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PbR: Are we up to the mark?

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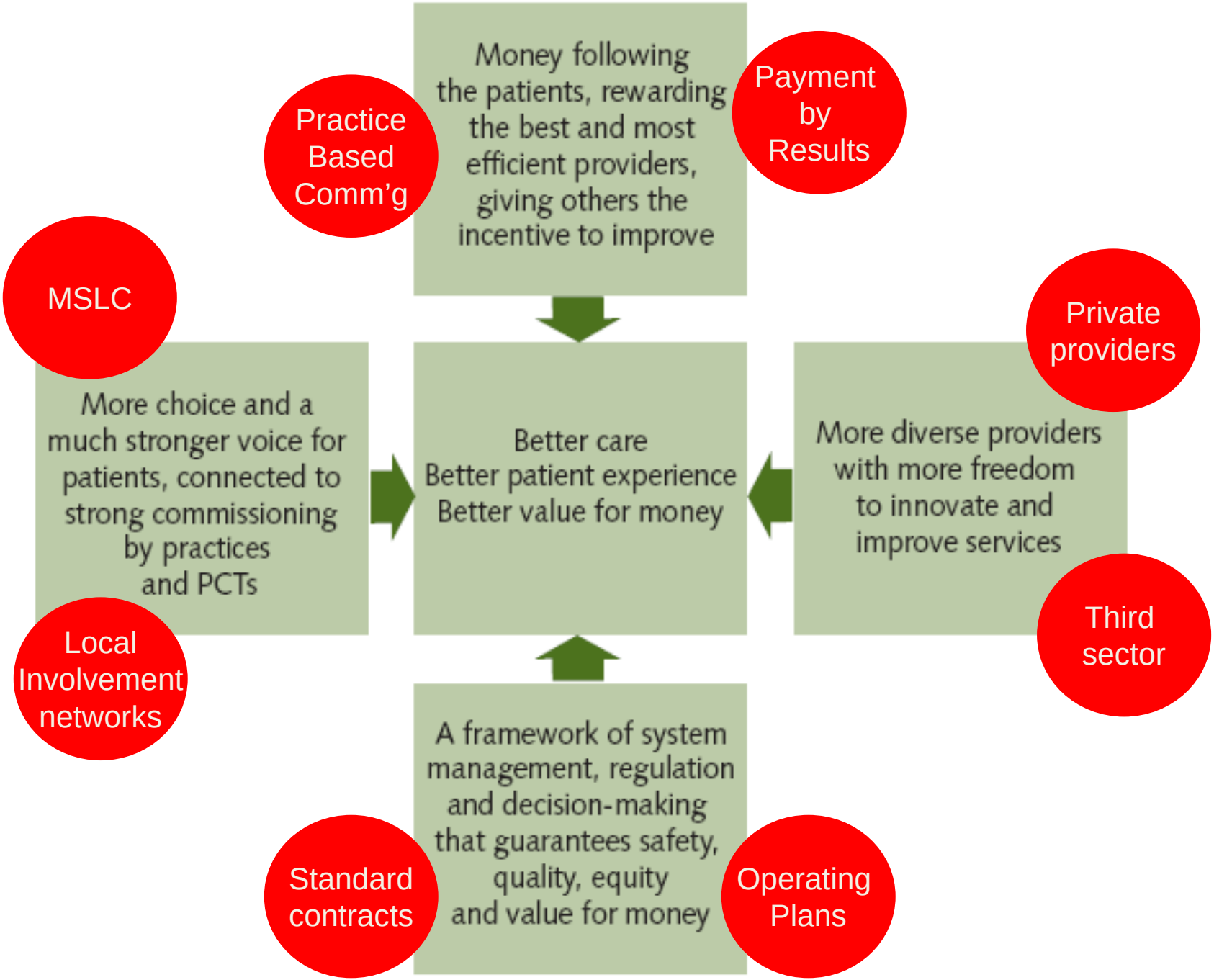
Aims of today

- Why do you need to know about commissioning?
- The importance of the relationship between midwifery services and commissioner
- Commissioning is about more than PbR
- Prepare to negotiate on the basis of a common understanding

What is ‘commissioning’?

‘*Any activity designed to ensure that services provided for children and young people and their families are the best possible services to meet their needs, consistent with available resources and priorities and not just those which have been provided in the past or which have developed in an ad hoc or uncoordinated way*’


Money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve
Practice Based Comm'g
Payment by Results
MSLC
More choice and a much stronger voice for patients, connected to strong commissioning by practices and PCTs
Local Involvement networks
Better care
Better patient experience
Better value for money
Private providers
More diverse providers with more freedom to innovate and improve services
Third sector
A framework of system management, regulation and decision-making that guarantees safety, quality, equity and value for money
Standard contracts
Operating Plans

Challenges for maternity commissioning

- Variety of quality standards
- Historic investment
- High public profile
- Specifying services
- Demographics
- Workforce

Building sustainable maternity services

- Clear strategic vision
- Link inputs to outcomes
- Ensure ‘appropriate’ resources go in from commissioner
- Ensure value-for-money through demonstrable productivity by provider
- A shared plan B

Working together

- Agree joint strategy/delivery plan
- Set the standards
- Short position statements
- Pragmatic appraisal of need
- Regular contact
- Attendance at MSLC
- Participation at SHA/networks
- Get things done!

Commissioning timescale

SDOs* compiled	Strategic Plan agreed	SDOs* Initial prioritisation	PbR tariff/ budget allocations	Draft Op.Plan & targets	Contracts agreed	Operating Plan agreed	Monitoring & review

- Service reviews
- LIT/Task & Finish groups
- MSLC/LINks
- National Strategy
- Health needs assessment

- Activity
- Finance
- Quality

*Service Development Opportunities (bids)

PbR and relation to Commissioning

- Activity
  - Describing ‘what’ is provided
  - Quantifying ‘how much’ is provided
- Spend
  - PbR Income
  - Non-PbR Income
- Outcomes
  - Measurable
  - Targets vs. other important

Describing your case mix

Low Risk Medical & Low Risk Social ❖Universal provision ❖Midwifery led care ❖NICE antenatal & guidance postnatal	Low risk Medical & High Risk Social ❖Enhanced midwifery led care ❖Strong links to Children's Centres and coordinated community support services
High Risk Medical & Low Risk Social ❖Obstetric led care with midwifery input	High Risk Medical & High Risk Social ❖Obstetric led with enhanced midwifery input and coordinated specialist support/services

Understanding your case mix

- Teenage pregnancy known to social services, drug user: booking appt + 8 further scheduled a/c + 3 home visits for defaulting + case conference + admitted to labour ward x 3 + SVD
- Previous intrapartum stillbirth, placental abruption, hypothyroidism: booking + 14 scheduled antenatal appts + admitted to day assessment x 9 + 1 home visit + C section + 5 postnatal visits
- Healthy supported woman having second child: booking visit + 7 antenatal + SVD

Audit of a London Trust 2009

- 1122 deliveries to women in XX PCT (a further 2,000 deliveries to women in other PCTs)
- 1702 women booked
- 14059 FUs recorded (8 per woman)
  - 48% with a midwife
  - 21% with a GP
  - 19% with an obstetrician
  - 12% other professionals or unknown

Benchmarking local units

	Trust A	Trust B	Trust C	Trust D
Av obstetric input per delivery	1	3.5	3.7	1.9
Ratio N12s: births	1: 1.25	1: 1.8	1: 1.1	1: 3.4
Normal births with complications	63.5%	91.5%	96%	71%
Spend per delivery	£3275	£2940	£4343	£2820

PbR - Recap the principles

- Way of paying for services using a national price list - “tariff”
- Providers are paid according to activity
- Activity x Price = Income
- Moves away from block contracts
- Applies to all NHS Trusts that have contracts with PCTs

Getting the best out of PbR

- HRGs and the local block contracts arrangements - do they make sense?
- Reference costs - how are they constructed and do they make sense?
  - Accuracy and efficiency
- Can you spot perverse incentives and historic under funding?
  - Moving from block to activity based for community
- Can you accurately describe case mix?
- How good is you record keeping?

Data you need to know (1)

Activity	Threshold	Code
Booking	Deliveries + 20%	560 1st
Routine scanning (dating + anomaly)	Bookings x 2	560 FU
Additional scans	To be agreed	501 FU
Obstetric 1st appointments	Identified high risk population	501 1st
Midwifery antenatal FU in clinical setting	NICE	560 FU
Midwifery antenatal FUs in women's homes	NICE	To be agreed
Antenatal and Postnatal telephone contacts	To be agreed	To be agreed
Antenatal assessment where woman is NOT admitted	Local benchmarks	501 1st
Antenatal assessment where woman IS admitted	Local benchmarks	NZ04A - NZ09

Data you need to know (2)

Activity	Threshold	Code
Deliveries Normal; assisted & C-section With or without complications	 Nat av as min To be agreed	 NZ01A -NZ03C
Excess bed days	Local benchmarks	NZ01A - NZ03C
Readmission rates Maternal and infant	Local benchmarks	
Postnatal contacts in clinical settings	NICE	560 FU
Postnatal care in women's homes	NICE	To be agreed
Parentcraft	All primips	To be agreed

Measuring your outcomes

- Targets
  - PSA targets
  - Maternity Matters Targets
- Local key performance indicators
  - % women booking by 12 weeks
  - % women receiving continuity of care antenatally
  - % of FGR detected
  - % women quitting smoking
  - % women breastfeeding
- CQUIN
  - Patient satisfaction
  - Continuity antenatally and postnatally
  - Closure of unit
  - NICE compliance
  - Births to term
  - Reduction in C-section

Maternity providers are from Venus and commissioners are from Mars?

Questions for providers

- What is in your PCTs Operating Framework for maternity?
- Has your PCT go a service specification for maternity?
- Who has set the PCT's PSA trajectories?
- Who is developing the CQUIN targets?
- What competencies has the PCT identified for WCC and how do these relate to maternity?

Questions for PCTs

- What do you actually commission?
- How much do you commission?
- How much do you spend and how do you know whether it is sufficient?
- What impact will HRG4 have on maternity spend?
- How do you measure outcomes?