Guidance on blended payment for emergency care

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https://improvement.nhs.uk/resources/national-tariff-1920-consultation/

Contents

1 Background

As set out in *Payment system reform proposals for 2019/20*, we propose to introduce a blended payment system for emergency care services in the 2019/20 National Tariff Payment System (NTPS). We propose redesigning how the payment system works for emergency care to:

- 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.

Where local health systems have already moved – or in future agree to move – to a different payment system as part of a move away from an episodic reimbursement system, they would be able to maintain or adopt this approach, as now, by using the provision in the tariff rules for local departure from the default approach, as set out in the local pricing rules.

2 What is a blended payment for emergency care?

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

Providers and commissioners should work together to agree realistic forecast levels of activity for emergency admissions, A&E attendances and ambulatory/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 would then be used to calculate the fixed payment by applying the 2019/20 HRG prices for emergency activity 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, commissioner 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. Further details will be contained in the 2019/20 dispute resolution guidance.[1]

This total fixed payment for emergency care would be the baseline to which the variable payment would apply. Where actual priced activity (based on activity x HRG price or local price) is higher than the forecast level of priced activity which forms the fixed payment, the provider would receive 20% of the difference between the fully priced value (based on activity x HRG price or local price) of this activity and the agreed fixed amount. Where priced activity is below the forecast level of priced activity, the provider would retain 80% of the difference between the fixed payment and the fully priced value of this activity.

As set out in the operational planning and contracting guidance for 2019/20, the contract value 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. However, the variable payment will apply from the agreed forecast level of priced activity (that is, before the MRET and 30-day readmission adjustments are made). Further detail on how the removal of these rules should be funded is set out below.

3 Marginal rate emergency rule

We propose to remove MRET for the 2019/20 NTPS.

As outlined in the NHS Operational Planning and Contracting Guidance 2019/20, providers would be eligible to receive additional central income equal to the MRET value confirmed by providers and commissioners as part of the Autumn 2018

[1] See: www.england.nhs.uk/nhs-standard-contract/

exercise. Control totals will be 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.

4 Emergency readmissions within 30 days

We propose to remove the 30-day readmission rule for the 2019/20 NTPS.

Currently, where money is retained from not paying for emergency readmissions, this 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 financial impact of removing the 30-day readmissions rule would form part of the activity and financial baseline for the blended payment approach. Providers and commissioners should have due regard to the values in the Autumn 2018 exercise combined with any subsequent actions when agreeing the appropriate volume and value of activity included in the blended payment baseline.

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

5 Scope of activity in the blended payment

The following activity which would be within the scope of blended payment is:

- all emergency admissions (admission method code 21-25, 28, 2A-2D[2])
- emergency admission excess bed days
- 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 ambulatory/same day emergency care activity, even if this is currently being coded as something other than an emergency admission or A&E attendance

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

- activity that is not currently nationally priced but meets those criteria.

All other activity would be excluded, specifically:

- all other admission methods
- specialised commissioned services,[3] both elective and non-elective
- all unbundled elements, such as critical care spells associated with emergency admissions and high cost drugs and devices.

Locally priced services included in the blended payment would need local prices to be agreed as normal, with regard to the local pricing rules as set out in the NTPS.

Ambulatory/same day emergency care is included in the scope of the blended payment to incentivise use of same day emergency care where clinically appropriate to do so.

There is a variable picture for how ambulatory/same day emergency care services are currently being recorded and paid for. Approaches include:

- using national prices for zero-day length of stay emergency admissions (with any short stay adjustments and MRET applied)
- using national A&E prices
- agreeing local prices
- recording the activity as an outpatient attendance as part of a ‘hot’ clinic.

We are therefore proposing that ambulatory/same day emergency care is included within the blended payment on whatever basis is currently being used to record this activity. Inclusion within the blended payment should mean payment for ambulatory/ same day emergency care is more straightforward to implement than at present.

Providers and commissioners should agree how this activity is currently being 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

[3] Services commissioned by NHS England Specialised Commissioning are excluded from blended payments as a default. However, we propose that MRET for these services would still be removed. In addition, planned level of activity should take into account the NHS England Specialised Commissioning Identification Rules, which are which are currently being updated. These changes will be finalised by the end of February to allow any relevant activity to be included in the agreed plans prior to contract signature.

partners to create a consistent approach to reimbursing ambulatory/same day emergency care activity in future tariffs.

6 Best practice tariffs

Changing the default payment system for emergency care to a blended approach would mean 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 are proposing to change the way BPTs are operationalised to fit into the blended payment system.

We propose to remove 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

We propose that commissioners and providers should agree activity levels for services which attract BPTs as part of the fixed element of the blended payment. 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 as an additional payment.

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.

7 Threshold

We propose to set 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 would continue to be made on an episodic basis, using the emergency care prices set out in Annex DtA.

The £10 million amount would include all elements of the blended payment (see Section 5) as well as MFF adjustments and expected BPT attainment rates but before the deduction of the MRET and 30 day readmission values.

Providers and commissioners could 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 make adjustments 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 being mandated nationally as part of the blended payment, but could be agreed via a local variation.

8 Break glass

In *Payment system reform proposals for 2019/20*, we proposed that contracts would include a ‘break glass’ clause which applies when activity is significantly higher or lower than assumed and requires the emergency care payment elements of the contract to be reviewed and potentially renegotiated.

We have analysed previous plan data alongside outturn activity levels and found there is 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 clause based on nationally available data.

We therefore propose that local areas will be required to set a break glass clause, and the level of actual priced activity at which a break glass clause is activated. These are to be agreed locally and set out in each contract. If areas agree that a break glass clause is not needed as part of their contract agreement, then this should be specified, but the default position should be that one is included within contracts.

The break glass arrangements would 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 commissioners could agree if the break glass threshold is reached. We are however proposing a default position, so that, unless the commissioner and provider agree otherwise, the break glass clause 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 would 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.

NHS England will provide model contract wording which providers and commissioners may use to describe the break glass arrangements.

9 Duration of blended payment

We propose that the 2019/20 NTPS will be valid for one year, from April 2019. We would 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 over-estimate of activity in any one tariff cycle is not hard-wired into contracts in future.

Appendix 1: Case studies – adopting a blended payment approach for emergency care

Our proposals for blended payment approaches were 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 two case studies of the work done in Berkshire West and Fylde Coast.

Berkshire West

For the financial year 2018/19, Berkshire West CCG (BWCCG) and Royal Berkshire 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 aforementioned 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 a number of benefits following the change in payment approach:

- Contract review meetings between BWCCG and RBFT have moved from monthly to every other month.
- There has been a reduced monthly challenge process between CCG and RBFT. 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).
- The payment approach has enabled a business case to be developed to reconfigure how the local commissioning support unit provides more value adding service, reducing transactional costs in BWCCG, with RBFT also realising resource efficiencies.

Fylde Coast

For the financial year 2018/19, commissioners from the Fylde Coast CCGs (NHS Fylde & 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 prior to 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.

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