

**Local payment  
examples**

**Urgent and  
emergency care:  
a potential new  
payment model**



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## 1. Introduction

### Audience

This document is intended for all organisations involved in the commissioning or delivery of urgent and emergency care (UEC) services, including NHS 111, community pharmacy, community care urgent response and social care urgent response services, in-hours urgent primary care, GP out-of-hours, 999, ambulance, walk-in centres, urgent care centres and emergency department attendances and emergency admissions.

It will be of particular interest to finance, contracting and commissioning staff seeking detailed guidance on how to approach the local development and implementation of a potential new payment approach to support UEC service reform.

Separately we are publishing a brief companion document *Making payment work better to support new models of urgent and emergency care*. This provides a short introduction to a potential new payment approach and is intended for chief executives, clinicians and others who do not need to access this detailed guidance.

### 1.1. Background

NHS England's review of UEC provision in England ('the UEC review')<sup>1</sup> and the *Five Year Forward View (5YFV)*<sup>2</sup> have highlighted the pressing need for service transformation if patients are to continue to receive high quality UEC in the future. The UEC review sets out a clear vision:

- for those people with **urgent care needs**, we should provide a highly responsive service that delivers **care as close to home as possible**, minimising disruption and inconvenience for patients and their families
- for those people with more **serious or life-threatening emergency care needs**, we should ensure they are treated in **centres with the very best expertise and facilities** to maximise the chances of survival and a good recovery.

Following the work that has come out of the UEC review, Simon Stevens, NHS England Chief Executive, announced that UEC will be "completely redesigned" within three years.<sup>3</sup>

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<sup>1</sup> <http://www.nhs.uk/NHSEngland/keogh-review/Pages/urgent-and-emergency-care-review.aspx>

<sup>2</sup> Available from: <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<sup>3</sup> <http://www.hsj.co.uk/news/acute-care/emergency/emergency-care-to-be-completely-redesigned-within-three-years-says-stevens/5085503.article>

A vanguard approach for unplanned care has been launched at a number of pilot sites across the country. It is intended that these sites will demonstrate what a redesigned UEC system should look like, with this model then rolled out across the country over the next two to three years. Vanguard sites will also trial and test new payment models and funding flows to support the new network care model. This document sets out a potential payment system that local areas could adopt to support revised UEC arrangements.

NHS England, in collaboration with system partners and patients, has published guidance documents to support commissioners and providers in the transition towards a networked approach to delivering care.<sup>4</sup> This document should be read in conjunction with that wider suite of guidance.

## **1.2. Purpose of this document**

NHS England and Monitor recognise that current forms of payment may create a barrier to co-ordination and collaboration, and that a new approach to payment may play a valuable role in enabling a networked model of care. For this reason, we published a discussion document in August 2014 setting out how a new approach to payment could better support the service reform and drive improved quality, co-ordinated care for patients within the budget available.<sup>5</sup>

This document sets out our progress since this initial discussion document. We outline potential payment options and provide detailed guidance on how a new payment approach might be implemented in practice.

The options described are at the development stage, and will be further developed and tested with the UEC vanguards during 2015/16, with some potentially implementing new approaches from April 2016. Updated versions of this document will be published as what we learn from this work, including how the proposed UEC payment approach will work alongside other payment models such as capitation, informs refinement of the payment design. An impact assessment will be carried out as part of this process.

This document does not cover in detail the parallel work on other potential cross-cutting improvements to the national payment system, such as the quality of cost data and the accuracy of nationally mandated prices. These are some of the key enabling factors and underlying data requirements for the potential new payment model and are briefly described in the Section 4.

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<sup>4</sup> <http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx>

<sup>5</sup> *Reimbursement of urgent and emergency care – discussion document on options for reform, August 2014*. Available from: [www.gov.uk/government/consultations/reimbursement-of-urgent-and-emergency-care-options-for-reform](http://www.gov.uk/government/consultations/reimbursement-of-urgent-and-emergency-care-options-for-reform)

### Note on the use of this document

Local providers and commissioners looking to implement the payment approaches set out in this document while they are in their current development stage must follow the rules and principles for locally determined prices given in Section 7.1 of the National Tariff Payment System.

This includes a requirement to send to Monitor and publish any locally agreed payment arrangements that lead to changes to the national prices set by Monitor.

Commissioners should also ensure that they follow the framework set out in the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013. Guidance from Monitor on these regulations is available [here](#).

## 2. What payment reform can do for UEC

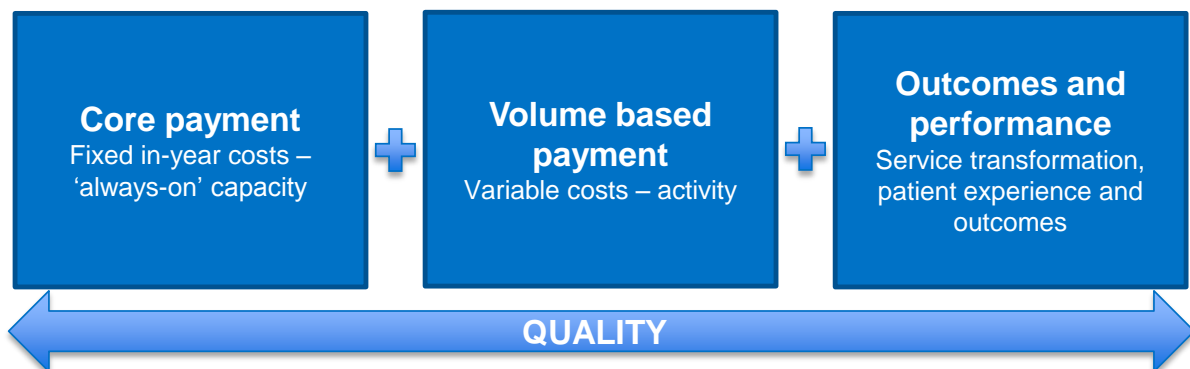
In this section, we describe a potential new payment approach together with a high level rationale for it, and then give greater detail on how we envisage each specific payment element can support improved delivery of UEC services.

This proposed new approach to payment is co-ordinated and consistent across all parts of the UEC network and incorporates the following three payment elements:

- **a substantial proportion of fixed core payment**, to reflect the ‘always-on’ nature of UEC services and concentrate providers’ and commissioners’ attention on planning capacity across the system to meet agreed access and quality standards
- **a proportion of volume-based payment**, to make it possible for individual providers to meet actual demand when this differs from expected demand, and to enable financial risk to be spread more efficiently across the network
- **payment linked to outcomes and performance**, to encourage co-ordination, deliver improved patient flow across the network and promote quality improvements (over and above minimum standards).

All payment would be on the basis of minimum access and safety standards being met, as illustrated in Figure 1.

**Figure 1: New three-part payment structure**



The sector broadly supported this three-part payment approach when we consulted on it in 2014 (for detail on sector feedback, see Appendix 1). Respondents recognised that payment is an important enabler of service reform and that the status quo may act as a barrier to progress.

A payment approach with the above elements would reflect the nature of UEC services and provide clear signals that enable a networked approach to meeting UEC needs. While payment is not the main lever for realising service change, it nevertheless has an important role to play. Each of the three elements of the

proposed approach can be used to support co-ordination and collaboration across the network to achieve the envisaged changes in patient flows:<sup>6</sup>

- The **core payment** can be used to reflect how capacity at each provider is expected to change as the new care model and changes in patient flows take effect over a three- to five-year period. When planned on a multi-year basis, this can enable investment in necessary services by reducing uncertainty as well as reassuring small or rural providers that the efficient fixed costs of providing agreed capacity will be covered regardless of the actual activity that takes place. This may be particularly important in the context of the current financial challenges the health sector as a whole is facing.
- The **volume-based payment** ensures that part of the payment continues to reflect the casemix and volume of patient needs actually met. Using a volume-based payment in combination with a fixed payment recognises patient activity and casemix as key cost drivers additional to the availability aspect of UEC services. For providers outside the acute sector that are currently on fully fixed contracts, it can provide a direct financial incentive to collaborate with the network to shift care out of hospital where appropriate. It can also provide a means through which individual providers are able to share the impacts they generate for the network as a whole, either through marginal prices or gain/loss sharing arrangements.
- As well as safeguarding quality, the **outcomes and performance payment** can be used to directly reward better co-ordination among providers within the network. It is envisaged that system-level metrics will play a particularly important role in driving behaviours, especially where they are transparent and shared across all providers in the network. It is expected that system-level metrics will need to be used in conjunction with organisation-level metrics.

The potential benefits of the proposed payment structure apply to UEC services across different care settings, including NHS 111, community pharmacy, GP out-of-hours (OOH), 999, ambulance, urgent care centre (UCC) attendances, emergency department (ED) attendances and emergency admissions. Currently, each patient handover carries disparate financial as well as assessment delay consequences. A key reason for payment reform is therefore to better align payment across UEC services and to reduce conflicting incentives. **The proposed payment approach would best support the transition to and operation of the new networked care model if it were applied to all UEC services and providers in the network.**

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<sup>6</sup> We expect these levers for supporting better planning and co-ordination across the network to supersede the marginal rate rule on emergency admissions used in the current payment arrangements.

The remainder of this document seeks to provide a clear direction for what we consider may be a pragmatic way forward for implementing a three-part UEC payment.

It should be noted that the potential benefits of this payment approach are not limited to UEC: they may also enable improved service delivery for other 'networked' models of care, especially where services have significant fixed costs.

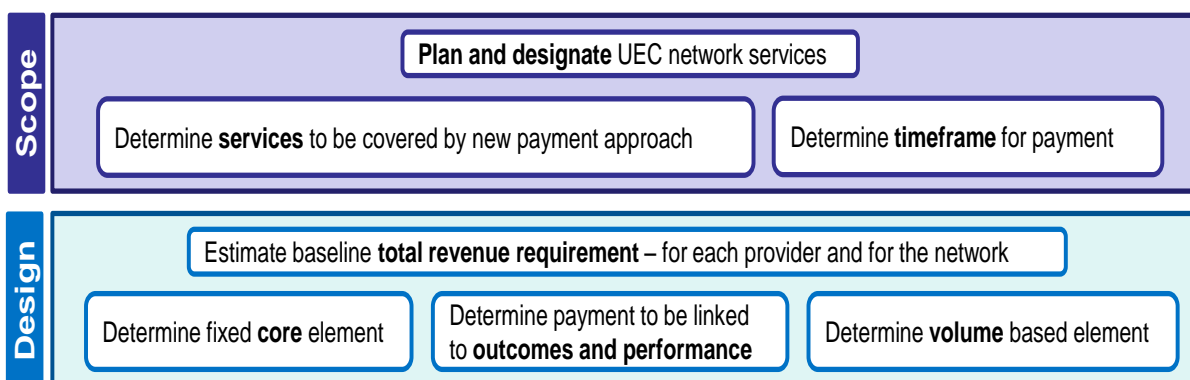


### 3. The payment design

This document focuses on pragmatic options that local areas could begin to test and transition to in the short term using data and other building blocks of payment that are available now. In addition, we discuss the potentially preferred longer-term options that may be feasible in some local areas now, but which will require further development of data flows and other enabling factors before they can be adopted nationally. This is supported by further work that we have carried out in response to feedback received to the August 2014 document and following discussions with a number of volunteer local sites.

In formulating a coherent and comprehensive payment approach that incorporates the desirable features set out earlier, Figure 2 shows the key steps to follow.

**Figure 2: Key steps to formulating a payment approach**



There are a number of possible options available at each step. At this stage of development we have not identified a single preferred option for each one.

In the remainder of this section, we set out high level options for each step in formulating the payment approach, essentially providing a 'tool box of options' from which local areas can construct a three-element payment approach that best meets their local needs and vision for service change. For each step we describe the envisaged basis for deciding between options and guidance on pragmatic approaches.

In deciding between alternative options, local areas should consider that any new payment approach ideally should:

- support continuous improvement and changes to models of care (eg implementing the UEC review recommendations)
- incentivise co-ordination across the UEC network (right care, first time, in most cost-effective setting)

- help ensure organisation- and system-level accountability for activity and costs
- be robust to unexpected casemix and volume of demand
- be practical to implement and operate (eg does not require governance or data infrastructure additional to the requirements of the care model).

This list reflects items specific to the networked model of UEC and feedback we have received from the sector, and should be considered in addition to Monitor's and NHS England's broader objectives for the payment system in general.

### **3.1. Plan and designate the UEC networked services**

A prerequisite for implementing the new payment approach is that the networked model for improved delivery of UEC has been planned and designated.

The expectation is that this work will follow national guidance and the formation of strategic UEC networks throughout England. Section 4.1 on key enabling factors provides more information on this.

### **3.2. Determine the services to be covered by the new payment approach**

The proposed three-part payment approach would best support the new networked care model if it were applied to all services and providers in the network. We recognise however that the available data flows and wider considerations limit how practical it is to apply this approach in the near term.

Particularly in the short term, local commissioners will need to decide the scope of coverage for any new payment approach with respect to the:

- services and types of care to be covered (eg should liaison psychiatry or ambulatory care facilities be covered?)
- local providers and commissioners that will be using the approach.

The choice of scope should take into account the criteria set out earlier in this section and consider whether:

- the scope adequately covers patient access points, such as NHS 111, 999 and ambulance services, that have a major role in directing patient flow in the network
- the scope adequately covers all providers of definitive care, eg community services such as community pharmacy, so that patient urgent care needs are met
- the building blocks, particularly data flows (see Section 4.2), are in place to enable implementation of the approach.

An option for the short term is that the payment approach covers the subset of the network where activity data and expenditure data that can be related to activity are readily available. Depending on local data availability, this could include NHS 111, GP OOH, 999, ambulance, UCC attendances, ED attendances and emergency admissions. This coverage would include the majority of the current expenditure in the network, the key patient access points as well as settings of definitive care. Liaison psychiatry and other mental health services may also be included within the scope of payment, depending on data availability and other building block considerations.<sup>7</sup>

### **3.3. Determine the timeframe for payment**

Given the service reforms envisaged in the UEC review, and the three- to five-year timeframe for implementation of the reforms, it is important to consider payment for the services over a number of years. Commissioners and providers will have an expectation of how care models and service provision are planned to change over time, how activity may shift across care settings and how quickly these changes may occur. This knowledge should inform decisions about how best to reimburse those services over time.

#### **Scope of the payment approach in the longer term**

Once data, currencies and other key enablers are in place, a consistent and co-ordinated payment approach could potentially cover all services within the UEC network. This will provide an opportunity for incentives to be aligned across providers and care settings.

We continue to consider what this will mean in terms of the specific services covered. Services additional to those listed in the approach above could include walk-in centres, community pharmacies, in-hours urgent primary care, community care urgent response and social care urgent response services. While key enablers are being established to allow further services to be reimbursed through a three-part payment, local areas can in the meantime aim to ensure that payment across all UEC services provides incentives for collaboration and co-ordinated care across the network.

A multi-year planning horizon for payment will be particularly helpful in providing transparency and reducing uncertainty for the investment in (and divestment from) capacity that is required across the different services in the network. The estimated total revenue requirement (see Section 3.4) and the fixed core element (see Section 3.5) can both be planned on a multi-year path to mirror and therefore enable the planned and agreed capacity shifts in the local network. Providers and

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<sup>4</sup> The services referred to in this document do not provide an exhaustive list of the UEC services that could be included within the scope of the new payment approach.

commissioners already have various tools to enable such an approach and multi-year contracts are being used in the sector.

This does not mean that the payment elements are necessarily fully fixed over a multi-year horizon – various checks and flexibilities can be built in. Monitor and NHS England are undertaking further research on how and when prices or currencies should be set on a multi-year basis and for what period.<sup>8</sup>

### **3.4. Estimate the baseline total revenue requirement**

Any payment approach in which a proportion of the payment is fixed requires an estimate of the baseline total revenue requirement for each service in the network, to inform the setting of the fixed and volume-based payment amounts (see Sections 3.5 and 3.7). It also provides a baseline against which any gains or losses can be measured (see Section 3.8). The estimates for each service can be summed to give an estimate for the network as a whole.

Providers, commissioners and system resilience groups (SRGs) within the network will produce such estimates as part of their usual strategic and operational planning processes. A number of guidance documents on demand forecasting and capacity planning are already available for local areas to use in producing these estimates (see Section 4.1). It is not for Monitor and NHS England to specify in detail the methods and datasets used for these estimates – the final decisions and agreements will be local.

Nevertheless, for these estimates to support improved delivery of care and provide a basis for the desired network-wide incentives, they should:<sup>9</sup>

- be forward looking in producing a best estimate of the expected costs of each service and of the network as a whole
- be based on robust data on patient needs, activity, service inputs and costs of those inputs in each care setting
- take into account the estimated impacts of key cost drivers.

The multi-year timeframe for payment is also expected to encourage greater transparency between providers and commissioners, including with respect to activity and cost data, and hence facilitate a more ‘open book’ approach to estimating revenue requirements.

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<sup>8</sup> Monitor has published early research into the desirability and feasibility of multi-year tariff cycles. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/381608/MultiYearTariffFTI.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/381608/MultiYearTariffFTI.pdf)

<sup>9</sup> The options for determining the baseline total funding requirement presented in this document have been informed by feedback to the August 2014 discussion document (see Appendix 1) and further discussions with the sector.

While key enablers are being developed to enable a more mature approach, pragmatic approaches to estimating the baseline funding requirement in the short term include:

- projecting forward from the current funding level for each service based on trends in activity and population demographics, and ensuring the expected impacts of the service changes on activity levels and inputs are taken into account
- forecasting activity growth and applying existing local or national prices for activity measures (for services where these are available)
- assessing planned changes in the mix of inputs (capacity) of the different services in the network and costing this schedule of inputs.

Regardless of which approach is used to determine the baseline total funding requirement, but particularly if activity- or capacity-based approaches are used, the basis of the estimate must mitigate against the risk of locking in the assumed mix of services (activity based) or inputs (capacity based) that will actually be provided. It is essential that the payment approach does not unduly restrict the freedom of the UEC network to reform service delivery.

Two further issues need to be addressed:

- No matter how the baseline is determined, there will be significant uncertainty surrounding it, not least because the impact of the planned service reforms is not known. This uncertainty will be more pronounced for services for which the available data cannot support mature estimation approaches.
- Feedback to the August 2014 discussion document (see Appendix 1) highlighted that determining the baseline total funding requirement is likely to be contentious and impacted by the relative negotiating strengths of providers and commissioners.

#### **Approach to determining the total funding requirement in the longer term**

A mature approach to determining the total funding requirement would be based on forward looking expected costs of each of the services in the network. The cost estimates would reflect the inputs (capacity) of each service required to treat the expected casemix of patients (activity), the latter taking into account projected population needs. The expected impacts of the planned changes on each component service would be taken into account throughout the process.

This approach has demanding information and capability requirements, including detailed demographic trends and health factors to inform an assessment of patient needs, robust casemix activity measures and capacity metrics to link inputs to costs. These may take a number of years to develop, particularly outside of admitted patient care (see Section 4.2).

The design and implementation options set out in the subsequent steps of the process aim to take these issues into account where possible.

### **3.5. Determine the fixed core payment**

The three main considerations in setting the core payment element are:

- whether it is used to reflect the availability-related costs of a planned minimum safeguard level of service or a planned total level of service
- the amount or proportion of costs that is fixed due to providing the always-on capacity to meet expected patient demand, compared to the amount or proportion of costs that varies from the planned levels with changes in patient activity and casemix
- the degree of financial risk that alternative amounts of fixed payment place on commissioners and providers, compared to their appetite/ability to absorb these.

#### **Minimum safeguard vs planned total level**

Use of the core payment element to reflect a minimum safeguard level of service would introduce an additional requirement into the planning process to determine what the minimum service levels should be. This process would be, to some extent, a hypothetical exercise providing limited additional help to service providers in their operational and investment planning. A pragmatic approach therefore would set the core payment element to reflect the availability-related fixed costs of the total planned service.

#### **Amount or proportion of fixed costs**

Research undertaken by Monitor and NHS England in 2014 showed that the proportion of fixed costs at the planned level of activity:

- is primarily determined by whether staff costs are considered fixed or variable
- varies substantially between different services within the UEC network
- is likely to vary between different providers of the same services, depending on the service delivery model used and existing capacity utilisation rates.

When partially fixed payment for EDs was introduced in Victoria, Australia, staff costs were treated as fully fixed, with reference to the staffing practices common in most EDs (ie staffing does not respond to demand changes) and an expectation that

the fixed payment would be rebased on a regular basis.<sup>10</sup> This reasoning led to an 80%:20% fixed-to-variable payment split being used, informed also by studies in the US<sup>11</sup> and France<sup>12</sup> that estimated that variable non-staff costs in EDs ranged from 5% to 23% (depending on patient acuity) and from 20% to 25% respectively. Monitor's and NHS England's research into cost structures, based on two case study local health economies, found that variable non-staff costs varied from near-zero to 20% for the different UEC services considered.

The above suggests that a relatively high proportion of payment should potentially be fixed, but that the proportion can vary between different services.

### **Consideration of financial risk**

Crucially, staff costs can only be considered fixed for relatively small changes between planned and actual casemix and volume. The more actual activity differs from planned activity, the greater the proportion of costs that would need to vary to address the difference. The impact of this could be mitigated by using a smaller proportion of fixed payment.

For this reason, determining the fixed core element needs to include consideration of the financial risk for different providers and commissioners within the UEC network. Their appetite and ability to bear demand and performance risk needs to be considered and the financial impact of alternative proportions of fixed payment under varying assumptions about planned and actual activity levels should be assessed.

Following from the above considerations, a pragmatic approach would be to calculate the core payment as a percentage of the baseline total funding requirement for each service over time (see Section 3.4). The percentage would be based on:

- a broad understanding of underlying cost structures using available benchmarks and top-down estimates of the split between fixed and variable costs at planned activity levels
- a consideration of volume risk placement arising from alternative core payment amounts.

This approach could enable local areas to establish round-number percentage estimates for the core payment element that broadly reflect the fixed costs of service provision without placing undue financial risk on any particular party.

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<sup>10</sup> Duckett SJ, Jackson T (2001) Paying for hospital emergency care under a single-payer system. *Ann Emerg Med* 37: 309-317.

<sup>11</sup> Williams RM (1996) Distribution of emergency department costs. *Ann Emerg Med* 8: 671-676.

<sup>12</sup> Berthier F, Andreu M, Bourjac M et al. (1998) Analysis of cost and of non-medical care load of patients seen in an accident and emergency department – the importance of clinical classification of emergency patients. *Eur J Emerg Med* 5: 235-240.

**Table 1: Potential short-term approach for deciding fixed payment proportion**

Criteria	% Fixed and when to select this option		
	80%	70%	60%
<b>Importance placed on availability and coverage aspect of the service</b>	Defining characteristics of the service	Important characteristics of the service	Not key characteristics of the service
<b>Proportion of costs that are known to be fixed</b>	Large majority	Majority	Significant proportion
<b>Confidence in the forecast total funding requirement</b>	High level of confidence	Some uncertainty	Significant uncertainty
<b>Need for funding certainty over time to facilitate investment</b>	High	Medium	Low
<b>Ability and willingness of the parties to take on risk associated with activity/volume higher than planned</b>	Providers are willing to take on risk in exchange for potential savings against the baseline	Providers are unable to take on risk or do not expect significant savings against the baseline	Exposing providers to the risk would threaten the viability of services if activity is much higher than planned Commissioners are willing to take on risk

Table 1 gives a number of alternative reference points/criteria as a guide to applying this pragmatic approach at a local level.

An example is a local area testing an approach where the core payment percentage is set as follows:

- 80% for NHS 111 and ambulance services due to:
  - availability and coverage being defining characteristics of the services
  - a large majority of costs (including staff costs) thought to be fixed
  - a desire to provide certainty for investment in additional services
- 70% for A&E services due to:
  - availability being a key characteristic of the service
  - some uncertainty about the forecast total revenue requirement
  - providers unable to take on the risk associated with a low proportion of volume-based payment in case volumes are higher than expected
- 60% for emergency admissions due to:



- significant uncertainty with respect to the impact of service reforms on the reduction in emergency admissions
- no major investment being planned for new services
- overly low proportion of volume-based payment potentially threatening viability of services if activity is much higher than planned.<sup>13</sup>

Annex 1 provides a more detailed example of a potential pragmatic approach to the core payment element.

#### Further development of the core payment element

It is possible to use a bottom-up modelling approach to directly estimate the cost (in £) of the fixed inputs required to provide the planned level and standard of service at each provider. First, the schedule and amount of inputs required to deliver the planned level and standard of service are estimated. Second, a detailed assessment is required of which types of inputs (doctors, nurses, equipment, consumables, etc) represent fixed costs and which inputs providers can or will need to vary should the casemix or volume of activity differ materially from planned levels.

Such bottom-up analysis requires a good understanding of provider costs and cost drivers, as well as providers being open with commissioners about their cost data. It is therefore likely to be resource intensive and reliant on good relationships across the network for implementation – and is not a pragmatic option, at least in the short term.

Before the national payment approach could rely on such analysis, further definition of national standard measures of inputs and cost categories, as well as standard modelling methods, are likely necessary. Monitor and NHS England will look to provide more detailed guidance on determining the core payment element as the alternative approaches and choices are tested.

### 3.6. Determine the payment to be linked to outcomes and performance

This requires decisions on the:

- source and amount of funds to link to this payment element
- metrics and their target levels on which payment will be based.

<sup>13</sup> A relatively high proportion of fixed payment for emergency admissions could also exacerbate any existing problems with exit block from A&E, other things being equal, as hospitals would have a financial incentive to admit fewer patients.

## Source and amount of funds

NHS England and Monitor will work with development sites to determine the potential source and amount of funds to be linked to performance of the network with respect to service transformation, patient outcomes and patient experience.<sup>14</sup> The two main options are:

1. Predetermine the amount (or proportion of total funding requirement) to link to the outcomes/performance. Funds can come from:
  - a top slice from the total funding requirement for each provider (requiring providers to earn back part of the cost-reflective fixed core or volume-based funding)
  - commissioner expectations of savings generated from implementing the new networked care model (operating as a potential bonus to providers to further invest in services).
2. Fund the element retrospectively from actual commissioner expenditure savings against the baseline total expenditure. This may involve establishing a gain/loss sharing arrangement (see Section 3.8) where the shares of the savings/overruns across the network are linked to outcomes and performance.

The two options can also be used in combination, with potential for shared savings providing an additional incentive over and above predetermined amounts.

NHS England and Monitor are not yet in a position to recommend one option over the other, nor the proportion of payment to link to outcomes and performance.

## Metrics and target levels for payment

Regardless of which option is chosen for the source of funds, payment should be linked to a basket of metrics that reflect:

- system/network-level performance
- organisation-level performance
- progress against implementation of the new care model
- patient outcomes and patient experience.

System-level outcome metrics and, in particular, those capturing progress with the implementation of the new care model can be used to directly incentivise and facilitate the service reforms. For example, part of this payment element could

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<sup>14</sup> We will also work with sites to determine the appropriateness or otherwise of using sanctions/penalties.

depend on completing investments (divestments) in (from) services, or new services coming online in agreed timeframes. The metrics, the targets set against them and the performance against the targets should be transparent to and known by all in the local network. NHS England is developing network-wide metrics that may be linked to payment in the future (see Section 4.2). It is anticipated that a mix of outcomes- and process-based measures will be defined and agreed.

It can take a long time to develop appropriate new metrics, to establish the data flows to enable reporting against them and to agree the target levels for each metric that would trigger payment (and that can also change over time).

Short-term pragmatic approaches, particularly for any testing during 2015/16, will need to use existing local and national metrics and indicators that are understood and supported by existing data flows. The Commissioning for Quality and Innovation Scheme for 2015/16 has a range of metrics aimed at encouraging provider collaboration, and the Quality Premium, Contract Sanctions and Better Care Fund also contain UEC metrics that may support local discussions.

Any chosen metrics will need to be clearly linked to the services to which the payment approach applies and provide a meaningful and reliable measure with respect to those services.

#### **Use of payment linked to outcomes and performance in the longer term**

Monitor and NHS England are working on more detailed principles to inform how best to link payment to outcomes and performance. This work will also further consider the appropriateness and effectiveness of linking different types of metrics to payment relative to other ways of using them (eg transparent monitoring and reporting without a link to payment).

The potential interactions with existing performance-related payment elements, such as the 30-day readmission rule and best practice tariffs, will need to be resolved. Similarly, there is a need to ensure that the metrics included in the payment approach are consistent with the wider contractual levers and targets given to commissioners.

We also recognise that new metrics are required to better measure and capture the quality, outcomes and performance of the UEC networks as a whole. It is important not to limit longer-term options to those metrics that are currently available. Section 4.2 describes some of the work in progress on that front.

### 3.7. Determine the volume-based payment

Decisions are required on the:

- currencies used for volume-based payment
- prices attached to the currencies that reflect the efficient average unit cost of the activity in each currency
- adjustments to the average unit cost prices to reflect the proportion of overall payment to be based on volume.

#### Currencies

Sector feedback to the August 2014 discussion document (see Appendix 1) was clear that the volume-based payment needs to be based on monetised counts of activity rather than directly on costs incurred, for payment to be implementable at a local level without excessive negotiation and monitoring burden.

Volume-based currencies used for payment would ideally group patient casemix into clinically meaningful bundles with similar expected resource needs. This would involve:

- use of existing currency definitions and datasets, including national currencies for admissions, attendances at EDs and UCCs/minor injuries units (MIUs) and for emergency ambulance services
- where there are new types of activity not reflected in the existing currencies, eg for new types of ambulance clinical hub services, either:
  - allocation of the new types of activity to the existing currencies
  - use the local variation regime to disaggregate existing currencies so that current and new types of activity can be distinguished
- for services without national currencies, a pragmatic approach would be to use simple contact counts for categories of activity that are currently separately reported at a local level, eg identifying and counting GP OOH telephone consultations separately from home visits, or NHS 111 calls resolved with and without clinical consultation (if available).

NHS England may in time refine the existing currencies or define new national currencies for services that do not yet have them. The ongoing and possible future efforts to improve the quality of data and the casemix-based currencies are described in Section 4.2.

## Prices

The currencies need to be monetised, both for the total funding requirement estimation and the volume-based payment estimation. Existing national and local prices can be used to do this, supplemented with simple local unit cost calculations where new prices are needed. This involves use of:

- existing national prices for admissions, attendances at EDs and UCCs/MIUs, with all the existing rules and adjustments applied as necessary (eg cost uplifts, efficiency factor, market forces factor (MFF), best practice tariff and any local modification adjustments)
- existing local prices for services with national currencies, such as emergency ambulance services
- local estimates where there are no existing national or local prices for currencies, such as for any short-term simple count currencies devised locally for GP OOH and NHS 111 services. A pragmatic starting point for these prices could be the total cost (or commissioner expenditure on the services) in a previous year divided by total activity in the same year.

Benchmarking may be used to validate local price estimates and to ensure efficiency considerations are taken into account.

Monitor and NHS England will look to provide more detailed guidance on using local estimates where necessary as the alternative approaches and choices are tested and piloted with the sector. We may also in time publish nationally calculated prices (whether mandated or provided as a reference) for a wider set of UEC services than currently available.

### **Adjustments to average unit cost prices**

The above approach aims to produce a price that reflects the efficient average unit cost of activity in each currency. Where the volumetric payment is made on top of a fixed core element paid separately in advance – and/or with the outcomes and performance payment element implemented as a top slice – it needs to be adjusted by a percentage multiplier. The multiplier will need to be set so that the three payment parts add up to 100% of the total funding requirement at the expected level of activity if outcomes and performance criteria are met.

To illustrate this, if the prepaid fixed payment element is set at 60% and 5% of the estimated total funding requirement is dependent on meeting outcomes and performance criteria via a top slice, the providers would be paid 35% of the average cost unit price for each unit of activity delivered, starting from units of activity above zero. (This means their revenues would also reduce only by 35% of the average unit cost price if activity is lower than planned.)

### 3.8. Determine any financial gain/loss sharing arrangements

Gain/loss sharing arrangements can be used with the three-part payment approach to further strengthen the incentives for providers in the network to co-ordinate to implement the new networked care model. They can be used to ensure that individual providers who generate benefits for other parts of the network or savings for the commissioners – such as ambulance services treating people over the phone or at the scene leading to fewer A&E attendances – are able to share in those wider benefits. This provides a direct financial incentive to collaborate on the planned service reform, and to shift activity to the most appropriate and cost-effective settings, without reliance on additional metrics on outcomes and performance.

However, implementation of gain/loss sharing arrangements could require a more sophisticated payment and contracting infrastructure, as well as stronger local relationships to agree and maintain the arrangements. For these reasons, they may not be a pragmatic solution for all UEC networks in the short term.

Monitor and NHS England have published a separate document to guide local areas in designing and implementing gain/loss sharing arrangements to support new care models.<sup>15</sup>

The multilateral gain/loss sharing local payment example illustrates one pragmatic way to implement the proposed three-part payment approach through a gain sharing arrangement. In summary:

- The three-part payment approach is implemented as described in this section and illustrated in the example in Annex 1 of this document.
- Commissioner expenditure against the volume-based element is monitored and compared to the baseline. Any underspend (gain) is shared periodically with providers.

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<sup>15</sup> *Local payment example: multilateral gain/loss sharing*. Available from: [www.gov.uk/government/publications/local-payment-example-multilateral-gainloss-sharing](http://www.gov.uk/government/publications/local-payment-example-multilateral-gainloss-sharing)

## 4. Key enablers

There are a number of core enablers that are needed to support the design and implementation of the three-part payment approach across the different UEC services. Local commissioners and providers looking to test or implement the approach in the short term will need to have in place a plan and associated governance arrangements for delivering the UEC service reform. They will also need to satisfy the underpinning data requirements for designing and operating the new payment approach. These are discussed in turn below.

Improvements in these enabling factors are needed particularly for the more mature or longer term options discussed above.

### 4.1. Planning and governance of the UEC network

The requirements for delivering the envisaged service changes will also be fundamental to the successful implementation of the new three-part payment approach.

#### Designation and planning

A prerequisite for implementing the payment approach described in this document is for the networked model of UEC to have been locally agreed and its implementation planned.

Requirements include:

- specification and agreement of desired outcomes, as well as the care model and system changes necessary to deliver these
- designation of providers within the network, eg providers of clinical advice hubs, UCCs, emergency centres and specialist emergency centres – including agreement on service specifications
- development and agreement of activity forecasts over a multi-year horizon, reflecting the envisaged system changes, and capacity plans to meet the forecasts to agreed quality and access standards<sup>16</sup>
- agreement on governance and operational protocols for the network.

NHS England's planning guidance for 2015/16<sup>17</sup> is clear that this work will be led by local SRGs in line with national guidance.

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<sup>16</sup> Development of demand forecasts and capacity plans to match demand over a multi-year planning horizon is necessary to inform the setting of the core payment element discussed in Section 3.5.

<sup>17</sup> Available from: [www.england.nhs.uk/ourwork/forward-view/](http://www.england.nhs.uk/ourwork/forward-view/)

## **Leadership, governance and operational management**

Requirements for the successful implementation of the new networked care models are:

- good leadership to encourage all providers and commissioners to support the network and collaborate towards delivering its shared vision for UEC reform
- network-wide governance and operational management structures to ensure shared as well as individual accountability for clinical and financial outcomes
- clear monitoring and reporting arrangements, including those for activity, cost and quality, to flag unexpected demand patterns and provide early warning of safety and/or quality issues.

### **4.2. Data requirements**

Data availability with respect to activity, cost, quality and outcomes is crucial to the successful design, implementation and operation of alternative payment approaches. Current data availability has fundamentally shaped the payment design options set out in this document. This section provides a fuller commentary on currently available data, their impact on feasibility of payment approaches across different care settings and how this may change in future as envisaged data improvements come online.

#### **Activity and casemix**

Patient activity data are essential for implementing the three-part payment approach, both to inform revenue requirements and pay the volume-based element, and to help track activity shifts against planned service reforms.

Ideally, payment approaches should use casemix-based currencies to reflect both the complexity of patients and the volume of activity. However, activity data using casemix currencies are currently available only for admitted patient care in hospital settings (the healthcare resource groups (HRGs)). In addition, ED attendances are classified into currencies that reflect the investigations and/or treatments patients receive, and there are four nationally mandated currencies for emergency ambulance services. We expect local areas to use national currencies, or local variations to those currencies where appropriate, as the basis for payment.

For services within the UEC network where national currencies are not available, local providers and commissioners should seek to classify activity count data into groupings that reflect meaningful clinical or operational differences in service delivery. For example:



- NHS 111 activity data are available on the number of calls received, calls answered, calls where a person was triaged using NHS Pathways and calls transferred to a clinical advisor<sup>18</sup>
- GP OOH activity data may include case volumes classified into broad categories such as calls resolved on the phone and cases requiring a home visit by a clinician.

Improvement of activity data and casemix currencies is one of Monitor's and NHS England's top priorities for improving the NHS payment system. In particular:

- we are working towards implementing the HRG4+ system for admitted patient care to better reflect patient complexity within the existing HRG categories
- we will review the need and opportunities to improve existing or develop new currencies outside of admitted care, to better reflect new clinical models, eg for ambulance services
- we will consider how best to use new sources of data, eg the Royal College of Emergency Medicine, the Health and Social Care Information Centre and NHS England are developing a new data collection standard for EDs across England.

## **Cost**

Cost and/or commissioner spend figures are required to price activity for the purpose of payment. The aim is for prices to reflect benchmarked efficient costs of each unit of activity.

Short-term pragmatic approaches will need to use existing national and local prices where available, or local estimates, as described in Section 3.7. Local estimates could be based on cost or commissioner expenditure data. At a minimum this would require an estimated breakdown of expenditure between the different volume-based payment currencies, eg to calculate local estimates for the price of different types of NHS 111 call.

A mature approach would base these prices on a national collection of standardised patient-level cost data from providers across all care settings. These data would be aggregated into standardised payment currencies for each setting and type of care. Finally, the grouped costs would undergo various benchmarking adjustments for efficiency and unavoidable cost differences.

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<sup>18</sup> The NHS 111 Minimum Data Set includes various performance metrics and patient dispositions, such as number of calls resulting in emergency ambulance dispatch or recommendation to attend A&E, primary care or another service.

## **Outcomes and performance**

Providers and commissioners in local care economies moving towards the three-part payment approach need to measure outcomes and performance on agreed metrics and track these against agreed targets. There needs to be a mix of whole-system metrics in addition to organisation-level metrics to encourage collaboration and co-ordination across the new networked model of care.

Short-term pragmatic approaches will need to use existing local and national metrics. In addition to those that local care economies have developed and are currently measuring, the 2015/16 Commissioning for Quality and Innovation (CQUIN) indicators could be used.<sup>19</sup>

NHS England, as part of the review implementation programme, is currently developing standardised metrics to capture system-wide outcomes and performance. Work on these metrics is at an early stage and in time it may be possible to use these metrics for payment purposes.

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<sup>19</sup> Available from: [www.england.nhs.uk/wp-content/uploads/2015/02/cquin-15-16-guidance.pdf](http://www.england.nhs.uk/wp-content/uploads/2015/02/cquin-15-16-guidance.pdf)

## Appendix 1: Sector feedback

Monitor and NHS England published a discussion document in August 2014 describing options for reforming the payment approach to UEC that would support the changes proposed in Sir Bruce Keogh's UEC review.<sup>20</sup>

We invited comments on the document and at a follow-up workshop for stakeholders in October 2014 sought feedback to help us address the main challenges to making the new payment approach work.

This appendix summarises feedback on the document and to the workshop, identifies key messages and highlights policy implications.

The **main feedback** was as follows:

- There was cautious agreement that the new payment approach could **support the Keogh vision** for UEC. Stakeholders appreciated that the new payment approach recognised the 'always-on' nature of UEC, focused on patient outcomes, encouraged a more 'joined-up' approach and rebalanced the risks and rewards associated with payment. Their caution was largely due to wanting more detail.
- A **centrally determined approach** was seen as valuable in terms of defining the overarching principle to be adopted while offering guidance on local adaptation. Some stakeholders suggested national defaults were needed, eg there was a strong call for **national default prices** to limit complexity, subjectivity, and implementation and negotiation burden, while allowing variations to be made locally where appropriate. National defaults may safeguard against imbalance of power (either way) between providers and commissioners in local negotiations.
- Stakeholders expressed strong support for the payment approach being based on a **clear understanding of underlying data** on costs, capacity, activity and quality.

Aspects of the **payment design** needing further consideration were as follows:

- Many stakeholders felt that Monitor and NHS England should **provide more detail** on how the payment approach would work in practice, and provide clarity on the **methodology for defining capacity** across the pathway and on **expected service standards** (eg seven-day services at a specified standard level).

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<sup>20</sup> Available from: [www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx](http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx)

- Monitor and NHS England should **clearly state the scope** of the proposed payment approach, including the **minimum range of services** that should be covered. A common comment was that the scope of the UEC network, generally and for the purposes of payment, should be extended to include parts of the pathway in primary and community care. However, the UEC reform should not rely solely on the effectiveness of NHS 111 and UCC services.
- **Central support is needed in developing and implementing** the payment approaches locally. Both commissioners and providers requested national guidance setting out the detail of the payment design methodology (eg calculation of baselines, determination of fixed and variable payment elements, definition of quality/outcome metrics).
- Clarity is needed on the **interaction between existing contractual incentive schemes** and the payment approach to ensure alignment of incentives, risks and rewards for activity across the UEC pathway.
- Clarity is needed on **how the new payment approach and incentives would align with other policy levers**. Payment reform in isolation was deemed insufficient to drive better collaboration and co-ordination. Instead, it needs to be considered alongside a number of other levers such as use of performance targets and information sharing between providers in the network.

Aspects of **implementation** needing further consideration were as follows:

- Stakeholders felt the proposed payment approach relied heavily on the **availability of appropriate skills** in each care setting to undertake the analysis required for local implementation. This was linked to the request for national defaults to aid implementation.
- Concerns arose in relation to **payment complexity** given that the new approach may increase transaction costs as well as require more robust management information, additional contract monitoring resources and technical expertise to design the payment. Stakeholders requested better identification and mitigation of the main implementation challenges. They also stated that the payment approach should **be transparent and not overly complex**. Clarity and transparency on how cash should flow in the system would help ensure system-wide accountability.
- Some variations of the three-part payment approach may require **an operational model different** from that which currently exists, eg organisational change may be needed with a lead provider or alliance model potentially enabling a less adversarial commissioning style and encouraging more strategic network-wide decision-making.

- Some stakeholders were concerned about the potential **pace of change**. The timescale suggested in the discussion document was felt to be unrealistic, especially implementation in 2016/17. Reforming the payment approach could be destabilising. A sensible **transition plan** to mitigate risks and explore less complex mechanisms at a more acceptable pace was suggested.
- Monitor and NHS England should provide **practical implementation examples** illustrating how options would work in practice, the prerequisites for implementation, how key parameters can be calculated in an evidence-based way and how the potential impacts on activity, costs, quality, etc can be estimated.
- Stakeholders expressed concern that the new payment approach may result in commissioners **under-commissioning activity** and/or providers **under-investing** if required capacity was estimated inaccurately. Providers could face high levels of financial risk, particularly during transition as activity shifts across care settings and if costs are 'sticky'.

## Annex 1: Example three-part payment

This annex sets out a potential pragmatic approach to designing and implementing a three-part payment for urgent and emergency care (UEC) services, following the process and design steps outlined in the main document. There are a number of possible approaches to establishing the three-part payment and the example we outline takes into account that moving to new ways of paying for services requires a sensible transition approach. In particular we make use as far as possible of building blocks that are already in place, eg existing currencies, pricing information and existing arrangements for monitoring and reporting activity data. The example is consistent with potential longer-term approaches that would rely on further developed building blocks and core enablers as discussed in the main document.

Below, we set out each of the payment design steps that local health economies would need to undertake to implement this new payment approach. All figures are **illustrative** only.

### Define the scope of the payment approach

Table A1 illustrates one potential short-term scope of coverage for a new UEC payment approach, with respect to the services and types of care to be covered and the local providers and commissioners who will use the new approach. The choice of scope here does not include every care setting or service along the UEC pathway, but a subset that aims to adequately cover patient access and triage points, bearing in mind which services/care settings have the building blocks/core enablers required for implementation readily in place.

**Table A1: Potential short-term scope of new payment approach**

Providers Commissioners Care settings	A	B	C	D	
	NHS 111	GP OOH	CCG1 Ambulance	A&E	EA
Services (and associated currencies)	Calls answered (estimate NHS 111 currencies based on evidence base)	Calls answered Home visits (estimate GP OOH currencies based on evidence base)	Hear and treat/refer See and treat/refer See, treat and convey UEC calls answered (use existing national ambulance currencies)	A&E attendances (use existing national A&E currencies)	Emergency admissions (use existing admitted patient care currencies)

## **Determine the timeframe for payment**

Given the envisaged three- to five-year timeframe for implementing the service reforms, any new payment approach is likely to operate over a number of years and providers and commissioners will need to agree on the appropriate timeframe. For simplicity, this example provides illustrative figures for the last year of the multi-year timeframe, when service reforms will have had an impact on patient flows.

## **Estimate the baseline total revenue requirement**

Table A2 illustrates a potential pragmatic option for establishing the baseline total revenue requirement (TRR) for each service (as defined above for the purposes of payment). The approach utilises currently available building blocks, such as activity data and price information, and estimates the TRR by:

- forecasting activity levels and taking into account assumed demographic growth, changes in casemix and the envisaged impact of service reform:
  - units of activity are either estimated (eg using simple contact counts for NHS 111 and GP OOH, as set out in the main document) or defined by existing currencies (eg HRGs for hospital admitted patient care and for A&E services)
- applying national, local and estimated prices (for acute services, ambulance services and NHS 111/GP OOH services respectively) to the forecast activity levels:
  - prices for NHS 111/GP OOH can be estimated as current spend/current activity
  - all prices are adjusted to reflect health cost uplifts and expected efficiency gains as usual.

## **Determine the fixed core payment**

A pragmatic approach to determining the core payment is to establish what proportion of the baseline TRR for each service should be fixed, and then to multiply the core payment percentage by the TRR for each service to establish a core payment in £ terms.

The rationale for choosing the illustrative core payment proportions listed in Table A3 for each service/care setting is explained further in the main document.

**Table A2: Illustrative estimation of baseline TRR**

Providers	NHS 111	GP OOH	Ambulance	A&E	EA
Current activity (annual)	160,000	25,000	40,000	100,000	30,000
Demographic growth + casemix change	3%	3%	3%	3%	3%
Forecast activity shift relating to service reforms	15%	8%	3%	-10%	0%
Forecast activity	189,520	27,810	42,436	92,700	30,900
Price	£15	£70	£170	£125	£1,150
Health cost uplift	3%	3%	3%	3%	3%
Efficiency gain	-2%	-2%	-2%	-2%	-2%
Baseline TRR ('000)	£2,870	£1,965	£7,282	£11,696	£35,869

**Note:** For simplicity, in Tables A2 to A5: (1) we show only a single (weighted average) price and aggregated level of activity for each care setting; (2) the single (weighted average) prices remain unchanged following the activity shifts; (3) some figures have been rounded.

**Table A3: Illustrative estimation of core payment element**

Providers	NHS 111	GP OOH	Ambulance	A&E	EA
Baseline TRR ('000)	£2,870	£1,965	£7,282	£11,696	£35,869
Core payment percentage	80%	60%	80%	70%	60%
Core payment amount ('000)	£2,296	£1,179	£5,826	£8,187	£21,521

### Determine the payment to be linked to outcomes and performance

In our example, payment is linked to outcomes and performance to provide explicit financial signals to both drive and facilitate network collaboration in delivering the envisaged service reforms, including changes in patient flows (see Section 3.6 of the main document).

The amount of funds for this payment element is assumed to be predetermined as 5% of the baseline TRR of each provider as illustrated in Table A4. This is a pragmatic option for illustration only, with the percentage reflecting a funding amount that has the potential to provide financial incentives to improve performance with respect to a number of nationally determined and/or locally agreed system- and organisation-level metrics. Each provider is able to earn the 5% back depending on performance against the agreed metrics.



It is important to note that the explicit financial incentives for co-ordinated service provision in our example operate predominantly through this element. The strength of these incentives therefore depends on choosing an appropriate set of metrics and target levels for performance against those metrics. The extent of the financial incentive provided is also limited to the predetermined amount of top slice for each provider (5% in this example).

**Table A4: Illustrative payment linked to outcomes and performance**

Providers	111	GP OOH	Ambulance	A&E	EA
Baseline TRR ('000)	£2,870	£1,965	£7,282	£11,696	£35,869
% of baseline TRR to be linked to outcomes and performance	5%	5%	5%	5%	5%
Max funding linked to outcomes and performance ('000)	£143	£98	£364	£585	£1,793

### Determine the volume-based payment

The previous design steps established a core payment amount and funding amount to be linked to outcomes and performance. For the volume based payment to contribute the correct remaining amount of total required funding, the price to pay for all units of activity delivered above zero across each service needs to be adjusted downwards (otherwise providers would be overfunded).

The percentage adjustment to apply to the price is, in this example, calculated by subtracting the core funding percentage and funding percentage linked to outcomes and performance from the baseline TRR. For example:

- for A&E services, the percentage adjustment is calculated as  $100\% - 70\% - 5\% = 25\%$  (ie 25% of the national tariff price is paid on all units of activity)
- for ambulance services, the percentage adjustment is calculated as  $100\% - 80\% - 5\% = 15\%$  (ie 15% of the locally established price is paid on all units of activity).

Table A1 above provided illustrative forecast activity levels across the UEC services in the network. The volume-based payment is paid on outturn levels of activity which may differ from the forecasts. Table A5 sets out illustrative volume-based payments paid on outturn activity levels in the last year of the multi-year plan; these differ from the forecasts and shows how outturn commissioner expenditure for each service differs from the estimated baseline TRR for that year as a result of the unforeseen activity shifts (higher NHS 111 and ambulance activity and lower A&E attendances and emergency admissions than expected in the baseline).

**Table A5: Illustrative estimation of volume-based payment**

Providers	111	GP OOH	Ambulance	A&E	EA
Price adjustment	15%	35%	15%	25%	35%
Marginal price	£2	£25	£26	£31	£403
Outturn activity shift	20%	8%	4%	-15%	-2%
Outturn activity level	197,760	27,810	42,848	87,550	30,282
Volume based payment on outturn activity ('000)	£449	£688	£1,103	£2,762	£12,303
Baseline TRR ('000)	£2,870	£1,965	£7,282	£11,696	£35,869
Outturn commissioner expenditure ('000)	£2,888	£1,965	£7,293	£11,534	£35,618



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