

## Delivering Integrated Healthcare in the Community: Understanding the Opportunities of a Radical New Model

Managing the healthcare needs of an aging population has necessitated a fundamental rethink in where and how healthcare is best delivered in England. Burgeoning demand for the management of long-term conditions, principally cardiovascular disease, diabetes, dementia and cancer, is leading to widely acknowledged problems in both funding and delivery.

This increased demand is manifested in problems such as 'bed-blocking,' where patients who require less acute care cannot be discharged from high-cost hospital facilities because there is no suitable alternative. Increased focus has been placed on accelerating patient discharge, and on avoiding hospital admissions in the first place. However, in light of the demographic changes, a more radical approach is required.

Healthcare commissioners are being encouraged by politicians and policymakers to design and develop, by 2018, an integrated healthcare system which would combine community-based healthcare and social care under one commissioning and provision structure. The 2012 healthcare reforms, which established more than 200 Clinical Commissioning Groups (CCGs) to drive decision-making down to the community level, increase local accountability and facilitate more coherent and cost-effective healthcare choices for the patient, will support this goal.

The challenge facing NHS, private sector and not-for-profit providers of healthcare services in England is how to reconfigure their capabilities to succeed in this new environment.

The current system is disjointed, with healthcare and social care commissioned and funded from different sources. Healthcare funding has typically been directed at acute NHS facilities, in which a large number of specialist services and patients are clustered, and at primary care. Social care has largely been funded by local councils, which commission everything from supported living to meals for the elderly.

In effect, the configuration and incentives inherent in the current system shape existing business models and make it more difficult for patients to be cared for in the most clinically appropriate and lowest cost setting – be that at home, in a local care facility, a GP clinic, or indeed in a hospital.

### Reshaping Healthcare in the Community

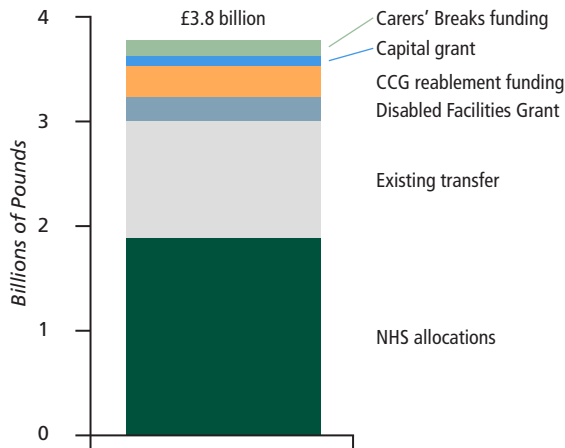
Recognizing this problem, the government is calling for improved integration of healthcare and social care services. In a policy statement released in early 2013, the Department of Health acknowledged: 'These services often don't work together very well. For example, people are sent to hospital, or they stay in hospital too long, when it would have been better for them to get care at home.'

To stimulate and accelerate the growth of community-based healthcare, £3.8 billion has been allocated to promote integrated care services, including £2.7 billion for local councils 'to help them join up NHS and social care services.' As an

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Figure 1

Breakdown of Funding for the Integration Transformation Fund (2014/15)



Source: NHS England; NAO Case Study on Integration 2013

added incentive, £1 billion of this funding is to be paid once local results are achieved. This Integration Transformation Fund will come into effect in 2015/16 (see Figure 1).

Successfully and widely implemented, integrated community-based care offers hospitals the potential to relieve the burden of increasing demand, reduce readmission rates and manage costs more effectively, giving them greater flexibility to reconfigure their services around their areas of strongest capability; it also offers patients greater scope to be treated and supported at home or in other local settings, which surveys show many would favor.

The challenge is how to build a more cohesive system that enables an increasing number of patients to receive an integrated blend of healthcare and social care delivered in the community, rather than in a hospital. Healthcare providers in the public, private and not-for-profit sectors are not currently configured or organized to deliver the scale and type of care when and where it is needed. The industry needs to reorganize to respond to this need, seeking new and innovative approaches to strategic partnering and contracting.

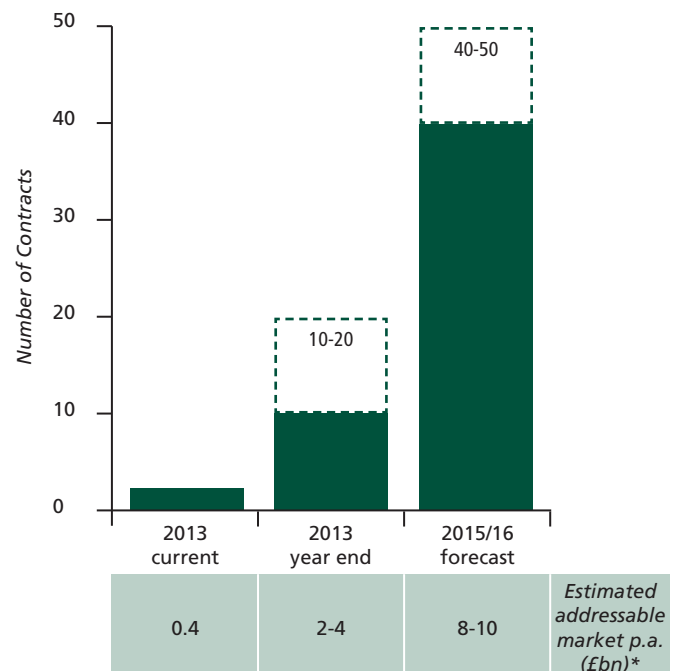
## A Substantial New Opportunity

Integrated care models are nascent and the lack of funding for them to date has resulted in limited experience of designing solutions and operating in this paradigm. However, there is some evidence that business models are emerging – for example, Care Plus Group is an employee-owned social enterprise described as a ‘fully integrated health and social care provider’ with c. £25m revenue from providing a wide range of services.

The scale of the market opportunity justifies potential providers allocating intellectual and financial resources to determine how best to engage. By 2015/16, L.E.K. estimates that there will be 40-50 contracts for integrated care services, worth £8-10 billion annually (see Figure 2). That figure covers spending on all forms of community care for the elderly, including residential care, domiciliary care, complex care, community nursing, tele-healthcare and palliative care. This is all publicly funded and may also offer providers exposure to a growing pool of private funding flows. L.E.K. expects CCGs to favor

Figure 2

Expected Implementation of Public Elderly Contracts



Note: \* Estimate based on Cambridgeshire tender, scaled by average population per CCG  
Source: HM Treasury, NHS, L.E.K. interviews and analysis

capitated models, with many contracts for extended periods of five years or more, embracing the full spectrum of community health and social care, although not always in the same contract at the same time.

Commissioners are still relatively inexperienced and have no established framework for how to structure and commission integrated community-based care packages. As a result, they are actively looking to providers to help design and implement innovative solutions.

Recent tenders in Oldham and Cambridgeshire give some indication of the opportunities available. Oldham's tender covers a broad array of services for the elderly, including community nursing, early discharge, respiratory services and palliative care. This is typical of the shift towards tendering a wide range of integrated services, thereby addressing many of the likely needs of a community. Cambridgeshire's tender is also a sign of things to come: it seeks to implement a delivery model in which providers receive outcome-based incentives according to the quality and effectiveness of care they give to the elderly. Both contracts provide a clear indication that commissioners are looking to providers to propose innovative partnership and delivery models, and demonstrate the opportunity for providers to influence the shape of new services.

To realize the potential of integrated community care and achieve potential efficiency gains, new contracting and delivery models will have to be replicated across the country – it is no longer a question of if, but how fast, where, and with whom these changes will be implemented.

## The Benefit of Early Mover Advantage

Integrated community-based care clearly represents a substantial – and immediate – opportunity, but at this early, experimental stage, it is understandable that many service providers are wary of the uncertainties. These uncertainties include the structure of contracts, the unpredictability of cost profiles, the nature of services to be commissioned, the lack of data, the role of partnerships, the delivery risks, and how to mitigate these risks. Extended duration, high-value contracts offer some certainty, but they may also present an additional

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barrier for organizations with a lack of experience, or who are unable to act as prime contractor, or who have had limited or no exposure to partnering for complex service delivery.

Both commissioners and existing providers are open to new solutions and L.E.K. believes that there is ample

scope for innovative providers to configure services in ways that can be clinically successful and economically viable. In our view, the advantages of early engagement outweigh the merits of waiting for others to make the initial running.

We also advise careful consideration regarding the engagement model. Most organizations need to evaluate what services they should deliver themselves and which are better provided by other parties. This suggests that each participant needs to determine the role of strategic partnerships in their tendering approach and the basis on which those partnerships will be structured. The agreement recently announced between Circle and Capita for the purpose of bidding for NHS contracts is an example of new collaborative approaches. Existing public sector providers also offer excellent potential for partnerships.

Service providers operating in this market will have to make significant adjustments to meet the growing need for integrated, community-based care, both in terms of the services they offer and the way in which they will be contracted. This will require a major shift, challenging providers at a fundamental level that many will find unsettling.

At present, most care providers contract and deliver services they control on a bi-lateral basis to the payor, within clearly defined risk parameters. In the future, lead contractor/sub-contractor models or multi-lateral partnership/consortium models are more likely to be required given the breadth of service delivered. Furthermore, the risk parameters are less well-defined, with the expectation that providers will be asked

to assume different and potentially hard to quantify types of risk with an increased emphasis on measurement of outcomes for initially uncertain rewards. In a recent series of interviews conducted by L.E.K., 90% of commissioners said outcomes would be an important or very important part of their future commissioning criteria.

The scope of services offered by providers may need to change in order to secure their participation. For example, NHS trusts may need to reconfigure their community nursing capabilities, requiring substantial investment at a time when resources are already stretched. Private hospital groups may be less affected given the elective nature of many of their procedures, though community-based admission-avoidance programs could impact referral patterns. Domiciliary care providers could stand alone as core service providers, partner with nursing services or develop nursing capabilities themselves to offer a fully controlled 'integrated service.' Mental health service providers with a strong clinical base of expertise may want to develop services to provide community-based outreach support. Finally, not-for-profit organizations may need to broaden their service proposition, obliging them to attract significantly more funding or develop strategic partnerships to maintain their role and influence.

In addition, organizations need to consider the implications of patient empowerment and how this impacts the need to provide more of a 'consumer experience.'

## A Risk Worth Taking

Many providers are understandably wary of entering this substantial but uncertain market until they have more conclusive evidence of which approaches and business models are likely to succeed. There are significant business risks and there is also the worry that a future government might change course, perhaps even dismantling the system in which CCGs are responsible for commissioning services.

L.E.K. believes that the strategic rewards of early involvement over the next one-two years will justify the risks. Early adopters will gain invaluable experience in how to reconfigure their business models and will build a significant head start in

## Understanding and Accepting the Risks and Uncertainties

Questions to consider when approaching the integrated care opportunity:

### Market Requirements

- Which care services are needed at the local level, and in which settings? What are the funding sources for these services? What is the optimal model for delivering them?
- How would political changes affect this market?

### Capabilities

- What are our core skills in this area? If we lack particular capabilities, can we build them or should we collaborate with those who already have them? What sort of organizations should we partner with?
- Do we have the requisite skills in areas such as public-sector contracting, managing partnerships with other providers, risk modeling and actuarial analysis?
- Do we want to contract with patients directly? If so, would this require that we build a consumer brand?
- What is the role of assistive technology in delivering community healthcare efficiently?

### Risk and Value

- Do we understand the nature and scale of the investment required to succeed in this space?
- What is our appetite for risk? Do we have a sufficient grasp of the economic, regulatory and operational risks of expanding into this area?
- When and how should we enter this market? Should we wait until there is greater clarity, or are there significant first-mover advantages?
- What contractual models are CCGs likely to favor? If their preference is for capitated contracts, how will this affect our risk exposure?

identifying the most innovative CCGs and choosing the best provider partners. Their hard-earned track record, outcomes-based data sets and experience will validate them in the eyes of commissioners.

Providers have the opportunity to create integrated solutions and become long term strategic partners to other providers and commissioners, which should in turn improve the quality of earnings from this market.

One thing is clear: structural change in the English healthcare system is already occurring and providers need to reposition themselves now to take advantage of the opportunities. In the current environment, doing nothing is a choice in its own right.

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