Shadow Year for Maternity Pathway Pricing

The Department of Health plans to introduce a new payment system for maternity services from April 2013.

The suite of published maternity documents (Feb 2012) provide background information on how and why the system has been developed, the structure of the system, how prices have been produced, business rules and frequently asked questions.

To prepare for the introduction of this new payment method, all maternity providers and commissioners will need to implement the pathway system during 2012/13 in order to commission using the currencies in 2013/14.

There are a number of key elements to this shadow year for every organisation:

- Development of baseline activity and casemix data in order that contracts between commissioners and providers can be agreed for 2013/14

  and

  Implementation of the data systems to collect information and flow the results to commissioners

- Understanding the financial impact of the change in payment system

  and

  A clear understanding of the networks and partner organisations that each provider works with throughout the flow of the whole maternity pathway

- Development of local outcome, quality and patient experience measures against which the commissioner will judge providers

  and

  Prioritisation of areas of the service to be focused upon for improvement

  and

  Development of strategies at providers in improving proactive care to prevent avoidable, costly unscheduled care

- An understanding of the underlying factors and characteristics that are prevalent in the local community in order that commissioners and public health can develop strategies to improve the health of their local populations to reduce the impact of complications in maternity care over time

Development of baseline activity and casemix data in order that contracts between commissioners and providers can be agreed for 2013/14

and

Implementation of the data systems to collect information and flow the results to commissioners

Antenatal

Initial information on the number and casemix of women for whom you receive the pathway payment is required. This is the information required for developing contracts with your commissioner.

Information is required for every woman, not just for the payment system, but to ensure that quality care is able to be provided to every woman based on their health and social care requirements.

Using the antenatal templates provided (either paper-based or spreadsheet or other local system), maternity staff undertaking the booking appointment should record the specific characteristics and factors that are relevant for each woman.

By aggregating the results of all booking appointments over a 3-month period to determine the proportion of women who are allocated to Standard, Intermediate or Intensive, this will provide a representative casemix for your population and can be compared with the national casemix.

National Average Casemix

	Antenatal	Births	Postnatal
Standard	**65.5%**		**64.2%**
Intermediate	**27.3%**		**35.0%**
Intensive	**7.1%**		**0.8%**
With CC		**28.6%**	
Without CC		**71.4%**	

You will also need to estimate information on

- the income and activity received from other lead providers for the care you provide for their women,
- the outgoings to other providers when they undertake care for your women

- transfers of lead provider status, both in and out.

Birth

Each of the birth HRGs, as currently coded, can be used to easily determine the proportion of births you undertake that are “with complications and comorbidities” and “without complications and comorbidities”.

The table below indicates how each HRG relates to the pathway HRGs, and the national proportions based on HES data

	With CC HRGs		Without CC HRGs	
Normal Delivery with CC	NZ11A	4.8%		
Normal Delivery without CC			NZ11B	32.7%
Normal Delivery with Epidural with CC	NZ11C	0.5%		
Normal Delivery with Epidural without CC			NZ11D	1.6%
Normal Delivery with Induction with CC	NZ11E	5.8%		
Normal Delivery with Induction without CC			NZ11F	16.3%
Normal Delivery with Post-partum Surgical Intervention	NZ11G	2.7%		
Assisted Delivery with CC	NZ12A	0.8%		
Assisted Delivery without CC			NZ12B	1.9%
Assisted Delivery with Epidural with CC	NZ12C	0.6%		
Assisted Delivery with Epidural without CC			NZ12D	1.1%
Assisted Delivery with Induction with CC	NZ12E	2.7%		
Assisted Delivery with Induction without CC			NZ12F	4.0%
Assisted Delivery with Post-partum Surgical Intervention	NZ12G	1.1%		
Planned Lower Uterine Caesarean Section with CC	NZ13A	2.5%		
Planned Lower Uterine Caesarean Section without CC			NZ13B	6.3%
Emergency or Upper Uterine Caesarean Section with CC	NZ14A	5.5%		
Emergency or Upper Uterine Caesarean Section without CC			NZ14B	7.5%
Caesarean Section with Eclampsia, Pre-eclampsia or Placenta Praevia	NZ15Z	1.6%		
		28.6%		**71.4%**

This information should be used to aid development of contracts between proividers and commissioners.

Postnatal

Initial information on the number and casemix of women for whom you receive the pathway payment is required. This is the information required for developing contracts with your commissioner.

Information is required for every woman, not just for the payment system, but to ensure that quality care is able to be provided to every woman based on their health and social care requirements.

Using information from the antenatal and delivery periods, the postnatal template provided (either paper-based or spreadsheet or other local system) should be completed for every woman to record the specific characteristics and factors that are relevant for each woman.

Previous testing of this area showed that much relevant information was not shared with the postnatal maternity staff. Unless this information is shared, it is likely that a lower level of care than deemed to be required will be delivered, resulting in lower levels of outcomes.

By aggregating the results of all postnatal data over a 3-month period to determine the proportion of women who are allocated to Standard, Intermediate or Intensive, this will provide a representative casemix for your population and can be compared with the national casemix.

We do not anticipate there will be much activity in terms of postnatal care provided by other providers nor transfers of lead provider. However, feedback on this would be useful.

Please note the specific issues in the Business Rules that would require immediate hospital care, but that are also paid separately outside the Pathway system through PbR HRGs.

Understanding the financial impact of the change in payment system, and

A clear understanding of the networks and partner organisations that each provider works with throughout the flow of the whole maternity pathway

We have supplied a spreadsheet, Shadow Year Template A, which providers could use to estimate the impact of the current pathway prices against their current planned contract value.

Development of local outcome, quality and patient experience measures against which the commissioner will judge providers, and

Prioritisation of areas of the service to be focused upon for improvement, and

Development of strategies at providers in improving proactive care to prevent avoidable, costly unscheduled care

Commissioners and providers should use the shadow year to develop an understanding of the outcomes, and metrics to measure those outcomes, against which a CQUIN-style financial incentive/penalty can be applied alongside QIPP improvements.

This will require an understanding of the specific areas where commissioners would like to focus for improvement, which need to be based on outcomes, quality and patient experience evidence.

An understanding of the underlying factors and characteristics that are prevalent in the local community in order that commissioners and public health can develop strategies to improve the health of their local populations to reduce the impact of complications in maternity care over time

The information collected through the pathway system – and/or the Maternity Minimum Dataset – will provide a rich source on the underlying health characteristics of the child-bearing population in your locality.

Sharing summarised results of that information may bring to the fore some issues of which NHS and public health commissioners may not have previously been aware. Public health strategies can then be commenced to reduce the incidence and prevalence of specific issues over time, which may lead to better outcomes in pregnancy.