

# **Guidance on blended payment for emergency care**

**A joint publication by  
NHS England and NHS Improvement**

March 2019

Classification: Official

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Version number: 1

First published: March 2019

Updated:

Prepared by: NHS England and NHS Improvement joint pricing team

Classification: OFFICIAL

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## 1 Background

In the 2019/20 National Tariff Payment System (NTPS) a blended payment system is the default payment approach for emergency care services (see Section 7 of the 2019/20 NTPS). NHS England and NHS Improvement have redesigned 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 are able to maintain or adopt this approach by using the provision in the tariff rules for local departure from the default approach, as set out in the new rules.

## 2 What is a blended payment for emergency care?

A 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 2019/20 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/ICSSs 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 2019/20](#),<sup>1</sup> 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 should be funded is set out below.

See [Appendix 1](#) for a worked example of how a blended payment might be agreed and operated.

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<sup>1</sup> [www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting/](http://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting/)

### **3 Marginal rate emergency rule**

We have removed MRET for the 2019/20 NTPS.

As outlined in the [NHS Operational Planning and Contracting Guidance 2019/20](#), 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.

### **4 Emergency readmissions within 30 days**

We have removed the 30-day readmission rule for the 2019/20 NTPS.

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.

## 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<sup>2</sup>](#))
- 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 same day emergency care (SDEC) activity, even if this is currently being coded as something other than an emergency admission or A&E attendance
- activity that is not currently nationally priced but meets those criteria.

All other activity is excluded, specifically:

- all other admission methods
- specialised commissioned services,<sup>3</sup> 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 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.

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<sup>2</sup> Please see the NHS Data Dictionary for more details  
[www.datadictionary.nhs.uk/data\\_dictionary/attributes/a/add/admission\\_method\\_de.asp](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp)

<sup>3</sup> Services commissioned by NHS England Specialised Commissioning are excluded from blended payments as a default. However, MRET would still be removed for these services.

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.

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 ambulatory/same day emergency care activity in future tariffs, building on the work underway to record SDEC activity as a Type 5 A&E service.

## 6 Best practice tariffs

Changing the default payment system for emergency care to a blended approach 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 system.

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 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

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 2019/20 NTPS.

The £10 million amount includes all elements of the blended payment (see Section 5), including market forces factor (MFF) adjustments and expected BPT attainment rates, 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.

## 8 Break glass

In [Payment system reform proposals for 2019/20](#), we suggested that blended payment contracts could 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.

Providers and CCGs are therefore required to set a break glass clause locally (unless they consider one is not required), as well as the level of actual priced activity at which the clause is activated. These details should be 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. However, the default position should be that one is included within contracts.

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 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 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.

## **9 Duration of blended payment**

The 2019/20 NTPS has been set for one year, taking effect from 1 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 overestimate of activity in any one tariff cycle is not hard-wired into contracts in future.

## Appendix 1: Blended payment worked example

### Agreeing the blended payment

#### *Step 1: Agreeing activity baseline*

- Based on analysis of historic levels of activity, including forecast outturn for 2018/19, provider and CCG agree a baseline level of activity for 2019/20 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 2019/20 NTPS (or local prices if agreed) to generate the value of planned activity that form the basis of the 2019/20 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.

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- 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)

## Appendix 2: Case studies – adopting a blended payment approach for emergency care

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 two case studies of such work in Berkshire West and Fylde Coast.

### 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 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 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.

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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.

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NHS Improvement publication code: CG06/19

NHS England Publishing Approval Reference: 000298