

PROVIDER  
REFLECTIONS:  
*TOWARDS AN  
EFFECTIVE NHS  
PAYMENT  
SYSTEM*



---

Phillippa Hentsch  
Head of Analysis

# **1. The payment system: ripe for reform?**



*It makes no sense to systematically underfund the tariff (prices set 12% below reference costs due to scaling factor) but then to issue some of this funding back as sustainability funding*

**Finance Director, acute trust**

*I think it was originally designed to reimburse the costs of care - given the provider sector deficit it has clearly failed. I have no idea why the marginal rate for emergency admissions is still in place other than to allocate system deficits to providers, who have little/no control over this aspect of their business*

**Finance Director, acute trust**



*The 500 pages of additional rules make it unwieldy to use and that complexity has weakened its credibility...changing the tariff doesn't, in itself, save money in the NHS overall...it is the operation of the contract/risk/payment mechanisms that might incentivise different behaviours that would do so.*

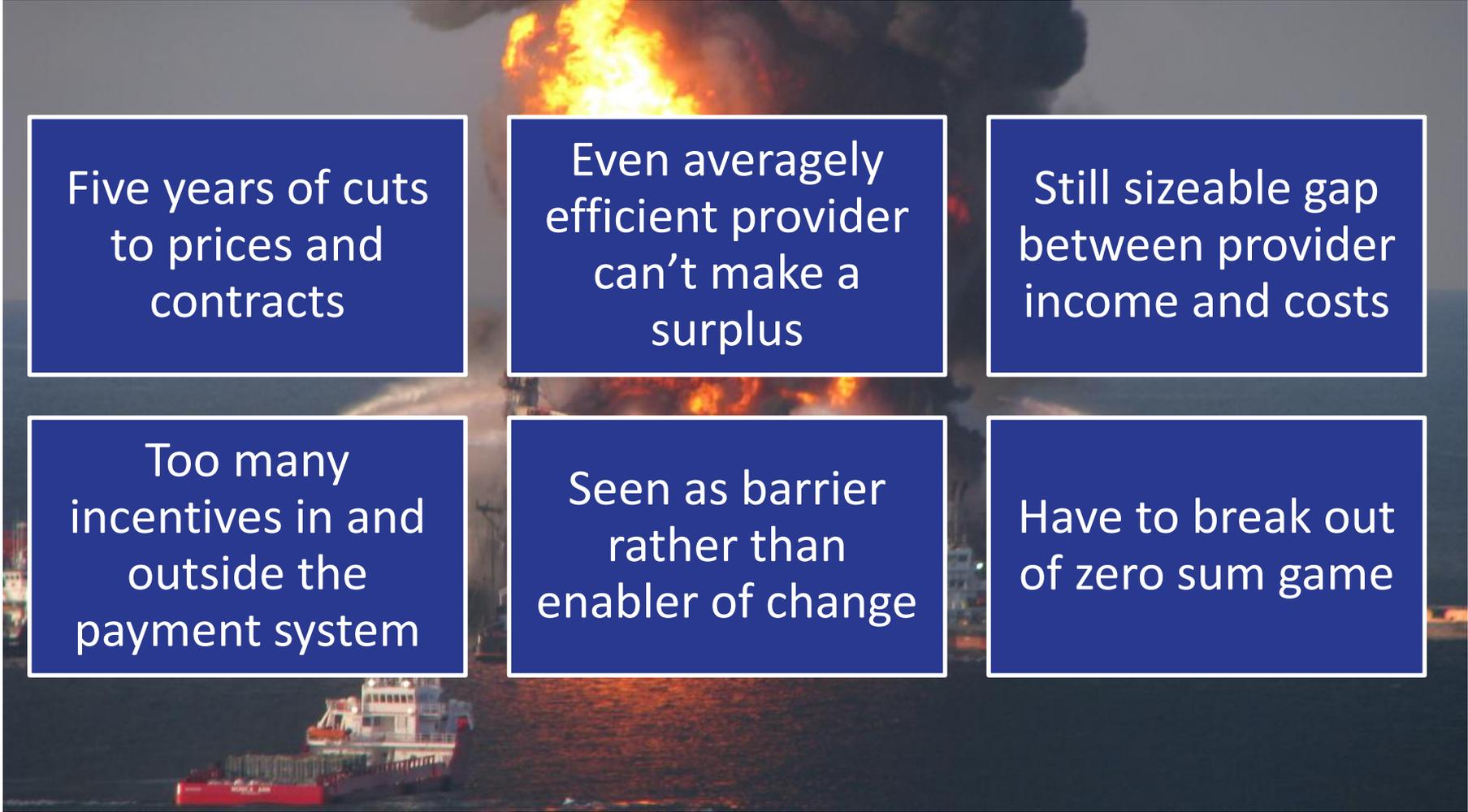
**Chief Finance Officer, acute trust**

*...it [the STF] is just a sticky tape solution over the tariff inadequacies – whole system needs reform in line with improved incentives to get things right first time.*

**Finance Director, acute trust**



# A burning platform for reform?



Five years of cuts  
to prices and  
contracts

Even averagely  
efficient provider  
can't make a  
surplus

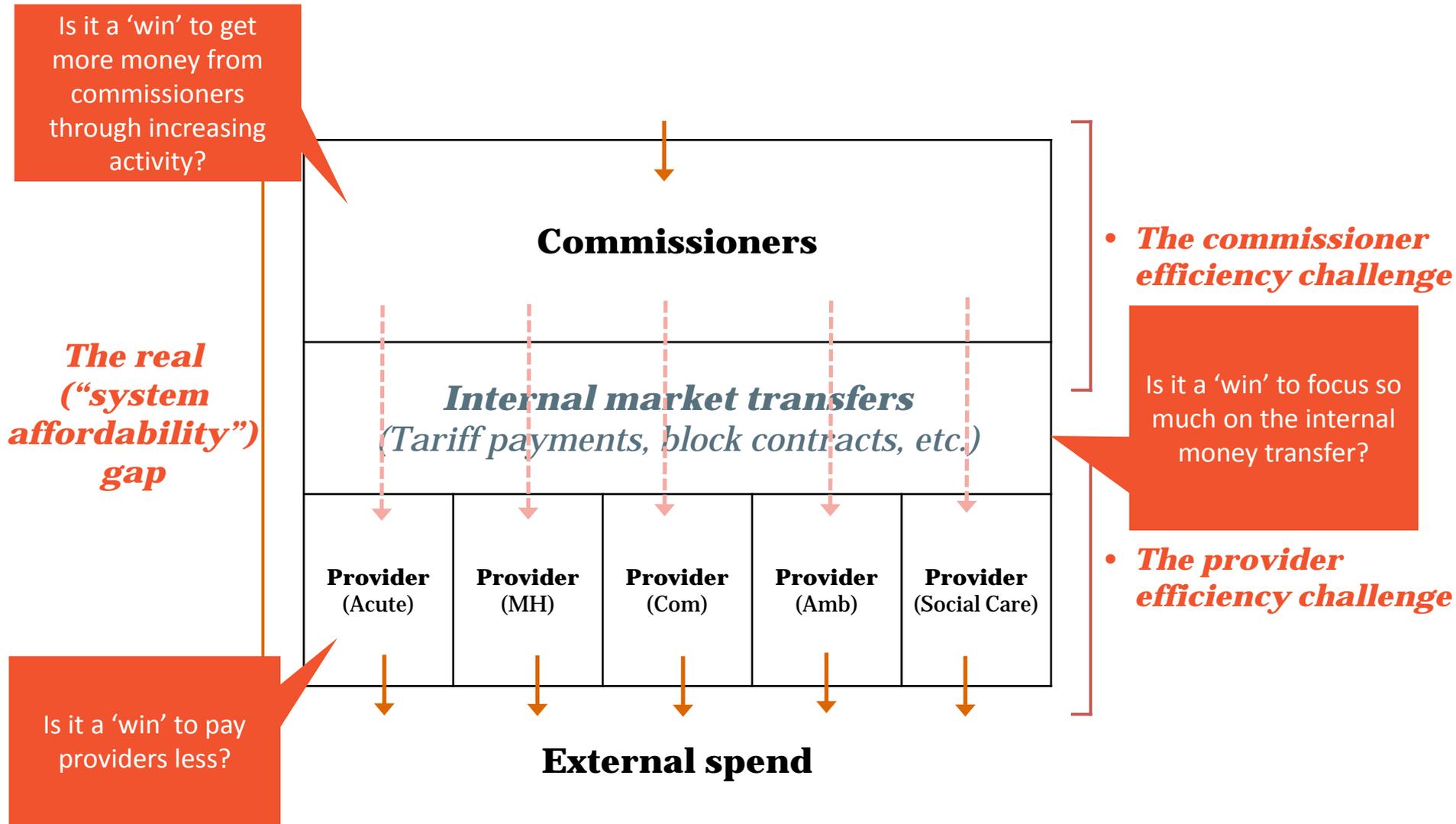
Still sizeable gap  
between provider  
income and costs

Too many  
incentives in and  
outside the  
payment system

Seen as barrier  
rather than  
enabler of change

Have to break out  
of zero sum game

# Internal market transfers ≠ system saving



# But we still need some form of national tariff

- Has had a **positive impact on efficiency**, more so than block contracts...but need to be careful of multiple layers of incentives and impact on activity growth
- **Relationships are developing at different speeds**, and some/most will still need a strong rules based system for many years to come
- It can **be compatible with local flexibility** – local prices and variations permissible although some cite it as a barrier...
- Often **required for local payments/innovations** – would have been difficult to design any of the innovative/outcomes based contracts without consistent measures of activity and unit cost
- Has **helped to improve data quality** and has led to **substantial investment in clinical coding, costing and info systems**; benchmarking service delivery costs and outcomes has been essential. This might falter on progress if not properly planned...
- We need **evolution not revolution**...in line with principles outlined in NHSP/HF report

## 2. Trends within the sector

# Dorset: simplicity over complexity

- Suspension of the national tariff
- Two year agreement of a collaborative agreement and system control total approach
- No increase in funding to Dorset providers
- System approach to holding activity at a maximum of 2016/17 levels
- Relentless focus on efficiency: £103m savings challenge in year (£18.8m in STF available to offset if targets are met)



- New capitated budget for 2017 for MSK services, where savings potential high.
- 15/16 baseline budget used, adjusted for:
  - Planned activity changes (e.g. reduction in acute inpatient services)
  - Additional costs of new model e.g. new triage service)
  - Stranded costs for the acute provider
- Total spend £34m, but aim to reduce by £2m in 18/19; community provider will see more than 40% cash increase.
- Additional activity is responsibility of the 'system' and attracts a marginal rate which goes in to risk/reward pool.



## NEW MODELS OF CARE IN PRACTICE

### INTEGRATED PRIMARY AND ACUTE CARE SYSTEMS VANGUARD

#### MID NOTTINGHAMSHIRE BETTER TOGETHER

Mid Nottinghamshire Better Together Vanguard is working towards the local health and care system being more joined up, and together partners have been reducing unnecessary hospital admissions for the area's highest risk patients.

**What means getting doctors, nurses, other health professionals and social care staff to work more closely together in a multidisciplinary team to support the needs of patients, their families and carers.**

**The joined up approach is better for patients as their care is better coordinated with the different people who look after them all sharing information and making sure that they are communicating effectively with each other. This means that they can more effectively spot patients who need extra help and allow them to be identified earlier, preventing health care deteriorating or complications which require a hospital stay from arising.**

**The model the Vanguard aims to identify and support the patients who are at the greatest risk of needing to be admitted to hospital in the future is known as the PROSA model of care.**

**This stands for three components:**

- **Probing risk**, which is looking at those who are most likely to end up in hospital soon due to complex conditions or other factors.
- **Integrated care**, which is everyone working together to support these people.
- **Self management and teaching** patients to manage their ongoing conditions and health needs with support in the community.

**The idea is that extra support is given to those most likely to require a hospital admission to keep them well and prevent an admission being needed.**

#### KEY FACTS IN NUMBERS

- The system has seen 22 per cent lower frequency of the national four hour emergency target in 2015/16, compared to the previous year.
- As a result of the urgent and proactive work, shortened Emergency Programs has been able to reduce bedblock by over 300 adult medical beds.
- The number of patients staying in hospital for more than 14 days has halved.
- The area is now one of the top performing in patients returning to their usual place of residence after a hospital stay.



# Morecambe Bay: pathways before payments

- Focus on getting the pathways right in ACS first; conscious decision to keep contractual issues to one side.
- Currently paid a mix of tariff payments and block contracts.
- Will operate under the principle of “one system, one budget”.
- Want to be light on contracting overheads with focus being on incentivising right behaviours to mobilise clinical model.

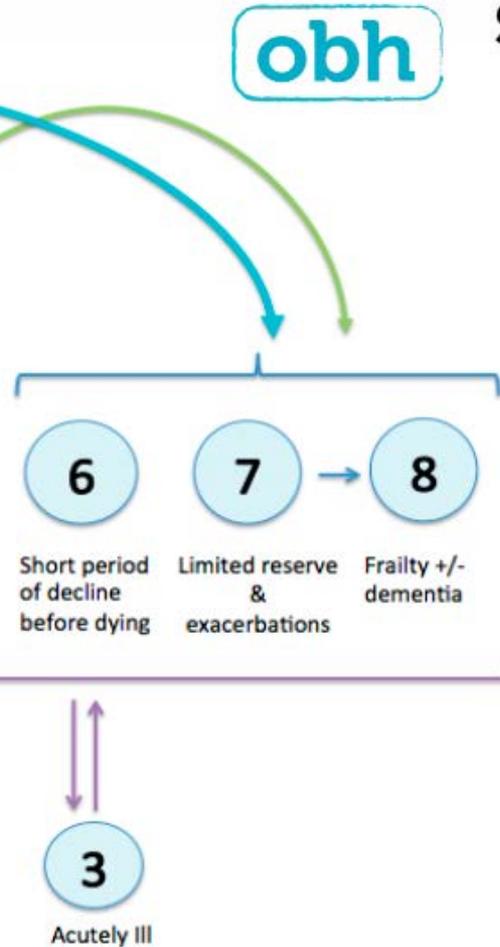


## Outcomes Framework- Population Segments



obh  
STOCKPORT  
TOGETHER

- Capitated budget, linked to outcomes: “without the outcome part, it is just a block contract, and that won’t drive improvement”
- Developed 38 outcome measures to supplement NHS constitution targets.
- Outcomes element would be far greater proportion of contract value than existing CQUIN incentives.
- Planning for simple three-way risk share for over performance



Source: *Segmentation for Outcomes*, OBH, 2016, adapted from *Bridges to Health*, Lynn et al, 2007.

Similar aims and principles but very different execution

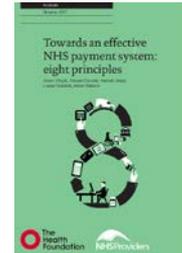
Some still using payment to incentivise behaviours

No one size fits all approach, but will they all work...?

Pathways before payments

National tariff prices still used as basis for contract

The role of outcome payments?



**To what extent do they meet the eight principles?**

1. Clear purpose
2. Realistic expectations about impact
3. National consistency with local flexibility
4. Appropriately, aligned incentives
5. High-quality data
6. Balance between complexity of design and ease of use
7. Independent oversight and support
8. Time to embed and evaluate systems

# 3. Looking to the future

# The big unanswered questions...

How do we bring **mental health and community services** on the payment reform journey?

What is the **efficiency factor** and what is it really for?

**How to fund capital**, now that the tariff/payment system doesn't or can't?

How to balance the **desire for ever more specificity and complexity in the payment design** with need for simplicity?

How do we continue to have a **rules based catch all payment system**, when different local areas and services need different solutions?

How to **guarantee genuine impartiality** from NHS England and NHS Improvement?

- Sector is starting to head off in different directions, and the **new principles provide a helpful grounding and coherence.**
- **Aims underpinning the payment system are changing**, and therefore the tools and incentives built in to them need to change too e.g. competition and choice used to be imperatives, now might be less meaningful in an STP world yet the national payment system has stayed the same.
- We might need to **let different parts of the system head off in different directions but quickly need to understand what works** through supporting evaluation and where promising approaches emerge, support spread across the sector. NHS England and NHS Improvement have key role here...
- Some form of **national tariff and national payment system will continue to be required**, but need to adapt this to meet current requirements.
- Need to **get language absolutely right**. Unhelpful to be talking about binary/artificial choice between tariff vs suspension of the tariff – both will continue to have a place.