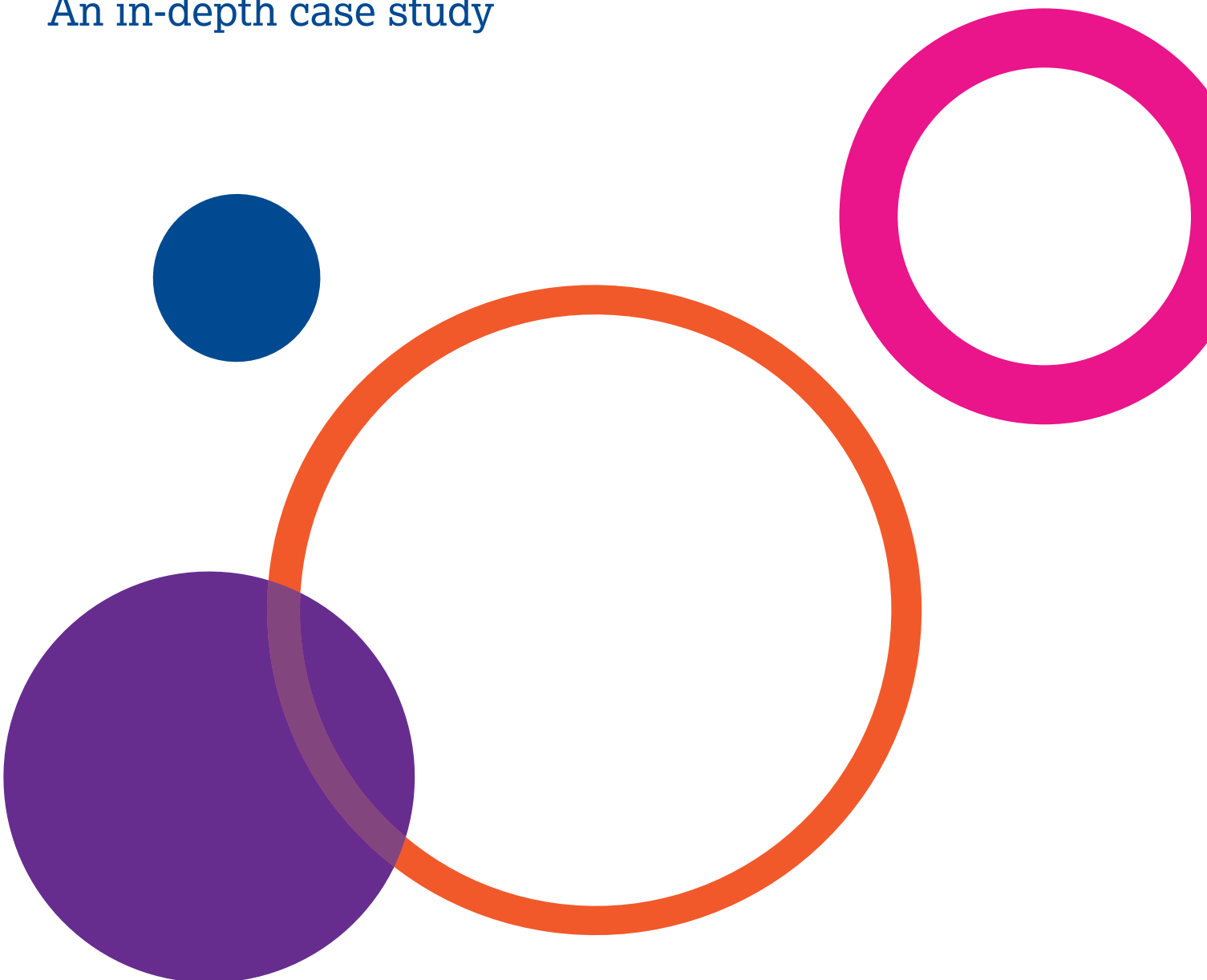


Financial reform as an enabler of change in Bradford

An in-depth case study



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Key points

- This case study explores how Bradford has used the financial levers of system controls totals and fixed-income contracts to align incentives, pool risk and achieve financial balance. This is the first in a series of in-depth case studies distilling practical learning for sustainability and transformation partnership and integrated care system leaders.
- Partners across the six places within the West Yorkshire and Harrogate Health and Care Partnership integrated care system (ICS) agreed to use fixed-income contracts as a way of maintaining control over annual healthcare spending. This was part of steps towards closing the financial gap across the ICS and meeting the system control total.
- For Bradford District and Craven Health and Care Partnership, moving to fixed-income contracts required changing the way in which local partners worked with each other. This helped to bring partners together and shift the focus from reactive responses to strategic planning and better population health management.
- The approach has led to a number of benefits, including providing greater certainty in financial spending and control of costs, and stopping acute activity that could be done elsewhere, such as urgent care and planned care. This has led to the redesign of outpatient care and the bolstering of community and preventative services.
- Yet fixed-income contracts on their own are not the main instruments for local system change. They do not designate a clear path for moving money from one part of the system to another; nor do they necessarily release cash savings to reinvest in upstream prevention and early intervention.

- To counteract these risks and ensure the full potential of fixed income contracts is achieved, five key lessons can be drawn from Bradford's experience. These lessons are aimed at systems leaders looking to develop a similar approach in their local system:
 1. Get the system fundamentals right: strengthen local partnerships, spend time setting and demonstrating a new culture, and prioritise what you will do together, for example by focusing on a small number of priorities you want to work on together and developing an agreed memorandum of understanding.
 2. Optimise the principles and behaviours for cross-organisational working, for example by being authentic and honest in conversations – contract as a group of senior leaders and stand by the Strategic Partnering Agreement, avoiding a 'winners and losers' approach.
 3. Use system governance to support shared accountability and to create space for joint problem-solving, by sharing data, for instance, and build a shared picture of financial issues.
 4. Maximise the benefits of using contracts while protecting against their limitations, for example the need to understand that this approach does not eliminate underlying deficits. Rather, it encourages partners to decide how best to use the available resources
 5. Recognise that the NHS, on its own, does not have the scope or the levers to achieve the local ambition for change, for example working more closely with local authority and voluntary sector in the development of future financial mechanisms.

Introduction

The journey from financial recovery to better value care is an aspiration of all local health and care systems. Yes despite this, tackling immediate financial pressures, such as provider deficits, remains the focus of most decision making in local systems.

This case study explores how Bradford, a city in West Yorkshire, has achieved financial balance by using the financial levers of system control totals along with fixed-income contracts to align incentives, and pool risk. It highlights the initial benefits and risks, both financial and non-financial, of moving from a tariff-based to a fixed-income contract model.

The case study is based on interviews with senior system leaders from Bradford District and Craven Health and Care Partnership and West Yorkshire and Harrogate Health and Care Partnership, an integrated care system (ICS). In particular, it explores what the integrated care partnership and system are learning about benefits and drawbacks of this approach, and offers early views about the impact. Participants in this research are listed at the end of this paper.

This is the first in a series of case studies on key topics with practical learning for sustainability and transformation partnership (STP) and integrated care system (ICS) leaders. Further case studies will follow on other system approaches to finance and place-based population health improvement.

About Bradford District and Craven Health and Care Partnership

Fact file

Geography and demographics

As a large geographic footprint, the place covers the densely populated city of Bradford and the rural areas of Craven, and includes significant areas of deprivation. The partners are responsible for meeting the health needs of 600,000 people, with nearly 590,000 people within Bradford itself. The population is one of the most diverse nationally, and significant health inequalities still exist across the different areas of the district.

The Bradford District and Craven Health and Care Partnership covers the district of Bradford and the rural area of Craven, and sits within the West Yorkshire and Harrogate Health and Care Partnership.

The health and care system

The Bradford District and Craven Health and Care Partnership is one of six areas that make up the West Yorkshire and Harrogate Health and Care Partnership. The whole of the ICS provides a common vision and shared plan across the six places, with local partnerships responsible for the planning and delivering of integrated care. The ICS partnership board sets the overall strategic direction, but the system partners have agreed that decisions and actions will follow a set of subsidiarity principles, with most decisions and actions occurring in each of the six places.

Integrated care partnership partners

Airedale, Wharfedale and Craven CCG, Bradford City CCG, Bradford Districts CCG, Airedale Hospital NHS Foundation Trust, Bradford Teaching Hospital NHS Foundation Trust, Bradford District Care NHS Foundation Trust, City of Bradford Metropolitan District Council, Bradford Voluntary Care Sector Alliance Ltd, Local Care Direct Limited, Modality Partnership, Wharfedale, Airedale and Craven Alliance, Bradford Care Alliance CIC Ltd

Building the partnership

Combining commissioners and providers, the Bradford District and Craven Health and Care Partnership has matured over several years, with local leaders increasingly focused on getting better value out of limited healthcare resources. Although not yet merged, the three clinical commissioning groups have been working as one, with a single operating team.

What is a fixed-income contract?

Fixed-income contracts are bilateral fixed payments agreed by commissioners and providers, based on planned activity levels. By removing a focus on transactional issues and limiting incentives to increase activity, these annual contracts provide a degree of certainty over provider income and commissioner spend.

The fixed-income amount reflects inflation, efficiency savings, system plans for transformation, changes in demand and delivery of the system control total.

The relationship with Bradford City Council has also been evolving, creating new opportunities for how the whole system can support the shared aims for better health and wellbeing. Decisions are taken by the partnership's integration and change board, and they are underpinned by a Strategic Partnering Agreement between all the partners. The partners are also working to create 13 community partnerships, using asset-based approaches. These places are expected to become centres for prevention and early help and are broadly aligned with primary care networks.

“We have spent considerable years building up our partnership. Only now are we able to have a single conversation about what we can afford.”

Closing the financial gap

In addition to setting direction, in 2018 the ICS partnership board agreed that all places would take steps towards closing the financial gap across the ICS and meeting the financial spending target for the ICS – the system control total. Partners agreed to use fixed-income contracts with healthcare providers as a way of maintaining control over annual healthcare spending.

The system control total is an annual financial target for each ICS or STP. Developed in response to NHS financial pressures and set by NHS England, and NHS Improvement the control total effectively caps spending for all commissioners and providers in the system, shifting the focus away from organisational autonomy. System leaders are expected to align their delivery plans with the control total.

The control total has 3 per cent efficiency savings built. By limiting growth in this way, fixed-income contracts would support the system's aims of recovering existing deficits, reducing demand on high-cost hospital care and tackling variation in care outcomes. Each local place would have the scope to determine how best to manage these contracts, monitor their progress and troubleshoot any difficulties with local partners.

The Bradford District and Craven Health and Care Partnership has been using fixed-income contracts only since April 2019, but the partners agreed that for the 2019/20 contracts, they needed to adopt the same principles and behaviours in closing off the 2018/19 contracts.

“Previously, there were no incentives across the system to manage money together. They are creating collective responsibilities for the system living within its means.”

The financial priorities for Bradford's local system are:

1. **recovery** to close the gap in NHS spend
2. **sustainability** – reducing demand on acute care (urgent and planned care) and reducing spending by reducing acute activity levels
3. **realising their ambition** – delivering care within existing resources.

The progress described in this case study covers 12 months of Bradford's initial journey towards financial balance and control. As the leaders we interviewed described, the situation for the integrated care partners is a snapshot in time, with the local system continuing to develop and evolve. Nonetheless, these reflections provide valuable early learning and insights for other integrated care systems that are choosing to use fixed-income contracts.

Moving towards fixed-income contracting

Moving to a fixed-income contract in Bradford required changing the way in which loyal partners worked with each other. This journey towards behaviour and culture change took two to three years, culminating in a Strategic Partnering Agreement (SPA) which laid out the principles for engagement.

Since mid-2018, the challenge has been to put these partnership principles into practice. Bradford's leaders agreed that the existing competitive behaviours were working against public service values, and they needed to make the best use of public money by collaborating instead. With the funding available fixed, the partners agreed that they had to work collectively, be less adversarial and more open and transparent.

Bradford's leaders explained that moving to a fixed-income contract was not a *fait accompli*. Although the partners had agreed to work differently, additional effort was required to gain support from their respective boards, especially the NHS providers. The notion that the system would 'succeed together and fail together' did not align with competitive contracting practices, income maximisation at NHS trusts and the expectations of NHS regulators.

“We had to have a series of internal and external conversations as system leaders and talked to sovereign boards to get support.”

The partners deliberately chose to close off the 2018/19 contracts and approached the 2019/20 contract planning round using the SPA's principles of engagement and collaborative behaviours, such as trust, openness, and total transparency about how individual partners are spending money. Positive benefits of this new way of working include:

- a move away from bilateral conversations and sometimes adversarial behaviours
- reduction in stress brought about by removing the usual 'to-ing and fro-ing' that characterised annual contract
- a reduction in the bureaucratic burden for both the commissioners and providers as the contractual discussions became a single partnership conversation
- the development of a more pragmatic mindset, asking: 'what can we afford?'

The financial recovery period is anticipated to take three years. Bradford's leaders have stressed the importance of not assuming that the fixed-income contracts are the sole driver of change. Rather, they are using a combination of the system control total, the fixed-income contracts and efficiencies from reducing duplication to manage both rising costs and growing demand for services in the local system.

“Aligning incentives across the system is evolving into conversations about quality and workforce, not only money.”

Partners' finance conversations are supported by a clear governance structure. In addition to the integration and change board, which involves the most senior local system leaders, two delivery boards involving both commissioners and providers have been established. The first is the system finance and performance committee, led by a finance director from one of the acute trusts and including both finance and operational directors. Its role has taken shape rapidly and is described further below. The second board focuses on quality and safety and has only just started.

“Fixed-income contracts are not the sole driver of change.”

Initial progress, early insights

It is still early days for determining whether the fixed-income contracts are achieving the financial recovery expectations set by the West Yorkshire and Harrogate Health and Care Partnership board Board. However, Bradford's system leaders stressed that fixed-income contracts on their own are not the main instruments for local system change. The early impact is not a story about disinvestment or moving money around the system. Rather, it is about how Bradford's partners are creating a local system that lives within its means.

A process of discovery

So far, the system's experiences with fixed-income contracting illustrate a process of discovery, from the changing of perspectives to the challenges of shifting behaviours up and down the system, and within and across organisations. For commissioners, the contracts reflect the baseline of activity levels. By incorporating planned efficiencies, they are providing the three CCGs with a degree of certainty about spending. This certainty has led them to focus on demand management programmes, including pathway redesign, to reduce emergency admissions and planned care.

However, with the contracts only covering NHS activity, there is growing recognition of the limitations of fixed-income contracts in addressing prevention and early intervention. A wider 'whole-system' partnership, including joint commissioning with the local authority and engagement with primary care, is a work in progress. The investment in prevention and early intervention across the whole system has not yet been addressed, and the partners are mostly focused on targeting resources to selected pathways such as respiratory and diabetes, while sharing the risk for acute activity levels and outcomes.

External consultants have suggested that 30 per cent of A&E demand could be shifted through early intervention, yet who will pay for early intervention is not yet decided. The system control total creates another anomaly for whole-system working, because the collective bottom line only applies to the NHS partners. Many of the people interviewed commented that the local reality is a system with two separate governance regimes and two separate finance regimes (local authority and NHS).

Best use of the public pound

“The finance and performance group is changing the conversations between commissioners and providers”

From the perspective of NHS providers, the fixed-income contracts have delivered income assurance for the financial year, and providers are beginning to approach the challenge of balancing trusts’ financial and operational goals differently. Rather than trying to find ‘savings’, the finance and performance committee is providing the structure and forum for joint efforts to manage growth by reducing demand.

Concentrating on the overall collective performance for the system, the group provides monthly oversight, with dashboards being used to monitor acute activity levels and trigger shared actions. The existence of the finance and performance group is changing the conversations between commissioners and providers, allowing for the recognition of differences while prioritising a handful of ‘big ticket’ items.

Although the metrics are evolving, the group is using a forecast model that shows ‘if we don’t do certain things, this is where we could end up.’ Along with the close monitoring of activity levels, they have an agreed mechanism for what they will do if they go above a certain level, but the mechanism has yet to be tested. It also remains to be seen how they handle end of year reckoning, for example how partners will work together to resolve any over-activity.

In regard to tackling business cases, collaboration appears to be making a real difference. Return on investment questions for the system are being asked, and there is an increasing clarity of spend, with talk about upstream and downstream effects, although not solely for the health service. With a shared in-depth picture of the local system, the group is also providing a bit of push-back into NHS England and NHS Improvement for this year’s financial planning process, challenging the regulator about what’s possible in regard to financial expectations.

Changing behaviours

Beyond the group, changes to behaviours have been more limited within NHS providers. Other incentives are at work, with day-to-day provider practices retaining their autonomy and usual working patterns. The larger cultural shift remains elusive. They are realising that behaviour change has to reach the front line in order to manage demand and reduce admissions.

Overall, the fixed-income contract approach is designed to control activity levels, but it is not the driver of collective decision making. Recognising that they still have a spending gap to close if the partners are to achieve their control total, they are asking together: “How can we reduce demand, and therefore reduce costs?” Previously, the incentives were to drive activity within each organisation because more activity resulted in greater income.

By focusing instead on finding ways to manage demand, they are standardising referral systems, redesigning outpatient care, stopping activity that could be done elsewhere (inappropriate referrals), and using population health data to target resources more effectively. How well these actions control activity levels is not fully understood. The partners are also starting to talk about efficiencies. Historically, partners have made decisions without considering other partners, but the new contracting arrangements are beginning to show that there is a different way to shift demand on acute services.

One version of the truth

Discussions at the integration and change board and the system finance and performance committee are testing the theory that savings will result from lowering activity levels. They have already found that a couple of NHS trusts are significantly ‘off plan.’ By sharing data and examining it together, the partners are finding that other factors, such as non-elective demand and increases in workforce costs, are adding to financial pressures and eliminating any potential savings from reducing activity levels. Collective solutions are being sought, from standardising waiting lists across providers to considering what they can defund or decommission.

“We are aiming for one version of the truth.”

The use of fixed-income contracts has helped steer conversations forward, but has not created a clear path for moving money from one part of the system to another – the thorniest of all issues. The leaders have acknowledged that the contracts are not releasing cash savings to reinvest in upstream prevention and early intervention. Neither are the contracts enabling the partners to shift resources into other parts of the system.

Instead, the fixed-income contracts are stopping acute activity that could be done elsewhere, without necessarily identifying how primary and community resources will be affected. The partners recognise that they are at the beginning of a long journey from financial recovery to delivering better value care.

The discussions are also testing risk behaviours within NHS providers and perhaps creating a handful of unintended consequences. Some leaders commented that, by not incorporating prevention, public health or primary care, the fixed-income contract approach creates short-termism around decision making. Others attributed this phenomenon to the effect of the control total.

Either way, the immediate financial pressures become the main focus, even though the partners recognise they need to give more attention to the long-term health and wellbeing agenda. Similarly, there are potential adverse effects on patient care. Early concerns have been raised about how lower activity levels and standardised waiting times are contributing to poorer patient access to care. A quality and safety committee has been established to monitor the impact on patient outcomes.

In addition to activity levels, the partners concede that a broader, rounder picture of provider data is needed to understand how patient care is changing as a result of the system working better together.

Trust

The partners understand the imperative to invest in prevention by backing local communities, yet demand pressures on health and care services continue to grow. System leaders are aware that trust between councils and the NHS requires consistent support and attention to relationships. One person observed that the increased closeness between NHS partners potentially ‘creates greater distance with the local authority’ and other local partners.

“Trust requires consistent support and attention.”

To counteract this situation, efforts are underway within the integration and change board and the two delivery committees to be more inclusive of the interests of the local authority and communities. For example, the finance and performance committee involves the finance director from Bradford City Council, but partners readily accept that it will take time before there is a collective view of the system’s total resources for health and care, including which resources to include. Who will pay for different interventions, especially prevention and early intervention, has yet to be settled. The expectation is that collaborative working practices will evolve further as the community partnerships take hold.

Lessons learned

While representing only a snapshot in time, the learning from Bradford can nevertheless be instructive to other place-based systems.

1. Get the system fundamentals right: strengthen local partnerships, spend time setting and demonstrating a new culture, and prioritise what you will do together.

- Recognise that it will take time to develop a new approach, and to ensure you get the basics in place before making more ambitious changes.
- Prioritise and agree areas of collaboration – find the four or five big things you want to do at one time.
- Foster key system leadership behaviours to include:
 - having a shared place-based vision and shared accountability
 - collaborative relationships, characterised by trust and openness
 - the willingness and mindset to work together, supported by a formal Strategic Partnering Agreement.
- Ensure there is a shared understanding of the starting financial position, recovery objectives, demand drivers and opportunities.
- Encourage the use of good and available local data, and create the capability to generate system intelligence.
- Work towards a clear system control total and a supportive ICS.

2. Optimise the principles and behaviours for cross-organisational working.

- Be authentic and honest in conversations with partners.
- Contract as a group of senior leaders.
- Stand by the Strategic Partnering Agreement, avoiding a 'winners and losers' approach.

3. Use system governance to support shared accountability and to create space for joint problem-solving.

- Be aware that the financial levers alone do not produce change; you need good governance structures in place, underpinned by clear agreement on roles and ways of working.
- Have open and honest conversations about real issues and the best use of money.
- Partners should develop a shared understanding of the whole financial picture for the local area to maximise the opportunities for early intervention.
- Share data early and often between partners.
- Provide resources and analytical capacity to support the programmes.

4. Maximise the benefits of using fixed-income contracts while protecting against their limitations.

- The fixed-income contract takes away perverse incentives and cyclical damaging behaviours from the competitive system, encouraging greater collaboration between local NHS partners. However, the approach does not eliminate underlying deficits. Rather, it encourages partners to decide how best to use the available resources.
- The fixed-income contract affords local areas a reasonable level of control on activity and demand for services – it is much easier to stop growth or reduce growth than it is to take costs out.
- Be aware of the drawbacks of fixed-income contracts for patient care quality and safety. Monitor both financial performance and care outcomes.

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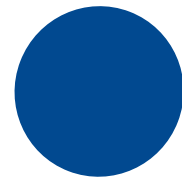
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