The Strategy Unit.

Rapid Evidence Scan

Integrated Care

April 2016

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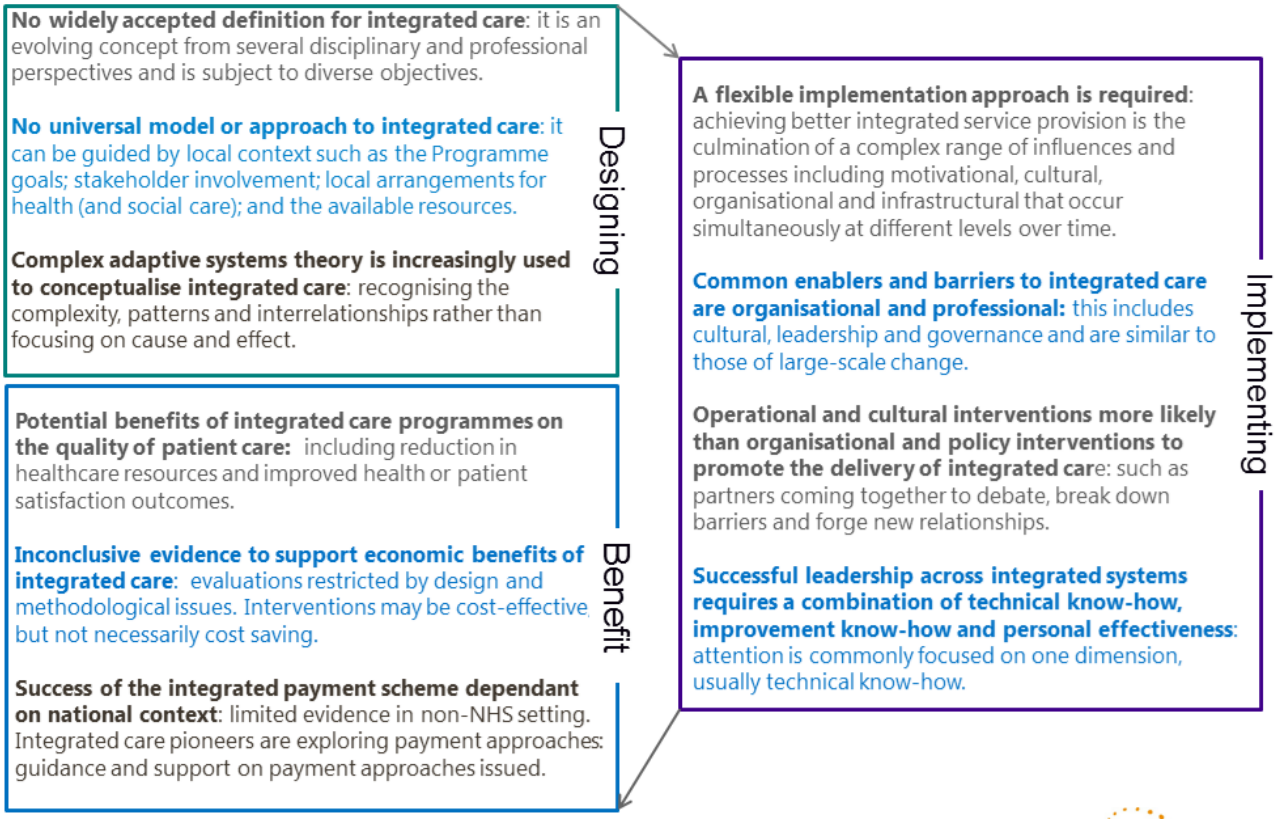
Contents

Summary


No widely accepted definition for integrated care: it is an evolving concept from several disciplinary and professional perspectives and is subject to diverse objectives.
No universal model or approach to integrated care: it can be guided by local context such as the Programme goals; stakeholder involvement; local arrangements for health (and social care); and the available resources.
Complex adaptive systems theory is increasingly used to conceptualise integrated care: recognising the complexity, patterns and interrelationships rather than focusing on cause and effect.
Designing
Potential benefits of integrated care programmes on the quality of patient care: including reduction in healthcare resources and improved health or patient satisfaction outcomes.
Inconclusive evidence to support economic benefits of integrated care: evaluations restricted by design and methodological issues. Interventions may be cost-effective but not necessarily cost saving.
Success of the integrated payment scheme dependant on national context: limited evidence in non-NHS setting. Integrated care pioneers are exploring payment approaches: guidance and support on payment approaches issued.
Benefit
A flexible implementation approach is required: achieving better integrated service provision is the culmination of a complex range of influences and processes including motivational, cultural, organisational and infrastructural that occur simultaneously at different levels over time.
Common enablers and barriers to integrated care are organisational and professional: this includes cultural, leadership and governance and are similar to those of large-scale change.
Operational and cultural interventions more likely than organisational and policy interventions to promote the delivery of integrated care: such as partners coming together to debate, break down barriers and forge new relationships.
Successful leadership across integrated systems requires a combination of technical know-how, improvement know-how and personal effectiveness: attention is commonly focused on one dimension, usually technical know-how.
Implementing

Introduction

Context

Integrated health and social care is considered to help improve the efficiency, quality and continuity of service delivery, thus leading to improved service user experiences and outcomes. The case for integration is reinforced by the need to develop whole-system working to address demands from an ageing population and increased prevalence of multimorbidity (Ham and Walsh, 2013). Within England, the Five Year Forward View (NHS England, 2014) is driving integration and place-based systems. Depending on the context, programmes are driven by a need to contain cost, to improve care, or often by both (Nolte and Pitchforth, 2014). Ham and Walsh (2013) suggest a step-change focusing on whole system working involving not only health and social care but also other services that influence the health and wellbeing of communities.

Defining Integrated Care

There is currently no widely accepted definition for integrated care (Armitage et al., 2009; Antunes and Moreira, 2011; Nolte and Mckee, 2014) which is often used interchangeably with concepts such as co-ordinated care, collaborative care and case management. Nolte and Mckee (2014) suggest this confusion arises from several disciplinary and professional perspectives and from diverse objectives. The NHS Confederation (2016) suggests a shift in focus from structures to patients: "The term 'integrated care' is frequently used to describe the structure of service providers, but to be meaningful it should instead be used to describe the provision of care that is coordinated around the needs of the individual".

Taxonomies and conceptual frameworks

There have been several attempts to develop a taxonomy that would enable systematic assessment of the structures and processes involved, prerequisites, effects on healthcare organisation and delivery, and user outcomes (Nolte and Mckee, 2008). The most common taxonomies differentiate:

- Type of integration (functional, organisational, professional, clinical);
- The breadth of integration (vertical or horizontal);
- The degree of integration (from linkage to full integration) ;
- The process of integration (structural, cultural, social).

Shaw et al (2011) describe five main types of integration:

1. Systemic – coordinating and aligning policies, rules and regulatory frameworks;
2. Normative – developing shared values, culture and vision across organisations, groups, individuals;

3. Organisational – coordinating structures, governance systems and relationships across organisations;
4. Administrative – aligning back-office functions, budgets and financial systems;
5. Clinical – coordinating information and services and integrating patient care within a single process.

Shaw et al (2011) refer to three additional types of integration referenced in the literature: informational; financial; and professional.

Others have categorised integration into levels - Ham and Curry (2011) describe three levels of integration:

- Macro Level – care across the full spectrum of services to populations e.g. Kaiser Permanente;
- Meso Level - care for a particular group of people with the same disease/condition e.g. older people;
- Micro Level - care for individual service users/carers through co-ordination, care planning etc.

Macadam (2011) highlights the significance of frameworks: "local or regional integration models should include framework features but combined in ways that are appropriate to the goal(s) of reform and local contextual features of care". Macadam found that the Hollander and Prince framework to be most developed, as it includes more features and depicts the linkage relationships among health and social care sectors. The three parts of the framework look at:

- Philosophical and policy prerequisites that underlie on-going support for those with disabilities;
- A set of best practices for organizing service delivery;
- A set of mechanisms for coordination and linkage across organizations and professionals.

Evans et al (2013) identified 14 categories of strategic approaches to integration, providing a meaningful set of concepts for high-level comparisons and tracking of strategies over time. The 14 categories are structured using four strategy content questions to reflect on current practice and to guide discussions and interactions:

1. Which organizations and services are targeted for integration?
2. What are the desired outcomes of integration?
3. How will integration be achieved?
4. When, where, or for whom does integration add value?

A recent report (Goodwin et al, 2014) highlights the conceptual framework developed by Valentijin et al (2013) which aims to improve understanding of the inter-relationships among various dimensions of integrated care:

- System integration
- Organisational integration
- Professional integration
- Clinical integration
- Functional integration
- Normative integration

Another emerging theory used to conceptualise integrated care is complex adaptive systems (CAS) thinking. The Health Foundation (2011) describes complex adaptive systems in its most simple form as a way of thinking about and analysing things by recognising complexity, patterns and interrelationships rather than focusing on cause and effect. Tsasis et al (2012) suggest adopting a CAS lens contributes to different ways of thinking about not only the healthcare system as a whole, but also the patient journey, the role of leaders, and the very process of integrating care. Tsasis et al (2013) recognise that the system is more than the sum of its parts, due to the focus on interdependencies between agents, sub systems and other systems, reporting on a study using outcome mapping to create a shared vision and roadmap.

Measuring and evaluating integrated care

- The evaluation of integrated care needs to include qualitative and mixed methods approaches that facilitate understanding of which integrative processes work, for whom, and in what circumstances.
- Many evaluations of integrated care programmes are starting to include some of the main elements identified in the literature as crucial for a successful integrated care organisations including; leadership, culture, governance, information and information technology, financial and contractual mechanisms, patient focus, and service and care model design.
- Conceptual frameworks can be used to guide evaluation, and assess inter-relationships among the dimensions of integrated care.
- Complex adaptive systems (CAS) thinking is an emerging theory used to conceptualise integrated care recognising the complexity, patterns and interrelationships rather focusing on cause and effect.
- Hospital use and costs are not the only impact measures, improvements in care process can be used as proxy measures.
- Patient reported measures of outcomes for integrated care programmes are important, however it is acknowledged that there is development needed as many existing measures are not totally applicable to integrated care.
- It is important to realise that planning and implementing large-scale service changes take time.

Integration is hampered by the lack of standardised, validated tools to evaluate implementation and impact (Armitage et al., 2009). Most of the literature reporting outcomes is based on perceived rather than objectively measured impact. Evaluations have typically focused on organisational and administrative integration with little assessment of outcomes (Shaw et al., 2011).

Shaw et al (2011) have adapted work by Strandberg-Larsen and Krasnik, listing existing methods used:

- Audit of medical records
- Analysis of registers data on hospitalisation rates
- Analysis of administrative datasets on hospitalisation rates compared to individually matched controls
- Self-assessment form for managers
- Annual surveys and disclosure reports, and financial data
- Questionnaire survey for managers and clinical leaders

- Qualitative interviews with hospital executives
- Interviews, web forms and workshops with service coordinators
- Questionnaires, interviews and focus groups with staff and managers

Shaw et al (2011) suggest that the evaluation of integrated care needs to include qualitative and mixed methods approaches that facilitate understanding of which integrative processes work, for whom, and in what circumstances. The evaluation of the North West integrated care pilot used a mixed methods approach, focusing on eight key objectives of the pilot were selected as the main elements identified in the literature crucial for a successful integrated care organisation (Curry et al, 2013). The mixed methods evaluation assessed the implementation and impact of the pilot against the following objectives:

- Establish governance structures for the pilot following a 'network approach';
- Align financial incentives across all organisations;
- Bring about cultural change and create a shared vision;
- Improve patient experience;
- Facilitate information sharing;
- Shift care out of hospital;
- Reduce emergency admission to hospital; and
- Improve care processes and clinical outcomes.

The Advancing Quality Alliance (AQuA) Integrated Care Discovery Communities also use key domains identified for integrated care to assessed integrated care; Fillingham and Weir (2014) report on the Advancing Quality Alliance (AQuA) Integrated Care Discovery Communities which have created an eight-domain framework to provide some structure and starting points to tackle the barriers to integrated care at system level, which incorporates:

- Service and care model design
- Workforce
- Information and information technology
- Financial and contractual mechanisms
- Governance
- Culture

- Service user and carer engagement
- Leadership

AQuA have also used these eight domains to create an Integrated Care Framework Assessment Tool to enable health economies to assess their current level of readiness in relation to the introduction of integrated care approaches as well as a tool to measure progress over time across the key enablers. Participants score themselves on a range from a 0 (low) to 5 (high) on their self-assessed capability level across each of the eight domains.

Although some evaluations of integrated care programmes are starting to incorporate devised lists of key principles of integration, international evidence suggests such elements are not commonly evaluated; a recent meta-review by Martinez-Gonzalez et al (2014) found that whilst the literature has identified a number of barriers and facilitators associated with delivering successful integrated care, many of these elements of integration are rarely assessed. The analysis of 27 systematic reviews assessed a list of ten key principles of integration (Suter et al, 2009). Most reviews covered 'comprehensive services across the care continuum' or 'standardization of care through inter-professional teams', but 'organizational culture', 'governance structure' or 'financial management' were rarely assessed.

Naylor et al (2015) report the use of shared metrics is a key feature of partnership working in the two areas covered by Northumbria Healthcare NHS Foundation Trust – Northumberland and North Tyneside. Eight system-wide metrics have been agreed with progress monitored through a bi-monthly integration board meeting involving commissioners, NHS providers and social care. The eight system-wide metrics are:

- total bed days;
- non-elective admissions in the last 100 days of life;
- hospital admissions for ambulatory care-sensitive admissions;
- patient health status (assessed using the EQ-5D tool);
- experience of co-ordinated care (patient- and carer-reported);
- ability to self-manage care;
- provision of anticipatory care plans;
- care home admissions.

A number of researchers make the case to include patient reported measures of outcomes for integrated care programmes. Mason et al (2014) state that evaluations should seek to consistently measure a range of effects and costs, including the routine assessment of unintended

consequences and barriers to implementation, as well as patient-reported measures of outcomes (PROMs) and experience (PREMs). This is echoed by National Voices (2013) who highlight a number of measures from the patient perspective:

- Patient Activation Measure (PAM);
- Patient Reported Outcome Measures (PROMs);
- Patient Experience Measures.

However, there are some risks as these measures have been designed and developed for use in relation to single episodes of care, usually in specific care settings, such as a consultation with a GP, or following a surgical treatment in hospital (National Voices, 2013). In the 2014 annual report on the progress of the integrated care pioneers NHS England (2015) recognise the need to develop a common language around measuring the impact on people's experience of care and their health and wellbeing.

From their experience of evaluating integrated and community-based care service models Bardsley et al (2013) consider the following points useful to consider when developing and implementing innovations and thinking about how to assess impact or commission a formal evaluation:

- Recognise that planning and implementing large-scale service changes takes time;
- Define the intervention clearly and what it is meant to achieve and how, and implement it well;
- Be explicit about how the desired outcomes will arise, and use interim markers of success;
- Generalisability and context are important;
- If you want to demonstrate significant change, size and time matters;
- Hospital use and costs are not the only impact measures;
- Pay attention to the process of implementation as well as outcome;
- Carefully consider the best models for evaluation;
- Work with what you have: organisation and structural change may not deliver outcomes.

Goodwin et al (2014) acknowledge that they experienced difficultly in trying to provide an overall comparative assessment of the success of the seven case study programmes because of the variation in the types of evaluations. The authors found there was a lack of robust evaluations suggesting this may be because:

- Evaluation is a secondary concern to service delivery. Not all programmes set out to prove or measure whether the service innovations they put in place worked.

- Evaluations are methodologically very complex and causality of effectiveness is hard to attribute.
- Lack of available data, and/or work to translate data into information to monitor outcomes.
- Lack of formal evaluation of impacts using controls, beyond process evaluations and data on professional and user views.
- No governance imperative and/or link to pay for performance to collect data to demonstrate performance.
- Professional resistance to use of hard measures of performance in an approach that relies on others to deliver and on the participation of patients.

Reflecting on how success is measured, particularly in relation to avoiding overly optimistic timeframes and outcomes, Wistow et al (2015) caution against the temptation to over-promise in the enthusiasm to get stakeholders on board. There is also a balance to be struck in demonstrating some progress to keep patients and communities engaged which could be helped by co-designing more patient-centred outcomes. Formative evaluation can help programme teams to form a view on what's working well and what isn't.

Reported outcomes

- In general the evidence shows beneficial effects of integrated care programmes on the quality of patient care, including reduction in healthcare resources and improved health or patient satisfaction outcomes, however much of the evidence base consists of small scale evaluations of local initiatives, and few including comparative designs.
- The evidence base around the economic benefits of integrated care is less clear - there is a paucity of robust evidence on the economic impacts of integrated care however it is not always possible to conduct a randomised control trial in the context of integrated care and thus many of the evaluated interventions report methodological issues.
- Evidence suggests a minimum of 3 to 5 years is needed to demonstrate an impact on health service activity. Consequently, longitudinal studies are needed to see if integrated care is realised over time.
- Interventions may be found to be cost-effective but not necessarily cost saving as the intervention can identify substantial unmet needs.

Effectiveness

Integrated care programmes seem to have positive effects on the quality of patient care (Ouwens et al., 2005; Martinez-Gonzalez et al., 2014), including hospitalisation; adherence to guidelines and compliance with medication; functional health status; patient satisfaction; and quality of life. Few reviews report evidence of reduced costs or of harm to patients (Martinez-Gonzalez et al., 2014).

There are also gaps in the research literature with few studies reporting objective measures of the impact of integration; instead perceived impacts of integration (obtained via questionnaires and surveys) constitute the majority of literature reporting outcomes (Armitage et al., 2009). Hwang et al (2013) explored the association between integrated healthcare delivery systems and changes in cost and quality, finding evidence of improvements in quality of care with respect to clinical effectiveness, lengths of stay, medication errors, and the number of office visits; however, there was little evidence on the impact of integrated care systems on cost of care. There is emerging evidence (Cameron et al., 2014) to suggest that joint working can lead to improvements in health and well-being and can reduce inappropriate admissions to acute care or residential care, but this tends to come from small scale evaluations rather than larger scale research.

Results from the sixteen Department of Health-funded integrated care pilots (ICPs) initiated in 2009 were reported by the RAND Corporation in 2012; the evaluation found fewer planned admissions (4% decrease, 21% in sites using case management) and outpatient visits (20% decrease, 22% in sites using case management) but increased emergency admissions (2% increase, 9% in case management sites). The evaluation however highlights the heterogeneity across the pilot sites making it difficult to generalise conclusions.

The work of a later ICP has been reported by the Nuffield Trust (2013) and Curry et al (2013). Formative evaluation showed some early evidence of improvements in diabetes care process and an increase in dementia case finding. Reductions in emergency admissions were not demonstrated during the first year; however, the authors noted it may be too early. Lessons from the evaluation later in the programme (Wistow et al., 2015) are shared in Lessons for successful integration.

Notably, whilst operating at scale offers some efficiencies, there are costs and tensions in the added complexity of, for example, additional governance structures, which should be acknowledged. A key message is the emphasis on system change, acknowledging that a focus on specific interventions or services can risk missing opportunities to effectively address wellbeing and prevention.

Lessons from the Nuffield Trust (2013) stress international evidence suggests a minimum of 3 to 5 years is needed to demonstrate an impact on health service activity. Similarly, the King's Fund report that successes seen in leading areas have only been achieved after several years of sustained effort, and the authors warn there is a need for realism regarding the pace of implementation, and the necessity of doing the 'ground work' before embarking on a process of transformative change (Naylor et al, 2015).

Most recently NHS England (2015) has reported on the Integrated Care and Support Pioneers programme that was launched in December 2013. The 2014 annual report shows that in the first year the pioneers are showing how integrated care, albeit not yet at significant scale, can improve their communities' health and experience of care. Small scale evaluations of the pioneers have shown reductions in use of healthcare resources (hospital (re)admissions, A&E attendances, and length of stay), reductions in care home admissions, and increased patient satisfaction with their care and feeling supported to manage their own health. Small savings have been reported for some pioneers with some pioneers presenting higher projected savings e.g. through more effective case management, each WELC (Waltham Forest, East London and the City) borough expects net savings of between £8m and £17m by 2017/18 through reducing emergency admissions.

Recent evidence (Sheaff et al, 2015) suggests that integration is an important enabler for patient centred care and continuity of care, working more effectively than less formal networks and offering a number of benefits, including:

- establishing accountability for co-ordination and continuity;
- facilitating patient transfer across boundaries;
- co-locating services;
- helping to resolve information governance issues;
- formalising relationships and ways of working;

- joining up the workforce;
- reducing administrative burdens and management costs;
- aligning overall goals and incentives;
- pooling income thus reducing perverse incentives around income allocation.

Cost-effectiveness

A literature review by Turning Point (2010) found evidence to suggest that integrated care can be cost effective, however future studies need to consider long term financial benefits: "many of the studies that concluded that integrated care is not cost effective were often conducted over relatively short time periods, and many of the benefits of integration will accrue as individuals remain independent well into the future" (Turning Point, 2010). More longitudinal studies to capture the financial benefits accrued over time would help address this.

A more recent economic review of systematic reviews by Nolte and Pitchforth (2014) found that utilisation and cost were the most common economic outcomes assessed by reviews but reporting of measures was inconsistent and the quality of the evidence was often low. The review reports some evidence of cost-effectiveness of selected integrated care approaches but the evidence base remains weak. The authors pose an important question when considering the outcomes of integrated care programmes as to whether integrated care is a complex strategy to innovate and implement long-lasting change or an intervention that ought to be cost effective and support financial sustainability; Nolte and Pitchforth (2014) propose that the evidence strongly points to the latter.

Currently, there is mixed evidence on the impact of integrated care in delivering sustained and long term reduction in hospital use (Mason et al, 2014), with some concerns as to the quality of the methodologies used in some studies. There is contention (Naylor et al., 2015) as to whether the growth of out-of-hospital care will translate into reductions in bed numbers in acute hospitals. This research on five case study sites in England - where acute hospital providers have engaged actively with the integration agenda - found a strong consensus among the hospital leaders that radically reducing the number of beds in acute hospitals in the short or medium term was not a realistic prospect. Naylor et al (2015) suggest integrated service models have provided a means of managing growth within existing bed capacity and this reduces commissioners' ability to realise 'cashable' savings in the short or medium term.

It is important to consider that a given intervention may be found to be cost-effective but not necessarily cost saving (Nolte and Pitchforth, 2014; Mason et al., 2014). Mason et al (2015) challenge the assumption that integrated care and integrated budgets will deliver savings, pointing out that integrated care may reveal (rather than resolve) previously unmet needs, thus initially

increasing demand. However, if integration improves quality of life, there are opportunities to improve value for money: "This does not mean that policy makers should disregard the potential of integrated finance, but rather that expectations should be realistic and careful research should be planned. […] If integrated funds are to be a model for the future, attention needs to focus on how they can be implemented in practice and it will be important not to underestimate the efforts required to forge and to maintain the relationships that underpin the financial mechanisms." Mason et al (2014) recommend that decision makers need to recognise that there may be trade-offs between different objectives, both in the short and longer term.

Lessons for successful integration

Approaches, enablers and barriers

- It is widely accepted there is no single model or approach to integrated care that can be applied universally - the approach taken will be guided by local context: goals of the project; stakeholders involved; existing local arrangements for health (and social care); and available resources.
- Common enablers and barriers to integrated care include: organisational issues; cultural, leadership and governance; and professional issues.
- Many of the barriers and facilitators to integrating care are those of any large-scale organisational change including issues relating to leadership, organisational culture, information technology, physician involvement, and availability of resources.
- Achieving better integrated service provision is the culmination of a complex range of influences and processes that occur simultaneously at different levels over time - the process requires a balance of activities which attend to motivational and cultural as well as organisational and infrastructural factors.
- Approaches to integrated care take time and require a flexible approach as many programmes are likely to involve an evolutionary process.
- Pay schemes are not widely reported, however a small European literature review suggests that the success of the payment scheme depends on the details of the specific implementation in a particular country, proposing that a blended payment scheme may overcome the barriers of each individual scheme and facilitate the integration of chronic care.

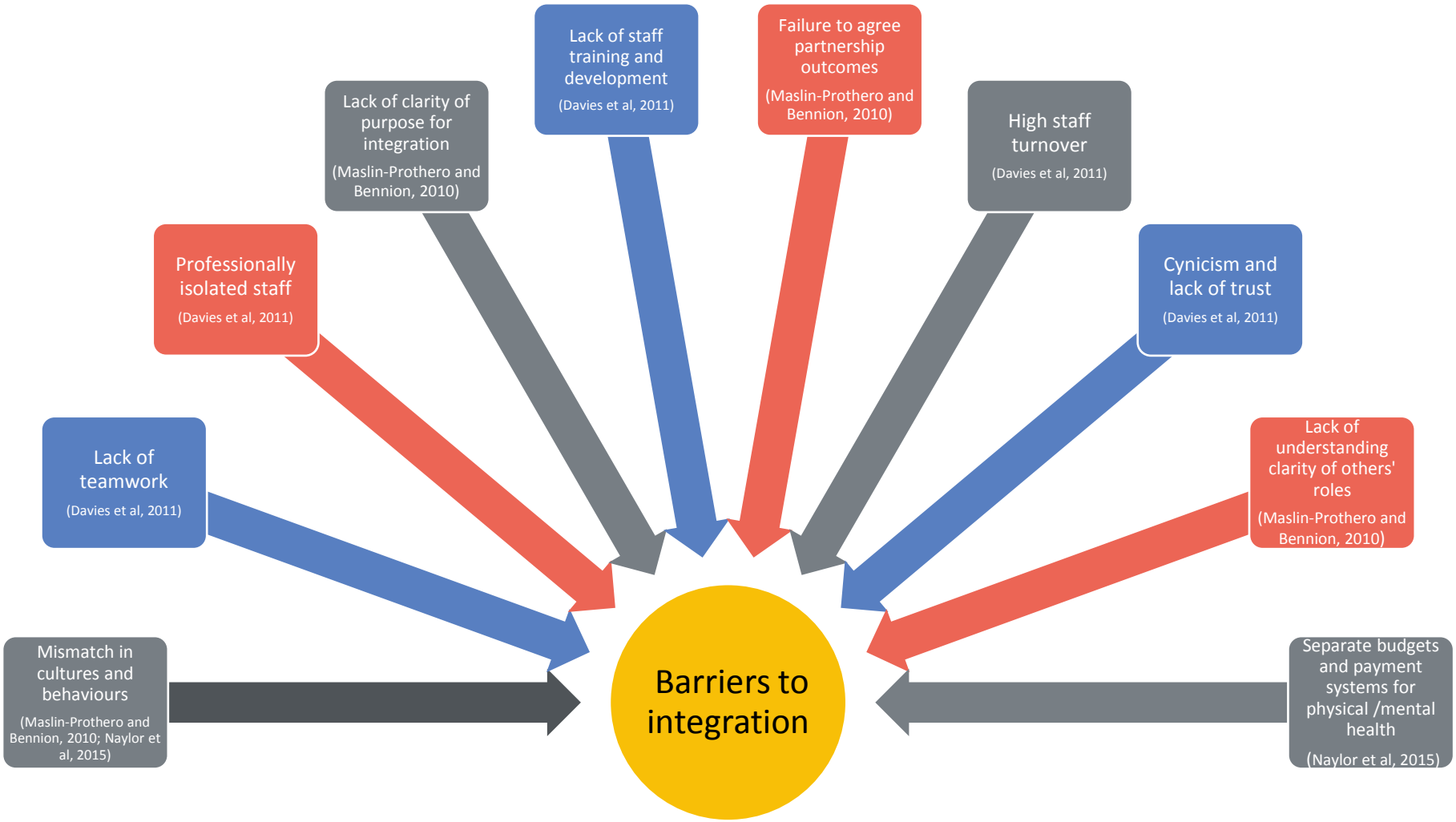
Macadam (2011) states integrated care is a process through which health policy goals can be accomplished; it is not an end in itself, and the approach taken depends upon the policy goal and the local context of service delivery relationships. This is a view Shaw et al (2011) share; decisions will be guided by the goals of the project, the stakeholders involved, existing local arrangements for health (and social care) and the available resources.

Consequently, Shaw et al (2011) suggest that the type of integration required is likely to vary and they propose that the following additional considerations are needed when thinking about how to integrate:

- some types of integrative process will be more important than others;
- the interplay between different types of integration can influence the value that can be secured; and
- integrative processes can have unintended effects.

Whilst a universal model to integrated care does not exist the literature contains a number of important lessons regarding barriers and facilitators of successful integration. Ham and Walsh (2013) outline sixteen key steps needed for a successful integrated care service:

1. Find common cause with partners and be prepared to share sovereignty
2. Develop a shared narrative to explain why integrated care matters
3. Develop a persuasive vision to describe what integrated care will achieve
4. Establish shared leadership
5. Create time and space to develop understanding and new ways of working
6. Identify services and user groups where the potential benefits from integrated care are greatest


Lack of staff training and development
(Davies et al, 2011)
Failure to agree partnership outcomes
(Maslin-Prothero and Bennion, 2010)
Lack of clarity of purpose for integration
(Maslin-Prothero and Bennion, 2010)
High staff turnover
(Davies et al, 2011)
Professionally isolated staff
(Davies et al, 2011)
Cynicism and lack of trust
(Davies et al, 2011)
Lack of teamwork
(Davies et al, 2011)
Lack of understanding clarity of others' roles
(Maslin-Prothero and Bennion, 2010)
Mismatch in cultures and behaviours
(Maslin-Prothero and Bennion, 2010; Naylor et al, 2015)
Barriers to integration
Separate budgets and payment systems for physical /mental health
(Naylor et al, 2015)

7. Build integrated care from the bottom up as well as the top down
8. Pool resources to enable commissioners and integrated teams to use resources flexibly Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector
9. Recognise there is no 'best way' of integrating care
10. Support and empower users to take more control over their health and wellbeing
11. Share information about users with the support of appropriate information governance
12. Use the workforce effectively and be open to innovations in skillmix and staff substitution
13. Set specific objectives and measure and evaluate progress towards these objectives
14. Be realistic about the costs of integrated care
15. Act on all these lessons together as part of a coherent strategy

The international literature provides important lessons regarding integrated care processes; a review of the literature emanating from the PRISMA (Program of Research to Integrate Services for the Maintenance of Autonomy) project, from Quebec shows that there are two key themes of interest to health policy-makers, project implementers, and researchers (Stewart et al.,2013):

- The importance of context (designing programs with an eye to local context); and
- Building in dynamism and adaptability.

A number of researchers have summarised important lessons learned by thematically categorising the barriers and enablers. For example Cameron et al (2014) categorise factors that promote and hinder integrated working between health and social care services into three main categories:

- Organisational issues:
  - Aims and objectives
  - Roles and responsibilities
  - Organisational difference
  - Communication and information sharing
  - Co-location

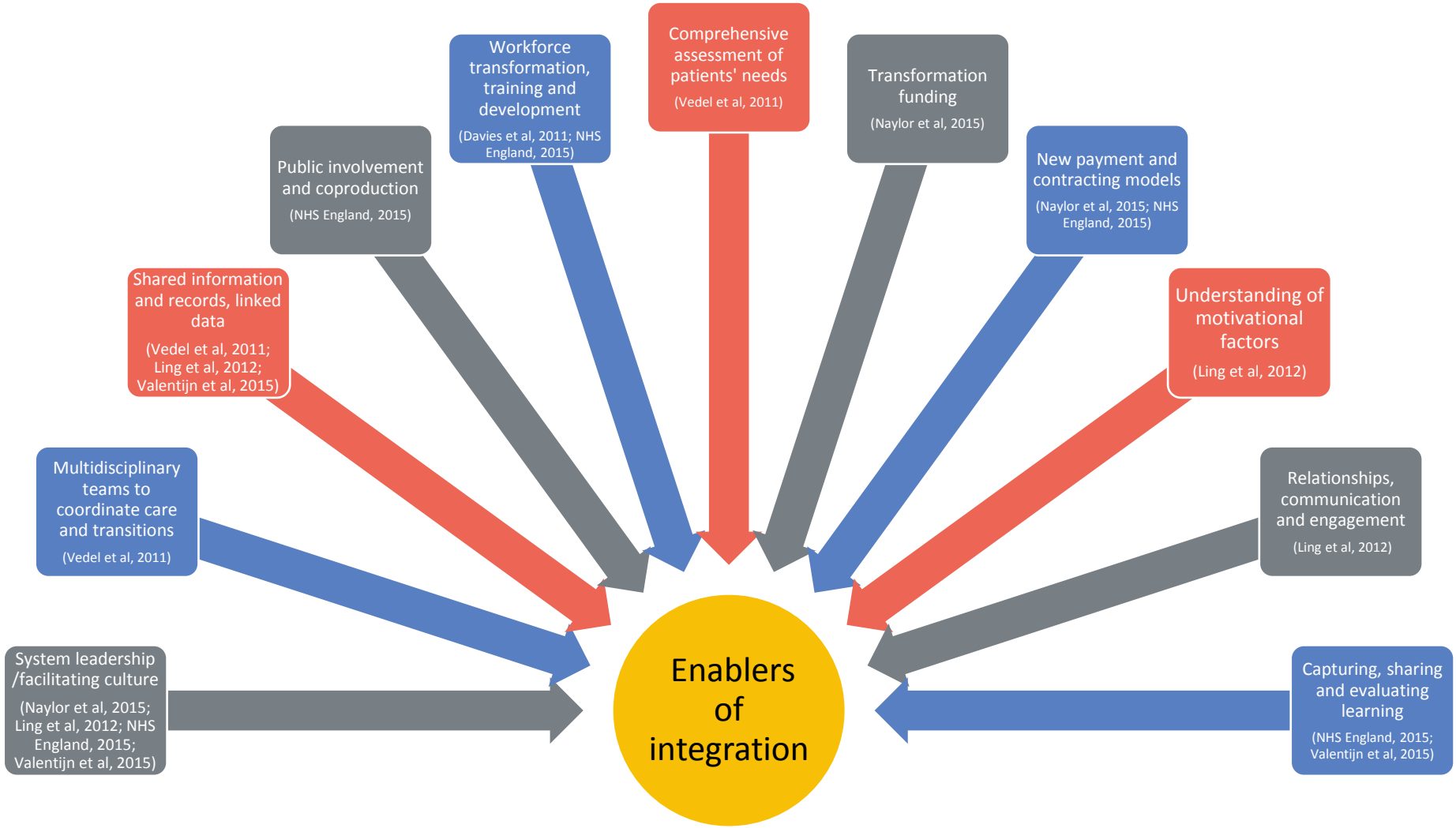
  - Strong management/appropriate professional support
  - Past history of joint working
  - Adequate resources
- Cultural/professional issues:
  - Different professional philosophies, ideologies
  - Trust, respect and control
  - Team building, team meetings and joint training
- Contextual issues:
  - Relationships and reorganisations
  - Financial uncertainty

Other thematic categorisations include that from the Association of Directors of Adult Social Services (ADASS) (2013) categorised by: organisation; culture, leadership and governance; and professional issues. More recently the King's Fund has recognised that achieving better integrated service provision has been the culmination of a complex range of influences and processes that occur simultaneously at different levels over time (Goodwin et al, 2014). Goodwin et al categorise key lessons for the successful adoption of integrated care according to a conceptual model of integration:

- System level
  - Recognise the importance of addressing this agenda of integrated care for frail older people.
  - Provide stimulus through funding or other means to support the development of local initiatives to improve care for this group of people.
  - Avoid a top-down policy that requires structural or organisational mergers.
  - Remove barriers that make it more difficult for localities to integrate care, such as differences in financing and eligibility.
- Organisational level
  - There is no single organisational model or approach that best supports integrated care.
  - The starting point should be a clinical/service model designed to improve the care that is provided rather than an organisational model with a pre-determined design.

  - It takes time for approaches to integrated care to develop and mature, with most programmes constantly evolving.
  - Fully integrated organisations are not the (end) goal.
- Functional level
  - Success appears to be related to good communication and relationships between those receiving care and the professionals and managers involved in delivering care.
  - Greater use of ICT is potentially an important enabler of integrated care, but does not appear to be a necessary condition for it.
  - Building relationships to support integrated care requires time to build social capital and foster trust.
- Professional level
  - Professionals need to work together in multidisciplinary teams or provider networks – generalists and specialists, in health and social care.
  - Within teams, professionals need to have well-defined roles, and work in partnership with colleagues in a shared care approach.
  - Patients with complex needs that span health and social care may require an intensity of support that is beyond what primary care physicians can deliver.
- Service level
  - A number of common elements in the design of the care process at a service level appear to be important. These include:
    - holistic care assessments;
    - care planning;
    - a single point of entry;
    - care co-ordination;
    - the availability of a well-connected provider network that can facilitate access to the necessary support, particularly for self-management.
- Personal level
  - All case studies had a specific focus on working with individuals and informal carers to support self-management.

- Continuity of care and care co-ordination to meet individuals' specific needs is important and highly valued.
- Personal contact with a named care co-ordinator and/or case manager is more effective than remote monitoring or telephone-based support.


Enablers of integration
Comprehensive assessment of patients' needs (Vedel et al, 2011)
Workforce transformation, training and development (Davies et al, 2011; NHS England, 2015)
Public involvement and coproduction (NHS England, 2015)
Shared information and records, linked data (Vedel et al, 2011; Ling et al, 2012; Valentijn et al, 2015)
Multidisciplinary teams to coordinate care and transitions (Vedel et al, 2011)
System leadership /facilitating culture (Naylor et al, 2015; Ling et al, 2012; NHS England, 2015; Valentijn et al, 2015)
Transformation funding (Naylor et al, 2015)
New payment and contracting models (Naylor et al, 2015; NHS England, 2015)
Understanding of motivational factors (Ling et al, 2012)
Relationships, communication and engagement (Ling et al, 2012)
Capturing, sharing and evaluating learning (NHS England, 2015; Valentijn et al, 2015)

Tsiachristas et al (2013) performed a literature review to explore payment schemes to promote integrated chronic care in Europe. Three payments schemes were explored (pay-for-coordination, pay-for-performance, and a single bundled payment used for all multidisciplinary care required by a patient or particular chronic disease during a predefined period of time) and the authors identified five countries that had implemented such payment schemes to promote the integration of chronic care on a national level; Austria, England, France, Germany and the Netherlands. Pay for coordination schemes were evident in Austria, France, and Germany; pay-for-performance in England and France; and bundled payment in the Netherlands. The authors found that while each payment scheme was unique they often experienced similar facilitators and barriers to their adoption and implementation.

A recent report from the Health Foundation (2016) has highlighted the need for stronger workforce planning in healthcare policy and strategy. The report suggests that workforce planning has focused on "hard" interventions and measures, such as performance management and productivity, neglecting the "softer" areas such as motivation, work-life balance and engagement which can have a significant impact on service outcomes. Priority recommendations include tackling staff shortages and developing new roles to deliver transformed health care. A joint report from RCGP/RCP (2016) highlights the opportunity of joining up training and development across primary and secondary care, giving examples of:

> *"The Tower Hamlets diabetes MDT service runs shared educational sessions between consultants, GPs, practice nurses, dieticians, diabetes specialist nurses and a diabetes psychologist. The consultant in the Sunderland dermatology service provides quarterly education sessions for GPs and other primary care staff in common dermatological ailments and treatments, as a means to ensure proper referral into both this service and hospital care."*

There have been some explorations of the implications of integrated care for particular patient groups. For example, Naylor et al (2016) suggest that integrated care programmes to date have typically focused on physical health thus missing an opportunity to deliver truly patient centred care, which considers the relationship between physical and mental health. Their report recommends new approaches to training and development to create "a workforce able to support integration of mental and physical health". Kossarova et al (2016) recommend a population view to assess the needs of children and young people, with design focused around the work by National Voices on how 'good, coordinated, integrated care' should look (National Voices and Think Local Act Personal, 2015).

Advocating a place-based approach to designing and delivering care, Ham and Alderwick (2015) argue that inherent "fortress mentality", an unintended consequence of perverse system incentives, is a barrier to addressing increasing demand. A collaborative approach will enable a concerted effort to address wider determinants of health and to tackle the prevention agenda. There are also

benefits from joined up planning and implementation, such as sharing skills, partnerships with third sector and independent organisations and development of new care models. The report calls for more strategic and integrated commissioning, based on long term planning, capitated budgets and the use of outcomes based contracts to deliver real change. 10 design principles are proposed:

1. Define the population group served and the boundaries of the system.
2. Identify the right partners and services that need to be involved.
3. Develop a shared vision and objectives reflecting the local context and the needs and wants of the public.
4. Develop an appropriate governance structure for the system of care, which must meaningfully involve patients and the public in decision-making.
5. Identify the right leaders to be involved in managing the system and develop a new form of system leadership.
6. Agree how conflicts will be resolved and what will happen when people fail to play by the agreed rules of the system.
    a. Develop a sustainable financing model for the system across three different levels: the combined resources available to achieve the aims of the system
    b. the way that these resources will flow down to providers
    c. how these resources are allocated between providers and the way that costs, risks and rewards will be shared.
7. Create a dedicated team to manage the work of the system.
8. Develop 'systems within systems' to focus on different parts of the group's objectives.
9. Develop a single set of measures to understand progress and use for improvement.

Learning from practice and experience

- Operational and cultural changes may be more likely than organisational and policy interventions to directly contribute to the delivery of integrated care.
- Evaluation of the approach to integration can be a valuable leadership development intervention; generating debate among partners, exchanging information, testing assumptions and coming together to develop a shared understanding of needs and strength across the community partners has helped leaders to break down barriers and forge new relationships.

- Successful leadership across integrated systems requires: technical know-how (service design, governance arrangements, innovative contracting and financial mechanisms, technological 'savvy'); improvement know-how (systems thinking, improvement science, large-scale change); and personal effectiveness (interpersonal skills and behaviours, coaching ability, a visionary and participative style).
- Areas where more substantial progress has been made, acute hospital leaders have invested considerable time and energy in building relationships with general practice. Particular support is needed for leadership in primary care.
- Experience reports the importance of clinician led integration at the clinical and service level, with support from managerial colleagues.
- Integration requires collective leadership enabling shared ownership and responsibility for the success of the whole organisation. Care should be taken to resist oversimplifying discussions regarding MCPs and PACS models as being a binary choice between 'primary care-led' and 'hospital-led' integration.
- There is a growing recognition of the value of seeing integration through the lens of Complex-Adaptive Systems (CAS) theory, moving away from a focus on organisational structures and towards an emphasis on the role of relationships and interactions in shaping change efforts; as such, cultural similarities and differences, learning and sense-making processes, and the voices of patients and their caregivers take on more central importance.

One of the most significant recent evaluations, of the North West London programme, (Wistow et al., 2015) shared a number of key findings:

- substantial investment in design and planning lay the groundwork for a series of early adopter projects;
- some fading of the clarity around the vision as the programme evolved, with confusion about how the programme aligned with other initiatives, highlighting the value of a 'single narrative for change';
- a shift from the comprehensive system-wide ambition to, in practice, more of a focus on services around the acute-community interface, reflecting national priorities (admissions avoidance) and local enablers;
- a bias towards health service concerns, arising from a predominantly NHS-funded model, suggesting missed opportunities to tackle the prevention agenda and to fully engage with public health;

- clear leadership, governance and management helped to champion the change and build credibility;
- involvement of patients, service users and carers added significant value to the design stage;
- variable levels of engagement amongst clinicians and frontline staff, suggesting a need to address key problems which frontline staff face on a day to day basis, to make a difference on the ground;
- the balance of providing support and standardisation whilst allowing local autonomy (for the early adopter projects funded through the programme) is difficult to achieve in practice;
- barriers to implementation which can only be addressed at national level, e.g. information governance; the need for a different style of leadership to enable collaborative working (system leadership) and the need for more support to develop the associated attributes and behaviours.

Calciolari and Ilinca (2011) analysed four established integrated care programmes (from the USA, Canada, Italy and Switzerland) recognised as successful and established to identify key success factors and the extent to which they can be considered transferable. The analysis found the four cases represent different paths to success. Joint approaches to case management, frequent patient monitoring, individualised care plans standard assessment instruments were found to be common across all cases but different specific factors were considered to be relevant to the attainment of successful outcomes e.g. integration of funding, joint care planning, co-location of services. Essentially, this highlights the importance of local context in shaping goals, and thus, paths to success: "mere technical intensity of integration is not a guarantee of success, rather, positive outcomes depend on the correct matching between operating means and the contextual, cultural and organisational factors present in each setting". The authors propose the main lesson learnt is that an overarching success factor is acknowledging the complexity of integration in healthcare and designing solutions accordingly.

Nicholson et al (2013) identified ten elements necessary for integrated primary/secondary health care governance across a regional setting, also indicating specific interventions shown to be effective for each element:

- Joint planning
- Integrated information communication technology
- Change management
- Shared clinical priorities
- Incentives

- Population focus
- Measurement – using data as quality improvement tool
- Continuing professional development supporting the value of joint working
- Patient / community engagement
- Innovation

Naylor et al (2015) report that while several areas have succeeded in agreeing a shared strategic plan supported by all of the main local partners, implementation can be more challenging. The authors emphasise that the different roles and responsibilities have to be clarified, and that there is a tendency for some acute hospital providers to assume that they will be leading the development of integrated models of care. Naylor et al (2015) observed that in some areas this provider assumed leadership could deter GPs and other community providers from engaging.

Naylor et al (2015) found that one of the most significant challenges has been engaging primary care within whole-system governance structures. In areas where more substantial progress has been made, acute hospital leaders have invested considerable time and energy in building relationships with general practice. Most progress has been made when acute hospitals have been able to frame their offer to primary care in terms of helping to lift some of the pressure off GPs. The authors identify a number of facilitating factors:

- direct contact between senior hospital leaders and general practitioners (GPs), for example, through regular practice visits, or via engagement with GP federations where these exist;
- a history of joint working between the acute trust and primary care;
- strong clinical leadership in general practice;
- telephone advice lines for GPs staffed by acute hospital staff;
- employing people with a primary care background at a senior level within the acute provider;
- joint educational sessions for GPs and consultants;
- working groups including primary and acute care professionals as part of local programmes on integrated care
- inviting feedback from GPs by email on pathways developed by consultants
- 'going with the energy' – for example, piloting new care models with one or two supportive practices before extending the offer to others.

Naylor et al (2015) also highlight a number of practical measures that can help in overcoming the barriers between acute and community services:

- establishing effective internal governance systems that support integration across business units;
- creating opportunities for interaction and mutual learning between acute and community professionals;
- developing job roles that span acute and community settings;
- using tangible service changes and early wins to demonstrate to staff the benefits of integrated models of care for patients.

There is also a need to improve relationships between primary care and social care (Glasby and Miller, 2015) which can be hampered by low awareness of roles and responsibilities and limited opportunities for engagement. Fillingham and Weir (2014) report on development work, undertaken by the Advancing Quality Alliance (AQuA) and The King's Fund which has adopted a 'discovery' approach to developing integrated care and the leadership capabilities supporting it. AQuA's eight domain Integration System Framework enables health economies to assess current levels of readiness as well as a tool to measure progress over time. The authors suggest that this process in itself has been an important leadership development intervention; generating debate among partners, exchanging information, testing assumptions and coming together to develop a shared understanding of needs and strength across the community partners has helped leaders to break down barriers and forge new relationships (Fillingham and Weir, 2014).

Fillingham and Weir (2014) also highlight the fact that leading across complex interdependent systems of care is a new and different role that needs to be undertaken alongside the already difficult task of leading successful institutions. Reference is made to West et al (2014), who make the case for collective leadership enabling a shared ownership and responsibility for the success of the whole organisation. Based on experience of five case study sites in England where acute hospital providers have engaged actively with the integration agenda Naylor et al (2015) recommend collective leadership, bringing together acute sector leaders with other providers and commissioners: "acute hospital leaders should avoid pursuing integrated care through unilateral action, but instead should invest time in building a consensus with local partners". The research by Naylor et al (2015) found that where collective system leadership is most advanced, this has been the culmination of relationship-building activities that have taken place over several years. Developing the necessary trust and a common understanding of the future has been a long journey in all of the case study sites, requiring sustained commitment and effort.

Naylor et al (2015) make reference to the models under the Five Year Forward View, warning that care should be taken to resist oversimplifying discussions regarding MCPs and PACS models as being a binary choice between 'primary care-led' and 'hospital-led' integration suggesting this is unlikely to foster the collective forms of system leadership that are needed.

The Discovery Community developed a framework for the knowledge and skills needed for successful leadership across integrated systems: including technical know-how (service design, governance arrangements, innovative contracting and financial mechanisms, technological 'savvy'); improvement know-how (systems thinking, improvement science, large-scale change); and personal effectiveness (interpersonal skills and behaviours, coaching ability, a visionary and participative style). Fillingham and Weir (2014) suggest that in order to become genuinely integrated there is a need to pay attention to all three dimensions. In reality, the authors suggest that leaders are often drawn to one or other of the dimensions and rarely all three. Fillingham and Weir (2014) highlight the need for effective interpersonal skills and the need for need for conceptual frameworks and practical tools offered by improvement science when working across systems of care.

Fillingham and Weir (2014) provide ten lessons for developing system leaders based on their review of the literature, and more specifically on three years' experience working with members of the AQuA Integrated Care Discovery Community:

1. Build the will to develop a new cadre of system leaders;
2. Adapt and apply the principles of complexity science and of leading large-scale change;
3. Adapt and apply the principles of improvement science;
4. Support the development of many system leaders at multiple levels within the system;
5. Have a place-based focus;
6. Develop effective mechanisms for handling conflict;
7. Build a virtuous triangle of new leadership roles, supported learning and effective governance;
8. Simultaneously develop system leaders and the system for developing system leaders;
9. Be patient, persistent and resilient; and
10. Measure impact.

Naylor et al (2015) report the following key characteristics of effective system leadership for integrated care:

- Taking a wider role in the local health system and accepting shared responsibility for the sustainability of the local health economy.
- Promoting collective leadership within and between organisations, creating a culture of collaborative working across the hospital and with external partners.
- Shifting from a hierarchical focus ('looking upwards') to a place-based one ('looking outwards').

- Agreeing shared metrics of success with local partners and mutual accountability.
- Taking a role in public health, prevention and wellbeing.
- Fostering relationships with local partners capable of sustaining collaboration alongside competition.

Naylor et al (2015) also highlight the importance of clinician led integration at the clinical and service level , with support from managerial colleagues: "Strong clinical leadership is often needed to overcome 'professional inertia' and resistance to change – something that was seen as a very real barrier in some of our case study sites". Their research found that a high level of clinical involvement in strategic leadership, and clinical ownership of the integrated care agenda specifically, was seen to be a critical enabler. Particular support is needed for leadership in primary care, and suggest acute hospital leaders have a role to play in supporting primary care leadership and, where necessary, facilitating the development of federations.

Evans et al (2013) warn that the shift in relative emphasis from context and organisational structures to operational activities and cultural issues does not imply that structural modification is however unnecessary. Similarly, modifications to governance, funding and accountability are usually necessary, but not sufficient for achieving integration. Furthermore, Evans et al (2013) believe that the failure of many early attempts at integration may have fuelled growing recognition of the value of seeing integration through the lens of Complex-Adaptive Systems (CAS) theory. Evans et al suggest there is a growing belief that integration strategies involving community-based partnerships, operational and cultural change, quality and patient-centred goals, and targeted patient populations may be more effective than, or may increase the effectiveness of, more traditional integration methods. Evans et al (2013) suggest replacing top-down control with mechanisms supporting dialogue, experimentation, and collaboration from the bottom-up maximize potential for the system to coevolve and self-organize in ways that positively impact performance.

Experience from the NHS integrated care pioneers (NHS England, 2015) has shown first year advances have been built on collaborative working between national and local agencies, including:

- Pioneer assemblies;
- Establishment of a pioneer support group;
- Senior sponsorship.

The New Care Models programme within NHS England has looked to learning from international models including the Southcentral Foundation's 'Nuka' model in Alaska (Collins, 2015):

> "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.
>
> Southcentral's leaders invested personally in defining their vision, mission and corporate goals, and in communicating these throughout the organisation. Employees across Southcentral genuinely understand its objectives and ethos and are able to use them as a frame of reference in their daily work.
>
> These initial investments helped Southcentral to develop a coherent model for how it delivers services, based on building sustained relationships between health care staff and their patients and delivering holistic, person-centred care.
>
> [...]
>
> Southcentral's leaders argue that its success cannot be attributed to a single part of the system. Instead, it requires continued effort across these multiple dimensions (vision, values, the operating model for services, supporting infrastructure, and workforce development) to sustain high performance at scale and over time."

Numerous other case studies are available which share the vision, implementation and learning from across the NHS and further afield:

- The Kings Fund maintain an interactive map of new models of integrated care in practice: http://www.kingsfund.org.uk/topics/integrated-care/integrated-care-map.
- Links to the New Care Model Vanguards can be found at: https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/
- The long term conditions year of care commissioning programme case studies can be found at: http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/ltc-year-of-care-commissioning-model.aspx
- Case studies focusing specifically on joining up physical and mental health can be found in a recent King's Fund report (Naylor et al, 2016).
- Case studies focusing specifically on services for children and young people can be found in a recent Nuffield Trust report (Kossarova et al, 2016).

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