Integration of Health and Social Care by 2020
Oliver Wyman Perspectives

MARCH 2017
Executive Summary

• An analysis of international best practice, and a review of current Health and Social Care integration across England, shows that limited progress has been made, and on current trajectories, Local Health Economies (LHEs) will not deliver the Government objectives by 2020.

• Financial incentives are used internationally to drive integration. Best practice is to introduce reward and risk in defined stages, based on the capability, maturity and ambition in integration of each accountable organisation. Financial incentives are only successful when appropriate enabling foundations are in place; an these include for example: aligned set of local data, actuarial understanding of ‘should be’ costs, safeguarding to ensure quality, new models of care operating on the ground, aligned incentives for all to meet.

• Discussion with a number of LHEs highlights the major challenge of building trust and sharing data effectively. A limited understanding of ‘what good looks like’, and sporadic leadership capability to drive integration are impeding progress. There is a lack of clarity and accountability on the outcomes expected of LHEs.

• A small number of LHEs (10%) exhibit readiness to take the step to integration. The remaining 90% are still some way from this objective. The system needs to take a segmented approach, giving greater autonomy to the leaders while encouraging incremental progress for the broader 90% of economies.

• There is strong evidence that a central team providing clear vision, goals and standards is required, with control of overall incentives for LHEs. This team needs to tailor this approach to match the level of maturity of each local system and focus on building an environment that encourages and holds systems to account as opposed to delivering on the ground implementation. Separately, incentives are needed to encourage those with first hand experience of implementing integration to play an active coaching role with those who are less advanced.

• For more than 90% of LHEs, incentives should be provided for getting the foundations in place and for incremental improvements in outcomes. For more advanced LHEs, financial risk and gain sharing structures, underpinned by transparent actuarial analysis of shared data, should provide the incentive.
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## APPENDIX

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A  What good looks like and where we are at today
Summary of findings
What good looks like and where we are at today

An analysis of international best practice, and a review of current Health and Social Care integration across England, shows that limited progress has been made, and on current trajectories, Local Health Economies will not deliver the Government objectives by 2020

- The government’s ambition is to achieve meaningful integration of health and social care, in all areas, by 2020
  - The primary focus must be on the patient, and those making the patient’s day to day care decisions, to achieve a shift in patient experience and to reduce acute costs, by providing proactive and coordinated care

- International best practice emphasises six enabling components necessary to achieve effective integrated care across today’s health system, including: Incentives to deliver integrated care; Committed leadership; Patient-centred models of care; Transparent data and interoperable technology; Patient-driven workforce capabilities; and a Collaborative culture
  - Effective incentives require a detailed, shared understanding of the population, well defined cost and quality measures, and clear incentives and risk share arrangements to drive progression, supported by an effective contracting process

- An initial review demonstrates that Local Health Economies (LHEs) are at different stages in their development towards integrated care, with few currently exhibiting best practice

- LHEs can be divided in to three broad categories, according to their progress in integration:
  - Stage 1 (the vast majority of LHEs): Minimal integration activity beyond Better Care Fund requirements, limited relationships across providers, Health and Social Care budgets largely separate
  - Stage 2 (c. 10% of LHEs): Providers aligned and coordinating care for some specific populations, some incentive and associated operating structures in place, including pooling of budget
  - Stage 3 (currently no LHEs in England): Coordinated care in place across all populations, care models developing through innovation, pooled budgets across providers moving towards full capitation
Overall ambition
The overall aim is to achieve meaningful integration of Health and Social Care, in every Local Health Economy (LHE) by 2020

Policy paper
Spending review and autumn statement 2015

Key points from the spending review
• Spending Round 2013 established the Better Care Fund which has driven the integration of funding for health and social care and enabled services to be commissioned together for the first time
• This year the NHS and local authorities in England shared £5.3 billion in pooled budgets
• The 2015 Spending Review states that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020
• Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements and met key government requirements
• The government will not impose how the NHS and local government deliver integration, but might include:
  – Accountable Care Organisations: e.g. Northumbria
  – Devolution deals: e.g. Greater Manchester
  – Lead Commissioners: e.g. North East Lincolnshire
Overall objective
Health and Social Care integration must remain centred on the needs of the patient, and those who make their day to day care decisions

Care today
“Complex, fragmented and under performing”

- Physician-centred
- Reactive and transactional care provided by multiple providers – often poorly coordinated
- Complex for patient to navigate – multiple points of contact
- Variation in patient experience and clinical outcomes
- Higher costs driven by lack of coordination between services and unnecessary use of acute emergency resources

Care tomorrow
“Patient-centered, high value population management”

- Patient-centred
- Proactive care that is managed by a care team – leading to reduced reliance on acute emergency resources
- Easy for patient to navigate – single point of contact
- Improved patient experience and clinical outcomes
- Reduced costs, especially in acute services, due to improved coordination and proactive care preventing unnecessary admissions

Implications for tomorrow’s local health economy
- All providers across health and social care cooperating proactively to focus on high-risk patients
- Multi Disciplinary Teams working across service providers to deliver a seamless care continuum for the patient
- Care provided at home/ in the community with greater leverage of the voluntary sector

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## Enabling components

There are six groups of enabling components which together provide the infrastructure for proactive and tailored integrated care

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<thead>
<tr>
<th></th>
<th>Incentives to deliver integrated care</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>Pay-for-performance system based on quality (e.g. shared savings, partial/full cap), with full control of funds for a meaningful population size</strong></td>
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<td></td>
<td><strong>Incentives and performance management systems aligned to the path forward to encourage integration over time and captured by an effective contracting process</strong></td>
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<td><strong>Enabled by a robust understanding of the LHE’s economics</strong></td>
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<thead>
<tr>
<th></th>
<th>Committed leadership</th>
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<td>2</td>
<td><strong>Strong leaders aligned, committed and able to drive transformative change at a local economy level, working within established structures and transparent governance</strong></td>
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<td></td>
<td><strong>Shared vision within and across individual providers, and a clear case for change for the LHE</strong></td>
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<td></td>
<td><strong>Ongoing engagement and alignment of key stakeholders on vision, journey, and success factors</strong></td>
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<thead>
<tr>
<th></th>
<th>Patient-centred models of care</th>
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<tr>
<td>3</td>
<td><strong>A deep understanding of the population and their needs to inform care mode design</strong></td>
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<tr>
<td></td>
<td><strong>Patient-centred outcomes at the heart of its operations, with focused models targeting populations</strong></td>
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<tr>
<th></th>
<th>Transparent data &amp; interoperable technology</th>
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<tr>
<td>4</td>
<td><strong>Data transparency covering populations, individuals and cost – accessible to the relevant stakeholders</strong></td>
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<tr>
<td></td>
<td><strong>Interoperable platform for informatics plug-ins to translate data to insight (e.g. remote monitoring, point of care insights on care gaps, risk stratification, financial systems etc.)</strong></td>
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<table>
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<tr>
<th></th>
<th>Patient-driven workforce capabilities</th>
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<tr>
<td>5</td>
<td><strong>Comprehensive clinician and health professional engagement</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Significant learning and development platform to train and support on-going workforce development, especially to create new roles (e.g. at health-social intersect)</strong></td>
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<td></td>
<td><strong>Recruitment of staff to support new services and skills requirements</strong></td>
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<thead>
<tr>
<th></th>
<th>Collaborative culture</th>
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<tbody>
<tr>
<td>6</td>
<td><strong>A patient-centred, customer focused culture</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Collaborative and co-operative ways of working, between and within individual provider organisations, retaining the ability to challenge</strong></td>
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<td></td>
<td><strong>Focus on continuous improvement with clear outcomes</strong></td>
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Progress in England

Local Health Economies can be segmented into three broad categories depending on their progress to achieve the minimum requirements for 2020:

1. **Stage 1: New starters**
   - Vast majority of LHEs and LAs
   - H&SC budgets remain largely separate
   - Minimum participation in the BCF
   - Limited relationships and minimal integrated activity between providers

2. **Stage 2: Progressive integrators**
   - e.g. Plymouth, Sunderland, Northumbria, South Somerset
   - Beginning to pool budgets and provide integrated care in discrete parts of the system/ for specific populations
   - Providers aligned and coordinating care
   - Have begun to put more formal structures in place to support operations and move towards risk-sharing

3. **Stage 3: Game changers**
   - No examples in England
   - Pooled budgets for all providers, operating under more sophisticated risk-sharing agreements (i.e. as part of an ACO track-style system), moving towards capitation
   - Coordinated care in place across all services and population types
   - Demonstrated improvement in outcomes
   - Care models developing through innovation, including tech enablement

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Goals for 2020 and approach must be defined depending on maturity of integration.
Financial incentive and risk sharing models
Financial incentives are used internationally to drive integration. Best practice is to introduce reward and risk in defined stages, based on the capability, maturity and ambition in integration of each accountable organisation. Financial incentives are only successful when appropriate enabling foundations are in place; implementation of this foundation must be a key focus for >90% of LHEs.

- A range of financial incentive models have been employed internationally, ranging from incremental change, driven from a series of small scale initiatives (e.g. Japan’s Care for the Elderly), through to a step-change approach, where financial risk/gain share models are applied to a whole population (e.g. the Alzira model, Valencia, Spain)

- The Centers for Medicare & Medicaid Services (CMS), responsible for half of US health expenditure, has achieved traction in integration by prescribing a broad set of proven care models and by offering Accountable Care Organisations (ACOs) a staged risk share model with clear tracks for development relevant to their capability, maturity and ambition
  - Early stage incentivisation comprises gain share only, with risk share introduced as progress is made over time
  - Clear accountability and associated performance tracking is linked directly to reward payments
  - A culture of innovation encourages participators to develop and pilot new models of care

- It is important to recognise the disincentives that exist in the English system today, often based on concerns with sharing risks and budgets with little transparency of data
  - The lack of data transparency is a key issue – without it a system cannot regulate ‘as is’ and ‘should be’ costs across various health and social care budgets, meaning a baseline integrated budget cannot be transparently agreed

- LHEs at different stages of integration require tailored incentives to progress – not all financial
  - Stage 1: Realising integration as a solution to specific ‘pain points’ (e.g. DToC), building the foundation to implement new care models, applying mechanisms to learn from those who have done it before
  - Stage 2: Gaining recognition for measurable outcomes, being autonomous in applying new models of care, harnessing mechanisms to reward individuals locally, gaining access to specific expertise
  - Stage 3: Achieving financial reward based on performance at organisational and individual level, being recognised as a ‘system leader’, supporting other LHEs to progress
## Financial Incentive Approach: High-level principles

We see two main types of incentive model employed, with a spectrum in-between.

<table>
<thead>
<tr>
<th>Incremental model</th>
<th>Step-change model</th>
</tr>
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<tbody>
<tr>
<td><strong>Value proposition to local system</strong></td>
<td>• “We enable you to begin the integration journey with low risk and limited resource / capabilities – take time to learn”</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>• Integration evolves through a series of small-scale initiatives</td>
</tr>
<tr>
<td></td>
<td>• These could be limited to a specific:</td>
</tr>
<tr>
<td></td>
<td>– Population group / geography</td>
</tr>
<tr>
<td></td>
<td>– Portion of shared budgets</td>
</tr>
<tr>
<td></td>
<td>– “Bundle” of care</td>
</tr>
<tr>
<td><strong>Key requirements for success</strong></td>
<td>• Well defined initiatives (albeit of low ambition)</td>
</tr>
<tr>
<td></td>
<td>• Transparency of outcomes delivered</td>
</tr>
<tr>
<td><strong>Risks / limitations</strong></td>
<td>• Complex contracting / bits and pieces</td>
</tr>
<tr>
<td></td>
<td>• Slow rate of change</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td>• Japan – Care for the Elderly</td>
</tr>
</tbody>
</table>
Case study: CMS financial incentive approach
In the USA, CMS bridges incremental and step-change incentives by offering ACOs a “staged risk share” model – starting with gain share only, and taking on downside risk over time

<table>
<thead>
<tr>
<th>Track 1: Shared savings</th>
<th>Track 2: Limited risk share</th>
<th>Track 3: Extended risk share</th>
</tr>
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<tbody>
<tr>
<td>CMS funding</td>
<td>CMS funding</td>
<td>CMS funding</td>
</tr>
<tr>
<td>100% Over-spend</td>
<td>at least 40% Over-spend</td>
<td>at least 25% Over-spend</td>
</tr>
<tr>
<td>0% Savings</td>
<td>up to 60% Savings</td>
<td>up to 75% Savings</td>
</tr>
<tr>
<td>ACO provision</td>
<td>ACO provision</td>
<td>ACO provision</td>
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</tbody>
</table>

- Virtually any ACO can move into Track 1 of the programme
- Contracts tend to be around specific targets, not whole population cost

- Currently ~90% of ACOs here

- Intermediate model has not been popular- not enough upside for innovators and too much for incrementalists

- Currently ~1% of ACOs here

- Track three opens up greater risk and savings sharing possibilities
- The preferred approach of organisations looking to made radical change with new care models

- Currently ~5% of ACOs here

Source: CMS Shared Savings Performance Fact Pack - April 2016
### Case study: CMS financial incentive approach

The vast majority of ACOs operate in the Shared Savings Program, but CMS is trialing models to motivate ACOs to move towards capitated budgets.

<table>
<thead>
<tr>
<th>Model</th>
<th>Value proposition</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Shared Savings Program</td>
<td>“I believe I can make savings, but don’t yet want to take on financial risk”</td>
<td>ACOs begin by sharing savings, with financial risks guaranteed by CMS – then encouraged to gradually take on more risk</td>
<td>Ongoing: Covering 7.7m patients</td>
</tr>
<tr>
<td>ACO Investment Model</td>
<td>“I want to share savings, but don’t have the capital to invest up front”</td>
<td>ACOs receive up-front payments from CMS based on population size and demographics</td>
<td>Announced: Not yet operational</td>
</tr>
<tr>
<td>Pioneer ACO Model</td>
<td>“I already coordinate care for patients, and want to take the next step to population health”</td>
<td>Similar to Shared Savings but with greater exposure to ACOs, if successful with this over two years they are eligible to move some payments to a population-basis</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Next Generation ACO Model</td>
<td>“I want to go further and faster than the Pioneer ACO Model”</td>
<td>Allows greater risk/reward exposure than Pioneer ACO model, using different benchmarking that is less reliant on historical expenditures. Allows ACOs to transition to all-inclusive population-based payments</td>
<td>Announced: Not yet operational</td>
</tr>
</tbody>
</table>

New models are opt-in for ACOs, who are assessed by CMS before being accepted.
Macro incentives in the English system
Macro incentives need to acknowledge and build on the current situation…

Current financial incentives in the English health and social care system

<table>
<thead>
<tr>
<th></th>
<th>CCG</th>
<th>Local Authority</th>
<th>Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current funding</strong></td>
<td>Budgets set by NHSE based on prior year budget and target population costs</td>
<td>LA funded by central government, business rates and council tax - ~1/3 spent on Social Care</td>
<td>Providers generally contracted on an amount per activity (e.g. set tariff per operation) or per block of activity</td>
</tr>
<tr>
<td><strong>Current situation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overspend</strong></td>
<td>CCG spending scrutinised but ultimately underwritten, may result in change of leadership</td>
<td>Local Authorities <strong>legally mandated to not over spend</strong> – but are able to borrow and shift spend between services</td>
<td>Foundation Trust spending scrutinised but ultimately <strong>underwritten</strong>, may result in change of leadership</td>
</tr>
<tr>
<td><strong>Underspend</strong></td>
<td>Degree of uncertainty around what will happen in the case of underspend</td>
<td>LAs able to retain any savings against their budgets</td>
<td>Foundation trusts able to retain any savings against their budgets</td>
</tr>
</tbody>
</table>
Macro incentives in the English system
... and there are also significant macro disincentives in the system

Social care overspend to soak up £8.5m of Shropshire Council’s extra funding

Social care overspend has doubled in three months
Leicester City Council’s overspend on adult social care up to £3.7 million

More than a third of adult social services expect to overspend in 2013-14
King’s Fund report finds 36% of adult services bosses expect their department to be in the red

Virtually all hospitals now in deficit
NHS trusts expect to overspend by £2.2bn, warns official report

Hospital heads for record overspend
NHS trust forecasting overspend of almost £50 million

Health

Social Care

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Social Care spend across England
There is a material range in social care expenditure per capita across the councils – this does not necessarily correlate to need

Per Capita Expenditure on Social Care by Council (from highest to lowest spend)
£, 2014-15

© Oliver Wyman
Macro incentives for the English system
LHEs at different stages of integration require tailored incentives to progress; from pain point solutions, to being provided freedom to act

Broad incentives to help LHEs progress across the stages

Stage 1: New starters
- Sticks are relatively ineffective
- LHEs unlikely to generate short term benefits they can share
- Solutions to small-scale pain points (e.g. reducing pressure on acute care)
- Redirect budgets to focus on prescriptive foundational developments (e.g. data)
- Mechanisms to learn from and follow “Game Changers”
- Pump-priming investment only following demonstrative outcomes

Stage 2: Progressive Integrators
- Recognition for achievements through integration to date and autonomy to embed the system
- Protection against downside risks
- Pump-priming investment
- Mechanism to incentivise individuals locally
- Access to expertise (e.g. actuarial support)

Stage 3: Game Changers
- Greater autonomy
- Mechanisms to personally reward themselves and others
- Financial incentives linked to quality performance at an organisational and individual level
- Financial incentives linked to active support of other LHEs
- Recognition as a system leader, with opportunities to monetise expertise

Goal
- Get started: Prove the case for integration – achieve tangible improvement to specific issues
- Establish integration as the norm: Embed integration as a formalised way of working – expand population scope
- Become system leaders: Become a world leader and share successes with LHEs in the system
Local Health Economy perspectives on the challenges of integration
Summary of findings
Local Health Economy perspectives on the challenges of integration

Discussion with a number of LHEs highlights the major challenge of building trust and sharing data effectively. A limited understanding of ‘what good looks like’ and sporadic leadership capability to drive integration are impeding progress. There is a lack of clarity and accountability on the outcomes expected of LHEs.

- We have consulted with a broad range of the more progressive LHEs, as well as relevant government departments including Cabinet Office, HMT, DH, DCLG, NHS England and NHS Improvement

- A number of challenges which impede integration at a local level were identified, for example:
  - The challenges of navigating information governance to put effective data sharing in place
  - Lack of trust/ weak relationships between commissioners, providers, and commissioners and providers
  - Limited understanding and practical capability to implement integration (e.g. population analysis, care models, contracting)

- In addition, more systemic issues relating to central government were also expressed, for example:
  - Lack of clarity on requirements, expected outcomes, and accountability
  - Multiple and unclear governance structures
  - Lack of funds to pump prime, and crucially, to incentivise progress
Local difficulties in integration
We have heard a variety of practical day to day difficulties from the leading local health economies on the path to integration…

Getting data sharing agreements in place between providers so we can actually use our data has been really difficult
- Vanguard PMO lead

We have been very frustrated with the social care providers, they have been too slow
- CEO, Acute provider

Our key priority is to balance budgets – we hope attempts to integrate care lead to improved outcomes.
- Strategic Co-operative Commissioning Director, County Council

We have had to upskill our teams to deliver a broader set of services- e.g. shifted less skilled work from district nurses – recruitment is difficult here
- Vanguard lead, primary care

Our goal is to get buy in from primary care but this was put on hold due to issues over the winter.
- Vanguard lead, acute provider

The other providers in the LHE don’t trust the acute provider to share cost savings fairly.
- Vanguard lead, primary care

The acute provider in our LHE is not interested in being involved and we just don’t have a functioning relationship
- Vanguard lead, primary care

We don’t have the data set up to track outcomes effectively at the moment but it’s something we will need to do in the future.
- Vanguard lead, primary care

Even though stakeholders agreed to the principle, the contracting process was extremely painful – there is so much governance to navigate at a local level
- CEO, regional CCG

Financial incentives feel a bit scary
- Vanguard lead, primary care

You need leaders who think ‘Let’s just get on with it!’ and it’s hard to get all of them to sit at the table.
- Vanguard lead, primary care

Social care and community care are afraid of losing financial control but much happier to be involved if the budget is transferred and we, as the acute provider, take on the risk
- Vanguard lead, acute provider

We need to be real system leaders instead of just organisational leaders, which is difficult given how we operate at the moment
- Head of Joint Commissioning, CCG

The CCG found additional funding from transformation reserves, but we need to find a sustainable solution.
- Vanguard lead, acute provider

It’s actually quite tricky to get multi-disciplinary teams to work together; some people are resentful if they’re managed by someone from a different provider; the culture and ways of working are very different
- Head of Joint Commissioning, CCG

GPs started to change their behaviour when they could see the waterfall effect of spend they were putting on other providers
- CEO, regional CCG

Source: stakeholder interviews
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Local difficulties in integration
... as well as more systemic issues relating to broader government

"There has been no clear legislation or policy decision" - CEO, CCG

"Local Government typically procures services through a competitive tender – this mindset does not always foster collaborative working between payers and providers" - CEO, regional CCG

"We need to find ways to incentivise all providers to work together that isn't just a block contract" - Head of Joint Commissioning, CCG

"Incentives need to be aligned across the local authority and acute providers to establish a shared sense of accountability and to get into real action" - CEO, CCG

"Pump priming would have been helpful - to pay for new roles such as care coordinators, or put locality teams in place" - CEO, CCG

"It is a cash issue, the Local Authority stop the work to balance the books" - CEO, CCG

"Governance is a challenge – the misalignment of social care and NHS" - CEO, Acute provider

"Central government messages are not always helpful – it feels as if the goalposts are changing" - Vanguard lead, primary care

"Slow approval and delivery of funds has been a real issue and has delayed implementation of our care model by six months" - Vanguard lead, primary care

"Bureaucracy has been a distraction – we do the micro management reporting, but has it led to improved quality of care?" - Vanguard lead, primary care

"The geographic coverage of the organisations just don’t match up; it’s hard to deal with two CCGs and a different footprint for the Local Authority as well as all of the different providers." - Vanguard lead, primary care

"Too many layers of government get in the way" - CEO, CCG

"We lack real role models, what works in practice" - CEO, CCG

Source: stakeholder interviews
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Local difficulties in integration
The barriers broadly divide into how integration is paid for, how it is understood and actioned at an LHE level, and how it is delivered on the ground

- **Clarity on accountability**
  - Lack of **clarity on requirements, expected outcomes, and accountability** across the system
  - Inconsistent policy, across different organisations and over time

- **Governance**
  - **Multiple governance structures** make decision making difficult, e.g.
    - Different approaches to service commissioning and provision; Competing priorities for funding etc.
    - Action is often driven by **individual committed leaders**, in the absence of defined accountability

- **Funding**
  - **Social care funding** under pressure, and not benchmarked/ assigned based on population needs
  - **Late payment** of promised funds/ cut of promised funds and **lack of cash flow** to get started

- **Data sharing**
  - **Data sharing policies** preventing provider organisations from sharing data
    - Prevents areas from developing an **actuarial understanding** of the population

- **Local blockers / vetoes**
  - One or more providers not cooperating fully
    - **Linked to a lack of trust and understanding** between providers, particularly acute and primary

- **Technical issues**
  - Lack of understanding of the **key process steps** required and how to approach the technical aspects of integration, e.g. contracting, care models, population analysis
  - **Limited infrastructure**, including capacity and capabilities for new, integrated services

- **Competition issues**
  - **Lack of competitive pressure in the provider marketplace** reduces urgency for action

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Source: Stakeholder interviews

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D The need for clear programme governance and effective support
Summary of findings
The need for clear programme governance and effective support

There is strong evidence that a central team providing clear vision, goals and standards is required, with control of overall incentives for LHEs. Separately, incentives are needed to encourage those with first hand experience of implementing integration, to play an active coaching role with those who are less advanced.

- Central programme governance is necessary to achieve universal traction in health and social care integration, to define the goals, overarching process, measurement, incentives and funding
- The centre should not be seen as a source of operational expertise – rather an architect of the programme structure with high odds of success and a trusted leader to hold all parties to their promises
- New models of care for LHEs should be clearly articulated and shared (e.g. Extensivist, Enhanced Primary Care, Ambulatory Surgery)
- Enablement partnerships, made up of organisations, teams and individuals, which ‘know what good looks like’, and who have first hand experience of implementing the new models, should partner with LHEs to provide specific, hands-on expertise and coaching. Incentives need to be created to encourage enablement organisations. This is not a role for the central team.
- Effective enablement is likely to go well beyond sharing of best practice within individual STPs
- International best practice of performance measurement of accountable care organisations should be applied to England:
  - Standardised, simple, value-focused metrics, applied consistently to all accountable organisations
  - Clearly defined and transparent reporting process
  - Prescribed collection of data with supporting tools
  - Initial credit for simply reporting metrics, regardless of performance
  - Metrics contributing to reward are increased over time
Establishing programme governance and enabling capabilities
There is strong evidence that a central team providing clear vision, goals, and standards is required, with control of overall incentives for LHEs

**Top-down support**

**Programme office**
Centrally-driven CMS-type organisation, focused LHE engagement
Defines goals, process, milestones and measurement
Controls finances and incentivisation

**Clear goals and incentives**
- Tailored according to the capability, maturity and ambition in integration of each accountable organisation
- Working alongside existing care quality incentives

**Bottom-up support**

**Enablement Partnerships**
Comprising agreed partnerships with organisations, teams and individuals
Provides hands-on, relevant support from those who know “what good looks like”
Stage 2 & 3 LHEs incentivised to participate

Separately, incentives are needed to encourage those with first hand experience of implementing integration, to actively coach those who are less advanced
Top down steerage and bottom up support
Effective support is crucial in allowing areas to achieve their goals and access incentive payments

**Programme office**

- Small central team, clear lines of government accountability, focused on PMO style activities, leverages expertise amongst LHEs and from 3rd parties
- Sets out **clear overarching strategy** to achieve national integration and **what that means for LHEs**
- Partners with LHEs to **agree specific goals** for what the LHE needs to achieve, within a specific timeframe
- **Provides funding**, according to the progress made by the LHE against a number of **published metrics**
- Provides a **broadly defined process** for LHEs to understand the pathway to progress, together with access to **expert resource** and relevant information

**Enablement Partnerships**

- Based on a core of **organisations, teams and individuals** who know “what good looks like” and have done it themselves, including teams:
  - From LHEs already at Stage 2
  - Organisations with proven toolkits (e.g. data integration, payment mechanisms, actuarial understanding)
  - May include international players to advise, coach and train
- Options to **how they are incentivised** include:
  - Share of value created
  - Time allocations with bonuses for outcomes

**Example organisation**

- Joint venture of:
  - Local health economies at Stage 2
  - US practitioners
  - Consultancy and toolkit providers

Effective support empowers areas to drive change and be rewarded for it
Metrics and measurement
Lessons from the US
**CMS performance measurement**

The Medicare Shared Savings measurement methodology is simple, clear and centrally managed – it links shared savings to a set of performance metrics.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 1 | **Simple, clear process**  
  • Standardised metrics applied to all ACOs  
  • Defined reporting process  
  • Transparency throughout – details of metrics, scoring and process are publically available |
| 2 | **Central support / measurement**  
  • CMS directly collects data on ~ 1/4 of metrics  
  • CMS has defined a list of 3rd parties to collect data on ~1/4 of metrics  
  • CMS has created a standardised web tool for ACO self-reporting on ~1/2 of metrics |
| 3 | **Development of metrics**  
  • Initially, ACOs are only required to report metrics and are not scored on performance  
  • Metrics “go-live” over time – i.e. become measured on performance vs. benchmarks  
  • Benchmarks and weights for each metric are calculated and published |

Many private payers in the US have used the CMS methodology as a template for their own provider performance measurement.
CMS incentivisation – worked example
The proportion of savings retained by an ACO is determined by both their performance score and their maturity (track)

**Track 1: Shared savings – ~90% of ACOs**

- **CMS funding**
  - 100% Over-spend
  - at least 50% Savings
  - up to 50%

- **ACO provision**

- **Savings vs. baseline** £3.00m

- **Performance Scores**
  - Patient experience: 5/16
  - Care Coordination: 10/22
  - Prevention: 12/16
  - At-risk: 4/12

- **Total** 31/66 (47%)

- **Retained by ACO**
  - £3.00m x 50% (Track)
  - £3.00m x 47% (Perf.)
  - £0.71m

**Track 2: Limited risk share – ~1% ACOs**

- **CMS funding**
  - at least 40% Over-spend
  - at least 40% Savings
  - up to 60%

- **ACO provision**

- **Savings vs. baseline** £3.00m

- **Performance Scores**
  - Patient experience: 14/16
  - Care Coordination: 18/22
  - Prevention: 16/16
  - At-risk: 10/12

- **Total** 58/66 (88%)

- **Retained by ACO**
  - £3.00m x 60% (Track)
  - £3.00m x 88% (Perf.)
  - £1.58m

**Track 3: Extended risk share – ~5% of ACOs**

- **CMS funding**
  - at least 25% Over-spend
  - at least 25% Savings
  - up to 75%

- **ACO provision**

- **Savings vs. baseline** £3.00m

- **Performance Scores**
  - Patient experience: 15/16
  - Care Coordination: 20/22
  - Prevention: 16/16
  - At-risk: 11/12

- **Total** 62/66 (94%)

- **Retained by ACO**
  - £3.00m x 75% (Track)
  - £3.00m x 94% (Perf.)
  - £2.12m

Source: CMS Shared Savings Performance Fact Pack - April 2016
Incentivising LHEs to accelerate integration
Summary of findings
Incentivising LHEs to accelerate integration

Funding and incentives for integration should primarily be based on the delivery of clear results. For more than 90% of LHEs, incentives should be provided for getting the foundations in place and for incremental improvements in outcomes. For more advanced LHEs, financial risk and gain sharing structures, underpinned by transparent actuarial analysis of shared data, will provide the incentive.

- Incentivising Stage 1 LHEs will need to strike a balance between ‘carrot’ (e.g. small incremental payments) and ‘stick’ (e.g. transfer of DToC costs) to drive appropriate behavioural change. Financial penalties for struggling organisations seldom have impact, and inevitably adversely affect integration.

- Goals and incentives for Stage 1 LHEs should be focused on:
  - Embedding foundation activities, which provide the practical set up for the LHE to achieve integration – for example a ‘pass/fail’ around simply collecting the data (i.e. no evaluation of the data)
  - Achieving incremental outcomes, which drive momentum and prove integration at a local level
  - Gaining funding once demonstrable results in foundation activities and incremental outcomes are evident

- Incentivising Stage 2 LHEs should be focused on them achieving meaningful financial reward, based on savings, patient experience and care coordination, in addition to existing care quality measures. This will be achieved by:
  - Developing a thorough understanding of the population through actuarial analysis
  - Implementing appropriate risk/ gain incentive models
  - Putting in place contracts between the different commissioners and the different provider organisations based on full transparency of population cost and activity data (e.g. focused on attribution, care coordination, performance management, reimbursement, care model selection, data exchange, etc)
Recap: Three broad stages of integration

Local Health Economies are on different trajectories to achieve the minimum requirements for 2020 – we see three stages of development

Local Health Economies can be segmented into three broad categories depending on maturity of integration

1. **Stage 1: New starters**
   - Vast majority of LHEs and LAs
   - H&SC budgets remain largely separate
   - Minimum participation in the BCF
   - Limited relationships and minimal integrated activity between providers

2. **Stage 2: Progressive integrators**
   - e.g. Plymouth, Sunderland, Northumbria, South Somerset
   - Beginning to pool budgets and provide integrated care in discrete parts of the system/ for specific populations
   - Providers aligned and coordinating care
   - Have begun to put more formal structures in place to support operations and move towards risk-sharing

3. **Stage 3: Game changers**
   - No examples in England
   - Pooled budgets for all providers, operating under more sophisticated risk-sharing agreements (i.e. as part of an ACO track-style system), moving towards capitation
   - Coordinated care in place across all services and population types
   - Demonstrated improvement in outcomes
   - Care models developing through innovation, including tech enablement

Goals for 2020 and approach must be defined depending on maturity of integration

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Incentivising “Stage 1” LHEs
Recap: Macro incentives for the English system

LHEs at different stages of integration require tailored incentives to progress, from solutions to specific pain points, through to freedom to act.

Broad incentives to help LHEs progress across the stages

1. **Stage 1: New starters**
   - Get started
     - Prove the case for integration – achieve tangible improvement to specific issues
   - Incentives
     - “Sticks” on their own are relatively ineffective
     - LHEs unlikely to generate short term benefits they can share
     - Solutions to small-scale pain points (e.g. reducing pressure on acute care)
     - Redirect budgets to focus on prescriptive foundational developments (e.g. data)
     - Mechanisms to learn from and follow “Game Changers”
     - Pump-priming investment only following demonstrative outcomes

2. **Stage 2: Progressive integrators**
   - Establish integration as the norm
     - Embed integration as a formalised way of working – expand population scope
   - Incentives
     - Recognition for achievements through integration to date and autonomy to embed the system
     - Protection against downside risks
     - Pump-priming investment
     - Mechanism to incentivise individuals locally
     - Access to expertise (e.g. actuarial support)

3. **Stage 3: Game changers**
   - Become system leaders
     - Become a world leader and share successes with LHEs in the system
   - Incentives
     - Greater autonomy
     - Mechanisms to personally reward themselves and others
     - Financial incentives linked to quality performance at an organisational and individual level
     - Financial incentives linked to active support of other LHEs
     - Recognition as a system leader, with opportunities to monetise expertise
Incentivisation approach
Finding the right balance between carrot and stick incentives will be crucial in ensuring that the change is sustainable

<table>
<thead>
<tr>
<th>Stick</th>
<th>Penalties for lack of progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DtoC example</strong></td>
<td></td>
</tr>
<tr>
<td>• <strong>Automatic transfer of DToC costs</strong> to the responsible party (e.g. Social or Community Care)</td>
<td></td>
</tr>
<tr>
<td>– May result in disputes between providers, that erodes trust and cooperation</td>
<td></td>
</tr>
<tr>
<td>– Can result in focus on “blame” rather than addressing the issue</td>
<td></td>
</tr>
</tbody>
</table>

- Can drive a **rapid response** through shared accountability if credible
- Does not require **incentive payments** to be funded
- Risk of penalty to a LA will **reduce funding available** because of the need to provision
- Will **reduce the trust** and cooperation essential to moving towards real integration
- Does not incentivise **individual behaviour**

<table>
<thead>
<tr>
<th>Carrot</th>
<th>Reward for progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DtoC example</strong></td>
<td></td>
</tr>
<tr>
<td>• <strong>Small incremental payments</strong> to reward improvements in DToC performance, shared across the system</td>
<td></td>
</tr>
<tr>
<td>– Affordable incentive payments likely to be small and may not shift behaviour alone</td>
<td></td>
</tr>
</tbody>
</table>

- **Does not negatively affect** any party directly – encourages all parties to work together
- **Reinforces positive behaviours** – and encourages further progress
- **Expensive** to implement – especially at a large enough scale to change behaviours
- **Difficult to design** – rewards can drive undesired behaviours or be misused
- Does not incentivise **individual behaviour**

Finding a balance between the two will be crucial to driving short term improvements and building a springboard to Stage 3

Focus of these materials

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Incentivising LHEs in Stage One to integrate Health & Social Care
‘New starters’ should be incentivised to set the foundations for integrated care, and achieve short-term incremental outcomes on the ground

Top-down support

Programme office
Centrally-driven CMS-type organisation, focused LHE engagement
Defines goals, process, milestones and measurement
Controls finances and incentivisation

Clear goals and incentives (alongside existing care quality incentives)

1) Establish foundation activities
Link financial incentives to development of a prescribed set of essential enabling foundations for integration

2) Achieve incremental outcomes
Link financial incentives to key integration outcomes e.g.
- DToC, Length of Stay, Number of Events, Patient Experience

Incentives linked to these goals can be a combination of both carrot (reward for progress) and stick (penalties for lack of progress, if appropriate)

Bottom-up support

Enablement Partnerships
Comprising agreed partnerships with organisations, teams and individuals
Provides hands-on, relevant support from those who know “what good looks like”
Stage 2 & 3 LHEs incentivised to participate

Integration efforts should fit alongside existing incentives and programmes (e.g. STP)
1) Foundational activities

Foundational activities do not always impact patients directly, but set the basis for an integrated system – there are degrees of progress against these areas

Example key foundational activities to integrate care systems

<table>
<thead>
<tr>
<th>Activity</th>
<th>Minimum development</th>
<th>Highly developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define vision of the future integrated system</td>
<td>Initial understanding of the fundamentals of integrated care and the value it brings, but no local application of these principles</td>
<td>Clear and shared vision of integrated care, leaders across providers aligned and a programme plan formulated with milestones etc.</td>
</tr>
<tr>
<td>Develop data capability</td>
<td>Shared data repository created, containing static patient-level data. Useful for strategic planning but not clinical purposes</td>
<td>Complete dataset, integrated at a population, individual record and charge code level – regular refresh available with suite of dashboards and tools</td>
</tr>
<tr>
<td>Conduct population analysis</td>
<td>Identification of highest cost cohorts, and what they cost across the care system</td>
<td>Fully risk-stratified population, with a clear understanding of demographic cost drivers at an individual level and the interventions required to address them</td>
</tr>
<tr>
<td>Understand prioritised models of integrated care</td>
<td>Appreciation that a basic range of integrated care models exist to address different priorities</td>
<td>Care model(s) understood in detail – processes, pathways, information requirements, workforce, economics etc. – and selected, implementation clear and underway</td>
</tr>
<tr>
<td>Pilot integrated care</td>
<td>Small-scale pilots run to trial impact of integrated care on specific issues (e.g. DTOC)</td>
<td>Full pilots run on a population segment, including all care providers (e.g. care for the frail / elderly)</td>
</tr>
<tr>
<td>Develop workforce capabilities</td>
<td>Early understanding by some of the leadership and front line staff on what integrated care means for the workforce (i.e. roles, skills, resource deployment)</td>
<td>New care roles defined in detail and workforce training in place to upskill existing staff</td>
</tr>
<tr>
<td>Partner with industry leaders</td>
<td>Awareness of specific areas where integration has been successful (e.g. Yeovil, Northumbria) and initial meetings held</td>
<td>Partnership agreed, with parties meeting regularly to share best practices</td>
</tr>
</tbody>
</table>

Incentivising foundational activities rewards longer-term development
## 2) Incremental outcomes

There is a set of key integration outcomes that measure the impact of incremental change on patients

### Example outcome areas

<table>
<thead>
<tr>
<th>Issue</th>
<th>Desired changes on the ground</th>
<th>Desired outcome(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescribing Social Care</strong></td>
<td>Encouraging primary care to more actively prescribe appropriate social care to patients will help encourage an integrated healthcare approach</td>
<td>Pilot schemes in local area to prescribe social care</td>
</tr>
<tr>
<td><strong>Delayed Transfers of Care (DToC)</strong></td>
<td>DToC is an ongoing issue – incentivisation must focus on moving patients out of hospital and into social care settings more quickly The obverse of DToC is early or inappropriate transfers of care, as recently highlighted by the Health Ombudsman</td>
<td>Improved co-ordination around transfers out of Acute settings</td>
</tr>
<tr>
<td><strong>Length of Stay</strong></td>
<td>Effective, integrated out-of-hospital care reduces the length of time patients are required to be in hospital – which can be achieved through a number of means</td>
<td>New care models piloted, e.g. extensivist hub or enhanced primary care</td>
</tr>
<tr>
<td><strong>Number of events</strong></td>
<td>Effective preventative care reduces the number of times patients are admitted to hospital – this would require coordination of providers</td>
<td>New care models piloted, e.g. extensivist hub or enhanced primary care</td>
</tr>
<tr>
<td><strong>Patient experience</strong></td>
<td>A key outcome of integrated care is improved outcomes for patients – this must be a key part of any integration incentive system</td>
<td>A fully integrated service from the patient perspective – not simply pooled budgets</td>
</tr>
</tbody>
</table>

Incentivising incremental outcomes rewards **tangible short-term progress**
2) Incremental outcomes
Emergency Bed Days per 1,000 for the over 65 is another measure that could be applied across all LHEs to indicate integration activity and trends.

Whilst many factors impact emergency bed days, this is a helpful, single metric, which can be applied universally.
Incentivising “Stage 2” LHEs
Risk-based contracting process: Illustrative Local Health Economy
Recap: Macro incentives for the English system
LHEs at different stages of integration require tailored incentives to progress, from solutions to specific pain points, through to freedom to act.

Broad incentives to help LHEs progress across the stages

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2. **Stage 2: Progressive Integrators**
   - Goal: Establish integration as the norm
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   - Goal: Become system leaders
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   - Incentives:
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     - Mechanisms to personally reward themselves and others
     - Financial incentives linked to quality performance at an organisational and individual level
     - Financial incentives linked to active support of other LHEs
     - Recognition as a system leader, with opportunities to monetise expertise
Incentivising LHEs in Stage Two to integrate Health & Social Care

Financial risk and gain sharing structures, underpinned by transparent actuarial analysis of shared data, will provide the incentive for more advanced LHEs.

**Top-down support**
- **Programme office**
  - Centrally-driven CMS-type organisation, focused LHE engagement
  - Defines goals, process, milestones and measurement
  - Controls finances and incentivisation

**Clear goals and incentives**
- (alongside existing care quality incentives)
  - **Financial risk and gain sharing models**
    - Financial incentives are borne from agreed risk and reward incentive models, based on actuarial population analysis from transparent data, and detailed in an agreed contract

**Bottom-up support**
- **Enablement Partnerships**
  - Comprising agreed partnerships with organisations, teams and individuals
  - Provides hands-on, relevant support from those who know “what good looks like”

**Actuarial population analysis** enables robust contracts to be developed, getting clear on important factors such as attribution, performance management, and reimbursement.
Illustrative local health economy: Risk-based contracting process
A process of understanding, analysis, and negotiation is required to formalise an incentive/ risk sharing model in a contract

High-level contracting process

**Step 1** Understanding

- Key questions
  - What is the overall spend in the local health economy and how does it break down across population and services
  - Who are the different payers and providers and what is their relative scale
  - What integration strategies are already in place or planned

**Output**: A clear understanding of readiness for the contracting process

**Step 2** Analysis

- Key questions
  - What are the drivers of population costs (e.g. age, medical conditions, gender, other demographics)
  - Using these drivers, what is the baseline cost for the population
  - How does this baseline cost differ between providers

**Output**: A baseline population cost, the foundation for financial contract negotiations

**Step 3** Negotiation

- Key questions
  - What is the model (e.g. shared savings upside only)
  - Where do savings and risks sit
  - How are patients attributed
  - What is the quality control / reimbursement methodology and T&Cs

**Output**: A finalised contract, agreed between parties

**Step 4** Go live

- Key questions
  - What mobilisation activities need to take place prior to commencement (e.g. operational changes)

**Output**: Implementation of the integrated services as defined in the contract
Illustrative local health economy: Understanding total spend

Of total health and social care spending, ~50% was on acute spending, whilst only ~15% was related to social care.

Overall Health and Social Care spend
Publically-funded only, Disguised LHE, FY13/14

- **Social Care**
  - Includes all care funded through the Local Authority
  - Privately funded Social Care spend is and additional ~50% of LA-funded spend in the UK on average
  - Encompasses homecare, residential / nursing care, daycare, equipment and direct payments

- **Mental health**
  - All mental health spending, including outpatient visits, admissions, emergencies and community visits

- **Community Care**
  - Includes community outpatient visits, community admissions Minor Injuries Unit, physio etc.

- **Prescriptions**
  - Cost of all prescriptions given over the period

- **GP visits**
  - Cost of all GP visits over the period
  - Costs assigned to patients based on number of interactions with the GP

- **Acute**
  - Major secondary care costs
  - Covers in and outpatient care, A&E and non-elective

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG

Source: OW analysis
Illustrative local health economy: Understanding overall spending distribution
The local health and social care economy follows the well-known 80:20 rule closely, with 19% of the population driving 83% of the total cost.

Health and Social Care Spend: Segmented by annual cost-per-patient
Publically-funded only, Disguised LHE, FY13/14

Health and Social Care spend

Least expensive patients are:
- Generally younger (average 35)
- Almost never requires any service other than minor GP care / prescription medicine

Most expensive patients are:
- Generally older (average 66)
- Almost always requiring significant GP time, prescription medication and acute care

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG
Source: OW analysis
Illustrative local health economy: Understanding Social Care distribution (1/2)
This concentration is even greater when looking purely at Social Care, with just 5% of the population driving 93% of the government social care cost...

Social Care Spend: Segmented by annual cost-per-patient
Publically-funded only, Disguised LHE, FY13/14

- A large proportion (80%) of the population receive no funded Social Care at all
- Social care even more heavily concentrated on the most expensive patients
- Health and social care integration must focus here

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG
Source: OW analysis

© Oliver Wyman
Illustrative local health economy: **Understanding** Social Care distribution (2/2)

… and when looking even closer, the top 100 patients in the area received Social Care representing 30% of total spend, mainly in Placement and Homecare

**Social Care Spend: Highest-cost patients only (>$5k H&SC spend)**
Publically-funded only, Disguised LHE, FY13/14

**Social Care spend breakdown**
Publically-funded, FY13/14

<table>
<thead>
<tr>
<th>Social Care category</th>
<th>% of Social Care spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing care</td>
<td>32%</td>
</tr>
<tr>
<td>Homecare</td>
<td>32%</td>
</tr>
<tr>
<td>Direct payment</td>
<td>10%</td>
</tr>
<tr>
<td>Professional support</td>
<td>7%</td>
</tr>
<tr>
<td>Daycare</td>
<td>4%</td>
</tr>
<tr>
<td>Equipment</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
</tr>
</tbody>
</table>

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG
Source: OW analysis

© Oliver Wyman
Illustrative local health economy: Understanding costs for expensive patients
The highest-cost patient population have almost half of their cost made up of Social Care, Community Care and Mental Health Care

Per-Capita Health and Social Care spend
Publically-funded only, Disguised LHE, FY13/14

- **Social Care spend** is concentrated on the most expensive overall patients – 24% vs. 2% for rest of population
- Most expensive patients also have a far greater proportion of **Mental Health and Community Care spend** – 21% vs. 7% for rest of population
- **GP and Prescription spend** is comparatively high for high cost patients, but not relative to their total
- **Acute spend** is very stable across populations, at just under 50% of per-patient spend

<table>
<thead>
<tr>
<th></th>
<th>Average age</th>
<th>Average cost per Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest of patient population</td>
<td>42</td>
<td>~£500</td>
</tr>
<tr>
<td>Patients costing more than £5,000</td>
<td>66</td>
<td>~£13,000</td>
</tr>
</tbody>
</table>

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG
Source: OW analysis

© Oliver Wyman
Illustrative local health economy: **Understanding** individual data granularity
Very granular data is required to accurately assess the “should be” cost of a population – the basis of a fully integrated system

<table>
<thead>
<tr>
<th>Indicative patient(1): Mrs S</th>
<th>2013/14 Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost item</td>
</tr>
<tr>
<td></td>
<td>Homecare</td>
</tr>
<tr>
<td></td>
<td>Equipment</td>
</tr>
<tr>
<td></td>
<td>Professional support</td>
</tr>
<tr>
<td></td>
<td>Other SC</td>
</tr>
<tr>
<td></td>
<td>Social Care</td>
</tr>
<tr>
<td></td>
<td>GP visits</td>
</tr>
<tr>
<td></td>
<td>Prescription medicines</td>
</tr>
<tr>
<td></td>
<td>Community services (physio)</td>
</tr>
<tr>
<td></td>
<td>Community unplanned inpatient emergency</td>
</tr>
<tr>
<td></td>
<td>Community services</td>
</tr>
<tr>
<td></td>
<td>Mental Health (Outpatient visits)</td>
</tr>
<tr>
<td></td>
<td>Acute: A+E</td>
</tr>
<tr>
<td></td>
<td>Acute: Outpatient</td>
</tr>
<tr>
<td></td>
<td>Acute: Non-elective and inpatient</td>
</tr>
<tr>
<td></td>
<td>Acute</td>
</tr>
<tr>
<td></td>
<td>Grand total</td>
</tr>
</tbody>
</table>

About Mrs S
- Female
- 90 years old
- High-cost patient (top 5%)
- Regular user of both Health and Social Care

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG

(1): Represents general characteristics of a group of elderly patients, the data here does not represent any single patient

Source: OW analysis
Illustrative local health economy: **Understanding** relative Social Care spend
It is also important to understand the position of each local health economy relative to regional and national averages

Per Capita Expenditure on ‘Personal Social Services’ by Council (from highest to lowest spend)
£, 2014-15

Illustrative local health economy: Understanding relative Social Care spend
Within Social Care, there is significant variation in the distribution of spending across the country

% Expenditure on ‘Personal Social Services’ by Type (with council minimum and maximum labelled)
% (£ bn), 2014-15


© Oliver Wyman
Illustrative local health economy: Understanding relative Social Care spend

The England average for proportion of Social Care spend focused on Residential and Nursing Care is 41%

% of Social Care Expenditure on Residential and Nursing Care by Council (from highest to lowest)

£, 2014-15

Illustrative local health economy: **Understanding**
A clear understanding of the local health economy and its readiness to integrate sets the context for the contracting process

High-level contracting process

**Step 1**
Understanding

Key findings
- **Key providers**: 20 GP practices; 5 Community hospitals; 1 Mental health team; 1 district general hospital; Many SC groups
- **Total spend** is ~85% healthcare spend, ~15% social care spend
- Area already developing new care models

**Step 2**
Analysis

Key questions
- What are the drivers of population costs (e.g. age, medical conditions, gender, other demographics)
- Using these drivers, what is the baseline cost for the population
- How does this baseline cost differ between providers

**Step 3**
Negotiation

Key questions
- What is the model (e.g. shared savings upside only)
- Where do savings and risks sit
- How are patients attributed
- What is the quality control / reimbursement methodology and T&Cs

**Step 4**
Go live

Key questions
- What mobilisation activities need to take place prior to commencement (e.g. operational changes)

**Output**
- A clear understanding of readiness for the contracting process
- A baseline population cost, the foundation for financial contract negotiations
- A finalised contract, agreed between parties
- Implementation of the integrated services as defined in the contract
Illustrative local health economy: **Analysing** population cost
An actuarial analysis of spend data yields a baseline cost for the population, forming the basis for negotiation & allowing individual provider budgets to be set

**Receive and understand data**
1. **Check granular costs** align with overall figures
2. Open a **dialogue with data providers** to ensure clear understanding of the metrics and how they should be used

**Run regression modelling**
2. Run a **multi-linear regression** on granular cost and activity data to determine how different factors drive cost
   - i.e. understand the per-patient cost of individuals depending on their age, condition, gender and other demographics

**Calculate benchmark costs**
3. Use per-patient costs to **calculate the benchmark** for the whole population
   - Apply benchmark to individual providers

**Sophistication of data**

<table>
<thead>
<tr>
<th>Granularity, Linkage</th>
<th>Some areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low, Poorly linked</td>
<td>• Costs understood at a budgetary level</td>
</tr>
<tr>
<td></td>
<td>• Little data sharing</td>
</tr>
<tr>
<td>Higher, Poorly linked</td>
<td>• Individual providers tracking activities and procedures</td>
</tr>
<tr>
<td></td>
<td>• Limited sharing between providers</td>
</tr>
<tr>
<td>High, Well linked</td>
<td>• Linked patient-level datasets assigning activities and costs across care spectrum</td>
</tr>
<tr>
<td></td>
<td>• Limited data on specific procedures and what providers carry them out</td>
</tr>
<tr>
<td>Best in class</td>
<td>• Costs understood at a <strong>claims file level</strong> – with every activity tracked and assigned to specific providers</td>
</tr>
</tbody>
</table>
Illustrative local health economy: Analysing population cost by age
Age is a good indicator of overall health and social care spend. Patients over 60 generally attract more spend, especially in acute, community and social care.

Average Health and Social Care Spend per patient per year
Publically-funded only, by patient age, Disguised LHE, FY13/14

Implications for cost attribution
- Population age is a good predictor of overall care costs for patients over 50
- Major drivers of increased cost for the older population are acute care, community care and social care
- A multi-linear regression model would strongly weight age as an explanatory variable, allowing costs to be assigned to providers

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG
Excludes Patients greater than 100 (as less than 5 sample size in each bucket)
Source: OW analysis
Illustrative local health economy: **Analysing** population cost by condition

Condition groups are a good predictor – major conditions at least triple the per-patient cost – but are more difficult to analyse prospectively.

### Average Health and Social Care Spend per patient per year

Publically-funded only, by condition group, Disguised LHE, FY13/14

<table>
<thead>
<tr>
<th>Condition</th>
<th>% of ppn.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No condition</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td>CHD</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>LVD Heart Failure</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>CKD</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
</tr>
</tbody>
</table>

- The prevalence of any condition is a major cost driver, an Asthma sufferer costs over 3x the average of someone with no major conditions.
- Spike in Social Care for Epilepsy.
- High acute costs for the obese population, little evidence of preventative community or social care.

### Implications for cost attribution

- Condition group is clearly a key indicator of population cost.
- However, this measure is difficult to use prospectively, as it is based on health outcomes – i.e. you need to predict how many people will develop diabetes from other risk factors.
- A multi-linear regression model would strongly weight condition as an explanatory variable, allowing costs to be assigned to providers.

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG.

Source: OW analysis

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Illustrative local health economy: **Analysing** population cost by gender
In our example, females cost around 20% more on a per-patient basis, and are more expensive across the majority of the care spectrum

Average Health and Social Care Spend per patient per year
Publically-funded only, by patient gender, Disguised LHE, FY13/14

<table>
<thead>
<tr>
<th>Gender</th>
<th>Average age</th>
<th>Mental Health</th>
<th>Community Care</th>
<th>Prescriptions</th>
<th>GP visits</th>
<th>Social Care</th>
<th>Acute</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>42</td>
<td>£125</td>
<td>£75</td>
<td>£70</td>
<td>£110</td>
<td>£950</td>
<td>£470</td>
<td>£180</td>
</tr>
<tr>
<td>Female</td>
<td>44</td>
<td>£145</td>
<td>£140</td>
<td>£70</td>
<td>£110</td>
<td>£1,150</td>
<td>£525</td>
<td>£180</td>
</tr>
</tbody>
</table>

**Implications for cost attribution**
- Gender is a predictor of overall care costs
  - Females are more expensive on average for all aspects of care with the exception of Mental Health
- This may be due in a small part to the slightly higher average age of the female population
- A multi-linear regression model would give some weight to gender as an explanatory variable
  - However it must be run separately on different cost components (e.g. Mental Health vs. Social Care)

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG
Source: OW analysis

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Illustrative local health economy: Analysing population cost by demographics
Detailed demographics should be combined with age, gender and condition to predict costs – e.g. mental health cost spikes in young urban patients

Average Health and Social Care Spend per patient per year
Publically-funded only, by MOSAIC group (demographic metric), FY13/14

<table>
<thead>
<tr>
<th>MOSAIC group</th>
<th>Acute</th>
<th>GP visits</th>
<th>Prescriptions</th>
<th>Community Care</th>
<th>Mental health</th>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wealthy people living in the most sought after neighbourhoods</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly people reliant on state support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active elderly people living in pleasant retirement locations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unclassified</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young people renting flats in high density social housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents of small and mid-sized towns with strong local roots</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower income workers in urban terraces in often diverse areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owner occupiers in older-style housing in ex-industrial areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young, well-educated city dwellers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Families in low-rise social housing with high levels of benefit need</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents of isolated rural communities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents with sufficient incomes in right-to-buy social houses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle income families living in moderate suburban semis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Successful professionals living in suburban or semi-rural homes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Couples and young singles in small modern starter homes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Couples with young children in comfortable modern housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Unsurprisingly, elderly people are the most costly, especially in Social Care
We see a spike in Mental health costs for younger people in urban areas
For most of the demographic groups, the overall spend and share between services is similar

Implications for cost attribution
• Detailed demographics may be predictive of care costs
  – Must be used carefully when considering the impact of age
  – It can be revealing for some pockets of the population
• A multi-linear regression model is likely to give little weight to more detailed demographics – as causality is largely captured by age, gender and conditions

Note: Data excludes NHSE specialist services and privately paid Social Care; Social Care funded via the LA, GPs funded directly from NHSE, all else funded by the NHS via the Local CCG
Source: OW analysis, Public Sector MOSAIC groups
Illustrative local health economy: **Analysing** baseline costs
Regression modelling forecasts a cost baseline, around which financial negotiations take place between parties

**Illustrative output of actuarial analysis of population cost**
Illustrative LHE, Entire population

**Implications for negotiations**
- Regression modelling of existing data would allow actuaries to forecast population cost
- This baseline is the foundation of the financial aspects of the contract negotiation
- This modelling also allows costs to be assigned to providers
Illustrative local health economy: **Analysis**

Detailed cost analysis reveals that age and condition are the strongest drivers of population costs, which is the actuarial basis for negotiations.

**High-level contracting process**

**Step 1**
Understanding

- **Key findings**
  - Key providers: 20 GP practices; 5 Community hospitals; 1 Mental health team; 1 district general hospital; Many SC groups
  - Total spend is ~85% healthcare spend, ~15% social care spend
  - Area already developing new care models

**Output**
A clear understanding of readiness for the contracting process

**Step 2**
Analysis

- **Key findings**
  - **Age and condition group** are the strongest predictors of overall cost—e.g. major conditions at least triple the per-patient cost
  - **This regression analysis sets a baseline cost, allowing:**
    - Cost forecasting based on demographics
    - Costs to be assigned to providers

**Output**
A baseline population cost, the foundation for financial contract negotiations

**Step 3**
Negotiation

- **Key questions**
  - What is the model (e.g. shared savings upside only)
  - Where do savings and risks sit
  - How are patients attributed
  - What is the quality control / reimbursement methodology and T&Cs

**Output**
A finalised contract, agreed between parties

**Step 4**
Go live

- **Key questions**
  - What mobilisation activities need to take place prior to commencement (e.g. operational changes)

**Output**
Implementation of the integrated services as defined in the contract
### Illustrative local health economy: Negotiating risk-based contracts

The incentive approach is codified in a contract, encompassing eight core contract elements:

<table>
<thead>
<tr>
<th>Contracting Elements</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Attribution</td>
<td>• Assigning patients to a provider based on a set of criteria (e.g. in the local area)</td>
</tr>
<tr>
<td>2) Care Coordination</td>
<td>• Coordinating services to both eliminate waste from the system and improve patient experience</td>
</tr>
<tr>
<td>3) Performance Management</td>
<td>• Measuring performance across many dimensions (e.g. cost, patient satisfaction, quality etc.)</td>
</tr>
<tr>
<td>4) Reimbursement</td>
<td>• Applying value-based reimbursement to reward providers for managing overall patient health</td>
</tr>
<tr>
<td>5) Care Model Selection / Dev.</td>
<td>• Creating care models to focus on providing care to patients with very specific needs (e.g. oncology, PCMH)</td>
</tr>
<tr>
<td>6) IT / Data Exchange</td>
<td>• Setting up data exchanges are required to collect, analyse and disseminate clinical and claim-based data</td>
</tr>
<tr>
<td>7) Steerage / Exclusivity</td>
<td>• Defining conditions to ensure all bodies are incentivised to keep patients in the given system</td>
</tr>
<tr>
<td>8) Terms and Conditions</td>
<td>• Detailing T&amp;Cs to consider length of the contract, term sheet, automatic renewal clauses</td>
</tr>
</tbody>
</table>

Example contract created for an American ACO.
Illustrative local health economy: **Negotiation**

Negotiations take place across eight core components, and are finalised in a contract between the agreed parties.

### High-level contracting process

**Step 1**  
**Understanding**

- **Key findings**
  - Key providers: 20 GP practices; 5 Community hospitals; 1 Mental health team; 1 district general hospital; Many SC groups
  - Total spend is ~85% healthcare spend, ~15% social care spend
  - Area already developing new care models

### Output

- A clear understanding of readiness for the contracting process

**Step 2**  
**Analysis**

- **Key findings**
  - Age and condition group are the strongest predictors of overall cost
  - Major conditions at least triple the per-patient cost
  - This regression analysis sets a baseline cost, allowing:
    - Cost forecasting based on demographics
    - Costs to be assigned to providers

### Key findings

- Patients assigned to providers based on agreed criteria
- Coordinating care team in place, funding agreed
- Metrics, benchmarking, weighting agreed for performance mgt
- Incentive models linked to reimbursement with agreed risk/gain share
- Care model selection (e.g. EPC) agreed

### Step 3**  
**Negotiation**

### Key findings

- A finalised contract, agreed between parties

### Step 4**  
**Go live**

- Key questions
  - What mobilisation activities need to take place prior to commencement (e.g. operational changes)

### Implementation

- Implementation of the integrated services as defined in the contract
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