Monitor
Making the health sector work for patients

NHS England

The maternity pathway payment system: Supplementary guidance

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Contents

Introduction

Purpose of this document

This document provides supplementary guidance to the '2014/15 National Tariff Payment System' (Annex 4A)[1] on the maternity pathway payment system for providers and commissioners implementing the pathway for the 2014/15 tariff onwards. In particular, this document:

- clarifies whether particular services are included or excluded from the pathway payment
- provides guidance on implementing the pathway system through establishing appropriate data flows and contracting and invoicing arrangements.

Context

The maternity pathway payment system was first mandated for use in April 2013. It was introduced to address two main issues arising from the previous episodic payment system:

- variance in the way organisations described and recorded antenatal and postnatal non-delivery activity
- organisations being paid for each inpatient spell, scan or hospital visit, possibly counter to the interest of some patients who would benefit from more proactive care, delivered closer to home.

As well as resolving these issues, the new system aims to encourage a more proactive and woman-focused approach to the delivery of maternity care. It also includes some services that were previously part of local contracts and not covered by mandatory national prices, such as community antenatal and postnatal care.

For payment purposes, the maternity pathway payment system is split into three modules, each of which is paid separately:

- antenatal
- delivery
- postnatal.

For the antenatal and postnatal pathways there are three case-mix levels – standard, intermediate and intensive – with higher payments for intermediate and intensive.

[1] See section 6.4.1 of the '2014/15 National Tariff Payment System', together with Annex 4A (available at https://www.gov.uk/government/publications/national-tariff-payment-system-2014-to-2015)

There are two prices for the delivery element of the pathway, split by whether or not there are complications and co-morbidities at a specified level that require additional care.

An intrinsic part of the new system is that a single payment (per woman per module) is made by a commissioner to a lead provider. The lead provider is responsible and accountable for all the care provided within the module, even if some elements are delivered by other providers. The lead provider reimburses the other providers from its single pathway payment. The maternity pathway therefore not only affects the way that commissioners and providers interact, but also, significantly, the way that providers work with other providers.

Inclusions and exclusions from the pathway payments

Pathway payments are essentially single payments for bundles or packages of care, rather than for separate contacts or episodes. Both providers and commissioners need to be clear about what is included in the package of care and what is excluded from it (and therefore must be paid for separately). These inclusions and exclusions are set out in Table 4A-15, found in Annex 4 of the '2014/15 National Tariff Payment System' document (the 2014/15 National Tariff).

In this section, we provide further detail about particular services where providers and commissioners have raised questions.

Early pregnancy unit and emergency gynaecology activity

Providers and commissioners have asked us to clarify whether certain activities that take place in emergency gynaecology or early pregnancy units are included or excluded from the maternity pathway.

a) Treatment function code 502 activity

In most cases, activity in emergency gynaecology or early pregnancy units will code to treatment function code (TFC) 502 (gynaecology) and will have a non-NZ healthcare resource group (HRG). This activity is **excluded** from the pathway payment (see the 2014/15 National Tariff, Table 4A-15).

However, many providers appear to have small amounts of activity that correctly codes to TFC 502 with an NZ (obstetric) HRG. Given that all NZ HRGs relate to pregnancy and the associated costs are included in the quantum, activity that does code to an NZ HRG is **included** within the pathway payment.

b) NZ HRG activity occurring before the first antenatal appointment

The 2014/15 National Tariff (Annex 4A, paragraph 5.4) states that the antenatal pathway starts at the first antenatal appointment with a provider (usually at around 10 weeks' gestation). Given that some early pregnancy unit and emergency

gynaecology activity occurs **before** the antenatal pathway starts, the question has been raised whether funding for that activity is included or excluded in the pathway payment.

We consider that this activity is **included** within the maternity pathway, and should not be invoiced for separately, for the following reasons:

- As stated above, all costs associated with the NZ HRGs are included in the quantum that determines the maternity tariffs. In other words, funding for this activity is already reimbursed through the existing pathway payment.
- All providers should be equally affected by the small amount of activity with an NZ HRG which takes place in early pregnancy units before the first antenatal appointment. As such, no provider should be unfairly disadvantaged by not being able to invoice separately for this activity.

c) Outpatient activity that should generate an NZ HRG if coded

Currently providers are not required to derive HRG codes for outpatient activity. We recognise that this might encourage providers to change practice and not to derive HRGs for activity with TFC 502 where this would generate an NZ HRG. However, if HRG codes are derived that are not TFC 502, we consider that this would constitute a change in coding and counting practice, and as such would be covered by the following condition in the NHS standard contract:[2]

> 'Either the Co-ordinating Commissioner (on behalf of the Commissioners) or the Provider may propose a change of practice in the counting and coding of activity compliant with national information and data standards. The Party proposing such a change must give the other Party written notice of the proposed change at least 6 months before the date on which that change is proposed to be implemented.'

We strongly encourage all providers to code all outpatient activity that would derive an NZ HRG.

Screening and immunisation

To dispel uncertainty about which elements of screening and immunisation programmes are included within the maternity pathway payment, screening and immunisation activity associated with maternal and neonatal care that is part of the national screening programme is **included** in the maternity pathway payment (2014/15 National Tariff, Table 4A-15).

The costs associated with this activity were not separated from the maternity HRGs or TFCs, and so are included in the quantum that determined the maternity pathway tariffs. NHS England issued guidance for providers and commissioners on this

[2] Available at: www.england.nhs.uk/nhs-standard-contract/

matter in January 2014 which is available at: www.england.nhs.uk/wp-content/uploads/2014/01/who-pays-for-what-fin.pdf

Fetal medicine

Fetal medicine is a specialist activity that has its own clinical reference group (CRG) responsible for specifying the service. We are aware providers and commissioners have been uncertain whether funding for fetal medicine (previously paid for directly by strategic health authorities rather than primary care trusts) is included in the maternity pathway payment. Despite the difference in the source of funds, we can confirm that specialist fetal medicine activity codes are included and costed into NZ HRGs.

As previously stated, all costs associated with the NZ HRGs were included in the maternity pathway payment system quantum that was used to derive the tariffs. This means there is no separate funding to reimburse fetal medicine service costs through direct contracts with NHS England specialised commissioning. Specialist providers of fetal medicine should invoice the lead provider for this activity. NHS England had issued guidance on coding and charging for fetal medicine in March 2014. Appendix B provides a copy of the circular that was issued as guidance.

We are working with the reference costs group to investigate activity coding for fetal medicine. If this activity can be differentiated from other antenatal activity and the costs can be reported separately, it may in future be possible to consider fetal medicine separately and contract centrally for these services. This would result in a corresponding reduction in the maternity pathway payment.

Coding specialist activity

In some cases, a woman on the intermediate or intensive pathway will receive care from other medical or surgical specialties **in addition** to the care they would have been receiving from that specialty if they were not pregnant. This is usually the case when pregnancy may affect an underlying medical condition. The new pathway payment system aims to include all care that a woman needs as a result of pregnancy, regardless of setting. We are aware providers have not coded and recorded such activity in a consistent manner.

To code activity in specialist clinics in a consistent way, providers should:

1. Use codes TFC 501 or 560 for all activity when the main reason for attendance is pregnancy, regardless of the medical specialty. This activity and its costs are included in the maternity pathway (that is, providers will not receive extra income outside the pathway payment). This principle applies regardless of whether the clinic provides other medical specialities that would use other TFCs.

2. Include these costs in the reference costs for TFCs 501 or 560 so that the future maternity quantum can take account of these costs.

3. Not attempt to operate specialty clinics for pregnant women where patients are coded to TFCs other than 501 or 560.

Data flows, contracting and invoicing

Update on the national maternity dataset

The national maternity dataset was originally expected to be in operation from October 2013. After some delay, it is now expected to be in use from April 2015.

The dataset will contain most of the data items needed to determine the pathway a woman is on (a few data items will not be included as part of the first release but will be added in later releases). Providers will not, however, be able to directly determine the lead provider for any woman from this dataset in the first instance. The dataset will be adjusted to provide this information in future releases.

Until the dataset is in use, we advise providers and commissioners to develop local arrangements to help identify the lead provider and resolve billing and invoicing issues. You can find further information on this in the following sections and in Appendix A.

Data flows for invoicing

Currently, there is no flow of activity information between one provider and another. Providers must establish a lawful basis to share activity information between themselves for the purposes of commissioning and invoicing. As this data is used for other reasons besides direct care (ie it is a secondary use) it requires an identified lawful basis under Schedule 2 and Schedule 3 of the Data Protection Act as well as consideration of the common law duty of confidentiality.[3]

Some providers ask women formally to consent to the use of their personal and confidential data (PCD). Providers wishing to do so may choose to use the following text in seeking permission from their patients:

"I _____, agree that for administrative purposes my personal information may be shared with other bodies providing me with maternity services."

It is important to remember, however, that any consent given is only valid for the particular purpose requested and time period specified. Your request for consent may be a useful opportunity to check who the woman's lead commissioner is; it may also be useful to request for consent for other purposes such as clinical and fiscal

[3] See Data Protection Act 1998, Schedule 2 or Schedule 3, at: www.legislation.gov.uk/ukpga/1998/29/contents

audits at the same time. If consent is not provided, the PCD of the patient cannot be used for these secondary purposes.

When seeking consent, it is important to provide clear and reassuring details about the proposed use of the patient's personal data: why it is necessary, how it helps both the patient and the healthcare provider. It is also important to ask the woman at an appropriate time, and to reassure her about the confidentiality and security of the information she provides.

Providers are also encouraged to speak to their organisation's information governance lead, who will be dealing with similar issues as part of the annual assurance review in the Information Governance Toolkit for both data flows and contracts.

Determining the lead provider

The antenatal pathway starts at the first antenatal assessment visit. At this point, the midwife makes an initial assessment of the pathway the woman will follow based on her medical history, results of the first scan and sometimes a blood test. As this information is required to determine the pathway, the 'lead provider' is defined as the provider undertaking the antenatal assessment. Other providers who deliver other elements of a woman's care should invoice the lead provider.

(i) Problems with identifying the lead provider

Problems can arise for other providers when the identity of the lead provider is not available to their finance departments for invoicing purposes. For most healthcares under the national tariff payment system, providers invoice a commissioner directly for the activity that they undertake (usually determined by the patient's GP code). However, for the maternity pathway, a provider may need to identify the lead provider in order to invoice for a particular patient.

Providers should consider:

- Developing internal systems to ensure that the lead provider is recorded in the woman's record (for example, providers can ask women for whom they do not have a record of an assessment who their lead provider is). This information should be made available to the finance department for invoicing purposes.
- Using the woman's GP code to identify the likely lead provider, where there are established patterns of provision. This is particularly relevant where women consistently access community midwifery services from a provider local to where they live (and which has acted as lead provider for antenatal care) but where they travel to a different provider for other key elements, such as scans and blood tests.

- Data Services for Commissioners Regional Offices (DSCROs) and Stage 1 Accredited Safe Havens (ASHs) associated with commissioning support units (CSUs) may be able to help providers and commissioners to identify the lead provider and support cross charging using local hospital IDs (patient identification numbers unique to each provider) and the local service level agreement monitoring (SLAM) reports. An example of how this can be done is included in Appendix A.

(ii) Problems with double booking

Some women, particularly in urban areas, go to more than one provider for an assessment visit. This may be because they do not find the first provider they attend convenient or for other reasons of personal preference. If this is not clearly communicated, both the first and other providers may think that they are the lead provider and invoice the commissioner for the same woman. Commissioners receive aggregated data and are unable to identify which patients they are being invoiced for, leaving them at the risk of paying twice for the same care.

Providers and commissioners need to put in place enduring policies and processes to minimise this risk. Commissioners should encourage their GPs to explain to women the importance of only booking once. In addition, providers should routinely check with women if they have already 'booked in' with another provider (women can of course choose to have elements of their pathway at another provider – but this provider cannot charge the commissioner as the lead provider).

Contracting issues

Under the maternity pathway payment system, the lead provider is clinically responsible for all the care within the pathway and will receive the full pathway payment from the commissioner. The commissioner and lead provider must have an NHS Standard Contract in place between them. Where maternity care is routinely shared by two providers, the lead provider should establish a sub-contract between itself and the other provider, setting out their obligations to each other in respect of the pathway and to each service user, and reflecting the NHS Standard Contract (and the relevant service specifications under it) that the lead provider has with its commissioner. Depending on the status of the respective providers (ie whether NHS trust, NHS foundation trust or independent sector) this arrangement may or may not have the status of a legally binding contract. The prices payable by the lead provider to the other provider for the services it delivers under this arrangement will be agreed between them, but NHS England has published non-mandatory episodic prices as a guide.

Where there is no formal written sub-contract in place, the relationship between the lead provider and the other provider will still be that of provider and sub-contractor.

By analogy with non-contract activity, the contractual obligations of the second provider to the lead provider (including service specifications) should be:

- deemed to reflect those set out in the NHS Standard Contract, in which the other provider has its own local commissioner
- in accordance with those obligations that the other provider should be expected to deliver the services it provides.

However, payment for this activity in this case will be made by the lead provider. Unless there is an alternative agreement, the prices payable by the lead provider to the other provider for the services it delivers will be agreed between them, but NHS England has published non-mandatory episodic prices that may be used as a guide.

Handling income/expenditure on maternity across the year end

Antenatal care often spans more than one financial year. To provide further guidance on how this should be treated in the context of the maternity pathway payment, Monitor, NHS England, the NHS Trust Development Authority, the Audit Commission, and the Department of Health issued additional information in the maternity pathway accounting guidance, available here: Maternity Pathways Accounting Technical Guidance.

Appendix A: CSU support in implementing the maternity pathway payment

Given some of the difficulties around identifying the lead provider in particular circumstances, some commissioning support units (CSUs) have been providing assistance to trusts by verifying and checking patient level information that cannot be passed between trusts or between trusts and commissioners. The section below provides an example of the work that NEL CSU has done in assisting the implementation of the maternity pathway payment system.

NEL CSU has evolved these solutions over time with assistance from the Data Services for Commissioning Regional Office (DSCRO) as well as the Stage 1 Accredited Safe Haven (ASH). This work has involved reviewing processes and ways of working, then adapting them to current circumstances. Where possible the service provided at NEL CSU has automated processes.

In all circumstances, NEL CSU have reviewed each stage of a data flow and ensured that it was lawful with the appropriate controls in place.

Example: provided by NEL CSU

The pathway approach calls for a significant change in the monitoring and linkage of datasets, both within and across providers. The only organisations who can have access to multiple providers' data to enable these linkages are DSCROs and CSUs operating as Stage 1 Accredited Safe Havens (ASH). As such, they can provide an important role in implementing the maternity pathway system.

The NEL CSU operates a solution that utilises data within the NEL DSCRO and NEL Stage 1 ASH. For simplicity the example below will be referred to as the NEL CSU solution but anyone using it should be clear that at each point those processing the data have a legal basis to do so.

NEL CSU receives data submitted from all trusts where maternity activity takes place but concentrates further analysis on the eight trusts that provide local maternity services in north and east London. This data includes:

- NHS number
- local hospital identification number
- maternity pathway type
- maternity pathway start date
- provider submitted point of delivery (POD)
- provider submitted HRG

- CDS date or charge date of activity
- total charged for the line of activity or pathway.

The most important field in this data submission is the patient's NHS number as it is the only unique identifier across providers. It allows accurate analysis of the maternity data flows to prevent commissioners paying twice and can resolve cross charging issues. Not all of the other fields will be populated in all cases. For example, the HRG field may not be populated by the trust for activity in some points of delivery (for example outpatient activity) and therefore stays blank.

The NEL CSU also receives the local service level agreement monitoring (SLAM) reports. Based on the above data the CSU can enable the implementation of the pathway by:

- Identifying and sharing information about the lead provider and supplying the local hospital identification number to help resolve cross charging issues as due to information governance restrictions, the NHS number (from the lead provider) cannot be shared with the other provider for invoicing and billing purposes. Therefore local hospital identification numbers are provided along with the lead provider codes for records being challenged.
- Challenging providers on the data that they have submitted to ensure that commissioners are being fairly invoiced.

Some of the main data checks and issues that NEL CSU helps to resolve are as follows:

Maternity activity with missing or invalid NHS number

Where commissioners cannot identify a patient receiving care via the NHS number, the check for potential cross-charging from multiple providers cannot be undertaken. In this case a payment is not made until the CSU has received assurance the trust is the lead provider for the woman's care.

Multiple delivery admissions within nine months

This identifies all delivery admissions being charged by providers that occur within nine months of a previous delivery admission date for the same patient. The CSU challenges any subsequent delivery admissions as these may have been billed incorrectly and are probably either duplicates or activity that has been incorrectly coded (it is accepted that after further provider checks, a small number of these may indeed be multiple deliveries within nine months).

Activity charged in SLAM reports with incorrect lead provider

This identifies all maternity activity charged by providers within local SLA monitoring reports, where the patient is registered with another provider as the lead provider. Providers are required to cross charge the lead provider for this activity and not raise duplicate charges to commissioners.

The lead provider is considered to be the first provider to submit the requested maternity case mix template within a two-week window of the first booking appointment. Where no provider has identified itself as the lead provider via submission of the template, the lead provider is considered to be the first provider to treat a patient on the current stage of the maternity pathway.

Activity not charged in SLAM with incorrect lead provider

This identifies all maternity activity reported but not charged by providers within local SLA monitoring reports for activity where the patient is registered with another provider as the lead provider. This activity has not been charged to commissioners, however by flagging the lead provider of this activity, it can enable cross charging between trusts and financial recovery to be reclaimed from the lead provider.

Maternity pathway charging not supported by maternity casemix data submission

This identifies activity charged as part of the maternity pathway that is not supported by a maternity casemix data submission. This can prevent confirmation that the trust is the lead provider for the patient as well ensuring that the patient's conditions and complexity support the casemix level that is charged (i.e. standard, intermediate or intensive). The CSU will challenge the provider for more information on the casemix and ensure the appropriate tariff can be paid**.**

Activity charges which should be covered as part of the maternity pathway tariff

This identifies activity that is charged separately to commissioners by the lead provider outside the pathway tariff, which should be included within the maternity pathway tariff. As a result this activity should not attract a separate payment, and should be covered by the maternity pathway payment that is also made to the lead provider. Similar to above, the CSU provides the local hospital ID numbers along with the pathway start date to enable providers to identify the activity and potentially cross charge each other.

Complexity level of the delivery pathway not evidenced

This highlights activity charged to Commissioners within Local SLA monitoring Reports that are charged at the complex delivery tariff that do not contain sufficient details to validate and confirm that a complex delivery charge should be accepted.

The CSU will request further evidence of the complex delivery having been performed. Otherwise, the standard delivery tariff is paid**.**

Charging is not done at the correct tariff

This identifies activity charged to commissioners that is not charged at the nationally published tariff rate. The CSU will challenge the provider on the difference between the charged value and the published tariff for the activity.

For further information, please contact:

Sue Anderson – Deputy Director, Claims Management, NEL CSU
Sue.Anderson@nelcsu.nhs.uk

Specialised Services Circular

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Specialised fetal medicine coding and charging for 2014/15

Circulation

For action	**For information**
Area Team Directors of Commissioning Area Team Heads of Specialised Area Teams to circulate to: Acute Trust Chief Executives; Acute Trust Medical Directors Commissioning Support Units (CSUs) Strategic Clinical Networks leads Clinical Reference Group Chair: Fetal Medicine CRG for onward circulation relevant CRG members National Clinical Director (Women and Children)	Regional Directors of Commissioning Regional Heads of Specialised Commissioning Regional Finance Leads

Background

From April 2013 NHS England took on the direct commissioning responsibility for specialised fetal medicine services as outlined in the list of prescribed specialised services and further expanded in the published manual http://www.england.nhs.uk/wp-content/uploads/2014/01/pss-manual.pdf . A supporting service specification E012 was published in April 2013

http://www.england.nhs.uk/wp-content/uploads/2013/06/e12-fetal-medi.pdf

NHS England developed and introduced identification rules (IRs) for specialised fetal medicine services. On further investigation it has become clear that these contain an anomaly; all fetal medicine charges should be included in the maternity pathway payments as determined by the 2014/15 National Tariff Payment System guidance.

Summary

As a consequence of the introduction of the maternity pathways payment ALL fetal medicine, including specialised, should be part of a recharge or SLA between maternity provider units for 2014/15. (Ref: Page 80; 2014/15 National Tariff Payment System guidance - Annex 4A: Additional information on currencies with national prices). NB Specialised fetal medicine services remain the direct commissioning responsibility of NHS England but the funding sits in the maternity pathways payment system – Area Teams should not be making additional direct payments.. The strategic planning, clinical governance oversight remain part of NHS England specialised services supported nationally by the fetal medicine clinical reference group.

During 2014/15, commissioned specialised fetal medicine providers are requested to continue to submit activity information to NHS England in the same format as currently, or any amended format already agreed with their Area Teams, but NHS England will not pay for this activity directly for 2014/15. Where providers do not currently identify fetal medicine activity, they should do this from 2014/15. Further guidance on this will be provided in the near future. Providers should instead ensure they have appropriate arrangements in place for invoicing referring Trusts, where appropriate, for this activity as part of the maternity pathways payment structure.

The maternity pathways payment system is structured in such a way that payment for the antenatal episode is made to the provider who commences the first antenatal appointment of attendance (the 'lead' provider). Where there is a fetal medicine referral for a specialised opinion and a woman is referred elsewhere, the lead provider, who has received the pathway payment for this woman as the booking hospital, will be required to pay the second provider under recharging arrangements.

Action

Area Teams are asked to ensure that this information is disseminated to providers, contract leads, CSUs and SCNs and implemented as part of the negotiation of 2014/15 contracts.

Further Information

Please send any queries to Jacquie Kemp jacquiekemp@nhs.net

	
James D Palmer National Clinical Director Specialised Services	**Pia Clinton-Tarestad** Head of Specialised Services

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

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