Monitor

Making the health sector work for patients

Moving healthcare closer to home: Implementation considerations

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About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

Contents

Introduction 4
Background 4
How to use this paper 5

Five challenges and some solutions 7
Challenge 1: Ensuring the scheme targets the intended patients 7
Why is this an important challenge? 7
How have schemes tackled this challenge? 7
Challenge 2: Meeting the needs of higher severity patients 8
Why is this an important challenge? 8
How have schemes tackled this challenge? 9
Challenge 3: Recruiting and motivating the right staff 11
Why is this an important challenge? 11
How have schemes tackled this challenge? 11
Challenge 4: Building credibility and scale 13
Why is this an important challenge? 13
How have schemes tackled this challenge? 14
Challenge 5: Collecting data to evaluate effectiveness and setting payment incentives 16
Why is this an important challenge? 16
How have schemes tackled this challenge? 17

Introduction

This paper is part of a suite of materials developed to support providers and commissioners making decisions about schemes to move healthcare currently provided in acute hospitals to community-based settings.[1] As set out in our summary paper, many providers and commissioners facing both demand growth and capacity constraints may be considering these schemes, particularly as they could deliver clinical and patient experience benefits. However, such schemes need to be well designed to be able to deliver any of these benefits, and there are challenges providers and commissioners will need to overcome when designing and implementing them.

These schemes present complex implementation challenges not only for the people and organisations directly involved but for the local health economy. In this paper we describe the five most frequently mentioned challenges and how providers and commissioners have tackled some of them to help the sector plan and implement community-based healthcare schemes.

The five challenges are:

1. Ensuring the scheme targets the intended patients
2. Meeting the needs of higher severity patients
3. Recruiting and managing motivating the right staff
4. Building credibility and scale
5. Collecting data to evaluate effectiveness and setting payment incentives.

Background

During this project we spoke to over 30 trusts implementing schemes to deliver care closer to home. We focused on schemes that treat patients who have a range of complex health and social care needs; these schemes usually target those who are experiencing a crisis or exacerbation in a long-term condition and who are often frail and elderly.[2] The objectives of the schemes we reviewed include:

- providing better patient care
- providing healthcare in a more appropriate setting for the patient

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[1] All the other materials are available at www.gov.uk/guidance/moving-healthcare-closer-to-home

[2] Our analysis focused on avoiding non elective admissions or reducing length of stay for patients. The schemes include care for patients with mental health conditions as a co-morbidity, but we have predominantly reviewed schemes that focus on patients with acute physical health needs.

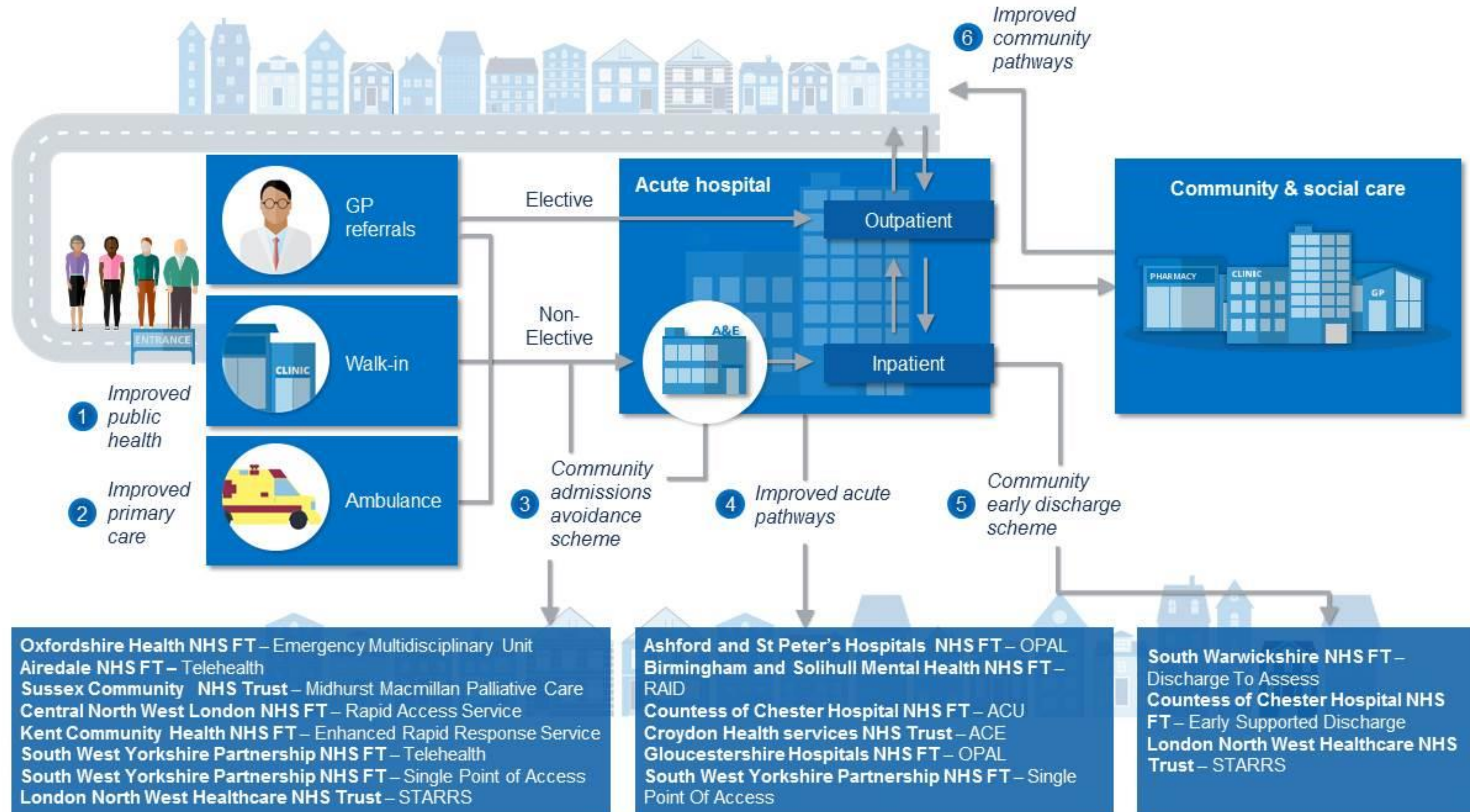
- getting patients to their most appropriate healthcare setting sooner, eg speeding up discharge from inpatient settings and reducing length of stay
- reducing inpatient hospital admissions
- alleviating demand at acute hospitals
- improving co-ordination of transitions of healthcare between different settings
- improving the cost-effectiveness of long-term provision of healthcare.

How to use this paper

This paper is supplemented by case studies we have developed of a number of the schemes we have spoken to.

Figure 1 (on the next page) summarises the case studies sited at the point they address the patient pathway; whether they aim to deliver admissions avoidance, improved acute pathways or improved discharge from acute settings.

Figure 1: The case studies sited on the patient pathway



Five challenges and some solutions

Challenge 1: Ensuring the scheme targets the intended patients

Why is this an important challenge?

To deliver financial benefits across the local health and care system, schemes that move healthcare to community-based settings need to treat patients who would otherwise be inpatients in an acute hospital.

It is possible that schemes could also treat patients who would not otherwise need acute hospital care. However, although schemes that do this may well benefit patients, addressing this unmet demand will mean the scheme takes less activity out of local acute hospitals or will cost more to deliver, as more patients are treated making it more difficult to realise cost savings.

There is a similar challenge for reablement schemes, which need to reach patients who would otherwise have long-term care needs but can successfully be assisted by reablement.

How have schemes tackled this challenge?

To tackle this challenge, schemes need to treat patients who would otherwise be in acute level care, and to keep this referral criterion in mind when accepting patients. If schemes accept referrals from GPs or other external referrers, they need to develop a strong relationship and communicate clearly the purpose of the service. For example, one trust we spoke to asked referrers to make decisions by asking: “Do you think this patient would eventually go to A&E?”

For admissions avoidance schemes, it is important to clarify whether the scheme aims to avoid admissions by **treating patients in a crisis**, or through **preventing patients experiencing a crisis**. We have mostly spoken to schemes that aim to do the former. In this case, **admissions avoidance** schemes could ensure they treat patients who would otherwise need acute hospital care by identifying patients from A&E departments as well as through GP and ambulance referrals. For example, the Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) from London North West Healthcare NHS Trust **‘picks’ suitable patients** from Northwick Park A&E and provides them with treatment and transport home. This approach could also mean the scheme is faster to set up than if it solely relied on establishing relationships with GPs and ambulance providers for referrals. Schemes that aim to avoid admissions through preventing patients from experiencing a crisis will need a different model of healthcare to identify patients far earlier.

The Midhurst Macmillan Palliative Care Service in Sussex and the Care Navigation Telehealth Service in South West Yorkshire are both schemes that aim to avoid admissions by preventing patients from experiencing a crisis. To ensure that they are effective, such schemes need to focus on the patients they can help most as often

intensive healthcare is provided to small cohorts. Focusing on palliative care is a good way to triage patients suitable for such schemes as there are clear triage criteria and strong evidence of patient benefits from avoiding hospital admissions.

Schemes that **reduce length of stay** target inpatients in acute hospitals, so they have a clearer pool of potential patients but must take care to select patients where there is scope to substantially and safely reduce the length of stay.

It is important to ensure that once patients are being treated through a community-based scheme they do not stay on it longer than they would have stayed in the acute setting. Successful schemes have **clear pathways with established endpoints and protocols** for onward care-planning and escalation to ensure patients do not stay longer than they need. This applies equally to admission avoidance and length-of-stay reduction schemes. Community-based settings can tend to keep patients on caseloads for observation, extending their stay longer than may be appropriate. Clear pathways and endpoints help schemes deliver healthcare that is appropriate to their patients and stands a chance of saving costs.

Defined pathways: South Warwickshire Discharge to Assess

South Warwickshire NHS Foundation Trust's Discharge to Assess (D2A) scheme enables the timely discharge of patients who no longer need to be on an acute inpatient ward from a medical viewpoint but still need some therapy or care support. The service runs on the explicit assumption that patients are only on the D2A pathways for up to six weeks. After four to six weeks they are discharged from the pathway and move on to, for example, care under their GP, self-funded care or local-authority-funded care. Care co-ordinators are essential to achieving this flow. They ensure continuous and appropriate healthcare for patients by following them through the D2A pathway and completing ongoing care assessments at its end.

Challenge 2: Meeting the needs of higher severity patients

Why is this an important challenge?

For a scheme to be effective in taking patients who otherwise would be inpatients in acute hospitals, it will need to meet the needs of those with severe acute and complex social care requirements. This can be more difficult in the community than in an acute hospital because practitioners may not have:

- as easy access to other staff to share ideas
- rapid and comprehensive diagnostics
- regular patient monitoring
- resources if patients' needs escalate rapidly.

Treating patients with severe health needs and complex social care needs safely and effectively in the community requires teams to adopt different ways of working and different attitudes to assessing risk.

Schemes that escalate large numbers of patients to the local acute hospital or use many acute services are too reliant on the acute hospital's resources. This will make it more difficult for them to save money as fewer acute resources will be freed up or taken out.

How have schemes tackled this challenge?

Schemes are organising themselves to respond quickly to patients who have immediate healthcare needs, building multidisciplinary teams (MDTs) that work with other services and deploying senior staff able to make rapid decisions.

Responding quickly

Successful schemes organise themselves to provide:

- **Comprehensive assessment** to establish the patient's immediate and ongoing healthcare needs. Most schemes aim to assess the patient face to face within two to four hours of referral. Schemes based at the hospital, such as Croydon Health Services' Acute Care of the Elderly Service and Ashford and St Peter's Hospitals' Older Persons Assessment and Liaison team, assess patients as soon as they arrive at the front door of the hospital. Early consultant and multidisciplinary review increase the likelihood that complex conditions are accurately recognised and appropriate treatment plans put in place.

- **Rapid diagnostic tests**, which are essential for making a comprehensive assessment quickly. Oxford Health NHS Foundation Trust's Emergency Multidisciplinary Unit (EMU) at Abingdon Community Hospital uses point-of-care diagnostics, which can return a reading for a range of blood tests in less than 10 minutes and enable rapid decision-making. STARRS has access to rapid diagnostics in Northwick Park Hospital (acute services), getting results on the same timescale as the A&E or acute wards.

- **Effective triage** to ensure that healthcare for higher risk patients unsuitable for the community-based scheme is immediately escalated. For example, 16% of patients referred to the EMU at Abingdon Community Hospital by GPs and ambulances are immediately taken to the local acute hospital's medical assessment unit, bypassing A&E, after initial contact and triage. The scheme's good relationship with the acute provider facilitates this escalation.

Rapid response: Kent Community Health NHS Foundation Trust Enhanced Rapid Response Service

Kent Community Health Enhanced Rapid Response Service (ERRS) takes referrals from primary care, the ambulance service, A&E and hospital discharge teams through a central unit. After referral the patient is seen at a time appropriate to the clinical severity of their condition established at triage. Most patients are seen within two hours of referral. An MDT member with advanced assessment and care-planning skills assesses the patient at home and admits them to a 'virtual ward' in their home. The team co-ordinates medical care, nursing and therapy to support the patient's recovery.

Multidisciplinary teams and working with other services

All the schemes we spoke to have an MDT of consultants, nurses and therapists – and often dieticians and pharmacists as well – to meet patient needs in a person-centred way. Services also must often co-ordinate healthcare across acute, community and social care organisations. In many cases, effective schemes embed staff from different organisations in their teams. For instance, several schemes, such as Croydon Health Services' Acute Care of the Elderly Service and Countess of Chester Hospital's Early Supported Discharge Service, directly employ social workers or care staff as part of the MDT. Having direct and protected access to care staff as part of the MDT helps schemes to provide holistic patient care. It also facilitates rapid co-ordination with other support services so that patients can be managed effectively in the home or community in the longer term. Some services also give staff training so that they can share skills between different professionals; for example, occupational therapists trained to provide some nursing input and vice versa.

Access to advice, such as through networks of informal relationships with clinicians in acute providers. This reduces risks related to staff making independent decisions when treating patients in the community. For example, the lead consultant of STARRS reported that the scheme's staff can phone colleagues who are specialists at Northwick Park Hospital for advice on specific patients. It may mean that a scheme can take on higher levels of clinical risk, although it will require clear governance relationships. These networks could be formalised through contractual arrangements. International examples[3] show providers using technology to facilitate these wider networks. For instance, in the US, community-based sites can provide intensive care services to stroke victims through 'eICU' hubs.

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[3] See *Exploring international acute care models* (Monitor 2014), for other case studies. Available at: www.gov.uk/government/publications/exploring-international-acute-care-models

Seniority of staff

Schemes generally deploy senior clinical staff for patients with severe needs. For example, on many schemes patients are seen by nurses at band 5, 6 or 7. Senior staff are able to take on levels of clinical risk associated with delivering acute-level care in the community and to make rapid, high quality decisions, often working alone. They are therefore key to the schemes' success. However, more senior staff tend to be more difficult to recruit (see Challenge 3).

Challenge 3: Recruiting and motivating the right staff

Why is this an important challenge?

The right staff working in the right way are essential for treating acutely unwell patients with complex conditions in the community. Treating patients closer to home requires **changes to traditional working patterns**, particularly for practitioners used to working in acute hospitals. This includes entering patients' homes, working independently without support and, in the case of telehealth, relying on new technology.

Recruitment issues complicate this. In addition to the NHS's currently widespread recruitment challenges, these schemes must **recruit staff willing to work differently**, usually merging a hospital-based skillset with a community-based approach. These ways of working are not yet embedded in the standard training available nationally. Challenges tend to be compounded by the instability of many schemes that are funded non-recurrently, including schemes that are trialling a new approach in the short term.

Because of recruitment challenges, many schemes are staffed by locums and agency staff, particularly at the outset. Some providers said that expense and lack of substantive leadership may limit their schemes' effectiveness as a result.

Without the right staff motivated to work in these circumstances, a scheme can risk being unsafe. If staff are unwilling to make difficult decisions independently, escalation rates may rise. If there are higher rates of escalation there may be a duplication of resources, and the scheme will not consistently reduce activity in the acute hospital. This will make saving money for the local health economy more difficult. Patients would also be moved around more, adding risks and compromising the quality of their healthcare.

How have schemes tackled this challenge?

Although many schemes still face significant challenges recruiting and motivating staff to work effectively, especially given current national shortages, we have seen some examples of overcoming these challenges. It tends to be done by creating an attractive job offer and focusing on the skills required rather than grade of staffing.

Providing an attractive job proposition

Schemes have done this by:

- Being **pioneering and new**. Many clinicians will be excited and attracted by involvement in delivering healthcare in a different way and having the opportunity to influence the development of something new. Staff with this attitude are also likely to be the most effective when working on the scheme. Schemes should ensure they highlight the new approach and benefit for patients when trying to fill posts.
- Having a **highly driven service lead**. This will be vital to market the scheme as pioneering and to attract other staff. We also found that the personalities of service leads have been important in overcoming barriers to developing schemes. We encourage organisations to consider giving service leads space to trial, evaluate and embed successful change. Trusts should pay particular attention to embedding good practice, so that the scheme will continue to be successful if the service leads move on. It is also important for providers to recognise that staff are often asked to develop and run a service alongside their normal work.
- Using technology to offer a **different working environment**. For example, we found that Airedale's telehealth scheme does not find it difficult to recruit staff as some people are attracted by the desk-based setting.
- **Promising staff a job** at the trust if the scheme does not secure recurrent funding, although this is easier for hospitals with a general staff shortage than for fully staffed hospitals. One trust promises that if the scheme ends recruits will continue to have a contract with the trust and will be redeployed to another part of the organisation.

Focus on skills rather than grade

Schemes have done this by:

- Empowering staff to do **competency-based nursing** (see STARRS example below) and cross-disciplinary assessments. When the nearest competent professional can carry out a wide range of tasks, and staff are willing and able to perform tasks usually assigned to a different type of practitioner, efficiency increases and patients benefit; for example, some occupational therapists are trained to provide some nursing input and vice versa.
- Hiring grades where there are fewer national shortages and **providing the right training**. Reablement schemes often face fewer recruitment challenges as they require a lower grade of staff, but these staff are often trained to work differently. For example, Central and North West London NHS Foundation

Trust (CNWL) trains its reablement staff in negotiation skills so they can better support the patient to return to independent living.

If these solutions are untenable or ineffective, and there are still recruitment challenges, our case studies suggest it is a good idea to move permanent staff to the new scheme and backfill other posts with locums. For example, when setting up the Older People's Assessment and Liaison (OPAL) service, Gloucestershire Hospitals NHS Foundation Trust moved existing geriatricians from the wards into the OPAL service and backfilled the wards with locums. OPAL benefited from committed senior practitioners who led, developed and embedded the scheme.

Skilled multidisciplinary teams with competency-based nursing: London North West Healthcare NHS Trust STARRS

Team members in the Short-Term Assessment Rehabilitation and Reablement Service (STARRS) based at Northwick Park Hospital are mainly recruited from the acute hospital and most have an acute background. STARRS includes a MDT of nurses and therapists, and is supported by a single point of access team which manages administration. The service relies on flexible, proactive and pragmatic staff and competency-based nursing. Nursing and therapy staff conduct cross-disciplinary assessments, and procedures can be carried out by the nearest competent professional. STARRS nurses must therefore be confident and able to make autonomous decisions about patients' care. In addition, rotating staff between different teams ensures community teams maintain their hospital-based skills and relationships.

Challenge 4: Building credibility and scale

Why is this an important challenge?

Building credibility is important for attracting referrals. GPs and ambulance providers need to trust the scheme enough not to send the patient straight to A&E. For schemes taking patients from hospital, hospital-based clinicians need to trust the scheme so that they do not hold on to patients. High escalation rates back to A&E or experiences of poor care will discourage hospital-based clinicians from referring into the scheme.

Without this credibility, schemes may:

- find it harder to operate effectively; there are economies of scale in operating some schemes – subscale schemes may be more expensive to run per patient than larger schemes
- fail to make an impact across the local health economy; larger schemes may also be better able to realise actual cost savings for an acute hospital

because they are more likely to consistently move sufficient bed days out of hospital to allow bed bays or a ward to close.

These factors are described in more detail in the financial impacts paper.

How have schemes tackled this challenge?

To build referrals, it is important for schemes to have:

- clinical models that enable treatment of patients with more severe health needs (see Challenge 2)
- evidence (for example, independent evaluations) that the clinical model is robust and effective in treating these patients (see Annex 1 of the financial impacts paper on developing business cases for the data required to develop robust evaluations and Challenge 5 for support on collecting high quality data)
- incentives that support scaling (see Challenge 5).

Schemes that have the right, evidenced clinical model and incentives for expansion can then build trust with referrers to increase the volume of referrals and achieve efficient scale through:

- **Promoting referrals.** Schemes that aim to avoid admissions need to reach out to GPs, ambulances and nursing homes to build awareness. Building this awareness and credibility may take some years. Schemes to reduce length of stay can employ staff to identify patients in acute hospitals and do not rely on referrals. For this reason, they can build scale faster.
- **Being open and accessible.** It is important that these schemes have opening hours aligned with need. Most schemes we looked at operate a seven-day service, many with 24-hour cover. We heard from providers that ambulance services for instance can lose confidence in referring patients to a scheme if it is frequently closed during their working hours. The Rapid Assessment Interface and Discharge service run by Birmingham and Solihull Mental Health Trust is based in hospital A&Es and offers 24-hour nursing to ensure that nurses are always available to respond without delays.
- **Having clear, broad admission criteria.** Most schemes had broad admission criteria: the admissions criteria at the EMU at Abingdon Community Hospital are framed as taking ‘all patients apart from…’ rather than ‘taking patients with…’. Being available to the widest pool of patients and flexible enough to accommodate referrers’ needs make it easier for referrers to use the service. Some providers told us that if schemes have very specific or complex criteria for referral, ambulances and GPs will refer patients to A&E. As discussed in Challenge 1, schemes need to balance this with the need to treat patients who would otherwise be in acute-level care.

- **Sharing or rotating staff** across settings where referrals come from. It is easier for schemes to build credibility for referrals from acute settings if clinicians have first-hand knowledge of the scheme. This has the added benefit of providing staff members with a richer skillset that may improve their ability to meet patient needs.

Even with credibility and trust, schemes may remain small-scale because of the nature of their services or their local health economy. But there are ways in which schemes can make sure they deliver a cost-effective service and have an impact on the sector's costs:

- **Exploiting economies of scope**. Schemes may need occasional consultant input or only sometimes need expensive diagnostic equipment, such as x-rays. It will not make financial sense to recruit a whole-time or part-time consultant or buy an x-ray machine, but trusts can arrange to use a portion of these resources through developing good relationships with other providers. For example, the EMU at Abingdon Community Hospital benefits from 50% of whole time equivalent (WTE) consultant time and two foundation house officer WTEs because of service level agreements with Oxford University Hospitals NHS Trust. Other schemes rely on access to A&E speed diagnostic facilities at acute hospitals. A scheme does not need to be run by an acute or integrated care provider to make use of joint working; good service level agreements are just as effective.
- **Expanding to other clinical commissioning group (CCG) areas.** Schemes may wish to provide services across CCG boundaries but these boundaries can act as barriers to schemes reaching efficient scale. Service leads have noted that to reach scale and deliver healthcare closer to home efficiently, services need the same or similar generic operating structure. Commissioners should bear this in mind and be flexible when developing service specifications with providers.

If an individual scheme cannot make an impact, **running multiple schemes** may be a good way to reach sufficient scale to be able to reduce costs in the acute hospital although, it is important that schemes do not target patient cohorts that overlap too much. For example, many providers run admissions avoidance and length of stay reduction schemes together to take out larger populations of patients and to benefit from the similar skillset required to deliver both schemes.

Expanding to wider geographies: Airedale NHS Foundation Trust

Teams of senior nurses provide 24-hour care to patients in care homes via video-link in Airedale's telehealth service. Because the service needs to run 24-hours, seven days a week to be credible, it is important that it is run at sufficient scale. However, as services are provided by video-link, the service can expand beyond the immediate Airedale area. The service now provides out-of-region care to patients in care homes in Cumbria, Bolton, Dartford and Gravesham. In addition, the same team has expanded the service offering to other patients using the same technology, including patients in prisons and in individual homes for end-of-life patients. This enables the scheme to benefit from economies of scale and operate more efficiently.

Challenge 5: Collecting data to evaluate effectiveness and setting payment incentives

Why is this an important challenge?

Most schemes we reviewed were funded by block contract by local CCGs, often on a non-recurrent basis. Payment incentives are essential to ensure schemes rapidly reach efficient scale and operate as efficiently and effectively as they can for maximum impact across the local health economy. With the alternative of A&E available as a 'treatment centre of last resort' for patients or frontline clinicians, designing organisation-level incentives to minimise its use can be difficult. As most schemes were set up as small pilots, incentives to foster their future growth, efficiency and effectiveness individually and at local health economy level were rarely a primary consideration at the outset.

When designing incentives, take into account that:

- schemes are often funded on a non-recurrent basis but this will not promote long-term planning
- schemes are often funded through a block contract, which may not encourage efficient levels of activity
- a trust might lose more revenue to a scheme than it can recover in reduced costs if there is a high proportion of fixed costs, even if the scheme is cost-effective for the local health economy as a whole
- financial benefits from these schemes may accrue to local social care organisations while costs fall on healthcare budgets.

These issues contribute to and are compounded by a lack of high quality service data. Good data collection is important in:

- **evaluating effectiveness** to ensure the right schemes are developed; without good quality data on the type of patients treated and the effect of the healthcare provided, it is difficult to evaluate and identify whether schemes have achieved their objectives

- **setting incentives** to ensure schemes operate effectively and efficiently, and gains and losses are shared across the local health economy; to set effective payment incentives, it is important to understand and measure the impact of schemes across different parts of the health economy, including social care.

How have schemes tackled this challenge?

Two actions taken while developing a scheme will help ensure it has the right incentives to maximise its impact: collecting high quality data and considering payment incentives from the outset.

Collect high quality data

Improvements in data collection and linking data at a person level will help track patients across settings and strengthen the evidence on outcomes. This includes collecting data on who is treated, inpatient bed days avoided (for example, by analysing risk-adjusted changes in non-elective bed days for a specific population) and the intervention's longer term impact (clinical and financial).

When thinking about what data to collect and how, you may find the following resources helpful:

- The annex on business cases in the financial impacts paper for developing schemes to move healthcare closer to home; this provides more detail on the data needed to demonstrate whether schemes work effectively.

- The Royal College of Emergency Medicine's work on improvements to the emergency care dataset.[4] This provides guidance and minimum standards on how to classify patients receiving emergency care and potentially also urgent care, which in turn can help understanding of the cost variations of different patient groups across providers.

- Monitor has been working on providing guidance on creating local person-level linked datasets to meet the information needs to enable integrated care; contact pricing@monitor.gov.uk for more information on this work. Linked datasets are essential for identifying which cohorts of patients will gain most

[4]Available at: www.england.nhs.uk/ourwork/tsd/ec-data-set/

benefit themselves from moving their healthcare to community-based settings and represent the greatest efficiency opportunities. They also enable tracking of impacts on patients over time and across settings so as to evaluate these schemes more comprehensively.

- Monitor's proposals for collecting patient-level costs[5] provide a timetable for collecting patient-level activity and cost data on community-based services.

Consider pricing incentives from the outset

Providers and commissioners should aim to set pricing incentives that ensure:

- financial gains and losses are adequately shared among commissioners and providers of health and social care
- providers of schemes are rewarded for operating efficiently and undertaking the volume of activity that delivers the best outcomes for the whole system.

However, by paying for emergency activity on an activity basis and community care on a block basis the payment incentives created run counter to where the patient should ideally be treated – neither service provider has any financial incentive to behave other than they do already. Incentives are no better aligned for integrated providers as payment approaches are split in the same way in their acute and community settings.

We found some examples of providers tackling this payment-related barrier to shifting healthcare closer to home. For instance, one trust we spoke to receives payment from the acute provider it works with for every patient discharged early from the acute hospital.

Monitor is currently developing tools to support price setting between providers and commissioners, and between providers and other providers trying to deliver healthcare in new ways. This includes:

- **Guidance on sharing gains and losses** across multiple providers and commissioners to support new models of care.[6] This sets out how to design a gain and loss sharing payment arrangement for local health economies when implementing schemes with uncertain outcomes. Alongside this guidance we will make available tools including an Excel-based modelling tool and workshop materials to support local areas to develop and agree gain and loss sharing payment arrangements.

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[5] Available at: www.gov.uk/costing-transformation-programme
[6] Available at: www.gov.uk/government/publications/multilateral-gainloss-sharing-an-introduction

- **Guidance on capitation-based payment** to enable integrated care[7] and supporting international case studies[8] with examples of how to design a capitated budget for a defined population. This type of payment can reward organisations which implement innovative care models that prevent ill health and promote independence. It would encourage providers not only to adopt admissions avoidance and supported discharge schemes, but to seek out best practice.

As part of our work following the Five Year Forward View, we are helping the vanguard sites for the new care models programme and integrated care pioneers design payment approaches and gather necessary data for their new care models. Much of this will be relevant to providers of existing schemes that move healthcare to community-based settings. We will add links to this work from this suite of resources as it is published.

This paper is part of a suite designed to increase awareness of the impact of moving care out of hospital. For more materials see Moving healthcare closer to home

[7] Available at: www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements

[8] Available at: www.gov.uk/government/publications/capitation-international-examples

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