Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

DH Department of Health

Maternity Services Pathway Payment System

A Simple Guide 2012/13

Gateway Reference: 17184

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The Royal College of Midwives

Introduction

This guide provides a summary of the proposed 2013/14 Payment by Results pathway funding system for maternity services. It also identifies what the NHS needs to do during 2012/13 to prepare for its implementation.

The Department of Health (DH), Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG), and Healthcare Financial Management Association (HFMA) are jointly publishing this guide.

History of Payment by Results

Payment by Results (PbR) is a payment per patient funding method; providers are due a payment each time they provide care for someone (i.e., every episode is paid for). It replaces other funding methods such as block contracts, which often provided fixed budgets irrespective of patient numbers or differences in patient complexity.

PbR was first introduced in 2003 for some elements of elective care. Since then, PbR has expanded to cover many other healthcare services, and is now the main funding mechanism between providers and commissioners of NHS care in England.

For further details on PbR, there is more information available on the DH website[1].

However, the system has not worked well for maternity care. In particular, there are problems with the way different organisations describe and record antenatal and postnatal non-delivery activity. These difficulties persist, despite changes implemented every year to attempt to resolve the problems.

The new pathway payment system from April 2013 aims to avoid these difficulties while also encouraging a more proactive and woman-focused approach to the delivery of maternity care.

[1] http://www.dh.gov.uk/health/category/policy-areas/nhs/resources-for-managers/payment-by-results/

Why the move away from 'episodic' PBR?

The episodic payment system provides payment for each inpatient spell, scan or hospital visit. In short, the more clinical interventions, the more a hospital is paid. Hospitals providing more proactive, community-based maternity care would in fact be worse off financially.

The new pathway payment system – in conjunction with choice and local contracts that focus on outcomes, quality and women's experiences – will remove these perverse incentives and free providers to develop the right services for their women without the prospect of losing income.

The pathway payment system is still a PbR payment system. It retains the important principle of 'money following the patient' while providing an incentive for prevention, and care closer to home.

This new payment system also expands the scope of Payment by results; care undertaken as part of local contracts – such as community antenatal and postnatal care – is covered by the pathway payment system instead.

How did we develop the pathway payment system?

The project began in September 2010 and involved a wide range of key stakeholders from the outset.

NICE guidance provided the initial foundation for the pathways, while clinical and commissioning experts developed the approach to allocating women to different pathway levels on the basis of their characteristics. Midwives across the country tested the system for two months, looking at the characteristics and factors affecting nearly 7,000 pregnant women.

In addition, several NHS providers undertook detailed costing work to ensure that the groupings created on the basis of service user characteristics really did bring together women that would consume similar levels of resources.

Using the information from the testing phases, price levels have been calculated to distribute the same level of total funding that has been spent

on maternity services in the past (approximately £2.5bn). The new pathway payment system changes the way money flows within maternity services, but has no impact on the overall level of funding.

What is different about this new payment system?

Under the new system, a commissioner will pay a provider for all the pregnancy-related care a woman may need for the duration of her pregnancy, birth and postnatal care. In general there will be no further payments for individual elements of activity, although there are a small number of clearly identified exceptions.

Each lead provider retains full responsibility for how they deliver care for their women, while commissioners will judge providers solely on how well they have delivered their overall service. The clear aim is to encourage proactive care and prevention, rather than reaction.

This responsibility remains even where a woman chooses to use a different provider, or is referred elsewhere, for an element of their care. In these circumstances, the lead provider, who has received the pathway payment for this woman, will be required to pay the second provider.

This 'single payment' approach contrasts with the current PbR mechanism, where each intervention or hospital attendance triggers additional payments.

What happens to the usual HRGs and other activity measures?

The current episodic system uses a number of "currencies" for payment. Healthcare Resource Groups (HRGs) cover the delivery events and a number of non-delivery related hospital admissions/ attendances. Other activity may be measured (and paid for) on the basis of outpatient attendances. There are also other forms of activity, such as home care checks, which are paid for outside of the PbR system.

In most cases, there is a set price or tariff for each unit of activity – for example for each HRG or outpatient attendance – and this is what a commissioner pays a provider organisation.

We will move away from the use of these currencies for payment purposes when we start using the new pathway system from 2013/14. However we will continue to collect – and publish - activity and costing information using these measures.

One of the uses of this data will be to inform how much a lead provider will pay a secondary provider if a woman is referred to, or chooses to access services at, that other provider.

What are the benefits of the new system?

The main emphasis of the new system is to ensure that women receive the highest quality, proactive maternity care that delivers the best outcomes and experience, and prevents the onset of avoidable conditions and complications.

This new system removes the financial reward for undertaking all interventions in a hospital setting, and delivers freedom to providers to deliver their services how they and their women deem best.

Overview of the pathway system

For payment purposes, the pathway is split into three stages. Women choose their lead provider for each stage of the pathway: antenatal care; delivery; and postnatal care. Commissioners pay once for each of these stages per woman.

This could mean three separate payments to the same lead provider or three payments to different lead providers.

At its core, the system is simple. And for most cases, it will provide a simple and easy to administer mechanism. However, it also needs to cope with non-standard events. Published 'business rules' provide transparent instructions on dealing with these issues, including:

- How to deal with choice or referrals where a different provider undertakes some elements of care.
- How to deal with a change in lead pathway provider and/or commissioner.

These rules are particularly important given that all providers of maternity care should be working

within a local network that ensures all choices are available to women throughout the maternity pathway.

2012/13 prices have been developed to ensure no drop in income for maternity services. To be exact, what this means is that if we took all the 2010/11 activity and paid for that using current 2012/13 PbR prices and local contracts, it would amount to £2.5bn of payments for maternity services. The same activity paid for under the pathway tariff would amount to exactly the same £2.5bn of funding. However, the fact that the new system provides 'per person' payments means that total income will change in line with the birth rate.

Antenatal care pathway

Although some elements of the antenatal care pathway may commence early in pregnancy, it is at the booking appointment where midwives collect comprehensive information on a woman's health and social care characteristics. This information is used to determine the payment level.

For antenatal care, the presence or omission of specific characteristics[2] allows categorisation of each woman into one of three levels of payment. These levels describe expected, average resource usage – *Standard, Intermediate* or *Intensive*.

Payment covers all antenatal care up to labour or induction. The Business Rules document details specific exclusions that are payable separately.

The main incentive is to deliver proactive, high quality antenatal care to prevent the onset of avoidable conditions throughout the whole maternity pathway, and to produce the best outcomes and highest levels of patient experience. This new emphasis may require a fundamental change to an organisation's current business model.

[2] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132663.pdf

The national proportions of women in each antenatal category, based on findings from the project, and the 2012/13 shadow prices (excluding Market Forces Factor[3]) are:

- Standard 65.5% £1,126
- Intermediate 27.3% £1,803
- Intensive 7.1% £3,000

Technical details on how the prices were developed can be found in the technical documents published on the DH website[4].

Intrapartum care pathway

Payments for the delivery itself will continue to be triggered by the specific codes attached to the birth/intrapartum spell. Providers should continue to code these in exactly the same way as they code them now.

However, the differently coded spells will be grouped to one of just two payment categories – "with complications or comorbidities" and "without complications or comorbidities"[5].

There will be no difference in payment for different methods of delivery - normal, assisted or caesarean section.

Normal deliveries are seen as having advantages for mothers and babies, where they are in line with mothers' preferences and in the absence of clinical indications to the contrary. The payment system aims to complement a culture based around normality. And it should

[3] The market forces factor provides a top-up to tariff prices for organisations to reflect unavoidable geographical cost differences principally related to staff, land and buildings

[4] http://www.dh.gov.uk/health/category/policy-areas/nhs/resources-for-managers/payment-by-results/

[5] The list of complications and co-morbidities can be found at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132715.pdf

support providers in developing an environment that attracts women to choose normality rather than intervention.

The national average proportions for with and without complications and comorbidities are shown below. The 2012/13 shadow prices (excluding Market Forces Factor) are also listed:

- With CCs 28.6% £2,434
- Without CCs 71.4% £1,506

Additional 'per day' payments will apply for patients who stay longer than pre-set durations (known as trim points).

Postnatal care pathway

The postnatal care pathway follows the same format as antenatal, with three levels of payment based on expected resource usage - *Standard, Intermediate* or *Intensive.* The relevant payment will be determined by a woman's specific health and social care characteristics and factors[6].

These factors and characteristics will include those collected at the antenatal booking appointment, but supplemented with information gathered throughout the previous stages of the maternity. There will be no need to collect "new" data.

The average proportion of women in each postnatal category, based on findings from the project, and the 2012/13 shadow prices (excluding Market Forces Factor), are:

- Standard 64.2% £243
- Intermediate 35.0% £307
- Intensive 0.8% £825

Next Steps - Shadow Year 2012/13

During 2012/13, providers should start recording the relevant information about their women.

6 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132665.pdf

This will enable them to understand their casemix and activity information, against which 2013/14 contracts can be developed with commissioners. This will also enable organisations to compare their current contractual income with what they would receive under the new pathway system.

Commissioners and providers should discuss and agree local outcome, quality and patient experience measures and expected levels of attainment for 2013/14, so that financial rewards and penalties can be built into contracts.

The DH will continue to develop the systems, engage further with stakeholders, and collect feedback on the implications and consequences of the new system.

Further information

More information on the Maternity Pathway PbR system can be found on the DH website at:

http://www.dh.gov.uk/health/2012/02/maternity-pathway-payment-system/

A suite of documents is available for download that explain in more detail:

- background to the development of the system,
- business rules for commissioning,
- further questions and answers,
- technical calculations, assumptions, and method for producing prices,
- the characteristics and factors that assign women to specific categories,
- what organisations need to do during 2012/13 and why, and
- templates that may help when collecting the information.

If you have any specific queries about Maternity Services and PbR that are not answered here or on the website, please email pbrcomms@dh.gsi.gov.uk