Monitor

NHS England

How can the NHS payment system do more for patients?

A discussion paper

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NHS England and Monitor's partnership

From 2014/15, NHS England and Monitor will have joint responsibility for the payment system for NHS funded care, as set out in the Health and Social Care Act 2012. Our partnership is relatively new, but we have been working together over the past year to understand how the payment system shapes NHS care and how we may develop it over time.

Within the partnership, we have different responsibilities. As the overall commissioner of health care services, NHS England will specify the units of purchase (currencies) for what commissioners buy on behalf of patients. Monitor is responsible for designing the payment rules and pricing methodologies which govern the flow of funding from commissioners to providers of NHS care from 2014/15 onwards. We will publish the results of our joint work in the National Tariff. This will set out the services and their national prices, how these prices are calculated and the rules associated with payment. In carrying out these tasks, NHS England is guided by its mandate[1], its clinical priorities and, above all, its commitment to understand and act on the needs of patients. Monitor is guided by its primary duty to protect and promote the interests of people who use health care services. All our joint work is informed by feedback from patient groups, clinicians, providers, commissioners, health and wellbeing boards and other members of the sector.

Preface

This discussion paper is the first publication to come from NHS England and Monitor's partnership on the critical issue of designing a comprehensive payment system for NHS services for the long term.

The respective duties of our two organisations put the patient at the heart of our decisions. In addition, we are both mindful of the constraints on NHS and social care funding. So our shared aim is that the payment system for the NHS supports continually improving quality for patients as sustainably as possible, with any risks shared appropriately between providers and commissioners. The system should include rules on payment approaches appropriate to the whole range of NHS care, while encouraging innovations in care delivery. It is unlikely that we will find a perfect design for the payment system. Trade-offs will be inevitable and we will have to prioritise where improvement can be made. But, ultimately, only through finding the best balance between quality, sustainability and risk can the payment system do more for patients.

During this time of change for the NHS, we recognise that commissioners and providers need the payment system to be predictable. So for 2014/15 the list of nationally mandated services and their prices will remain very close to the 2013/14 list. At the same time, recognising the need for some immediate changes to the payment system, we will encourage local experimentation in payment to support service redesign and develop a programme for research and development. Monitoring and evaluation of this work will provide more evidence on which to base longer-term changes to the payment system.

Our thinking about NHS payments in the longer term is at a very early stage. This paper presents for discussion and development with commissioners, providers, health care professionals and other sector stakeholders our early thoughts on:

- setting objectives for the NHS payment system;
- designing the payment system;

[1] The mandate for NHS England was published in November 2012 by the Secretary of State https://www.gov.uk/government/publications/the-nhs-mandate

- strengthening the foundations of the payment system; and
- exploring design options.

It also sets out the timetable for the 2014/15 National Tariff, the first that Monitor and NHS England will jointly produce. We invite stakeholders to tell us what they think and to work with us in shaping the long-term strategy for the payment system over the coming months. Your feedback will complement the wide-ranging engagement process being undertaken by NHS England on the overall vision for the NHS. We will bring together the responses to this discussion paper and the emerging vision for the NHS in a joint Monitor-NHS England long-term strategy for the payment system, which we hope to publish before the end of this year.

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Summary of our early thinking

Over the past year or so, Monitor and NHS England have asked ourselves how together we can design a payment system that does more for patients. We want the design of the system to promote value for patients, where promote value means continually improve the quality of care using scarce resources sustainably. Below is a summary of some of our thinking and these are the ideas that we particularly want to test with the sector.

Setting objectives for the NHS payment system

1. The sector needs support to change patterns of care in the interests of patients
2. The payment system influences behaviour
3. But the payment system is only one among many levers for change
4. Trade-offs will be inevitable
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Designing the payment system

6. Understand the different types of patient need and patient care
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15. Changing the payment system will take time, so prioritise some short-term improvements

Introduction

Until a decade ago, NHS funding was largely transferred from commissioners to NHS health care providers through block grants and contracts with locally determined prices. These were intended to cover providers' costs but gave little incentive to improve care, efficiency, or waiting times. To focus providers on improving all three, in 2003 the NHS introduced Payment by Results (PbR) to elective care. This approach to setting prices for specified treatments or services underpins much of the NHS payment system for hospital care today.

The transfer of responsibility for design and oversight of the NHS payment system to NHS England and Monitor offers a timely opportunity to stand back and understand how the system works today and how it may develop in future. We have set ourselves the task of answering the following question: "How can the payment system do more for patients?" We want the design of the system to promote value for patients, where promote value means continually improve the quality of care using scarce resources sustainably. Our thinking on the design of the payment system is still at a preliminary stage, and we would welcome input from commissioners, providers and other stakeholders to help us design the payment system for the longer term.

Part One of this document gives the context for this discussion and Part Two describes the development of the NHS payment system to date. Some early ideas on how to design a payment system for the longer term are set out in Part Three for discussion with the sector, with a view to publishing a long-term strategy incorporating stakeholders' contributions by the end of the year.

We expect that changing the payment system will take some time. More immediately, the final part of the document sets out what stakeholders can expect from the 2014/15 National Tariff. This includes an explanation of the timetable, approach and policy rationale for Monitor and NHS England's first National Tariff.

At the end of the document, we set out how we plan to enlist stakeholders in developing our long-term strategy for the NHS payment system. Please tell us what you think of the ideas presented here and how to improve them.

Part One: The context for this discussion paper

NHS England and Monitor have taken on joint responsibility from the Department of Health for the payment system for NHS care as a requirement of the Health and Social Care Act 2012. Our respective duties place an emphasis on putting the patient at the heart of our decision-making, ensuring services are delivered to a high quality, as sustainably as possible. Monitor and NHS England are working in partnership to design the payment system, with each partner contributing its particular expertise. Our partnership is under-pinned by joint governance[2].

We are taking on these new responsibilities for the payment system at a time when the sector faces major challenges, including growing demand for services, increasing expectations and a tight fiscal climate. We recognise that the design of the payment system must support the sector in meeting these challenges and must balance the risks they entail, so that NHS services meet patient needs without spending beyond NHS means.

The NHS payment system governs the flow of funds from commissioners to providers of NHS-funded care. Under the Department of Health PbR system, £29 billion of health care services have national prices. This represents almost one third of all NHS spending on patient care and more than 40% of spending on secondary care[3]. The scope of PbR is updated annually. The payment system set out by Monitor and NHS England in the National Tariff Document will encompass the majority of NHS spending on direct patient care. For services that do not have nationally mandated prices, the National Tariff may include rules governing payment arrangements.

We have been given the opportunity, over time, to create a single coherent system governing the payment of NHS services. We therefore aim to design an over-arching payment system that will need to include methodologies for setting prices at a national level as well as variations and rules for local price-setting and payment and to be appropriate for all aspects of health care. If we design the payment system correctly, it can strengthen local contracting by supporting commissioners and providers with better information, clearer rules, and the time and space they need to make local decisions that are in the best interests of their local populations.

[2] The partnership is underpinned by joint governance arrangements set out in the following paper agreed by NHS England and Monitor's boards in February 2013 www.monitor.gov.uk/about-monitor/what-we-do/publication-scheme-guide-the-information-we-publish/monitor-board-papers/bo-13

[3] Source: 2011-12 Department of Heath Annual Accounts; PbR Simple Guide

Part Two: Our starting point – the NHS payment system

The payment system for NHS-funded care has evolved steadily over the past decade. Recent years have seen many adaptations to the original Payment by Results (PbR) approach, aimed at improving quality and efficiency beyond elective care. However, stakeholders' responses to 'mainstream' PbR point to emerging difficulties and a need for development.

The evolution of Payment by Results

Over time, the scope of PbR has been extended to include non-elective care, accident and emergency, and outpatient services for all providers. In 2010/11, the NHS introduced tariffs based on 'best practice' care and in 2012/13 mandated national currencies for much of adult mental health services.

PbR has had positive results. It has supported a broader choice of providers for patients as, under PbR rules, "the money follows the patient". PbR has also encouraged hospitals to reduce growth in unit costs.

Recent developments in the NHS payment system have broken new ground in the design of payment for non-acute public health care services. Innovations include currencies for needs-based 'clusters' for mental health, 'years of care' payment approaches for life-long conditions such as paediatric diabetes and cystic fibrosis, and pathways-based payment for maternity services. Projects are already under way to develop outcomes-based payment for psychological therapies (Improving Access to Psychological Therapies) and capitation-based payment for high-risk, multi-morbid populations (Long-Term Conditions Year of Care).

The case for change

Through such incremental changes, PbR has developed into a payment system that seeks to achieve broader policy objectives than solely higher throughput. However, commissioners and providers have told us that, taken as a whole, the current NHS payment system does not always promote the best value service design for patients. Their views are echoed by a number of recent reports on the NHS payment system[4].

Outcomes. A prominent concern is that, in the main, PbR still pays for activities, not patient outcomes. These may match closely in some cases, but not all. Good patient outcomes may result from many different types of care, including one-off interventions, discrete episodes, or continuous case management. But there are few types of care in which paying for activities is sufficient to encourage the best patient outcomes.

Integrated care. Operating separate payment approaches within the health sector and across health and social care is often cited as a barrier to delivering integrated care. For a patient to experience coordinated, person-centred care, providers will need to work together, focusing jointly on delivering high quality patient care sustainably. The payment system

[4] See *Payment by Results*, the King's Fund, January 2013 www.kingsfund.org.uk/publications/payment-results-0, *Patient Level Costing: Can it yield efficiency results?* from the Nuffield Trust, September 2012 www.nuffieldtrust.org.uk/publications/patient-level-costing-can-it-yield-efficiency-savings, *An evaluation of the reimbursement system for NHS-funded care - A Report for Monitor*, PWC, February 2012, www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/monitors-new-role/evaluation-the-reimbursement-system-0 ,*Integration*, a report from the NHS Future Forum, January 2012, www.gov.uk/government/uploads/system/uploads/attachment_data/file/152172/dh_132023.pdf, *2012 Accountability Hearing with Monitor,* Report of the House of Commons Health Committee, Section 4 on Pricing, February 2013 www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/652/652.pdf

could be used to create new incentives that would help to embed the necessary coordination and care planning.

Information. PbR prices are not always based on good information on cost and quality. Users struggle to understand the resulting widespread volatility in prices from one year to another, which does not seem to be driven by changes in the underlying cost of providing the service. Accurate cost information is generally scarce, not all hospitals can assess costs at patient-level, and costing systems are even less developed in community and mental health services. More significantly, the lack of patient-level data on quality limits our national understanding of what represents good outcomes for patients.

Flexibility. Faced with patchy information and sometimes inappropriate incentives, some providers and commissioners are opting to negotiate local contract terms. Flexibility is permitted under PbR if it supports innovation, service redesign or the treatment of an unusual mix of patients. However, if commissioners and providers agree local prices without clear rules to follow, the quality and sustainability of care may be put at risk.

Time horizon. The annual cycle of new prices and new contracts for many NHS services inhibits longer-term planning, potentially constraining innovative investment and decisions on reconfiguring services. Users also complain that cost and coding lags put PbR prices a step behind clinical practice, which can also stifle innovation.

Part Three: Discussion points for shaping the payment system in the long term

The issues outlined above and our review of PbR are our starting point for shaping the NHS payment system. We suggest that in order to design a single, coherent payment system for NHS care for the long term we will need to develop and refine our ideas on the following four tasks:

- setting objectives for the payment system;
- designing the payment system;
- strengthening the foundations of the payment system; and
- exploring design options.

This section sets out our first thoughts under each task, for discussion with the sector over the coming months.

Setting objectives for the payment system

The first task is to identify the over-arching objectives of the payment system that the design of the system needs to deliver. Our current reasoning is as follows.

The sector needs support to change patterns of care in the interests of patients

The NHS needs to change. Increasing patient needs and growing expectations combined with restricted funds means that the NHS must deliver more and better health care with much the same level of funding in real terms for the foreseeable future. Services need to be redesigned to offer improved patient outcomes at lower cost. Health care services need to be better coordinated with each other and with social care, so that patients have better experiences and outcomes. Commissioners need to know which providers serve patients best, in terms of both outcome and value, so they can make choices that are both high quality and sustainable for the local – and national – health economy.

We believe that the design of the NHS payment system can support both commissioners and providers in making the changes that NHS care needs. NHS England is working with the sector to develop the vision for the NHS, and the payment system must be designed to help realise the vision.

The payment system influences behaviour

Our confidence in the payment system as a tool for effecting change rests on the power of payment approaches and price signals to influence behaviour. Prices, whether national or local, provide signals to providers and commissioners to inform their decision-making. Commissioners must decide what services they can afford to buy, and providers must decide what services they can sustainably provide. Prices informed by accurate, patient-level information on the cost and quality of services help commissioners to identify which services are best value for patients and best suited to the local health economy. Prices can also help providers to identify which activities to invest in. Taking all price signals together, the payment system should, ideally, result in an efficient allocation of scarce resources to the benefit of patients.

Additionally, specifying standard units of purchase can help spread proven good practice. Paying for patient outcomes, if possible, can challenge a provider to decide how best to achieve those outcomes, alone or with partners. Designing the payment system to account for links between health care, social care, public health, housing, education and employment could stimulate more innovative ways to improve outcomes for local people.

However, the payment system may influence behaviours adversely as well as positively. For example, providers or commissioners may react in unanticipated ways to signals from the payment system, perhaps because the signals are not clear or conflict with other incentives. We recognise that we must take particular care to design the system to encourage positive change.

But the payment system is only one among many levers for change

We also recognise that the payment system alone cannot bring about all the changes the NHS needs. Nor is it the only lever enabling change in the NHS. Our view is that designing a payment system informed by accurate information and clear objectives could significantly help to improve patient outcomes and experiences when combined and co-ordinated with other tools and incentives. These may include:

- operational levers, such as clinical guidelines, NICE quality standards, technology appraisals and the design of contracts, including reporting requirements and sanctions; and
- reputational levers, including transparent public reporting of quality levels and patient outcomes, and feedback from local clinical leaders.

For some types of care, patient choice and competition may also have a role to play in effecting change. Patients armed with information on the quality of care can spark a beneficial rivalry among providers seeking to attract patients. Equally, commissioners can use a competitive tender to specify the outcomes they want to purchase over a defined period and assess different approaches offered by potential providers.

Trade-offs will be inevitable

The basic function of a payment system for publicly-funded health care is to regulate the flow of funds from the government to health care providers. However, a well-designed payment system, supported by accurate information on the costs and quality of care, can do more. Different payment approaches within a system can, for example:

- drive productivity;
- signal which models for delivering care are the most effective;
- reward quality improvement;
- allow the money to follow the patient,
- allocate financial risk sustainably; and
- ensure that people always have local access to services.

However, international evidence suggests that the payment system cannot do all of these things at once. Different payment approaches may be more or less suited to different circumstances depending on local or national priorities. Selecting suitable approaches will involve making trade-offs between competing priorities, for example, allocating resources sustainably and ensuring people have local access to services, to find the best balance in each case for patients and the sustainability of the sector as a whole.

The payment system should support continuous quality improvement, sustainably delivered, with appropriate allocation and management of risk

The design of the payment system should aspire to go beyond regulating the flow of funds from the Government to health care providers and focus on promoting value for patients. By value we mean continual improvement in the quality of care, using scarce resources as

sustainably as possible. To achieve this overall aim, we suggest the payment system should:

- reimburse providers for delivering specified outcomes for patients rather than particular treatments or inputs;
- promote the long-term, sustainable well-being of the whole person;
- allow for different payment approaches where people's care needs differ, with room for local flexibility bounded by a clear structure of rules; and
- signal clearly to commissioners and providers the choices available to them that will promote sustainably better outcomes for patients.

We believe that pursuing these four objectives will help us to design a payment system that meets its overall aim by supporting the improvement, redesign or reconfiguration of services to meet local population needs. We recognise that developing new patterns of care will take some time. Therefore in the short term, we should also consider how best to build on the existing payment system by improving payment approaches both for services which already have a national price and for locally priced services.

In developing the payment system to promote value for patients we must be mindful of the allocation and management of risk. If a provider receives from commissioners less than it costs that provider to deliver good quality care, it becomes increasingly at risk financially. But without incentives to manage provider costs and limit commissioner spending, the affordability of NHS funding overall is compromised. In seeking to achieve a sustainable balance, the design of the payment system must reflect that different payment approaches allocate risk differently between providers and commissioners. For example, block grants put providers at risk of having to serve more patients than the grant can pay for, while activity-based funding puts commissioners at risk of paying for unanticipated increases in patient demand.

The payment system needs to allocate risk between providers and commissioners appropriately and sustainably. We must distinguish between risks to individual health economies and risks to the affordability of care in total. To allocate risk appropriately and sustainably, we need to understand the underlying drivers of patient demand and service cost and seek to apportion risk to those best placed to manage it.

Designing the payment system

Health care is complex and varied and our design of the payment system must account for this complexity. The steps set out below reflect our preliminary thinking on a suitable design process.

Understand the different types of patient need and patient care

Looking across the NHS as a whole, patient needs appear likely to differ systematically. If this is the case, then patients could benefit if the payment system included a variety of tailored payment approaches. Once we understand these different needs, we can describe the patterns of care best able to meet them sustainably and to a high level of quality. Our initial work suggests that patient needs and patterns of supply may differ along three main dimensions:

- proactive and ongoing versus reactive and episodic;
- simple and routine versus complex or rare; and
- planned in advance versus unscheduled or emergency.

Proactive versus reactive. Many patients need proactively managed, ongoing care at some stage in their lives. Patients may need this kind of proactive care on an intensive and

ongoing basis because they have a number of long-term conditions or co-morbidities. The best outcomes for these patients may be achieved through planned coordination across care settings, providers and time. This might require coordination of, for example, primary care, social care and housing to manage an individual's circumstances and needs proactively and avoid distressing emergency episodes. Elderly patients are particularly likely to need this pattern of ongoing care but so could a child or young person with a lifelong condition. In contrast, some patients require only single episodes of reactive care, for example, when they need a single scan, diagnostic test or outpatient consultation.

Routine versus complex and rare. For common or 'routine' conditions requiring episodes of care that can be planned in advance, for instance, joint replacements or hernia repairs, it seems appropriate for patients to be able to choose from among the potentially numerous qualified providers and for the money to follow the patient. But patients with rare diseases or complex care requirements will need treatments involving specialist equipment or scarce expertise. Only a few providers with the right expertise and equipment will be clinically safe and economically sustainable at a national or regional level to serve these patients effectively and efficiently.

Planned versus unscheduled. People may experience a variety of 'unscheduled' needs that require care to be on permanent stand-by. The provision of this care has to be planned to allow for uncertain patterns of demand. For example, life-threatening emergencies such as serious accidents or strokes need to be met by dedicated trauma centres and stroke units. These must be fully staffed and available to deliver quality care round the clock. Less urgently, people who want to manage their own 'unscheduled' minor ailments can use the growing array of on-tap advice available through a variety of channels, including online and by phone. In contrast, services that meet planned patient needs can be designed to meet known volumes. These services become more sustainable when the fixed assets they use, for example, operating theatres, are scheduled to be in use as much as possible.

If we plot the variety of patient needs along the dimensions outlined above, a number of more or less discrete contexts of care emerge. Patients may fall into more than one context but may nevertheless have a dominant need. This will indicate the most appropriate provision of care that they require. We believe that thinking about patients' care needs in this way is a useful starting point for considering how we might apply different payment approaches to different contexts of care.

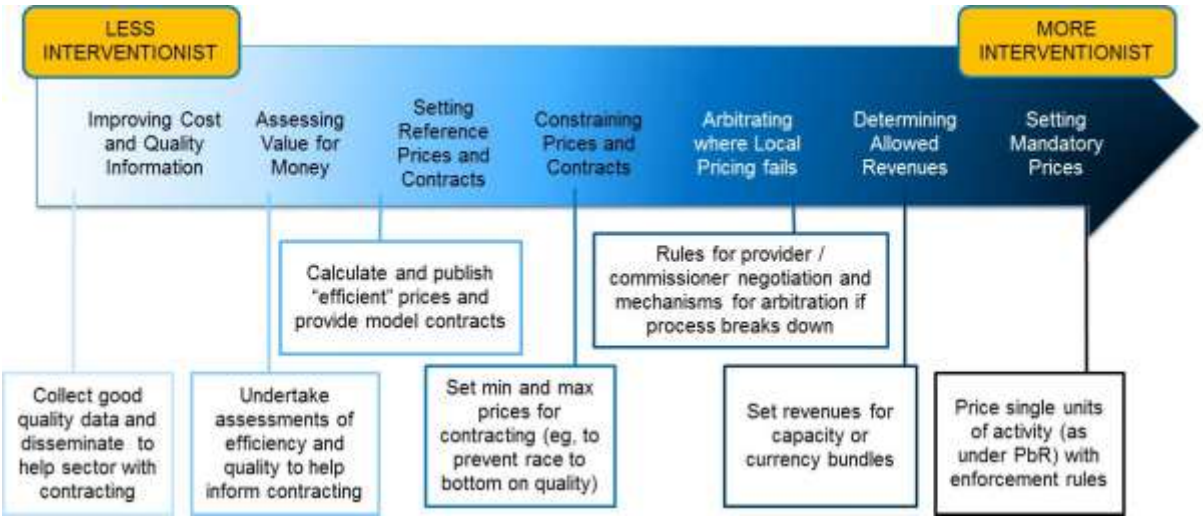
Understand the different payment approaches

The payment approach that is most effective in achieving higher quality care and better value for patients could vary according to the context of care. If the design of the payment system matches the most appropriate payment approaches to each different context of care, then it should promote the system's overarching aim of higher quality and better value provision across all contexts of care.

A payment approach includes the unit of purchase and how the price is set. The experience of other countries and other regulated sectors suggests that there may be different ways to specify units of purchase and regulate price-setting. The spectrum of price-setting regulation ranges from offering support for local payment decisions to mandating and enforcing national prices for tightly specified units of purchase (See Figure 1). At the less interventionist end of the spectrum of price-setting, regulators can improve the information available (about the costs of patient care and the relationship between cost and quality) to inform local decision-making. These local decisions could be about both the unit of purchase and the price. Choices made by both patients and commissioners can be guided by this information on quality. In the middle, a regulator can set rules to constrain and improve local negotiations. For example, the regulator might require an annual efficiency adjustment or set

out criteria for local price-setting. At the other end of the spectrum, in some circumstances it may be more appropriate for the regulator to require prices or revenues to be nationally determined. Such circumstances might include where there is no alternative local provision for a particular service and the provider is a local monopoly.

Figure 1. Illustrative spectrum of ways to regulate price-setting



In choosing the appropriate way to regulate price-setting, we might want to consider in particular:

- who has access to what information (information availability and asymmetry);
- the relationship between commissioners and providers, including the scope for commissioners or patients to choose between a range of providers;
- the interaction between different services that patients may need simultaneously or sequentially in order for their care to be delivered to a high quality and efficiently; and
- commissioners' priorities and capabilities.

We also need to choose the appropriate units of purchase for each context of care. In simple terms, the units commissioners can purchase may be inputs, outputs or outcomes, although they can make a number of detailed choices within each of these categories. For example, an input might be a certain level of capacity or staffing, an output might be a procedure or clinical contact, and an outcome might be a fully recovered or independent patient. Units of purchase may be standardised nationally or determined locally. Nationally standardised units of purchase make it easier for local commissioners and providers as well as Monitor and NHS England to compare costs or outcomes across different providers. However, specifying units of purchase at a national level can reveal a tension between standardisation and personalisation. Standardising a particular way of doing things or a certain staffing level may be appropriate where there is clinical consensus on the pattern of care that is best for patients. However, standardisation may be less appropriate in contexts of care where individual patients' needs are likely to differ extensively and the provider may need greater flexibility to choose between treatment options.

Make sure the payment system is flexible enough to accommodate different payment approaches

Activity-based payment approaches such as PbR work best in contexts where the activity has well-defined start and finish points, is planned in advance and is always beneficial to the patient. It is helpful where the two priorities are enabling choice for patients and increasing productivity. However, since priorities will differ across contexts of care, it seems unlikely

that a single payment approach will suit all contexts. Instead, the design of the payment system for the NHS may need to be sufficiently flexible to accommodate a range of approaches which can be applied to different care contexts.

A payment system with flexibility 'built in' will also be better able to keep pace with changes in patterns of care and encourage innovation. In creating our design, we can build on some of the preliminary investigations by the Department of Health into other possible payment approaches for the NHS. In addition, we plan to undertake new research. This may include exploring opportunities for using pathway payment approaches to incentivise the coordinated delivery of planned care in the most appropriate setting, be this closer to the patient's home or in a specialist centre. We would also like to identify opportunities to calculate efficient prices using benchmarking and cost analysis, and to understand contracting behaviours better, in order to help develop a framework for local negotiations.

Strengthening the foundations of the payment system

Whatever the long-term direction of the strategy for the NHS payment system, there are some widely-accepted foundations for a successful system that we aim to put in place, as well as some features that we believe will improve the design.

Improved cost and quality information leads to better decisions

Good patient-level cost and quality data are essential for aligning the payment approaches with priority clinical outcomes and running an economic, efficient and effective health care organisation. We aim to improve the flow of accurately coded and allocated cost data, for example through patient-level information and costing systems (PLICS), and associated quality data, for example patient reported outcome measures (PROMS), patient experience, measures, and clinical audit data. We intend to use this data to inform national prices and rules for price-setting and payment. We also intend to publish better data on cost and quality to support commissioners and providers in making local payment decisions. Better data, particularly about outcomes and patient experiences, will also help patients to choose between providers and treatments.

More simplicity may bring benefits

Frequently introducing new classifications, adding more detail or changing the formula for adjustments may not represent the best return on effort to improve the payment system. Each new level of detail increases the risks associated with micromanagement, such as encouraging unanticipated behaviours or stifling innovation. We believe that simplifying the system where possible could reap rewards, particularly when there are overlapping payment approaches in operation, as is currently the case. When different approaches interact, they can weaken the signals that the design of the overall system seeks to send. Those involved in the delivery of care may not behave as anticipated, and patients may be worse off as a result.

Predictability is important

For the payment system to be as effective as possible in supporting better outcomes for patients, its processes need to be predictable and timely. Commissioners and providers need time to respond to the signals that prices send, so prices and all relevant payment rules need to be made available early in their contracting cycles. More certainty about price levels over longer periods will support more confident investment decisions, as well as decisions to disinvest. Making payment system processes more predictable could entail setting prices or rules for multi-year periods, if appropriate.

Once we have confirmed our payment system design, and have made clear to the sector its decision rules and their rationale, we intend to keep to the design, making it easier for the sector to predict the likely direction of payment system decisions.

Legitimacy is essential

We believe legitimacy is achieved by basing policy on the best available evidence and being transparent. The National Tariff must be based on the best available data, include a clear methodology, and encompass appropriate rules and guidance. As far as possible, we intend to base policy decisions on evidence from commissioners, providers, clinicians and technical experts. A payment system with reduced lags in costing data will reflect frontline care better and may support rapid uptake of innovations that have proved their value to patients. Therefore we aim to reduce delays between cost collection and price setting.

The new regulatory regime introduces checks and balances into the process for developing payment system policy. These include the right to make formal objections to our methodology. If more than half of the sector object, this will trigger a referral to the Competition Commission. To make the policy development process more transparent, we will formalise, publish and consult on our methodology for developing national prices. We also intend to clarify the rules, for example on how and when price-setting can be locally negotiated.

Clear rules, enforced where appropriate, underline incentives

We believe that the payment system should encourage commissioners and providers to innovate in the design of services and in their business models in the best interests of patients. However, commissioners and providers need to be disciplined in observing the rules of the payment system to ensure that the system as a whole meets its objectives for the benefit of patients.

The Health and Social Care Act sets out clearly that commissioners and providers must comply with the national prices and rules set out in the National Tariff. Monitor will prioritise enforcement relating to breaches of National Tariff rules, as well as the licence conditions that concern pricing, in line with our published approach to enforcement[5]. We will be publishing more detailed enforcement guidance alongside the 2014/15 National Tariff Document.

Exploring design options

We want to test our preliminary ideas, set out above, to make sure our eventual payment system promotes value for patients. We are also looking for more evidence on the impact of different payment approaches. Some short-term improvements will be needed because the long-term strategy will take time to implement.

Gather evidence through more research and development, with monitoring and evaluation

We recognise that current payment rules are not working in patients' interests in all services. We want to allow more widespread local experimentation in payment approaches straight away to support patient-centred service redesign. We are aware that some localities have already started thinking about new payment approaches and this is something we want to encourage. However, we intend to guard against any increase in risk to patients from such experimentation by developing variation rules that take into account potential risks and the

[5] See Monitor's *Enforcement Guidance* at www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-7

capabilities of service providers. For example, we will aim to make clear in what circumstances local experimentation in price-setting is permitted and with what degree of freedom. In addition, we will gather evidence about local price-setting and its effects. We have already started research into local price negotiations for services that do not have a national price. Over time, building on this research we will seek to capture and share good practice and reduce transaction costs in contract negotiations for locally priced services.

Changing the payment system will take time, so prioritise some short-term improvements

With a better understanding of the application and effects of different payment approaches, like those set out above, and whether they could be adopted, we will be able to set out clearly a long-term strategy for the NHS payment system. Implementing this strategy will take some time. The first phase of implementation will comprise researching, developing and testing new payment approaches.

While we develop the long-term design of the payment system, we want to identify which short-term improvements to existing payment approaches are priorities. We will review the current payment system processes and rules, to identify what works well and what does not. Where we find changes are needed, we will ensure that the transition is well managed and not destabilising. We have already started to review jointly four existing policies:

- the 30% marginal rate rule for emergency admissions;
- reimbursement of the treatment of very complex and costly patients and complex services;
- the rules governing mental health reimbursement; and
- the flexibility rules that currently support appropriate local experimentation in pricing.

We will be asking for submissions of evidence to support these reviews.

Part Four: What happens next and how to give your feedback

This section describes how the payment system will operate for 2014/15. It includes the timetable for the next 12 months and the approach, policy rationale and consultation process for the 2014/15 National Tariff Document. Finally, it explains how stakeholders can get involved in developing the long-term strategy and providing feedback on more immediate changes.

A new National Tariff timetable

The Health and Social Care Act sets out clearly what must and can be included in the National Tariff concerning price-setting methodologies, national prices, rules and variations. It introduces a statutory consultation on the methodology for setting national prices and potential referral to the Competition Commission if more than half of the sector objects to the proposed methodology. In order to be consistent with the provisions set out in the legislation, the National Tariff documentation explaining the payment policy for 2014/15, the methodology used to calculate national prices, the prices themselves, and the rules and variations that must be applied, will look and read very differently from the existing PbR guidance. We also aim to make the documentation as user-friendly as possible, differentiating between audiences, separating the "must do's" from the "could and should do's" and signalling clearly what users can object to formally. Before publishing our first National Tariff document, we will be gathering sector views on the new form and content, so that we can improve it further this year and in future.

Introducing the statutory consultation also means that the timetable for the 2014/15 National Tariff Document has been brought forward. The previous process for developing PbR Guidance, with a sense-check in September and road-test in December, is being replaced for this year by a new engagement process starting in June 2013. The statutory consultation will likely take place in September 2013 (subject to the timing of secondary legislation). If the objection threshold is not exceeded, we hope to publish the 2014/15 National Tariff Document in December 2013 or early January 2014, at least two months earlier than in previous years.

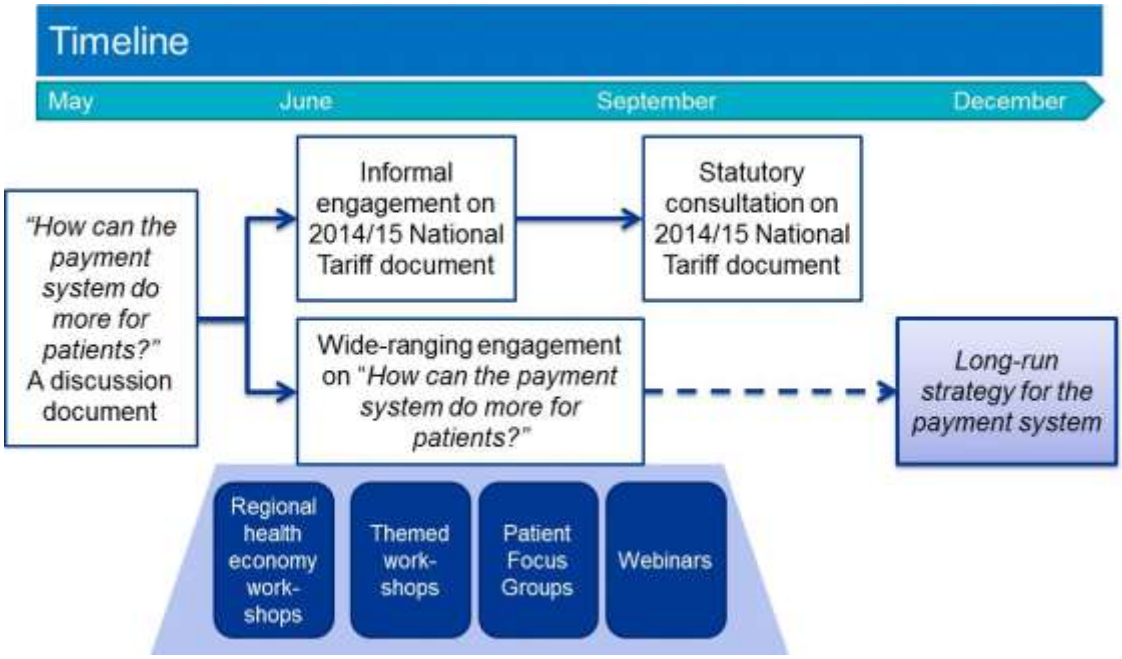
Our policy rationale for the 2014/15 National Tariff

The change in timetable, combined with feedback from the sector asking for more clarity and certainty about national prices and rules, means that we are proposing that the 2014/15 National Tariff Document is largely based on prices and rules set out in the 2013/14 PbR Guidance. We intend to reduce volatility in mandated prices and currencies, a particular problem raised by stakeholders, by not updating tariffs in line with latest reference costs and making very few changes to Healthcare Resource Group (HRG) design. The 2014/15 prices and currencies will be almost exactly the same as in the 2013/14 price and currency list, with only essential, system-wide adjustments for factors such as efficiency, inflation and CNST[6]. We will also update the rules governing mental health local price-setting, underscoring the importance of collecting quality and cost data.

As noted above, we will encourage local experiments in pricing where these are linked to new patterns of care within a framework of flexibilities. We are particularly interested in supporting payment approaches for integrated health and social care delivery models.

[6] The clinical negligence scheme for trusts

Figure 2. Opportunities to engage in the development of the payment system



Starting the discussion with you

Over the next 12 months we are planning a range of opportunities for stakeholders to engage in the development of the long-term strategy for the payment system and the production of the 2014/15 National Tariff Document (see Figure 2). As part of this, we will be engaging with patients and patient groups to help us better understand their different types of care needs. We are grateful for all stakeholders' views on the ideas for the payment system design set out in this document and for any other ideas about the objectives and design of the payment system in the long-term.

In particular, we are interested in your responses to the following questions:

1. We suggest that objectives for the payment system should be:
    - to reimburse outcomes for patients rather than treatments or inputs;
    - to promote the long term, sustainable well-being of the whole person;
    - to allow for different payment approaches for different care needs with room for local flexibility bounded by rules; and
    - to signal to providers and commissioners available choices that will sustainably promote better outcomes for patients.

    How do we make sure that the payment system delivers for patients? Are these the right objectives? What is missing?

2. We propose that patient needs and patterns of supply can be described in three main dimensions:
    - proactive versus reactive;
    - routine versus complex and rare; and
    - planned versus unscheduled.

What do you think of this way of categorising patterns of supply according to patient need? Could you add to this proposal or suggest alternatives?

3. We suggest that there is a spectrum of different ways to regulate payment.

   What are your views on the different degrees of intervention in the spectrum and when they might be appropriate?

4. For 2014/15 we aim to ensure that payments are predictable, but at the same time we want to allow for experimentation as well as immediate improvements where necessary.

   What do you think of this approach?

How to respond

Please send us your answers to the above questions, and any other comments you have, by **5pm on Friday 19 July 2013**. Details on how to respond can be found below. You can also let us know your views at one of the forthcoming sector engagement events.

We will use your feedback, received in writing or through our face to face dialogue, to inform our long-term strategy, which we will be working on through the year.

You can find a response form at www.monitor.gov.uk/pricing. This is our preferred way of receiving your comments. However you are also welcome to send your response by email (paymentsystem@monitor.gov.uk) or post (Payment system discussion paper, Monitor, 4 Matthew Parker Street, London, SW1H 9NP).

If you have any questions about this document please email paymentsystem@monitor.gov.uk or england.paymentsystem@nhs.net

Confidentiality

If you would like your name, or the name of your organisation, to be kept confidential and excluded from the published summary of responses or other published documents, you can request this on the response form. If you send your response by email or post, please don't forget to tell us if you wish your name, or the name of your organisation, to be withheld from any published documents.

If you would like any part of your response - instead of or as well as your identity - to be kept confidential, please let us know and make it obvious by marking in your response which parts we should keep confidential - an automatic computer-generated confidentiality statement will not count for this purpose. As we are public bodies subject, for example, to Freedom of Information legislation we cannot guarantee that we will not be obliged to release your response even if you say it is confidential.

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