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ESSS Outline

Health and Social Care Systems Redesign

Andreea Bocioaga

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Introduction

This evidence summary seeks to address the following question relating to health and social care systems: *What are some successful models of system redesign in health and social care?*

About the evidence presented below

The evidence below reflects on some successful aspects of systems redesign in health and social care.

Accessing resources

We have provided links to the materials referenced in the summary. Some materials are paywalled, which means they are published in academic journals and are only available with a subscription. Some of these are available through The Knowledge Network with an NHS Scotland OpenAthens username. The Knowledge Network offers accounts to everyone who helps provide health and social care in Scotland in conjunction with the NHS and Scottish Local Authorities, including many in the third and independent sectors. You can register here. Where resources are identified as 'available through document delivery', these have been provided to the original enquirer and may be requested through NHS Scotland's fetch item service (subject to eligibility).

Where possible we identify where evidence is published open access, which means the author has chosen to publish their work in a way that makes it freely available to the public. Some are identified as author repository copies, manuscripts, or other copies, which means the author has made a version of the otherwise paywalled publication available to the public. Other referenced sources are pdfs and websites that are available publicly.

Background

This current evidence search was sparked by an inquiry into how models of social care can be redesigned to integrate prevention and community led support into the ways they deliver services. In order to understand health and social care redesign, let us consider what are the current operating models of social care.

In Scotland and the rest of the UK (and parts of the western world) most models of health and social care take an integrated approach to care.

World Health Organisation ([2016](#)) Integrated care models: an overview

A World Health Organisation report ([2016](#)) argues that there is no unifying definition or understanding of integrated care. This is partially because of the complex nature of integrated care.

The report argues that integrated care can be considered from several perspectives.

1. One is a process-based perspective. The process-based definition is used by many national governments to understand the different components of integrated care. A process perspective of integrated care focuses on a set of methods and models of funding, administrating and organising service delivery designed to create connectivity, alignment and collaboration. The aim of these processes are to enhance quality of life, to increase consumer satisfaction and system efficiency by cutting across services, settings and providers. This perspective has been criticised for its mechanistic focus.
2. Another conceptualisation of integrated care focuses on a user-led approach where users are involved in planning their care with people who work together (this definition was adopted by the UK Government). The focus is on understanding the user, their caring

needs and on putting them in control. Services then coordinate and deliver services to achieve the best outcomes for the service user.

3. Thirdly, there is a health system based definition. This definition acknowledges that integrated care is achieved through the alignment of all health system functions and effective change management. From this perspective, integrated health services delivery is defined as an approach to strengthen people - centred health systems.

In Scotland, integrated care was formalised with the Joint Board Act ([2014](#)). The Joint Board Act was intended to help shift resources away from the acute hospital system towards preventive and community-based services ([Audit Scotland 2018](#)). However, there is still a lack of agreement about whether this has been achieved in practice – or whether rising demand for hospital care means that more resources are needed across the whole system ([Audit Scotland, 2018](#)).

Moreover, health care systems are facing increasing complexity. Complexity is considered here in terms of one of the most commonly accepted notions—the interconnectedness of elements in a system ([Kannampallil 2011](#)). Interconnectedness refers to the influence of a system's components on each other. In this sense, complexity is relative: it increases with the number of components in a system, number of relations between them, and uniqueness of those relations. Integration in health and social care often means that all of the elements of care delivery have to be interconnected in terms of strategic aims, staff, financial decisions and service delivery.

Implicit in these definitions is the focus on the needs of individual families and communities. In practice, however, integration faces many challenges.

A Local Government Association ([2018](#)a) report highlights a range of the challenges experienced by current Health and Social Care systems when it comes to providing user focused goals, early intervention and preventative care. Some of these challenges are the result of:

- ## A focus on organisational performance

A Care Quality Commission (CQC) report in (2018)identified that currently, commissioning and performance management encourage organisations to focus on individual performance, rather than on working together to jointly improve service users outcomes.

Moreover, IPC (2018) found that often organisations have separate performance regimes and outcomes frameworks which encourage them to prioritise their own organisational performance rather than collaborate, even if this will not improve overall outcomes for individuals and populations. This leads to a narrow and eschewed focus that undermines the principle of "user led" integration.

- ## System leadership and organisational culture

The Care Quality Commission (2018) found that none of the systems they visited had a fully joint, system-wide accountability framework. This means leaders are not accountable for the outcomes of a wider system, beyond the accountabilities of their individual organisations.

Audit Scotland (2018) also suggests that many current HSCPs have a lack of collaborative leadership and strategic capacity. They have a high turnover in leadership teams. There are frequent disagreements over governance arrangements and often HSCPs are unwilling to safely share data with staff and the public. Local areas that are effectively tackling these issues are making better progress.

Audit Scotland (2018) also stresses that an appropriate leadership capacity to which all partners align with must be in place, and engaged with. The report advises that change cannot happen without meaningful engagement with a range of stakeholders like staff, communities and politicians. "At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland" (p 5).

- **Strategy**

Strategy is crucial to a successful and effective HSCP. Audit Scotland ([2018](#)) however, found that health and social care services have not linked the resources they have to their strategic priorities or longer-term plans. HSCPs still have work to do to ensure their priorities are linked to available resources, and to implement ways of working that are sustainable over the longer term.

Moreover, Local Government Association ([2018](#)a) highlights that some Local Authorities do not have detailed implementation/commissioning plans to inform their strategic plan. Of those which do, about half of these provide a link to resources. More needs to be done to show how the shift from the current ways of working to new models of care will happen and when positive changes to people's lives will be achieved.

Workforce planning is a particularly important element of strategic planning. IJBs need to work closely with their partners to ensure that their strategic plans for service redesign and improvement link with and influence workforce plans. Local authorities must be able to demonstrate what skills are required to ensure they can deliver services in the right place at the right time. Many HSCPs experience workforce planning and recruitment as a challenge as they struggle to recruit and retain the workforce. The contribution of the third and independent sector should be part of workforce planning ([Local Government Association 2018](#)a).

Moreover, it seems that councils and NHS boards are not treating IJBs' finances as a shared resource for health and social care. This is despite the requirement to do this in the legislation, and budget processes set out in integration schemes describing budget-setting based on need. Partners must work with the IJBs to establish an approach to financial planning that considers the priorities of health and social care in the local community. Councils and NHS boards can be unwilling to give up financial control of

budgets, and IJBs can struggle to exert their own influence on the budget-setting process (Audit Scotland, 2018).

Longer-term, integrated financial planning is needed to deliver sustainable service redesign. Nonetheless, HSCPs are struggling to balance between medium to long term planning, typically three to five years and five years plus, alongside annual settlements, current commitments and service pressures. Local Government Association (2018a) has called for longer-term financial planning in the health sector and local government for many years. This is a critical gap as the changes under integration are only likely to be achieved in the longer term (Local Government Association 2018a).

- ● **Health inequality**

Moreover, providing health and social care effectively is made more complicated by the complexity of health inequality. Oliver (2018) highlights that current social care funding models do not match population need. He argues that what we use in service delivery is an "inverse care law" first described by Julian Tudor Hart, whereby those most in need receive the poorest access to care. None of this aligns with national policy ambitions to prioritise prevention, reduce inequalities, and improve population health (Appleby & Deeming 2001).

Local Government Assocation (2018b) also highlights that health inequality is a systemic issue that cannot be tackled with small add-on interventions. To address unequal access to health and social care, an integrated poverty-reduction strategy is needed, tailored to specific places and communities that is cross-sectoral and addresses deprivation and inequality through authority-wide partnership. For example, programmes for poverty reduction should not focus only on housing provision or estate regeneration, but should include improved transport links, access to local services and amenities, and safer communities, all of which are important to creating better environments and reducing health inequalities.

NHS Confederation ([2016](#)) suggests that focusing on one part of the system is unlikely to solve system-wide problems. Approaches that examine how the system operates as a whole, based on outcomes for individuals using services and shared metrics, will encourage collective responsibility. It is important to redesign services around individuals' needs in relation to a specific place. This should combine to provide the best opportunities to improve people's health and wellbeing, including closing health inequalities, and helping to bring financial sustainability.

King's Fund ([2012](#)) found that the health and social care system gives too little priority to preventing illness and actively supporting people to live independent and healthy lives: "it is often the failure of these different elements to work together that is of greatest concern to patients and users. The traditional dividing lines between GPs and hospital-based specialists, hospital and community-based services, and mental and physical health services mean that care is often fragmented and poorly coordinated. Despite growing recognition of the benefits of holistic, patient-centred, team-based care and of generalism, as well as specialist knowledge, integrated care is the exception rather than the rule" (p.26). The report advises that transforming delivery means:

- enhancing the role of patients and users in the care team
- changing professional roles
- rethinking the location of care
- using new information and communication technologies
- harnessing the potential of new medical technologies
- making intelligent use of data and information

The evidence above highlights that place and locally embedded health and social care systems are essential to effective service delivery that is meaningful to the community and the individual. The argument for a place-based approach is that place is 'a magnet for partnership and the basis for stronger community participation' ([Scottish Government, 2011:10](#)). Yet, there is little evidence of place-based interventions that have achieved

improvements to public services, while reducing public spending (Bynner, 2016).

System redesign and transformation is often talked about as better integration. Evidence on systems redesign and transformation is often focused on those systems that are aligning the principles of integrated care with the processes of service delivery.

Below explores some case studies of successful system transformation in Health and Social Care where all of the aspects discussed above are essential.

Case studies

[Neylor and Wellings (2019) A citizen-led approach to health and care](#)

King's Fund conducted an independent evaluation of the redesign of health and social care in Wigan. Their report also includes the perspective of service users which adds further strength to the evidence presented.

Wigan Council is seen as a successful ongoing transformation in terms of how public health and care services are delivered. At the heart of the redesign is an attempt to strike a new relationship between public services and local people. The term that has been coined locally to encapsulate the new approach is the 'Wigan Deal'.

In practice, the redesign is characterised by an organisational culture that promotes accountability, risk and responsibility. Nonetheless, Wigan's move towards redesigning their health and social care delivery was spurred by a series of severe sector cuts.

Crucial to the success of the Deal seems to be a consistency of messaging and a buy-in to the goals of the Deal by both staff and the community. Central to the redesign of Wigan's care sector is a change in how public servants understand their role and a change in the relationship between the staff delivering services and those in receipt of services.

The Wigan Deal consists of the following key components:

- working with local people in an 'asset-based' way that seeks to recognise and nurture the strengths of individuals, families and communities and to build independence and self-reliance
- creating a culture in which innovation is encouraged and frontline staff are permitted to make decisions for themselves and rethink how they work

- empowering communities, including by investing in local voluntary sector organisations and community groups
- creating the conditions for closer partnership working between agencies

There are two key pivotal points in Wigan's journey of transformation. These are the area's involvement in two projects: Nesta's Creative Councils programme, and the Life Programme.

"Different Conversations"

Through the Creative Councils funding Wigan worked with an anthropologist. He introduced staff to ethnographic research methods which are about setting aside assumptions and preconceptions, and taking time to listen, to observe and to explore the world through the eyes of the person or people being studied. One of the pivotal moments in the early history of the Wigan Deal came when this group of social care professionals started adapting these techniques for use in their daily practice. This meant that social care professionals were using these skills to find out more about what people valued in life, asking them broader questions and having what became known as 'different conversations'. This then became the foundation for a wholly new approach, at first for adult social care, and subsequently for other public services.

The Life Programme

The Life Programme was targeted at families with complex needs, often in contact with multiple agencies but with little positive impact on their lives. As observed by a senior leader of Wigan Council: 'We were spending a fortune containing people's problems but sometimes not actually helping them to move on". The programme aimed to allow families to take greater control over their lives. They were assisted by professionals who would help participants to make their own plans and help them develop the ability to build positive relationships, to work, to be part of a community and to live a healthy life. By 2013, an evaluation of the Life Team's work was showing

positive results, including better outcomes for families. This success encouraged local political and executive leaders to consider a very different way of delivering services.

Outcomes and implications of the Deal

The Deal has been hailed a success, both for its improvement in user outcomes but also from a financial perspective.

The Wigan Deal has led to the introduction of new professional roles: social care officers that deal with less complex cases with no safeguarding responsibilities.

Some, however, have criticised the Deal for introducing extensive staff cuts disguised as personalisation.

The Wigan Deal also led to the launch of The Deal for Communities Investment Fund in 2013. The aim of the fund was to support community groups and projects across Wigan through small investments (up to £2,000), start-up investments (up to £10,000) and 'big idea' investments (more than £10,000).

Between 2013 and 2018, £10 million was invested through this route. The fund has stimulated a different way of working between the council and local community groups:

- A collaborative commissioning relationship

This is seen as a deliberate blurring of the purchaser–provider split. Interviews with voluntary sector leaders show that the change in approach had been noted and appreciated – they now saw the council as both a commissioner and a partner.

- Health Citizenship

As part of the Wigan Deal, the public health team developed what it refers to as a 'citizen-led' approach to public health. This was done to empower local people to lead health improvement activities through a number of roles,

including community health champions, young health champions, dementia friends and autism friends. This approach was about 'giving control back to local people', based on the reality that 'the lack of control many people experience in their lives is what leads to them being unhealthy'.

- Community link workers

Community link workers are a linchpin in Wigan's approach to health. They are local people with a detailed knowledge of their community, recruited to support people with the non-medical aspects of health. This includes providing health coaching to build people's confidence and their ability to take control of their health and wellbeing.

The Wigan Deals is hailed as a gold standard of a whole system redesign due to its success, both in reducing costs and in improving outcomes for service users. There are not many examples, however, of full system redesign. Nonetheless there are examples of service redesign in specific areas of health and social care. In 2018 a collaborative project between Association of Directors of Adult Social Services, the Association of Directors of Public Health, the Local Government Association, NHS Clinical Commissioners, the NHS Confederation and NHS Providers produced a series of reports highlighting several successful service transformations across England to improve people's health and care outcomes.

Local Government Association (2018) Integrating health and social care: Plymouth case study

Plymouth's Integrated Fund launched on 1st April 2015, pooling the city's budgets for Wellbeing, Children and Young People, Community and Enhanced services, for both local authority and Clinical Commissioning Group spend. At the same time, the local authority's adult social care staff transferred to the appointed integrated provider of adult health and social care, which started to see significant improvement in delivery in 2015/16.

In order to address the challenges posed by changing demographics and disparity of need across the health and wellbeing landscape, a whole system

approach was required which included access to improved housing, employment, education and skills. This 'one system, one budget, delivering the right care in the right place at the right time' approach enabled cross party support for the city.

The wellbeing strategy and accompanying action plan focuses on prevention and includes planned care. Plymouth also took the decision to weave mental health into all strategies rather than holding it separately to promote a 'No Health without Mental Health' approach across the health and wellbeing system.

The success of integration in Plymouth reflects the themes considered above around leadership, strategy and performance. Key elements of this involve:

- trust and relationships with a significant ongoing investment in joint organisational development
- clear shared vision: a purpose that was locally driven
- determined leadership overcoming barriers to deliver the vision
- the certainty that the single all-encompassing integrated fund was key to ensuring that everyone was motivated and engaged in delivering improved outcomes for the city

Joint strategic leadership was key and the relationship between the Director of Public Health, Strategic Leader for People and Chief Operating Officer for the Clinical Commissioning Group ensured that barriers were addressed swiftly. This was particularly apparent with the development of the Integrated Fund. Plymouth worked with Bevan Brittan to develop the financial framework and risk share arrangements. Where budgets couldn't legally be pooled they were aligned.

The Integrated Fund covers:

- public health
- leisure services
- housing services
- children's services

- adult social care
- primary care
- community health services
- acute provision
- running costs.

Livewell includes all primary health community-based services, excluding GPs and works closely with the voluntary sector within local communities. The city has continued to invest in preventative services, illustrating the city's vision that prevention is a key enabler to wellbeing and health improvements.

Plymouth has started more recently to implement Community Wellbeing Hubs. The Hubs will serve as flexible bases for the multi-disciplinary teams including primary health and social care where colleagues engage in social prescribing, hold case reviews, collaborative working and where the public can access information, advice and support.

Dougall et al (2018) Transformational change in health and care - Reports from the field, King's Fund

Bromley by Bow Healthy Living Centre is a health centre that focuses on the connection between social and physical health.

Factors that contributed to its success are its leadership and the focus on community led services.

Some of the challenges faced by the service were a strong opposition from an established healthcare system as it was going against established practices.

Overall, the model is heralded as a success as it challenged commissioners to think differently about quality and inspired new ways of regulating services based on quality rather than tick-box methods. For a health system that is accustomed to measuring outputs and targets, Bromley by Bow offers a different kind of challenge: How do we know if people are really healthier and

more productive in their lives? How can we measure the direct impact of its projects?

The model has been reproduced successfully in other areas as well - for example, the Robin Lane Health and Wellbeing Centre in Pudsey and others in Tower Hamlets. These attempts highlight that success is not achieved by following the exact format of the Bromley by Bow model - it is not possible to replicate the exact combination of circumstances, interpersonal relationships, entrepreneurship, that helped make Bromley by Bow deliver such transformational change.

Local Government Association (2018) [Integrating health and social care: Croydon case study](#)

Another area heralded for its success in service redesign is Croydon. The One Croydon Alliance is a partnership of health and social care organisations including Croydon Council, Croydon Clinical Commissioning Group, Croydon GP Collaborative (representing vast majority of local GPs), Croydon Health Services NHS Trust, the South London Maudsley NHS Foundation Trust, and Age UK Croydon. This partnership is underpinned by the overarching Croydon Council priorities of early intervention, prevention and place based working.

In 2014, the Council and Clinical Commissioning Group decided to establish an outcome-based commissioning approach for people aged over 65. They undertook an extensive engagement exercise with local people to agree local outcome priorities which are summarised in the five 'I statements' below:

- I want to stay healthy and active for as long as possible
- I want access to the best care available in order to live as I choose and as independent a life as possible
- I want to be helped by a team or person that has had the training and has the specialist knowledge to understand how my health and social care needs affect me
- I want to be supported as an individual with services specific to me

- I want good clinical outcomes

Croydon's process of redesign is characterised by a careful step-by-step approach and evaluating impact at each stage.

Croydon is already seeing the benefit of two new models of integrated care. The first model made up by multi agency teams called 'huddles' - meet weekly at the GP surgery to plan the care of people with complex needs to reduce the risk of hospital admissions. The second focuses on promoting independent living for older people through reablement, rehabilitation, and rapid response delivered seamlessly by an integrated team of social and health care professionals operating out of a single building with one budget.

Central to Croydon's success are also strong leadership and commitment to the goals at every level. This has led to a new approach to commissioning characterised by each agency working towards a shared performance management framework to ensure that shared objectives are being realised and risks are jointly identified and mitigated. This overcomes some of the challenges of having different performance measurements across agencies.

Nonetheless, Croydon is experiencing ongoing challenges as a result of IT systems that don't talk to each other, inflexible employment rules, different rules on information governance, separate regulatory systems and trying to manage the transformation while doing the day job.

By April 2018 the new, integrated ways of working have been expanded across the whole of the health and social care system, taking a whole population approach.

King's Fund (2015) [Intentional whole health system redesign: Southcentral Foundation's 'Nuka' system of care](#)

Southcentral is widely regarded as one of the most successful examples of health system redesign in the United States and internationally. Like the NHS, Southcentral is a state-funded health system, with a large proportion of its resources coming from taxation. In the mid-1990s, it faced many of the

challenges that NHS organisations are currently seeking to address. It therefore seems to be a relevant case study for local organisations embarking on system-wide redesign.

Southcentral's transformation began when it was given control of a single budget and responsibility for a broad range of services for its population. It delivered transformation entirely 'from within' rather than as a response to top-down performance management, competition or changes to payment systems.

Southcentral provides an example of orderly and intentional whole health system redesign, starting with careful consultation with the community, and followed by the development of objectives and principles that inform the service delivery model and allocation of resources, rather than rushing to solutions or attempting simply to copy blueprints from other systems.

Low scale transformation

[Dundee Sources of Support (SOS) social prescribing and community referral scheme](2012)

Dundee SOS is a scheme offered to patients who present to their GP with low mood and other indicators of poor mental health. It gives people the chance to access non-medical, community-based support. It was developed by a small working group. The group included representatives from: the Healthy Living Initiative Maryfield Medical Centre, Dundee health and employability scheme, 'Discover Opportunities'. Patients are offered the opportunity to talk confidentially, to a link worker, and can speak at length about the causes of their poor mental wellbeing. They are then supported to access local activities and services that will help to address their specific circumstances. Services range from practical help with issues like debt, benefits and legal advice, to help dealing with the consequences of these issues, including social isolation and low confidence.

[Dougall et al (2018) Transformational change in health and care Reports from the field, King's Fund](#)

Birmingham - transformation in A&E and emergency service, integrating psychiatric help

Birmingham A&E created a model of care that attempted to address clinical needs, and to help the acute and mental health trusts with their performance and financial concerns. This multi-focused approach enabled them to get senior buy-in. The model brought together three aspects of mental health care:

1. needs around acute mental health issues
2. the ward challenges and
3. substance misuse, predominantly alcohol, and acknowledging that acute hospitals struggled with alcohol.

The group decided that a pilot study would give them an opportunity to test their hypothesis and find out whether the new model would have the anticipated impact on quality, timeliness and efficiency of care in acute hospitals. One interviewee described the importance of this clinical and academic approach: 'I realised that we had to have data to prove the worthiness of the project and what we want to achieve. From the clinical point of view I set the clinical processes, how we're going to see the patient and all these kinds of things. From the academic point of view, I set up the datasets, the questions and the process of collecting this data'. They worked with academic colleagues and built an evaluation model containing a range of parameters in the three key areas that they needed to see impact: quality, cost and activity. They included capability in this system to link these measures for financial modelling – for example, costs associated with length of stay, and thus cost reductions. They also included measures of staff and patient experience, which the group found invaluable.

Conclusion

The evidence above highlights some of the key elements that are essential for HSCPs to deliver user-focused, preventative and community-based care.

King's Fund (2019) report details the elements of a system redesign (page 7). It argues that radical changes involve the emergence of an entirely new form/structure, often prompted by a shift in what is considered possible or necessary, which results in a profoundly different structure, culture or level of performance (Ackerman 1997). The King's Fund has carried out research which suggests that successful transformational change in health and care is more likely to happen when a number of enabling conditions are in place, as listed below (Dougall et al 2018).

- Transformation is often emergent 'from within' and led by frontline staff and service users, rather than being imposed by external pressures such as national targets.
- Transformation requires collaborative styles of leadership in which power and responsibility are distributed across the system, and with relationships that cut across boundaries.
- Transformational change in health and care systems is often organic, with strategic goals emerging over time rather than in advance, albeit transformations are often guided by a core purpose that is constant.
- Learning and adapting are a critical part of the process of transformation and organisations need to have the right data and skills to be able to change direction when necessary.
- Significant time is often required to allow new relationships to be built and for trust to be established before transformation can take place.

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