

**Reforming the
payment system
for NHS services:
supporting the
Five Year
Forward View**



Contents

Executive summary	3
1. Background	5
1.1. Our objectives for the payment system	5
1.2. Purpose of this document	7
2. Payment approaches with the potential to enable new care models in the Forward View	7
2.1. Integrated care	9
2.2. Urgent and emergency care networks	10
2.3. Elective care and specialised services	11
2.4. Mental health services	12
2.5. Next steps for payment transformation	13
3. The information building blocks needed to deliver payment system reform	14
3.1. Why better activity, cost and quality data matters to patients	14
3.2. Classifying patient-level activity data	15
3.3. Patient-level cost data	16
3.4. Quality measures and data	17
3.5. Data linkage	18
3.6. Improving data usage	20
4. A phased timetable for reforming the payment system	20
4.1. Local health economy adoption paths	21
4.2. Phased approach to transition	22
4.3. A role for all players in reforming the payment system	25

Executive summary

In October 2014, the national organisations responsible for delivering NHS services in England set out their joint vision for the NHS in the 'Five Year Forward View' (the 'Forward View').¹ Improvements to the payment system will be critical to developing and delivering the new care models that the Forward View describes, alongside changes in other enablers such as contracting, technology and the workforce.

NHS England and Monitor first set out the case for reforming the payment system in May 2013. Based on research and engagement with the sector, we have identified several payment approaches with potential to help realise the vision of the Forward View. To develop the payment system so that it begins to support a rapid shift to new models of care by 2020, we now want to work in even closer partnership with local providers and commissioners of care, including those in social and primary care. We want to develop the following payment approaches further with the sector to support the new care models that will benefit patients:

- To support integrated care models, such as Multi-specialty Community Providers and Primary and Acute Care systems, a form of capitated payment covering primary, secondary, community and mental health and, where possible, social care.
- To support the development of urgent and emergency care networks, a three- part payment approach comprising payments for capacity, activity, and quality, which shares risk between providers and commissioners across the networks to ensure patients receive the care they need in the right setting at the right time.
- To support high quality elective care and specialised services, a mix of payment approaches, including payments for episodes of care linked to best practice and year of care payments for looking after patients with, for example, life-long conditions.
- To support parity of esteem for mental health services, a mix of payment approaches all linked to outcomes and recovery, with mental and physical health integrated where desirable, and a move to mandatory national prices for episodes of care that follow established treatment pathways where appropriate.

¹ <http://www.england.nhs.uk/2014/08/15/5yfv/>

Alongside these payment approaches, the second group of reforms we propose comprise improvements to the information building blocks underpinning the payment system. In this regard, we propose over the next five years:

- To develop a comprehensive set of currencies (units of healthcare for which a payment is made), including HRG4+ for admitted acute care, and new currencies, particularly for targeted areas of community health, mental health and specialised services.
- To introduce a single mandated patient-level cost collection across all care settings, to improve payment regulation.²
- To work with partners to support commissioners and providers in linking cost, activity and outcome data across care settings.
- To work with partners to develop quality measures for payment purposes.
- To build the sector's capability in capturing and using high quality cost, activity and outcome data.

Implementing the reforms outlined above would result in a blended, rules-based NHS payment system. Broadly speaking, the payment system is likely to comprise menus for locally determined payments, from which commissioners and providers could choose the most appropriate approaches for their local models of care and service contracts; a number of national prices for episodes of care delivered by centres of excellence and specialised services networks; and national guide prices for all other currencies.

We expect reform of the payment system to take place in three broad phases over the next five years, with the overall pace of change subject to progress in developing the care models described in the Forward View and the resources available. The local pace of moving to new payment approaches may vary with differences in the circumstances of local health economies.

This paper sets out a clear direction for the payment system and is our point of departure for transition to the new blended system. We will adjust the transition approach in the light of all we learn as the sector builds the new payment system, and taking into account the clinical and financial context in which the health sector operates.

To realise the potential benefits for patients as quickly as possible, everyone involved in the NHS needs to play their full part in introducing the payment reforms

² See Monitor's 'Improving the costing of NHS services: proposals for 2015-2021', available at <https://www.gov.uk/government/consultations/improving-the-costing-of-nhs-services-proposals-for-2015-to-2021>

and new models of care. Success will depend on national and local organisations owning and leading change.

1. Background

In October 2014, the national organisations responsible for delivering NHS services in England set out their joint vision for how services will develop over the next five years in the ‘NHS Five Year Forward View’ (the ‘Forward View’).³ The Forward View proposes a number of new models for providing NHS care that will break down barriers between GPs and hospitals, between physical and mental health and between health and social care. As well as improving the quality of patient care, the efficiency of these new models is expected to be crucial in closing the £22 billion gap⁴ between resources and patient needs projected to emerge over the next five years if the NHS does not change.

The Forward View does not envisage a ‘one-size-fits-all’ solution for the shape of NHS services. Nor does it expect to see a thousand flowers blooming. Rather, it proposes that commissioners and providers in each local health economy should develop and deliver the new care models most appropriate for patients in their area. Changes to the payment system, including but not limited to the national tariff, will be critical to delivering the locally developed new care models that the Forward View describes and in helping to increase efficiency.

NHS England and Monitor became jointly responsible for the national tariff under the Health and Social Care Act 2012. We set out the case for making changes to the existing payment system in May 2013.⁵ Evidence showed that, while the predominantly activity-based payment system had helped bring down hospital waiting times and enabled patients to choose providers for elective care, it needed reform to promote the best value design of services for NHS patients. Many of the priorities we identified then, such as the need to improve the activity, cost and quality information underpinning the payment system and to reform payment to support integrated care, are also priorities for achieving the vision set out in the Forward View.

1.1. Our objectives for the payment system

NHS England and Monitor work together to create the framework of payment rules, prices and regulatory arrangements – such as the specification of data standards, collection of provider costs, the cycle of national tariff consultations and development projects – that together comprise the NHS payment system. To develop the payment

³ www.england.nhs.uk/2014/08/15/5yfv/

⁴ *Ibid*

⁵ See ‘How can the NHS payment system do more for patients? A discussion paper’, available at: <https://www.gov.uk/government/consultations/how-can-the-nhs-payment-system-do-more-for-patients>

system so that it supports a rapid shift to the models of care that will serve patients well and sustainably in line with the Forward View, we now want to work in closer partnership with local providers and commissioners of care, including of those in social and primary care.

A payment system developed in close partnership with commissioners and providers that helps to realise the vision in the Forward View will, by definition, help meet the objectives for the payment system that NHS England and Monitor proposed to the sector in May 2013. These are that it should encourage:

Continuous quality improvement. The payment system needs to promote the long-term, sustainable well-being of the whole person by reimbursing providers for delivering specified quality outcomes for patients rather than particular treatments or inputs.

Sustainable service delivery. The payment system needs to incentivise best practice efficient and accessible delivery of care, to make sure that NHS funding goes as far as it can for patients.

Appropriate allocation and management of risk. The payment system can help to make sure that financial risks in the NHS, caused by demand pressures or operational performance, sit with those organisations, whether commissioners or providers, that are best able to influence or absorb them in the context in which they arise. Commissioners and providers need to work together to agree the risk sharing arrangements that minimise financial risks to local health systems and maximise benefits to patients from NHS funding.

There are bound to be trade-offs between quality, sustainability and risk management in different circumstances. The design of the payment system can do more for patients by guiding local commissioners and providers in striking the best balance between these three objectives for patients in their local areas.

A payment system designed to meet these three objectives will result in better patient outcomes for the resources available by supporting better contracting discussions and agreements between providers and commissioners, the people who ultimately determine how care is provided to patients. Two types of change in particular would support better contracting discussions between them:

- Improvements to payment regulations (eg the mix of mandatory prices and local price-setting rules). Changes that promote transparency and accountability will help to guide providers and commissioners to the best decisions for patients in different contexts.
- Improvements to the information underlying the payment system. Reliable and consistent data about service volumes, costs and quality will support more considered, better informed decisions for patients.

The payment system is not the only factor that needs changing to meet these objectives. Monitor's recent research on financial and non-financial incentives concluded that changes to incentives created by the payment system need to complement other factors that influence commissioners' and providers' decisions, to achieve their full potential benefits for patients.⁶ Reforms to the payment system therefore need to be aligned with changes to a range of other enablers, including the duration of commissioner allocations and contracts, workforce training, provider targets and reporting, arrangements for sharing of clinical records and IT systems. NHS England will work with Monitor and others to ensure the necessary enablers for the new models of care are in place.

1.2. Purpose of this document

As the Forward View acknowledges, new care models will take time to develop. So will the supporting payment system. However, NHS England and Monitor have been working on changes to the payment system for some time, and are already developing payment approaches suitable for some of the new care models. We are now in a position to signal to the sector the overall direction of the payment system reform that we propose, explain the details of new payment approaches and improvements to the underlying information building blocks that we envisage, and set out a high level approach for when and how these can be introduced. The purpose of this document is to provide that explanation and detail. The following sections outline:

- Section 2: Payment approaches with the potential to enable the new care models identified in the Forward View
- Section 3: The information building blocks needed to deliver payment system reform
- Section 4: A phased timetable for reforming the payment system.

2. Payment approaches with the potential to enable new care models in the Forward View

We have started to identify for further development those payment approaches with potential to enable the care models outlined in the Forward View, building from research and engagement with the sector. We continue to explore which blend of activity-based, outcomes-based and capitated payment approaches will together do most for patients and which we should therefore propose to mandate. However, we are certain at this stage that the eventual blend will need to align the interaction of

⁶ See 'Research on financial and non-financial incentives', available at <https://www.gov.uk/government/publications/reforming-the-payment-system-for-nhs-services-supporting-the-five-year-forward-view>

payment approaches across settings of care – mental health, social, community, primary, acute and ambulance – and across related health services, such as health research, education and training. Moreover, since every payment approach has the potential for perverse consequences, we also know that further work on the design of payment approaches should seek to pre-empt or mitigate these.

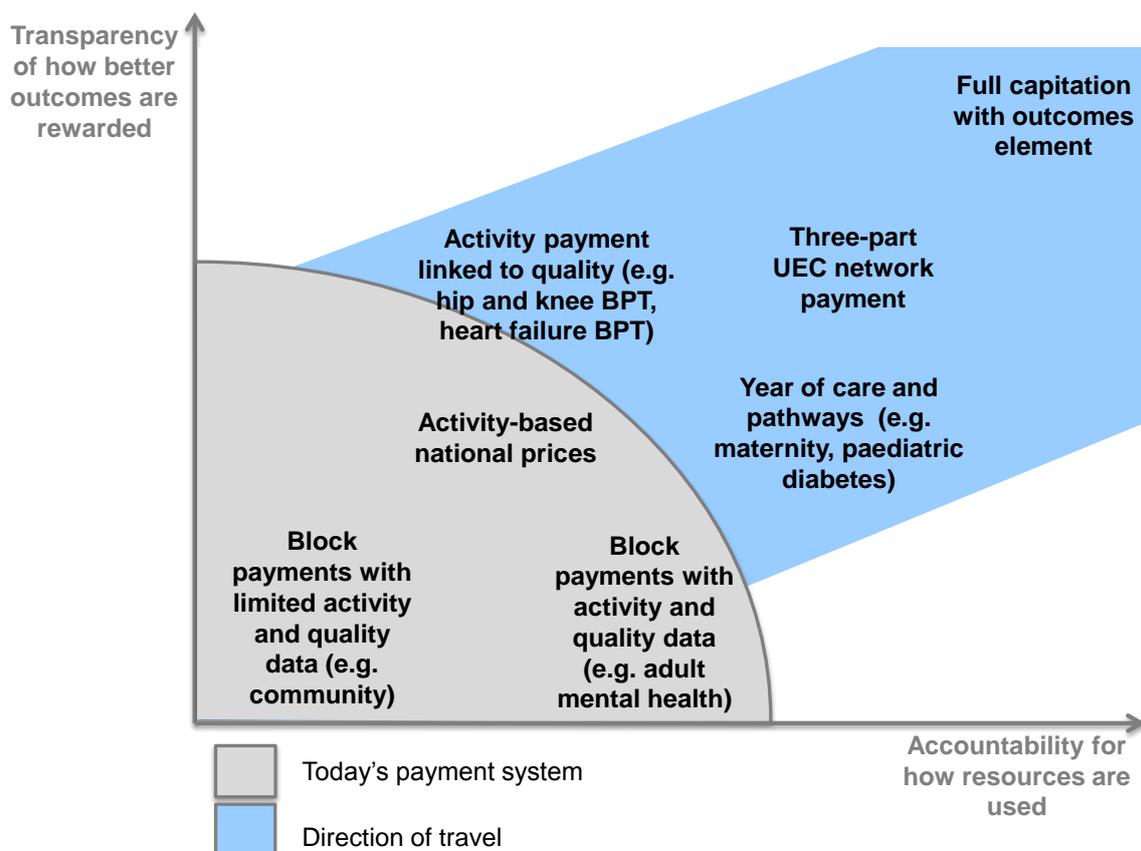
Less uncertainty about the future direction of the payment system could accelerate delivery of the potential patient benefits of new payment approaches. A national tariff that creates a more predictable environment for commissioner/provider negotiations will support investment, innovation and long-term planning. With this in mind, Monitor recently assessed the effects of publishing the national tariff over multi-year periods.⁷ This preliminary research suggests there is merit in Monitor and NHS England publishing the national tariff less frequently, perhaps every three or even five years, in order to promote long-term planning and the efficient provision of services.

In considering further how and when to publish the national tariff, Monitor and NHS England will take account of new care models, new payment approaches, the power of payment incentives, and related dependencies such as multi-year commissioner allocation cycles.

The rest of this section describes the payment approaches that we envisage enabling the models of care described in the Forward View, as summarised in Figure 1.1.

⁷ See 'Review of multi-year national tariff cycles', available at <https://www.gov.uk/government/publications/reforming-the-payment-system-for-nhs-services-supporting-the-five-year-forward-view>

Figure 1.1: Transparency and accountability of different payment approaches



We compare how current and potential new payment approaches support increased transparency and accountability for the value of care delivered, which are necessary for commissioners and providers in determining sustainable local care models.

2.1. Integrated care

The Forward View sets out how traditional models of care are increasingly a barrier to the personalised and co-ordinated health services that patients need. It describes two new models of care, the Multispecialty Community Provider (MCP) and Primary and Acute Care (PAC) systems, which aim to promote more integrated care for patients. These new care models will be promoted alongside Integrated Personal Commissioning.⁸ The payment system will need to adapt to provide support for the new care models, allowing for different permutations in different local areas.

The Forward View makes clear that identifying a single provider entity with financial and clinical accountability for the whole health needs of a population is at the radical end of the integrated care spectrum and will take time and expertise to implement. However, we envisage that some form of capitated payment, covering as much of primary, secondary, community, mental health and social care as possible, would

⁸ www.england.nhs.uk/wp-content/uploads/2014/09/ipc-prospectus-updated.pdf

remove financial barriers to the efficient operations of an MCP or a PAC. In time, the capitated payment could be calculated using a formula, perhaps building from the existing formula used to calculate primary care funding. Related quality and outcome measurement should focus providers on what matters to patients and counteract any perverse incentives for providers arising from capitated payment, for example, to shift costs to other providers or to ration care.

Some local areas are already beginning to embrace these ideas. We will continue to support them, to ensure they can make rapid progress (see progress snapshot 1). For example, NHS England is considering making available new model contracts for voluntary take up in 2016/17.

Progress snapshot 1: Capitation – a new payment approach with potential to enable integrated care⁹

Monitor and NHS England have published a capitation payment model to support and guide commissioners and providers keen to implement capitated payment approaches within the rules for local price setting. This model describes how to calculate a capitated payment step by step, starting with a relatively simple form of payment to a lead accountable provider for meeting the care needs of a targeted population group. Population groups suitable for a lead

accountable provider include people with serious mental illness, multiple long-term conditions, the elderly, or children/ young people with complex disabilities.

2.2. Urgent and emergency care networks

The Forward View proposes to organise urgent and emergency care (UEC) in co-ordinated networks to help patients get the right care, at the right time and in the right place. This builds on Sir Bruce Keogh's Urgent Care Review. NHS England and Monitor have already begun work to revise the payment system to support such networks.¹⁰

The payment approach for urgent and emergency care networks needs to enable activity to shift between the network's component services, which include 111 and ambulance services, as well as community and mental health rapid response and liaison teams, while recognising that these services need to be 'always on'.

⁹ See 'Capitation: a potential new payment model to enable integrated care', available at <https://www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements>

¹⁰ Phase 1 report of NHS England's review of urgent and emergency care led by Professor Sir Bruce Keogh (the 'UEC Review') (November 2013) 'Transforming urgent and emergency care services in England – Urgent and Emergency Care Review End of Phase 1 Report'. NHS England has also published an update on the review (August 2014) 'Transforming urgent and emergency care services in England – Update on the Urgent and Emergency Care Review'.

Some of the new models of care in the Forward View will intersect with elements of the urgent and emergency care network. For example, some urgent secondary and community care would be included in PAC arrangements paid for using one of the new capitated payment approaches. A payment approach for urgent and emergency care must therefore accommodate any overlapping service delivery models without paying for them twice.

Based on our current research and sector engagement, the new payment approach for services in urgent and emergency care networks is likely to combine three elements, each of which could include quality indicators with full payment conditional on their achievement:¹¹

- a capacity element to reflect the ‘always on’ nature of the services (this element may change over time, to reflect locally planned shifts in capacity)
- an activity element to manage risk and to support patient choice
- an incentive element to help align the many different types of provider and commissioner involved with the network.

The payment approach will require more accurate demand forecasting, in order to understand and allocate appropriately financial risk arising from changing patterns of demand and to manage the intersection with new MCP and PAC models of care covered by capitated payments.

The Forward View points out that smaller acute hospitals may need to adopt new models of care to be viable. For example, they may need to work as part of a chain or in conjunction with specialist centres, and to use technology differently. The capacity element of the three-part UEC payment could offer all UEC providers, including any smaller acute hospitals that provide UEC services, reimbursement that reflects efficiently incurred costs of providing agreed levels of ‘always on’ capacity.

2.3. Elective care and specialised services

The Forward View proposes that NHS England will work with local partners to drive the consolidation of services into centres of research and service excellence where there is strong evidence linking service quality to the volumes of patients treated. Specialist providers will also be encouraged to develop networks of their specialist services over a given geography, delivering co-ordinated services that encompass the full continuum of patients’ care pathways from diagnosis, to treatment and support for ongoing self-care.

¹¹ See ‘Reimbursement of urgent and emergency care: options for reform’, available at <https://www.gov.uk/government/consultations/reimbursement-of-urgent-and-emergency-care-options-for-reform>

We suggest that payment approaches for these care models are standardised nationally, to ensure equity of access. In addition, and where meaningful, patients should be able to choose their provider, with the money following patients' choices. In some cases, specialised services will need payment approaches tailored to their different characteristics, for example, where fixed costs are high and demand unpredictable. In other cases, evidence may support using differential payments to incentivise targeted best clinical practice or patient outcomes. In summary, there is potential for:

- Continuation and refinement of existing acute episodic payments, with an incentive linked to best clinical practice for targeted areas – for example, hip and knee replacements, and specialist rehabilitation.
- Further development of year of care approaches for conditions requiring ongoing care – for example, HIV and paediatric diabetes.
- Testing of capitated payments that align financial and clinical accountability in a lead accountable provider responsible for managing whole programmes of care, and reflect the costs of specialised network co-ordination and maintaining clinical expertise – for example, for the majority of cancer care.
- Designing and testing new definitions for commonly occurring episodes of care delivered by mental and community health services in discrete areas, where these are currently lacking.

The payment approaches for these models of care will also need increasingly to allow for changes in settings of care as more patients receive more of their specialist or elective treatment closer to home.

2.4. Mental health services

The Forward View sets out the need for the NHS to drive towards an equal response to mental and physical health, ensuring timely access to evidence-based care for all patients and towards a holistic approach to treatment where patients have both physical and mental health needs. The ambition is to achieve genuine parity of esteem between physical and mental health by 2020, as well as to improve access levels across the entire range of mental health services.

The payment system can help achieve the ambition set out in the Forward View, particularly through enabling the integration of mental health services with other parts of the health system. There are already examples of local payment approaches incentivising such integration.

A mix of payment approaches for mental health services is likely to do most to achieve the Forward View vision. This mix may include capitated payment approaches that cover co-ordinated mental and physical healthcare, while some

other mental health services may be better paid for by care episode with nationally mandated prices.

Achieving these reforms will depend on continuing to improve – and make better use of – existing costing and activity data for mental health services, as well as quality and outcomes metrics, so that payment is more closely linked to the effectiveness of care. As discussed in more depth in Section 3, further development of these information building blocks is required. This will include further refinement of the currency model for adult mental health services (the care clusters) and development of new currencies for child and adolescent mental health services (CAMHS).

2.5. Next steps for payment transformation

At this stage, we are in the process of publishing examples of the potential payment approaches described below for commissioners and providers to test. As we evaluate their results, we will prioritise where improvement can be made and refine the model payment approaches accordingly. We will also need to capture any payment lessons learned as new models of care are scaled up and rolled out, and to develop 'readiness criteria' to assess whether proposed improvements are ready to be mandated. When the model payment approaches are sufficiently well-developed and their benefits to patient care sufficiently well-evidenced to meet these criteria, we will consult the sector on mandating their use in appropriate circumstances.

Our approach to undertaking payment transformation is outlined in more detail in Section 4, but the four main areas in the transition can be summarised as:

Demonstration of new payment approaches for integrated care, urgent and emergency care networks and pathways/ years of care: The local payment case studies and payment models accompanying the 2015/16 national tariff are the first stage in describing the new payment approaches for local areas to test. These approaches will be refined over time to capture learning, including lessons from future local experiments.

Benchmarking: Publication of reference price data to support efficiency benchmarking and cross-charging between providers. This data can sit underneath many of the new payment approaches, including for integrated care (eg where a patient chooses to go out of area) and UEC.

Evaluation and support: Ambitious demonstration sites will be rapidly testing and formatively evaluating innovative payment approaches as they progress towards the new models of care. Our early thinking on this part of the transition is that we will work closely with these sites to gather evidence on the impact of the new payment approaches. However, we will also prioritise working with distressed local health economies (LHEs) to support their adoption of new payment approaches.

Continuous improvement: Some existing payment approaches, including the best practice tariffs and maternity pathway, would benefit from review and refinement. In particular, the maternity pathway needs to support the choices women make.

3. The information building blocks needed to deliver payment system reform

A high quality payment system is built on high quality data from providers across the care system about the volume of provider **activity**; what their services **cost** to deliver; and the **quality** of their services, which in healthcare is generally understood as a combination of the quality of clinical outcomes, clinical processes, patient experience and patient safety.

With these three key building blocks of activity, cost and quality data, local providers and commissioners can negotiate the reimbursement of care in the best interests of patients. Improving the accuracy, extent and use of timely activity, cost and quality data recorded at the level of individual patients in all care settings is critical to improving the payment system as a whole.

This section details why improving the information building blocks of the payment system matters to patients and how we propose it should be done.

3.1. Why better activity, cost and quality data matters to patients

More accurate recording and widespread linking of patient-level activity, cost and quality data will make it easier for providers to manage their services for patients effectively and efficiently and also improve the payment system in patients' interests.

If providers can measure and record their activity, costs and quality data at the level of individual patients, they will have the raw material for understanding exactly how and where they are using their resources, and how they might use those resources differently to deliver higher quality care at the same or lower cost. If different providers across social, community, primary and secondary, and mental health care settings can link and share data at this level of granularity, they can collectively manage NHS resources to make sure patients get the best quality care for the funding available.

With comprehensive linked patient-level data, regulation of the payment system can also become both more subtle and powerful as an instrument for encouraging the best use of NHS resources for patients. Prices, be they national or local, can be more transparently underpinned by the efficient costs of care for different types of provider and different patients. Evaluation of the impact of different care models will be easier (see progress snapshot 2), while commissioners and regulators will be better able to compare the use of resource, and hold providers to account.

However, progress towards using better data more effectively for patients and carers must take into account concerns over the use of sensitive data. Our proposals in this area need to align with the National Information Board's (NIB) proposals to strengthen the governance of personal data use. These include moving to consent-based data-sharing, so that all citizens know and can agree to the use made of their health data.¹²

Progress snapshot 2: Methodology for Impact Assessment¹³

Monitor has developed an impact assessment (IA) framework to help identify the benefits, risks and potential unintended consequences of policies before they are implemented. Better quality activity, cost and quality data will give us better inputs to support assessment of the potential impact of policies on commissioners, providers and patients (including regarding their impact on equality and health inequalities). We will continue to develop and apply the IA framework over time as our ability to describe and measure accurately the impact of policy proposals improves, and in line with feedback from the sector.

3.2. Classifying patient-level activity data

Recording patient-level activity provides a rich dataset for individual organisations. However, to compare patient-level data across organisations it is essential that providers and commissioners have consistent and stable ways of grouping or classifying similar activities and patients. Approaches to grouping activity already exist for some aspects of care (see progress snapshot 3), and existing approaches are subject to continual refinement, particularly to cover increasingly specialised and/or rare acute activities (eg HRG4+).

However, there is still scope to develop nationally standardised ways of classifying out-of-hospital services, some mental health services, palliative care and end of life care. For some of the new models of care, it may be necessary to develop further groupings of patients, by virtue of their similar levels of need for care.

Standardised groupings may not always be used to form the basis of payment (ie become currencies with mandated national prices) but instead be used for benchmarking. Where possible, groupings used for benchmarking or price-setting would draw on the same source activity data captured in the patient's clinical record.

¹² See 'Personalised Health and Care 2020: Using Data and Technology to Transform Outcomes for Patients and Citizens, A Framework for Action', available at:

<https://www.gov.uk/government/publications/personalised-health-and-care-2020>

¹³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332134/NationalTariff2015-16_ImpactAssessmentFramework.pdf

Next steps for classifying patient-level data

We want to develop a comprehensive set of currencies to support national prices and prices set locally. Our priorities include:

- Developing standard classifications, to be nationally mandated, for out-of-hospital care (both at home and in clinics); mental health services (CAMHS); palliative and end of life care; and specialised services currently without standardised currencies.
- Refining existing currencies to ensure that urgent and emergency care network clinical activities (potentially including emergency department and ambulance activities) are classified in a way that is consistent with future UEC networks; that the currency model for adult mental health services (the care clusters) is improved; and that HRGs reflect patient complexity (ie HRG4+).

Progress snapshot 3: Development of adult mental health clusters¹⁴

Reaching agreement on the mental health care clusters has been a significant step forward in developing a consistent method of classifying adult mental health services. The clusters describe a group of mental health service users with similar needs and allow individuals to be compared with each other in a variety of ways. The clusters can be used as the basis for developing evidence-based packages and pathways of care. As the quality of cluster data improves, it can be used for assessing the complexity of a clinical caseload and how this is reduced over time through the provision of effective early intervention services and recovery focused pathways.

3.3. Patient-level cost data

As with activity data discussed above, the current lack of detailed cost data is a potential barrier to developing new payment approaches for many services. Patient-level cost data that can be used for multiple purposes is the most basic cost data building block.

Patient-level cost data comprises all the direct and indirect costs arising from all points of contact between a person and NHS healthcare providers (ideally including providers of primary care and also social care). Capturing these costs would allow for important comparisons. For example, total costs of care for people with comparable needs but with different care pathways could be compared with their

¹⁴ See Annex 7c of the 'National Tariff Payment System 2015/16': 'Mental Health Clustering Booklet (V4.0) (2015/16)'

different outcomes, such as differences in improvement to patients' confidence in self-management or in clinical outcome measurements.

Patient-level costs can also be aggregated to compare how productively scarce and/or expensive resources such as staff time and operating theatres or diagnostic equipment are used as well as how economically inputs such as drugs and devices are procured. These comparisons can help providers and commissioners make intelligent service improvement and investment decisions, as they increase understanding of variations, making them easier to manage. They can also help to inform more rigorous payment approaches and price setting.

Additionally, where patient-level costs are accurately reconciled with expenditure recorded in accounts, Monitor and NHS England can be confident that all relevant provider costs are captured only once, assuring us that public funds are used effectively.

Next steps for patient-level cost data

Monitor has recently published a vision for costing and proposals for transition for engagement.¹⁵ Subject to feedback from the sector, Monitor proposes:

- Instead of three separate cost collections from providers, introducing a single patient-level cost collection based on patient-level information and costing systems (PLICS). This collection would identify separately the costs of patient care at the patient level, education and training, and R&D and commercial activities. Monitor is proposing to introduce a single cost collection across acute and ambulance trusts by financial year 2018/19, mental health trusts by 2019/20 and community service providers by 2020/21.
- To develop national costing dictionaries for types of resources used by providers, activities incurring the costs of these resources and groupings of these activities as they occur in patient care.
- A phased transition from using reference costs for price-setting to using patient-level costs. Before beginning the transition, Monitor must be able to generate reference costs for individual trusts from patient-level cost collections.

3.4. Quality measures and data

While there are many ways to define quality in the context of healthcare, current definitions broadly encompass clinical outcomes, clinical processes, patient experience and patient safety, as noted above. The specification and design of quality measures, particularly of those for use in the payment system, is crucial to

¹⁵ [Improving the costing of NHS services: proposals for 2015-2021](#)

ensuring they lead to genuine improvements in the quality of care received by patients rather than merely incentivising improvements in reported compliance with a sub-set of target measures. However, nationally collected performance data on quality measures is limited (eg many national audits are only snapshots in time), so measures of quality for payment purposes need to be developed further.

Quality can be measured at both a population level (eg percentage of all Improving Access to Psychological Therapies patients returning to employment) and the individual patient level (eg blood sugar levels within a target range for a diabetes patient). Outcome measures are generally better indicators of value for patients than other types of quality measure, but a number of features can make estimating and collecting outcome measures challenging. For instance, in some cases, a 'good' outcome can only be shown by measurements taken over a long period of time. To illustrate, a patient with long-term conditions and other frailty factors needs long-term support to help them gain and maintain their independence and so prolong their quality of life. In other cases, small samples, unreliable data, or the influence of a large number of external factors may bias or skew outcome measurements. Therefore measures of the quality of clinical processes and patient experiences (eg patient reported outcome measures) also need to be developed for payment purposes.

Furthermore, transitioning to payment approaches in which quality performance is a significant component may require providers and commissioners to play different roles and strengthen certain capabilities. Monitor and NHS England will need to support this capability-building, for example by creating model contracts and publishing guiding principles for designing payment approaches based on quality performance.

Next steps for quality measures

We will draw on NHS England's work on clinical indicators and work with user groups, NICE, and clinical audits to develop meaningful and consistent quality metrics (outcomes and clinical processes) that can be monitored in relation to payment. NIB recently published a framework for action which includes several

programmes looking at the development of quality measures, including those related to payment. We will work closely with other partners to take this work forward.¹⁶

3.5. Data linkage

The development of comprehensive patient-centred cost, activity, and quality data will in itself be a significant step towards new models of care supported by appropriate payment approaches.

¹⁶ [Personalised Health and Care 2020: Using Data and Technology to Transform Outcomes for Patients and Citizens, A Framework for Action](#)

However, the experience of the Integrated Care Pioneers and other sites developing new approaches to integrated care has generated considerable interest in the need to link patient-level data across multiple providers and settings in comprehensive patient-level datasets. Developing linked datasets is crucial to supporting not only new payment approaches but also care co-ordination, clinical decision-making, new models of care and local financial risk management. If developed appropriately and embedded in both commissioner and provider decision-making processes, linked datasets can also become an invaluable tool for empowering people and patients in choosing and managing their own care.

The NHS has all the ingredients for succeeding in this endeavour since it has one of the best adoption rates in the world for electronic health records in primary care and the advantage of an existing unique patient-level identifier in the NHS number. The Forward View proposes that the NHS number will be used in all settings, including social care. However, there are still numerous challenges that require resolution. For example:

- data quality can be inconsistent across care settings
- quality measures tend to operate at the provider level, but different providers may use different measures
- there are still information governance issues to resolve before providers will legally be able to link patient-level datasets across care settings. However, national initiatives are underway to resolve these issues (see below).

Next steps for data linkage

Monitor's forthcoming user guide on linking patient-level data will help areas develop locally held linked datasets while the following national initiatives are in development:¹⁷

- HSCIC's re-launch of the Information Governance Toolkit reflecting enhanced information governance and data security requirements. This is expected in late 2015.
- NIB's roadmap for moving to a new approach on disseminating and using personal and confidential data. NIB proposes to publish the roadmap by April 2016, with a view to implementing the approach by 2020.

¹⁷ ['Personalised Health and Care 2020: Using Data and Technology to Transform Outcomes for Patients and Citizens, A Framework for Action'](#)

3.6. Improving data usage

Improving the information building blocks of the payment system would improve payment regulation, as outlined in subsection 3.1 above. But the direct impact of better data on the sector's decision-making could bring even greater and faster benefits for patients. Given this, Monitor and NHS England will strongly encourage and support both providers and commissioners in making best use of the better data as it becomes available. We will focus on building skills, competencies and capability within the sector to enable:

- Faster and more widespread convergence of data reporting based on shared data standards and more accurate coding.
- Benchmarking of performance, quality and value. Transparent benchmarking (eg public ranking on quality measures) can be an effective incentive to improve quality.¹⁸

Next steps for improving data usage

Monitor is considering ways to provide organisational mentoring and support for the local use and reporting of accurate costing and coding data in poorly performing trusts. This support will sit alongside Monitor's national audit programme and compliance efforts.

Finally, we will help to develop the Secondary Uses Service (SUS)¹⁹ to expand its remit from services with national prices to include new payment approaches that use local prices and cover all care settings. This will link to the NIB's proposals to agree a core secondary uses dataset which all providers will need to make available by April 2016.²⁰

4. A phased timetable for reforming the payment system

The momentum behind the Forward View and the transformation already under way in pioneering integrated care, securing parity of esteem between mental and physical health, and standardising maternity, urgent and emergency care and specialised services networks presents a clear opportunity to move ahead swiftly with reforming the payment system.

¹⁸ See 'Research on financial and non-financial incentives', available at <https://www.gov.uk/government/publications/reforming-the-payment-system-for-nhs-services-supporting-the-five-year-forward-view>

¹⁹ The SUS is a single repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

²⁰ 'Personalised Health and Care 2020: Using Data and Technology to Transform Outcomes for Patients and Citizens, A Framework for Action'

Reform will need to happen at a rapid pace, in alignment with the overall programme proposed in the Forward View and within available resources. However, even with rapid progress, the payment system cannot be reformed overnight. Transition will be phased, as Monitor and NHS England make available to the sector new payment approaches to be tested, refined and eventually embedded in the payment system rules. This phasing also reflects the need for the NHS to continue delivering quality care today, at the same time as designing and demonstrating new care models for tomorrow.

The crowdsourcing exercise we carried out (see progress snapshot 4) showed us that commissioners and providers required the transition to follow five principles. It should: be as **predictable** and as **simple** as possible; be **locally adaptable** to different and changing environments; support **ambitious** changes in models of care and the payment system; and also be **realistic** about the pace at which these changes can be nationally mandated.

Progress snapshot 4: Crowdsourcing

The long-term payment system design ‘crowdsourcing’ exercise ran in February 2014 and invited a range of stakeholders to participate in an online discussion forum. This crowdsourcing exercise provided over 500 inputs in the form of votes, ideas and comments that shaped the payment system design as whole, and particularly our approach to transition.²¹

This section clarifies for commissioners and providers how and when we propose the payment system will change over the next five years.

4.1. Local health economy adoption paths

Systematic reform of the payment system across the NHS can't be achieved uniformly across different local health economies (LHEs). Some aspects of reform can take place at the same time everywhere, such as most of the improvements to the information building blocks and refinements to existing payment approaches. But local commissioners and providers may need to vary the order in which they adopt new payment approaches or customise the specific ‘menu’ or combination of payment approaches they adopt. Not all LHEs will be able to progress towards local data linkage at the same pace; LHEs will need to take into account:

- where they need to be in terms of both the development of new care models and the payment approaches that would best enable such innovation

²¹ See ‘February 2014 crowdsourcing exercise on the design of the NHS payment system’, available at <https://www.gov.uk/government/publications/reforming-the-payment-system-for-nhs-services-supporting-the-five-year-forward-view>

- where they are now compared to where they need to be, with regard to having in place the requisite information building blocks
- how quickly they can change, which will depend on local capability and readiness for transition.

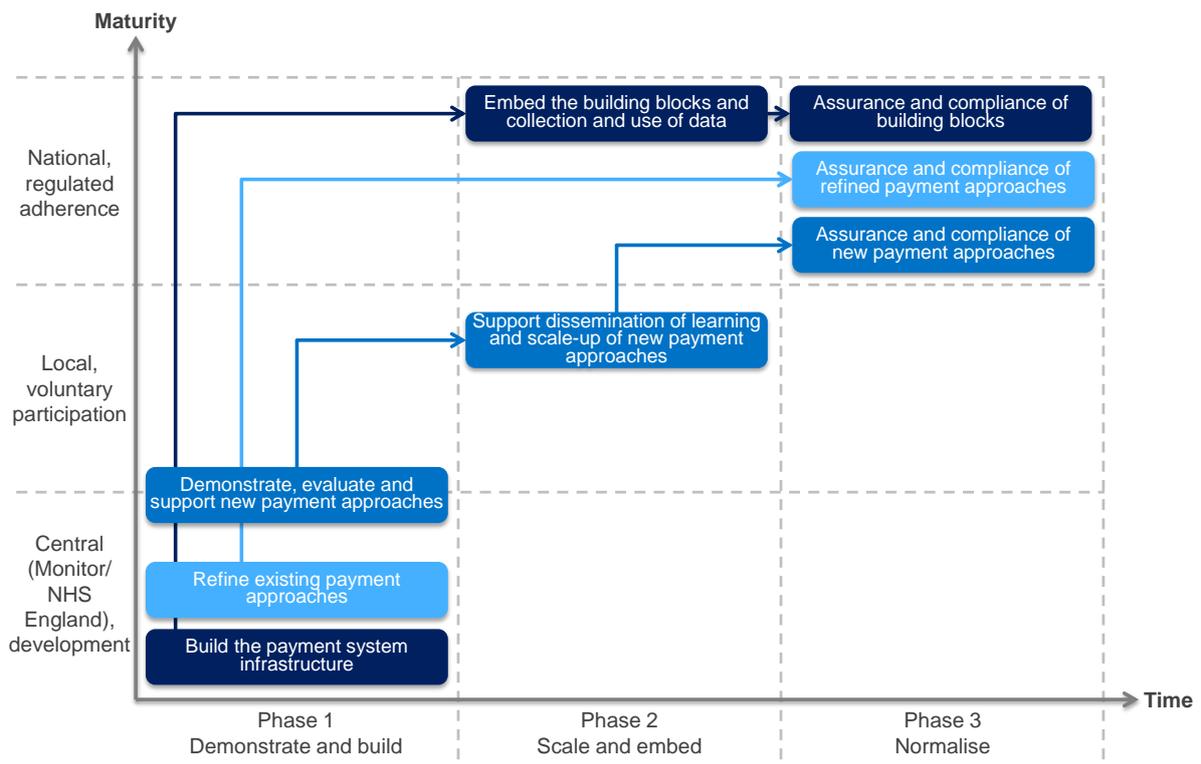
Given differences between LHEs, we think one single adoption path is unlikely, although we expect that local areas with similar capability and care model ambitions are likely to have similar paths. But to make sure all local health economies adopt the new models of care and payment approaches best suited to local patients' needs as quickly as possible, NHS England and Monitor will use a blend of support and more formal regulatory intervention that is tailored to different local adoption paths.

4.2. Phased approach to transition

Although the exact nature and timing of transition to new models of care and new payment approaches in different services areas and geographical areas is likely to vary, we propose that overall reform of the payment system takes place in three broad phases over the next five years, with each phase building on the previous one. Just as we expect commissioners and providers in all local health economies to work on adopting the information building blocks and moving to refined existing payment approaches at a rapid pace, so must NHS England and Monitor work to support a rapid transition to new payment approaches.

The steps we envisage taking in each phase of the transition are summarised in Figure 4.1 and described below.

Figure 4.1: Transition phasing



Phase 1: Demonstrate and build

Build the payment system infrastructure: Monitor and NHS England, with the support of the sector, need to focus on developing the necessary information building blocks to support new models of integrated and patient-centred care. Our priorities for building these foundations include developing HRG4+, introducing currencies for targeted areas of community, mental health and specialised services, developing costing dictionaries and moving to a single cost collection across acute and ambulance trusts, mental health trusts and community service providers. We will work with partners to develop quality measures that can be used for payment purposes. Monitor will also publish a user guide on linking patient-level datasets.

Refine existing payment approaches: We will assess existing payment approaches that would benefit from evidence-based review. These will include the maternity pathway; payments for admitted acute episodes; and best practice tariffs. Subject to the results of our review, we will refine or continue existing payment approaches.

Demonstrate, evaluate and support new payment approaches: We will work with LHEs best placed to take the initiative on co-developing new payment approaches, such as the UEC three-part payment approach, and capitated payments for integrated care (see progress snapshot 5). Where we have regulatory teams supporting operations in distressed LHEs, pricing teams will also support the design of new payment approaches, as payment reform may play an important role in

improving the LHE's financial sustainability. With the learning and evidence gained from demonstrations, we will be equipped to decide if, when and with what refinements the payment approaches could begin to be adopted more widely.

Progress snapshot 5: Integrated Care Payment Forum

A small number of local areas (pioneers and others) that are keen to progress towards a capitated payment approach from 2015/16 (in shadow form, in most cases) are participating in an Integrated Care Payment Forum, supported by Monitor and NHS England. Contributions from the Forum members, together with the Long-term Conditions Year of Care sites, have informed the development of the capitation payment model we have published.²² Through working with people in these ambitious local areas, we aim to refine the capitation payment model and produce supplementary guidance that enables wider uptake. We will continue to conduct locality workshops on payment and contracting design options, so that we can help address local areas' needs. Due to widespread expressions of interest, we are considering starting a second forum for those keen to explore integrated care payment approaches for their 2016/17 contracts.

Phase 2: Scale and embed

Embed the building blocks and collection and use of data: Plans to improve costing among NHS care providers²³ mean many acute providers may move to a single collection of costs based on patient-level cost data in phase 1, so we propose to move to using patient-level costs for setting national prices for episodic and specialised care in phase 2. Data reporting will need to meet the new standards required for the patient-level cost collection over time. During this phase, the use of data will also be improved, both centrally (eg for better impact assessment and more rigorous price calculation) and locally (eg by using benchmarking to build capability).

Support dissemination of learning and scale-up of adoption of proven new payment approaches: By rapidly disseminating lessons learned during phase 1 (the first phase of demonstration and evaluation), we will support and encourage wider adoption of proven new payment approaches. This should help other LHEs catch up with the leaders. We expect LHEs to be able to customise their adoption paths over a three-year period, as described in subsection 4.1. As new payment approaches for services or patient groups supersede previous rules or prices, and as new currencies

²² See 'Capitation: a potential new payment model to enable integrated care', available at <https://www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements>

²³ 'Improving the costing of NHS services: proposals for 2015-2021'

are introduced (eg for specialised services), it will be important for us to signal clearly which of the prices we publish are nationally mandated and which are guide prices for local negotiations.

Phase 3: Normalise

Assurance and compliance: As the new payment system takes shape, we may propose to mandate particular payment approaches if and when evidence shows this will benefit patients. We will first assess our proposals against 'readiness to mandate' criteria and put forward only those proposals that satisfy these criteria in the statutory consultation on the national tariff, supported by an assessment of their impact. Depending on the sector's response to that consultation, we would mandate changes to payment approaches and information building blocks.

We envisage that implementing the reforms outlined above would result in a blended, rules based payment system. Broadly speaking, it is likely to comprise menus for locally determined payments, from which commissioners and providers could choose the most appropriate for their local models of care and service contracts; a number of national prices for episodes of care delivered by centres of excellence and specialised services networks; and national guide prices for all other currencies. Although the new payment rules will offer commissioners and providers a more adaptable framework for use in local contracts, Monitor will enforce the new regulatory framework firmly enough to ensure commissioner and provider compliance, in order to protect and promote patients' interests.

4.3. A role for all players in reforming the payment system

There are roles in reforming the payment system for actors at both the national level, especially Monitor and NHS England, and at the local level, especially providers and commissioners. In 2014/15 Monitor and NHS England focussed on permitting commissioners and providers to vary payment arrangements to support local innovation, while maintaining stable national prices as a default. In 2015/16 we are publishing local areas examples of how to develop and implement alternative approaches to payment, for local commissioners and providers to demonstrate in practice.

Looking to the future, there are two ways people in local areas can be at the forefront of payment innovation:

Costing improvement partners: working with Monitor, providers in any care setting – mental health, community, ambulance or acute – can help to develop best practice costing standards for patient-level costing. They can also help by participating in development collections.

Payment demonstration sites: working with Monitor and NHS England, commissioners and providers can help to design and/ or demonstrate local payment examples, as part of a payment development programme.

Get involved: be at the forefront of payment innovation

Monitor and NHS England are working with several sites to develop payment demonstrations. If you would like to find out more about our payment development programme, please contact us at paymentsystem@monitor.gov.uk.

For further information on costing improvement partners, please refer to 'Improving the costing of NHS services: proposal for 2015-2021'.²⁴

Commissioners and providers can also work on their own local improvement activities, such as by creating local linked datasets, provided this is in line with information governance requirements. In fact, successful transition will depend on local-level initiatives in areas other than those outlined above. However, LHEs should report local variations and share information in line with the published national tariff rules²⁵ to ensure everyone benefits from the resulting lessons and innovations.

As local health economies move to new models of care and local leaders partner with NHS England and Monitor to demonstrate and evaluate new payment approaches, our collective knowledge and experience will grow. As we begin this transition, we need to reinforce the virtuous cycle of continuous learning and improvement already in motion. We will continue to reflect on our progress and listen to the sector on how we could do better.

This paper presents a clear direction for the payment system and is our point of departure for transition. However, we will adjust the transition approach as needed in the light of all we learn as the sector builds the new payment system, taking into account the clinical and financial context in which the health sector operates.

²⁴ ['Improving the costing of NHS services: proposals for 2015-2021'](#)

²⁵ The rules for local variations are published as part of the National Tariff Payment System.

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

This publication can be made available in a number of other formats on request. Application for reproduction of any material in this publication should be made in writing to enquiries@monitor.gov.uk or to the address above.