2020/21 National Tariff Payment System

Guidance on the maternity pathway payment

November 2020

Contents

1. Purpose of this document

1. Section 7.3 of the 2020/21 National Tariff Payment System (NTPS)[1] sets out the rules for payment for maternity services. These state that the payment approach should either be:

   - a blended payment, involving fixed, risk share and outcomes elements
   - the maternity pathway payment.

2. 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/

3. The document *Guidance on blended payments* gives detailed guidance on the blended payment for maternity services. This document provides guidance on the maternity pathway payment.

4. During the development of the 2019/20 NTPS, NHS England and NHS Improvement identified that the maternity pathway payment covered some public health services which, under the Health and Social Care Act 2012,[2] should not be subject to national prices.

5. The maternity pathway payment covers an integrated package of care offered to pregnant women and their babies. The pathway includes a number of public health services commissioned by NHS commissioners by virtue of arrangements between the Secretary of State and NHS England under section 7A of the NHS Act 2006 ('Section 7A services'). These services are an established part of clinical practice and it is hard to separate out the costs of many of the Section 7A services from the care routinely provided during pregnancy and the maternal and neonatal screening and immunisation programmes the woman and newborn baby receives. In most cases, we do not have detailed costing information for these activities.

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

2 See, in particular, section 116(11) of the 2012 Act.

6. As such, the 2019/20 NTPS made all prices for maternity care were made non-mandatory. This was felt to be the most appropriate mechanism to maintain the integrity of the package of care provided to women and newborn babies.

7. It is important to note that this change was introduced solely to address the mix of services issue. The non-mandatory prices continue to be calculated using the costs associated with the delivery of the maternity pathways and are subject to the same adjustments for the cost base, cost uplift and efficiency factor as national prices.

8. This means that maternity prices are calculated to the same standard as nationally priced services. For the purposes of agreeing prices to be used locally, it would be reasonable to consider them as such. Providers and commissioners using the maternity pathway payment are strongly encouraged to use the non-mandatory prices as if they were national prices.

9. This approach is continued in the 2020/21 NTPS. Although commissioners and providers are required by tariff rules to use either the blended payment approach or the maternity pathway payment approach, the prices themselves under the pathway approach remain non-mandatory. Those prices are also available for commissioners and providers to use when calculating the blended payment, but again the specific unit prices are not mandatory.

10. The maternity pathway prices and supporting information on factors, definitions and technical information are available in the *Non-mandatory prices* workbook.

2. Agreeing prices for maternity pathways

2.1 Maternity pathway payments

11. Pathway payments are a single payment for a bundle of services[3] that may be provided by several providers for an entire episode or whole pathway of care for a patient. They are designed to encourage better organisation and co-ordination of care across a pathway and among different healthcare providers.

12. The maternity pathway payment system splits maternity care into three phases: antenatal, delivery/birth and postnatal. For each stage, a woman chooses her pathway provider, identified as the 'lead provider'. The commissioner makes a single payment to the lead provider of each phase to cover the cost of care.[4] The level of payment for the antenatal and postnatal phases depends on clinical factors that affect the intensity of care a woman and her well baby are expected to need. The birth episode payment is based on what happens during the birth.

13. Women may receive some of their care from a different provider for clinical reasons or because this is their choice. This is paid for by the lead provider, as it receives the entire pathway payment from the commissioner.

14. Table 1 sets out what is included and excluded from the three stages of the maternity payment system.

[3] 2012 Act, Section 117 provides that a bundle of services may be specified as a single service (ie a currency) to which a national price applies, where those services together constitute a form of treatment.

[4] Antenatal care for uncomplicated pregnancies www.nice.org.uk/guidance/cg62/chapter/guidance

Table 1: The maternity pathway payment system

Area	Included	Excluded
Admitted patient care	All activity against NZ*[5] HRGs (regardless of TFC)	All activity against non-NZ* HRGs (regardless of TFC)
Outpatient care	All activity against NZ* HRGs (regardless of TFC) apart from the identified exclusions All attendance activity against TFC 501 (obstetrics) and 560 (midwife episode) - includes **non-specialist** fetal medicine - includes any activity in emergency gynaecology or early pregnancy units that codes to 'NZ*' HRGs, even if before the antenatal assessment visit	All activity against non-NZ* HRGs (except with a TFC of 501 or 560) An attendance TFC other than 501 (obstetrics) or 560 (midwife episode) Emergency gynaecology and early pregnancy activity will normally code to TFC 502 or non-NZ* HRGs and will therefore be excluded **Specialist** fetal medicine
Antenatal education	Antenatal education activity	
Critical care		All maternal and neonatal critical care activity
Community/ primary care	All maternity community-based antenatal/postnatal care	All primary care activity applicable to payment under the GP contract. A woman may choose to have some of her maternity pathway delivered by her GP or for the practice to be the lead pathway provider, but any care delivered by the GP will be paid for under the GP contract

[5] NZ* denotes any HRG beginning with the code NZ.

Area	Included	Excluded
Scans, screening and tests	All maternity ultrasound scans, and all relevant maternal and newborn screening that is part of National Screening Programmes	The analysis elements of the screening process undertaken by specialist diagnostic laboratories under a separate commissioner contract Specialist fetal medicine
Immunisation	All specified immunisations of the newborn that should occur before handover to primary care	
Birth	The birth, irrespective of type and setting, with the specified exception	Births for women referred to a specialist centre identified as having an abnormally invasive placenta
Post-birth care	Well/healthy babies, both during the delivery module and pathway checks/screening during the postnatal module	Pathways for unwell/unhealthy babies. Babies requiring admitted patient care treatment will have their own admission record
Pre-pregnancy care		All pre-pregnancy/pre-conception care and reproductive services
Non-maternity care	Advice on risks in the context of pregnancy and referral to other relevant professionals where necessary for resolution (if possible)	All activity that is the named responsibility of other professionals or providers who receive payment to deliver that care for the population (eg drug and alcohol services, mental health services, stopping smoking services, weight management services, etc)

Area	Included	Excluded
Ambulance transfers		Any maternity care provided by an ambulance service
Accident and emergency		All unscheduled A&E activity
Clinical Negligence Scheme for Trusts (CNST)	CNST costs related to maternity	
High cost drugs and devices		All specified high cost drugs and devices not covered by national prices

3. Structure of the maternity pathway

3.1. Introduction

15. This section sets out guidance and business rules for each of the three pathways.

3.2. The antenatal pathway

16. The antenatal pathway[6] starts when the pregnant woman has her first antenatal appointment with her maternity provider, at around 10 weeks' gestation. It ends when the birth spell begins or at the termination or miscarriage of the pregnancy.

17. The level of the payment to the provider for the antenatal phase depends on the assessment at the first antenatal appointment and associated tests. From this assessment, women are assigned to one of three casemix levels: standard, intermediate or intensive. The level assigned is based on a range of clinical and social characteristics and history from previous pregnancies (factors).

18. The characteristics (factors) that determine casemix level and payment, and details of the technical information relating to the factors, are available in the *Non-mandatory prices* workbook.

19. A woman may have multiple factors during the antenatal phase. The following allocation rules apply:

    - If a woman has one or more of the 'intensive resource' characteristics, she is allocated to the intensive pathway, irrespective of any other factors.
    - If a woman does not have any of the intensive resource characteristics but has any one (or more) of the intermediate resource characteristics, she is allocated to the intermediate pathway. Irrespective of how many intermediate factors the woman has, this is the correct resource level allocated for her care.

[6] Any activity that takes place before the first antenatal appointment in an emergency gynaecology or early pregnancy unit, and which codes to an NZ* HRG, is included in the antenatal pathway and should not be invoiced separately from the pathway payment.

- If a woman does not have any of the listed characteristics, she is allocated to the standard resource pathway.

20. Some women develop complications during their pregnancy (or complications might be disclosed after the antenatal assessment appointment) that require higher levels of care than initially determined. The standard pathway price has been developed based on the reported average cost for women on the pathway. This takes into account changes in complexity for a proportion of women.

3.2.1. Pregnancies that end early

21. The antenatal payment is payable for all pregnancies that involve an antenatal assessment, regardless of when the pregnancy ends. The cost of obstetric/maternity-related healthcare activities (with an NZ* HRG or coded to TFC 501 or 560) for pregnant women whose pregnancy ends before the antenatal assessment **must not** be paid separately. In some cases of termination or miscarriage, depending on the healthcare requirements of the woman, a birth payment and/or a postnatal pathway payment may still be warranted.

22. Contracts must contain local outcomes and quality measures to incentivise reducing the number of avoidable pregnancy losses.

3.3. The birth episode pathway

23. The birth episode begins at the point of admission for birth or induction of labour and includes all postpartum care of women and their babies (unless the babies have identified health problems) until they are transferred to community postnatal care.

24. There are seven delivery pathway prices, including a setting-specific price for home births. The remaining six prices are mapped from HRGs, as set out in the *Non-mandatory prices* workbook.

25. Commissioners will only pay once per intrapartum episode, to the organisation that delivers the baby or babies. This organisation is the lead provider financially responsible for the whole intrapartum episode up to transfer of responsibility to community postnatal care. Where more than one provider shares the care (eg the woman delivers at one provider and another provides postpartum in-hospital care), it is the responsibility of the providers to agree a fair split of the income.

26. Home births continue to be collected in the admitted patient care other delivery event commissioning dataset (CDS) and are paid at the same rate as a normal delivery without complications.

27. An additional daily payment will apply for patients who stay in hospital longer than five days.

3.4. The postnatal pathway

28. The postnatal pathway begins after the woman and her baby or babies have been transferred to community postnatal care and ends after they have transferred to primary care and/or health visiting services.

29. This pathway follows the same format as the antenatal pathway, with three levels of casemix depending on the expected resource use − standard, intermediate or intensive. The level will usually be assigned when a woman is discharged after the delivery episode and is based on her specific health and social care characteristics collected at the antenatal booking appointment, which can be supplemented with information gathered over her pregnancy. For details of the postnatal risk factors, see the *Non-mandatory prices* workbook.

30. The commissioner will make one payment for all postnatal pathway care included in the scope, regardless of the care setting. When a woman chooses to use a different provider for an element of her postnatal care (an investigation, spell or appointment, etc) or is referred to a different provider for any reason, it is the responsibility of the lead pathway provider to pay the other organisation. If the woman and her baby are separated, eg for a social services removal, the lead provider is the one that accepted the woman and should agree a reasonable split of the payment with any other providers.

31. All postnatal care, as defined in NICE clinical guideline 37 *Postnatal care up to 8 weeks after birth*[7], including the six-week postnatal care review if undertaken by the maternity team, is included in pathway payments, even if maternity healthcare has already been transferred to primary care or a health visitor. There is no defined time period for provision of community postnatal care by the maternity team.

[7] www.nice.org.uk/guidance/cg37

32. There are some specific exceptions for postnatal complications, which should be paid for based on the relevant HRGs. NICE guidance identifies the following complications as requiring immediate urgent acute care:

    a. postpartum haemorrhage

    b. genital tract sepsis

    c. venous thromboembolism

    d. breast mastitis, abscess

    e. postnatal wound infection requiring surgery

    f. pulmonary embolism.

33. Payment will be claimed in the usual way from local commissioners. If these complications are identified before discharge from hospital after the birth, they are included in the birth payment.

34. Commissioners and providers should determine whether any activities during the maternity pathway could reduce the incidence of such complications, or whether any local policies contribute to the incidence of complications. CQUIN or Quality, Innovation, Productivity and Prevention (QIPP) programme indicators could be developed locally.

35. Commissioners should introduce local outcome and patient experience indicators to ensure high quality care and that the timing of responsibility handover is safe.

3.4.1. Arrangements between providers

36. A woman may receive some of her care from a provider other than her lead provider for clinical reasons or because this is her choice. In this case, the lead provider that received payment from a commissioner will need to pay the other organisation. This also applies if a pregnant woman needs care from another NHS provider while she is on holiday or unable to access her lead pathway provider.

37. Further guidance[8] has been published on the nature of the arrangements between the providers and on information flows.

[8] www.gov.uk/government/publications/maternity-pathway-payment-system-guidance-for-nhs-providers-and-commissioners

38. Prices must be agreed between the two providers. For some activity, non-mandatory prices are provided in the *Non-mandatory prices* workbook. These are a guide to the amounts to be invoiced and paid between providers. Providers should be proportionate and fair in invoicing the lead provider. Providers must not invoice local commissioners for NZ* HRGs or TFC 501/560 activity or elements of maternity care costs. In the case of doubt, help can be sought from Commissioning Support Units or Data Services for Commissioners Regional Offices to establish which organisation is the lead provider.

39. The amount invoiced should reflect the primary reason the woman accessed an alternative maternity provider. For example, if this was for an antenatal obstetric opinion, the antenatal clinic attendance should be invoiced, irrespective of whether the woman was subsequently referred on for additional investigations.

40. In certain cases, a woman may change her lead antenatal provider. This should lead to a transfer of funding between the two providers. The proportion of the pathway payment remaining unspent at the time of transfer depends on the stage of pregnancy the woman has reached (see Table 2). This table was developed through analysis of the pathway costing data provided by NHS trusts and foundation trusts and input from our clinical advisors.

Table 2: Proportion of pathway price to refund or transfer on change of pathway provider

Gestational age	% of the antenatal MPP by gestational age	% of the total antenatal MPP retained by lead provider
5–15+6 weeks	26%	26%
16+0–20+6 weeks	19%	45%
21+0–24+6 weeks	7%	52%
25+0–30+6 weeks	14%	66%
31+0–35+6 weeks	14%	80%
36+0–40+6 weeks	14%	94%
≥41 weeks	6%	100%

41. A new provider may choose to reassess the woman's pathway at the time of transfer. If the new information suggests that a higher resource pathway would be applicable, the pro-rata payment must be based on the value of the higher resources pathway.

42. When a woman changes both commissioner and provider (eg if she moves to a new house), any refunds to the original commissioner (by the original lead provider) are based on the original categorisation at the antenatal assessment appointment. For example, if the original pathway was standard, the proportion of refund is based on the standard payment price. The payment by the new commissioner to the new lead provider, however, will be based on the latest information and may be a proportion of the higher resource pathway. Examples are provided in Table 3 below to aid understanding of this issue.

Table 3: Examples of transfer scenarios[9]

Action/activity	Consequence
Example 1	
Woman categorised as standard care based on antenatal assessment appointment information	Payment of, for example, £1,200 for standard antenatal care by commissioner A to provider A after antenatal assessment appointment
Woman develops gestational diabetes week 23	Onset of gestational diabetes (one of the intensive factors)
Woman moves lead provider in week 29, no change in commissioner	Change in provider
Payment transfer	Lead provider A pays 33% of intensive price (eg £3,000 * 33% = £1,000) to lead provider B
Example 2	
Woman categorised as standard care based on antenatal assessment visit information	Payment of, for example, £1,200 for standard antenatal care by commissioner A to provider A after antenatal assessment appointment

[9] Please note: this example does not use actual prices.

Action/activity	Consequence
Woman develops gestational diabetes week 23	Onset of gestational diabetes (diabetes is one of the Intensive factors)
Woman moves house in week 29, new provider and new commissioner	Change in commissioner and provider
Refund	Provider A refunds 33% of standard payment of £1,200 to commissioner A = £400
New payment	Payment of 33% of intensive payment (eg £3,000 * 33% = £1,000) from commissioner B to provider B

3.5. Information flows for the antenatal and postnatal pathways

43. The Maternity Services Data Set (MSDS) has collected data since April 2015. More information on data collection and reporting can be found on the NHS Digital website.[10]

[10] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set

Contact us:

NHS England and NHS Improvement

Wellington House
133-155 Waterloo Road
London SE1 8UG

improvement.nhs.uk
pricing@improvement.nhs.uk

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Publishing Approval Reference: