



2020/21 National Tariff Payment System Guidance on blended payments

November 2020

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1. Introduction

The [NHS Long Term Plan](#) makes a number of commitments on payment, including that “reforms to the payment system will move funding away from activity-based payments and ensure a majority of funding is population-based” and “we will move to a blended payment model, beginning with emergency care, with a single set of financial incentives aligned to the commitments in the Long Term Plan.”

The 2019/20 National Tariff Payment System (NTPS) introduced blended payments for emergency care and adult mental health services. For 2020/21, we have also introduced blended payments for maternity services and outpatient attendances, while piloting the approach for adult critical care. Please note: as part of the NHS response to Covid-19, during 2020/21 most providers and commissioners are using block payment arrangements, using a local variation/departure under the rules set out in Sections 6 and 7 of the NTPS. For details of the payment arrangements, see: www.england.nhs.uk/coronavirus/finance/. These payment arrangements would mean that service-specific blended payments will not be implemented in 2020/21.

This document brings all the guidance relating to blended payments into one place. It is published alongside the 2020/21 National Tariff Payment System (NTPS).¹

The document is structured as follows:

- **Part A: What is blended payment** – an introduction
- **Part B: Guidance on blended payment for specific services:**
 - Emergency care
 - Outpatient attendances
 - Maternity services
 - Adult mental health services
- **Part C: Case studies** – examples of blended payments in practice.

If you have any questions about blended payment, please contact pricing@improvement.nhs.uk

¹ The 2020/21 National Tariff Payment System, including all annexes and supporting documents, is available from: <https://improvement.nhs.uk/resources/national-tariff/>

Part A: What is blended payment?

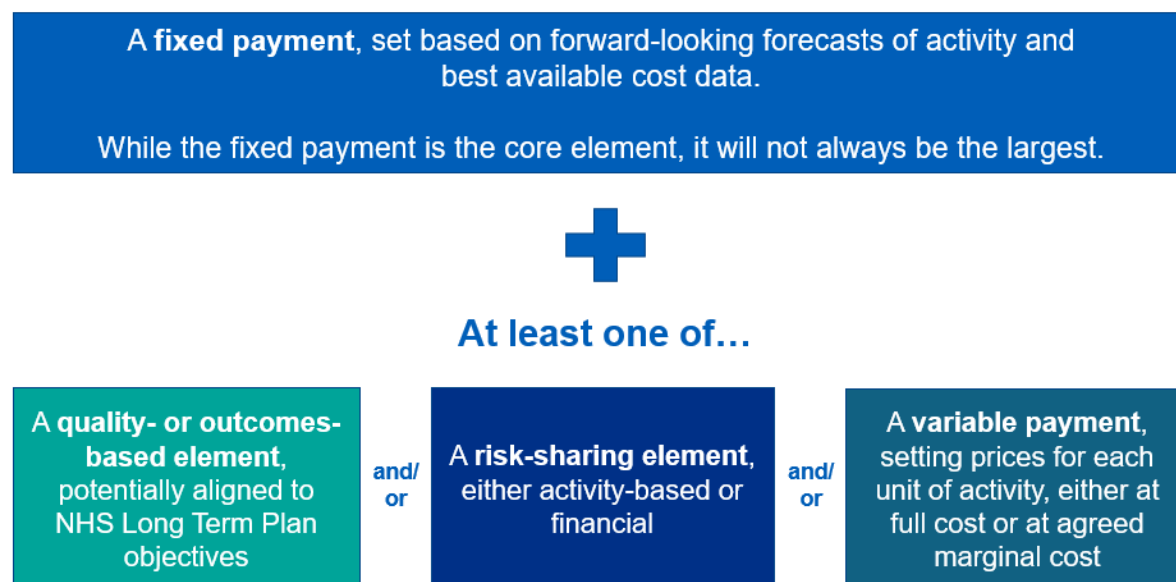
2. What is blended payment – and why is it being introduced?

Blended payment is not a single payment approach; rather, it is a flexible framework that can reflect local requirements and feasibility at a given point in time. Different models of blended payment allow a range of payment approaches to be combined. Fundamentally, blended payment comprises:

- a fixed element with one or more of:
 - a quality- or outcomes-based element
 - a risk-sharing element
 - a variable payment.

Figure 1 summarises these elements.

Figure 1: Constructing a blended payment



Whatever the final design, blended payment aims to:

- support local health systems in managing their collective financial resources and using those resources to maximise quality of care and health outcomes
- provide shared incentives for reducing avoidable or low-value activity and redirecting resources to higher-value interventions, properly reimbursing these
- support a rigorous, transparent approach to coding, counting and costing activity, allowing it to be analysed alongside data on needs and outcomes to support continuous improvements in efficiency and the effectiveness of resource utilisation
- reduce unnecessary transactions and free up administrative resource.

2.1 Why is blended payment being introduced?

We know that the current payment system can act as a barrier to achieving high quality integrated care in a financially sustainable way, and can make it harder to promote collaborative behaviours within systems. There is widespread consensus that activity-based payments are not, at least in their current form, the right mechanism to support the aims of the Long Term Plan, to shift resources away from reactive service provision and towards proactive preventative care. Equally, where services are paid for on a simple block contract approach, this is unlikely to support investment in new capacity and innovative service models.

Blended payment and service development

Blended payment approaches can help to break the link between activity and income, encouraging providers and commissioners to adopt the most cost effective, joined up approaches for delivering patient outcomes. This allows providers to focus on outcomes and delivering the right amount of care at the right time, in the most effective way, rather than relying on bringing patients in to receive a payment for activity.

Some potential examples of the benefits of the blended payment model are:

- For cancer services, diagnostic services are paid on an activity basis but outpatient attendances are not. As such, there should be no incentive to

bring patients in for an outpatient appointment when they could be sent straight to test.

- For patients after cancer treatment (in line with locally agreed personalised stratified follow-up pathway protocols), follow-up appointments are arranged around patients' needs and desires, and their risk factors. Many people at low risk of cancer recurrence can be supported to self-manage while continuing to get their recommended cancer surveillance tests/scans, but would not need to attend a follow up clinic regularly.
- Providers could monitor patients remotely, where appropriate, and only bring them in when appointments are necessary without the trust losing income.
- A provider and commissioner could agree to run an assessment unit for older people within the emergency department as part of the emergency care blended payment. This unit could review and discharge older people where appropriate, providing a better patient experience and reducing avoidable admissions, but without the trust losing income.

For examples of innovative approaches to improving care, supporting new models and managing demand, look at the [NHS Innovation Accelerator innovations](#).

We have worked extensively with sustainability and transformation partnerships (STPs) and developing integrated care systems (ICSs), discussing the current payment system and what reforms are needed to support local and national objectives. The following issues surrounding the current payment system were commonly raised and are seen as the main issues that need to be addressed:

- Fragmented payment approaches make it challenging to integrate and reconfigure care models across settings of care.
- Existing payment mechanisms create incentives which are not aligned to current priorities.
- Prices do not necessarily reflect cost.
- The payment system does not always support collaborative behaviours.

2.2 Departing from the blended payment approaches

The national tariff sets out rules for blended payments for specific service areas (see Part B). However, as with any part of the tariff, providers and commissioners can use the flexibilities provided in the rules and choose not to implement these specific blended payment approaches. They may decide to vary the approach (for example choosing a different variable rate for the emergency care blended payment), or to use a different payment approach altogether (such as agreeing whole population budgets).

Any of these locally agreed approaches must be consistent with the applicable NTPS rules. Section 6.1 of the 2020/21 NTPS states that commissioners and providers must apply the following three principles when agreeing a local payment approach:

- The approach must be in the best interests of patients.
- The approach must promote transparency to improve accountability and encourage the sharing of best practice.
- The provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches.

Blended payments is consistent with these rules and principles, as it is based on collaboration and transparency between system partners in developing local payment approaches. It is designed to support patient interests by aligning funding flows to efficient and effective models of service provision.

Further guidance on locally determined prices and local departures from blended payments can be found in Section 6, Section 7 and Annex G of the 2020/21 NTPS. Any local departures, local variations, local prices and local modifications must be submitted in accordance with these rules, using the templates which can be found on the [locally determined prices](https://improvement.nhs.uk/resources/locally-determined-prices/) webpage.²

² <https://improvement.nhs.uk/resources/locally-determined-prices/>

Part B: Guidance on blended payments for specific services

This part contains guidance on blended payments for the following services. The guidance supports the rules in the 2020/21 NTPS.

- Emergency care (Section 7.1 of the 2020/21 NTPS)
- Outpatient attendances (Section 7.2 of the 2020/21 NTPS)
- Maternity services (Section 7.3 of the 2020/21 NTPS)
- Adult mental health services (Local pricing rule 7, Section 6.4.4 of the 2020/21 NTPS)

3. Blended payment for emergency care

The detailed rules for the blended payment for emergency care are in Section 7.1 of the 2020/21 NTPS. This guidance supports these rules.

3.1 Why is there a blended payment for emergency care?

The blended payment approach for emergency care is likely to achieve the following benefits, compared to an episodic reimbursement system:

- Support a more effective approach to resource and capacity planning that focuses commissioners and providers on making the most effective and efficient use of resources to improve quality of care and health outcomes.
- Provide shared incentives for commissioners and providers to work together to reduce avoidable non-elective admissions, reduce avoidable use of hospital A&E services, and ensure patients receive the right care in the right place at the right time – with providers and commissioners having shared financial responsibility for levels of hospital-based activity.
- Fairly reflect the costs incurred by efficient providers in providing care and provide incentives for continuous improvements in efficiency.
- Minimise transactional burdens and friction and provide space to transform services.

3.2 What is a blended payment for emergency care?

The emergency care blended payment comprises a fixed amount (linked to expected levels of activity) and a volume-related element that reflects actual levels of activity. The fixed payment operates at an individual clinical commissioning group (CCG)-to-provider level.

Providers and CCGs should work together to agree realistic forecast levels of activity for emergency admissions, A&E attendances and same day emergency care for 2019/20. Agreed forecast activity should reflect the effects of demographic pressures as well as realistic assessment of the impact of system efforts to reduce

demand. This forecast is then used to calculate an agreed value of planned activity by applying the 2020/21 HRG prices for emergency activity (published in Annex A of the NTPS) and any associated national variations (published as part of the NTPS) or local prices where appropriate.

Commissioners and providers should involve their sustainability and transformation partnership (STP) or integrated care system (ICS) and other local system partners in planning discussions and in agreeing levels of activity. Where discussions between provider, CCG and STPs/ICSs do not lead to agreement, NHS England and NHS Improvement regional teams will look to resolve disagreements over forecast activity levels before areas enter arbitration.

This agreed value of planned activity for emergency care is the baseline to which the variable payment applies. Where the value of actual activity (based on actual activity × HRG price or local price) is higher than the value of planned activity, the provider receives 20% of the difference between the fully priced value (based on activity × HRG price or local price) of this activity and the agreed amount. The HRG prices are subject to applicable national variations and the short stay emergency adjustment specified in Annex A. Where the value of actual activity is below the agreed level, the provider retains 80% of the difference between the agreed level and the fully priced value of this actual activity.

As set out in the [NHS Operational Planning And Contracting Guidance 2020/21](#),³ the value of planned activity agreed via the blended payment approach will be reduced by the agreed 2017/18 value of both the marginal rate emergency rule (MRET) and 30-day readmission rules. This creates the ‘fixed price’ which is payable by the CCG to the provider. However, the variable payment will apply from the agreed value of planned activity (that is, before the MRET and 30-day readmission adjustments are made). Further detail on how the removal of these rules is being funded is set out below.

See Section 3.10 for a worked example of how a blended payment might be agreed and operated.

3.3 Marginal rate emergency rule

The blended payment means that the MRET rule no longer applies.

³ www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21/

As outlined in Section 5.5 of the [NHS Operational Planning and Contracting Guidance 2020/21](#), providers are eligible to receive additional central income (on top of the fixed price paid by the CCG) equal to the MRET value confirmed by providers and commissioners as part of the Autumn 2018 exercise. Control totals have been set on the basis that for every £1 in MRET funding, the provider must improve its bottom-line position by £1. MRET funding will be paid quarterly in advance, subject to providers agreeing their control total.

3.4 Emergency readmissions within 30 days

The blended payment means that the 30-day readmission rule no longer applies.

Under the 30-day readmission rule, money retained from not paying for emergency readmissions should be re-invested by the commissioner in post-discharge services that support rehabilitation and reablement to prevent avoidable readmissions. Providers and commissioners should discuss the effectiveness of any such investments in reducing readmissions and take this into account when agreeing the level of planned activity.

The consequences of CCGs changing their previous investments relating to the 30-day readmissions rule should form part of the discussions around planned activity for the blended payment approach. Providers and CCGs should have due regard to the values in the Autumn 2018 exercise combined with any subsequent actions (for example, an audit outcome or agreed information that reliably updates the Autumn 2018 exercise), when agreeing the appropriate volume and value of activity included in the blended payment.

Avoidable emergency readmissions remain an indicator of service quality. We expect providers and commissioners to continue to monitor and review the number of avoidable emergency readmissions.

3.5 Scope of activity in the blended payment

The following activity is within the scope of the blended payment:

- all emergency admissions ([admission method code 21-25, 28, 2A-2D](#)⁴)
- emergency admission excess bed days

⁴ Please see the NHS Data Dictionary for more details www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp

- A&E attendances at Type 1, 2 and 3 A&E facilities, including urgent treatment centres where they are classified as a type 3 A&E service
- all same day emergency care (SDEC) activity, even if this is currently being coded as something other than an emergency admission or A&E attendance

This includes activity described above, even if it does not have a price in Annex A.

All other activity is excluded, specifically:

- all other admission methods
- specialised commissioned services,⁵ both elective and non-elective
- all unbundled elements, such as critical care spells associated with emergency admissions and high cost drugs and devices.

For services which were previously locally priced and do not have HRG prices set out in Annex A of the NTPS, but are included in the blended payment, local unit prices need to be agreed.

SDEC is included in the scope of the blended payment to incentivise its use where clinically appropriate to do so.

There is a variable picture for how SDEC services are currently being recorded and paid for. Approaches include:

- using Annex A prices for zero-day length of stay emergency admissions (with any short stay adjustments and MRET applied)
- using A&E prices
- agreeing local prices
- recording the activity as an outpatient attendance

SDEC activity is therefore included within the blended payment on whatever basis has previously been used to record this activity. Inclusion within the blended payment should mean payment for SDEC is more straightforward to implement than previously.

⁵ Services commissioned by NHS England Specialised Commissioning are excluded from blended payments as a default. However, MRET would still be removed for these services.

Providers and CCGs should agree how SDEC activity has been recorded and how it will be recorded in future, taking into account the counting and coding provisions as part of the [Standard Contract](#). We will work with system partners to create a consistent approach to reimbursing SDEC activity in future tariffs, building on the work underway to record SDEC activity as a Type 5 A&E service in the emergency care data set (ECDS).

3.6 Best practice tariffs

Changing the default payment approach for emergency care to a blended payment means changing the way certain best practice tariffs (BPTs) operate. We do not want to remove the financial incentive for providers to deliver best practice and so we have changed the way BPTs are operationalised to fit into the blended payment.

We have removed the same day emergency care BPT. This BPT over-reimburses certain activity which takes place on the same day rather than overnight. We would expect discussions between providers and commissioners to look at emergency activity as a whole and decide the best way to manage and treat patients where same day emergency care is part of the most appropriate emergency care pathway.

The following BPTs are either wholly or partially related to emergency care:

- acute stroke care
- chronic obstructive pulmonary disease (COPD)
- diabetic ketoacidosis and hypoglycaemia
- fragility hip fracture
- emergency laparotomy
- heart failure
- non-ST segment elevation myocardial infarction
- paediatric diabetes
- pleural effusion
- transient ischemic attack.

As part of the fixed element of the blended payment, CCGs and providers should agree activity levels for services which attract BPTs. This should be valued using the base or non-BPT achieved price. Where providers achieve best practice (as set out in the rules for each BPT), they will receive the difference between the best practice price and the base price.

Where actual activity is above forecast activity, the additional BPT activity priced using the base price will be paid at 20%, as per the variable payment rules. However, where the provider achieves best practice on this extra activity, they will be eligible to receive all of the difference between the best practice price and the base price.

3.7 Threshold

The blended payment for emergency care has a threshold of £10 million (based on the expected value of emergency activity at the provider for the CCG at the start of the year). For cases where the expected activity under the contract is below this value, payment will continue to be made on an episodic basis, using the emergency care unit prices published in Annex A of the 2020/21 NTPS.

The £10 million amount includes all elements of the blended payment (see Section 5), including market forces factor (MFF) adjustments but before the deduction of the MRET and 30-day readmission values.

Providers and CCGs can also consider agreeing a tolerance level around the expected level of activity where small variances would not result in any change to the expected contract value. This may help to reduce administrative burden by avoiding the need to adjust for small variances on expected levels of activity. It could also be used to manage any small differences in forecast levels of activity between provider and commissioner. The inclusion of a tolerance level is not mandated nationally as part of the blended payment but could be agreed via a local variation.

For contracts where the HRG unit price is payable (that is, emergency care contracts below £10m and Specialised Commissioning contracts), the total annual payment for the activity should be still be reduced by the agreed 2017/18 value of both the MRET and 30-day readmission rules.

3.8 Break glass

A 'break glass' provision applies when activity is significantly higher or lower than assumed, unless the commissioner and provider agree it is not required. The provision requires the emergency care payment elements of the contract to be reviewed and potentially renegotiated.

Analysis of previous plan data alongside outturn activity levels suggests a high level of variation between plan and outturn levels at organisation level. Some of this is likely due to known changes in treatment pathways and coding and some may be due to variability in plan estimates. This makes it difficult to set a break glass provision based on nationally available data.

Providers and CCGs are therefore required to set a break glass provision locally (unless they consider one is not required), as well as the level of actual priced activity at which the provision is activated. These details should be set out in each contract. If areas agree that a break glass provision is not needed, then this should be specified. However, the default position should be that one is included within the agreement between commissioner and provider.

The break glass arrangements should have two components:

- a trigger point (%) where actual priced activity is above or below the planned level
- a set of binding arrangements which will apply if the trigger point is reached.

There are many different possible payment responses that providers and CCGs could agree if the break glass threshold is reached. However, the default position is that, unless the CCG and provider agree otherwise, the break glass provision will set out changes to the variable rate which will apply at different levels above the break glass threshold. This will seek to share utilisation risk between provider and commissioner for levels of activity which are very different to those forecast as part of the fixed element of the blended payment.

These arrangements are to be agreed and included in the contract at the point of signature.

As with agreement on the level of activity, if the parties cannot agree on these components, NHS England and NHS Improvement regional teams will look to resolve disagreements.

We encourage providers and commissioners to discuss whether there are more targeted ways of varying the payment arrangements during the year depending on the nature of the actual level of activity.

3.9 Duration of blended payment

The 2020/21 NTPS takes effect from date of publication. However, financial arrangements moving providers and commissioners to block payments have been introduced for 2020/21 in response to Covid-19. These arrangements have been implemented as local variations to the NTPS, meaning blended payments have not been used for this year. We would usually expect that the blended payment would be updated for each tariff cycle, including agreeing levels of emergency activity to inform the fixed element of the blended payment. This would ensure that any under- or overestimate of activity in any one tariff cycle is not hard-wired into contracts in future.

Areas should not automatically roll over any under- or over-performance against plan. Before any agreement is made, there should be discussions about why that difference has occurred and the likelihood of such activity occurring again.

3.10 Worked example

Please note: this example is purely for illustrative purposes. Local areas should discuss and agree the blended payment elements that are most appropriate to their local situations.

Agreeing the blended payment

Step 1: Agreeing activity baseline

- Based on analysis of historic levels of activity, including forecast outturn for 2019/20, provider and CCG agree a baseline level of activity for 2020/21 for each point of delivery that is within the blended payment.

Step 2: Agreeing adjustments to the baseline

- After discussions, there is agreement that proposed QIPP schemes plus the extra impact above trend of any continued MRET and readmission reinvestment schemes will reduce this historic activity by 2%.
- However, there is also predicted demographic and service growth in excess of historic levels that will potentially increase activity by 4%.
- The end adjustment is therefore an increase to the historic trend of 2%.

Step 3: Calculating value of planned activity

- This agreed activity level is multiplied by the HRG prices published in Annex A of the 2020/21 NTPS (or local prices if agreed) to generate the value of

planned activity that form the basis of the 2020/21 contract. The HRG prices are subject to applicable national variations and the short stay emergency adjustment specified in Annex A. Therefore, if the baseline activity level led to a payment of £100m, after the net adjustment of 2% in activity, this leads to the value of planned activity of £102m (final figures will be dependent on exact case mix).

- This figure should also include expected activity in any HRGs where a BPT applies. The base HRG price (ie not including the additional best practice payment) should be used to calculate the agreed price-weighted activity.
- This value of planned activity, £102m, is the amount over and under which the 20% variable rate applies

Step 4: Adjusting for MRET and 30-day readmissions

- In the Autumn 2018 exercise, an MRET adjustment of £3m and a 30-day readmission adjustment of £2m was agreed by the provider and CCG. These are then removed from the value of planned activity, meaning the fixed price payable by the CCG is £97m.
- If the provider agrees their control total, £3m relating to their 2017/18 MRET amount is paid centrally by NHSE (not by CCGs).
- The agreed fixed price of £97m is then paid in accordance with the agreed contract terms over the financial year. The additional payments associated with BPTs (over and above the base HRG payment used in the calculation of the agreed level) are paid on an activity basis.

Step 5: Agreeing the break glass

- The last element to be agreed is the break glass. Through negotiations, the provider and CCG agree to set the break glass points at £105m (above) and £94m (below).
- They agree that for activity beyond the break glass points, a variable rate of 80% would apply.

Applying the blended payment

Once the year is underway there are four outcomes, assuming the provider agrees their control total:

- **The value of actual activity is higher than expected and breaches the break glass.** In this example, total value of actual activity comes to £110m. The provider will receive:
 - their fixed price payment: £97m
 - 20% of the difference between £102m and £105m: £0.6m
 - 80% of the difference between £105m and £110m: £4.0m
 - £3m from agreeing their control total
 - Total: **£104.6m** (of which £101.6m payable by the CCG)
- **The value of actual activity is higher than expected but below the break glass.** In this example the total value of actual activity comes to £104m. The provider will receive:
 - their fixed price payment: £97m
 - 20% of the difference between £102m and £104m: £0.4m
 - £3m from agreeing their control total
 - Total: **£100.4m** (of which £97.4m payable by the CCG)
- **The value of actual activity is lower than expected but above the (lower) break glass.** In this example the total value of actual activity comes to £98m. The provider will receive:
 - their fixed price payment: £97m
 - £3m from agreeing their control total
 - Provider would 'pay back' 20% of the difference between £102m and £98m: £0.8m
 - Total: **£99.2m** (of which £96.2m payable by the CCG)
- **The value of actual activity is lower than expected and breaches the break glass.** In this example the total value of actual activity comes to £90m. The provider will receive:
 - their fixed price payment: £97m
 - £3m from agreeing their control total
 - Provider would 'pay back' 20% of the difference between £102m and £94m: £1.6m
 - Provider would 'pay back' 80% of the difference between £94m and £90m: £3.2m
 - Total: **£95.2m** (of which £92.2m payable by the CCG)

4. Blended payment for outpatient attendances

The detailed rules for the blended payment for outpatient attendances are in Section 7.2 of the 2020/21 NTPS. This guidance supports these rules.

4.1 Why is there a blended payment for outpatient attendances?

Outpatient attendance reimbursement has been largely unchanged since being introduced across the NHS in 2005/6. Since then, there has been a shift in how care is delivered to patients, with more emphasis on shifting care out of the acute setting, an increased use of one-stop shops and multidisciplinary appointments, the introduction of advice and guidance services, the introduction of virtual clinics and the move to offering patients more digital services.

We have been working with providers and commissioners, as well as the NHS England and NHS Improvement Outpatient Transformation Programme, to understand how the way outpatient attendances are paid for could support or hinder movements to new clinical models of care for patients currently seen in outpatients. We feel that the payment approach for outpatients must:

- be an enabler for local health systems who are looking to redesign their care models and transform their services
- be as simple to implement as possible, reducing the administrative burden the payment system places on providers and commissioners.

Compared to an episodic payment system, a blended payment approach would better support the way outpatient services are being delivered and how they will evolve to support the NHS Long Term Plan. A blended payment approach places more emphasis on system planning and working and less emphasis on individual units of activity delivered by consultants in a face-to-face setting, which can create barriers to shifting care to non-acute settings.

4.2 What is a blended payment for outpatient attendances?

Outpatient attendances are coded based on groupings relating to clinical specialty, defined by treatment function code (TFC), attendance type (first or follow-up attendance, face-to-face or non-face-to-face, consultant-led and non-consultant-led) and whether they are single professional or multiprofessional clinics. Section 4.14 gives more details of the outpatient attendances currencies.

The blended payment for outpatient attendances operates at an individual commissioner-to-provider level. It comprises the following elements:

- A **fixed element** based on an agreed level of activity between provider and commissioner. This will be built up using agreed activity volumes, TFC unit prices published in Annex A and agreed local unit prices for activity where there was not previously a national price. Guide prices are published in the *Non-mandatory prices* workbook to support agreement of local unit prices. The fixed payment should also include the costs of delivering advice and guidance services, which must be agreed between provider and commissioner.⁶ See Section 4.6
- A locally determined **quality- or outcomes-based element** to support the successful delivery of the advice and guidance services identified as part of the fixed payment. Additional quality- or outcomes-based elements can also be agreed. See Section 4.7.
- An optional **risk share element** where providers and commissioners agree to share financial risks if external factors lead to unanticipated demand outside of their direct control. This would be determined locally. See Section 4.8.

4.3 Scope of activity in the blended payment

The following activity is within the scope of the blended payment:

- All outpatient activity that groups to a WF* HRG,⁷ when grouped with the local payment grouper, that are a result of:

⁶ For 2020/21 we have removed the non-mandatory benchmark prices for advice and guidance, which were published in the 2019/20 *Non-mandatory prices* workbook. Removing these prices supports the ambition for local areas to fully reflect the particular design of their service for their patient population. Further information on advice and guidance services is available at www.england.nhs.uk/elective-care-transformation/best-practice-solutions/advice-and-guidance/

⁷ WF01A, WF01B, WF01C, WF01D, WF02A, WF02B, WF02C, WF02D

- no procedure(s) being recorded
- only procedures ignored for grouping being recorded
- only codes from OPCS category X62 Assessment being recorded
- advice and guidance services related to this activity.

The following activity is excluded:

- outpatient procedures that do not generate a WF* HRG when grouped with the local payment grouper
- diagnostic imaging (TFC 812)
- all activity commissioned by NHS England other than specialised services (for example, armed forces, secondary dental care, prison health)
- outpatient attendances as part of the payment pathway or blended payment approach for maternity services
- same day emergency care activity covered by the emergency care blended payment
- activity covered by the cystic fibrosis pathway.

Outpatient procedures which do not group to a WF* HRG, or those that only group to a WF* 'alternate' HRG in SUS+ secondary processing, should be reimbursed by using either:

- the specified national price for the outpatient procedure HRG in Annex A
- the relevant outpatient attendance price (based on the TFC) or relevant local price, adhering to the local pricing rules.

Outpatient attendances that were previously locally priced do not have prices in Annex A of the 2020/21 NTPS. However, these attendances should be included in the blended payment and local unit prices would need to be agreed, adhering to the local pricing rules set out in Section 6.4.1 of the 2020/21 NTPS. Guide prices are published in the *Non-mandatory prices* workbook to support agreement of local prices. Any new non-face-to-face activity, which would replace face-to-face activity,⁸ should have the same unit price as face-to-face activity.

⁸ This should reflect a change in mode of delivery only: a like-for-like for substitution when clinically appropriate (such as when there is no need for a physical examination), and where the quality and safety of care can be maintained.

4.4 Threshold

The threshold for the blended payment for CCG commissioned activity is a full-year annual value for planned activity of £4 million, based on the expected value of in-scope outpatient attendance activity at the provider for the commissioner at the start of the year. For cases where the expected full-year annual value of activity in scope of the blended payment under the contract is below £4 million, payment would continue to be made on a per attendance basis, using the outpatient unit prices published in Annex A of the 2020/21 NTPS, and locally agreed prices where applicable.⁹

Where providers and CCGs agree that moving to a blended payment model for smaller contract values is desirable, they can agree and submit a local variation to use a blended payment for their contract.¹⁰

There is no threshold for specialised commissioned activity by NHS England.

4.5 Best practice tariffs

Changing the default payment approach for outpatients to a blended payment means changing the way certain best practice tariffs (BPTs) operate. We do not want to remove the financial incentive for providers to deliver best practice and so we have changed the way BPTs are operationalised to fit into the blended payment.

The following BPTs are either wholly or partially related to activity in scope of the outpatients blended payment:

- Transient ischaemic attack
- Paediatric epilepsy
- Paediatric diabetes
- Parkinson's
- Rapid colorectal diagnostic

As part of the fixed element of the blended payment, commissioners and providers should agree activity levels for services which attract BPTs. This should be valued using an agreed expected level of best practice attainment.

⁹ Guide prices are published in the *Non-mandatory prices* workbook to support agreement of local prices.

¹⁰ See [Locally determined prices](#) for templates and guidance on submitting local variations.

4.6 Fixed payment

Providers and commissioners should work together to agree a fixed payment that is based on realistic forecast levels of activity for all outpatient attendances within the scope of the blended payment as well as the cost of delivering advice and guidance services.

Agreed forecast activity should reflect the effects of demographic pressures as well as realistic assessment of the impact of system efforts to reduce avoidable activity, deliver more care through non-face-to-face options, and shift care into different care settings – in particular, shifting care away from acute settings where appropriate.

In agreeing the level of activity, commissioners and providers should agree appropriate advice and guidance services for relevant specialties (see Step 3 in Section 4.11) and include what impact any new advice and guidance services may have on the level and distribution of outpatient activity. This agreed value of planned activity for outpatient attendances is the baseline from which the fixed payment is calculated.

We recommend that this forecast should be undertaken at TFC level, split by first and follow up, single and multiprofessional, consultant-led and non-consultant-led and face-to-face and non-face-to-face.

The value of the forecast activity should then be calculated using the TFC prices included in Annex A of the 2020/21 NTPS.¹¹ Where activity does not have a unit price in Annex A (for example, non-face-to-face and non-consultant-led activity), a local unit price should be agreed.¹²

¹¹ The prices in Annex A are those that had a national price in previous tariffs.

¹² The *Non-mandatory prices* workbook contains prices for non-face-to-face and non-consultant-led activity. The workbook also includes benchmark prices for outpatient attendances with the frontloading of first attendances removed (see Section 4.9). These prices are intended to assist local areas with the calculation of the fixed payment.

Incentivising wider role out of non-face-to-face delivery of care

Alongside the 2019/20 NTPS non-mandatory prices were published for consultant-led non-face-to-face follow up attendances.¹³ These were calculated, based on reference costs data, as 68% of the price of the face-to-face attendance. The activity covered by the relevant HRGs encompassed different types of non-face-to-face activity (for example, a telephone call, remote health assessment, video consultation).

The feedback we have received suggests that the cost of delivering a video consultation is similar in costs, for the same patient, to a face-to-face attendance. Therefore the price of activity which is planned to switch from a face-to-face consultation to a non-face-to-face consultation should be set at the face-to-face attendance price when building the fixed payment.¹⁴

The fixed payment for outpatient attendances is therefore calculated from a combination of:

- agreed activity, multiplied by Annex A TFC price or local price
- agreed reimbursement for delivering advice and guidance services.

Commissioners and providers should involve their sustainability and transformation partnership (STP) or integrated care system (ICS) and other local system partners in planning discussions and agreeing levels of activity. Where discussions between provider, commissioner and STP/ICS do not lead to agreement, NHS England and NHS Improvement regional teams will look to resolve disagreements over forecast activity levels before areas enter arbitration.

A more detailed step-by-step approach to agreeing a fixed payment is set out in Section 4.11. Section 4.12 provides an example of how this process might work in practice.

¹³ See the 2019/20 *Non-mandatory prices* workbook.

¹⁴ Activity previously delivered as a face-to-face attendance in 2019/20 (and generating a WF01A, WF01B, WF02A or WF02B HRG) which is planned to be delivered as a non-face-to-face attendance in 2020/21 (and generating a WF01C, WF01D, WF02C or WF02D HRG) priced at the same level as the corresponding face to face price

4.7 Quality- or outcomes-based element

As part of the blended payment, providers and commissioners must agree a quality-based element related to the successful delivery of advice and guidance services. The details of this element should be agreed locally. Local areas may choose to agree additional quality- or outcomes-based elements to provide a financial incentive for the delivery of certain targets for outpatients activity.

When determining the advice and guidance quality-related element, providers and commissioners may want to consider the following points:

- The metrics to be used to measure achievement.
- What level of attainment and trajectories should be set for these metrics.
- The total amount of money attached to the quality-based element (ie the total that could be gained).
- How much money should be attached to specific achievement levels (ie how much should providers gain as they move towards 100% attainment of the metric?).

Section 4.13 sets out some examples of how the quality-related element could be determined. However, local areas are free to establish their own arrangements.

Any further quality or outcome measures are optional for 2020/21. Over the coming months, we intend to develop further national guidance to support this element in future tariffs. Our work will focus on clinically relevant metrics to support high quality patient care and is likely to align with Long Term Plan and outpatient transformation objectives.

Setting a quality element: an example

To support delivery of the cancer waiting time target for prostate, colorectal, lung and oesophago-gastric cancer, local areas could use the metrics set out in the following table as the basis of a quality element of their blended

payment.¹⁵ These metrics were identified with clinical advice by the NHS Cancer Programme.

Pathway	Stage	Time point
Colorectal	Straight to Test Colonoscopy or CT Colon / CT / Flexi Sig +/- oesophago-gastro-duodenoscopy (OGD)	By day 14
Prostate	14 day pathway: One stop diagnostics clinic (consultant led), including: mpMRI before biopsy, targeted biopsy and systematic biopsy (where appropriate)	By day 7
Lung	Fast track lung cancer clinic, including CT scan and first new patient appointment happening by this time.	By day 6
Oesophago-gastric cancer	Straight to Test OGD (+/- biopsy) by day 7 with histology reported within 72 hours.	By day 7

To use the metrics as part of the blended payment:

- payment should also be linked to the overall delivery of the Faster Diagnostic Standards by the provider
- target percentages and the size of the outcomes-based payment will need to be agreed locally.

See Section 9.2 of this document for more details of quality- or outcomes-based approaches and potential benefits.

4.8 Risk share element

A risk share is designed to reflect that actual levels of activity may be different from plan. It can share financial risks between providers and commissioners if external factors lead to unanticipated demand outside a provider’s direct control.

The risk share element is an optional component of the outpatient attendances blended payment. It can be set out between a provider and commissioner in a

¹⁵ For more information about these pathways, see: www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/

number of ways, which range from high level agreements to more prospectively agreed mechanistic agreements. Any arrangements agreed should be included in the contract at the point of signature.

Some examples are set out below. However, these are just some possible payment responses that providers and commissioners could agree to manage variation from planned activity.

‘Break glass’ clause

Activity which is slightly above (or below) the level agreed as part of the fixed payment is assumed to be managed using existing infrastructure and staffing, with only marginal costs being incurred (or saved) by the provider. However, blended payment contracts could include a ‘break glass’ clause which applies when activity is significantly higher or lower than assumed and requires the contract to be reviewed and potentially renegotiated.

Adjustment based on level of GP referrals first attendance activity

Setting a risk share linked to first attendance GP referrals recognises there may be an unavoidable cost pressure on the provider if demand is higher than expected. Designing it in this way also means that if follow-up activity is higher than expected, or intra-trust referrals increase, there wouldn’t be any extra payment as some of these may be inside the provider’s control. The advice and guidance services agreed may impact on how any activity-based risk share is constructed.

Activity-based risk share arrangement

Activity-based risk sharing is the sharing between commissioner and provider of savings (gains) or overspends (losses) generated through lower/higher than expected utilisation of a service. For gains and losses to be transparently measured, they must be linked to specified activities. In this context, gains and losses could be calculated as the difference between the value of a pre-agreed volume of activity and the value of the actual activity. These values are calculated by multiplying the respective activity volumes by the same unit price(s). This over or under-spend is then shared between the provider and commissioner, based on pre-agreed shares. This could be based on all in-scope activity or just sub-sections of activity

For further details on risk-sharing, please see our [risk sharing webinar series](#). Section 9.3 of this document also contains details of potential risk share approaches, and provides more detailed guidance on activity-based risk sharing.

4.9 Frontloading policy

In previous tariffs first attendances have been over-reimbursed and follow-up attendances under-reimbursed. This transfer in cost (frontloading) was set at a TFC level and ranged from 0% to 30%. This was intended to incentivise a change in the delivery of outpatient follow-up activity, encourage more efficient models and free up consultant capacity.

These aims should now be supported by the blended payment model. In particular, commissioners and providers need to agree the level of forecast activity and ensure that, as a part of this process, they are agreeing how they will work as a system to reduce unnecessary demand and activity and shift care into different care settings, particularly away from the acute setting where appropriate.

However, we do not want to destabilise funding flows at the same time as shifting the emphasis to the blended payment model and agreeing activity levels. As such, for the 2020/21 NTPS frontloading factors **have not** been removed from the outpatient attendance prices published in Annex A.

For those that want to use prices without frontloading, as more cost-reflective prices, we have calculated a set of non-frontloaded benchmark prices for guidance. These are published in the *Non-mandatory prices* workbook. Areas who want to can use these prices to construct their blended payment by agreeing a local departure from the tariff rules (see rule 5 in Section 7.2 of the 2020/21 NTPS).

We will consider removing differential frontloading rates from all outpatient attendance prices for the next tariff, subject to engagement and consultation.

4.10 Duration of blended payment

The 2020/21 NTPS takes effect from date of publication. However, financial arrangements moving providers and commissioners to block payments have been introduced for 2020/21 in response to Covid-19. These arrangements have been implemented as local variations to the NTPS, meaning blended payments have not been used for this year. We would usually expect that the blended payment would

be updated for each tariff cycle. This would ensure that any under- or overestimate of activity in any one tariff cycle is not hard-wired into contracts in future.

Areas should not automatically roll over any under- or over-performance against plan. Before any agreement is made, there should be discussions about why that difference has occurred and the likelihood of such activity occurring again.

4.11 Agreeing a fixed payment – a step-by-step approach

Providers and commissioners should work together to agree a fixed payment that is based on realistic forecast levels of activity for all outpatient attendances within the scope of the blended payment. They can do this by working through the following steps:

1. Agree activity levels for activity within scope of the blended payment
2. Determine a price for the activity
3. Agree reimbursement for relevant advice and guidance services
4. Calculate the fixed payment

1. Agree activity levels for activity within scope of the blended payment

To allow the Annex A outpatient attendance prices to be applied, we encourage providers and commissioners to agree activity levels at the level of these prices (TFCs), split by:

- first and follow up
- single and multiprofessional
- consultant-led and non-consultant-led
- face-to-face and non-face-to-face.

As a starting point, providers and commissioners should consider the previous year's activity levels as the baseline. They should then adjust this for forecast activity, based on the impact of changing health needs, demographic changes and historic trends for the upcoming year. They should also consider the following:

- Any planned changes in patient flows, such as:

- any plans to transform outpatient pathways where some activity may be delivered by an alternative provider (eg community services or first contact practitioners based in primary care)
- shifting some care to be delivered non-face-to-face instead of face-to-face (using the same unit price)
- the impact of any new advice and guidance service on activity levels.
- The full-year effects of recurring changes (where not already reflected fully in the baseline period) and any non-recurring activity changes.
- Any changes in commissioning policy that impact on the volume of care commissioned, including STP/ICS plans and Long Term Plan implementation plans. For example, the impact of increasing referrals relating to suspected cancer should be taken into account, especially where public health campaigns are introduced in-year, causing spikes in demand.
- The impact of waiting lists and historic capacity on demand.
- Any efficiency savings schemes that would affect patient volumes or pathway steps needed to treat patients, for example, QIPP schemes.

Plans for efficiency savings and their impact on activity plans will need to have a clear rationale for the scale and timing of impact, be underpinned by robust plans that are properly formed, have clinical engagement, contain measurable objectives, measurable success criteria and a trajectory for delivery of efficiency savings plans.

Efficiency savings schemes should also include details of:

- revised volumes of care to be delivered, at a granular level of detail
- assumptions that have been tested and includes realistic trajectories and profiles
- key performance indicators that measure the success of the scheme, enabling each party to understand if it is delivering the expected change.

When agreeing contracts, providers must recognise the level of capacity that they have in order to meet demand in a safe and sustainable way.

2. Determine prices for the activity

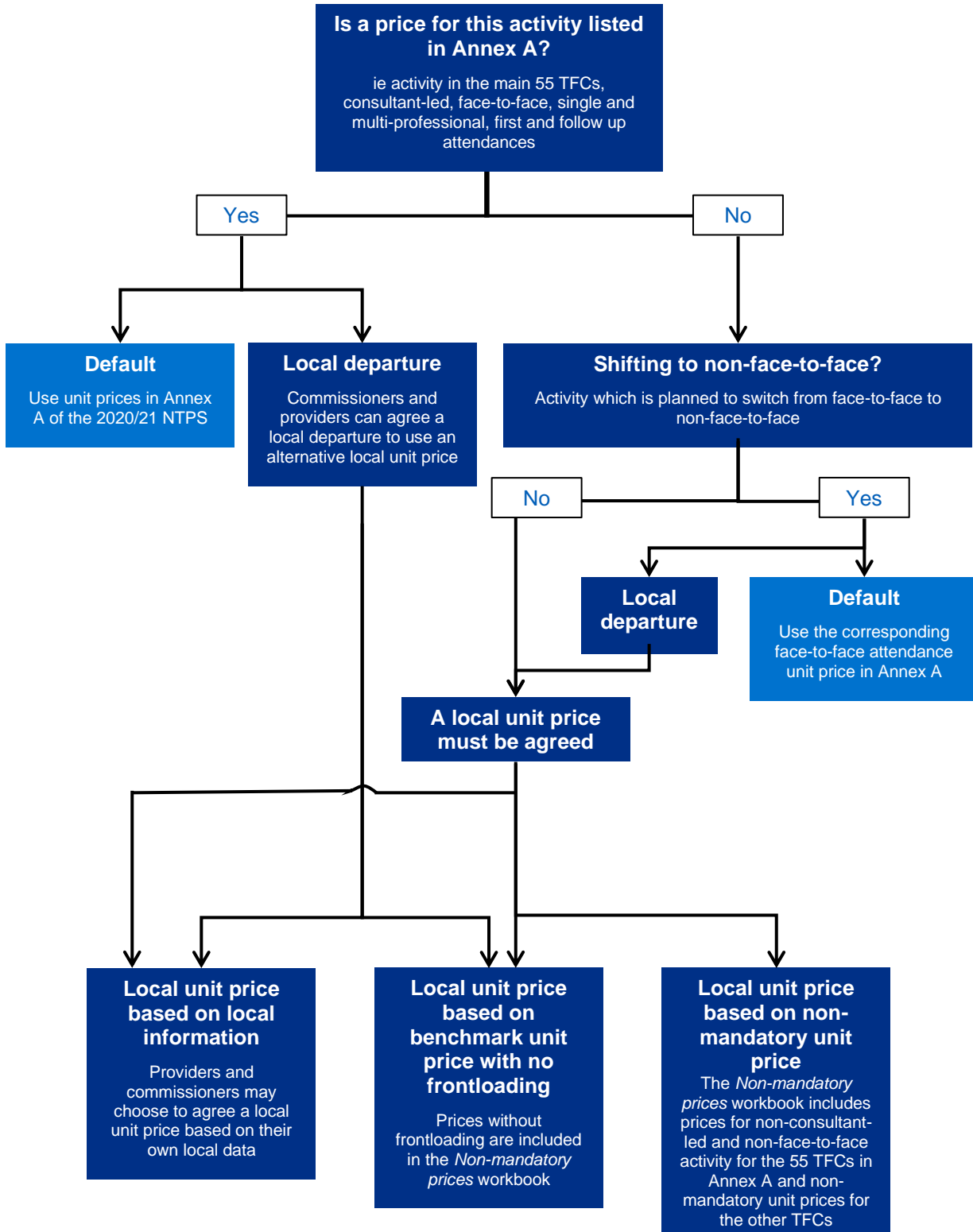
Annex A of the 2020/21 NTPS includes prices for outpatient attendance activity that had national prices in previous tariffs. The Annex A price should be the default price providers and commissioners use unless they agree a local departure and use a

locally agreed price (in accordance with rule 5 of the outpatient rules). For activity that did not previously have a national price and does not have a unit price in A, a local price must be agreed. The *Non-mandatory prices* workbook contains prices for some of this activity which can be used as a guide and to support agreement of local variations and local prices.

To incentivise the wider role out of non-face-to-face delivery of care, activity which is planned to switch from a face-to-face consultation to a non-face-to-face consultation, should be paid at the face-to-face attendance price.

Figure 2 illustrates the options for agreeing which price to use for outpatient attendance activity. The prices referred to are in Annex A or the *Non-mandatory prices* workbook.

Figure 2: Flow chart demonstrating options for determining unit prices for activity.



Please note: options in light blue marked “Default” are the prices that should be used unless a local agreement is made to depart from the blended payment rules.¹⁶ Where prices from Annex A or the *Non-mandatory prices* workbook are used, national variations including the market forces factor (MFF) should be applied to the prices. See Section 5 of the 2020/21 NTPS for more details of national variations.

3. Agree reimbursement for relevant advice and guidance services

An advice and guidance service allows one clinician (often, but not exclusively, in primary care) to seek non-urgent advice from another (usually a specialist) prior to referral.

Advice and guidance is defined as non-face-to-face activity which can be:

- synchronous (eg a telephone call); or
- asynchronous – enabled electronically through the NHS e-Referral Service (e-RS), or through other IT platforms or dedicated email addresses where there is agreement from all stakeholders.

Advice and guidance services are facilitated by local arrangements which should include the expected response time for asynchronous activity.

Advice and guidance services are essential to allow GPs to ask for expert advice from a relevant specialist team before referring a patient into an elective care pathway. When working well, these services should reduce the number of inappropriate referrals, make sure appropriate referrals are allocated to the correct clinic and upskill GPs in knowing which patients should be referred and which may be safely managed in other care settings. Such services may also apply to appropriate consultant-to-consultant referrals in secondary care.

The types of advice that may be requested include (but are not limited to):

- treatment plans
- interpretation of results
- advice on appropriateness of referrals or tests.

The advice and guidance service specification, including the expected response time for asynchronous activity, and the cost of delivering the service should be agreed locally between provider and commissioner for a particular commissioner’s

¹⁶ See the outpatient attendance blended payment rules in Section 7.2 of the 2020/21 NTPS

patients and added to the fixed payment. The anticipated effects of the advice and guidance service should also be reflected in the agreed level of outpatient activity.

Providers and commissioners should also agree a method of locally recording and tracking advice and guidance services so that they can assess their rollout/ impact to inform future planning.

It may not be appropriate for advice and guidance services to be available for all specialities (eg small specialised areas may not have the staff capacity to provide such a service). However, providers and commissioners should aim to have this service available where possible. This is in line with the aims of the Outpatient Transformation Programme.

When advice and guidance services are not already in place and the costs for setting up and providing the service in the local system are not well understood, providers and commissioners should consider the following impacts on costs:

- The [electronic referrals system](#) (e-RS) can be used to submit and respond to advice and guidance requests, meaning that any technology investment requirements should be relatively low. Advice and guidance activity can also be captured and tracked through e-RS, meaning there does not need to be a large investment to capture this activity data.
- The service needs to have dedicated capacity to ensure that requests are responded to in a timely manner. Some requests may be time intensive (eg requiring a consultant to review patient notes and test results before responding). The capacity to carry out this work needs to be part of the job planning for consultants and other relevant staff. This may require a change in staff distribution or an increase in WTE to cover the service.
- There will be initial staff training costs for the provider (receiving requests) and setup costs for the commissioner (eg training GPs to submit requests, increasing awareness of the service with GPs and agreeing requirements for their use of the service).
- Service requirements will also need to be considered (eg responding to requests within 48 hours), as well as any cost implications they may have (eg weekend cover).

A toolkit to support all aspects of e-RS advice and guidance can be found on the NHS Digital website.¹⁷ NHS Digital have also published advice and guidance case studies which illustrate examples of successfully implementing an advice and guidance service.¹⁸

4. Calculate the fixed payment

The final fixed payment is calculated from the activity agreed in step 1 multiplied by the prices for this activity agreed in step 2 (including MFF and other national variations), plus the advice and guidance service costs agreed in step 3.

The fixed element for outpatient attendances is therefore calculated from a combination of:

- agreed activity multiplied by Annex A TFC price or local price
- agreed reimbursement for delivering an advice and guidance service.

Please note: as the 2020/21 NTPS was published part way through the year, any fixed payment for 2020/21 would be calculated by reference to the activity in the period from publication of the NTPS to the end of the year, rather than the full year. The worked example below however describes a whole year calculation.

4.12 Agreeing a fixed payment – a worked example

The below is a mocked-up example of how provider A and commissioner Z could agree a fixed payment using the steps outlined in Section 4.11.

To simplify this example, provider A only provides ENT services for commissioner Z's patients, and all activity is single professional. Provider A also provides services to commissioner X. However, agreement for activity and cost of delivering advice and guidance services are only based on commissioner Z's patients.

Please note: All activity levels, planned service impacts and the estimated cost of delivering advice and guidance for the commissioner's patients are fictional and for the purposes of demonstration only.

¹⁷ <https://digital.nhs.uk/services/e-referral-service/document-library/advice-and-guidance-toolkit>

¹⁸ <https://digital.nhs.uk/services/e-referral-service/case-studies>

1. Agree activity levels for activity within scope of the blended payment

Following the stages outlined below, the provider and commissioner agree planned activity levels for 2020/21, as shown in table 1. The stages are:

- i. They note the activity levels in 2019/20, split by: first and follow-up, consultant-led and non-consultant-led, face-to-face and non-face-to-face.
- ii. They then agree expected changes in activity for 2020/21, taking into account demographic changes and non-demographic activity growth.
- iii. They calculate the 2019/20 activity plus expected growth.
- iv. At this stage (last column in table 1), they agree the impact of planned services changes:
 - They estimate the introduction of an advice and guidance service will reduce attendances by 2,250, with some reduction in first attendances and subsequent follow-up attendances, reducing total planned activity to 76,500.
 - They agree to transform delivery of some consultant led follow-up activity so that from 2020/21 non-face-to-face planned activity is set at 7,000.
 - They agree a general shift of activity from consultant-led to non-consultant-led delivery in areas of care where it is deemed clinically appropriate.

Table 1: Stages to determining planned activity levels for 2020/21¹⁹

		Stage:						
		i	ii	iii	iv			
TFC	HRG	First Attendance or Follow-up	Consultant-led or non	Face-to-Face or non	Activity 2019/20	Expected growth	2019/20 activity plus growth	Include planned change to service delivery
120	WF01B	FA	CL	F2F	20,000	5%	21,000	18,500
120	WF01B	FA	nCL	F2F	5,000	5%	5,250	7,000
120	WF01A	FUp	CL	F2F	40,000	5%	42,000	30,000
120	WF01A	FUp	nCL	F2F	10,000	5%	10,500	14,000
120	WF01A	FUp	CL	nF2F	-	-	-	7,000
<i>Total</i>					<i>75,000</i>		<i>78,750</i>	<i>76,500</i>

¹⁹ FA: First attendance, FUp: Follow-up, CL: consultant-led, nCL: non-consultant-led, F2F: face-to-face, nF2F: non-face-to-face.

2. Determine a price for the activity

Next, the provider and commissioner agree the price for each type of activity (table 2), based on the following considerations:

- Where activity has a TFC price specified in Annex A, it should be the default price for that activity unless a local departure is agreed. In the example, the provider and commissioner chose to use the Annex A price for consultant-led face-to-face activity.
- For consultant-led follow-up activity that was delivered as face-to-face in 2019/20 but will be delivered as non-face-to-face in 2020/21, the blended payment rules state this should be priced at the same rate as face-to-face activity. Again, the provider and commissioner chose to use the Annex A price and not agree a local variation.
- For non-consultant-led activity, there is no default unit price to be used. The provider and commissioner agreed local unit prices based on the prices in the *Non-mandatory prices* workbook.

As each of the prices are agreed based on nationally published default and guide prices, the providers' MFF of 1.05 will be applied.

Table 2: Agreed prices for planned activity

TFC	HRG	First Attendance or Follow-up	Consultant-led or non	Face-to-Face or non	Price	Determine price based on:
120	WF01B	FA	CL	F2F	£123	Default price as per Annex A
120	WF01B	FA	nCL	F2F	£81	Local price based on <i>Non-mandatory prices</i>
120	WF01A	FUp	CL	F2F	£53	Default price as per Annex A
120	WF01A	FUp	nCL	F2F	£49	Local price based on <i>Non-mandatory prices</i>
120	WF01A	FUp	CL	nF2F	£53	Activity delivered as a face-to-face attendance in 2019/20; priced same as face-to-face activity

3. Agree reimbursement for relevant advice and guidance services

The provider and commissioner agreed the cost of running an advice and guidance service for commissioner Z's patients. Though provider A may also be delivering this service to commissioner X's patients, they agree the proportion of the total cost of the service that relates to commissioner Z's patients at £150,000.

4. Calculate the fixed payment

Using the information agreed in steps 1-3, the fixed payment is calculated as £5,913,975. This is illustrated in table 3:

Table 3: Calculating the fixed payment

TFC	HRG	First Attendance or Follow-up	Consultant-led or non	Face-to-Face or non	Planned 2020/21 activity	Unit price	Unit price after MFF	Payment
120	WF01B	FA	CL	F2F	18,500	£123	£129.15	£2,389,275
120	WF01B	FA	nCL	F2F	7,000	£81	£85.05	£595,350
120	WF01A	FUp	CL	F2F	30,000	£53	£55.65	£1,669,500
120	WF01A	FUp	nCL	F2F	14,000	£49	£51.45	£720,300
120	WF01A	FUp	CL	nF2F	7,000	£53	£55.65	£389,550
Advice and guidance								£150,000
Total fixed payment								£5,913,975

The provider and commissioner agreed a schedule of payment over 2020/21.

4.13 Agreeing a quality-related payment – advice and guidance service delivery

As part of agreeing the fixed payment, providers and commissioners must agree which advice and guidance services are commissioned, along with expectations around service delivery and an agreed cost of reimbursement. They should then supplement this agreement by having a quality-related payment for the actual delivery of these services in-year. This payment should be locally determined but could focus on:

- response time to requests and how these compared to what was agreed (eg the percentage answered with 48 hours)
- the availability of consultant time to review requests (eg how many consultant programmed activities are assigned to the activity)
- the number of requests received from GPs and whether this is significantly different from what was planned (percentage over or under plan).

A level of payment should then be attached to the agreed metrics and used to adjust the amount paid as part of the fixed payment. For example, if the advice and guidance part of the fixed payment was £100k:

- if the number of responses within 48 hours is different from the plan of, say, 75%, then each 1% change could change the fixed payment by 1%, so each percentage point above plan would pay the provider an extra £1k, and each percentage point below plan would see the provider pay back £1k
- if the number of GP requests was planned for 2,000 per year, and the actual was 4,000 per year, an extra payment could be made on top of the fixed payment to recognise this. This could be a straight percentage increase (so a doubling of requests leads to a doubling of payment) or something more nuanced.

See Section 9.2 of this document for more details of quality- or outcomes-based approaches and potential benefits.

4.14 Guidance on outpatient attendance activity

Outpatient attendance activity is based on groupings that relate to clinical specialty, defined by TFC²⁰, attendance type²¹ (first or follow-up attendance, face-to-face or non-face-to-face), and single professional or multiprofessional clinics.

Separate unit prices are set based on:

- clinic type, categorised according to treatment function code (TFC)
- consultant-led or non-consultant-led
- first or follow-up attendances
- single professional or multiprofessional clinic
- face-to-face or non-face-to-face

²⁰ TFCs are defined in the [NHS Data Model and Dictionary](#) as codes for 'a division of clinical work based on main specialty, but incorporating approved sub-specialties and treatment interests used by lead care professionals including consultants'.

²¹ "First attendance code" or "First attendance" is used to derive the HRG

Consultant-led and non-consultant led

The NHS Data Model and Dictionary definition²² of a consultant-led service is a “service where a consultant retains overall clinical responsibility for the service, care, professional team or treatment. The consultant will not necessarily be physically present for all consultant-led activity but the consultant takes clinical responsibility for each patient's care”.

A consultant-led service does not apply to nurse consultants or physiotherapist consultants.

First and follow-up attendances

There are separate health resource groups (HRGs) for first and follow-up attendances, derived from the information recorded in “First attendance”. A first attendance is the first or only attendance for one referral. Follow-up attendances are those that follow first attendances as part of a series for the one referral. The series ends when the consultant does not give the patient a further appointment, or the patient has not attended for six months with no planned or expected future appointment.

If after discharge a new referral occurs and the patient returns to the clinic run by the same consultant, this is classified as a first attendance. The end of a financial year does not necessarily signify the end of a particular outpatient series. If two outpatient attendances for the same course of treatment are in two different financial years but less than six months apart, or the patient attends having been given a further appointment at their last attendance, the follow-up price applies.

To incentivise a change in the delivery of outpatient follow-up activity, encouraging a move to more efficient models and freeing consultant capacity, we set first attendance prices higher than those reported in reference costs and offset this by decreasing the corresponding follow-up attendance price. This transfer in cost (frontloading) is set at a TFC level and ranges from 10% to 30%. A full list of these TFCs is in Annex A. See also Section 4.9 for details of frontloading and blended payment.

²²https://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_led_service_de.asp?shownav=1

Some clinics are organised so that a patient may be seen by a different consultant team (in the same specialty and for the same course of treatment) on subsequent follow-up visits. In this case, commissioners and providers may wish to discuss adjusting funding to recognise that some of the appointments captured in the data flow as first attendances are, as far as the patient is concerned, follow-up visits.

There has been some concern about levels of consultant-to-consultant referrals, and when it is appropriate for them to be paid as a first rather than follow-up attendance. Given the range of circumstances in which these may occur, it is not feasible to mandate a national approach to recording these types of attendance and their payment.

Multiprofessional and multidisciplinary

Annex A contains separate unit prices for multiprofessional and single-professional outpatient attendances, which reflect service and cost differences. The multiprofessional price is payable for two types of activity, with the following OPCS codes:

- X62.2: assessment by multiprofessional team not elsewhere classified for multiprofessional consultations²³
- X62.3: assessment by multidisciplinary team not elsewhere classified for multidisciplinary consultations.²⁴

Multiprofessional attendances are defined as several care professionals (including consultants) seeing a patient together, in the same attendance, at the same time. The TFC of the consultant clinically responsible for the patient should be applied to a multiprofessional clinic where at least two consultants are present. Where there is joint responsibility between consultants, this should be discussed and agreed between commissioner and provider.

Multidisciplinary attendances are defined as several care professionals (including consultants) seeing a patient together, in the same attendance, at the same time when two or more of the care professionals are consultants from different national main specialties.

²³ [www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/multi-professional_consultation_\(national_tariff_payment_system\)_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/multi-professional_consultation_(national_tariff_payment_system)_de.asp?shownav=1)

²⁴ [www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/multi-disciplinary_consultation_\(national_tariff_payment_system\)_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/multi-disciplinary_consultation_(national_tariff_payment_system)_de.asp?shownav=1)

The relevant OPCS code can only be applied when a patient sees two or more healthcare professionals at the same time. The clinical input of multiprofessional or multidisciplinary attendances must be reported in the clinical notes or other relevant documentation. The relevant OPCS code does not apply if one professional is supporting another, clinically or otherwise (eg by taking notes, acting as a chaperone, training, professional update purposes, operating equipment and passing instruments). Nor does it apply where a patient sees single professionals sequentially as part of the same clinic. This would count as two separate attendances and should be reported as such in line with existing NHS Data Model and Dictionary guidance on joint consultant clinics.²⁵

The multidisciplinary attendance definition does not apply to multidisciplinary meetings (that is, when care professionals meet in the absence of the patient).

Commissioners and providers should exercise common sense in determining which attendances are multiprofessional and which are multidisciplinary, and document this appropriately in their contracts.

An example of a multiprofessional attendance is when an orthopaedic nurse specialist assesses a patient and a physiotherapist provides physiotherapy during the same appointment.

Examples of multidisciplinary attendances are:

- a breast surgeon and an oncologist discuss with the patient options for surgery and treatment of breast cancer
- a respiratory consultant, a rheumatology consultant and a nurse specialist discuss with the patient treatment for a complex multisystemic condition, eg systemic lupus erythematosus
- a patient (and potentially a family member) sees a paediatrician to discuss their disease and a clinical geneticist to discuss familial risk factors.

Examples of when the multiprofessional or multidisciplinary definitions do not apply include:

²⁵<https://webarchive.nationalarchives.gov.uk/20160921192516/http://systems.digital.nhs.uk/data/nhsdmds/faqs/cds/admitpat/consact>

- a consultant and a sonographer, when the sonographer is operating equipment for the consultant to view the results
- a maxillofacial consultant and a dental nurse passing examination instruments to the consultant
- a consultant and a nurse specialist, when the nurse specialist is taking a record of the consultation
- a consultant and a junior doctor, when the junior doctor is present for training
- a consultant ophthalmologist and a nurse, where the nurse administers eye drops or gives the sight exam as part of the consultation.

Face-to-face and non-face-to-face

There are separate health resource groups (HRGs) for face-to-face and non-face-to-face attendances, derived from the information recorded in “First attendance”²⁶.

Non-face-to-face attendances are described as “telephone or telemedicine” consultations. Telemedicine is the use of telecommunication and information technology for the purpose of providing remote health assessments and therapeutic interventions. This could include video or voice messaging services on mobile phones, computers and tablets.²⁷

Services previously with national prices

The introduction of blended payment involves the removal of outpatient attendances from the scope of national prices in 2020/21. Providers and commissioners would, however, need to apply the rules set out in Section 7.2 of the 2020/21 NTPS to agree the amounts payable for outpatient attendances.

These rules state that TFC prices for outpatient attendances published in Annex A should be used. These are unit prices that were national prices in previous tariffs.

Annex A includes the prices for consultant-led outpatient attendances based on clinic type, categorised according to treatment function code (TFC). With prices for first and follow-up attendances, for each TFC, as well as for single professional and multiprofessional clinics.

²⁶ “First attendance code” or “First attendance” is used to derive the HRG

²⁷ www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/t/telemedicine_de.asp?show_nav=0

These outpatient attendance prices remain applicable only to pre-booked, consultant-led attendances and in accordance with the service conditions in the [NHS Standard Contract](#).

When an attendance with a consultant from a different main specialty occurs during a patient's admission and replaces an attendance that would otherwise have taken place, it should attract an Annex A price, provided it is pre-booked and consultant-led.

Outpatient attendances do not have to take place on hospital premises. Therefore consultant-led outreach clinics held in a GP practice or a children's centre should be eligible for the Annex A price. For these clinics, it is important to make sure the data flows into SUS+ to support payment for this activity. However, home visits are not eligible for the Annex A price and are subject to local price setting.

Services previously without national prices

For TFCs that do not have a price in Annex A – ie those that were not national prices in previous tariffs – the price should be set through local price-setting, in accordance with the rules on local pricing (see Section 6 of the 2020/21 NTPS, particularly Section 6.4.1).

To support local systems in agreeing local prices, we have included some prices for outpatient attendances in the *Non-mandatory prices* workbook.

To further incentivise the use of new delivery models for follow-up appointments, increased use of non-face-to-face appointments or wider adoption of technology, these prices include non-consultant-led and non-face-to-face prices.

However, to support targeted and clinically appropriate shifts in activity to non-face-to-face delivery, the blended payment rules for outpatient attendances stipulate that, when activity delivered as a face-to-face attendance in 2019/20 is planned to be delivered as a non-face-to-face attendance in 2020/21, it should be priced at the same level as the corresponding face-to-face price.

General

When a patient has multiple distinct pre-booked outpatient attendances on the same day (eg one attendance in the morning and a second separate attendance in

the afternoon), each attendance is counted separately and will attract a separate price unless a local pathway price has been agreed with commissioners.

If, following an outpatient attendance, a patient attends an allied health professional (eg a physiotherapist), the costs of the latter attendance are not included in the price for the original attendance and these attendances will be subject to local price setting (in accordance with the rules on local pricing).

Commissioners and providers should use the NHS Data Model and Dictionary to decide the category of outpatient attendance and day-case activity.²⁸ Furthermore, providers must ensure that the way they charge for activity is consistent with the way they cost activity, and consistent with any conditions for payment included in contracts.

For some procedures undertaken in an outpatient setting, there are national prices based on HRGs. If more than one of these procedures is undertaken in a single outpatient attendance, only one price is applicable. The grouper software will determine the appropriate HRG, and the provider will receive payment at the relevant price.

Where a procedure-driven HRG is generated, SUS+ determines whether the HRG has a mandatory national price and, if so, applies it. Outpatient procedures for which there is no national HRG price will be paid according to the relevant outpatient attendance national price.

Outpatient pathways

The outpatient attendances blended payment should not stop commissioners and providers agreeing local departures (in accordance with rule 5 in Section 7.2) that reflect local pathways and/or National Institute for Health and Care Excellence (NICE) guidance, either within the acute setting or across acute and community settings.

²⁸ The [NHS Data Model and Dictionary](#) Service sets out the definitions to be applied. It provides a reference point for assured information standards to support healthcare activities in the NHS in England.

Examples of these could include specific pathways of care in dermatology, or cover pathways for patients with more complex needs that do not have a discrete TFC for identification and reimbursement.

For more details on local departures, see rule 5 in Section 7.2 of the 2020/21 NTPS.

5. Blended payment for maternity services

The detailed rules for the blended payment for maternity services are in Section 7.3 of the 2020/21 NTPS. This guidance supports these rules.

5.1 Why is there a blended payment for maternity services?

The maternity blended payment approach should help to address issues reported with the maternity pathway payment, particularly provider-to-provider payments. Blended payment should also assist local maternity systems (LMSs) to plan at a system-wide level, supporting the introduction of recommendations from the [Better Births](#) report, and other initiatives such as Saving Babies Lives Care Bundle v2.

We recognise that moving to blended payment may be a significant change. As such, for 2020/21, local areas can choose to use either the blended payment, described here, or continue to use the maternity pathway payment.²⁹ See *Guidance on the maternity pathway payment* for more details.³⁰

5.2 What is a blended payment for maternity?

The maternity blended payment involves:

- a fixed payment, based on agreed activity levels and unit prices. These unit prices may apply at either pathway or HRG level (see Section 5.4)
- a locally determined quality- or outcomes-based element
- an optional risk sharing element.

5.3 Scope of activity in the blended payment

The blended payment includes all services within the scope of the maternity pathway that are commissioned by CCGs.

²⁹ Providers and commissioners can also agree to use a different approach. See rule 6 in Section 7.3 of the 2020/21 NTPS for more details.

³⁰ Available from: <https://improvement.nhs.uk/resources/national-tariff-2021-consultation/>

5.4 Fixed payment

To set the fixed payment, commissioners and providers first need to agree the level and type of activity required to deliver system strategic objectives for the population they serve. In doing so, they should ensure the needs of women from the most deprived quintiles and from Black/ethnic minority groups are explicitly considered. The fixed payment for each provider should be based on recent and anticipated activity.

Providers and commissioners need to decide if they are going to agree activity levels – and prices – based on the maternity pathway or at an HRG level (see examples below for how each of these options could be used). Choosing either option, or developing a local approach, will depend on local circumstances, data availability and the preference of financial and clinical system leaders.

Whichever approach they choose, providers and commissioners would need to:

- review historic activity data over the last three years
- reach agreement on how system strategic objectives will impact on activity
- review data on levels of activity undertaken by other providers both within and outside the local system, and the associated costs
- show system leadership to deal with any gaps in data or risk currently being managed in the system.

A key objective for the maternity blended payment is to minimise provider-to-provider payments. The following examples include the steps needed to achieve this and see more details of the process in the section below.

Calculating the fixed payment using pathway prices

The fixed payment can be constructed using activity levels and prices for the maternity pathway as the starting point. This could then be adjusted for any activity invoiced by other providers to the lead provider.

This approach may be the most appropriate method if:

- systems want to maintain the pathway approach for clinical or operational reasons

- data at pathway level is more accurate than at HRG level, or HRG-level data is not available
- systems would like to build the fixed payment using a less granular approach than the HRGs.

The calculation would involve providers and commissioners undertaking the following steps:

- Use historic activity and complexity data to identify the numbers of women booking with each provider for each phase of care and level of intensity. (Note: Activity forecasts must be built up from provider to LMS level, **not** the other way around.)
- Compare planned activity with historic activity and actual payments for each phase and intensity level of the maternity pathway. Review forecast activity for the next period if there are material differences between previous forecast and actual activity.
- Consider any changes required to support strategic objectives. These will need to be agreed at the LMS level.
- Multiply the agreed activity by the relevant prices – either those published in the *Non-mandatory prices* workbook or locally agreed prices where appropriate. If using the *Non-mandatory prices*, providers' MFF values should be applied.
- Providers disclose the level of invoicing they have received from other providers, separating out those from providers within the LMS and those from outside. They should also disclose the level of receipts from providers within the LMS. (It may be useful to look at the type of activity routinely being undertaken outside of the LMS to understand whether there is scope for developing services locally.)
- Adjust the fixed payment up or down for net impact of activity delivered by other providers in the LMS or delivered for other providers.
- Agree any additional transformation investment that will form part of the fixed payment, preferably at the LMS level.
- The commissioner should retain funding to reimburse any activity delivered by providers outside of the system (LMS or place based). Any payments would normally be paid at the HRG level.

Calculating fixed payment using HRG prices

As well as prices for the maternity pathways, the *Non-mandatory prices* workbook also contains HRG prices for maternity activity.

Using HRG prices to set the fixed payment would involve analysing activity and complexity data at HRG level in the system to identify all maternity activity delivered by all providers.

This approach may be more appropriate than using pathway prices if:

- systems are confident about the data of all providers in the system
- it has been agreed that the clinical benefits of delivering a pathway of care (using the antenatal, delivery and postnatal phases) can be separated from the payment approach
- pathway level data isn't sufficiently detailed
- the system feels confident that any income differences between the HRG payment and pathway approach can be managed through system leadership.

The calculation would involve the following steps:

- Agree the most appropriate HRG-level historical activity data to use,³¹ such as:
 - prior year
 - three-year average
 - prior year, adjusted for previous two-year average.
- Analyse activity and complexity at HRG level for activity delivered by providers outside the local system.
- Review and resolve data anomalies; for example, compare historical forecasts with actual activity, benchmarking with similar areas, and audit data quality.
- Consider any adjustments needed to support strategic objectives. Ideally agree these across the LMS but at a minimum between each provider and commissioner.

³¹ Relevant data sources are likely to include SUS/HES, maternity services dataset (MSDS) submissions, reference cost and patient-level cost (PLICS) submissions.

- Multiply predicted activity by the HRG prices published in the *Non-mandatory prices* workbook, or locally agreed prices. If using the *Non-mandatory prices*, providers' MFF values should be applied.
- Adjust the fixed payment up or down for net impact of activity at HRG level delivered by other providers in the LMS or delivered for other providers.
- Agree any additional transformation investment that will form part of the fixed payment, preferably at the LMS level.
- Determine activity delivered out of LMS area (eg by reviewing SUS/HES data or recorded provider to provider invoices). The Commissioner should retain funding to reimburse that activity.

Provider-to-provider payments

A key objective for the maternity blended payment is to minimise provider-to-provider payments. This can be done by using the following process.

Within LMS

This requires transparent conversations between providers and commissioners across the LMS to understand local patient flow patterns. This will help determine how much funding should go to each provider in the LMS as part of the fixed payment.

Data is available for the numbers of women who have been booked for maternity care for each phase of the pathway with any provider, and the percentage attracting each payment level. At the moment, commissioners have little visibility of any care delivered outside of the lead provider. It is necessary to share this information to allow the fixed payments to take account of previous provider-to-provider transactions.

Recommended approach

Providers and commissioners should agree a set of principles such as:

- the method of coding and costing activity
- using data from the previous two or three years to determine trends in patient flows within and outside the LMS, and the actual type of activity undertaken.

These principles can be used to determine the likely levels and costs of provider-to-provider payments, and to make adjustments to each providers' fixed payment within the LMS. The impact should be cost neutral across the LMS. Providers and

commissioners must agree the tolerance levels of activity/costs (+/- X %) to be included within the intelligent fixed payment. Using tolerance levels will allow for small variance in anticipated patient flows. The frequency of the review of this tolerance level should be agreed at the outset, but we would recommend a minimum of an annual review. Where the tolerance levels are exceeded then a risk share agreement should be used (see Section 5.6).

Outside LMS

For any maternity activity taking place outside of the LMS (or agreed planning boundary) the commissioner should reimburse the relevant provider directly. This would remove the need for provider-to-provider transactions.

Ad hoc maternity care (eg accessed by women who are on holiday), should be charged to the woman's residential CCG using the non-mandatory HRG prices.

Where providers and commissioners choose to use the maternity pathway payment for 2020/21, we would recommend shadow testing the blended payment approach, particularly the inclusion of provider-to-provider invoicing in the fixed payment, in preparation for 2021/22 when we are likely to propose blended payment as the default payment approach for maternity services.

5.5 Quality- or outcomes-based element

The quality- or outcomes-based element of blended payment needs to be agreed locally. However, it is expected to link to Better Births and NHS Long Term Plan deliverables for maternity services. This section sets out a set of principles that should be used for this element.

It also includes examples of appropriate measures that can be used to set the element, with an initial focus on process measures. These measures have been developed with the NHS England and NHS Improvement maternity policy team. Initially, local systems may choose to monitor and report on agreed outcomes metrics, rather than link them to payment.

The aims for maternity services set out in the [NHS Long Term Plan](#), and the recommendations from the [Better Births](#) report, support safer and more personalised care.

- For safer care this means halving the rate of stillbirths, neonatal deaths, maternal deaths and intrapartum brain injuries by 2030 (from a 2010

baseline). It also means reducing the rate of pre-term births by 25% from a 2015 baseline.

- For personalised care this means care centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information. It is best measured by what women report about their experience of care, such as through the CQC survey of users of maternity services.

The quality- or outcomes-based element of blended payment should support the achievement of these aims.

We recognise that in maternity care, as in other clinical areas, outcomes are often attributable to several provider organisations. Measurable change may not be demonstrable over the near term. Many of these measures will need to be implemented and monitored at LMS level.

As such, it may be appropriate for quality- or outcomes-based element of the blended payment to initially operate in shadow form. This would involve monitoring process measures as a proxy for whether providers are in a position to deliver the outcomes needed for their LMS plan. These would not initially be related directly to a payment. As systems develop, it should become easier to monitor outcomes and build them into the payment model.

The following principles should apply to any agreed quality or (proxy) outcome measures. The measures should be:

- achievable yet stretching
- timely
- meaningful
- clearly defined
- meeting local and national priorities
- relevant to target population
- unlikely to lead to double incentives (for example where something is already covered by CQUIN).

Measures should be derived from:

- Measures of clinical quality (safety, clinical effectiveness and experience of care), which are already routinely monitored to ensure the delivery of high-quality care. These should be locally agreed and based on routine quality measures already used by commissioners and providers.
- Measures of transformation associated with the implementation of Better Births and the NHS Long Term Plan. It is important that these are included as systems receive transformation funding to implement them and, as they are evidence-based initiatives, they will lead to outcomes improvement.

With this in mind, Table 4 describes some measures that could be considered. LMSs may also choose to use measures that reflect their local priorities. It should be noted that the planned dates are likely to be affected by the Covid-19 pandemic

Table 4: Examples of potential quality or outcome measures

Measure	Local Data Source	Further details
Safer Maternity Care		
Implementation of the Saving Babies' Lives Care Bundle v2 (SBLCB) <ul style="list-style-type: none"> • Reducing smoking in pregnancy • Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR) • Raising awareness of reduced fetal movement (RFM) • Effective fetal monitoring during labour • Reducing preterm birth 	Local assurance. Trusts complete a quarterly survey, (returned to maternity clinical networks) for the purposes of national monitoring.	Further details on the Saving Babies' Lives Care Bundle (v2) are available here .
Proportion of births before 27 weeks of gestation in a maternity	Badgernet	A key objective for providers, in line with the Neonatal Critical Care Review

Measure	Local Data Source	Further details
unit with appropriate on-site neonatal care available.		interim 'Neonatal Themes Report'. The expectation is currently set at 85%.
Use of the Perinatal Mortality Review Tool (PMRT) for deaths of babies (suitable for review using the PMRT)	Provider assurance	A key objective for providers, in line with the Neonatal Critical Care Review interim 'Neonatal Themes Report'. The expectation is currently set at 95%.
Personalised care		
Number of women who have a Personalised Care & Support Plan	MSDS – available via Data Services for Commissioners	Further details on Personalised Care & Support Plans can be obtained from Regional Maternity Programme Boards.
Women receiving continuity of carer	MSDS – available via Data Services for Commissioners	Further details and technical guidance on continuity of carer measurement is available from Regional Maternity Programme Boards
Number of women giving birth in midwifery settings	MSDS – available via Data Services for Commissioners	A national target has not been set because whether birth in a midwifery setting is right depends on the choices and circumstances of individual women. However, if service provision more closely reflects what women say they want, the number of women using midwifery services would increase. LMSs will need to determine what is appropriate locally depending on the current pattern of service use, clinical case mix and input from service users.
Implementation of an LMS wide postnatal improvement plan.	Local assurance	Further details available from Regional Maternity Boards

To ensure the measures are accurate and usable, it is essential that:

- the provider submits data to the Maternity Services Dataset v2.0³² to the required standard (see Section 5.8)
- the provider's maternity information system is compliant with the [Information Standards Notice \(ISN\)](#) for direct maternity care.

Several transformation measures are included in the [Maternity Incentive Scheme](#). To avoid any issues of double incentive, we intend to align the measures within this scheme with any measures proposed to be part of the blended payment in future years.

As set out above, it may be appropriate for the process/outcome measures to operate in shadow form in 2020/21, without being linked to payment. Throughout this 'shadow' year, providers and commissioners should do the following to prepare for the measures becoming part of the payment approach in future years:

- Ensure robust data capture is in place to support the developing payment model, prioritising elements outlined in Table 4.
- Monitor whether the agreed changes to outcomes are being delivered, recognising any local contextual factors, for example availability of transformation funding, workforce etc, that may make these less or more difficult to achieve in the short term.

If payment is linked to any of the agreed measures, providers and commissioners should consider how the quality- or outcomes-based element would operate. For example, it could be either:

- a bonus on top of a payment that reimburses for efficient costs of providing the services
- withholding part of a payment that reimburses for efficient costs until required outcomes are met.

See Section 9.2 of this document for details of other quality- or outcomes-based approaches and potential benefits.

³² MSDS v2.0 is an update to the data set. It mandates the submission of all maternity records in scope of the data set, including records that are held on paper which must be submitted in the required electronic format. The key data tables for MSDS v2.0 completion in 2020/21 are included Section 5.8.

5.6 Risk share

For 2020/21, the risk share element of blended payment for maternity services is optional.

A risk share should be designed to balance the benefit, or burden, of a risk materialising based on the partners' management contribution and ability to bear risk. The objective should be to create an environment where the management of the risk is optimised.

In the case of maternity services, birth levels are fairly predictable, with reliable ONS data available. However, a risk share could be worth considering, particularly to address the following potential risks:

- Utilisation risk: the volume or complexity of women choosing a provider being different from the assumption in the system plan and fixed payment.
- Estimating risk: for new initiatives, or activity, included in the plan (and fixed payment) the actual cost and implementation timescale may be different from the assumption in the system plan and, therefore, the fixed payment.

The important features in designing a risk share are:

- designing, agreeing and documenting the risk share agreement in advance, including all partners
- tolerance levels of variation before risk share features apply, and the levels that would subsequently apply once triggered
- how variations will be paid (+/-). This could be:
 - based on marginal rate of agreed price
 - based on full rate of agreed price
 - a combination of both, depending on the scale of variation.

Risk sharing is aimed at supporting collaborative system planning. Risk sharing establishes a governance arrangement, framework, or agreed specifics on how risks (or benefits) can be appropriately shared across commissioners and providers in a system.

For further details on risk-sharing, please see our [risk sharing webinar series](#). Section 9.3 of this document also contains details of potential risk share approaches, and provides more detailed guidance on activity-based risk sharing.

5.7 Duration of blended payment

The 2020/21 NTPS takes effect from date of publication. However, financial arrangements moving providers and commissioners to block payments have been introduced for 2020/21 in response to Covid-19. These arrangements have been implemented as local variations to the NTPS, meaning blended payments have not been used for this year. We would usually expect that the blended payment would be updated for each tariff cycle. This would ensure that any under- or overestimate of activity in any one tariff cycle is not hard-wired into contracts in future.

Areas should not automatically roll over any under- or over-performance against plan. Before any agreement is made, there should be discussions about why that difference has occurred and the likelihood of such activity occurring again.

5.8 Key data tables for MSDS submission

Submission of data to the Maternity Services Dataset is required of all maternity providers. Providers should ensure their systems and processes are updated to enable full submission, prioritising the following data tables/fields.

Data tables

- MSD000 MSDS header
- MSD001 Mother's demographics
- MSD002 GP practice registration
- MSD101 Pregnancy and booking details
- MSD102 Maternity care plan
- MSD201 Care contact (pregnancy)
- MSD202 Care activity (pregnancy)
- MSD301 Labour and delivery
- MSD302 Care activity (labour and delivery)
- MSD401 Baby's demographics and birth details
- MSD405 Care activity (baby)
- MSD901 Staff details

Other key data fields for completion

- At least 90% of HES births expectation (unless reason understood) (MSD401)

- At least as many unique bookings as the number of births submitted in the month (unless reason understood) (MSD101)
- Estimated Date of Delivery for 95% of bookings (MSD101)
- Valid postcode for mother at booking in 95% of records (MSD001)
- Valid ethnic category (Mother) for at least 80% of bookings. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)
- Continuity of carer plan fields completed for 90% of bookings (MSD102)
- Personalised care plan fields completed for 90% of bookings (MSD102)
- Valid presentation at onset of delivery codes for 90% of births (MSD401)

6. Blended payment for adult mental health services

The local pricing rule for the blended payment for adult mental health services is in Section 6.4.4 of the 2020/21 NTPS. This guidance supports this rule.

6.1 Why is there a blended payment for adult mental health services?

The blended payment approach for adult mental health services supports the ambition for mental health services outlined in the [NHS Long Term Plan](#) and subsequent [NHS Mental Health Implementation Plan for 2019/20 – 2023/24](#). The [NHS Long Term Plan](#) pledged a renewed commitment to mental health, stating that mental health services will grow faster than the overall NHS budget, with new ringfenced local investment worth at least £2.3 billion a year by 2023/24.

The blended payment approach for adult mental health services also reflects the importance of the following issues:

- Improvements to data quality to ensure accurate recording of patient activity and cost data as well as patient outcomes.
- The need to increase access to services and to continue to improve outcomes for service users.
- Ensuring that commissioners will meet the requirements of the Mental Health Investment Standard.
- Helping the service to free up capacity to reduce waiting lists through better benchmarking.

6.2 What is the blended payment for adult mental health services

The blended payment approach for adult mental health services consists of the following elements:

- a fixed payment based on the agreed forecast level of activity required to meet the objectives set out in the planning guidance
- a variable element based on an estimate of the variable cost of delivering activity
- an element of payment linked to locally agreed quality and outcomes measures and the delivery of access and wait standards
- an optional risk share agreement, if providers and commissioners consider this appropriate locally.

Providers and commissioners can modify this approach to suit their local needs. However, where commissioners and providers cannot agree a local approach, we would expect them to use the one set out in this document. The NHS England and NHS Improvement regional teams would support local areas with this.

Mental health clusters remain the currencies against which activity data must be reported to NHS Digital's Mental Health Services Data Set (MHSDS).³³ As such, mental health clusters are the basis for the blended payment approach. There is flexibility for providers and commissioners to agree alternative currencies as the basis for blended payments at a local level, where this complies with the local pricing principles and relevant local pricing rules, and to agree an alternative payment approach that better suits their local health economy.

6.3 Fixed payment

In establishing the fixed payment element, providers and commissioners should work together to agree realistic forecast levels of activity and the total anticipated costs of delivering the associated activity.

The starting point will be a good understanding of historic activity and unit costs. Looking ahead the forecast activity must align with delivering the strategic objectives set out in the [Five Year Forward View for Mental Health](#) and the [NHS Long Term Plan](#) of providing increased access to evidence-based services to meet local population health needs. The Long Term Plan committed to an additional investment in mental health services of at least £2.3 billion a year by 2023/24.

³³ MHSDS – the Mental Health Services Dataset is the patient-level dataset for mental health services in England. A monthly submission to the dataset is mandatory for any provider of NHS funded care, including independent sector provider. This requirement is set out in the [Standard Contract](#).

Forecast activity should also reflect demographic pressures and a realistic assessment of the impact of system efforts across the local health economy to increase access to meet population needs efficiently. Activity plans (and the fixed payment) may need to be updated in-year to reflect final LTP implementation plans.

In agreeing planned activity, commissioners and providers should involve their sustainability and transformation partnership (STP) or integrated care system (ICS), and other system partners in planning discussions.

6.4 Variable element

The variable element should reflect the best possible estimate of the incremental costs of activity increasing or decreasing.³⁴ This will need to be agreed locally and should reflect the different cost structures of relevant services.

Payment terms for the fixed and variable elements need to be agreed and activity will be subject to monitoring and review – for example, each quarter. Providers should supply fully coded and costed activity to support the review process.

Providers and commissioners may want to consider an agreement for how to manage situations where actual activity differs significantly from forecast activity. This may include reopening the fixed payment or agreeing a different variable rate to reflect the actual cost of delivering the revised activity levels.

Local pricing rule 7 also includes a requirement to link an element of payment to access, quality and outcomes.

6.5 Quality- or outcomes-based element

The [Five Year Forward View for Mental Health](#) recommended a payment system that would support improvement in access to, and the quality and outcomes of, mental health services, providing a means of assessing and comparing value. The tariff's local pricing rules require providers and commissioners to link an element of payment to agreed access, quality and outcomes measures.

The building blocks for developing and sustaining a quality- or outcomes-based payment include:

³⁴ The default activity level should be the cluster currencies. However, providers and commissioners can agree alternative currencies if this follows the relevant local pricing rules.

- leadership and engagement
- transparency
- rationalised reporting
- improving and learning focused NHS.

These are outlined in more detail in [Delivering the Five Year Forward View for Mental Health: Developing Quality and Outcomes Measures](#).

Commissioners should outline in their sustainability and transformation plans how they will use outcomes to drive standards and quality in accordance with the vision as set out in the [Five Year Forward View for Mental Health](#) and [NHS Long Term Plan](#) underpinning a blended payment approach. Commissioners and providers are free to decide which quality and outcome measures are linked to payment. However, services must be measured and benchmarked against national access standards.

An element of payment for quality or outcomes should form part of the variable element of the blended payment approach (rather than the fixed payment element). We recommend that the value of the quality or outcomes component should initially be set at a minimum of 2% of the total contract value.

Quality and outcome measures which can be used include:

- people on care programme approaches (CPA) followed up within seven days
- proportion of people on CPA with a crisis plan in place
- age standardised mortality rate from suicide
- bed occupancy rate
- use of accident and emergency for people using mental health services
- mental health IAPT and EIP waiting time targets
- access to cognitive behaviour therapy for people with schizophrenia
- validated patient and clinician reported outcome tools.

For more information, see [Health of the Nation Outcome Scales \(HoNOS\)](#).³⁵

³⁵ HoNOS was developed during the early 1990s by the Royal College of Psychiatrists as a measure of the health and social functioning of people with severe mental illness. The scales contain 12 items measuring behaviour, impairment, symptoms and social functioning. The scales

See Section 9.2 of this document for more details of quality- or outcomes-based approaches and potential benefits.

6.6 Risk share

Providers and commissioners may choose to include either a financial- or activity-based risk share in their blended payment.

For further details on risk-sharing, please see our [risk sharing webinar series](#). Section 9.3 of this document also contains details of potential risk share approaches, and provides more detailed guidance on activity-based risk sharing.

6.7 Duration of blended payment

The 2020/21 NTPS takes effect from date of publication. However, financial arrangements moving providers and commissioners to block payments have been introduced for 2020/21 in response to Covid-19. These arrangements have been implemented as local variations to the NTPS, meaning blended payments have not been used for this year. We would usually expect that the blended payment would be updated for each tariff cycle. This would ensure that any under- or overestimate of activity in any one tariff cycle is not hard-wired into contracts in future.

Areas should not automatically roll over any under- or over-performance against plan. Before any agreement is made, there should be discussions about why that difference has occurred and the likelihood of such activity occurring again.

are completed after routine clinical assessments in any setting. www.rcpsych.ac.uk/events/in-house-training/health-of-nation-outcome-scales

Part C: Case studies

The blended payment approach was informed by work being done by providers and commissioners around the country, that are working to develop payment systems that support their local ways of working. Here we share case studies of such work and other examples of blended payments that have been implemented by local areas.

We will work with local areas to develop case studies. If you would be interested in sharing your experiences of implementing blended payment, please contact pricing@improvement.nhs.uk

7. Case studies

7.1 Berkshire West

For the financial year 2018/19, Berkshire West CCG (BWCCG) and Royal Berkshire NHS Foundation Trust (RBFT) agreed to develop a different approach to payments, as part of becoming a Wave 1 integrated care system (ICS) site. They agreed to move away from national prices for all acute services contracted.

The payment approach they chose centred on agreeing a fixed payment, aligned to the ICS system operating plan, with a local mechanism for dealing with payments for material variations in activity. This approach required a level of trust and system leadership from both partners. The objectives were to:

- create an environment to stimulate clinical and operational transformation
- focus attention on value and cost management
- reduce the confrontational and transactional impact of previous payment approaches
- facilitate greater collaboration between ICS partners to enable the transformation.

It is too early to report the qualitative impact of this change in payment approach, or even specifically attribute any individual system clinical or performance outcome to this specific change. However, the impact on the business relationships reported by the system, shown below, highlights several benefits following the change in payment approach:

- Contract review meetings between the CCG and the acute provider have moved from monthly to every other month.
- There has been a reduced monthly challenge process between the CCG and the acute provider. This has shifted the focus away from challenging activity recording from a financial perspective to improving the quality of coding to improve clinical decision-making. The approach is being promoted with associates.
- The payment approach has made it easier for parties to have conversations about how to do the right thing rather than arguing about different sets of

numbers. This is leading to improved relationships and an increasing number of ideas on how to take out non value-added administrative activity. For example, there is a live project to resolve an archaic and time-consuming approach to intra-provider recharges.

- The payment approach has enabled ICS partners to propose pathway changes without concern about the impact on income generation to one specific partner.
- Any contract alignment work is easier to complete and can be done by either organisation, without challenging reconciliations and wasting time finding out that the contracts are not aligned (which was the experience in 2017/18).

7.2 Fylde Coast

For the financial year 2018/19, commissioners from the Fylde Coast CCGs (NHS Fylde and Wyre and NHS Blackpool) and Blackpool Teaching Hospitals NHS Foundation Trust (BTH) agreed an aligned incentives contract that adopted the principles of the blended payment approach.

The contract covered all acute services provided by BTH for the CCGs' population. The main strategic objectives were to create an environment to support the joint ambition to better manage demand and flow for non-elective activity and to improve the quality, experience and cost performance of the system.

The contractual arrangement was based on historic contract value, with an agreed activity plan (based on 2017/18 levels) and adjusted for any known changes. The contract value was a fixed block for a fixed amount of activity. The contract had a health economy agreement for activity levels (and cost) significantly over the plan. This was agreed through a collective planning approach. The contract offered the opportunity for the provider to retain the savings from any activity level below the agreed plan.

The impact of this approach for both the commissioner and provider was to shift the focus away from income and onto system value, enabled by joint understanding of the true cost of services.

Contract-related meetings are now much more focused on performance metrics, rather than escalated coding and counting challenges, as these no longer impact on

income. Changes are being made to internal processes to improve the accuracy of coding and hence the data on which decisions are made, without the risk that this will lead to a dispute over any changes. This has led to a definite reduction in tension and there is more collaborative working on system reform, such as payment reform and cost reduction through pathway redesign.

The system is also committed to improving the quality of information available and has invested in the development of a business intelligence platform (Nexus) that can track patient journeys in real time.

This approach was initially trialled for non-elective activity, in response to a difficult performance position during the previous winter. The work highlighted where patients had been inappropriately admitted through A&E and where opportunities for more appropriate intervention had been missed before the A&E attendance.

This supported the introduction of primary care streaming to get A&E attendees into the right setting.

Pilot work is ongoing to attach system costs to activity to inform standardisation of treatment in each part of the pathway (where appropriate) and support pathway redesign and system decision-making

Future work will focus on moving from the current cost- and block-based approach to one using service costs as the building block, with a clear set of incentives and outcome metrics across care pathways and neighbourhoods.

7.3 North East London

Background

North East London Foundation Trust (NELFT) covers a population of 4.3 million. It provides adult mental health services for approximately 12,000 people living in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, spending around £82 million each year on their care.

How are services currently paid for?

NELFT adopted mental health clusters when there were first introduced and has continued to use clusters in all adult and older adult in-scope services. NELFT has had a patient-level information and costing system (PLICs) in place for

approximately seven years and has used cluster-based activity information to develop local prices. Discussions with CCG partners are based on this information.

Since 2015/16 NELFT have been live trading (using clusters as part of the payment approach) on three clusters, one from each superclass (non-psychotic, psychotic or organic). There is a risk share with cap and collar with a marginal rate. The cap is set at +/- 5% and the collar at +/- 7.5%, with a marginal rate of 12.5%. This limits the financial exposure for both NELFT and the commissioners. Having this mechanism in place has enabled closer collaborative working between them. It has also focussed attention on what the data is able to show about patient care, rather than just considering the financial consequences.

Over the last four years, since this arrangement has been in place, the gap between anticipated and actual activity has reduced. In addition, NELFT and the commissioners have gained a better understanding of the benefits delivered from additional investments. One of the clusters selected for live trading was cluster 10 (first episode psychosis with/without manic features). This means it has been possible to track the increase in demand as a result of the first episode psychosis (FEP) referral to treatment target (RTT), and to have a better understanding of the cost of providing services to this client group.

NELFT provides its monthly contacting information based on all clusters. As such, the trust would be able to monitor the full impact were live trading to be implemented across all areas.

Clustering has meant that there is better knowledge of the patient profile within the trust and it has provided granular information, allowing comparisons between like services. It has also meant that the trust can now confidently report Health of the Nation Outcome Scales (HoNOS) data as a consistent outcome measure used across all its adult/older adult mental health services. This would have been unlikely without clustering.

Since 2018, an element of the contract has focused on the implementation of DIALOG as a patient-reported outcome measure (PROM). Currently, there is no financial impact based on what the measure and the focus for this year is related to expanding the use of DIALOG beyond Early Intervention in Psychosis (EIP) into service users on a care programme approach within crisis resolution team services.

NELFT would describe their current contracting arrangements as being in the spirit of a blended payment mechanism, but acknowledge further development is required in respect of the quality- or outcomes-based element of blended payment.

How will services be paid for in the future?

Going forward, NELFT would anticipate moving from evidencing the implementation of outcomes to what the outcome measures can tell us about the patient experience and the efficacy of service provision.

Over the past few years there has been a significant improvement in clinicians' understanding of the importance of accurate record keeping. As a result, data quality has improved.

Learning points

- It is challenging to move to an outcome-based culture in an organisation that historically has been predominantly activity focussed.
- Having a consistent resource supporting this workstream has enabled the trust to embed its chosen approach to the point where clustering is seen as business as usual.
- There is now a better understanding of how long it takes to embed a process change – in this case, the introduction of clustering and the use of PLICs data to inform discussions with commissioners
- NELFT also appreciates that it can take time to establish a process that people have sufficient confidence in for financial flows to be attached to it.
- A better understanding of how the concept of mental health blended payment mechanisms fit in the new world of ICSs and the transformation of services is still needed.

We will be working with other mental health service providers and commissioners to develop further case studies of how they are implementing the blended payment approach.

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