

Maternity Services and Payment by Results – A Simple Guide – Updated 2009/10 Version

Gateway Reference: 11971

This guide updates the previous *Simple Guide to Payment by Results and Maternity Services* and seeks to provide an easy to understand summary of the Payment by Results funding system and how it works. It is published jointly by the Department of Health (DH), Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG), who have collaborated on this.

Background

Payment by Results (PbR) was first introduced in 2003, replacing funding through historic budgets. It allows for greater transparency in NHS funding, with organisations reimbursed based on the care women receive.

PbR reimburses activity at an organisational level, not a service level. There have been substantial real terms increases in the prices paid for maternity care in recent years.¹ Real terms increases relates to those increases not accounted for by inflation, such as rising pay costs. However, whilst this extra money is going to Trusts, it is not always reaching maternity service budgets.

¹ For instance the real term increase in the price for assisted delivery without complications in 2009/10 is over 7%.

Your Contribution:

Has your maternity service budget increased to reflect more money coming through PbR? Discuss with your finance colleagues.

For inpatient care, PbR uses Healthcare Resource Groups (HRGs). HRGs are a unit of payment. Each HRG is paid for on an individual patient spell basis. In developing HRGs groups of patients having a similar diagnosis and/or undergoing a similar procedure using similar amounts of resource are grouped together. Most will have a national set price, or tariff.

When a hospital treats a patient, their diagnosis and treatments are recorded and coded. This information determines which HRG the patient is assigned to and the appropriate tariff is received. The hospital will then receive the appropriate tariff payment.

Clinical coding is the process whereby information written in the patient notes is translated into coding data and entered onto hospital information systems. 10 top tips developed by the Health Informatics Unit at the Royal College of Physicians can be found at: <http://www.rcplondon.ac.uk/clinical-standards/hiu/Documents/Top-Ten-Tips-for-Coding-A-Guide-for-Clinical-Staff.pdf>

For outpatient consultations, hospitals are paid for an attendance, with the treatment

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function code being used to identify the specialty e.g. obstetrics. Each specialty has two groups of outpatient activity, first appointment and follow-up appointment, each with their own national tariff.

The national tariff for each HRG and outpatient code is based on the average cost of treatment. This explains why the tariff for caesarean section is higher than the tariff for normal birth – a caesarean section simply costs more (e.g. in clinical time and requiring more senior, expensive staff) than a normal vaginal birth.

Costs are reported by the NHS each year as part of the annual reference cost exercise. It is vital that organisations return accurate costings related to the activity during this yearly exercise. This will help us ensure that the tariff is set at a sustainable long-term price and reflects the true cost of providing services, including work with social services, patient advocacy etc. All the major costs need to be included such as staffing and consumables, as well as overheads such as the premium for the Clinical Negligence Scheme for Trusts, of which a considerable proportion relates to maternity services and use of NHS premises. As tariff is based on the average of the reference costs (at its crudest)², if your trust is efficient and has

below average costs, it will benefit from the tariff making it profitable to attract more activity.

Your Contribution:

Are the reference costs for your maternity services accurate? Speak to your finance colleagues.

Are you involved in the return of costs for your maternity service? If not ask your finance colleagues to be involved.

How do your costs compare with similar units?

The national tariff is paid by the commissioner (e.g. the PCT or Practice Based Commissioner) to the provider. It is actually the minimum that a provider receives, because a Market Forces Factor (MFF) adjustment is applied to take account of the fact that it is more expensive to provide services in some parts of the country than in others. The average MFF for England is 8.5%. You can find out what your Trust's MFF is on the DH website³.

decisions, exclusion of costs relating to drugs and devices and to include the conversion of data based on episodes to data based on spells. Further information can be found on the DH PbR Website at:

http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_081238

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http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091793

² Various normative adjustments are made to the average of the reference costs, for instance to reflect excess bed days, policy

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obstetrician/midwife and another specialist e.g. a diabetes doctor/nurse.

- Midwifery led services (TFC 560) now attracts the same tariff as consultant led (TFC 501). This will allow midwife-led community outpatient services to be reimbursed on the same basis as an obstetric outpatient appointment;

- Introduction of non-mandatory non face-to-face consultation tariff set at £23. The tariff is designed to apply where there is an opportunity for discussion between patient and healthcare professional. For instance, a telephone call to explain the implications of test results to a woman would warrant the use of this tariff, but a telephone call, text or e-mail to report a result would not. The introduction of this tariff is intended to support the replacement of face-to-face activity with a more convenient option;

- Increases in prices to accommodate increased Clinical Negligence Scheme for Trusts payments;

- Obstetric outpatient price increase by £20million to reflect a more complex casemix and additional antenatal visits to address late-bookers as part of the Maternity Matters commitment. **This is the only Maternity Matters Funding to flow through tariff (see paragraphs 20,21 Payment for Results Guidance for 2009-10)**

Summary of key changes for PbR and Maternity Services 09/10

- Introduction of HRG4, introducing splits for adults and children and more HRGs for non-birth admissions;

- Reimbursement for joint clinics involving both an

Which Maternity Services are funded through Payment by Results?

Birth

(table 1)

HRG	HRG	2009/10	Long	Excess
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Label	Description	Prices	stay trim point	bed day payment
NZ01A	Normal Delivery 19 Years and over with CC ⁴	£1,881	9	£408
NZ01B	Normal Delivery 19 years and over without CC	£1,174	4	£362
NZ01C	Normal Delivery 18 years and under with CC	£1,921	9	£403
NZ01D	Normal Delivery 18 years and under without CC	£1,177	4	£385
NZ02A	Assisted Delivery with CC	£2,288	7	£394
NZ02B	Assisted Delivery without CC	£1,728	6	£346
NZ03A	Caesarean Section 19 years and over	£2,579	7	£420
NZ03B	Caesarean Section 18 years and under	£2,654	7	£327
NZ03C	Caesarean Section with complications	£3,626	8	£346

While most HRGs have two national tariffs, one for elective and non-elective care, the very nature of birth as an unscheduled event means that it does not make sense to have this distinction. Table 1 shows the new maternity delivery HRGs and prices for 2009/10.

⁴ CC = complications and comorbidities. Examples include moderate pre-eclampsia or single plasma exchange

The national tariffs apply regardless of whether the birth occurs in an obstetric unit, a co-located midwife led or a stand-alone midwife led unit.

For 09/10, home births continue to receive the same tariff as a normal delivery over 19 years without complications. Further work remains to be done to identify the long term sustainable price for home birth activity.

If mothers have to stay in a maternity unit for a longer than expected period of time after giving birth, (for clinical reasons relating to the mother, not the baby), then that is what is known as excess bed days, which are then paid to the hospital on a per day basis, in addition to the tariff. When excess bed days start being paid, depends on the length of stay that is set as a “trimpoint”. For instance, the trimpoint for NZ03B (Caesarean Section for 19 years and over without complications) is 7 days. This means that a payment of £2,579 is applicable to any length of stay up to 7 days. However, after 7 days, for each day that a woman stays in hospital, an excess bed day payment is made – the payment per day is £420.

Your Contribution:

Are you recording delivery outcomes accurately to reflect the new HRGs?

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Are you recording lengths of stay accurately?
Are your information systems recording home births to ensure you are paid for them?

501	£145	£145	£65	£78
560	£145	£145	£65	£78

Antenatal Care (care during pregnancy)

The tariff for births, only relates to the actual birth event and the costs associated with it – it does not include antenatal care.

A major change for 2009/10 is that all antenatal clinics are subject to a national tariff, regardless of whether they are consultant or midwife led. Antenatal care for which a consultant is clinically responsible (even if the actual clinic is carried out by a midwife) should be coded as speciality 501. If the clinic is the responsibility of a midwife it should be coded as 560.

As table 2 shows, in 2009/10 the same price has been set for both types of outpatient activity.

It does not matter where the clinic is located, it could be in a hospital or in a community setting such as a Children's Centre. The main distinction on community-based services not within the scope of PbR is services provided at home, due to the limitations of current data definitions and flows. However, to receive payment, the organisation will need to report through the Payment by Results Secondary User Service, which will require them to have robust information systems to support the service.

Table 2 sets out the prices for multi-disciplinary team consultations. This could be when a pregnant woman also has a consultation with a diabetic nurse at an outpatient appointment.

Work is ongoing with the National Screening Committee to clarify funding arrangements for Fetal Anomaly Screening in 09/10 – although a national screening programme, when it was introduced 75% of Trusts were already carrying out some form of screening and so no additional funds were provided. This means that some trusts will have included the costs of Fetal Screening in their reference costs, but others will not. For the guidance supporting the collection of NHS

(table 2)

Outpatient Code	First Outpatient (Single Professional)	First Outpatient (multi-professional)	Follow Up – Single Professional	Follow Up - multi-professional
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Reference Costs in 08/09, DH have sought to clarify the position in relation to the collection of costs attributed to the NHS Screening Programmes. Nationally, work is ongoing to identify the most appropriate means of addressing issues relating to the costs of screening, and whether or not tariff is the most appropriate means of taking this forward. For the purposes of 09/10, existing arrangements should be continued.

Antenatal admissions

There are HRG codes for antenatal contacts and admissions not related to women giving birth. HRG4, now offers a greater range of maternity codes, including age splits between adults and children. This will be particularly beneficial for better differentiating between episodes of care that previously grouped to N12s.

While these prices reflect the costs as reported by providers to the DH, there is some concern at their applicability in all cases, and work is continuing to refine pricing in this area for 2010/11.

NZ04A	Clinical Contact for Observation (ante-postnatal) 19 years and over	£499	1	£382
NZ04B	Clinical Contact for Observation (ante-postnatal) 18 years and under	£499	1	£366
NZ05A	Clinical Contact for Investigation (ante-or-postnatal) 19 years and over	£708	1	£394
NZ05B	Clinical Contact for Investigation (ante-or-postnatal) 18 years and under	£708	1	£404
NZ06Z	Clinical Contact with full investigation (ante or postnatal)	£731	1	£415
NZ07A	Admission for observation only 19 years and over	£798	4	£414
NZ07B	Admission for observation only 18 years and under	£798	4	£295
NZ08A	Admission with investigation 19 years and over	£1,040	6	£349
NZ08B	Admission with investigation 18 years and younger	£1,040	4	£328
NZ09Z	Admission with full investigation	£1,450	9	£378

(table 3)

HRG Label	HRG Description	2009/10 Prices	Long stay trim point	Excess bed day payment

Your Contribution:

Are you correctly coding your antenatal care and receiving the tariff where appropriate?

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What was the value of your community midwifery block contract and has it been adjusted to reflect the new tariff arrangements?

Postnatal Care

Most postnatal care is delivered in a mother's own home and so, as with antenatal home visits, there is no tariff for this activity. Again, this will typically form part of the midwifery block contract.

Any postnatal care provided in a clinic setting will receive the outpatient attendance tariff for treatment function code 501 (obstetric) or 560 (midwife episode) – see table 2. There is currently no tariff for health visiting.

Midwives' visits to a pregnant woman's home do not have a tariff and reimbursement for these should continue to be negotiated locally. Typically, this is included in a community midwifery block contract. Improved data flows should enable this activity to be better quantified in future, potentially allowing the development of a tariff.

Parentcraft or parent education classes do not have a set price, nor are we planning to develop one in the future given the variation in the provision of such services.

How will Payment by Results change in the future?

Payment by Results is still a relatively new funding mechanism and continues to evolve to better reflect clinical practice and use more robust costing and activity data.

An assessment will be made as to the impact of HRG4 on maternity services, to ascertain whether any refinements need to be made to the tariff 2010/11.

Midwifery Home Visits

In future, midwife home visits – for either antenatal care, intrapartum assessment or postnatal care – could be funded on an activity basis, although there may be discrepancies in costs between a rural and urban area, making a single national tariff unsuitable. NICE guidance on the number of midwife contacts as part of a package of antenatal care could be used by PCTs to ensure the appropriate number of contacts are funded.

Other options for funding could include developing a tariff for the antenatal pathway. This would be relatively straightforward for low risk women, but it could prove difficult to have a pathway for high risk women, as their care will vary considerably, depending on "risk" factors. Women can also move from low risk to high risk during the course of a pregnancy.

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Whatever approach is taken, there is a clear need to move away from the block contract approach where there is no link between payment received and care provided.

Patient Level Information and Costing Systems

Costing for Reference Costs identifies average costs for groups of similar patients. DH is encouraging Trusts to use the **Patient Level Information and Costing Systems (PLICS)**, which seek to cost up exactly how much care would cost for an individual woman e.g. staff time, consumables, ward space etc. This approach allows further analysis of the data to understand how the costs range from patient to patient. A step-by-step guide to PLICS, as well as the latest clinical costing standards can be found at:

http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHScostingmanual/DH_080056

Your Contribution:

Discuss with your finance colleagues implementing PLICS for your services

And Finally....

PbR does not operate in isolation and maintaining a safe, high quality service that delivers the commitments set out in

Maternity Matters remains the priority for maternity services.

Further information

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

<http://www.dh.gov.uk/pbr>

And on the RCM website at:

<http://www.rcm.org.uk>

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

Your Help Needed!

DH is currently leading three strands of work to further refine PbR for maternity services:

- 1) An assessment of the impact of HRG4 on maternity services;
- 2) Understanding the costs of antenatal screening programmes and identifying an appropriate mechanism for the payment of such services;
- 3) Convening a Maternity PbR Working Group to identify a way forward for community based ante and post-natal maternity services;

Your help will be invaluable with all of the above-mentioned projects. DH are keen for PbR to be developed from the bottom-up, influenced by maternity services.



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- Do you have any modelling on the impact of HRG4 and maternity services locally you can share with DH?
- What antenatal screening costs is your organisation returning through the NHS Reference Costs Exercise?
- Do you have any costs in relation to parentcraft and aquanatal classes to help inform discussion as to what form of currency may be suitable for such services?
- Are you interested in becoming a PbR development site to help refine and improve PbR? If so, then please contact paul.griffiths@dh.gsi.gov.uk to discuss possible areas of focus. At present there are no sites covering maternity services and we would welcome your participation.