Position paper: Reforming payment mechanisms for community services
NHS Confederation Community Health Services Forum
November 2013

Executive summary
There is a clear need to ensure that payment mechanisms across the NHS enable resources to be shifted to support the development of more community-based, integrated models of care, in line with the changing needs of patients. Providers of community health services have also long been concerned that the block contracts currently used to pay for almost all their services leave them vulnerable, both to disproportionately high savings requirements, and to having to deliver far more care than forecasted and paid for. The NHS Confederation's Community Health Services Forum (CHSF) is pleased that Monitor and NHS England have recognised the need to reform payment mechanisms and are working on developing a payment system that is fair to all providers and so better enables them to meet patient needs.

This paper sets out the emerging consensus view from CHSF on both overall principles for ongoing reform of payment mechanisms, and practical measures that should be adopted in the meantime. It is based on the presentations and discussions at a workshop attended by over 50 community services providers, with input from commissioners of community services, in October 2013. It aims to provide a strong basis for further discussion and policy development.

As new payment mechanisms are developed for community services, CHSF members want the following principles to be followed:
1. Develop a mixed and flexible system, with different approaches applied depending largely on the availability and extent of evidence on costs and patient outcomes. This system will need to be flexible and evolve over time as data and good practice also evolve. This mirrors the emerging view from a number of stakeholders and the Community Tariff Working Group.
2. Focus on outcomes and pathways, not inputs and processes. This approach should find support across the system and could facilitate integrated working and joint accountability. This should include outcomes patients define and report for themselves.
3. Look to payment systems to enable (remove barriers to) a new model of care which is more integrated and community-based, reflecting the needs of the population. This should include removing disincentives to integrated working, creating incentives for prevention, and having some consistency across the whole system in how care is measured and rewarded.
4. Generate some stability and transparency to enable planned change. Longer term contracts, and more transparency on costs, would support leaders to plan and invest in changes, where necessary.

The difficulties of securing suitable clinical data to enable a payment system more accurately based on patients' outcomes, and on the real costs of activity in community services, have been known for some time. Community providers are committed to addressing this and there is an ongoing, provider-led and provider-funded, programme to develop quality indicators and outcome measures.
However, it will take several years to develop both quality data and new payment mechanisms. While this work continues, a number of measures would help support both the shift to more integrated, community-based models of care and the development of new payment mechanisms: the development of these new models of care:

- Changes to payment mechanisms in the short term which focus on outcomes wherever possible, and create incentives for prevention
- Longer (3-5 years) contracts to allow for strategic planning and resource shift
- Use of CQUIN by commissioners to improve data quality (and, in some cases, quantity)
- National endorsement of, and continued engagement by providers in, the programme to develop quality indicators and outcome measures for community services
- Piloting, road testing and evaluation of new methods including mixed currencies and payment systems, enabled through national support and risk-sharing agreements.

About the Community Health Services Forum
The NHS Confederation's Community Health Services Forum brings together and represents organisations that provide NHS funded health services in community settings. Our members provide a wide range of out of hospital services in both rural and urban settings in different parts of the country. We are the only Forum to bring together the full range of providers of community health services.

The Forum's members include Community NHS Trusts and Foundation Trusts, social enterprises, independent sector providers of community health, and integrated community/mental health and community/acute trusts. The Forum also brings providers of community services together with commissioners of those services to discuss issues relevant to the whole sector.
Payment mechanisms for community services need reform

Reform of payment mechanisms across the NHS to address current challenges is a whole system issue. In particular, there is a clear need to ensure that payment mechanisms across the NHS enable resources to be shifted to support the development of more community-based, integrated models of care, in line with the changing needs of patients. Earlier in 2013, the NHS Confederation set out a 'whole system' view in its initial response to Monitor and NHS England's discussion paper on reforming the payment system. This emphasised that the incentives in the current system are complicated and fragmented, and do not reflect changed policy intentions nor the current efficiency challenge. Similarly, Monitor's own evaluation of payment mechanisms and the King's Fund's report on payment by results concluded that the payment system needed to evolve to meet a new set of challenges. These challenges include addressing the needs of people with long term conditions; multiple conditions in an ageing population; integrating care, and the need to address the relative neglect of preventative care - all areas where community services will play a central role.

Providers of community health services have also for some time been concerned that the current approach of paying for them primarily through block contracts is not well suited to the challenges they face. They have long argued that block contracts leave them vulnerable to being required to make more than their fair share of savings, as commissioners can more readily reduce the amount of a block contract than control expenditure on services that attract payment for every activity (e.g. payment by results (PbR)). Linked to this, they are also vulnerable to having to deliver more care than is affordable, where demand from patients is far higher than expected and paid for. Overall, there is wide agreement that the payment mechanism also fails to support and enable the shift to a new model of care which delivers more outside acute settings, is more integrated and emphasises prevention more strongly. However, there is also recognition that block contracts have offered a degree of stability and certainty about income, and that there are risks as well as benefits in moving to activity based payment systems.

We are pleased these issues were recognised by Monitor and NHS England in the discussion paper that launched their review of payment mechanisms. This paper sets out the emerging consensus view from CHSF on some principles for reform, as a contribution to the further ongoing thinking.

The data challenge

The difficulties of securing suitable clinical data to enable a payment system more accurately based on patients' outcomes, and on the real costs of activity in community services, have been known for some time. A large proportion of care provided by community services cannot be split neatly into 'episodes' and there is complexity and variation in both the extent of the needs of patients and the ways in which they are treated.

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1 NHS Confederation (2013), NHS Confederation response to 'How can the NHS payment system do more for patients?'
3 Appleby, J. et al (2012). Payment by results: how can payment systems help to deliver better care?. The King's Fund
4 Monitor (2013), Discussion paper - How can the NHS payment system do more for patients?
which services are delivered – and it is often unclear for how long a patient will require care. There is significant variability across community providers in the extent and quality of the data they collect which would form the building blocks of a developing payment system. Extensive work is needed across the sector to understand what it costs an efficient and effective service to meet patient needs and deliver the right outcome. Even then, community care is inherently very complex and the costs may be hard to model in all service lines or teams.

Work has been underway for some years to develop currencies for mental health services, based on care clusters which describe similar patient needs, covering short-term non-complex illness through to long-term complex and challenging mental ill health. The 21 clusters form the currencies and together with a range of clinically meaningful indicators and outcome measures are the basis for moving to a ‘payment by results’ system. The challenges in developing a new payment system in mental health have many parallels with those in community services in terms of developing clear descriptors of patient needs, understanding the resources required to provide their care and measuring those costs reliably. Work to develop and pilot mental health currencies has also required a great deal of investment - and all of this investment has come from providers themselves rather than from government. An additional challenge has been the modification of clinical information systems for recording and reporting information previously not required, but now essential to inform costing processes. One clear lesson for community services from the experiences of mental health providers is that any new activity and outcome-based system will take time and widespread sector commitment to develop.

This lesson is also reflected in the experiences of other countries. At our CHSF workshop in October, Anita Charlesworth highlighted that many had been cautious about using episodic payments for many types of sub- and non-acute care because of the risk that in incentivising financial efficiency they could also incentivise ‘skimping’ on care and make integrated working harder. For patients with long term conditions, many systems with activity based payments still include an element of payment based on the duration of care.

Community providers themselves are committed to improving their understanding of actual costs and outcomes achieved, as the basis for improving quality and efficiency. In the future, this would also enable contracting and payment arrangements which would be more satisfactory from both provider and commissioner perspectives. Providers also suggested that it could be helpful to link activity to improve data quality to CQUIN payments.

Four principles for future payment mechanisms for community services
Based on the discussion at the workshop and further consultation of community services providers since, we urge the following principles be used in developing new payment mechanisms for community services.

1. Develop a mixed, flexible system
For some years, commentators have favoured an expansion of payment by results into the community health services sector, but following work undertaken by the community tariff working group and others to look at how this could work in practice it
is clear that payment by results will not be practical or appropriate in all types of community service.

A minority of care provided in the community can already be costed sufficiently clearly and accurately to potentially enable PbR. For example, treating a leg ulcer could be considered an episode of care and remunerated on a case-based basis. However, there is a huge range of permutations of both patients’ needs and local service standards which makes it questionable whether a PbR approach will be suitable in many contexts. It is also notable that some countries have developed data to generate case-based costings for services equivalent to English community services, and have chosen to use this as a basis for block contracting with more transparency and accountability rather than take on the challenges and risks of developing something similar to payment by results. There are also some services such as immunisation which could sensibly be paid for on a capitated basis.

The CHSF agreed with the emerging conclusion of the national community tariff working group, that there should be a mixed system of payments, rather than a 'one size fits all' solution.

Emerging conclusions from the Community Tariff Working Group (CTWG)
The CTWG is made up of representatives from providers, commissioners, Monitor, NHS England, NHS Information Centre and Department of Health. It has been exploring how payment by results might be applied in community services and working closely with Monitor and others to shape the approach adopted.

The group has identified a number key aspects of a potential model to introduce PbR to community services:

- Consistent assessment of patient complexity based on bio/social criteria.
- Consistent approach to assessing clinical acuity of patient based on single / co-morbidity of patient, and relative stage of long term condition development.
- Pricing model should encourage prevention and self management
- Incentives to deliver improved outcomes should be self financing, and shared across all contributors to encourage integrated working
- Need to assess whether complexity of patient permutations and local service standards in community lend itself to national pricing; or a national framework with local pricing

It has also become clear to the group that one size cannot fit all and the future system is likely to need to combine all of the below:

- Capacity payments (with some activity based payment and performance monitoring)
- Block contracts and PbR/bundled pathways for different kinds of planned care
- Year of Care to incentivise proactive, preventative approaches

This mirrors the emerging view from stakeholders including the King's Fund, HFMA and others that thereform of payment mechanisms across the whole NHS to meet its
new set of challenges cannot be met through a single approach but will require a combination of different mechanisms as well as some flexibility. Noting lessons from other health services, a recent briefing from the NHS European Office, HSRN and LSE, *Lessons from Europe: the value of tariff redesign,*\(^5\) also emphasised the need to blend different ways of paying providers. At our CHSF workshop in October we heard from the CTWG Chair, Gary Andrews of Liverpool Community Healthcare, that the need for a mixed system had also been borne out by detailed exploration of the options across the health system in Liverpool.

It is notable that in those areas where activity-based payments can work well in future, it will still take several years to develop good quality data, categorise the care provided in ways that both relate to cost and are clinically meaningful, and develop sound costings. Additionally, policies intended to drive more personalisation of care, including the ‘Year of Care’ model, capitated budgets and personal health budgets, will certainly affect how we look at paying for community services and may turn out to be transformative. So it will be vital that the mixed system that is adopted is flexible enough to evolve, as both national policies and data about the costs and quality of community services continue to develop.

2. Focus on outcomes and pathways, not inputs and process

There is strong agreement that community services should be measured on, and paid for, patient outcomes rather than inputs and process. Where services are currently measured on the number of contacts district nurses have with patients this does not reflect newer, more integrated and efficient models of care using multidisciplinary teams. Using patient outcomes as a basis is consistent with thinking across the system. Presenters at our workshop, whether commissioners or providers, favoured this direction of travel.

It will be important that new mechanisms support personalised care; outcomes that patients themselves want should be measured and rewarded – including palliative outcomes as well as functional outcomes. It was felt this kind of approach would potentially strengthen the provision of palliative care and also support shared decision making around the kinds of lives people want to be enabled to lead. A number of providers commented on the importance of ‘bottom-up’ costing, i.e. starting with the outcomes the patient wants and then costing the care that needs to be wrapped around the patient to achieve them. It will be important that the way in which new payment mechanisms are developed allows for this approach, to enable the NHS to deliver personalised care.

**The Australian example**

At our October workshop, Anita Charlesworth highlighted lessons for NHS community providers from the approach adopted in Australia to paying for sub-acute and non-acute care. This is the health system which has gone furthest in developing an alternative to block contracts for community and similar services.

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An important lesson is that assessment of a patient’s quality of life and functional status was found to be far more effective than clinical diagnosis in predicting costs.

They have developed a case mix classification tool (AN-SNAP) based on impairment, function and age. The tool has been used for activity reporting since 1999, and is now also used for planning, funding allocation and benchmarking functional outcomes; the aim is to start using it for actual payments very soon. Payment is based on episodes and per diem, with rules on both short and long stay outliers. It is not fully setting neutral and payments differ by provider types.

In providing an example of how an alternative approach to paying for community services based around a patient's overall health rather than specific diagnosis might work, this suggests an outcome-focused approach should be feasible, at least for some groups of patients.

Community providers are very aware that initiatives seeking to drive more personalised, integrated care could drive further change in models of care and affect the approach to costing different types of care. Of particular significance are the Year of Care approach, personal health budgets, and the range of new contracting mechanisms (e.g. prime contracts) which commissioners are being encouraged to use in support of more integrated models of care. A stronger focus on outcomes is common to all of these approaches. We suggest costing services and paying community providers on the basis of outcomes for patients as far as possible should help support the adoption of these solutions within a mixed system. Further, if personalisation and personal health budgets are not considered when developing payment mechanisms for community we may stall progress on personalisation.

3. Look to payment systems to enable change rather than drive it
It will be important to be realistic about what payment mechanisms can achieve. Evidence shows that payment mechanisms play a limited role in driving the kinds of change the health service is looking for (such as integration). Drivers such as leadership, cultural change and data sharing are seen as far more effective than new payment mechanisms in bringing about integration of care, though there is evidence that inflexible payment systems can make it harder to integrate care. At our October workshop, Anita Charlesworth highlighted the Alzira model in Valencia, in which a provider receives a fixed annual sum for each inhabitant to offer free, universal access to its range of primary and secondary care services under a long term contract. This is a rare, or possibly the only, example of a change in payment mechanism driving change in the model of care – in this case a more integrated and cost efficient model. (Further information on the Alzira model can be found in The search for low cost integrated healthcare (NHS European Office, 2011). ⁶)

There is some evidence that payment by results and similar approaches in other health services have helped drive provider efficiency, but it is questionable how far this results from the improvements generated in data about outcomes and costs rather than from PbR as a mechanism for payment.

⁶ NHS European Office (2011), The search for low-cost integrated healthcare, NHS Confederation
It was also noted that most evaluation of ‘payment by results’ dates from 2008 and earlier so does not capture the impact of more recent innovation and experimentation in the payment system. Often, various factors will have been used to adjust the impact of the mechanism, reflecting additional policy objectives or unintended consequences, but these tend to receive little attention despite their impact. So in practice we have relatively limited understanding of how successful changes to the payment system have been in achieving their stated objectives – which is worrying, particularly if we were to seek to use payment mechanisms to drive change.

While new payment mechanisms may not inherently drive more care into or nearer people’s homes, community providers are looking for the overall payment system to do much more to enable community based, integrated care – in line with the needs of the growing number of people with multiple long term conditions. In particular, the disincentives to whole system working and integrated care in the current payment system need to be removed. To bring about change, payment mechanisms will need to be accompanied by other policy measures to drive integrated, community based care.

It would also be helpful if care were measured and rewarded in relatively consistent ways. Better payment systems for community services need to develop in conjunction with changes in other sectors. Where people’s care is provided partly in community and partly in other settings, a lack of flexibility in payment mechanisms for other types of provision could constrain the further development of care in community settings and the improvement of care pathways. If all the relevant providers are trying to use the same rules, similar currencies and the same reward structure this would help support integrated working, innovations in care provision and joint accountability.

It is already accepted that where changing the model of care requires a reduction in acute sector capacity we will need to find ways of managing the risks to organisations’ financial viability. It will also require commissioners with a really strong understanding of community services and their potential, and acute providers that are prepared potentially to become smaller.

It will be important for sustainability of the NHS overall that future pricing models include incentives for self care and prevention, particularly given that existing incentives tend to reward secondary care rather than the prevention or reduction of the need for care.

4. Generate some stability and transparency to enable planned change

In the short to medium term it is likely most community services will continue to be paid for through block contracts. Many community providers would like to see longer term contracts for community services, of at least three years but ideally longer, to enable strategic planning for services, including to shift resources. The degree of volatility in the current payment by results system (PwC has found that 40% of prices change by 10% or more each year7) is clearly challenging for acute providers and

7 PwC (2012)
Community providers want to see greater stability in new mechanisms. However, there is recognition this stability will need to be balanced with responding in a reasonably timely manner to changes in information and good practice. Clearly there is potential to negotiate changes to a longer term contract where there is a good reason – for example, service reconfiguration which changes significantly the clinical case mix and level of demand in ways that could not have been predicted when entering into the contract.

Linked to the point above, community providers also want to use the opportunity of developing better data on costs and outcomes in services to improve our understanding about the viability of individual services. They are very aware that it may be extremely difficult to shift resources out of acute settings in ways which are safe and sustainable for the remaining services in those organisations, and argue that transparency across the system can only help what will be very difficult judgements and discussions. A good payment system would allow leaders to understand whether or not their services would be viable in future and plan and invest to make changes where necessary.

**Conclusion**

Community providers want to see new mechanisms for paying for the care they provide, to better align payment with outcomes and remove barriers to providing more care in an integrated manner and in community settings, reflecting the future needs of the population.

They are also actively committed to improving greatly the data available about the care they provide, as a better understanding among both providers and commissioners of real costs and patient outcomes can only benefit both the accuracy of the payment systems and the spread of high quality, safe and effective practice.

As new payment mechanisms develop, community providers want to see:

- a mixed system, with different approaches applied depending largely on the extent of evidence on costs and patient outcomes. This will need to be flexible and evolve over time as data and good practice also evolve.
- a focus on patients’ pathways and measuring and paying for outcomes – including outcomes patients define and report for themselves
- enabling (removing barriers to) the shift of care into and closer to patients’ homes and to greater integration of care – reflecting the needs of the population
- stability and transparency in the new system

We recognise that it will take several years to develop and implement new payment mechanisms, given the need to improve data to be used as a basis for pricing, and agree a framework which is both financially realistic and clinically credible. This is underlined by the time taken in mental health to develop currencies, as well as by international examples. For example, Anita Charlesworth cited the four years taken so far by the Prometheus system in the USA, which is developing cross system payments based on patient outcomes but has found the fair allocation of risk ‘phenomenally difficult’. We also note that some of the most promising approaches,
such as bundled payments and Year of Care, are still relatively new and untested, at least in the context of English community services, and need further exploration.

In the meantime, a number of measures could aid both the shift to more community-based, integrated models of care and the development of new payment mechanisms.

- Community providers would like to see longer (3-5 year) contracts to allow for strategic planning and shifting of resources; this is currently happening in very few places.
- Commissioners should consider including in CQUIN an element on improving data quality and in some cases, quantity, in community services. This could both help secure the data required to improve payment mechanisms and support a better conversation between commissioners and community providers.
- Changes made to the payment system in the short term should focus on rewarding improved outcomes where possible, and incentives for prevention need to be created.
- Endorsement nationally and from the centre of, and the engagement of providers in, the ongoing programme which aims to develop quality indicators and outcome measures for community services.
- Nationally supported opportunities, facilitated with risk sharing agreements, to enable piloting and road-testing and evaluation of new methods including mixed currencies and payment systems.

If you have any questions about the contents of this position paper, please contact Kate Ravenscroft, Policy Manager, kate.ravenscroft@nhsconfed.org, 020 7799 8675
Appendix: the CHSF workshop on payment mechanisms

Overview
As a review by Monitor and NHS England of the payment system in the NHS was underway, the NHS Confederation's Community Health Services Forum (CHSF) held a workshop for over 50 community services forum members and a number of CCGs in October 2013. This sought to explore current learning on payment mechanisms relevant to community services and develop a set of principles for reforming the way we pay for community services.

The workshop included presentations from:
- Anita Charlesworth, Nuffield Trust
- Julie Wood, Director, NHS Clinical Commissioners, Kate Lavington, South Gloucestershire CCG and Rebecca Harrold, South Gloucestershire Council
- Mike Dinan, Director of Financial Operations at the Royal Free London FT (an acute provider perspective)
- Paul Wilkin, Director of Finance, Rotherham, Doncaster and South Humber FT (a mental health provider perspective)
- Gary Andrews, chair of the Community Tariff Working Group

All presenters drew out some lessons for community services from experiences elsewhere, which were debated in a question and answer session.

Attendees also discussed the emerging conclusions of the Community Tariff Working Group, a practical forum containing representation from commissioners, regulators and providers that aims to influence the community tariff agenda, as well as the experiences of community services providers and their reactions to the lessons presented.

Learning from experience: commissioning
Julie Wood, Director of NHS Clinical Commissioners, set out that commissioners are looking for payment mechanisms which:
- Help deliver the strategy for more out of hospital care within a very constrained fiscal environment
- Support the move towards outcomes based commissioning whilst acknowledging the need for some process metrics (about inputs and interventions) to demonstrate delivery towards the outcomes sought
- Reflect what the CCG intended to commission within its specification for services and not what it didn’t!
- Do not inadvertently incentivise more activity above that commissioned
- Enable services to be de-commissioned with a sensible conversation about co-dependencies
- Are ‘fair’ to the commissioner AND the provider and enable sensible conversations to be had, where contracts are ‘over or under heating’
- Secure greater alignment between the currency used for payment - e.g. fixed payment / local PbR / clusters - with the contracting arrangements within which delivery will operate, including different contracting models (e.g. prime contractor / vendor models) as well as different payment mechanisms
Enable CCGs to drive forward service transformation and redesign of care pathways across service settings
Enable ‘joined up’ delivery between organisations and aligned incentives, where that is the right thing to do ‘in the best interest of patients’
Provide an opportunity for longer term contracting based on a shared understanding of commissioner requirements and provider aspirations for delivery

Honest conversations about how we manage within the difficult fiscal environment will be key over the next few years. A shared understanding of risk by both commissioners and providers will be crucial.

The workshop also heard from commissioners from South Gloucestershire, who were in the process of letting a block contract for their community provision. They had sought to overcome some of the disadvantages commonly experienced with block contracting, by contracting for five years and developing a specification based around outcomes in domiciliary, outpatient and hospital-based services rather than specifying the delivery model. Bidders’ approaches to working with social care providers was also tested.

Learning from experience: mental health

- Mental health providers had been keen to find alternatives to block contracts for a number of reasons, including a lack of understanding by commissioners of mental health costs and activity, the associated risk of topslicing and the sense they were not taken as seriously as acute services. This has parallels with the views expressed by community providers.
- Paul Wilkin, Director of Finance, Rotherham, Doncaster and South Humber FT, expressed strong support for the development of currencies to pay for mental health services. The huge variation in patients and their journeys had made currency development very challenging – and this will be an issue in community.
- Stressed the degree of capacity and investment required in mental health in both the short and long term to make currencies work. They have already spent three years on this and there is still a long journey ahead, but the trust is already starting to see the benefits and gain a better understanding of their services.
- Emphasised the support of commissioners is crucial to the development of currencies, and in addressing challenges such as establishing that reference costs are different from the costs on which contracts are based.
- Had been able to adapt clinical systems to deliver the data needed for costing and payment, but they are not really designed to give activity and cost data and there can be issues around consistency. They do not yet have a standard outcome tool, but are looking to develop this as part of CQUIN, having already got an element of CQUIN on data quality.
- Peer support had been crucial in the process of developing currencies and benchmarking costs; this had been a key benefit of participation in the north east pilot.
- Emphasised that PbR needed to focus on patients’ pathways and the quality of their care. Clinical outcome measures are being developed for each cluster.
Learning from experience: acute sector

- Mike Dinan, Director of Financial Operations at the Royal Free London FT, addressed the common belief that acute trusts receive most of their income from PbR: his trust receives 45% of its income this way. NHS England is their largest single customer.
- Clinical commissioners have adopted different approaches to rising demand for care, with some using ‘cap and collar’ and some moving to block contracts in an effort to control costs rigidly.
- Would happily move to payment based on pathways and bundled outcomes.
- 'Best practice' or normative pricing, rather than average cost pricing, is also welcomed.
- As an example of an alternative to block contracting, the trust currently purchases a package of care from a community provider to deliver the later part of an acute episode of care in an out of hospital setting but still under the auspices of the acute team. Prices for bundles of care have been negotiated with the community provider which effectively acts as a provider to provider tariff.
- The trust also invests directly in its own and community staff as part of a rapid triage initiative to reduce unnecessary admissions and readmissions.
- Mike also highlighted the complexity of the current payment system and the desirability of approaches which are relatively simple to administer.

Learning from experience: service redesign and payment mechanisms in Liverpool

- Modelling had confirmed that PbR in its current form would not be sustainable for much longer in Liverpool's health economy, and that services will need to change. Local leaders had therefore come together to explore alternatives.
- Service change actions are likely to include development of a robust 'menu' of acute and non-acute support for urgent care, and the removal of duplicated specialist services. These areas need to be considered on a medium to long term basis, to allow for planned change.
- The need to move at pace to a new model is clear - the ability of the local health economy to support any dual running is declining every year, especially as efficiency savings are built into the prices paid by commissioners.
- Clinicians unanimously say that pricing could make or break the changes to services that will be required, and are also clear that pricing will not drive change.
- It will also be important to long term sustainability to consider how to incentivise all parts of the system to push self care and prevention.
- Clear that it would be difficult to develop the costing model sufficiently to unbundle costs into clusters - the work of district nurses, for example, would contribute across all three clusters.
- Felt that it would be more straightforward to move to bundled payments across a new system, where appropriate, but much harder to cost year of care payment, partly because data is still developing.
- They had also looked at including patient specified outcomes as one of the factors which determines the price paid, by simply adding or subtracting a patient outcome element from the overall price depending on whether the patient's specified outcome was met.
Liverpool is now at a point where they are reflecting on what the health and care system overall is looking to achieve, before reviewing whether the payment mechanisms they propose to adopt will support this. One thing they are seeking to do is develop an integrated model of care and then ensure the payment system enables this. They plan to:

- identify certain groups to trial bundled payments
- explore further how Year of Care would work in Liverpool
- develop a capacity-based approach for the reimbursement of urgent care.