The Researcher in Residence model [104] could be a very useful vehicle for rapid, real-time and action-orientated research to understand the important opportunities for transformation in this turbulent period [105]. This insight will be critical to strengthen alliances with community partners for population health to improve lives and opportunities for all.

In unprecedented times and in an uncertain and rapidly evolving political, economic and health and social care landscape, there is one certainty: Scotland’s integration story will continue to unfold.
REVIEWERS

Ana M Carriazo MD PhD, Senior Advisor, Regional Ministry of Health and Families of Andalusia, Spain.
Dr Axel Kaehne, Reader Health Services Research, Medical School, Edge Hill University, UK.

COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR AFFILIATIONS

Anne Hendry @orcid.org/0000-0001-6162-3760
University of the West of Scotland, GB
Maimie Thompson
University of the West of Scotland, GB
Peter Knight
Public Health Scotland, GB
Eleanor McCallum
Health and Social Care Scotland, GB
Alison Taylor
Scottish Government, GB
Helen Rainey
University of the West of Scotland, GB
Andrew Strong
The Health and Care Alliance Scotland, GB

REFERENCES

1. Briggs AM, Valentijn PP, Thiagagarajan JA, Carvalho IA. Elements of integrated care approaches for older people: a review of reviews. BMJ open. 2018; 8(4): e021194. Available from: https://bmjopen.bmj.com/content/8/4/e021194. DOI: https://doi.org/10.1136/bmjopen-2017-021194
2. Borgermans L, Marchal Y, Busetto L, Kalseth J, Kasteng F, Suija K, et al. How to improve integrated care for people with chronic conditions: Key findings from EU FP-7 Project INTEGRATE and beyond. International Journal of Integrated Care. 2017; 17(4): 7. DOI: https://doi.org/10.5334/ijic.3096
3. Baxter S, Johnson M, Chambers D, Sutton A, Goyder E, Booth A. The effects of integrated care: A systematic review of UK and international evidence. BMC Health Serv Res. 2018; 18(1). DOI: https://doi.org/10.1186/s12913-018-3161-3
4. Looman WM, Huijsman R, Fabbricotti IN. The (cost-) effectiveness of preventive, integrated care for community-dwelling older people: a systematic review. Health Soc Care Commun. 2019; 27(1): 1–30 Available from: https://pubmed.ncbi.nlm.nih.gov/29667259/
5. Liljas AEM, Brorström F, Burström B, Schön P, Agerholm J. Impact of Integrated Care on Patient Related Outcomes Among Older People – A Systematic Review. Int J Integr Care. 2019; 19(3): 1–16. DOI: https://doi.org/10.5334/ijic.4632
6. Martínez-González NA, Berchtold P, Ullman K, Busato A, Egger M. Integrated care programmes for adults with chronic conditions: a meta-review. Int J Qual Heal Care [Internet]. 2014 Oct; 26(5): 561–70. DOI: https://doi.org/10.1093/intqhc/mzu071
7. Goodwin N, Dixon A, Anderson G, Wodchis W. Providing integrated care for older people with complex needs. Lessons from seven international case studies. London: The King’s Fund; January 2014. Available from: https://www.kingsfund.org.uk/publications/providing-integrated-care-for-older-people-complex-needs
8. Willis CD, Riley BL, Stockton L, Abramowicz A, Zummach D, Wong G, et al. Scaling up complex interventions: insights from a realist synthesis. Heal Res Policy Syst [Internet]. 2016 Dec 19; 14(1): 88. Available from: http://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-016-0158-4. DOI: https://doi.org/10.1186/s12961-016-0158-4
9. Greenhalgh T, Papoutsi C. Spreading and scaling up innovation and improvement. BMJ [Internet]. 2019 May 10; 365: l2068. Available from: http://www.bmj.com/lookup/doi/10.1136/bmj.l2068. DOI: https://doi.org/10.1136/bmj.l2068
10. Pile KE, Greenhalgh T. The challenge of complexity in health care. Br Med J. 2001; 323(7313): 625–8. DOI: https://doi.org/10.1136/bmj.323.7313.625
11. Pawson R, Greenhalgh T, Harvey G, Walshe K. Realist review – a new method of systematic review Art. 12, page 12 of 15 Goderis et al: Evaluating Large-Scale Integrated Care Projects designed for complex policy interventions. J Health Serv Res Policy [Internet]. 2005 Jul 4; 10(1_suppl): 21–34. Available from: https://journals.sagepub.com/doi/10.1258/1355819054308530. DOI: https://doi.org/10.1258/1355819054308530
12. Nurjono M, Shrestha P, Lee A, Lim XY, Shiraz F, Tan S, et al. Realist evaluation of a complex integrated care programme: Protocol for a mixed methods study. BMJ Open. 2018; 8(3). DOI: https://doi.org/10.1136/bmjopen-2017-017111
13. Stokes T, Atmore C, Penno E, Richard L, Wodchis WP, Richards DW, et al. Protocol for a mixed methods realist evaluation of regional District Health Board groupings in New Zealand. BMJ Open. 2019; 9(3): 1–8. DOI: https://doi.org/10.1136/bmjopen-2019-030076
14. Goderis G, et al. Evaluating Large-Scale Integrated Care Projects: The Development of a Protocol for a Mixed Methods Realist Evaluation Study in Belgium. Int J Health Serv Research Policy. 2020; 20(3): 12, 1–15. DOI: https://doi.org/10.5334/ijhsr.5435
15. Read DMY, Dalton H, Booth A, Goodwin N, Hendry A, Perkins D. Using the Project INTEGRATE Framework in Practice in Central Coast, Australia. Int Journal Integ Care. 2019; 19(2): X: 1–12. DOI: https://doi.org/10.5334/ijic.4624
16. Kirst M, Im J, Burns T, Baker GR, Goldhar J, O’campo P, Wojtak A, Wodchis WP. What works in implementation of integrated care programs for older adults with complex
needs? A realist review. Int J for Quality in Health Care. 2017; 29(5): 612–24. DOI: https://doi.org/10.1093/intqhc/mzx095
17. Van Kempen EA, Van der Vleugl-Brouwer W. Integrated Care: a definition from the perspective of four quality paradigms. Journal of Integrated Care. 2019; 27(4): 357–367. DOI: https://doi.org/10.1080/JICA-06-2019-0029
18. Lewis L, Ehrenberg N. Realising the true value of integrated care: Beyond COVID-19. Oxford: International Foundation for Integrated Care; 2020. [cited 2020 Oct 22]. Available from: https://integratedcarefoundation.org/realising-the-true-value-of-integrated-care-beyond-covid-19.
19. European Commission. Tools and Methodologies to Assess Integrated Care in Europe. Report by the Expert Group on Health Systems Performance Assessment. 2017; 15. Available from: https://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/2017_blocks_en_0.pdf.
20. Valentinj PP, Schepman SM, Opheij W, Bruijnzeels MA. Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. Int J of Integ Care. 2013; 13: e010. DOI: https://doi.org/10.5334/ijic.886
21. Bodenheimer T, Sinsky C. From Triple to Quadruple Aim: Care of the Patient. Ann Fam Med. 2014; 12(6): 573–6. DOI: https://doi.org/10.1370/afm.1713
22. Taylor A. New act new opportunity for integration in Scotland. Journal of Integrated Care. 2015; 23(1): 3–9. Available from: https://www.emerald.com/insight/content/doi/10.1108/JICA-11-2014-0041/full/html. DOI: https://doi.org/10.1108/JICA-11-2014-0041
23. National Records Scotland. “Projected Population of Scotland (2014-based).” Edinburgh; 2015. Available from: www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/population-projections-scotland/2014-based.
24. National Records of Scotland. Registrar General Annual Review; 2018. Available from: https://www.nrscotland.gov.uk/files/statistics/rgr18/rgr18.pdf.
25. The Scottish Government. Scottish Health Survey 2017: volume one – main report. Edinburgh; 2018. Available from: https://www.gov.scot/publications/scottish-health-survey-2017-volume-1-main-report/.
26. McLean G, Guthrie B, Mercer SW, Watt GC. General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland. Br J Gen Pract. 2015; 65(641): e799–e805. DOI: https://doi.org/10.3399/bjgp15X687829
27. Barnett K, Mercer S, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of Multimorbidity for Health Care, Research, and Medical Education: A Cross-Sectional Study. The Lancet; 2012. Available from https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60240-2/fulltext.
28. Audit Scotland. What is integration? A short guide to the integration of health and social care services in Scotland. Edinburgh: Audit Scotland; 2018. Available from https://www.audit-scotland.gov.uk/uploads/docs/report/2018/briefing_180412_integration.pdf.
29. Christie C. Christie Commission on the future delivery of public services. Scottish Government, 2011. Available from: www.gov.scot/publications/commissionfuture-delivery-public-services/.
30. Scottish Government. Reshaping Care for Older People: a Programme for Change 2011–2021. Available from: https://www2.gov.scot/Resource/0039/00398295.pdf.
31. Hendry A, Taylor A, Mercer S, Knight P. Improving Outcomes through Transformational Health and Social Care Integration – The Scottish Experience. Healthcare Quarterly. 2016; 19: 73–79. DOI: https://doi.org/10.12927/hcq.2016.24703
32. Mead E. In Amelung VS (ed.), Handbook of Integrated Care. 2017; 525–539. Springer. Available from: https://link.springer.com/chapter/10.1007/978-3-319-56103-5_32. DOI: https://doi.org/10.1007/978-3-319-56103-5_32
33. Scottish Government. Integration of Adult Health and Social Care in Scotland Consultation: Scottish Government Response. Edinburgh: Scottish Government; 2013. Available from: https://www.gov.scot/publications/integration-adult-health-social-care-scotland-consultation-scottish-government-response/.
34. Hendry A. Creating an Enabling Political Environment for Health and Social Care Integration. Int J Integ Care. 2016; 16(4): 7, 1–3. DOI: https://doi.org/10.5334/ijic.2531
35. Scottish Government. Public Bodies (Joint Working) (Scotland) Act 2014. Edinburgh: Scottish Government; 2014. Available from: https://www.legislation.gov.uk/asp/2014/9/contents/enacted.
36. Busetto I, Luijkx K, Calciosanti S, Ortiz LGG, Vrijhoef HJ. Barriers and Facilitators to Workforce Changes in Integrated Care. Int J Integ Care. 2018; 18(2): 17, 1–13. DOI: https://doi.org/10.5334/ijic.3587
37. Timmins N. Leading for integrated care ‘If you think competition is hard, you should try collaboration.’ London: The King’s Fund; 2018. Available from https://www.kingsfund.org.uk/sites/default/files/2019-11/leading-integrated-care-summary.pdf.
38. Miller R, Stein KV. The Odyssey of Integration: Is Management its Achilles’ Heel? Int J Integ Care. 2020; 20(1): 7, 1–14. DOI: https://doi.org/10.5334/ijic.5440
39. Baylis A, Trimble A. Leading across health and social care in Scotland: Learning from chief officers’ experiences, planning and next steps. London: The King’s Fund; 2018. Available from: https://www.kingsfund.org.uk/sites/default/files/2018-07/Scottish_officers_final.pdf.
40. Best A, Greenhalgh T, Lewis S, Saul JE, Carroll S, Blitz J. Large-system transformation in health care: A realist review. Milbank Quarterly. 2012; 90: 421–56. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1468-0009.2012.00670.x. DOI: https://doi.org/10.1111/j.1468-0009.2012.00670.x
41. Evans JM, Daub S, Goldhar J, Wojtak A, Purbhood D. Leading integrated health and social care systems: Perspectives from research and practice. Healthc Q. 2016; 18(4): 30-5. DOI: https://doi.org/10.12927/hqc.2016.24553

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

43. Scottish Parliament. Public Audit and Post Legislative Scrutiny Committee. Available from: https://www.parliament.scot/parliamentarybusiness/CurrentCommittees/101363.aspx.

44. Audit Scotland. Health and social care integration: Update on Progress; 2018. Available from: https://www.audit-scotland.gov.uk/report/health-and-social-care-integration-update-on-progress

45. Miller R. Crossing the Cultural and Value Divide Between Health and Social Care. Int J Integr Care. 2016; 16(4): 10. DOI: https://doi.org/10.5334/ijic.2534

46. Middleton L, Rea H, Pledger M, Cumming J. A Realist Evaluation of Local Networks Designed to Achieve More Integrated Care. Int J Integr Care. 2019; 19(2): 4. DOI: https://doi.org/10.5334/ijic.4183

47. NHS Education Scotland. Leadership and Management Programmes. [webpage on the internet]; 2020. [cited 2020 Oct 22]. Available from: https://learn.nes.nhs.scot/641/leadership-and-management-programmes/you-as-a-collaborative-leader/.

48. Public Health Scotland. Health and Social Care Integrated Resource Framework; 2019. Available 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.

49. Scottish Government. Scottish Budget 2020-21; 2020. Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/publication/2020/02/scottish-budget-2020-21/documents/scottish-budget-2020-21/scottish-budget-2020-21/govscot%3Adocument/scottish-budget-2020-21.pdf.

50. Audit Scotland. NHS in Scotland 2019; 2019. Available from: https://wwwaudit-scotland.gov.uk/whs-in-scotland-2019.

51. Community Care and Health (Scotland) Act. 2002. [webpage on the internet]. [cited 2020 Oct 22]. Available from: https://www.legislation.gov.uk/asp/2002/5/contents.

52. Scottish Government. Independent Review of Adult Social Care in Scotland; 2021. Available from: https://www.gov.scot/publications/independent-review-adult-social-care-scotland/.

53. Andrews N, Gobday J, le May A, Miller E, Petch A, Webber M. Story, dialogue and caring about what matters to people: progress towards evidence enriched policy and practice. Evidence & Policy; 2020. DOI: https://doi.org/10.1327/174426420X15825349063428

54. Personal Outcomes Network. Available from: https://personaloutcomescollaboration.org/.

55. Petch A, Cook A, Miller E. Partnership working and outcomes: do health and social care partnerships deliver for users and carers? Health and Social Care in the Community. 2013; 21(6): 623–633. DOI: https://doi.org/10.1111/hsc.12050

56. Scottish Government. Health and Social Care Standards My support, my life. Edinburgh: Scottish Government; 2017. Available from: https://hub.careinspectorate.com/media/2544/sg-health-and-social-care-standards.pdf.

57. Scottish Government. Self-directed support strategy 2010-2020: implementation plan 2019–2021; 2019. Edinburgh: Scottish Government. Available from: https://www.gov.scot/publications/self-directed-support-strategy-2010-2020-implementation-plan-2019-21/.

58. Scottish Government. Carers’ charter: your rights as an adult carer or young carer in Scotland. Edinburgh: Scottish Government; 2018. Available from https://www.gov.scot/publications/carers-charter/.

59. Stewart E, Greer S, Erica A, Donnelly P. Transforming health care: the policy and politics of service reconfiguration in the UKs four health systems. Health Economics, Policy and Law. 2019 April; 12: 1–19. Available from: https://www.cambridge.org/core/journals/health-economics-policy-and-law/article/transfocusing-health-care-the-policy-and-politics-of-service-reconfiguration-in-the-uk-s-four-health-systems/6BC5FD0A0FA269EB74B7047F48CAD5C6.

60. Scottish Parliament. Are they involving us? Integration Authorities’ engagement with stakeholders. Edinburgh: Scottish Parliament; 2017. Available from http://www.parliament.scot/S5_HealthandSportCommittee/Reports/IA_report.pdf.

61. Coutts P, Brotchie J. The Scottish Approach to Evidence: A Discussion Paper. Alliance for Useful Evidence; 2017. Available from: https://www.parliament.scot/S5_HealthandSportCommittee/Reports/IA_report.pdf.

62. MacLeod M, Emejulu A. Neoliberalism with a community face? A critical analysis of asset-based community development in Scotland. Journal of Community Practice. 2014; 22: 430–450. DOI: https://doi.org/10.1080/10705422.2014.959147

63. Health and Social Care Scotland’s Statement of intent. Available from: https://hscscotland.scot/media/spotlight/statement-of-intent-future-collaborative-conversations-and-five-essential-elements.html.

64. Down Griesbach. Health and social care integration: How is it for you? Views from the public sector; 2019. Available from: https://www.alliance-scotland.org.uk/wp-content/uploads/2019/05/Health-and-Social-Care-Integration-How-is-it-for-you-Views-from-the-Public-Sector.pdf,
65. Healthcare Improvement Scotland ihub. [webpage on the internet]. [cited 2020 Oct 22]. Available from: https://www.hihub.scot/improvement-programmes/.

66. Scottish Government. Scotland’s Digital Health and Care Strategy: enabling, connecting and empowering. Edinburgh: Scottish Government; 2018. Available from: https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/.

67. Scottish Government. The Scottish Government’s National Performance Framework. Edinburgh: Scottish Government; 2020. Available from: https://nationalperformance.gov.scot/sites/default/files/2019-06/A_citizen-led_approach_to_health_and_wellbeing.pdf.

68. Scottish Government. Clinical and care governance framework: guidance; 2015. Available at: https://www.gov.scot/publications/clinical-care-governance-framework/.

69. Scottish Government. The Health and Social Care: Integrated Workforce Plan. Edinburgh: Scottish Government; 2019. Available at: https://www.gov.scot/publications/national-health-social-care-integrated-workforce-plan/.

70. Scottish Government. GMS contract: 2018. Edinburgh: Scottish Government; 2017. Available from: https://www.gov.scot/publications/gms-contract-scotland/.

71. Scottish Government. Delivering a new GMS contract in Scotland: memorandum of understanding. Edinburgh; 2017. Available from: www.gov.scot/publications/delivering-the-new-gms-contract-in-scotland-memorandum-of-understanding/.

72. Scottish Government. NPF Scotland’s Wellbeing – Delivering the National Outcomes; 2019. Available from: https://nationalperformance.gov.scot/sites/default/files/documents/NPF_Scotland%27s_Wellbeing_May2019.pdf.

73. Scottish Government. Core Suite of Integration indicators. Available from: https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/social-and-community-care/core-suite-of-integration-indicators/.

74. Scottish Government. Acute Hospital Activity and NHS Beds Information. [webpage on the internet]. [cited 2020 Oct 22]. Available from: https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/social-and-community-care/core-suite-of-integration-indicators/.

75. Scottish Government. Acute Hospital Activity and NHS Beds Information. [webpage on the internet]. [cited 2020 Oct 22]. Available from: https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/social-and-community-care/core-suite-of-integration-indicators/.

76. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

77. Smith M, Skivington K. Community Links: Perspectives of community organisations on the Links Worker Programme pilot and on collaborative working with primary health care. University of Glasgow; 2016. Available at: http://www.healthscotland.scot/media/1253/27362-community-links-evaluation-report-april-2016-cr.pdf.

78. Hendry et al. International Journal of Integrated Care  DOI: 10.5334/ijic.5633

79. Scottish Government. Available at: https://ihub.scot/wp-content/uploads/2018/04/25-April-2018-EXTERNAL-EXPERT-PANEL-REPORT-published.pdf.

80. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. Health Equity in England: The Marmot Review 10 Years On. London: Health Foundation; 2020. Available from: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on. DOI: https://doi.org/10.1136/bmj.m693.

81. Naylor C, Wellsings D. A citizen-led approach to health and care. Lessons from the Wigan Deal. London: King’s Fund; 2019. Available from: https://www.kingsfund.org.uk/sites/default/files/2019-06/A_citizen-led_approach_to_health_and_care_lessons_from_the_Wigan_Deal_summary.pdf.

82. Scottish Government. The Health and Social Community Care Management/Governance Framework: implementation guide; 2015. Available from: https://www.gov.scot/publications/clinical-care-governance-framework/.

83. Scottish Government. Integrated Workforce Plan. Edinburgh: Scottish Government; 2019. Available at: https://www.gov.scot/publications/gms-contract-scotland/.

84. Scottish Government. Information Governance Framework. Available from: https://isdscotland.org/Health-Topics/Health-and-Social-Community-Care/docs/Guide-to-Data-to-Support-HSCPs.pdf.

85. Scottish Government. Developing a Culture of Health, The role of signposting and social prescribing in improving health and wellbeing; 2017. Available from: https://www.gov.scot/wp-content/uploads/2017/10/ALLIANCE-Developing-a-Culture-of-Health.pdf.

86. Scottish Government. Clinical and care governance framework: guidance; 2015. Available at: https://www.gov.scot/publications/clinical-care-governance-framework/.

87. Scottish Government. From Fixer to Facilitator, Evaluation of the House of Care programme in Scotland. Matter of Focus; 2018. Available from: https://www.matter-of-focus.com/

88. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

89. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

90. Scottish Government. Scottish and Social Prescribing in Improving Health and Wellbeing: A citizen-led approach to health and care. Lessons from the Wigan Deal. London: King’s Fund; 2019. Available from: https://www.kingsfund.org.uk/sites/default/files/2019-06/A_citizen-led_approach_to_health_and_care_lessons_from_the_Wigan_Deal_summary.pdf.

91. Scottish Government.好 to Data to Support Joint Strategic Commissioning and Needs Assessment; 2018. Available from: https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/docs/Guide-to-Data-to-Support-HSCPs.pdf.

92. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

93. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

94. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

95. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

96. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

97. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

98. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

99. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.

100. Scottish Government. Scottish Government. Let’s Talk about Integration; 2018. Available from: http://www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/.
90. Public Health Scotland. Source Tableau Platform. [webpage on the internet]. [cited 2020 Oct 22]. Available from: https://www.isdscotland.org/Health-Topics/Health-and-Social-Care/Health-and-Social-Care-Integration/Introduction/.

91. Baker A, Leak P, Ritchie L, Lee A, Fielding S. Anticipatory Care Planning and Integration: A primary care pilot study aimed at reducing unplanned hospitalisation. British Journal of General Practice. 2012; 62(599): e113-e120. DOI: https://doi.org/10.3399/bjgp12X625175

92. Finucane A, Davydaitis D, Horsemann Z, Carduff E, Baughan P, Tapsfield J, Murray, S. 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. DOI: https://doi.org/10.3399/bjgp19X707117

93. Public Health Scotland. Percentage of End of Life Spent at Home or in a Community Setting. [webpage on the internet]. [cited 2020 Oct 22]. Available from: https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/social-and-community-care/percentage-of-end-of-life-spent-at-home-or-in-a-community-setting/.

94. Barrie K, Miller E, O’Brien M, Hendry A. Compassionate Inverclyde Evaluation Reports; 2018. Available from: https://ardgowanhospice.org.uk/how-we-can-help/compassionate-inverclyde/

95. Scottish Government. Health and Care Experience Survey, 2019. [webpage on the internet]. [cited 2020 Oct 22]. Available from: https://www2.gov.scot/Topics/Statistics/Browse/HealthGPPatientExperienceSurvey.

96. Scottish Government. Long-term monitoring of health inequalities. Edinburgh: Scottish Government, 2020. Available from: https://www.gov.scot/publications/long-term-monitoring-health-inequalities-january-2020-report/.

97. Scottish Government. Coronavirus (COVID-19): evidence gathered for Scotland’s route map -equality and Fairer Scotland impact assessment; 2020. Available from: https://www.gov.scot/publications/equality-fairer-scotland-impact-assessment-evidence-gathered-scotlands-route-map-through-out-crisis/.

98. Scottish Government. Local Governance review. Available from: https://www.gov.scot/publications/local-governance-review-analysis-responses-ask-public-sector-organisations-outline-alternative-arrangements-public-service-governance/pages/2/.

99. COSLA Blueprint for Local Government. 2020. Available from: https://www.cosla.gov.uk/__data/assets/pdf_file/0021/19551/LG-Blueprint.pdf.

100. Scottish Parliament. European Charter for Local Self Government (Incorporation) (Scotland) Bill. [webpage on the internet]. [cited 2020 Oct 22]. Available from: https://www.parliament.scot/parliamentarybusiness/CurrentCommittees/115604.aspx.

101. Public Health Scotland. A Scotland where everybody thrives. Public Health Scotland’s strategic plan 2020–23. Available from: https://www.publichealthscotland.scot/our-organisation/a-scotland-where-everybody-thrives-public-health-scotland-s-strategic-plan-2020-23/.

102. Fooks C, Goldhar J, Wodchis W, Baker R, Coutts J. Integrating Care in Scotland. Healthcare Quarterly. 2018; 21(3): 37-41. DOI: https://doi.org/10.12927/hcq.2018.25702

103. Dayan M, Edwards N. Learning from Scotland’s NHS. London: Nuffield Trust; 2017. Available from: https://www.nuffieldtrust.org.uk/research/learning-from-scotland-s-nhs.

104. Marshall M, Pogel C, French C, Utley M, Allwood D, Fulop N, et al. Moving improvement research closer to practice: the Researcher-in-Residence model. BMJ Qual Saf. 2014; 23(10): 801–5. DOI: https://doi.org/10.1136/bmjqs-2013-002779

105. Glasby J, Miller R. Ten lessons for integrated care research and policy – a personal reflection. Journal of Integrated Care. 28(1): 41-46. DOI: https://doi.org/10.1108/JJCA-11-2019-0047

TO CITE THIS ARTICLE:
Hendry A, Thompson M, Knight P, McCallum E, Taylor A, Rainey H, Strong A. Health and Social Care Reform in Scotland – What Next? International Journal of Integrated Care, 2021; 21(4): 7, 1–14. DOI: https://doi.org/10.5334/ijic.5633

Submitted: 01 November 2020    Accepted: 04 August 2021    Published: 29 October 2021

COPYRIGHT:
© 2021 The Author(s). This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC-BY 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See http://creativecommons.org/licenses/by/4.0/.

International Journal of Integrated Care is a peer-reviewed open access journal published by Ubiquity Press.