Monitor
Making the health sector work for patients

NHS England

2015/16 National Tariff Payment System: Engagement on local payment arrangements

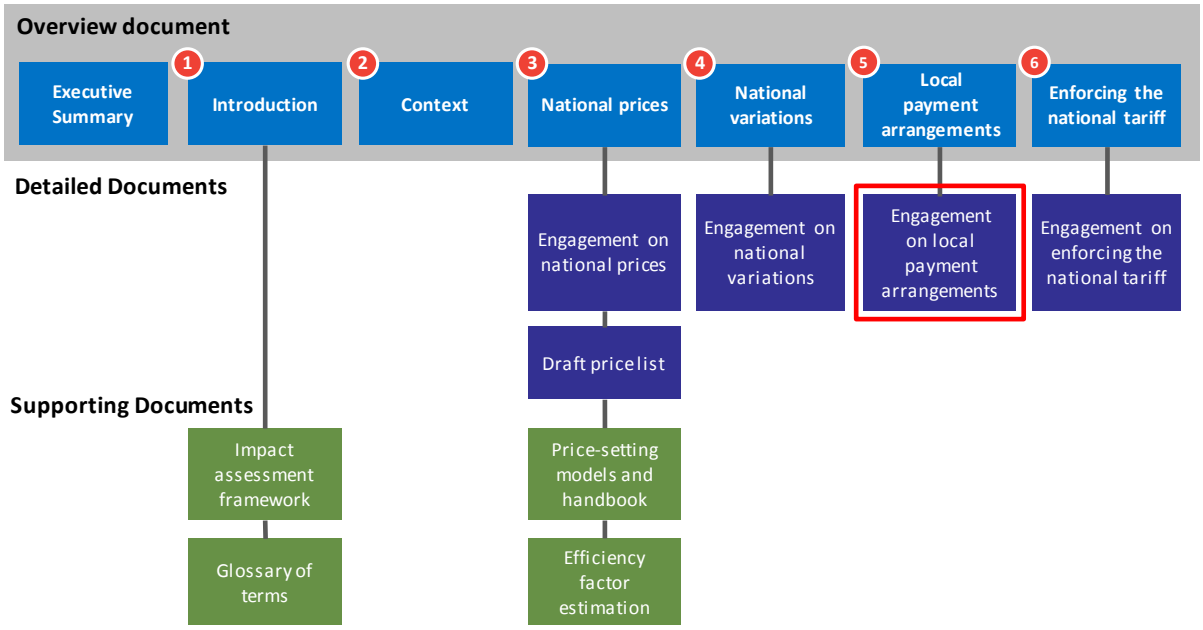
www.gov.uk/monitor

Contents

1. Introduction

This paper is part of a set of engagement documents we are publishing on the 2015/16 National Tariff Payment System (see Figure 1). It sets out the changes we are proposing to make with regard to local payment arrangements[1] compared to the '2014/15 National Tariff Payment System'.

Figure 1: Map of 2015/16 National Tariff Payment System engagement documents



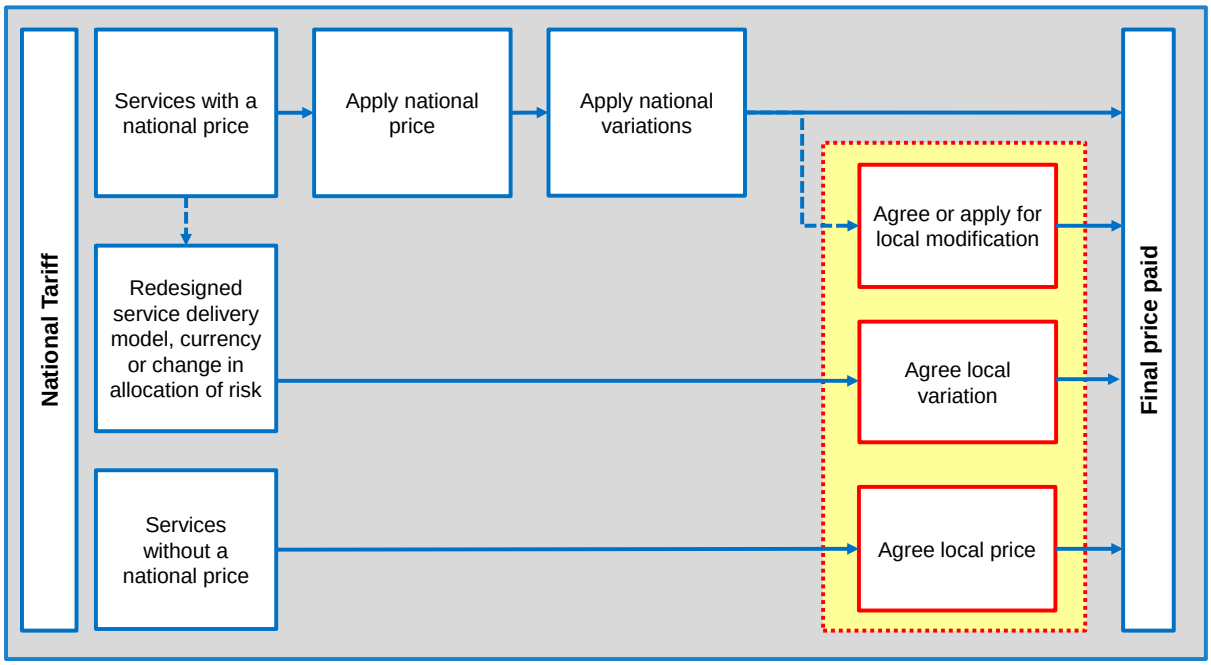
Many prices for NHS healthcare services are agreed locally rather than determined nationally. We refer to arrangements for agreeing prices and service designs locally as 'local payment arrangements'. In the '2014/15 National Tariff Payment System' we set out three types of local payment arrangements:

- local modifications to a national price
- local variations to a national price
- local prices sometimes (but not always) based on nationally specified currencies.

The national tariff sets out the rules under which local variations may be agreed, the rules for determining local prices and the methods Monitor uses to decide whether to approve local modifications. Figure 2 illustrates how local payment arrangements fit within the national tariff.

[1] Note that in the '2014/15 National Tariff Payment System' these were referred to as 'locally determined prices'. We have changed the name to 'local payment arrangements' since these arrangements may include locally agreed service designs..

Figure 2: How local payment arrangements fit into the National tariff



NHS England and Monitor want to help the sector make the best use of the local payment arrangements in the 2015/16 National Tariff Payment System as tools for service transformation. The sector faces a particularly challenging financial year in 2015/16, as well as a general longer term sustainability challenge and the pressure to better meet patient needs. Meeting all these challenges is going to require changes to how care is organised and delivered. Many local health economies are already undertaking work to design and implement such changes.

For these reasons, we expect that commissioners and providers will be looking to use local payment arrangements in 2015/16 to help facilitate the service changes necessary to meet the immediate and long-term challenges. Our emerging ideas on long-term payment system reform are yet not sufficiently tested to warrant mandatory national roll-out for 2015/16. However, they may be suitable for local use, based on the specific needs of local health economies.

In addition to these proposals, NHS England has recently set out plans for a new integrated personal commissioning (IPC) programme, which will blend comprehensive health and social care funding for individuals, and allow them to direct how it is used.

1.1 Summary of proposals for national prices

This document sets out how we propose to support providers and commissioners' use of local payment arrangements. We have grouped these proposals into four areas:

- **Setting payment rules for mental health services:** We want to ensure local payment approaches enable a person-centred approach to care and parity

between physical and mental health. We expect local payment arrangements for mental health services to be transparent, be in the best interest of patients and ensure accountability. We do not believe this can be done through simple block contracts. We propose to continue the existing rules for determining local prices and develop supplementary guidance, which will help providers and commissioners to move to payment models that better support current and future challenges.

- **Supporting innovation through examples of payment designs:** As our long-term reform of the payment system is being developed, we propose to support providers and commissioners in applying the principles and rules for local payment arrangements by providing examples of payment designs that are aligned to Monitor and NHS England's emerging ideas of long-term payment system redesign.

- **Setting prices that reflect the efficient cost of provision:** While we recognise that cost structures may be different across different parts of the sector, the data currently available does not allow us to estimate such differences with sufficient accuracy. In the absence of a better alternative, we do not propose to change the rule that requires local price-setting to have regard for the efficiency and cost uplift factors used for national prices. However, we want to engage with stakeholders on how the guidance we provide in this area can be most helpful to local negotiations.

- **Promoting value in acute services without national prices:** We are inviting the sector to provide feedback on two policy options we are considering that are aimed at promoting value for patients from payment for acute services without national prices,[2] and at accelerating the pace of convergence towards only remunerating efficient costs for specialised services. The options represent two alternative policy responses: either signposting existing commissioner contracting options in guidance or using the 2015/16 national tariff to introduce a new local price-setting rule.

As part of our engagement on local payment arrangements, we encourage stakeholders to provide feedback on the potential impacts of the policy proposals in this document on groups with protected characteristics (as defined under the Equality Act 2010) or any other impacts that may affect patients, including any evidence that is relevant to identifying those impacts.

[2] This includes services commissioned by NHS England or by clinical commissioning groups (CCGs) from acute providers of acute physical health care services (ie it does not include community, mental health and transport services). Commissioning for Quality and Innovation (CQUIN) payments, and reimbursement of high-cost drugs, devices and procedures would also be excluded.

1.2 Structure of this document

The rest of this document is structured as follows:

- Section 2 summarises the current principles, rules and methods for local payment arrangements
- Section 3 sets out proposed minor updates to the specific rules for mental health services and explains how they are to be applied
- Section 4 describes how we propose to support local innovation and service transformation through examples of payment designs
- Section 5 discusses our proposals for how local prices should be adjusted for cost inflation and efficiency savings
- Section 6 presents options we are considering to promote value in acute services without a national price
- The annexes provide additional information on the proposed local payment design examples.

2. Principles and rules for local payment arrangements

The '2014/15 National Tariff Payment System' specified the principles that should be applied to the agreement of all locally determined prices, the rules that apply to local variations and to local prices, and the method that Monitor uses to determine local modifications. This section sets out the current principles, rules and methods we propose to retain and highlights those where changes may be proposed for 2015/16.

2.1 Principles for all local payment arrangements

The principles commissioners and providers should apply when agreeing local payment approaches are described in the '2014/15 National Tariff Payment System':

- local payment approaches must be in the **best interests of patients**
- local payment approaches must **promote transparency** to improve accountability and encourage the sharing of best practice
- providers and commissioners must **engage constructively** with each other when trying to agree local payment approaches.

We do not propose to change these principles for 2015/16. However, given the need for significant service redesign to put services on a sustainable basis, it is increasingly important that providers and commissioners adhere to these principles. We propose to issue further guidance on this.[3]

2.2 Rules for local variations

Commissioners and providers can use local variations to agree adjustments to national prices or the currencies for those prices. The national tariff provides the rules under which those variations may be agreed. Local variations are the main mechanism through which commissioners and providers can design alternative payment approaches that better support the services required by patients.

The rules for local variations are:

- the commissioner and provider must apply the principles listed at 2.1 above
- the agreed local variation must be documented in the commissioning contract between the commissioner and provider, which covers the service to which the variation relates
- the commissioner must publish a written statement of the local variation on its website as required by the Health and Social Care Act 2012 (the 2012 Act), using the summary template provided by Monitor

[3] For 2014/15, we issued the 'Guidance on locally determined prices' and we intend to update it for 2015/16.

- the commissioner must also submit the written statement of the local variation to Monitor.

We do not propose to change these rules for 2015/16. However, we do propose to change some of the guidance for local variations. This is set out in '2015/16 National Tariff Payment System: Engagement on enforcing the national tariff'.

2.3 Method for local modifications

Local modifications are intended to ensure that healthcare services can be delivered where they are required by commissioners for patients in situations where the cost of providing services is higher than the national price.

The '2014/15 National Tariff Payment System' describes:

- the circumstances in which local modifications may be appropriate
- the process for local modification agreements and applications
- our method for considering local modifications, including how we determine whether services are uneconomic
- Monitor's obligations concerning the publication of local modifications
- Monitor's duty to notify NHS England and clinical commissioning groups (CCGs) where it is satisfied that the continued provision of commissioner requested services is being put at risk by the configuration of local health services.

We do not propose to change the methods for local modifications in 2015/16. However, we do propose to change some of the guidance for local modifications. This is set out in '2015/16 National Tariff Payment System: Engagement on enforcing the national tariff'.

2.4 Rules for local prices

For many NHS services, there are no national prices. Some of these services have nationally specified currencies, but others do not. In both cases, commissioners and providers must work together to set prices for these services. The 2012 Act allows NHS England and Monitor to set rules for local price-setting for such services, including rules specifying national currencies for such services. The rules are presented in this section as they appear in the '2014/15 National Tariff Payment System'.

We have set both general rules and rules specific to particular services. There are two types of general rule:

- rules that apply in all cases when a local price is set for services without a national price
- rules that apply only to local price-setting for services with a national currency (but no national price).

General rules for all services without a national price

Rule 1: Providers and commissioners must apply the principles in Subsection 7.1 when agreeing prices for services without a national price:

- local payment approaches must be in the best interests of patients
- local payment approaches must promote transparency to improve accountability and encourage the sharing of best practice and
- providers and commissioners must engage constructively with each other when trying to agree local payment approaches.

Rule 2: Commissioners and providers should have regard to the national tariff efficiency and cost uplift factors for 2014/15 (as set out in Section 5 [of the '2014/15 National Tariff Payment System']) when setting local prices for services without a national price for 2014/15, if those services had locally agreed prices in 2013/14.

We do not propose to change Rule 1 or Rule 2, other than to update the references to dates and sections of the documents as relevant. We discuss our proposals for the efficiency and cost uplift factors in Section 5 of this document.

General rules for services with a national currency but no national price

Rule 3:

a) Where there is a national currency specified for a service, the national currency must be used as the basis for local price-setting for the services covered by those national currencies, unless an alternative payment approach is agreed in accordance with Rule 4 below.

b) Where a national currency is used as the basis for local price-setting, providers must submit details of the agreed unit prices for those services to Monitor using the standard templates provided by Monitor.

c) The completed templates must be submitted to Monitor by 30 June 2014.

d) The national currencies specified for the purposes of these rules are the currencies specified in Annex 7A (acute services), Subsection 7.4.4 (mental health services) and Subsection 7.4.5 (ambulance services).

We do not propose to change Rule 3, other than to update the references to dates and sections of the documents as relevant.

Rule 4:

a) Where there is a national currency specified for a service, but the commissioner and provider of that service wish to move away from using the national currency, the commissioner and provider may agree a price without using the national currency. When doing so, providers and commissioners must adhere to the requirements (b), (c), (d) and (e) below, which are intended to mirror the requirements for agreeing a local variation for a service with a national price, set out in Subsection 7.2

b) the agreement must be documented in the commissioning contract between the commissioner and provider which covers the service in question

c) the commissioner must maintain and publish a written statement of the agreement, using the template provided by Monitor, within 30 days of the relevant commissioning contract being signed or in the case of an agreement during the term of an existing contract, the date of the agreement;

d) the commissioner must have regard to the guidance in Subsection 7.2.3 when preparing and updating the written statement and

e) the commissioner must submit the written statement to Monitor.

We do not propose to change Rule 3 and Rule 4, other than to update the references to dates and sections of the documents as relevant.

The '2014/15 National Tariff Payment System' sets out the services with a national currency but no national price that Rule 3 and Rule 4 apply to:

- working age and older people mental health services
- ambulance services
- specialist rehabilitation
- critical care – adult and neonatal
- HIV adult outpatient services
- renal transplantation
- positron emission tomography and computerised tomography (PET/CT)
- cochlear Implants
- transcatheter aortic valve implantation (TAVI)
- complex therapeutic endoscopy
- dialysis for acute kidney injury (HRGs LE01A, LE01B, LE02A, LE02B).

For 2015/16, we are proposing to introduce national prices for cochlear implants, TAVI, complex therapeutic endoscopy and dialysis for acute kidney injury. In those circumstances these services would be no longer be subject to Rule 3 and Rule 4.

Specific rules for acute services with no national price

Where acute services – commissioned by a CCG or by NHS England – do not have a national price, providers and commissioners are required to set prices locally. For some of those services, there is a national currency that should be used as the basis for setting local prices. For others, there is no nationally specified currency. This subsection covers both cases. There are also a number of high cost drugs, devices and listed procedures that are not reimbursed through national prices and whose price must be negotiated locally. These are also covered by these rules.

Rule 5 is specific to acute services without national currencies.

Rule 5: For acute services with no national currencies, the price payable must be determined in accordance with the terms and service specifications set out in locally agreed commissioning contracts.

We are inviting stakeholder feedback on whether this rule requires changing. The possible change would be under one of the two options we are considering to promote value for patients from payment for acute services without national prices (see Section 6).

Rule 6 is specific to acute services with national currencies.

Rule 6: Providers and commissioners must use the national currencies specified in Annex 7A as the basis for structuring payment for acute services covered by those national currencies, unless an alternative payment approach has been agreed in accordance with Rule 4 in Subsection 7.4.2.

We do not propose to change Rule 6.

The '2014/15 National Tariff Payment System' sets out the national currencies that Rule 6 applies to:

- specialist rehabilitation (25 currencies based on patient complexity and provider/service type)
- critical care – adult and neonatal (13 HRG-based currencies)
- HIV adult outpatient services (three currencies based on patient type)
- renal transplantation (nine HRG-based currencies)
- PETCT (HRG RA42Z – Nuclear Medicine category 8)
- cochlear implants (HRGs CZ25N (without CC) and CZ25Q (with CC))

- TAVI (HRG EA53Z)
- complex therapeutic endoscopy (HRG FZ89Z)
- dialysis for acute kidney injury (HRGs LE01A, LE01B, LE02A, LE02B).

If we introduce national prices for cochlear implants, TAVI, complex therapeutic endoscopy and dialysis for acute kidney injury in 2015/16 (in line with our proposals), these services would be no longer be subject to Rule 6.

In addition to the above rules, we are considering whether an additional rule should be added in order to promote value for patients from payment for acute services without national prices. The issue is discussed in Section 6.

Rules for high cost drugs, devices and listed procedures

A number of high cost drugs, devices and listed procedures are not reimbursed through national prices. Their use tends to be concentrated in a relatively small number of providers, rather than evenly spread across all providers providing services covered by the relevant currency. As a result of this and their high cost, a provider using one of these drugs, devices or procedures more frequently than the average could face significant financial disadvantage if they were included in national prices, because the national price would not reflect the specific higher costs faced by the provider.

Rule 7:

a) As high cost drugs, devices and listed procedures are not national currencies, Rules 3 and 4 in 7.4.2, including the requirement to disclose unit prices, do not apply.

b) Local prices for high cost drugs, devices or listed procedures must be paid in addition to the relevant national price for the currency covering the core activity. However, the price for the drug, device or procedure must be adjusted to reflect any part of the cost already captured by the national price.

c) As the price agreed should reflect the actual cost to the provider, the requirement to apply the national tariff efficiency and cost uplift factors detailed in Rule 2 in 7.4.1 does not apply.

We are inviting stakeholder feedback on whether this rule requires changing, so that it ensures that providers strive at all times to secure best value for the listed drugs, devices and procedures. We also propose to update the list of high cost drugs and devices. This is discussed in '2015/16 National Tariff Payment System: Engagement on national prices'.

Specific rules for mental health services

The rules established in the '2014/15 National Tariff Payment System' for mental health services include specific rules for:

- use of the adult mental health cluster currencies (Rule 8)
- agreeing local prices using the care clusters (Rule 9)
- agreeing local prices when not using the care clusters (Rule 10).

Rule 8:

a) The 21 care clusters specified above [in original] must be used as the currencies for agreeing local prices for the services covered by the clusters in 2014/15, unless an alternative payment approach has been agreed in accordance with Rule 4 in Subsection 7.4.2.

b) When using the care clusters, patients must be allocated to a cluster in the following situations:

i) when initial assessment is completed (typically within two contacts, or two bed nights)

ii) when scheduled re-assessment occurs or

iii) when any re-assessment occurs following a significant change in need.

c) Patient allocations must be regularly reviewed in line with the maximum cluster review periods.

d) Providers must use the mental health clustering tool (Annex 7C) to assign a care cluster classification to patients, and record and submit the cluster allocation to the Health and Social Care Information Centre (HSCIC) as part of the Mental Health Minimum Data Set.

e) Initial assessment must be treated as a standalone currency and paid for separately. At the end of an initial assessment, a patient's interaction with a provider may conclude or continue. If the patient's interaction with the provider continues, all ongoing assessments and reassessments form part of the allocated cluster.

f) Cluster 0 must only be used when it is not possible to determine which cluster should be assigned to a patient at the end of the initial assessment.

Rule 9:

a) For each care cluster, quality indicators must be agreed between providers and commissioners. The recommended quality indicators can be found in Section 4 of the 'Guidance on mental health currencies and payment'.

b) The agreed quality indicators must be monitored on a quarterly basis by both providers and commissioners.

c) Providers must complete the Mental Health Minimum Data Set in all cases.

d) Providers and commissioners must ensure that any agreed payment approach enables appropriate patient choice.

e) Once agreed, the local prices for the care clusters must be submitted to Monitor by providers in line with the requirements of Rule 3 set out in Subsection 7.4.2.

Rule 10:

a) Providers and commissioners of services covered by the care cluster currencies may agree prices without using the care clusters as the basis for payment. In doing so, they must adhere to the requirements set out in Rule 4 in Subsection 7.4.2.

b) Providers must complete the Mental Health Minimum Data Set in all cases, including the cluster allocation, whether or not they have used the care clusters as the basis for payment.

In addition to rules 8–10 above, '2014/15 National Tariff Payment System' states that commissioners and providers must adhere to the general rules (Rules 1 to 4) above when agreeing prices for mental health services that are not covered by the adult cluster currencies.

For 2015/16, we propose to amend requirements under Rule 8(d), Rule 9(c) and Rule 10(b) to reflect:

- the new name for the Mental Health Minimum Data Set (MHMDS) – in January 2014 the it was renamed the Mental Health and Learning Disability Data Set (MHLDDS)
- the new requirements for Improving Access to Psychological Therapies (IAPT) service data submission to be included in the MHLDDS with effect from 1 July 2014.

Specific rules for ambulance and patient transport services

Rule 11:

a) Providers and commissioners must use the four national currencies specified above as the basis for structuring payment for ambulance services covered by those national currencies, unless an alternative payment approach has been agreed in accordance with Rule 4 in Subsection 7.4.2.

b) Quality and outcome indicators must be agreed locally and included in the commissioning contracts covering the services in question.

c) Once agreed, the local prices must be submitted to Monitor by providers in line with the requirements of Rule 3 set out in Subsection 7.4.2.

The '2014/15 National Tariff Payment System' also states that:

- providers and commissioners may wish to agree prices without using the four ambulance currencies, for example, to support the redesign of urgent care services to align with the introduction of 111
- when agreeing prices for ambulance services not covered by the national currencies, providers and commissioners must adhere to the general rules (Rules 1 to 4).

We are inviting stakeholder feedback on whether this rule requires changing. This is because we are aware many payment approaches are used in 2014/15, and because we are encouraging widespread uptake of the local payment examples, of which a number could impact ambulance services (see Section 4). Furthermore, as part of our work to support the review of urgent and emergency care carried out by Sir Bruce Keogh, we anticipate that the currencies for ambulance services may need to change to promote more urgent care needs being resolved in or close to patients' homes.[4]

[4] More detail on the latest thinking can be found on NHS England's website.

3. Applying existing rules to mental health services

NHS England and Monitor's overarching objective for the National Tariff Payment System is that it should promote value for patients, by which we mean it should promote securing high quality services at an efficient price, with an appropriate allocation of financial risk. This applies to mental health and physical health services equally. This section sets out our proposals for the 2015/16 National Tariff Payment System that are specific to mental health services in addition to the changes to the rules specific to mental health services described in Section 2.

We propose to:

1. restate our commitment to existing rules for agreeing local payment arrangements, including MHLDDS data submission requirements (Rules 8, 9 and 10) and Reference Cost data based on care clusters
2. restate that, in line with these rules, we expect providers and commissioners to use care clusters as the currency for payment, unless they develop an alternative approach that will, among other things, apply the principle that local payment approaches must be in the best interests of patients
3. restate that, in line with these rules, we expect all local payment contract arrangements to be transparent and be in the best interests of patients.

We discuss each proposal in turn below.[5]

Questions:

1. Do you think our proposed guidance on applying the rules will sufficiently clarify for commissioners and providers how to develop local payment arrangements for mental health services?

3.1 Data submission requirements

Robust data related to services, activity, patient outcomes and costs are vitally important for both central and local decision-makers and are a key tool for understanding patient needs, understanding costs and assessing value for money. The mental health clusters (complemented by full International Classification of Diseases 10 (ICD 10) coding of mental and physical health diagnoses) will remain the currency building block for mental health services for working age adults and older people. All provider organisations continue to be required to return their

[5] These proposals have been informed by stakeholder engagement and clinical input facilitated by NHS England. An overview key themes emerging from that work is available on NHS England's website.

Reference Costs for in-scope services based on the clusters, and to submit clustering data to the HSCIC as part of their overall MHLDDS monthly submissions.

Consistent with our duties, if needed, we will consider compliance or enforcement measures to ensure appropriate levels of data provision and data quality.

3.2 Payment approaches that are in patients' best interests

We want providers and commissioners to use payment approaches that enable person-centred care and support delivery of treatments that evidence proves to be effective, regardless of whether the treatments relate to physical health, mental health or a combination of the two. This will help ensure patients have access to the treatment that is right for them.

As noted in Section 2, mental health services are covered by rules for local payment arrangements, which require use of care clusters as the currency for local price-setting and reporting for adult mental health services. Despite the introduction of the care clusters, most local agreements still rely on simple block contracts. We believe that block payments that have limited levels of transparency regarding service provision, patient outcomes, quality and value do not work in the interests of commissioners, providers and, most importantly, patients. They do not facilitate a transparent understanding of what services are being delivered, what outcomes are achieved, or what it costs to deliver effective and efficient services. Further, they do not facilitate policies that enable patient choice or the wider roll-out of personal budgets.[6]

Whilst we are not proposing any substantive change to the rules governing local payment arrangements for mental health, we are proposing to revise our guidance to clarify our expectations about how mental health services are paid for, and to offer illustrations of innovative payment models that providers and commissioners may wish to consider. This is intended to support the sector in developing payment arrangements for provision of mental health services that are both transparent and tailored to meet local needs.

This guidance would emphasise that the care clusters are the default local payment arrangement for mental health services and other payment arrangements should only be used where the principles of local pricing are applied; in particular, that arrangements should be in the best interests of patients. Additionally, our guidance would illustrate how we expect the three principles of local payment arrangement to

[6] A personal health budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. They are intended to enable people with long-term conditions and disabilities to have greater choice, flexibility and control over the healthcare and support they receive. More information about personal health budgets can be found on NHS England's website.

be applied in practice to mental health services. For example, to satisfy these principles, we expect a local payment arrangement to:

- require better accountability and data reporting by:
    a) capturing care cluster data (complemented by full ICD10 coding of mental and physical health conditions) to make sure providers are accountable to their services
    b) requiring the routine use and monitoring of outcome measures
    c) specifying and rewarding the achievement of recovery-focused outcomes
- support service improvement by:
    a) ensuring that service configuration reflects user needs, making effective use of risk stratification tools
    b) supporting improved care co-ordination
    c) aligning care with the best available evidence, most critically with NICE guidelines
    d) supporting the principles of care closer to home and use of the least restrictive setting
    e) providing for effective crisis care in line with the requirements of the Crisis Concordat, which outlines how services should work together to respond to people who are in mental health crisis
    f) encouraging integrated person-centred care
- allow for appropriate risk-sharing within the sector, between commissioners and providers as well as between different providers.

We do not expect every health economy using the clusters as the basis of payment in 2015/16 to move to a full cost and volume contract. Instead we want to encourage a thoughtful analysis of local demand patterns for mental health users and constructive engagement between actors in the health economy to determine payment arrangements that share risks fairly between providers (mental health and physical health) and commissioners.

We will set out how this might be done in the guidance, and also illustrate several alternative payment approaches that are being pursued. These are:

- payment based on outcomes measures
- risk-sharing mechanisms

- payment based on integration of physical and mental health
- pathway-based payments.

Local payment design examples are discussed further in Section 4. Annex A offers more detail on some of the examples we are considering. These examples do not preclude other local payment approaches being designed and implemented, as long as they satisfy the local price-setting principles and rules.

4. Supporting innovation with examples of payment designs

This section sets out how we plan to use the 2015/16 National Tariff Payment System to support service innovation while we continue to evaluate potential long-term payment designs. We propose to put forward a series of payment design examples ('payment examples') that support service improvement and reconfiguration, and encourage providers and commissioners to adopt them in 2015/16, as appropriate for their needs. Where there is a critical mass of adoption and testing of these examples in 2015/16, they can generate an evidence base to inform decisions on whether to mandate the approaches in 2016/17 or beyond. These examples would follow the principles and rules for local prices or local variations to national prices.

Questions:

2. Would the planned topics and content of the proposed payment examples help you to make more effective use of local payment arrangements to support the changes you are planning to make to respond to the short-term and long-term challenges?

3. What benefits and costs do you see from making the approaches used in the payment examples the default national payment approach potentially from 2016/17?

4.1 Payment examples

The payment examples would be selected on the basis of being able to deliver, in 2015/16 or over the longer term, the three aims of the payment system:

- improved outcomes for patients
- more efficient use of resources and
- appropriate allocation of risk.

They would provide details of the rationale for pursuing a specific payment design to support service innovation, the key payment design choices that local health economies will need to make (eg a currency specification, or altering national prices at the margins to share financial risk) and the requisite enablers for successful implementation and evaluation (eg data flows, leadership). Each example would set out how to measure and monitor whether the arrangements succeed in delivering benefits to patients and value for money. Where possible, we will use actual practice, from the NHS or abroad, to illustrate particular design choices as well as setting out what alternatives exist.

We propose developing two types of payment examples: case studies of innovative payment approaches already in use in the NHS to be tested further ('case studies'), and payment approaches that require further development as well as testing within the NHS ('proofs of concept').

Case studies would highlight innovative approaches to delivering and paying for care that have been implemented within the NHS and proved they can deliver the aims of the payment system. They would feature examples that we have come across in our interactions with the sector and from local variations submitted for 2014/15. They would feature a locality that is using the approach. We will provide additional comment to help other localities adopt a similar approach if it is appropriate for their needs.

Proofs of concept are likely to be approaches that we are considering as part of our long-term payment system design, but require further development, testing and validation. We expect that these payment examples will largely require pooled budgets, greater levels of system-wide change, and more advanced data solutions than the case studies. It is unlikely that all local health economies will be ready to adopt these examples in 2015/16, as the process of establishing the necessary prerequisites could take time. Rather, the examples should demonstrate the potential of these new payment approaches and specify the capabilities required for implementation.

Many of these payment examples would support innovations in service delivery that cross current service boundaries and structures, including those between mental and physical health, to better meet patient needs. Examples we are currently considering include:

- proof of concept local variations and/or local prices to test alternative payment approaches that enable person-centred co-ordinated care for those who are frail, elderly or have multiple long-term conditions, as envisaged through the IPC programme, by:

    a) capitation payments for all of the care needs of patients, enabling the pooling of health and social care funds

    b) a disease-specific per person per year payment for the care required by that patient relating to a dominant health condition such as muscular dystrophy, Parkinson's disease or type I diabetes

    c) a community-based comprehensive assessment, self-care support and care co-ordination service

    d) sharing financial and quality risk across multiple providers and a commissioner

e) a personal health budget that gives an individual access to independent advice and brokerage, person-centred planning and control over how money is used (including the option of a direct payment)

- proof of concept local variations that test a potential new payment approach (or approaches) to support implementation of the recommendations of the review of urgent and emergency care carried out by Sir Bruce Keogh, which we consider to be probable bases for future payment system for urgent and emergency care to be nationally rolled out potentially from 2016/17
- proof of concept local variations to implement an integrated outpatient tariff to test and support the reconfiguration of hospital outpatient services
- proof of concept local variations to implement marginal prices for inpatient elective care to improve patient waiting times and experience
- case study local payment variation for mental health services that support bilateral financial risk sharing, based on outcomes
- case study payment example for liaison psychiatry as a way to improve the quality and efficiency of acute care for mental health patients
- case study currency model for secure and forensic mental health services, which have been tested over the past two years, along with guidance on the use of quality and outcome metrics within the model
- case study payment example local prices for an outcomes-based payment approach for IAPT services, which has been developed and piloted for the past two years.

Annex A provides more detail on each example. Annex B sets out the type of content we propose these payment examples cover.

We hope to work closely with a number of local health economies engaged in relevant service changes to develop these examples more fully over the summer and autumn this year. The work to identify and engage with local health economies has already started. We now ask any providers and commissioners that would like to volunteer for this co-development effort with NHS England and Monitor, or to find out more about it, to please contact paymentsystem@monitor.gov.uk.

Looking further ahead, we plan to provide implementation support to fully test and refine the payment examples in 2015/16. We also want to ensure that there is a robust process in place to evaluate the suitability of the payment examples for national roll-out in the future. We are currently working on the detail of our evaluative approach.

5. Setting and adjusting local prices to reflect efficient costs

Local prices are agreed between commissioner and providers, or determined by commissioners through formal competitive procurement processes, subject to the applicable rules in the national tariff. As with all prices, local prices should take into account the costs incurred by providers when providing the services in question, as well as the efficiencies that providers can be expected to achieve.

In the case of a multi-year contract that has not expired, the contract will often set out an agreed mechanism for annual adjustment to local prices. Where a contract is expiring, commissioners may undertake a formal procurement process to commission a replacement service and establish the local price for the service as part of this process. In this situation, however, commissioners may also decide to place a new contract for the new financial year with the existing provider. In the latter case, a local price for a service will have been set in the previous year and that price will be the starting point for negotiation of the price for the new year, with the commissioner and provider considering what adjustments may be necessary. Such adjustments should reflect providers and commissioners' expectations of increases or achievable reductions to the efficient costs of providing NHS services, relative to the local price agreed for the previous year.

Under the national tariff for 2014/15, commissioners and providers have to comply with the requirement in Rule 2 of the local pricing rules (see Section 2 above), that where a local price had been agreed in the previous year, providers and commissioners should have regard to the cost uplifts and efficiency factor for national prices when agreeing the local price for the following year. This does not require commissioners and providers to apply the national price adjustments, but provides a reference point for negotiation.

As set out in Section 2 above, we do not propose to change Rule 2 for 2015/16 (other than to update the years referred to in the rule). As this would mean that commissioners and providers should continue to have regard to the adjustments for national prices, in this section we discuss the two components of the cost adjustments proposed for 2015/16: the cost uplift factor and the efficiency factor.

Question:

4. How can we strengthen guidance to support local negotiations so as to ensure that local prices reflect efficient costs?

5.1 Cost uplift factor

The cost uplift factor for national prices quantifies our expectation of increases in the cost of providing NHS services that are outside providers' control. For the '2014/15 National Tariff Payment System', we used an approach consistent with that used by the Department of Health (DH) under Payment by Results, which is tailored to the expected cost pressures facing NHS providers. This approach includes uplifts in four categories:

- input cost inflation – this includes pay increases, drug costs and changes in operating costs, as well as general inflation
- changes in the cost of the Clinical Negligence Scheme for Trusts (CNST)
- changes in capital costs (ie changes in costs associated with depreciation and private finance initiative (PFI) payments)
- additional costs as a result of any new requirements in NHS England's Mandate. We call these 'service development'.

For each of these factors, we calculated price adjustments to reflect the additional expected cost pressures in 2014/15 for an average provider. We are proposing to retain this approach for 2015/16.

The approach used for national prices is necessarily generic. For local prices, providers and commissioners have an opportunity to identify specific cost pressures providers may be facing, which may be different from those assumed by the cost uplift factor applied to national prices. It would be up to local negotiations to agree where such circumstances should be reflected in the local price.

Service development

NHS England and Monitor are committed to setting the national tariff in a manner consistent with our principles of transparency, evidence base, consultation with the sector and impact assessment; and in accordance with our statutory duties. We are also keen to produce the national tariff in time to inform commissioning rounds, which typically begin the spring of the year before they come into effect. That requires publication of the national tariff statutory consultation notice no later than October.

In the '2015/16 National Tariff Payment System: national prices methodology discussion paper' (the methodology paper) we expressed our commitment to reviewing our processes for service development uplift and, in particular, how we engage with stakeholders and how we consider relevant evidence. We had extensive discussions on the issue at the workshops we held following the publication of the methodology paper. In light of these discussions, we will engage on service development once the Mandate is published, and will ensure that we hear

from a broad range of relevant stakeholders (including providers for all service types, commissioners and clinicians). We will incorporate the information into the service development uplift published in the National Tariff document in December.

5.2 Efficiency factor

The efficiency factor for national prices quantifies our expectation that providers should deliver services at a lower cost without compromising quality. For the purpose of national prices, we are only interested in efficiency as far as it relates to providers delivering a service for a lower unit cost. Our efficiency estimate should not include system-wide savings (for example, reducing activity levels), as these savings would be accrued by commissioners and should not be reflected in prices. However, this may not be entirely accurate for local prices, where it may be appropriate to reflect some system-wide savings in the price if these savings are retained by the provider (an example might be some block contracts).

Estimation approach

We want to develop a consistent framework for estimating and setting the efficiency factor for 2015/16 and in subsequent national tariffs. Such a framework would offer more predictability and clarity for providers and commissioners. In turn, that should allow for better planning and, ultimately, better outcomes for patients. However, we recognise that it may not be possible at this stage to apply an ideal framework, owing to issues around data quality and availability.

We think there may be reason to expect different scopes for future efficiency gains across different parts of the healthcare sector. However, the data[7] currently available are insufficient and not always comparable – in particular for services provided outside acute settings – for us to confidently estimate the efficiency factor at different levels of disaggregation. In light of this, we propose to set a single efficiency factor for the national prices in the 2015/16 national tariff.[8] This single efficiency factor would be estimated from acute sector data, which are currently more robust. We have proposed that the approach we would take to identifying that single efficiency factor would involve weighing evidence from both top-down econometric techniques and bottom-up models, and would be supported by stakeholder views and our impact assessment.

Stakeholder engagement on this proposal has been extensive and the vast majority of stakeholders agreed that while there may be different scopes for efficiency gains across the sector, we could not estimate them accurately for 2015/16. As such, most stakeholders agreed with our proposed approach of setting a single efficiency factor,

[7] The key data lacking for non-acute services is on costs. However, we would also require accurate and comparable data on activity (casemix) and other factors that affect providers' costs.
[8] We have proposed this in '2015/16 National Tariff Payment System: National prices methodology discussion' paper. While that paper was focused on the methodology for setting national prices, it did acknowledge the potential implications of the approach we settle on for services with a local price.

based on an estimate from the acute sector. Nevertheless, some stakeholders – notably independent providers of mental health services – disagreed with our proposal. We did not, however, receive an alternative proposal that explained how we could estimate differential efficiency factors. Some stakeholders suggested that the guidance supporting Rule 2 should identify a range for the efficiency factor, rather than a single number, as a potential way of addressing this issue.

While the estimation approach is focused on services provided in acute settings, we want to engage with stakeholders to understand how such an estimate can best be used in the guidance we provide for adjusting the payment of services that do not have national prices. We also note that, under Rule 2, providers and commissioners may agree prices that reflect different assumptions about efficiency, where they have good reasons for doing so.[9]

Overall, we consider that our proposal represents a balanced approach in light of current data constraints, and is supported by the majority of stakeholders. The process we are following for setting the efficiency factor for 2015/16 is set out in '2015/16 National Tariff Payment System: Engagement on national prices'. In the rest of this section we briefly explain how we have arrived at our estimated range for this single efficiency factor. Further detail is provided in the 'Engagement on national prices' paper mentioned above.

Estimating the efficiency factor for 2015/16

The scope for future efficiency gains can be thought of as consisting of two elements:

- Catch-up – this captures the saving associated with a provider becoming as efficient as the most efficient comparable provider (controlling for casemix, demographics, quality and input costs).
- Frontier shift – this captures the sector-wide savings from technological advances and service delivery optimisation.

Setting the efficiency factor would, at a minimum, include an estimate of the frontier shift. For national prices, since they are based on average costs of providing NHS services, it may be reasonable for the efficiency factor to also include the catch-up component.

We commissioned an independent study from Deloitte to carry out a thorough analysis of the evidence for an efficiency factor in 2015/16, based on data from the acute sector.[10] In line with the proposed approach, Deloitte focused on econometric analysis, supported by a bottom-up model. For the econometric models, Deloitte

[9] These reasons would need, for example, to be consistent with the principles for local payment arrangements: best interest of patients, transparency and constructive engagement.
[10] Deloitte, 'Evidence for the 2015/16 national tariff efficiency factor – a report for Monitor'

developed two 'core models', which have slightly different statistical properties. They also tested how sensitive the results were to the inputs and modelling assumptions.

The Deloitte study estimated how much more efficient a provider of average efficiency would have to become to achieve the efficiency of providers at the 60th, 70th, 80th and 90th percentiles. In deciding on the efficiency factor, we will need to apply judgement to identify the appropriate catch-up target for the average provider in terms of percentiles.

Table 1 summarises the estimates for both elements of the efficiency factor from the econometric models. The analysis has estimated frontier shift across acute providers of 1.2–1.3% (in the core models) per annum on average over the period 2008/09 to 2012/13. The bottom-up model estimated a range of 1.0–1.4% for the catch-up component. Given that the bottom-up model cannot capture all catch-up actions, and is based on a single provider, the Deloitte study identifies the range from the bottom-up model to be broadly consistent with the catch-up to the 60th or 70th percentiles in the econometric models occurring over a single year.

Table 1: Summary of Deloitte's estimates of the efficiency factor for 2015/16

	Frontier shift	Averagely efficient provider catching up to			
		60th percentile	70th percentile	80th percentile	90th percentile
Core models	1.2 – 1.3%	0.9 – 1.2%	2.2 – 2.4%	3.7 – 4.0%	5.0 – 5.6%
All models and sensitivities	1.0 – 1.8%	0.7 – 2.0%	2.2 – 2.9%	3.2 – 4.2%	4.3 – 5.9%

Sources: 'Evidence for the 2015/16 national tariff efficiency factor – a report for Monitor'

In our judgement, the estimates in Table 1 indicate that a range of 2–4% efficiency gains in a single year is supported by historical evidence on the frontier shift and on the scope for catch-up. However, the financial challenges that the sector is expected to face in 2015/16 are significant. As a result, it is expected that extraordinary effort will be required to achieve efficiency improvements across all parts of the sector to outpace historical trends. For providers, this would mean that either the frontier shift, catch-up rate, or both will need to exceed previously delivered efficiency gains. Consequently, we are proposing a range of 3–5% for the efficiency factor for 2015/16.

We carried out preliminary analysis based on the simplifying assumption that local prices are adjusted using the efficiency factor (and cost uplifts) for national prices. Our preliminary analysis looked only at providers of predominantly acute care. Our initial findings suggest that a significant number of providers would be face operating deficits in 2015/16 if they missed the efficiency factor by 2% or more. As an illustrative example, if we set an efficiency factor of 5% but providers were only able to reduce operating expenditure by 3%, we would expect more than half of providers to have operating deficits in 2015/16. However, if providers meet our efficiency target

or miss it by less than 1%, the expected impact would be much smaller, with a much lower number of providers projected to face operating deficits in 2015/16.

6. Promoting value for patients in acute services without national prices

In this section we set out two options we are considering for promoting value for patients from payment for acute services without national prices, and accelerating convergence to prices that reflect most efficient costs. Specifically:

- Option 1: Providing guidance setting out an expectation that providers would demonstrate efficient costs of providing acute services that do not have national prices
- Option 2: Introduce a new rule (or revision to the existing Rule 5) for local price-setting that would have the effect of limiting annual growth in the price paid for acute services without national prices, by reference to past trends.

Question:

5. How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? What issues would need to be considered in implementing each option?

Analysis of Reference Costs and income data for acute providers suggests that commissioner payments for services without national prices have grown much faster over the past five years than payments for services with national prices.[11] Monitor income data for smaller acute hospitals also identified non-tariff income as a way in which commissioners provide financial support to trusts.[12] Further work is required to understand the relative contribution of non-tariff activity and prices in driving this increase. Nevertheless, these observations raise concern as to whether this rate of payment growth is in line with the best allocation of scarce NHS resources on behalf of patients.

In considering this issue, several factors are worth noting:

- While all acute trusts experienced growth in non-tariff income in 2012/13,[13] the impact of growth in non-tariff payments appears to be particularly apparent in the relatively stronger financial position of acute teaching hospitals and specialist hospitals.[14] For example, between 2010 and 2014 specialist

[11] For example, our preliminary analysis of provider income suggests that income for services without national prices grew at 10% on average annually between 2009/10 and 2012/13. This trend is not fully explained by growth in activity volumes, suggesting effective unit price rises.
[12] Monitor, 'Facing the future: smaller acute providers'
[13] Nuffield Trust, 'Into the red? The state of the NHS' finances', figures 3.5 and 3.9, pp.27-29.
[14] Monitor, 'Performance of the foundation trust sector: year ended 31 March 2014'

providers experienced a lower decline in their profit margins compared to other types of acute trusts. Of course, there are various reasons why teaching and specialist trusts may perform more strongly than other types of acute trusts. These include greater potential for economies of scale and scope, more diverse income sources or greater scope to negotiate higher prices.

- There is significant pressure on the specialised services budget. In the medium term, NHS England is considering changes to how acute services without national prices are commissioned.[15] This may lead to payment approaches being proposed in future years to reflect greater standardisation around efficient models of care.

- Progress in convergence towards only remunerating efficient costs for specialised services without national prices over the past year has been limited and there remains a strong bias towards pre-existing arrangements. It is unclear whether these reflect value for patients. The lack of good costing and benchmarking data, including data that will identify and validate the more efficient service delivery models, limits the potential for evidence-based contract negotiations between commissioners and providers – although cost variation across England suggests there is scope for greater efficiency.

Given existing financial pressures and the additional financial challenge of 2015/16, NHS England and Monitor would like to engage the sector on possible changes to local payment arrangements aimed at promoting better value for patients from payments for acute services without national prices, and at accelerating the pace of convergence towards only remunerating efficient costs for specialised services. We are considering two policy options, which we would like feedback on, in advance of making a preferred policy proposal in the statutory consultation notice. The options being considered are:

- **Option 1:** Provide guidance alongside the national tariff to explain that while the cost uplift and efficiency factors are a reference point for local price negotiation, local prices should reflect efficient costs, in line with the principles for local payment arrangements. In order to demonstrate such efficiency, much greater transparency would be required from providers (such as cost and activity benchmarking). This could be accompanied by changes to the NHS Standard Contract that strengthen provisions for commissioners to control how much activity they reimburse.[16]

[15] NHS England's commissioning intentions (October 2013) set out an aim to secure provider commitment to adopt the most efficient practices for local prices, with a view to converge towards the best quartile costs.

[16] NHS England will be seeking views from stakeholders on the effectiveness of the current service condition 29, as part of the process for engagement on the development of the NHS Standard Contract for 2015/16 www.england.nhs.uk/wp-content/uploads/2013/12/sec-b-cond-1415.pdf

- **Option 2:** Introduce a new rule (or a revision to the existing Rule 5) for local price-setting in the national tariff that would have the effect of limiting annual growth in the price paid for acute services without national prices, by reference to past trends. For example, this rule could require one of the following:

    a) the adoption of:

        - marginal rate price-setting for those services where well established activity information flows are in place, with the marginal rate (%) linked to how low the local price is compared to benchmarks

        - the indexation of block contract prices, for services without activity flows, to a base year, with any upwards volume adjustments at a marginal price.

    b) the introduction of service level revenue caps, for example, for each commissioner, which would operate across multiple providers, and align payment to the share of total activity undertaken by providers in a given period, with regular in-year monitoring

    c) an alternative solution that would achieve similar aims – we welcome any suggestions from the sector.

While both of the options set out above will be considered , it is not clear whether a commissioning or contracting solution (as per option 1) is sufficient to ensure the level of response needed to secure improvements in value for patients in time for 2015/16.

Furthermore, we are considering two potential requirements, which could be introduced in addition to either option:

- full disclosure by providers of activity and cost data relating to the services in question

- credible provider service transformation plans that must be agreed with commissioners, in order to secure greater efficiency for non-tariff services.

Additional work is needed before we can conclude whether a policy change can be proposed for the statutory consultation notice for 2015/16. We are engaging with the sector on this issue and will continue to do so. We will also conduct a thorough

assessment of the impact of introducing either option.[17] Our high-level consideration of the options has identified the following non-exhaustive list of potential impacts:

- **Positive impacts:** costs of efficient care are revealed; improved allocation of constrained healthcare resources across different types of care; savings can be reinvested by commissioners into additional care; opportunities to ensure clinical and financial sustainability are both met.
- **Negative impacts:** providers and commissioners do not adapt quickly enough, stranded costs create barriers to exit, and providers' financial sustainability is further challenged – this has a negative impact on quality of care; reduction in patient choice subject to a provider being able to exit provision (via a de-designation of a commissioner requested service).

Some of the negative consequences could be mitigated with careful monitoring of activity and quality data and, if needed, the appropriate use of local modifications should structural cost differences to services with national prices be revealed.

[17] In line with our impact assessment framework, we will be assessing the likely benefits, costs, risks and potential unintended consequences of the two policy options.

Annex A: Detail on proposed payment examples

This annex provides further detail on the local payment examples we may publish in a guidance document that would supplement the 2015/16 National Tariff Payment System. These examples cover:

- proof of concept local variations and/or local prices to test alternative payment approaches that enable person-centred co-ordinated care for those who are frail, elderly or have multiple long-term conditions, through:
    a) capitation payments for all of the care needs of patients, enabling the pooling of health and social care funds
    b) a disease-specific per person per year payment for the care required by that patient relating to a dominant health condition such as muscular dystrophy, Parkinson's disease or type I diabetes
    c) a community-based comprehensive assessment, self-care support and care co-ordination service
    d) sharing financial and quality risk across multiple providers and a commissioner
    e) a personal health budget that give an individual access to independent advice and brokerage, person-centred planning and control over how money is used (including the option of a direct payment)
- proof of concept local variations that test a potential new payment approach (or approaches) to support implementation of the recommendations of the review of urgent and emergency care carried out by Sir Bruce Keogh
- proof of concept local variations to implement an integrated outpatient tariff to test and support the reconfiguration of hospital outpatient services
- proof of concept local variations to implement marginal prices for inpatient elective care to improve patient waiting times and experience
- case study local payment variation for mental health services that support bilateral financial risk sharing, based on outcomes
- case study payment example for liaison psychiatry as a way to improve the quality and efficiency of acute care for mental health patients
- case study currency model for secure and forensic mental health services, which have been tested over the past two years, along with guidance on the use of quality and outcome metrics within the model

- case study payment example local prices for an outcomes-based payment approach for IAPT services, which has been developed and piloted for the past two years.

We encourage commissioners and providers to consider these examples when developing local payment arrangements for 2015/16. Further, we would welcome feedback from the sector on how they have applied innovative payment approaches or service design in practice, as well as any evidence evaluating the impact of the new approach. Such testing will enable refinement of these payment approaches, and help inform both local and national payment approaches in the future.

A.1 Payment approaches to support the delivery of patient-centred co-ordinated care

Monitor and NHS England are committed to exploring reform of the payment system to support the delivery of patient-centred co-ordinated care across the country, which is necessary for people with complex care needs from multiple providers and in different care settings. Sector feedback indicates that the current payment system is perceived as a barrier to integrated care, as it is fragmented and does not reward prevention and care co-ordination across providers. There is strong momentum for the sector to move towards more integrated care at pace, especially for the most fragile populations (eg patients with multi-morbidities), with added impetus created by NHS England's recent announcement on the IPC programme.

The opportunity

A number of local care economies (eg Integrated Care Pioneers) are currently working on the design and implementation of innovative payment approaches aimed at supporting new care delivery models. These payment approaches look to put patients at the centre of the care system, and reward prevention and care co-ordination. There is also some promising international evidence that, where implemented well, quality and efficiency improve under some of these innovative payment models.

Our proposal

We propose to publish a series of payment examples that present five approaches to support the delivery of patient-centred co-ordinated care:

- capitation payment for a target population
- condition-specific year of care payment
- payment for needs assessment and care co-ordination activity
- multilateral gain/loss sharing arrangements
- Personal health budgets.

It is worth noting that these approaches are not all mutually exclusive (eg personal health budgets, see below, are compatible with each of the other four options). We plan to publish a payment example for each of these options. Where necessary, these examples will also refer to guidance from NHS England on commissioning and contracting changes that may be needed together with the payment approach.

i. Capitation payment for a target population

This payment to a provider (or group of providers) would cover the majority (or all) of the care provided to a target population (eg patients with multiple long-term conditions) across different care settings. The payment would cover the care needed by a patient even if the particular instance of care were not related to the reason why he/she is part of the target population.

This example would set out:

- factors to take into consideration when selecting the target population
- a possible basis for price calculation
- potential roles for risk mitigation mechanisms.

Capitation payments would allow providers to share in (some of the) gains generated for the system, and make them financially responsible for whole person care. Capitation payments would, therefore, encourage prevention and care co-ordination, producing better care, at better value, for the patients.

ii. Condition-specific year of care payment

A lot of work has been undertaken with clinicians and commissioners to develop and deliver a ‘year of care’ pathway payment currency for patients with cystic fibrosis. We would like to build on this success (alongside other pathway approaches such as for HIV outpatients) by preparing a payment example for other conditions, which could include muscular dystrophy, Parkinson’s disease or type I diabetes.

A disease-specific year of care payment is aimed at ensuring that patients with a complex single condition receive seamless care for that condition in a patient-centred manner, in the most appropriate healthcare setting. This approach would also facilitate the use of early intervention procedures and treatments to slow down progression of the disease.

We propose publishing a payment example in which:

- the currency and associated price will be a series of complexity-adjusted yearly bandings, with the bands reflecting the higher costs associated with caring for more complex patients

- the bands will range from covering patients with the least intensive needs (such as a small number of outpatient appointments and oral medication) to those who require regular hospitalisation for complications and intravenous medication
- the price would cover most activity associated with the specific condition, such as inpatient and outpatient activity, medicines as recommended by national clinical guidelines, and community interventions and re-ablement
- payment bandings would be assessed on an annual basis to ensure that patients continue to be allocated to the most appropriate band for their condition.

We recognise that some aspects of this activity are already captured by existing service definitions and payment made to primary and community care clinicians. The example will, therefore, also provide guidance on how to untangle this activity as a separate currency to avoid double payment.

iii. Needs assessment and care co-ordination service payment

For those economies that are not yet able to transform their commissioning and provider landscape, or move towards more innovative models of payment for integrated care (eg capitation payments), there needs to be a viable alternative (rather than a 'do nothing' approach) to encourage more co-ordination of care around the needs of the individual.

Work undertaken across the sector suggests that patients' outcomes and experience of care could be improved by having a nominated lead who will oversee the complete co-ordination of their health and social needs on their behalf. The lead will ensure that they are receiving the most appropriate treatment in the most appropriate setting, while at the same time promoting self-management of their conditions.

Payment would be made to a provider to undertake a care co-ordination and assessment service over a fixed period of time for patients with long-term conditions, so that their health and social care needs are fully integrated. The provider would be responsible for co-ordinating *all* care (not just the care it provides).

The provider of this service could be one the following (among other possible types of providers):

- GP practice
- nurse co-operative
- community provider
- social care provider.

iv. Multilateral gain/loss sharing arrangements

Multilateral gain/loss sharing arrangements can sit on top of an underlying payment approach, including the current payment arrangements. Commissioner(s) and provider(s) set a total commissioner spend baseline, and agree how gains and losses (ie difference between the baseline and actual commissioner spend) would be shared between the relevant parties. The effect of this agreement is to adjust retrospectively the price paid for the care delivered.

This payment example would set out:

- a possible method to calculating the commissioner spend baseline
- a potential approach to sharing gains and losses across parties to the arrangement.

Similarly to capitation payments, multilateral gain/loss sharing arrangements would allow providers to share (some of the) gains generated for the system and would, therefore, encourage providers to focus on whole-person care.

v. Personal health budget

A personal health budget (PHB) is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. Key features of PHBs include access to independent advice and brokerage, person-centred planning and control over how money is used (including the option of a direct payment).[18]

Following the implementation of PHBs for those in receipt of NHS continuing healthcare, we think PHBs could be used to help individuals who have multi-morbidities and who require more flexibility in the way their care is delivered. This is one of the drivers behind NHS England's IPC programme.

PHBs could be used in addition to any of the payment options mentioned above, allowing an individual to tailor the services they receive. While they cannot cover payment for acute or core primary care services, PHBs may include social care services. Funding for PHBs comes from within a CCG's overall budget for purchasing healthcare services, so we would need further analysis to determine a method for setting the value of the budget devolved to the individual (whether virtually or as a direct payment).

[18] A direct payment is when the individual receives the money directly to buy the care and support they have decided they need, in agreement with their local NHS team. They have to show what the money has been spent on, but the individual, or their representative, buys and manages the services themselves.

This payment example would set out:

- the cohort of patients suitable for receiving PHBs
- how the PHB amount could be calculated, including in the context of other payment approaches outlined above
- important differences between direct payments and notional budgets, including what advice is available via brokerage services and peer networks
- illustrations of different services that can be secured by an individual with a PHB to improve their health and wellbeing; such as additional carers, personal assistants, exercise vouchers and relaxation classes.

A.2 Payment approach to support the reform of urgent and emergency care

The review of urgent and emergency care carried out by Sir Bruce Keogh (the 'UEC review') set out a vision for a new way to deliver urgent and emergency care as a co-ordinated system that covers all patient touch points from first contact and urgent primary care to specialist emergency centres. Monitor and NHS England are committed to exploring reform of the payment system to support the delivery of service changes set out by the UEC review.

The opportunity

Sector feedback and work undertaken by Monitor and NHS England to date suggest that the current way different parts of urgent and emergency care delivery are paid for acts as a barrier to the type of service reform and new behaviours set out by the UEC review. To support the delivery of the necessary service changes, the way the different services are paid for needs to change to:

- enable co-ordination between different providers and care settings
- enable system-wide accountability for activity and patient outcomes
- better match the economic model of how the services are organised and delivered to avoid distortions to behaviour.

A payment approach that is consistent across the different parts of the urgent and emergency pathway, recognises the 'always-on' fixed-cost nature of the services, and facilitates sharing in system-wide results of individual provider actions can act as a real enabler for delivering better quality, co-ordinated care to patients. It can also improve value for money for the tax payer.

Our proposal

We propose to publish a payment example that tests the concept of combining a payment for capacity and activity together in a co-ordinated way across multiple parts of the urgent and emergency care system. The example would set out:

- the proposed basis for determining the reimbursed cost of a planned level of capacity
- the proposed basis for sharing financial gains and losses from variations in demand (reflecting either success of the service changes or uncontrollable factors) between multiple providers and one or more commissioners
- potential roles for quality of care and patient outcomes in the payment approach.

Where necessary, the example would also reference to guidance from NHS England on commissioning and contracting changes that may be needed together with the payment approach.

A.3 Payment approach to support the use of an integrated outpatient tariff

As part of the development of our long-term payment system strategy, Monitor and NHS England conducted analysis of the opportunities to improve patient value in planned care.

This analysis identified variation in follow-ups to first appointments even after low quality, specialty and patient need are accounted for. Alongside this we are aware that some commissioners set ratio limits on providers for the proportion of follow-up to first appointments. There also appears to be low uptake of the non face-to-face tariff even though there are opportunities for channel shift (eg tele and Skype consultations) in the delivery of outpatient care. Current currency design is focused around consultant presence at appointments and this might not enable level shift (nurse or primary care follow-up where appropriate) in outpatient care. Channel and level shift could significantly increase the value of outpatient spending – for example, sub-groups of patients who have had access to these types of reconfigured services have reported a range of benefits. The delivery costs associated with this care can also be lower.

The opportunity

While existing ratio limits used by commissioners can help control growth in follow-up appointments, this mechanism does not enable the type of transformation in outpatient care delivery that we and the sector would like to see. An integrated outpatient tariff could address this by making a single payment for a patient's first and all related follow-up appointments, based on the average ratio of follow-ups to first appointment at a specialty level across providers. This 'bundle' of first and

follow-up appointment payments would enable commissioners to incentivise providers to reduce unnecessary or lower value follow-ups while also giving providers the financial flexibility (via a single payment) to reconfigure their outpatient services in a way that maximises value for patients (using channel and level shift as appropriate given different care types and patient needs).

Our proposal

We believe the application of an integrated outpatient tariff could be a key enabler to increase the value of outpatient spending to the benefit of patients. We therefore propose to publish a payment example for an integrated outpatient tariff that commissioners and providers could apply to test and support the reconfiguration of outpatient services. The example would set out:

- how to calculate an integrated payment for an outpatient episode for each specialty
- options for calculation that vary the scope or level of integrated payments (eg using national or local data for the scope of comparisons; using average or different percentile bases for determining follow-up appointment levels)
- ways in which consultant-to-consultant referrals could be treated when using an integrated outpatient tariff.

Where necessary, the example would also reference guidance from NHS England on commissioning and contracting changes that could be required alongside the payment approach.

A.4 Payment approach to maintain access to planned care

Despite the NHS' current constrained financial situation, it is important that patient experience and quality of care is maintained. Recent results show that performance against the 18-week referral to treatment standard is falling and some patients experience long waits for care. Commissioners and providers can look to address this through the way planned care is paid for. We are looking at whether a payment example would help with this process.

The opportunity

Local health economies vary in their performance against waiting standards and opportunity for additional activity. By establishing a payment approach for planned care, or certain specialties where there is a risk of waiting lists becoming particularly long, providers can be encouraged to provide additional care at marginal cost and receive commensurate additional revenue.

This exploits the fact that providers determine their capacity to deliver care for patients according, in part, to signals provided by the price level and the available budget for the activity. It is, therefore, possible to determine a structure of payments

which incentivises utilisation of spare capacity to undertake activity, where this is desirable to meet the needs of a local population. This has the potential to improve patient outcomes, patient experiences and value for money.

Our proposal

We propose to develop a payment approach where commissioners can set a threshold of activity, with activity undertaken above this level paid for at a marginal rate. Design of the payment approach could mirror the current marginal rate rule for emergency admissions, or take a more complex arrangement, such as the approach used in Victoria, Australia. This approach limited the total funds that could be spent on planned care, and the price paid was determined retrospectively, depending on the total outturn activity. In designing this payment approach, commissioners could work with providers to ensure sufficient activity is undertaken within their area to improve patient waiting times.

However, we need to undertake further work to understand the complexity of the payment approach, whether it is compatible with patient choice and referral to treatment targets, and its impact on provider sustainability and market entry. The analysis of these issues may result in this proposed local payment design example being withdrawn.

A.5 Bilateral risk sharing with outcomes – a mental health case study

There is a desire across the system to shift to a more patient-centred approach to care, with seamless integration of healthcare services that meet all the needs of each individual patient. National policy has increasingly focused on the importance of outcomes as part of patient care. The strategy document, 'No health without mental health', sets out the long-term ambitions for the transformation of mental healthcare in England. The strategy is built on six objectives that work towards improving the mental health and wellbeing of the population (ie infants, children, young people, adults and older adults). It also seeks to improve the outcomes for people with mental health problems by ensuring they have equal access to high quality services. Currently, there are variations in the use of the mental health currencies and anecdotal evidence suggests that some CCGs are looking at alternative payment approaches with strong links to outcomes and better allocation of financial risk.

The opportunity

One opportunity to incentivise a more integrated, patient-centred approach to care is to move to a risk sharing model linked to outcomes. Moving to an outcome-based payment would incentivise providers and commissioners to provide and pay for services that promote better outcomes for patients, instead of simply paying for services that are offered to the patient.[19,20] This model also promotes better quality of

[19] Joint Commissioning Panel for Mental Health, 'Outcome specifications'

care for patients, encourages integrated care across providers, and can enable commissioners to procure mental health outcomes for a whole population.[21]

Our proposal

We propose to develop a payment example that will support commissioners and providers in testing a bilateral risk-sharing outcome-based payment approach for mental health services under the local price-setting rules. Despite the national drive to develop outcome-based payment models, there are currently no suitable national currencies. As a result, we propose to publish details of the payment approaches that could be adopted locally. The example would include:

- two approaches that could be adopted locally to support the delivery of outcome-based payments, for example, a lead provider or prime contractor model
- the factors commissioners and providers should consider when selecting the patient population and associated outcomes on which to base payment
- how the payment approach can be linked to a set of defined and locally determined outcome measures
- how to incentivise efficient working by ensuring the financial risks and gains are agreed between providers and commissioners.

We will draw on examples from local models to inform this payment example.

A.6 Liaison psychiatry – integrating mental and physical healthcare

The prevalence of mental health conditions among people with physical health conditions is high. It is estimated that approximately 30–60% of patients admitted into general and acute hospitals have a co-morbid mental health condition, and many of them will not have their mental health conditions diagnosed or treated.[22] The impacts of not treating mental health co-morbidities are poorer outcomes for the patients and higher costs of care for providers and commissioners. The evidence suggests that mental health co-morbidities increase hospital costs by 45–75% per patient.[23]

The opportunity

Liaison psychiatry, also known as psychological medicine, addresses the mental health needs of people who are being treated primarily for physical health problems

[20] Oxfordshire Clinical Commissioning Group Governing Body, Outcomes based contracting business cases
[21] West Cheshire Clinical Commissioning Group, Mental Health Integrated Provider Hub
[22] Centre for Mental Health, Liaison psychiatry in the modern NHS
[23] Centre for Mental Health, Liaison psychiatry in the modern NHS

in physical health settings. The service can provide rapid access to specialist mental health support within an acute hospital, including A&E departments.[24] The evidence highlights that an effective liaison psychiatry service promotes integrated care and generates system efficiencies. The benefits associated with the service are improved quality of care and better outcomes for patients that lead to cost savings generated through reduced lengths of stay, fewer readmissions and better care of long-term conditions.[25,26,27]

The benefits of liaison psychiatry have also been highlighted in several strategy documents. In 2014, NHS England's Anytown CCG initiative[28] published an example of how CCGs can use liaison psychiatry interventions to improve local health services and close the financial gap. The Crisis Concordat also committed its signatories to the provision of adequate liaison psychiatry services in hospitals with an A&E department.[29]

Our proposal

We propose to develop a payment example that will describe an approach commissioners and providers could use when implementing liaison psychiatry models within their local health economy. Given that there is no specified national currency for liaison psychiatry services in England, we propose to publish details of the relevant service models and accompanying payment approaches. In particular, the payment design example will include:

- local service delivery models that promote better outcomes for patients and yield savings for the local health economy when compared to the effects of not implementing liaison psychiatry services
- a possible method of calculating the price of a liaison psychiatry service using the local price-setting rules
- detail of how the payment approach can promote integrated care and how financial risks and gains can be equitably shared among all partners.

This payment example will also feature the experiences of several local health economies that have implemented a liaison psychiatry service. We will highlight how their payment approaches have enabled provision of appropriate levels of liaison psychiatry services within the local health economies.

[24] Royal College of Psychiatrists, Liaison psychiatry for every acute hospital – integrated mental and physical healthcare
[25] Centre for Mental Health, Liaison psychiatry in the modern NHS
[26] Royal College of Psychiatrists, Liaison psychiatry for every acute hospital – integrated mental and physical healthcare
[27] Joint Commissioning Panel for Mental Health, Liaison mental health services to acute hospitals
[28] NHS England (2014), Any town toolkit
[29] Aitken et al. (2014), Providing effective liaison psychiatry to English hospitals with an accident and emergency department (working paper)

A.7 Secure and forensic services – a pathway payment

Secure and forensic services consume a high percentage of the total sum spent on mental health services, despite being used by a relatively small population. It is estimated that secure services work with between 7,000 and 8,000 people per year and cost the NHS approximately £1.2 billion a year.[30] Currently all secure and forensic services are commissioned by specialist commissioners. However, there are variations in the amount regional specialist commissioners currently pay for secure and forensic services despite having similar client groups.

The opportunity

Over the past three years, the DH and NHS England have worked with specialist commissioners, providers, clinicians and the independent and voluntary sectors to develop, test and pilot a new currency model for secure and forensic services. The new currency model will lead to a consistent payment approach for these services across England. Building on the work for mental health services to working age adults and older people, the currency design combines (forensic) clusters and care pathways. The former describes the current presenting needs, and the latter describes the likely length of stay and expected patient journey. The new currency ensures that quality and outcome metrics can be built into the payment approach.

Our proposal

We propose to publish a payment example that will outline the currency, quality indicators and outcome measures that can be used to incentivise service improvements, sustainable recovery and care provision in least restrictive settings. The example will also describe work currently underway to develop guidance for care packages and a methodology for calculating local prices.

A.8 IAPT services – an outcome-based payment

The available evidence shows that approximately 25% of the adult population in England will experience a mental health problem within any given year, with depression and anxiety the most common mental health problems.[31] The strategy for mental health, 'No health without mental health', points out that improving equitable access to psychological therapy is a fundamental step in ensuring that:

- the mental health and wellbeing of the population is improved
- there are improved outcomes for people requiring mental healthcare.

Psychological therapies are seen as an important element of the package of care for people with depression and anxiety disorders, and for many people these therapies

[30] Centre for Mental Health, 'Pathways to unlocking secure mental healthcare'
[31] Mental Health Foundation, Mental Health Statistics

may be the only interventions they receive. The IAPT programme for adults (over 18 years old) has supported increased access to NHS-commissioned services for depression and anxiety in England. The overriding objective of the IAPT programme is to support commissioners of NHS services in delivering:

- NICE-approved, evidence-based psychological therapies for people with depression and anxiety disorders
- equitable access to services and treatments for people experiencing depression and anxiety from all communities within the local population
- increased health and wellbeing, with at least 50% of those completing treatment moving to recovery and most experiencing a meaningful improvement in their condition
- patient choice, and high level of satisfaction from people using services and their carers
- timely access, with people waiting no longer than the locally agreed waiting times standard
- improved employment, benefit, and social inclusion status including help for people to retain employment, return to work, improve their vocational situation and participate in the activities of daily living.

The opportunity

An outcome-based payment approach for IAPT services has been developed and piloted for the past two years. The payment approach is based on NICE guidance, but allows for local tailoring of delivery arrangements, and includes:

- a flat rate for assessment
- cluster-based activity payments according to an agreed local activity schedule reflecting casemix complexity and severity
- payment for agreed local outcomes in the domains of equitable access, clinical outcomes and non-clinical outcomes (eg employment, wellbeing, patient experience and choice).

Over time it is expected that the majority of payments will be associated with performance against these outcomes.

Our proposal

We propose to publish the payment approach that has been tested in 28 sites around the country for the past two years. The local payment example will include

information on:

- the IAPT data set requirements for price-setting, including mental health clusters, patient flow, patient experience and outcome data
- how commissioners and providers can ensure their 2015/16 IAPT payment arrangements include an element of payment for outcomes that reflect local circumstances
- the outcome-based payment approach being refined by ongoing piloting, which commissioner and providers could start to adopt.

Annex B: Proposed content of the payment examples

The payment examples will be simple, short publications that we plan to publish alongside the '2015/16 National Tariff Payment System' final document. NHS England and Monitor will create them to assist commissioners and providers consider the application of the local payment rules to support service changes. The examples will follow a standard structure, as set out below.

Introduction

This section will be the same for all payment examples. It will describe the different types of payment examples and explain the selection criteria and rationale for their publication alongside the 2015/16 National Tariff Payment System. It will also introduce the wider framework to support behavioural change that the payment examples will be set in, taking into consideration culture, care models, contracts and the core enablers for change.

Outline of the issue

This section will set out the current problem affecting delivery of care and patient outcomes that the payment example will seek to address, considering questions such as:

- What patient needs will be addressed by the service changes that the payment example will support? Where are we now and why is it an issue for the envisaged service changes?
- What are the implications for the envisaged service changes from retaining the current payment model?

Outline of the opportunity

This section will provide a summary of the proposed solution to the issue that the payment example offers. This will include:

- A brief overview of the solution and where it has been successfully implemented (within the NHS or internationally)
- What are the key outcomes this payment example aims to achieve
- Whether the payment example is a local price or local variation (including which local payment rules apply to it).

The payment design

This section will provide details of the payment design and, where applicable, the payment terms for the services in question. This will include consideration of the key players and stakeholders that need to be engaged throughout the process.

Where applicable, this section will also explain what services are included in this approach and how this differs to the existing model of care and payment. The

payment design will cover:

- **Currency:** What is the preferred currency for this approach?
  eg Is it a capitation for a segment of the population? Is it for a unit of activity or for a bundle of care?
- **Price:** What is the method of calculation of the price for this currency?
  eg Is it based on historical spending for the population? Is it based on the costs associated with the service model? How do funds flow between multiple providers of care?
- **Accompanying incentives:** Are there any accompanying incentives which will need to be linked to the payment approach?
  eg Is payment linked to quality or payment outcomes? Are there any specific efficiency incentives attached to the payment for example marginal rates or risk shares?

Core enablers for success

To support the delivery and implementation of the payment approach, the design example will also address the core enablers for success. In particular it will consider the data and information requirements of this payment approach. We will also set out, where applicable, any additional safeguards to ensure accountability for quality and access to services we expect to be in place with the use of the payment example.

Measurement and evaluation

Transparent measurement and evaluation of the patient benefits and value for money are a key part of the rationale behind the payment examples. It will also be important to identify any unintended consequences or perverse incentives that had not been anticipated. This section of the payment example will set out the measures and metrics of the clinical, financial and patient reported outcomes that we expect to be reported and used to evaluate the success of the payment example in supporting the service redesign.

Wider considerations

Where applicable the design example will include signposting to other documents which support the implementation of the relevant service changes and the payment example. This may include signposting to service specifications, or contract and commissioning guidance.

Related examples

This section will include information on other related examples. Where available from within the NHS, but also relevant international examples.

Annex C: Detail on preliminary impact assessment

This annex provides detail on our preliminary analysis of the impact of the proposed guidance on payment rules for mental health services. Final impact assessments for all the proposals for 2015/16, including an equality analysis, will be published alongside the statutory consultation notice in the autumn. We encourage stakeholders to provide feedback on the potential impacts of the policy proposals in this document on groups with protected characteristics (as defined under the Equality Act 2010) or any other impacts on patients, including evidence that is relevant to identifying those impacts.

Table C1: Impact assessment of proposals to publish guidance on payment rules for mental health services

Issue	Options assessed
Despite the introduction of care clusters, most local agreements still rely on block contracts that have limited levels of transparency regarding service provision, patent outcomes, quality and value. We want to place more emphasis on patient outcomes, and make providers and commissioners more clearly accountable for patent outcomes, quality and value.	Option A (**baseline**): No change to existing guidance Option B (**proposal**): Publish guidance that reiterates our commitment to the rules and principles for agreeing local payment arrangements (transparency, best interest of patients, constructive engagement; MHLDDS data submission requirements and reporting Reference Costs based on care clusters).
Proportionality test	**Form of assessment**
Mental health is a large and important area of care, but we do not expect this proposal to be of significant concern for the sector. The updated guidance should still give providers or commissioners enough freedom in the way that they design local arrangements. This suggests that the proposed new guidance for 2015/16 requires a limited preliminary impact assessment.	We consider a high-level, qualitative impact assessment is appropriate for this proposal.
Input from stakeholder engagement	**Key assumptions**
Care clusters were mandated for use from 2012 by the Department of Health following a four year development programme. We have also engaged informally with a number of stakeholders.	The analysis in this impact assessment relies on the assumption that providers and commissioners will try to comply with the payment rules and guidance for mental health services where possible.
Interaction with other policies	**Risks**
Payment for mental health services is subject to the same rules and principles as other local price-setting.	A possible risk is that the new guidance disrupts existing local agreements that are meeting patient needs. We expect that this risk can be managed by providers and commissioners, by making use of our options for adapting the rules to meet the needs of local situations – including rules relating to local variations. Our intention is that the rules and guidance strike a balance between placing more discipline on the commissioning of mental health services and allowing enough freedom to deal with local issues.

Benefits	Costs
The proposal has the following incremental benefits compared to the baseline scenario: • More transparency for mental health services: the new guidance should lead to providers and commissioners having a better understanding of the services being delivered, the outcomes achieved, and the costs of delivering effective services. Over time, we expect this to lead to better use of resources, to the benefit of mental health patients. • Encourage best practice in both the design of mental health services and the payment system that supports them: the combination of payment rules and guidance should promote measures that will improve patient outcomes, such as the use of outcome measures in the payment system and the delivery of integrated, person-centred care.	The proposal has the following incremental costs compared to the baseline scenario of no change: • There will be some administrative costs associated with the new payment guidance, particularly in the short-term as providers and commissioners take time to understand them and make operational changes in response to the new guidance. We are clarifying existing rules and, therefore, providers and commissioners may have limited changes to make. • Data collection and reporting costs could increase for those providers that are not currently following rules and guidance relating to agreeing payment for mental health services or meeting standards for reporting requirements.

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

© Monitor (July 2014) Publication code: IRCP 10/14
NHS England Publications Gateway Reference **01876**