Teneo®
The Global CEO Advisory Firm

Improving the value of care through greater system integration

What are the design fundamentals of an effective Integrated Care System?

January 2020

Executive summary

The challenge

Australia's healthcare system is under increasing pressure, driven by rising demands and shifting patient expectations. In order to best meet the demand for healthcare services, it is of growing importance that the appropriate care is provided to the right patients, in the right place and at the right time.

To enable the effective and sustainable delivery of patient-centric, seamless care in an appropriate setting, new care models are required. One internationally endorsed model is an Integrated Care System (ICS).

Integrated Care Systems

The term integrated care is defined by the New South Wales Government as: "The provision of seamless, effective and efficient care that reflects the whole of a person's health needs, from prevention through to end of life, across physical and mental health, in partnership with the individual, their carers and family and across public/ private and Commonwealth/ State boundaries."[1]

The primary function of an ICS is to overcome system siloes and misaligned incentives and thereby to facilitate collaborative, cross-system working. If well designed, an ICS can enhance value for care by utilising existing resources effectively to improve patient outcomes and care experiences.

However, designing and implementing an ICS is no simple feat. One particular challenge faced by those looking to develop an ICS is that there is no 'one size fits all' model. To cater for local nuances in population demographics, provider services, funding models and legislation, all ICSs must, to some extent, be designed from the bottom up.

Fundamentals of success

To help health systems navigate the ambiguity regarding model design, we have provided guidance for those wishing to start or progress their journey toward the implementation of an effective and sustainable ICS model.

By following this guidance, we hope that health systems will be better placed to unlock clinical and operational benefits at pace, and ultimately implement an ICS model that best meets the needs of their local population.

Our guidance focuses primarily on the following four fundamentals of a successful ICS model:

1) A relentless focus on improving population health and wellbeing;
2) Designing an ICS of an appropriate scale and scope;
3) Developing an effective governance structure and supporting processes; and
4) Effectively engaging stakeholders to build support and momentum.

These fundamentals are explored in more detail within this report.

Teneo®

An introduction
Working with the CEOs, Boards and senior executives of the world's leading companies, Teneo provides strategic counsel across their full range of key objectives and issues.

To solve for the most complex business challenges and opportunities, Teneo offers a unique set of integrated services.

These services include:
- Management Consulting;
- Strategy & Communications Advisory;
- Risk Advisory; and
- Capital Advisory.

Our local offer
Founded in 2011, Teneo now has more than 800 employees based in 19 offices around the world.

Having supported clients in the Australian market since 2015, Teneo established its Sydney branch in 2018.

The Sydney office currently advises a number of leading, ASX listed organisations; providing both on-the-ground expertise and ready access to Teneo's global talent pool.

Sources: 1) NSW State Health Plan: Toward 2021. NSW Government. 2014

An introduction

The challenge

Australia's healthcare system is under increasing pressure, driven by rising demands and shifting patient expectations. The key challenges currently faced by the system are noted in figure 1 below.

To best meet the demand for healthcare services, it is of growing importance that the appropriate care is provided to the right patients, in the right place and at the right time. Broadly speaking, the sustainable and effective delivery of such care requires healthcare systems to achieve the following objectives:

- Develop personalised, patient centric care and establish seamless, streamlined treatment pathways;
- Where appropriate, shift activity closer to home; and
- Increase focus on prevention and early diagnosis - moving away from the provision of episodic treatment for acute illnesses, and towards initiatives that address the wider determinants of health and wellbeing.

To unlock the benefits associated with the above objectives, new models of care are needed to overcome service siloes and drive system integration. One model that shows particular promise is an Integrated Care System (ICS).

Figure 1. Key challenges facing Australia's healthcare system

Integrated Care Systems

'Integrated care' refers to the provision of seamless, holistic, patient-centric services that address both the health and wellbeing needs of a defined population. The effective provision of such care requires local healthcare bodies to take collective responsibility for:

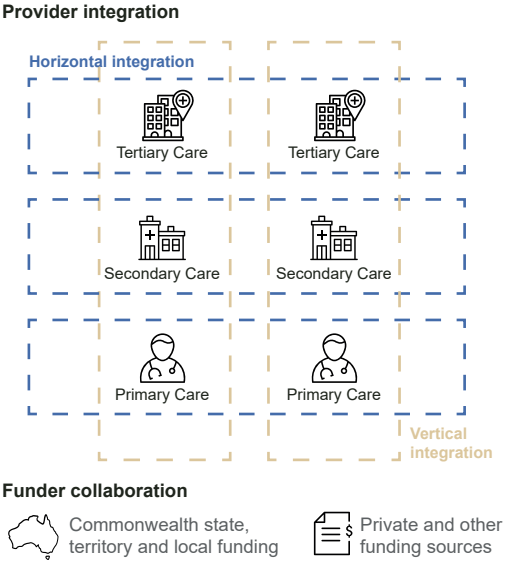
- The delivery of high-quality, equitable care across organisational boundaries;
- Improving the health and wellbeing of the local population; and
- The effective use of available resources.

As a result, integrated care is reliant on system-wide collaboration, including both:

- **Provider collaboration:** Horizontal and/ or vertical integration (see diagram right) can enable the effective and equitable delivery of the right care, in the right place, at the right time.
- **Funder collaboration:** The support of commissioners and private funders is also critical to the delivery of high-quality care services. Such bodies can help overcome the numerous barriers to care integration which include, but are not limited to, the existence of funding siloes and counter productive financial incentives.

In short, the successful and sustainable delivery of integrated care requires the adoption of an Integrated Care System (ICS).

Figure 2. An overview of the dimensions of system integration



Progress to date

Integrated care in Australia

There is a general consensus that the roll-out of integrated care models would help unlock performance improvements within the Australian healthcare system. As a result, numerous organisations have already sought to implement, or at least trial, new models of care delivery. However, due to the complexity and scale of change required, many organisations appear to be in the earlier stages of ICS implementation.

The challenge of developing and implementing an effective ICS is that there is no 'one size fits all' model. All care models must adapt to local nuances in population demographics, provider services, funding models and legislation. The resulting spectrum of care models in development in Australia mirrors that seen abroad, with current models ranging from condition specific care coordination programmes, to whole-system integrated care models designed at the level of a Local Health District.

Countries that have shown particular, sub-national, progress in this space include: the United States, New Zealand, Germany, Sweden and the United Kingdom, amongst others. One example of which is detailed below:

Case Study: The Canterbury system, New Zealand[1]

Faced with an aging population, rising admissions and poor waiting times, and with the local District Health Board (DHB) running a deficit, Canterbury's existing care system was deemed unsustainable. With the option to build additional system capacity (and retain the existing service model) considered unaffordable, the DHB sought to develop a new model of care that would facilitate health and social care integration and thereby deliver 'the right care, right place, right time by the right person'.

The DHB's vision was to create a 'one system, one budget' health and social care environment, in which all those involved in the system would work collaboratively to improve care. To help realise this vision, the DHB committed to invest in both enablers of change and system improvement initiatives, including:

- Sustained investment in the upskilling of both staff and contractors. This included the provision of tailored training to enhance the leadership and innovation capabilities within the healthcare system.
- The introduction of new contracting models, which saw hospital payments decoupled from hospital activity volumes and the development of alliance contracting for a range of external services (including district nursing, mental health and laboratory services). The latter of which helped share the risk/rewards of any system changes and thereby supported collaboration.
- The development of integrated 'HealthPathways', an Acute Demand Management System, a Community Rehabilitation Enablement and Support Team, falls and medication management services and enhanced General Practitioner services.

Fundamentals of success

To help health systems navigate the ambiguity regarding model design, we have sought to provide guidance for those wishing to start or progress their journey toward the implementation of an effective and sustainable ICS model. By following this guidance, we hope that health systems will be better placed to unlock clinical and operational benefits at pace, and ultimately implement an ICS model that best meets the needs of their local population.

Our guidance focuses primarily on four fundamentals of a successful ICS model. These model fundamentals, based on our experience and expertise in this space, are shown on the right.

Figure 3. Fundamentals of a successful ICS model

These model fundamentals will be explored in more detail over the coming pages.

1) The quest for integrated health and social care: A case study in Canterbury, New Zealand. Timmins N, Ham C. The King's Fund 2013

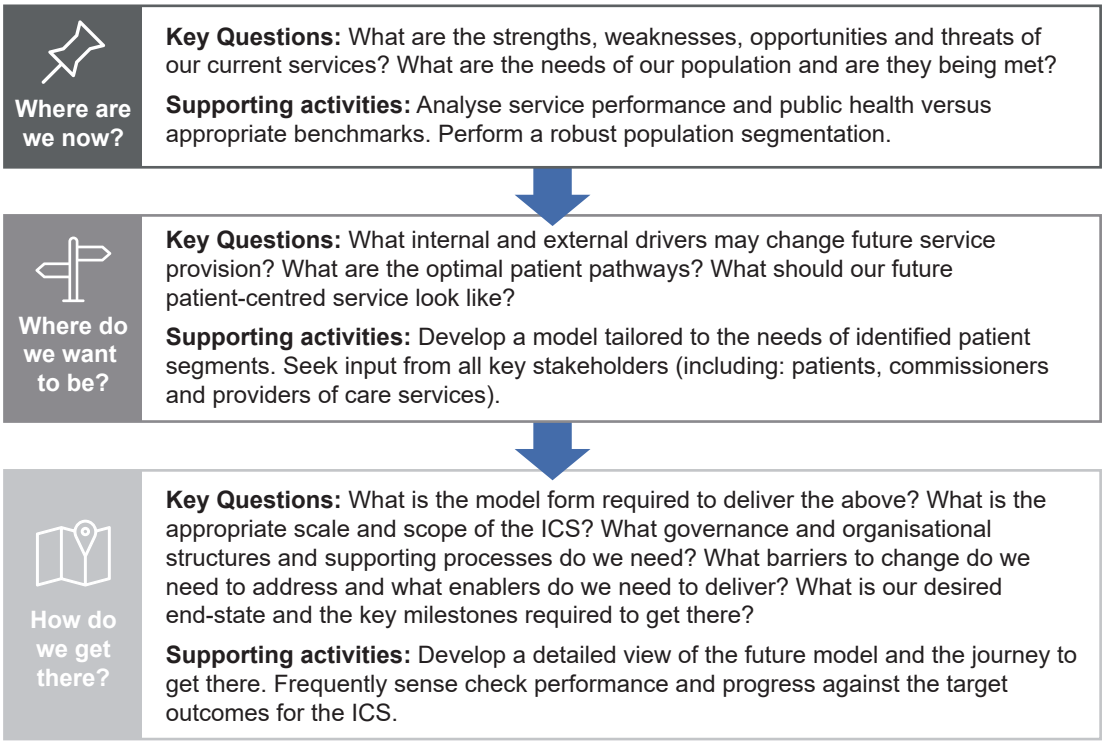
Improving population health and wellbeing

The primary aim of an ICS should be to unlock sustainable improvements in the health and wellbeing of individuals, communities and populations.

Traditionally health providers have concentrated on delivering reactive care to the acutely ill. However, with growing demand and shifting patient expectations, many recognise that this model needs to change. Healthcare systems must consider the health and care needs of the entire local population by working collaboratively to provide the right care, in the right place, at the right time. Critically, this requires health systems to be tailored to best meet the needs of patient cohorts, prioritise preventative and public health initiatives and, where appropriate, seek to deliver care in a lower acuity setting.

To support the above, and to ensure the needs of the patient remain front of mind, it is recommended that the design of an ICS model follows the 'function before form' mantra. Broadly speaking this results in the following approach:

Figure 4. High-level 'function before form' approach for ICS model design



One step that often proves challenging is population segmentation. To best tailor services, and thereby maximise the health and wellbeing benefit of any system changes, one must first divide the population into groups of individuals with similar healthcare needs. These groups must be, as far as possible, mutually exclusive, collectively exhaustive, and of an appropriate size.

A frequent hurdle when looking to segment the local population is the availability of quality data. Without a robust dataset to work from one cannot expect to maximise the benefits of ICS implementation.

However, if done well the population segmentation will:

- Indicate where best to focus ICS resources in order to deliver the greatest outcome improvements;
- Inform pathway improvements and ultimately the design of the ICS 'end-state' model; and
- Enable the prioritisation of integrated care initiatives for implementation, proof-of-concept programmes, and the unlocking of sizeable population health and wellbeing benefits at pace.

Appropriate scale and scope

As previously noted, there is no consistent approach to defining an Integrated Care System. Consequently, examples of ICSs differ significantly in their size and scope, with commissioners and providers developing what is deemed to be the most effective organisational and operational models on a case-by-case basis. The variation in the resulting models is often driven by a need to:

- Achieve sufficient scale to coordinate change and realise efficiencies;
- Cater for local variation in demand in order to best meet the needs of the population; and/ or
- Align with the existing footprints of local healthcare bodies.

The variation in ICS design is evident across geographies and can be demonstrated by the examples to the right.

To effectively deliver the desired benefits, those seeking to develop an optimal ICS model must first focus on the needs of the patient population. To do so, there is often value in building the model from the bottom up (i.e. one should first design the desired patient pathways for each well-defined patient cohort).

Such an approach often results in the creation of a series of ICS 'levels', the names of which often vary from system to system. An example of the possible levels of an ICS is detailed in figure 5 below:

The Diabetes Care Project[1]

Across three states, the project piloted five enablers of a more coordinated model of care management.

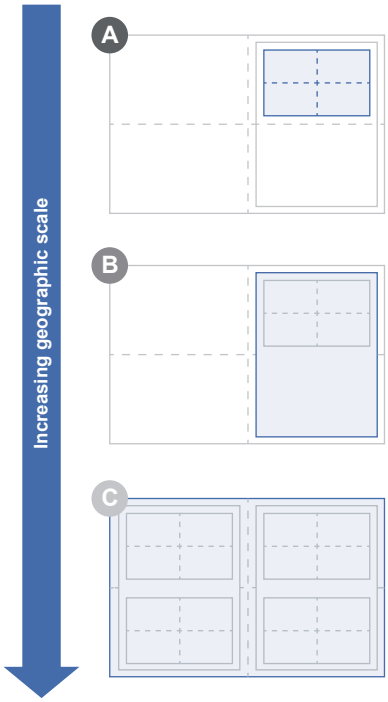
The tested enablers included: an integrated information platform (for patients, GPs and AHPs)*; continuous improvement processes informed by data-driven feedback; flexible funding (allocated based on patient risk stratification); support payments linked to population outcomes; and funding for care facilitation.

Central Coast Integrated Care Programme[2]

The programme centred around the following objectives:

- To develop a 'whole of system' commissioning function jointly governed by the Local Health District and the Primary Health Network;
- To establish a person-centred, integrated system architecture; and
- To catalyse change in models of care for targeted, high-risk populations.

Figure 5. Illustrative 'levels' of a large-scale ICS



A. Local Care Partnership (LCP)

Collaborative partnerships working at a more local level to deliver care services and drive improvements in the health of the local population. Such a partnership supports the integration of secondary and out of hospital services.

LCPs can be further sub-divided into Local Care Networks, which operate at the neighbourhood/ suburb level. The aims of these networks can include the strengthening of primary care and the delivery of integrated care for well-defined patient populations.

B. Cross-LCP Collaborative Partnership

A partnership working across LCPs. Such partnerships may be deemed beneficial if one or more of the following criteria are met:

- There are benefits of scale (clinical/ operational) however, the size of the population and available resources does not warrant coordination at the level of the ICS;
- Providers within an LCP work across LCP boundaries; and/ or
- There is value in subdividing the ICS and delegating some responsibilities due to the scale and complexity of the area covered.

C. Integrated Care System (ICS)

An umbrella partnership which delivers services requiring system-wide coordination (e.g. specialised services). An ICS can also: establish the future strategy of the system; coordinate activities to drive equitable, quality care delivery; implement enablers; and centralise the management of back office functions and system assets.

The scale of the ICS should support the delivery of the responsibilities noted above, whilst ensuring that the partnership remains sufficiently agile to both adapt to change and drive improvements at pace.

Notes: *General Practitioners and Allied Health Professionals.
Sources: 1) Evaluation Report of the Diabetes Care Project. The Department of Health (2015); 2) Central Coast Integrated Care Program. Formative Evaluation: Technical Paper. March 2018

Developing effective governance

Establishing an appropriate ICS form (i.e. its governance and organisational structure) is often one of the more challenging aspects of system development. The complexities faced stem from a number of drivers, including:

- **Existing regulations and legislation:** These can impact lines of clinical accountability, in addition to the financial expectations of provider organisations. They also place an emphasis on driving competition, a behaviour that is often found to be in direct conflict with the level of collaboration required to effectively integrate services.
- **Perverse incentives:** For a whole system approach to prove effective, sovereign organisations need to prioritise activities that benefit the local patient population and care system as a whole, rather than their individual organisation. However, funding mechanisms often disincentivise the required system changes.
- **Lack of trust between key stakeholders:** Without a simple solution to the existing regulatory and legislative environment, change programmes are typically reliant on strong inter-stakeholder relationships.
- **Appetite for risk:** The drivers noted above all impact stakeholders' appetite for risk. With all wide-scale system transformation programmes there are likely to be both 'winners' and 'losers'. Without adequate mechanisms to mitigate risks, the downside possibility of any given system change may be deemed unacceptable.

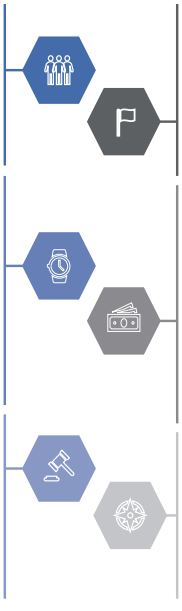
As a result of these complexities, there is often a need to find a balance between ICS forms that facilitate real change at pace, and those that minimise the risk for all involved parties. If not successfully managed this can prevent the development of an optimal ICS model and therefore, the realisation of the desired clinical and operational benefits.

For an ICS to prove successful, its governance model should encompass the key traits illustrated in figure 6 below.

Overall there are numerous ways to encourage the desired behaviours and unlock value. These should be considered on a case-by-case basis and include:

- **Commissioning:** The introduction of integrated commissioning functions, control totals, and outcome-based commissioning to enable collaboration.
- **Pooled risk:** The pooling of budgets to provide care for defined populations can also take place at a provider level. Additionally, providers could introduce risk and reward sharing agreements to prevent any one provider 'losing' as a result of an alternative care delivery model.
- **Collaborative agreements:** To formalise collaborative partnerships a spectrum of collaborative agreements or new corporate vehicles may be developed. Globally these range from memoranda of understanding and alliance agreements, to joint ventures and other new legal entities.

Figure 6. Key traits of an ICS governance model



Ensures appropriate representation

- Involves key stakeholders and ensures every partner feels fairly represented and empowered.

Sets realistic yet ambitious goals

- Short-term outcomes should help build momentum and trust in both the approach and emerging relationships.

Drives implementation at pace

- Implementation should not be too resource intensive.
- The aim of the model must be to realise some (but likely not all) population health benefits in the short to mid-term.

Manages financial risk

- The model must help overcome any misaligned incentives.
- This could be achieved by incorporating whole population budgets, outcome-based payments, and risk/ reward mechanisms.

Clarifies accountability

- When proposing amendments to service delivery it is imperative that the future clinical accountability of the service is clearly defined.

Provides sufficient flexibility

- Rather than specifying the actions required, desired behaviours should be encouraged. This ensures the partnership can respond to change.

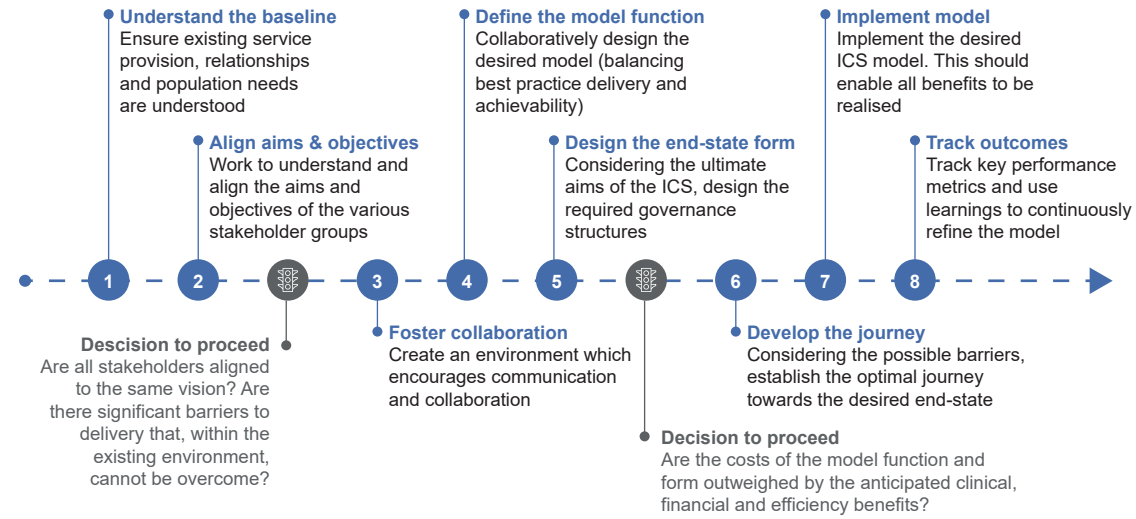
Effectively engaging stakeholders

For an ICS to prove successful, its development and implementation must be supported by a comprehensive programme of stakeholder engagement. Critically, a programme focused on building both trust amongst all key stakeholders and the momentum required to unlock benefits at pace.

The importance of developing trust between key stakeholder groups cannot be underestimated. Without robust relationships it may prove impossible to gain consensus on any actions beyond the development of a simple, non-binding, collaborative agreement. For most, faith in the quality, reliability and fairness of fellow stakeholders is deemed to be the bedrock upon which ICS models must be built.

To help develop the relationships required to drive real change, it is often beneficial to view the design of a new care system as a journey to the desired end-state model. A high-level example of an ICS journey is outlined in figure 7 below.

Figure 7. Illustrative ICS journey



To support such a journey, it may be advantageous to consider the 'softer' contractual options as stepping stones to the desired end-state. Softer options, such as memoranda of understanding, provide excellent opportunities to bring together the providers and commissioners of health services, build understanding and familiarity, and drive early momentum. Collectively these benefits will help:

- **Unlock alternative model forms:** As noted above, trust is required to mitigate against risk aversion. By developing trust between stakeholders, a wider range of transformational opportunities (e.g. those posing a greater risk to certain parties) may be unlocked.
- **Demonstrate partnership value:** Although softer agreements may not facilitate large-scale transformation, they can unlock benefits and help demonstrate proof of concept. Furthermore, such agreements can support the roll-out of system-wide enablers required to realise greater clinical and operational benefits later in the ICS journey.

That said, it should be noted that where strong stakeholder relationships already exist and where the makeup of a health system is comparatively simple, a greater step-change can be achieved much earlier in a journey towards system integration.

When ascertaining the appropriate path to take, it is vital that the desired end-state remains front of mind. By ensuring the ultimate function and form of the ICS is considered, effective milestones can be developed to support the journey.

To establish the preferred ICS journey, it is important for key stakeholders to consider the following:

- Do we have a history of collaboration? Do we have the strength of relationships required to drive change at pace?
- Are there quick wins that we could address in the shorter-term through the development of a 'softer' contractual model?
- Are there barriers to the full implementation of the desired end-state ICS model that we could address through the use of alternative contractual options?
- Are there external drivers that could pose significant risks were we to drive a wide-scale integration programme at pace?
- Does the proposed journey enable the realisation of clinical and operational benefits in a timely manner?

Effectively engaging stakeholders (continued)

To support the above and effectively unlock system improvements, a detailed, long-term stakeholder engagement strategy will be required. Figure 8 details the key success factors of an effective programme of stakeholder engagement.

Figure 8. Key success factors for stakeholder engagement

Success factors	High-level description
Engage the right stakeholders	• To design an optimal, patient-centric care system it is vital to engage a wide range of stakeholder groups at the appropriate stage of the process and in the preferred manner (e.g. surveys, workshops, one-to-ones, other). • Key stakeholder groups include, but are not limited to: tertiary, secondary and primary care providers covering physical health, mental health and wellbeing services; ambulance services; commissioning bodies and private funders; and patient groups.
Align stakeholder aims and objectives	• Although at face level the aims of key stakeholder groups may appear consistent, it is likely that their objectives and preferred approaches differ substantially. • This creates a risk of conflict between stakeholder groups which, if not properly understood and well managed, can cause significant challenges when developing an ICS. • Consequently, it is important to listen to all stakeholders, capture their 'red lines' and concerns, and invest time to align aims and objectives at the start of the process.
Establish forums for collaboration	• To help develop familiarity, understanding and trust amongst stakeholders, it is important to establish both formal and informal forums which support regular, transparent stakeholder communication.
Define the narrative	• To ensure the programme of work, its aims and objectives, and the role of each stakeholder group is well understood, it is important to develop a tailored narrative. • This narrative should be used to inform all stakeholder-specific messaging.
Develop effective and tailored communications	• Communications regarding both the ICS development process and its outputs should be centrally managed and tailored to specific shareholder groups. • It is critical that there is sufficient transparency throughout the process to facilitate the ICS journey. That said, it is also important that stakeholders receive an appropriate level of information; balancing the need for compelling, concise messages with the detail required to create excitement and drive momentum.

Additional considerations

Beyond the four fundamentals of ICS design there are a number of additional aspects that require careful consideration. Collectively, these additional considerations will support the development of a robust and effective care system that delivers sustainable health and wellbeing benefits for local individuals, communities and populations.

Although not exhaustive, a couple of the key considerations that would support the successful design of both the function and form of an ICS are noted in figure 9 below:

Figure 9. Additional considerations when designing an ICS

Understanding the baseline

To ensure the proposed ICS model both meets the needs of the local population and addresses any areas of underperformance or care inequality, one must first understand the 'as-is' model of care. This includes understanding existing organisational structures, stakeholder relationships, service performance, areas of unwarranted variation and the underlying health of the population.

The collation and analysis of data, often across providers, is required to establish a robust as-is baseline. This data can also be leveraged to define the patient cohorts for which a tailored ICS model can be built.

Driving continuous improvement

A process of continuous improvement should be established to track delivery success, provide opportunities to enhance benefits realisation, and capture learnings.

This requires the development of appropriate key performance indicators, and the tracking of the selected metrics against both the historic baseline and target outcomes. These target outcomes should be realistic, yet appropriately ambitious, helping drive progress towards key milestones and the proposed model end-state.

A Teneo case study

Case Study: Designing a London-based Integrated Care System

Context
In 2016, to improve health and care delivery, UK local councils and NHS bodies came together to form collaborative partnerships. The aims of the resulting 44 Sustainability and Transformation Partnerships (STPs) were to enhance care coordination, agree system-wide health and care priorities, and improve the health and wellbeing of the local population.

While STPs were a significant step forward, the general consensus was that a new model of care with a larger emphasis on integration was needed. This paved the way for Integrated Care Systems as a preferred model for the future healthcare system in England.

Health commissioners and providers in a London-based STP identified the patient and system benefits that may be available through a model of integrated care. Subsequently, Teneo was engaged to explore potential ways in which an ICS(s) could be implemented across the STP region.

The STP encompassed six London boroughs, each with their own Clinical Commissioning Groups and Local Authorities. The six boroughs were served by three acute providers, two Mental Health Trusts, and numerous primary, community, social, and voluntary sector organisations. Collectively this created a highly complex funding and provider environment.

Approach
Teneo's involvement in the development of an STP-wide ICS was divided into three main phases of work, each underpinned by an extensive programme of stakeholder engagement.

Figure 10. An overview of the phases of work undertaken

01
The initial phase of the engagement focused on:

- Developing the aims, objectives and expected benefits of an ICS model; and
- Understanding the key enablers and barriers to ICS development and implementation.

02
During this phase Teneo identified potential design and implementation options and assessed the benefits and risks associated with each approach.

This included advising on population segmentation, governance and organisational forms.

03
For the preferred design and implementation option, Teneo created an implementation plan.

To support this, Teneo conducted a 'readiness assessment' for each geography that evaluated the existence of ICS-like arrangements, current levels of integration, barriers to further integration, and capability gaps.

To ensure all stakeholders were aligned, representatives from the provider and commissioner organisations were regularly consulted. By providing a range of forums in which to share and discuss the end-state options available, its was possible to design an effective and implementable integrated care system.

About Teneo

An Introduction to Teneo

Teneo is a market leading CEO advisory firm that works with the CEOs, Boards and leaders of the world's largest and most complex companies. Teneo has extensive experience supporting health and social care providers to navigate complex market challenges, drive growth and unlock sustainable performance improvements. Operating across a range of geographies and having served a broad range of clients, our Global Health & Social Care practice brings an in-depth understanding of market dynamics and best-practice solutions.

Within health and social care, key client groups have included: Primary Care, Secondary Acute Care, Diagnostics, Mental Health, Community Care, Residential and Domiciliary Care, Health Consumer, Fitness and Wellbeing, and Special Education and Fostering.

Our global offer

Founded in 2011, with a vision of redefining the advisory industry, Teneo now has more than 800 employees based in 19 offices around the world.

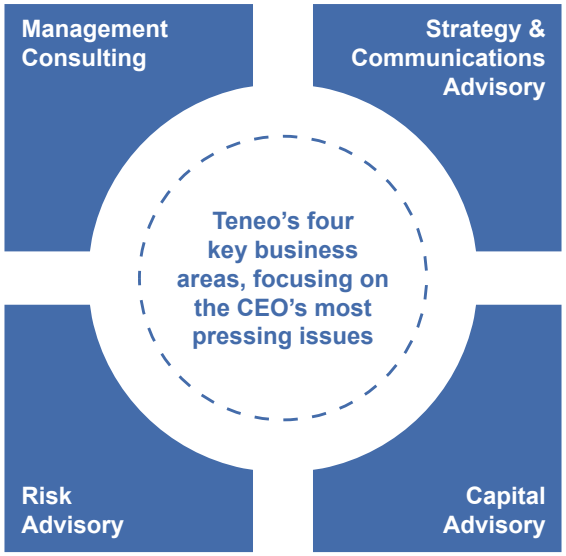
Across these offices, our teams provide clients with a unique set of services and a non-replicable group of diverse, highly talented senior professionals.

Management Consulting

Advisory focused on strategic decision-making and business plan implementation, to help companies fully realise their business goals

Risk Advisory

Advisory focused on helping corporations anticipate and mitigate risks associated with geogpolitics, physical security and cybersecurity



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